
BETWEEN THE ACTS

**Community mental
health services
1959–1983**

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Preface

This work arose from a meeting in 1981 of a Working Group newly convened by the Nuffield Provincial Hospitals Trust to examine factors that might be associated with varying degrees of success or failure in the implementation of health services policies. In the early nineteen-sixties I had been involved in the study of some of the pioneering developments in community-oriented mental health services. Although my main research interests had shifted away from that field in the intervening years, I was fairly clear that the hopes of those early years had largely failed to materialize. It seemed to me that it would be useful to assess more accurately the changes that had actually taken place and, to the extent that there was indeed a discrepancy between early hopes and subsequent achievement, to consider what the underlying factors may have been. The suggestion of a study on these lines was warmly welcomed by the Working Group and by the Trustees.

The first five chapters of this book summarize the main trends in hospital and community services for mentally ill people during the period between the Mental Health Act of 1959 and the Amendment Acts of 1982/83, and take account of major official documents, administrative changes and some influential shifts in ideas. Chapters 6 to 9 are based upon the assumption that to understand what happened—and even more, what did not happen—during that period it is necessary to evaluate the roles of certain key professions, and accordingly examine the changes that occurred in social work, community psychiatric nursing, general medical practice, and

psychiatry, their preoccupations, pressures, and priorities. To get these into perspective, it has generally been necessary to begin each chapter with a review of the condition of the profession in question in the few years immediately preceding the 1959 Act. Chapter 10 discusses briefly the work of some of the major voluntary organizations involved in mental health services. Throughout these chapters I have concentrated on provision for mentally ill and emotionally disturbed people, and have deliberately not dealt with the rather different history of services for the mentally handicapped. Chapter 11 describes recent developments in a number of areas where, often contrary to the general trend, interesting and forward-looking community provisions have been created. The final chapter speculates about the causes of the observed shortcomings, reviews some very recent proposals for remedying the defects, and asks what affect the newest trends in the management of the National Health Service are likely to have on the growth of community services for mental illness.

My very grateful thanks are due to the Trustees of the Nuffield Provincial Hospitals Trust and to Gordon McLachlan in particular for their support of this work, and to the members of the Working Group on Critical Factors on Policy Implementation for their interest and encouragement; among the members of a group with which it has been a great pleasure to work I should like especially to thank my former colleague Stuart Morrison. Isobel Macpherson worked assiduously at extracting statistical information and scrutinizing the literature, Margaret Brown has been a dedicated secretary, and Kathleen Murray has meticulously read and commented on each chapter; I am deeply grateful to each of them. It will be obvious to any reader that this book is in many ways a highly personal statement, for which no-one but the author should be held responsible.

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Glasgow, February 1984.

1

Trends in practice and policy

Preludes to change

The promotion of 'care in the community' as the preferred objective of government policy for the mentally ill flowed from the convergence in the late 1950s of several different trends and developments. Clinical innovations, administrative and legal changes, advances in professional and in public attitudes played parts which are separately identifiable, even though it may be impossible to assign a precise weighting to the influence of any one of them.

Chlorpromazine and reserpine are often seen as the principal initiators of the trend which is the central concern of this chapter and around which discussion of the problems of community care has largely revolved—that is, the steady reduction in the resident population of the psychiatric hospitals. The first specifically psychotropic drugs came into general use in 1954–5, and it was in the latter year that the first sign of a fall was observed—a fall, that is, not in the numbers admitted for treatment, for these continued to increase steadily, but in those enumerated as 'occupying beds' in mid-year or end-of-year censuses. Some writers have questioned whether the early tranquilizers were indeed directly responsible for this early contraction, pointing out that a similar fall in numbers had begun in American mental hospitals a year before their introduction, while in Scotland there was an interval of about three years between take-up and the first indication of any decline. It is undeniable that other relevant influences both preceded and ran in parallel with new

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therapies, but in the longer term it is very highly improbable that the discharge of established long-stay patients could have been maintained or the length of stay of newly-admitted patients could have been brought down and kept down, had it not been for the efflorescence of psychotropic drugs during the period under review.

Some of the relevant influences were already well established in varying proportions of mental hospitals before the pharmacological revolution. Since the introduction of ECT in the 1930s there had been a gradual increase in the number of voluntary admissions (first made possible in public hospitals in England and Wales by the far-sighted Mental Treatment Act of 1930) and a shift in the role of the mental hospital from that of essentially custodial institution to one which strongly emphasized active treatment measures. That shift was quite dramatic in some establishments, decidedly tentative in others; but overall it came more and more to be recognized that psychiatric treatment could alleviate if not cure many types of disorder, and as a result general practitioners began to lose their reluctance to send any but their most severely disturbed patients to the mental hospital. As admissions rose, their numbers inevitably included a higher proportion of patients whose illnesses were at a sufficiently early stage to be susceptible to treatment, and the mental hospital began increasingly to justify its dawning reputation as a therapeutic centre.

The incorporation of mental hospitals into the administrative framework of the National Health Service reduced the isolation of psychiatry from other branches of medicine and probably helped to reduce the stigma of mental illness. Voluntary admission soon became the rule rather than the exception; during the decade between the inauguration of the NHS and the passage of the Mental Health Act mental hospital admissions increased by about 80 per cent, but the proportion of compulsory admissions among them fell from 40 to 12 per cent of the total. Locked wards began to diminish in numbers, and in some exceptional institutions disappeared altogether, with no untoward consequences. The padded cell and the straitjacket became reserved for one of the less glorious chapters in the history of the treatment of the mentally ill.

Another significant trend of this period was a slowly growing recognition among psychiatrists of the importance of the social context of psychiatric treatment. This viewpoint developed independently of the pharmacological and biochemical approaches to

mental disorder, and was sometimes thought of as an alternative to them. The concept of the mental hospital as a 'therapeutic community' was influenced by theoretical and experimental work in the social sciences and by some of the achievements of military psychiatry during the Second World War. It sprang from the assumption that the course of the patient's illness might be influenced by his social milieu no less than by the strictly medical treatment he received. To transform a traditional or even a thoroughly up-to-date mental hospital into a therapeutic community in the full sense proved to be an extremely difficult undertaking, demanding profound changes in attitudes, behaviour, and relationships on the part of hospital staffs at every level, with the concomitant surrender of many established and anxiety-containing institutional supports. It is not surprising that there were few examples of completely successful achievements of this kind. In a modified form however the concept spread, its diffusion aided by the growing recognition that the social and clinical deterioration of long-stay psychiatric patients was often a product of their institutional treatment rather than an inevitable consequence of the primary illness. But a growth of interest in the social rehabilitation of long-stay patients was encouraged principally by practical considerations which stemmed from the rising admission rate.

In the typical mental hospital of the 1950s, virtually all the active work with new patients went on in a handful of wards, while a large majority of all beds were occupied by patients who had been in residence for a long time—sometimes a very long time. As the pressure on overcrowded hospitals continued to grow, ideas about industrial therapy and rehabilitation found support among a number of medical superintendents, though it could not be said that their impact was comparable in scale to that of the new drugs that were simultaneously becoming available.

Outside the hospital, there were some significant developments in the years preceding the Mental Health Act. The most important of these was the growth of psychiatric out-patient services. First established by local authorities under powers conferred by the 1930 Act, their development had been greatly stimulated when the NHS Act transferred clinical responsibilities to the new Regional Hospital Boards. The number of new patients seen annually at psychiatric clinics, whether as a preliminary to admission, for active out-patient treatment or for diagnosis and referral back to the general

practitioner, rose by 50 per cent from about 90,000 in 1949 to about 140,000 ten years later. Local authority services for the mentally ill were few and far between. When they lost their mental hospitals to the Regional Hospital Boards, local health authorities acquired instead a statutory responsibility for the initial care and removal to hospital of persons dealt with under the Lunacy and Mental Treatment Acts, together with permissive powers in respect of the prevention, care, and after-care of all types of illnesses, so far as this was not otherwise provided for. The latter powers were rarely used in the field of mental illness. There were a few outstanding medical officers of health who built up valuable community-based services, but by the end of the 1950s only one English local health authority in six had either engaged a psychiatric social worker or designated one of its medical officers with a special responsibility for mental health services.

New legislation

The Mental Health Act of 1959 followed on the report of a Royal Commission on the Law Relating to Mental Illness and Mental Deficiency that had begun work under the chairmanship of Lord Percy some five years earlier. At that time the Lunacy Act of 1890, though modified in many ways by subsequent legislation, was still in force, and there was a general sense that the time was ripe for a major review of the statutory basis of provision for both patient groups. The Royal Commission began its deliberations to the accompaniment of a non-partisan debate in the House of Commons which concentrated less on legal questions than on matters of staff shortages, overcrowded and out-of-date hospital accommodation, and lack of public awareness.

In its report, delivered in 1957, the Commission summarized the existing law and procedures and put forward a series of recommendations. The most important of these were that mental hospitals should no longer be specially designated so that in principle any patient might be treated in any hospital—it was recognized, of course, that specialization of function would continue, but this should no longer be based on legal necessity; that mentally ill and mentally subnormal patients should, wherever possible, be admitted to and discharged from hospital, like any other patients, without special legal formalities of any kind; that where compulsion was

unavoidable the necessary certificates should be those of two doctors, normally the family practitioner and the hospital psychiatrist, and not a magistrate's order; and that the responsibilities of the Board of Control should be taken over by the Ministry of Health, with the new regional mental health review tribunals accepting responsibility for investigating cases of alleged wrongful detention.

The report gave some attention to the role of the local authority. This was identified as the provision of a wide range of services for patients who did not need medical or nursing treatment. The services in question should include preventive work, residential care for a variety of patient groups, and general social support; 'social help and advice should be available to all patients and to their relatives'.

The Mental Health Bill, introduced into Parliament in December 1958, contained 146 clauses and eight separate schedules. It repealed the whole of 15 earlier Acts and parts of 37 others, substituting a common legal code, covering both mental illness and mental subnormality, for a tangled mass of legislation. Kathleen Jones contrasts the debate on the second reading in January 1959, when 'the House showed itself alert, interested, and exceedingly well informed', with the muddle and lack of basic knowledge displayed in the debate five years earlier. She adds 'Perhaps this is as good an index as any other of the change in public opinion which had taken place in the intervening years.' The Bill itself reflected the major recommendations of the Royal Commission's report, and although the parliamentary debates brought forward a number of amendments these were essentially matters of detail and did not involve any significant change of principle.

Although the Mental Health Act should be regarded as a major advance in building an appropriate legal and administrative foundation for the mental health services, there was one major policy objective which it was not particularly well designed to promote. In introducing the second reading of the Bill, the Minister of Health had observed that 'One of the main principles we are seeking to pursue is the re-orientation of the mental health services towards care in the community.' But although the patchy and for the most part very unimpressive records of the local authorities who should be responsible for such care was emphasized in the debate, there had been a firm government decision that there should be no earmarked grant specifically for the development of these services. The new Act set out the existing powers of local authorities in some detail, but it conferred

no new obligations upon them. There were no very obvious grounds for optimism as to the response that might be expected of local authorities should the demand for community services increase, but to gain a clearer impression of their intentions the Minister of Health invited the County Councils and County Borough Councils to submit an account of their current provisions for mental health services and of their proposals for expanding them over the next three years.

The local authority returns could have done little to increase confidence. On the mental subnormality side, where there was a good deal of experience to draw upon, the proposals were on balance appreciably better defined than in the far less familiar area of the community care of the mentally ill. Such problems as the nature and extent of the needs of patients and their families, and the types of service and of staff best suited to meet those needs seemed to have been adequately considered only in exceptional instances. For the most part, the statements of intent with regard to change in staffing, to ensuring training opportunities for existing staff, to providing residential and day-care facilities, were couched in vague and general terms and with a minimum of firm commitment. It was obvious that on the local authority side there was little enthusiasm to contribute new solutions nor even any deep awareness of what the problems of community care were likely to involve. It is a sad commentary on the lack of initiative and imagination which characterized a large section of the public health services in the years after the transfer of local authority hospitals to the new NHS that so few were prepared to respond to the challenge of this new policy initiative. If this did not augur well for the new policy, at first no more than a formula expressed in very broad terms, events that were soon to follow created a heightened sense of the likely disparity between needs and provisions.

The Hospital Plan

Early in 1961 Geoffrey Tooth and Eileen Brooke, respectively a medical officer on the staff of the Ministry of Health and a statistician, published a paper in the *Lancet* on 'Trends in the mental hospital population and their effect on future planning'. It was a succinct essay in extrapolation. The authors recognized two principal problems in estimating future bed requirements for mental illness: at

what rate might the existing long-stay population of the mental hospitals be expected to dwindle away, either by death or discharge, and how many beds would be needed by future patients—short-stay, medium-stay, and long-stay? They attempted to solve the first problem by recording the experience, over the period 1955–9, of those patients who at the end of 1954 had been continuously resident in hospital for more than two years. There had been 112,000 such patients, occupying about three-quarters of all designated mental hospital accommodation, but by the end of five years their numbers had been reduced by death and discharge to less than 78,000. If the same rates prevailed, none of the long-stay patients who had been resident in hospital at the end of 1954 would remain there after about 16 years.

Bed requirements for future short-stay cases (up to three months) and for medium-stay cases (three months to two years) were assessed by calculating the duration of stay of patients admitted in the mid-fifties, with upward adjustments to allow in particular for the substantial increase in admissions between 1956 and 1959. It was assumed that there would be a gradual build-up of new long-stay patients; recent experience suggested that over 15 years the need for such beds might gradually rise to about 0.89 per 1000 population and thereafter remain constant. Overall, therefore, it should be possible within 15 or 16 years to meet all in-patient psychiatric needs by the provision of about 1.8 beds per 1000 population.

Tooth and Brooke accepted that this estimate might be affected by various factors. On the one hand, improvements in psychiatric treatment might accelerate still further the decline of the mental hospital population. Other trends, however, might have a reverse effect: increased life expectancy would possibly lead to more psychogeriatric admissions, the rate of rehabilitation and discharge was likely to decline as the hard core of organically deteriorated patients was reached, and, thirdly, 'maintenance in the community will depend on the existence of a social atmosphere which tolerates eccentrics and an economy which enables them to be largely self-supporting.'

There must be few statistical enquiries, either before or since 1961, that have so rapidly and unquestioningly been accorded the status of foundation of a new national policy as was the not very sophisticated forecasting exercise of Tooth and Brooke. The *Hospital Plan for England and Wales*, presented to Parliament by the Minister of

Health in January 1962, based its proposals for mental illness services wholly on the forecast in question, ignoring the authors' caveats, and transforming their qualified predictions into explicit policy objectives. By 1975 the number of beds in mental hospitals would be reduced to 80,000 from a 1960 total of 147,000. There was to be a substantial increase in the provision of psychiatric beds in general hospitals, but the proposed growth from 5000 to 12,000 would not of course go any way to offset the rundown of the old mental hospitals. Regional variations in bed provision, at that time quite substantial need not, it was assumed, be taken into account, and the ratio of beds to population should be uniform over the whole country. It was also asserted, though without supporting argument, that in planning the services in these terms no account needed to be taken of any contribution which the community services might develop; it was no doubt assumed that as the discharge rate of long-stay patients in the base years 1955-9 had not been affected by the very low level of community provision, it was unnecessary to adjust the predicted departure rates for the next 13 or 14 years. Indeed, if community services were to expand during that period, it should be possible, according to the Hospital Plan, for the hospital population to be reduced even faster:

The ratio of 1.8 hospital beds per 1000 population adopted as the probable limit of requirements for the mentally ill by 1975 . . . takes no account of any contribution from expanded community mental health services. These services are still very much in their infancy. Thus only four residential hostels especially designed for the mentally ill have so far been provided by local authorities. But many more are planned: over 150 are included in their programmes for the next few years. Concurrently, there should be a notable increase in the amount of home care, as more trained social workers are recruited for work with the mentally ill. . . . All this expansion of local authority services cannot fail to have a considerable effect on the hospital provision that will need to be made in the future.

Community care—concept and reality

Many contemporary observers viewed the prospect outlined by the Hospital Plan with decidedly mixed feelings. That the huge and often geographically remote asylums inherited from the Victorian Poor

Law, and the attitudes associated with them, had become wholly anachronistic was not in dispute. The achievements of those pioneering psychiatrists who had succeeded in transforming a handful of such institutions into active therapeutic communities were the more impressive for having been brought about in spite of both architectural impediments and human inertia. Indeed, it was easy to construct an intensely optimistic vision of the future which went well beyond even the stated intentions of the Hospital Plan, with all the old asylums demolished and responsibility for psychiatric care transferred wholly to the general hospitals, its wards and its consultants—and increasingly, with the proliferation of psychotropic drugs, its treatment methods—indistinguishable from those of medicine and surgery. While some writers drew attention to distinctive features of psychiatric illness, its natural history, its social repercussions, and its management which might not harmonize too readily with the prevailing professional style and ethos of the general hospital—even at the limited scale on which transfer was in fact proposed—for most psychiatrists the prospect of lessened isolation, of closer and more effective links with other, and in the public's eyes, more prestigious branches of medicine, was understandably attractive.

Nor was mental illness the only area of human problems in which long-established habits of dependence upon large-scale, segregated residential establishments were being called in question. Parallel ideas were abroad concerning the management of mental handicap—or mental subnormality, to use the standard term of that period, embodied in the 1959 Act. Non-institutional services had, of course, a longer history. But what was particularly significant was a flowering of psychological research which demonstrated, *inter alia*, the developmental advantages that accrued to mentally subnormal children cared for by their parents, in comparison with those looked after in good traditional institutions, and went on to show by quasi-experimental methods that many of the gains of family care could be captured by the use of small residential units that reproduced some of the features of the domestic environment. There was no suggestion, as far as mental subnormality was concerned, of a move towards the general hospital; indeed, the dominant lines of thought tended to de-emphasize the specifically medical and medically-related aspects of care and instead to focus on problems of learning and motivation. Highly relevant to the development of new, non-institutional models

of care were research findings which challenged customary assumptions, and demonstrated that people in the medium ranges of subnormality could under appropriate conditions be helped to achieve significantly higher levels of social competence than were allowed for in the conventional wisdom. The way forward seemed to be through the strengthening of educational provisions, the development of supportive social services to families, and an increasing emphasis on residential care, where that was inescapable, in small home-like units located within the communities they served.

The child care services also were in a state of rapid change. Beginning in the early 1950s there was a steady reorientation away from 'taking children into care' to preventive and supportive work with the child's own family. Very soon social work practice was outstripping the existing legislation, and when the Ingleby Committee was set up by the Home Secretary in 1956 it was asked among other matters to consider whether 'local authorities responsible for child care . . . should . . . be given new powers and duties to prevent or forestall the suffering of children through neglect in their own homes.' In its report, published in 1960, the Committee strongly favoured the development of preventive measures which would keep children out of residential care. The Children and Young Persons Act, 1963, made it the duty of local authorities to provide advice, guidance, and assistance such as might reduce the need to receive children into or keep them in care, and empowered them to give material and even monetary help to families. There was of course no possibility that residential care would become superfluous. During this period preferences tended to shift away from the very small units favoured by the Curtis Committee to medium-sized establishments—say 20 to 40 places—divided into a number of smaller living units; but the large, impersonal 'orphanages' and 'homes for destitute children', relics of the Poor Law or of Victorian charity, were discarded by statutory and voluntary child care services alike.

Reservations about the proposed new pattern of mental health services, then, did not stem from any sense that it was out of keeping with the spirit of the times or that it was likely to prove detrimental to powerful professional interests. Some commentators entertained suspicions about governmental motives, and wondered whether the alacrity with which the Tooth and Brooke forecast had been made a cornerstone of the Hospital Plan was born of a belief that the smaller the mental hospital population, the lower the cost to public funds.

But even if the cynical interpretation was accurate, it did not necessarily follow that the policy deserved to be dismissed. The intentions underlying social legislation and administrative change are often debatable and sometimes morally questionable, but the actual consequences of implementation may be quite at variance with anything that the legislators or administrators had in mind. More to the point was widespread doubt as to whether the implications of the intended reduction of mental hospital provisions had been seriously evaluated by those with a nation-wide responsibility for policy and planning. Though the Ministry of Health's administrative structure and advisory mechanisms were relatively simple in comparison with later developments they were not wholly unsophisticated. Yet it seemed that a greatly over-simplified and over-optimistic model of mental illness, its management and its social repercussions, had been embraced.

It had become commonplace among those with progressive views on the subject to claim that mental illness and its treatment did not differ fundamentally from the general run of medical and surgical conditions and their management. Leaving to one side the more challenging philosophical issues concerning the nature of mental illness that were not raised for debate until later in the 1960s, there had already accumulated, by the time of the Hospital Plan, substantial evidence that there were in fact very important differences between the characteristic natural history of psychiatric illness and even that of the chronic medical disorders, let alone the acute conditions that could be swiftly, even dramatically cured by surgery or antibiotic therapy. It had rapidly become clear that drug treatment in psychiatry, however impressive and beneficial its impact, was very often symptomatic only. As the average length of stay in hospital shortened, the readmission rate rose, indicating a high frequency of relapse among successfully treated patients. By the early 1960s half of all the patients being admitted to psychiatric hospitals or units were returning to familiar territory. Most practitioners and observers would agree that a pattern of repeated admissions and discharges was clearly preferable to one of long, unbroken confinement. There was no reason why a service with a greatly reduced bed complement could not cope with this changed pattern of patient flow. But beyond the simple statistics of admission and discharge important research findings were becoming available from studies in social psychiatry. Many of the subtle relationships between psychiatric disturbance

and social interpersonal factors had not yet been sensitively explored, but it was already evident that among chronic psychotics serious breakdown and a consequent need for readmission to hospital was often associated with tensions and disturbances in the former patient's immediate environment; as a corollary, other studies began to assess the severity of the burden imposed on the families of discharged patients and the limited professional resources available to them.

Critics asked whether the new policy would in practice amount to more than the transfer of a burden from trained staff to untrained families and the community at large. Richard Titmuss wrote in 1961:

We may pontificate about the philosophy of community care; we may feel righteous because we have a civilized Mental Health Act on the statute book; but unless we are prepared to examine at this level of concrete reality what we mean by community care we are simply indulging in wishful thinking.

To scatter the mentally ill in the community before we have made adequate provision for them is not a solution; in the long run not even for H.M. Treasury. Considered only in financial terms, any savings from fewer hospital in-patients might well be offset several times by more expenditure on the police forces, on prisons and probation officers; more unemployment masquerading as sickness benefit; more expenditure on drugs; more research to find out why crime is increasing.

But the Hospital Plan, unveiled in the following year, displayed a casual optimism about future prospects and was notable for its rudimentary quantitative forecasting and a pronounced lack of interest in the 'level of concrete reality' to which Titmuss had drawn attention—that is to say, the social, economic, and psychological implications of mental illness. Commenting on the Plan in 1963, Rehin and Martin observed:

If fewer beds are available, the level of demand will probably adapt itself before very long to the new level of provision, as will the hospitals' own admissions and discharge policies. The crucial question is not whether the proposed changes are possible in practice, but whether they are desirable in principle. We need to consider what is the extent of need for psychiatric services; what proportions of the need are most effectively dealt

with by different types of clinical service; how the social consequences of psychiatric illness can best be mitigated; how different clinical and social services can best be co-ordinated.

The next twenty years saw changes in psychiatric hospital provision and in community services, the scale of which is fairly easily charted. They occurred in the context of far-reaching developments in the health services and social services, and in the structure and attitudes of the relevant professional groups. These developments can be understood in organizational and sociological terms, though they can rarely be quantified. We can go on to speculate about the influence of these contextual factors on the achievements and the failures of community care.

2

1961-70: *The divided decade*

The political interest generated by the Royal Commission Report, the new legislation, and the dramatic proposals for change in the mental hospitals was not sustained in the early 1960s. For a period of four or five years the level of Parliamentary interest remained low. During the four sessions 1962/63 to 1965/66 the number of questions asked of Ministers in the Commons fluctuated between five and nineteen annually; these totals included all aspects of psychiatric care—costs, staffing, hospital standards, the use of compulsory powers, patient statistics, and research. The only occasion on which significant parliamentary interest was expressed in the quality of volume of services for the mentally ill was a debate in March 1965, on a motion introduced by Mr D. Griffiths. This motion welcomed the progress made in the development of services for the mentally disordered, and encouraged the government to ensure further growth. The debate was amiable if somewhat inconsequential. It ranged over mental illness and mental handicap, and touched on the problems of the special hospitals in the wake of a highly-publicized escape from Broadmoor. Little was said in the debate that could not have been said—and was not said—when the Mental Health Bill was under discussion several years earlier. Members drew a good deal on their personal impressions of hospitals or other services in their own constituencies, and there was a lot of emphasis on problems of overcrowding, out-of-date accommodation, and staff shortages. The particular significance of contemporary trends seems not to have

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been very sharply appreciated. One exception was the contribution of Mr J. Silverman, who alone drew attention to the growing need for community mental health services and their rather slow development. The motion was put, and agreed without a division.

Against this background of a low level of overt political concern fairly rapid changes took place in the scale and type of psychiatric services. There was very little attempt at systematic evaluation of these developments and even routine monitoring of change was for most of the decade piecemeal and sporadic. The Medical Research Council took important steps forward in establishing research units in social psychiatry and in the epidemiology of mental disorder; both of these have undertaken fundamental research of very high quality, but neither saw it as their responsibility to maintain a comprehensive overview of directions in the mental health services. Academic discussion of current and projected future trends tended to emphasize difficulties but was generally inconclusive.

Patterns of patient movement

The forecast of a decline in the resident population of the mental hospitals, so speedy that all those who were long-stay patients at the time of its publication would have been discharged or have died within 15 years, was widely criticized on technical grounds. Some writers questioned the method used for estimating future reductions in the chronic population, claiming that the data suggested a curvilinear rather than (as had been assumed) a linear rate of decline; if this criticism was valid, it followed that future bed requirements were being under-stated, as many of the long-stay patients would still remain in hospital years after the date of presumed total attrition. Other critics thought it unrealistic to assume that admission rates having risen steadily up to 1959 would thereafter remain unaltered while residence rates which had only recently begun to decline would continue to do so indefinitely. Other technical criticisms concerned the arbitrary and possibly inappropriate time-intervals used to define hospital groups by duration of stay.

Through the 1960s, the resident population of the psychiatric hospitals continued to fall by between 2000 and 3000 per annum. Since the 1961 statistical forecasts had been given the status of policy objectives, the observed trends could not be taken as direct confirma-

tion of the accuracy of the prediction. As more detailed patient statistics became available, however, it was clear that different and to some extent conflicting processes were at work. The inherited residue of 'established' long-stay patients was indeed diminishing, though not at as rapid a rate as predicted. Admissions, so far from levelling off at or near the 1959 frequency, continued to increase year by year through the decade of the sixties. The rate of increase was between 5000 and 10,000 admissions annually, made up in approximately equal proportions of new in-patient cases and readmissions. Discharge rates were maintained at a high level, implying a vigorous intention to avoid the build-up of a large new long-stay population. As a result of this combination of processes, the number of psychiatric patients occupying hospital beds had fallen to 118,000 by 1968.

Implicit in these figures are of course specific patterns of activity in the wards of the psychiatric hospitals and units, and in particular a continuation if not an acceleration of the characteristic styles of care that had become dominant in the latter part of the 1950s, emphasizing intensive treatment and rapid discharge, with a fairly high risk of readmission. This trend was maintained by continuing advances in pharmacotherapy. Following the powerful achievements of the tranquilizers, there was massive investment and research by the pharmaceutical industry in search of new psychotropic drugs. Most importantly, there emerged the tricyclic anti-depressants and the monoamine oxidase inhibitors. Many psychiatrists welcomed these as civilized alternatives to ECT. Although the evidence of clinical trials suggested that in the treatment of severe depressive illnesses ECT was more effective than drugs, the latter offered major opportunities for the management of mild and moderate cases. It seems likely that such cases accounted for a significant fraction of the increased psychiatric admission rate in the sixties.

The dominant position of depressive conditions in the work of mental hospital and general hospital psychiatrists in the mid-sixties is confirmed by an analysis of all such admissions during the year 1964. There were 155,000 admissions, of which a fraction under one half (75,000) were first admissions. Fifty-eight thousand admissions (37 per cent of the total) were classified as depressive psychoses (ICD 296); 35 per cent of the first admissions fell into this category. In addition, 23,000 admissions (15 per cent of the total) were classified as psychoneurosis (ICD 300). Obviously, a proportion of the latter

were neurotic depressive conditions, but it is impossible to disentangle these from other psychoneuroses. It seems probable therefore that at least 40 per cent and possibly nearer to one-half of all admissions in that year fell into the category of depressive illness of varying degrees of severity.

General hospital psychiatry

The continuing emphasis on intensive treatment and rapid discharge might have been expected to give a further impetus to the move to relocate psychiatric care within general hospitals. In fact, the progress made in that direction was quite modest. Although the old mental hospitals were shrinking, none of them was actually closed during the 1960s; and although precise information about developments in the general hospitals is hard to come by, it seems clear that the rate of advance on that front was a good deal slower than had been expected at the beginning of the decade. The available places in general hospitals, however, were used efficiently; up to 1970, annual counts of psychiatric patients never exceeded 4000, but in the course of any one year the number of admissions was well in excess of 20,000, rising in 1970 to more than 25,000. While a high proportion of the beds in mental hospitals continued to be occupied by long-stay patients, there were virtually no 'blocked' beds in the general hospital units. Whether this was because no new long-stay population was being created there, or because those for whom early discharge did not seem a realistic probability were promptly transferred to the nearest mental hospital, was a matter for debate during the period under review.

Much of the discussion concerning general hospital psychiatry centred on the work of several units in the Manchester region. Departments in general hospitals were particularly firmly established there, and accounted for more than 10 per cent of all mental illness beds. The units in Bolton, Oldham, Burnley, and Blackburn were all fairly well publicized, and their activities were analysed with varying degrees of sophistication. The psychiatrists who worked in these units wrote enthusiastically about their potential, and claimed that they could provide in-patient psychiatric services with bed: population ratios less than half of those at which the Hospital Plan had optimistically aimed. Supporting links with traditional mental hospitals seemed not to be needed except in relatively rare instances.

How adequately was general hospital psychiatry meeting the needs of patients and their families? It was claimed that general hospital units provided earlier and closer links between families and psychiatric staff, facilitating treatment, and minimizing tensions between patients and their families. Studies in Oldham suggested that it was indeed possible to achieve a high degree of continuity of care in a district service based on a general hospital, enjoying particularly close links with the local authority; these enquiries did not however provide direct evidence of the ways in which the services and their consequences were actually experienced by patients and their families.

Some relevant information is provided by Hoenig and Hamilton who carried out a four-year follow-up study of patients from two general hospital units. One of these was at Burnley, where the ratio of psychiatric beds to population was exceptionally low. Their tentative conclusion with respect to Burnley was that 'No part of the ... service seemed overloaded and ... both patients and relatives seemed satisfied. Neither would have preferred admission to mental hospital as an alternative'. However 'there was, nevertheless, a high degree of morbidity; social rehabilitation was far from complete and a considerable burden was carried by the households.' Downham's conclusion from these findings that '... this policy is effective (and) ... does not make undue demands on the community' is perhaps on the optimistic side, but the absence of comparative data makes it difficult, as indeed Hoenig and Hamilton recognized, to assess the findings with any confidence. Looking at the development of in-patient services in the 1960s one might suspect that the distinction between mental hospital and district general hospital was less significant, from the point of view of acceptability to the patient and the burden on his family, than the availability of high quality professional skills and the quality of extramural services, both clinical and social.

Out-patient and day services

Out-patient services continued to expand throughout the 1960s almost as rapidly as during the previous decade. The 1960 figure for new out-patients was some 46 per cent higher than the corresponding figure for 1950, and in the next eight years it rose again by a further 32 per cent, reaching a total of 196,000. There were signs however that

this increase was levelling off; 1968 showed only a very small increase over 1967. From the total of recorded out-patient attendances it may be inferred that the average number of attendances per new patient was in the region of seven. The average however almost certainly concealed a wide range of variation. Studies carried out in the early 1960s indicated that between 30 and 50 per cent of out-patients put in a single attendance only, being subsequently either admitted for in-patient treatment or simply not appearing again in the records of any specialist service, at any rate for the next twelve months. For those who remained in a treatment relationship as out-patients the average duration of contact was 10-12 weeks. As well as providing a diagnostic service, a means of entry to the hospital wards for some and a direct treatment service for others, the out-patient clinics also made a contribution to the after-care of former in-patients. That contribution however was a limited one; in the areas studied an average of one-third of all discharged patients were seen at an out-patient clinic within three months of leaving hospital. In terms of diagnosis, the make-up of patients attending at out-patient clinics was not vastly different from that of all psychiatric patients in the services investigated—*affective psychoses* were by far the largest diagnostic group, *neuroses* were recorded rather more frequently than among patients in general and *schizophrenia* somewhat less commonly; *senile psychoses* and *organic conditions* were rarely referred to the out-patient services. There was therefore no serious question during the 1960s of out-patient psychiatry replacing the hospital wards. To some extent they were providing an active treatment which offered an alternative to intra-mural care, particularly it seemed for younger rather than older patients and for the married rather than the single; there may well have been more subtle social and clinical differences between those treated while still living at home and those for whom admission was deemed desirable. To a large extent however—and an extent that varied from district to district—out-patient psychiatry complemented the in-patient service by providing pre-admission screening and post-discharge follow-up.

The first psychiatric day-hospital in Britain was established in 1946, but by the end of the 1950s there were 45, and during the next few years the number trebled. Interestingly, the original day-hospital, which carried the then unusual term '*social psychiatry*' in its title, did not prove to be an example for later developments. Some of

the day care that came to be provided within the health services made use of hospital wards, while in other cases separate premises were utilized, either within the grounds of a psychiatric institution or, less frequently, on an independent site. The latter tended to have closer links with community services, but in the majority of instances the day-hospital was very closely associated with the other clinical provisions. Sheldon and May, reviewing the work of the Croydon day-hospital, divided its functions into short-term active treatment, long-term support, including relief for relatives, convalescence after discharge from mental hospital, and the management of relapse which would otherwise require readmission to in-patient care. The balance of these functions varied from one day-service to another, as did the diagnostic mix of patients. Perhaps the most important variable was the presence or otherwise of psychogeriatric patients. Where day-care services were devoted largely to the needs of elderly demented patients the characteristic pattern of activity naturally differed a good deal from those where the bulk of the patients were ambulant and regarded with greater therapeutic optimism. In addition to medication, most day-units provided social activities and various forms of domestic, quasi-industrial, and leisure opportunities. During the 1960s the number of patients admitted to day-hospital care rose from 5700 at the beginning of the decade to 22,200 in its last year. Although even the latter numbers were small in comparison with the numbers admitted as in-patients, the expansion of day-services was an important advance, providing significant foci for the development of community-oriented psychiatric services.

Doctors and nurses

In this decade all modes of health service provision of psychiatric services were extended to larger numbers of clients. Although annual numbers of patients are not additive, as clearly many individuals received services from two or three sources, there can be no doubt that there was a significant increase in the total number of persons drawn into the ambit of the mental health services. This inevitably entailed some corresponding growth in professional staffing. Between 1963 and 1970 the number of hospital medical staff working in the field of mental illness in England went up from 1652 to 1879, an increase of 14 per cent. A significant part of that increase was attributable to a rise from 159 to 228 in the number of psychiatrists

working specifically with children. It should be noted however that the growth in psychiatric manpower during the 1960s did not run ahead of the expansion of hospital medical services generally. Indeed, the number of hospital-based doctors in non-psychiatric specialties rose more steeply than did the medical staffs of psychiatric hospitals and units. In 1963, 'mental illness' accounted for 8.67 per cent of all hospital medical staff, in 1967 for 8.34 per cent, and by 1970 for only 8.00 per cent.

Developments in nursing staffing are more difficult to evaluate, as in the published returns nurses working in hospitals and wards for the mentally ill are aggregated with nurses in establishments for the mentally handicapped. Between 1962 and 1970 total nursing staff grew from 45,676 to 56,626. Registered nurses however formed a diminishing fraction of these totals. In 1962 17,567 mental nurses, or 38 per cent of the total, were fully qualified, but by 1970 the proportion of qualified staff had fallen to 34 per cent of the enlarged total.

Community-based provisions

Although it had originally been claimed that the proposal to reduce substantially the number of mental hospital beds was not dependent on any developments in community services, the logic of that assertion had never been particularly clear. Earlier evidence had indicated that significant proportions of former psychiatric patients retained complex personal problems and social needs, liable to give rise to further breakdown, and a demand for further hospitalization. Major studies published in the mid-sixties (Grad and Sainsbury, 1966, 1968; Brown *et al.*, 1966) confirmed and amplified the picture of the chronic ambulant patient with recurrent morbidity and heavily burdened family. It was by no means certain that the provision of community services would eliminate these difficulties, but even the more modest question of how far problems could be alleviated and burdens eased proved difficult to answer conclusively in the absence of highly developed services sufficiently closely co-ordinated with the plans and practices of neighbouring hospitals to ensure continuity of care. Yet to ensure the development of community services of appropriate quality, variety and scale, let alone to bring about a sensitive matching of hospital-based and local authority provisions, was an extraordinarily difficult task for the Ministry of Health and its

successor, the Department of Health and Social Security. Local authorities were—and remain—autonomous bodies, responsible to their own electorates and not easily driven into the expansion of particular services by central government. The rate support grant, however complex the formula according to which it was calculated, imposed no obligation on local authorities to devote particular elements in the grant to particular purposes. In the Commons debate of March 1965 Mr Silverman raised the question of earmarking grants for mental health purposes, to be assured by the Minister (as had been the case when the same suggestion had been brought up in connection with the 1959 Bill) that the principle of the block grant was inviolable. Although therefore the continuing emphasis on rundown of beds and early discharge could not fail to expand the community pool of psychiatrically disturbed persons with pressing personal and social difficulties, officers of the central department could advise, encourage, and suggest norms of provision but could do little or nothing to require local authorities to establish and maintain supportive and rehabilitative services.

In 1962 the Minister of Health asked local health and welfare authorities to prepare ten-year plans for the development of their health and welfare services and to keep those plans under review. Provisions for the mentally ill were of course only one element in the plans of the local authorities, which also covered maternity and child welfare, services for the mentally handicapped, the elderly, and the physically handicapped. A summary of the plans was published in April 1963. A similar exercise was carried out later in that year and in July 1965 a second revision was called for, with forecasts covering the decade 1966-76. These were published in June 1966.

Not surprisingly, the 1962 returns indicated marked variation between local health authorities in their current level of provision of services for the mentally ill. Perhaps it would be more accurate to say that in most areas very little was then available, while in a small proportion of local authorities there was evidence of active interest in this field of work. In the whole of England and Wales there were in use or under construction in March 1962 only 18 local authority hostels for the mentally ill, providing a total of 340 places. The great majority of local authorities obviously provided no hostel accommodation; the then London County Council had one, as had Middlesex County Council. The position was similar in respect of centres for the mentally ill—a term used in the report to cover social clubs, day-

centres, and job training centres; in all, there were 23 such facilities in England and Wales. Plans for the future were more ambitious; it was anticipated that by 1972 there would be 103 day-centres and 211 hostels across the country, the latter offering a total of 4812 places. But on this basis there would still in 1972 be nothing resembling uniformity or even similarity of provision; there were many health authorities with neither day-centres nor hostels which had no intention of undertaking any capital expenditure on premises for the mentally ill and many more which had no plans to extend their existing limited facilities.

It is more difficult to comment on either contemporary variations or planned increases in the number of social workers in the community-based mental health services. The area returns as published do not show separate figures for social workers thus deployed, but aggregate them with other social workers in the local authority health and welfare services. In 1962 there were 2943 such social workers, and indications that local authorities planned to increase the total rather rapidly at first, to 4265 in 1967 and then more slowly to 4879 in 1972. At the time of the survey a high proportion of local authorities clustered fairly close to the national average of 0.08 social workers per thousand population, though a few were staffed at twice that level or even higher. The range of variation seemed unlikely to narrow significantly in the future, to judge by the targets laid down for 1972. The large counties of Essex, Kent, and Hertfordshire, for example, all stated as their objectives for 1972 social work : population ratios no higher than the 1962 national averages.

But of the approximately 3000 social workers identified in 1962 fewer than 40 per cent were employed in mental health services. In the Ministry's view the number so engaged should be doubled, so as to give the ratio of 0.05 per thousand population recently recommended for the mental health services by the Younghusband Committee. However, the majority of those who were designated as social workers were not professionally qualified. Only 10 per cent were classified as having had 'university or equivalent professional training' and a further 15 per cent as having received 'general training in social work'. The 1972 projections envisaged increases in both 'trained' categories, to 16 per cent and 32 per cent respectively of the new total; slightly more than half of all social workers would still be untrained. It is unlikely that very different proportions were

envisaged specifically for the mental health field, as the Younghusband recommendations had included only 260 university-trained psychiatric social workers among eight times as many mental welfare officers.

A study of the activities of mental welfare officers and psychiatric social workers, carried out in five areas in the early 1960s, throws some light on similarities and variations in the work actually being undertaken in the local authority sector. Differences in the ways in which mental welfare officers were used related largely to differences in the numbers employed in relation to population size; in the area with the most limited provision they functioned almost exclusively as 'duly authorized officers', while in areas more generously provided with mental welfare officers there was greater involvement in after-care and other supportive work. Nevertheless it was generally the case that contacts between mental welfare officers and their clients were most commonly undertaken in order to help initiate a psychiatric treatment process. A high proportion of interviews followed on requests from general practitioners or police officers to assess the strength of the case for compulsory admission. Social work of a longer-term character nowhere accounted for more than a minority, though in some places a quite significant minority, of all the activities undertaken by local authority mental health social work staffs. (Rehin, *et al.*, 1964)

The report on the Ministry's 1965 survey provided considerably more detailed information than its predecessor; categories of staff and types of accommodation were both disaggregated so as to provide useful data relating to the development of mental health as well as of other health and welfare services. Some distinct achievements were recorded. In particular, social worker establishments had expanded more rapidly than had been anticipated in the earlier forecasts. Just over 4000 were in post at the end of 1965, including 1600 in the mental health field; recruitment had been stronger in the county boroughs and the recently created London boroughs than in the county council areas. The proportion of professionally qualified workers remained low, with just over 20 per cent holding either a university qualification or the Certificate of the Council for Training in Social Work; several two-year non-graduate courses had been set up under the auspices of the latter body, which had been created specifically to promote the training of social work staff for the health and welfare services. Over the ten year period 1965-75 local

authorities in England and Wales planned—or at any rate—hoped to increase the number of mental health social workers by more than a thousand; but by that time, it was expected, there would be as many professionally trained workers as there were in 1965 qualified and unqualified together.

The 1965 returns indicated also developments in the provision of special premises and associated facilities for mentally ill clients. The number of hostels had more than doubled since the earlier reports, as had the number of places that they offered, although it was still obviously the case that the large majority of local authorities made no provisions of this kind. There were however plans for further growth in many of the areas which already operated some hostels and promises of new construction in some of those—such as Coventry, Leicester, Devonshire, and Nottinghamshire—which until 1965 had not embarked on any hostels. By 1971, it was claimed, the number of hostels and of hostel places would have increased to between four- and five-times the 1965 figures, with a further if less dramatic increase by 1976 to a total of nearly 5000 hostel places for former psychiatric patients. Day-services had grown quite impressively since the earlier Ministry enquiry and seemed set for further rapid expansion. There were now 28 workshops and occupational centres, with 659 places, a type of service until very recently provided only—though on a very much greater scale—for mentally handicapped people. A four-fold increase was planned for the next five years and a small additional expansion for 1971-76. Social centres and clubs for the mentally ill appeared in 1965/66 to have been multiplied very rapidly in the three or four preceding years. The local authority reports drew attention to 162 such facilities—but with none in Liverpool, Hull, or Staffordshire, for example, only one each in Birmingham and Manchester and 16 in Greater London; the marked contrast with the 1961/62 returns presumably resulted from the inclusion of social clubs established in premises used for a variety of purposes. Overall, a further increase of about 50 per cent was planned for the next five years.

In the short-term, the 1965 forecasts proved to be unrealistically optimistic. By 1970 the number of professionally qualified psychiatric social workers in the service of local authorities in England and Wales had risen only to 289 rather than the hoped-for 449. Hostel places were expected to be available for 3609 mentally ill patients, but by the end of 1970 only half that number had actually been

provided. Beyond 1970/71 detailed comparisons with earlier predictions, area by area, take on less and less meaning as new administrative and professional developments followed one another in quick succession—the reorganization of the National Health Service, the creation of unified social service departments within local authorities, and the restructuring of local government itself. Their impact and implications are discussed later in this report.

Heightened concerns

The last years of the decade were marked by a significant heightening of the salience of mental illness, in terms of both overt political activity and broader social awareness. If a watershed year has to be identified, it should probably be 1967. Parliamentary references become more frequent, begin to display a sharper awareness of social issues, and from time to time reflect sophisticated anxieties somewhat removed from the well-intentioned but not highly informed paternalism of earlier debates. During the parliamentary session 1966/67 there were 50 members' questions in the House of Commons, in contrast to only five in the immediately preceding session.

In December 1966 Mr W. S. Hilton, in a debate on the adjournment, referred to the high psychiatric admission rate of the London Borough of Tower Hamlets (of which his constituency formed part), and raised general questions about the relationship between psychiatric illness and social deprivation. He raised once again the possibility of special grants to local authorities, pointing out that those with the largest proportionate burdens of mental illness tended to be the poorest authorities, and like others who had asked similar questions in the past was assured that nothing could be done. (It should not be supposed of course that the new wave of interest in mental health matters had spread to the general body of MPs; during the December, 1966, debate Mr I. Mikardo rose to claim that this was the first time he had been present at a debate without a single Opposition member in evidence).

The mental health problems of deprived areas—a term gaining increasing acceptance with the introduction of the urban aid programme—was raised again in Parliament in April 1968. On that occasion Mr E. Moonman, in a debate on the adjournment, concentrated specifically on the issue of after-care for former psychiatric patients. While emphasizing the disproportionate diffi-

culties of poor local authorities with a high level of social-psychiatric problems and limited resources, he claimed that there was in general a marked lack of appropriate provisions. The ministerial response was sympathetic, acknowledging some imperfections but insisting that there were encouraging indications of significant progress. Mr Moonman was one of the backbenchers most actively involved in mental health matters, and it is hard not to suspect that it was his hand which held the baton that orchestrated a barrage of parliamentary questions in March 1970. A dozen MPs asked a series of identical questions, each seeking statistical information with regard to his own constituency. What had been the mental hospital admission rate per 10,000 population in 1968 for Basildon? for Birmingham? for Barrow-in-Furness? And the rates of discharge and referral to local authorities for community care? And the out-patient consultation rate? The costs of community care? The statistics of bed usage? The suicide rates? Whether the object of these questions was to draw attention to the overall low level of provisions, or to variations between local authority areas, or merely to the shortcomings of official statistics, is not very clear. If the latter was intended, the battery of questions was certainly effective; in most instances, the only reply that could be given was that 'figures . . . were not readily available'.

The increased though of course still modest level of parliamentary interest in community mental health services was but one expression of significant shifts in concerns and attitudes among a wider public. To speak of public opinion at large in this connection would almost certainly be unrealistic; there is no particular reason to suppose that mental health matters ever assumed a burning importance for the majority of citizens, any more than they did for the majority of their parliamentary representatives. But 'public opinion' is made up of a diversity of social and educational groups, and over time these change in their scale, composition, and orientation.

During the period under review rapid changes were taking place, one of whose effects was to extend the range of persons who judged psychiatric illness and its management to be legitimate matters of public concern. The assumption that specially qualified medical practitioners spoke with unique authority on these subjects—an assumption clearly implicit in most earlier discourse in and out of Parliament—was challenged; indeed, by one of those inversions of familiar values that were to become increasingly common in the late

sixties and seventies, there emerged a new mode of dissent which disputed the social and moral basis of the psychiatrist's authority and attempted to overturn long-established distinctions between sanity and insanity.

By no means all of the heightened awareness of mental health matters flowed from a radical critique of fundamental assumptions. We can distinguish three levels of concern and associated areas of debate, reflecting increasing degrees of departure from taken-for-granted beliefs: public scandals over specific cases of ill-treatment and mismanagement; a more widely generalized attack on psychiatric hospitals and other residential institutions; and the root-and-branch criticism of what quickly came to be known as the anti-psychiatry movement. It is not possible to discuss these trends more than very briefly in the present context, though some of their consequences and implications will be taken up in later chapters.

Hospitals for the mentally ill, the mentally subnormal, and the elderly sick, whatever their darker history, were now places where dedicated doctors and overworked nurses did their best for patients, often under trying conditions. The conventional wisdom ran through almost all public discussion of the mental health services, even when the thrust of the argument had been that new patterns of care—general hospital units, community-oriented services—were desirable objectives. The possibility that doctors could be neglectful and nurses dishonest, unkind, even brutal, was not commonly acknowledged, and early allegations of ill-treatment were received with scepticism and indignant denial. In the summer of 1967 two independent attacks were launched on the quality of care, understood in the most basic terms, in specific institutions. Whatever public disbelief they evoked, neither could be ignored. Official enquiries were initiated, on a pattern that was soon to become familiar.

Sans Everything, published in June 1967, was a compilation of statements describing acts of cruelty and neglect perpetrated mainly by nursing auxiliaries against geriatric patients in seven hospitals, most of them psychiatric hospitals. The names of the institutions, the patients, the staff members concerned and, in most instances, the writers were concealed by the use of pseudonyms. The allegations were debated in Parliament on 11 July, and at the request of the Minister of Health the six regional hospital boards responsible for the hospitals in question each set up an independent committee of enquiry with a QC as chairman. Their 'findings and recommenda-

tions', published in July 1968, appeared as six separate reports; no attempt was made to draw general conclusions. Most of the allegations contained in the book edited by Barbara Robb were dismissed as inaccurate or grossly exaggerated or unsubstantiated. In view of the uncertainty about some personal identities and, even more, of the considerable time lapse since the incidents referred to, conclusive proof either way would obviously have been almost unobtainable, and it is understandable that the committees of enquiry should have given much of their attention to the state of their institutions at the time of their visits. There is quite a striking contrast between the denial of specific charges of improper practices and substandard environments, and the lists of proposed improvements with which most of the reports end. The committee that investigated psychogeriatric services at Friern Hospital, for example, made 23 recommendations covering such matters as staff increases, staff training, better communication, and improved administrative practices.

Almost simultaneously with the publication of the Robb book, the *News of the World* forwarded to the Minister of Health a statement it had received from a former employee of Ely Hospital, a subnormality hospital (with some psychogeriatric patients) near Cardiff, alleging ill-treatment and pilfering by members of staff, indifference on the part of the chief male nurse to complaints, and lack of care by the physician superintendent and another doctor. An extremely detailed enquiry was carried out by a committee under the chairmanship of Mr Geoffrey Howe, QC. Their report, a model of its kind, concluded that 'the situation at Ely has proved to be sufficiently disturbing to make (the complainant's) concern well justified.' Far-reaching changes were recommended in about every aspect of the hospital's activities in order to bring them roughly into line with modern standards. The need for closer liaison with the local authority and for some development of community-based services was emphasized.

The government's readiness to investigate complaints led to further charges and criticisms of institutions which, in spite of the more publicized developments in hospital care, seemed not to have moved beyond the philosophy of the Poor Law. Old barriers of silence were broken and fears of reprisal put to one side. It became increasingly hard to dispute that there were too many Augean stables under the haphazard control of Hospital Management Committees.

In 1968 the Minister of Health tentatively suggested that there might be an Ombudsman-type appointment for the National Health Service, in parallel with the Parliamentary Commissioner for Administration appointed in the previous year. The proposal was withdrawn in the face of strong objections from the medical profession and was not revived until 1972, after a further mental hospital scandal. Meanwhile the Ministry had established the Hospital Advisory Service in 1969, specifically to visit and report upon hospitals for the mentally handicapped and the mentally ill.

Critiques of institutional life

As the Ely report had recognized, deliberate cruelty was not the only cause of institutionally imposed suffering and humiliation for handicapped and mentally confused patients. The casual and unthinking perpetuation of coarse and insensitive methods of work, unmodified by training and passively encouraged by *laissez-faire* styles of management, was capable of inflicting serious and widespread damage, especially in establishments occupying decayed, outdated premises, and starved of most resources. This was in varying forms the burden of a number of major publications which between 1959 and 1970 addressed general issues of residential care rather than local scandals.

Russell Barton's *Institutional Neurosis* was contemporaneous with the passage of the Mental Health Act, and its main theme provided encouragement both to those who were emphasizing social and industrial rehabilitation within the mental hospital, and perhaps even more to those dedicated to its total replacement. An experienced psychiatrist and mental hospital administrator, he argued that the environment of the traditional long-stay ward tended to bring about deterioration rather than improvement in the patient's initial condition. Apathy and withdrawal were the consequences of enforced idleness, the loss of contacts with the outside world and the dictatorial attitudes of nursing staff. The classical features of chronic schizophrenia were the product of a distinctive social environment rather than an inevitable stage in the natural history of the illness.

Perhaps surprisingly, it was a full decade before Barton's hypotheses received experimental confirmation. In *Institutionalism and Schizophrenia* John Wing and George Brown presented in 1970 the

results of a detailed clinical and social study of chronic psychotic patients in three hospitals, one of them Russell Barton's own. By meticulous objective assessment of symptoms, behaviour, and attitudes they were able to demonstrate the powerful extent to which the degree of clinical deterioration in long-stay psychotic patients was dependent on the way in which the members of the nursing staff saw their job and went about it. A distinctly depressing finding was the vulnerability of progressive change. Intensive and sustained effort by a dominant figure was essential to bring about major advances in the characteristic patterns of life and work in a traditional hospital, even though they fell short of the 'therapeutic community' ideal. But, these achieved, the retirement or promotion of the reforming physician superintendent was disturbingly speedily followed by a regression on the part of the institution to the conditions that preceded the advances so painfully achieved.

Other books published in the 1960s diminished still further the credibility of long-stay residential establishments. Peter Townsend's *The Last Refuge* exposed the material and social impoverishment of much local authority provision for old people, and Pauline Morris's *Put Away* examined in sociological terms institutions for the mentally handicapped and those admitted to them. But perhaps the most influential publication in that field during the decade was Erving Goffman's collection of essays entitled *Asylums*. First published in the United States in 1961 and in Great Britain two years later, *Asylums* spoke most convincingly not to policy-makers but to the relatively new and rapidly growing body of young people who had profited from the explosive expansion of higher education. Social workers were among these, although until after the creation of new comprehensive social service departments their numbers were not very great. However, the social science disciplines in general had been major beneficiaries of the multiplication of university and polytechnic departments; and their products, who became teachers, or further education lecturers, or community workers, or provided the staff of the proliferating pressure groups of the time, warmed to writers such as Goffman who examined public institutions, employing a language that was detached and distinctive, wholly independent of the vocabulary and the values of those who made the institutions work. It was Goffman who developed the valuable concept of the 'total institution', of which the enclosed mental hospital was in many ways the ideal exemplar. The way in which

people assumed the status of patient and became incorporated in the total institution was characteristic of the management of what was deemed by powerful forces in society to be deviant behaviour; it involved rituals of degradation, segregation from normal life, and the imposition of a new and damaged identity which re-shaped the reactions of others to the victim of this process, now relegated to a morally inferior social position. The origins of the behaviour judged to be deviant are not examined. Goffman was an elegant and influential exponent of labelling theory, which other contemporary American sociologists had built up with particular but not exclusive reference to delinquency. The notion of human problems as resulting principally from the reactions of social agencies, and of those agencies as essentially destructive rather than helpful or curative forces, proved very attractive to a generation which leaned strongly to a neo-Rousseauistic view of human beings as fundamentally good and innocent until corrupted by social institutions. But the writer who in the 1960s most powerfully disturbed conventional assumptions about the nature of mental illness and of psychiatric treatment was not an American sociologist but a Scottish psychiatrist.

Anti-psychiatry

It is a striking fact that not only Ronald Laing but the four or five other exponents of 'anti-psychiatry', were all themselves British and American trained psychiatrists. Varying in their political orientations and the precise focus of their attacks, they shared a view of mental illness as a 'myth'. They claimed that unless it was possible to demonstrate unequivocally that a particular set of behavioural and subjective symptoms had a basis in organic pathology, there could be no serious justification for employing the conceptual apparatus of medical investigation and treatment. To speak of illness was, at best, to speak metaphorically. The man or woman who came to a psychiatrist was not a patient with a disease requiring diagnosis and treatment, but rather someone who was experiencing difficulties of relationship or of communication, and who needed to achieve a better understanding of himself and of others, to liberate himself from destructive ties. While such an account of mental disturbance would not necessarily entail the elimination of the psychiatrist, it would severely restrict the range of 'treatments' available to him and

the formulation of his objectives, and perhaps especially call in question the legitimacy of his connections with the medical profession and the medical ethos.

In a series of stylistically memorable publications which spanned the decade—*The Divided Self*; *Sanity, Madness and the Family*; and *The Politics of Experience*—Laing focussed principally upon schizophrenia. He claimed to show, through a detailed phenomenological examination of selected cases, that behaviour which on superficial inspection seemed bizarre, meaningless, and clearly pathological, made a particular kind of sense when properly understood—understood as a response to untenable situations, conflicting and intolerable pressures, involuntary involvement in multi-conspiratorial networks of myth-enriched family intrigue. In its more advanced stages the Laingian analysis saw insanity as an active and creative response to the destructive forces of society. The schizophrenic, on this view, was engaged on a voyage of discovery, achieving experience and perception of an immediacy and authenticity that reached far beyond the puny capacity of rationality.

This is not the place to comment on the evidential basis of 'anti-psychiatry' writings, the relevance of their analogies or their modes of interpretation. 'anti-psychiatry', as the very label implies, was and to some extent remains an ideology. What is relevant here is not its manifest absurdity when approached in rational-scientific terms, but its place in the history of attitudes and beliefs. The important questions concern the factors affecting the acceptability of the ideology, not the verifiability of its component hypotheses. It is arguable that if fewer psychiatrists had been indissolubly wedded to a constrictingly narrow organic view of mental illness and its treatment, and that if the movement for progressive environmental change in psychiatric institutions had enjoyed wider success, the attractions of Laingian theory would have been less. But this is probably a peripheral consideration, less influential than the extent to which 'anti-psychiatry', like simple labelling theory, harmonized with quite widely prevalent values and aspirations of the time. Models of mental illness which identified the patient (especially the sensitive young schizophrenic) with the radical critic of a dehumanizing society, his family with the oppressive forces of the established order, and defined the collusive psychiatrist as an agent of control and coercion, were dramatically congruent with the sharp questioning of established institutions and the quest for solutions either

through the embrace of revolutionary ideals or through a search for personal spiritual salvation that attracted large numbers of the educated and partly-educated young during the late sixties. Included among them were more than a few social workers, hungry for new professional ideologies and in particular for ideas which gave them some moral advantage in the unequal battle for status and independence with the most firmly established of professions. How this affected relations between the two groups is a matter for speculation in later chapters.

3

1971-9

Reorganization and reappraisal

Reforming the welfare

Social policy in the early 1970s was dominated by the administrative reorganization of both health and social services. There were a few years in which governments of both major political parties were seized by a passion for re-shaping major components of the public services. This remarkable phase, in which the construction of organization charts became the thinking man's variant of sympathetic magic, had begun under the Wilson administration; one of its earlier fruits had been the creation of super-Ministries, including the Department of Health and Social Security. But Mr Heath's government was no less avid for structural change, and the voice of the management consultant was heard again in the land. Of the experiments in restructuring which were to have major implications for the mental health services, the reform of local authority personal social services came earliest in the decade.

The relevant Act was a legacy from the previous administration; indeed, it had travelled swiftly through Parliament only shortly before the 1970 General Election. The Act in its turn had been substantially based on the recommendations of a committee under the chairmanship of Mr F. (later Lord) Seebohm, appointed at the end of 1965 'to review the organization and responsibilities of the local authority personal social services in England and Wales, and to consider what changes are desirable to secure an effective family

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service'. In a detailed report, published in July 1968, the Seebohm Committee had recommended 'a new local authority department, providing a community based and family oriented service, which will be available to all.' The new department should take over the services at present provided by children's departments, the welfare services provided under the National Assistance Act, 1948, educational welfare and child guidance services, and the mental health social work services, as well as some other social welfare functions. The place of the Seebohm Report in the history of social work theory and ideology and the more general implications of the Local Authority Social Services Act will be considered in chapter 6. Our present concern is with the most direct consequences of the transfer of responsibility for mental health social services to the new multi-purpose authorities.

The proposal to effect this shift had proved one of the most controversial of the Seebohm recommendations. The report had not been wholly consistent in its approach to this subject. 'In the task of co-ordination', it had commented,

the contribution of the public health doctor, the community physician of the future, responsible for a defined population will, we believe, be crucial. If he is effectively to link local medical services, including those for the mentally disordered, and to relate these to the social services, he will have to become involved in a new range of activities. . . .

Nevertheless, and in spite of the strong views of public health practitioners that their existing responsibilities for the mentally disordered should be continued, the report went on to argue that 'it would be a great mistake to exclude the mental health social services from the new departments.' Some local authorities had 'outstanding achievements' to their credit, 'but the general level did not argue for preserving the *status quo*'. The change was proposed partly because 'the families of the mentally disordered tend to suffer from inter-related social disabilities' (although it was not clear precisely what was referred to), partly because to exclude these services would mean further segregation of the mentally disordered (though it was not really self-evident that this would be the case) and partly because the separation of services 'would perpetuate just those difficulties and failures that led to the establishment of our Committee in the first place.'

Commenting on the Seebohm proposals, two critical observers had remarked:

... it appears probable that such advantages as accrue to the mentally disordered and their families will be counter-balanced, if not outweighed, by some newly created drawbacks. If there is an argument against separating the community care of mental disorder from other forms of community care, there is surely an argument of at least equal validity against bifurcating the care of a specific group of patients. With community services provided by local authorities and medical services operated by new Area Boards, it seems almost inevitable that there will be new barriers to continuity of care. (Martin and Rehin, 1969)

In the debates on the 1970 Bill there was support from both sides of the House for the new legislation and universal praise for the Seebohm Report. In retrospect, it is clear that virtually none of the problems that were shortly to dominate the lives of the proposed social services departments was anticipated by contributors to the debate. Lord Balniel one of the very few Members to make any reference to mental health services, sounded a cautionary note when he expressed the hope that the machinery that was being created would not become 'a new source of division' between health and welfare services.

After the implementation of the Act it becomes exceedingly difficult to assess quantitatively the scale of social service provision for the mentally ill. Some developments can be simply measured, of course. Between 1970 and 1975 the number of places in day-centres for the mentally ill increased by 30 per cent, from 2616 to 3403, and the places in local authority homes and hostels were multiplied by as much as 45 per cent, from 1753 to 2545; these achieved figures fell far short of the targets predicted in the mid-sixties by the former health and welfare authorities, but even before reorganization it was clear that the latter were excessively optimistic. However, if we ask how many local authority social workers under the new dispensation were involved with mentally ill clients or their families, or how frequently problems associated with psychiatric disturbance appeared in the caseloads of social workers, we look in vain for answers. The new directors of social services embraced the principle of the multi-purpose social worker. The inherited mental health specialist staff sometimes continued to function as advisers but more often were

promoted to management posts or moved away into expanding social work education; from now on one could count social workers but not types of specialists. As to the nature of the clientele, the problems they presented and the ways in which the new departments responded to them, there is simply no useful statistical information. That field social workers were immensely busy was hard to dispute, but it was some time before it became possible to discern the contours of the work in which they were engaged. In the absence of research or statistical data, there developed among psychiatrists and many of their colleagues an almost universal impression that the mentally ill received scant attention from the reorganized social services; and that this was due not to lack of continuity but to the emergence of entirely different and unanticipated priorities.

Restructuring the NHS

The reorganization of the National Health Service in 1974 was the culmination of a long and complex series of administrative, professional, and political moves. The first tentative official proposals for change had appeared on the twentieth anniversary of the birth of the NHS. As successive governments moved slowly towards the massive task of reorganization, new motives became apparent and new policy objectives were incorporated in the design; possibly in the process the original intentions were partially lost from view.

The NHS had not been very long established before it became evident to many commentators that the tripartite structure which it had inherited was proving an enduring source of weakness. Its disadvantages were not equally apparent in all areas of medical care. Difficulties most commonly arose in respect of those conditions which were long-term and had significant social repercussions, and where the patients and their families were liable to be involved simultaneously or consecutively with all three branches of the Health Service. As the artificiality of the tripartite system became increasingly obvious in respect of mental illness *inter alia*, the demand for reform grew. The brief and relatively undocumented Green Paper which proposed that the functions of all the existing Regional Hospital Boards, Boards of Governors of Teaching Hospitals, Hospital Management Committees, and local Health Authorities should be transferred to 40 or 50 new Area Boards, each with comprehensive responsibility for the whole range of health services

for a population of one million or so, held out the promise of a new structure which, though it could not of itself solve the problems of providing continuous and comprehensive care, would at least provide an invaluable precondition.

A second Green Paper in 1970 argued for about twice the number of all-purpose health authorities, with enlarged membership (20-25 instead of 15 as in the earlier proposal). There would be a large number of district committees, without budgets, to supervise the running of local services, and regional health councils with mainly advisory functions. The participatory flavour of this document however was short-lived. By the time the 1972 White Paper appeared, concerns about management, planning, and the efficient utilization of resources had become dominant. The larger number of health authorities was accepted, but their membership was to be of the smaller size recommended in 1968; appointment was to be on the basis of managerial ability, and there would be no direct representative of medical practitioners, nurses, other health service employees, or local authorities. There was to be a strong regional tier with executive and supervisory functions, and it was through the regional boards that the area authorities would receive their budgets.

From the point of view of the integration of services relevant to the needs of the mentally ill, the National Health Service Reorganisation Act, 1973, had two major shortcomings. As we have seen, the social work and related functions of the local authority medical officers of health (including the home help service) had already been ceded to the new social service departments; now the post of medical officer of health was abolished, and the residual health service responsibilities of the local authority such as health visiting, together with a variety of planning, liaison, and information functions, were taken over by the 'community physicians' of the newly-created health authorities. Secondly, general medical practice secured a large measure of exemption from the control of the area health authorities through the establishment of Family Practitioner Committees to which essential regulatory functions must be delegated. However, it is questionable whether any systematic co-ordination of general practitioner with other health services would ever have been possible as long as family doctors insisted on retaining the status of independent contractors.

The Reorganisation Act provided for statutory professional committees at both regional and area levels, with a right to be consulted and a duty to advise; the medical advisory system was

designed to avoid domination by either hospital or general practitioner interests, and was paralleled by advisory structures for each of the other major professional groups involved. Internal management arrangements were not laid down by the Act, but were prescribed administratively by the Secretary of State. The key element was the creation of consensus management teams at each level of administration, with doctors, nurses, administrators, and treasurers operating on a basis of parity. The clinical members of the area management teams were to be the chairman and deputy chairman (one a general practitioner and one a hospital consultant) of the area medical committee in the case of single-district areas; in multi-district areas separate district medical committees were set up, each with its chairman and deputy chairman sitting on the district management team. Area medical officers and district community physicians were responsible for a variety of important planning and advisory functions, but had no executive control over clinicians; their ability to influence decisions would depend on their ability to gather relevant information and to marshal arguments, to negotiate and persuade. It was all a far cry from the separation of lay and medical administrative responsibilities and the essentially hierarchical arrangements that had characterized the original NHS structure.

Strategic planning was to be a centrally important function of the reorganized NHS. This was to involve a great deal more than bricks-and-mortar decisions. The central department, itself reorganized into multi-professional service development groups, would issue national guidelines concerning major health care objectives, and within these areas and districts would formulate their own long-term plans against a background of extensive discussion and consultation with professional and community groups. In principle, the new planning machinery provided an excellent means whereby changes in resource allocation could be effected and the balance of emphasis shifted, to some extent at any rate, between different areas of health service activity. Services for the mentally ill as well as services for the elderly would it was hoped benefit from the operation of the new planning system, at the expense of fields of work that involved elaborate technology and high concentrations of skilled personnel, and that applied with uncertain effectiveness to relatively small groups of patients.

An additional consultative requirement stemmed from the recognition that many aspects of health care planning could not be

adequately accomplished exclusively within the framework of the NHS. The Reorganisation Act specifically required local authorities and area health authorities to establish joint consultative committees within which the possibilities for collaborative action could be considered. Initially, these proposed bodies would be in no position to redistribute resources across authority boundaries. This proposal was received with more scepticism than enthusiasm, especially by doctors who already found themselves calculating how much time it would be possible to spare from committee activities to engage in clinical practice.

It is arguable, and with a good deal of justification, that no comprehensive estimate of the effectiveness of NHS reorganization can fairly be made. The Act came into effect at the same time as a change of government; the incoming ministers thought the plan excessively elaborate and generally distrusted its managerial philosophy. More importantly, financial crisis soon loomed. A profound decline in the nation's economic position led to restrictions on public expenditure and policies of income restraint. The latter were associated with a disturbing growth of trades union militancy throughout the NHS, involving professional groups previously assumed to be immune. In the changed economic climate the whole concept of strategic planning—which many of those most directly concerned had not grasped very successfully—became extremely problematic. The Labour administration, by taking steps at an early stage to separate strategic planning from the cycle of arrangements for dealing with short-term developments, came close to reducing the former to the status of a paper exercise with little practical significance. But in any case, the restriction of income inevitably created greater competitiveness and greater defensiveness. If additional resources needed to be found for some worthy health service cause, the probability was that this could only be achieved by reducing the share of some better established sector. Psychiatric Paul could not be paid more without plundering surgical Peter. Those areas of practice that were deemed to be over-generously resourced tended to enjoy high prestige, both in the profession and in the eyes of the general public, and had little inclination to surrender gracefully.

Nevertheless, there were probably weaknesses in the most basic assumptions of the 1974 reorganization that would have reduced its chances of fulfilling its objectives even if the economic and political

climate had remained more propitious. It was excessively elaborate, making duplication of effort almost inevitable and creating a mass of management posts, particularly in professional hierarchies, when it was anything but clear what the precise nature of the management responsibilities would amount to or how they would affect activity at the operational level. In setting up elaborate advisory and consultative structures, the reorganization proposals over-estimated the extent to which practitioners, especially health service professionals with a primary and demanding commitment to the practice of medicine or nursing, would have time and inclination to engage in activities that many conceived of as of only marginal relevance. Perhaps too the heavy emphasis on structure and organizational pattern was accompanied by a certain lack of awareness of the forces that actually affect the work behaviour of individuals in complex settings—not least the forces of inertia and the impermeability of much behaviour in organizations to management directives.

The history of long-stay institutions exemplifies particularly well the capacity of established practices to resist change in spite of managerial revolutions. Revelations of ill-treatment in mental illness and mental handicap hospitals had provided clear indication of weakness in hospital management. When in 1971 yet another scandal erupted, this time at Whittingham Hospital, a very large psychiatric establishment in north Lancashire, the committee of enquiry demanded the resignation of the hospital management committee as a precondition of any constructive change, and the Secretary of State made it clear to the chairman of the regional hospital board that this would indeed be essential. (The hospital, interestingly, was one which the Manchester RHB, with its strong commitment to general hospital psychiatry, had scheduled for gradual run-down, but which nevertheless continued to admit large numbers of long-stay patients). But although the damning report by the committee of enquiry rightly criticized the weakness of the management system and the lack of adequate professional advice, it should not be supposed that the national reorganization which followed necessarily had a transforming effect on all long-stay institutions. New cases of ill-treatment and abuse of patients continued to come to light for several years. St Augustine's, South Ockendon, and Normansfield were later entries on the roll of shame, and provided impressive evidence of the durability of total institutions.

Trends in patient and staff numbers

During the early 1970s the scale and deployment of mental health services continued to change, in ways which appeared to be little influenced by the impending, concurrent or recently completed administrative restructuring. The size of the resident population of psychiatric hospitals and units continued to decline. Between 1970 and 1975 the rate of reduction averaged 4000 a year, and by the latter year it was possible to say that although the number of available psychiatric beds was still slightly higher than the figure predicted in the Tooth and Brooke estimates and the 1962 Hospital Plan, the actual number of patients in residence (87,300) had fallen below the level which thirteen or fourteen years earlier had seemed to many observers unattainably low. Admissions, having continued to climb steadily through the 1960s and early '70s, thereafter remained fairly constant, with only apparently random fluctuations from year to year.

Within the in-patient statistics, two trends are worthy of note. First, psychiatric units located in general hospitals came to play an even more active part during the early 1970s. Although the number of places available in 1975 fell far short of the expanded provision originally hoped for, there had nevertheless been a significant increase from 1970 onwards, after several years without growth. In 1975 there were on a single day some 5400 in-patients in general hospital units, compared to 3300 in 1970. The rate of patient movement in these units remained high, with in each year approximately eight admissions per bed (possibly slightly less if some allowance is made for some under-utilization associated with intervals between discharges and new admissions). In short, as new units in general hospitals were brought into use they proved increasingly attractive at the expense of the older psychiatric hospitals. Although a census in 1975 would have shown that only one psychiatric patient in 16 was being treated in a general hospital ward, the latter admitted one in four of all that year's psychiatric patients. It follows of course that patient flow in the mental hospitals was a great deal slower. If there were eight general hospital admissions for every place, the corresponding ratio for the specialist mental hospitals was only 1.6 to one; even so, this indicated greater mobility than the approximately 1:1 ratio of the middle 1960s. If there was any specific danger arising from the vigorous growth of general

hospital psychiatry, it was that a disproportionate share of encouragement and resources might be channelled there at the expense of the mental hospitals, slowly declining but still very important, numerically, socially, and clinically. That the anxieties of those who had seen this as a hazard of the 1962 Hospital Plan had not been unnecessarily pessimistic was made clear by the forthright comments of the committee that had enquired into Whittingham Hospital.

Another significant trend concealed by apparent constancy in the number of psychiatric admissions was a shift in the balance between first and subsequent admissions. In 1970 the number of people admitted for the first time for in-patient psychiatric care fell after many years of steady increase, then continued to decline slowly for about five years before reaching a plateau. Readmissions however continued to rise gradually through the early seventies; by 1975 two out of every three people becoming in-patients had a previous history of intramural hospital treatment.

How were these trends related to changes in the usage of health services other than the hospital ward and to developments in the local authority sector? With somewhat fewer patients entering the wards in the first place and an increased readmission rate among those who have received in-patient care, questions inevitably arise both about alternative sources of initial treatment, and about the role of supportive services for discharged patients. As far as hospital out-patient psychiatry is concerned, it seems clear that there is no question of these services substituting for admission. Indeed, the number of new out-patients had reached its peak in 1968/69; during the early 1970s the fall in new in-patient admissions was matched by a small but steady reduction in the new patients referred annually to the consultative clinics. Between 1970 and 1975 the decline was from 215,000 to 188,000. Nevertheless, these services were busier than ever, the ratio of total attendances to new patients rising from approximately seven-to-one to about eight-to-one. Day-patient places within the NHS, however, increased by more than a half in the early seventies, as did the number of new patients and the total number of attendances. The former went up from 22,200 in 1970 to 36,400 five years later. It may well be that this very marked growth in day-hospital activity, with total attendances in 1975 amounting to 2.7 millions, provided an acceptable alternative to traditional in-patient admission in some cases. The other plausible factor was an increasing tendency for general practitioners, as they became more confident in

the use of psychotropic drugs, to manage patients with apparent psychiatric disturbance without referral for specialist opinion and treatment. In retrospect, it is not possible to assess the relative strengths of the two processes in shifting, slightly but significantly, the established pattern of psychiatric care.

Although the reorganization of local government, first in Greater London and later over the remainder of the country, makes it impossible to compare in detail the forecasts of the early 1960s with the progress actually achieved in the early 1970s, we can identify some general trends in provisions for the mentally ill in the local authority sector as a whole. From 1970 to 1975 there were marked improvements in the scale of both residential and day-care provision. The number of places in homes and hostels for mentally ill clients was increased by 45 per cent, from 1753 to 2545, while places in day-centres went up by 30 per cent, from 2616 to 3403. Welcome though these advances were, they fell a very long way short of what might be judged an appropriate response to the human needs implicit in a continuing decline in the long-stay hospital population and an extremely high rate of relapse and readmission among those admitted in the first instance for short-term. The virtual disappearance of specialized social work in the local authorities and the general absence of joint planning between health and personal social services combined to impart to the concept of community care an increasingly hollow ring. There were too striking differences between local authorities, in comparison with which inter-regional variations in health service provision seemed of minor significance. In 1974/75, for example, there were still 45 English local authorities which spent nothing at all on the provision of day-centres or clubs for the mentally ill; only five of these were London Boroughs, and 19 were County authorities. The average expenditure of the Inner London Boroughs was six times that of the Metropolitan Districts and eight-times that of the Counties. In respect of residential care for the mentally ill, the London Boroughs spent on average about three-times as much as local authorities outside London.

Before turning to consider the major policy document issued by the Department of Health and Social Security in October 1975 we should discuss briefly the changes in professional staffing that took place in the immediately preceding years. Hospital medical manpower devoted to mental illness services increased by one-third between 1970 and 1975; the rate of growth now exceeded that of

hospital medical staff in general, the latter advancing by one-quarter during the period in question. The number of nurses also increased by about thirty per cent, but the registered nurses expanded their numbers only very slowly, and came to form a decreasing proportion of the total nursing complement. Other, less familiar professions had begun to make their mark on the psychiatric scene; clinical psychologists, virtually unrecognized until the 1960s, numbered about 500 by the middle of the next decade. Even in the mid-seventies, the qualified manpower devoted to the mental health services seemed relatively modest when set against the scale of the work. In the words of the White Paper *Better Services for the Mentally Ill*, 'The equivalent of 835 full time consultant psychiatrists share clinical responsibility for about 250,000 adult in-patients each year, over 1½ million out-patient attendances, and more than 2 million day-patient attendances.'

The 1975 White Paper

Mrs Barbara Castle's *Better Services for the Mentally Ill* had some defects of a kind not uncommon among official publications and some virtues which by contrast are encountered only rarely. A good deal of this review of the appropriate patterns of care in and out of hospital was rather bland, over-generalized, even at times verging on the platitudinous. Nevertheless, it was strikingly honest and open in its recognition of the extent to which the developments of the previous 15 years had failed to live up to the earlier hopes and expectations, and in its readiness to accept that central government no less than the local authorities must accept some of the blame for these shortcomings.

The government's 'broad policy objectives' were described in the White Paper as an expansion of local authority personal social services; the relocation of the specialist services in local settings; the establishment of 'the right organizational links' within and between the health services and the local authority social services; and a 'significant improvement in staffing' to allow for prevention, early intervention, and multi-professional assessment and reviews. (para. 2.22) Central to what was seen as an emerging pattern for the mental health services was the acceptance by the multi-disciplinary specialist therapeutic team of a commitment to 'the people and services of the "district" as a whole, and not simply to the hospital.' (para. 3.11)

Geographical location, though potentially important in this respect, was not a crucial factor; the easier accessibility of the general hospital psychiatric unit might cease to be an advantage if excessively selective admission policies were pursued.

The White Paper pointed to a decline of interest in rehabilitation, found fault with precipitate discharge policies which took no account of the availability of supporting social services, and spoke critically of the reluctance of 'some' psychiatrists and nurses to admit patients with behaviour problems or with chronic illnesses not obviously amenable to treatment. Nor were community services in a position to accept 'social care' responsibilities shrugged off by treatment-oriented hospital psychiatric services.

... non-hospital community resources are still minimal... The failure... to develop anything approaching adequate social services is perhaps the greatest disappointment of the last 15 years. As a result the balance of existing facilities... bears increasingly less relation to acknowledged needs. (para. 2.8)

The whole concept of community care, which the government still saw as of fundamental importance, was thus placed at risk. In an unusually forthright summary of the problem the White Paper observed:

Those who work in the health and social services fields have to recognize that families and relatives, and indeed the public at large cannot be expected to tolerate under the name of community care the discharge of chronic patients without adequate arrangements being made for after-care and who perhaps spend their days wandering the streets or become an unbearable burden on the lives of their relatives; hostels which are so selective that they are only half full while people needing residential care are told they are unsuitable; appeals which go unanswered for help in crises while authorities or professional officers debate boundaries of responsibility. (para. 2.27)

These words, recalling some of the gloomier predictions of the early 1960s, immediately raise questions about the causes of the imbalance that had developed—the ratio of hospital expenditure to social services expenditure on services for the mentally ill was in the region of 20 to 1—and about possible routes towards a more

appropriate pattern of provision. The White Paper acknowledged that

... it would be foolish to pretend that unification of the social services has not brought many problems in its wake... in a developing social services... there is a real danger that groups such as the mentally ill will be given a low priority...

Nevertheless, the principle of the unification of personal social services was defended, and its (presumably potential) '... positive advantages for mentally ill people' emphasized, in very much the same terms as Seebohm had employed (paras. 3.23, 3.22). There had perhaps been too much dispersion of specialist skills; social service departments should maintain a nucleus of staff with special expertise in such fields as mental illness. The White Paper did not touch however on the political and financial implications of placing responsibility for community mental health services on autonomous local authorities, structurally separate from the NHS.

In reviewing future needs, *Better Services* discussed sensibly the case for a flexible and varied pattern of day provisions and short-term and long-term residential accommodation. The problems of the chronically mentally ill, the elderly mentally infirm, and people without a home or a settled way of life were sympathetically summarized. Guidelines were provided for 'services at district level' in terms of numbers of places per 100,000 population, though it was not always clear how these had been arrived at. Further chapters dealt with the psychiatric problems of childhood and adolescence and with the needs of alcoholics and drug addicts; none of this was very profound or original, and to some readers it was a faintly disconcerting thought that in 1975 there should still be a need for rather elementary information and advice. Professional staffing in almost every field was judged to be inadequate quantitatively and in some cases improvement in the quality of training was looked to; for social work in particular, it was hoped that recent moves towards the development of post-qualifying training would help to build up a new cadre of specialists.

In the matter of achieving the objectives of the 'better services' adumbrated in the White Paper, the document itself could give only limited guidance. The shortfalls were clear, but financial stringency in the public sector made it impossible to offer additional resources in the short-term. Indeed, the Secretary of State made it clear in her

foreword that there had been considerable internal debate as to whether it was wise, in the circumstances of the time, to issue the White Paper at all. But perhaps '... there will be a modest growth in real terms in the amounts available for the health and personal social services after (the next three or four years)' (para. 11.15). In the meantime, work should begin on the planning of services at the district level, using the machinery of the Joint Consultative Committees established under the NHS Reorganisation Act to ensure joint involvement of health and local authority services. By what means these bodies, still for the most part embryonic and certainly nowhere dynamically forceful, could be motivated to overcome barriers which had hitherto been a major impediment to progress was not a question that the White Paper addressed. It was not a negligible document however. Although it displayed no great depth in its analysis of the reasons for the failures it identified, its very openness in documenting, with a minimum of apologia, the shortcomings of community care makes it an important milestone in the development of British mental health services.

Joint finance

Mental illness was not the only area in which the Department of Health and Social Security found itself confronted by frustrating difficulties when it sought to bring about shifts in the priorities accorded to different client groups within the NHS. The complex planning systems incorporated in the reorganized Health Service made unwarranted assumptions about the levels of specialized knowledge and analytical sophistication that participants would bring to bear in the areas and districts. But even if the essential tools for identifying needs and determining priorities had been readily accessible, there were no obvious means by which the central department could influence the use that was made of them. Indeed, it was a central tenet of the new organizational pattern that there should be the greatest possible amount of decentralized decision-making. Total resources would be determined centrally and even, as under the RAWP formulae, be deliberately reallocated between regions. But how these were to be deployed within regions or areas was something to be arrived at by negotiation at the appropriate level. The DHSS could try to persuade, encourage, cajole, or even threaten, but in practice it was most unlikely to play a *dirigiste* role.

When sums of money notionally earmarked for particular purposes were in practice deflected to other uses, the Department had to accept this with as good a grace as it could muster.

This created major difficulties as far as the so-called 'Cinderella' services were concerned. It had been recognized for some time that in addition to mental illness, mental handicap and geriatrics were seriously under-resourced, and that what in terms of national health care needs most observers regarded as an excessively high proportion of health services expenditure was being devoted to more dramatic ventures in acute medicine and surgery. To bring about any planned change within the NHS itself was difficult enough; to shift the balance between health and local authority services was, for reasons already indicated, virtually impossible. The principle of 'joint financing', introduced in 1976, was an important means by which DHSS became able to overcome some obstacles of long standing.

Joint financing established specified sums within the total budget of the health authorities which could be used to pay for local government developments if these were likely to relieve pressure on health services. Over a number of years, however, responsibility for jointly financed schemes would be gradually transferred to the local authorities. Health authorities and local authorities were encouraged to set up high level joint care planning teams, with sub-groups to examine separately services for the elderly, the mentally handicapped, and the mentally ill. Although there was some understandable caution on the local authority side, stemming from a reluctance to commit future resources, the scheme gradually gathered momentum. The amount of money involved remained modest. In 1977, for example, the 'forward planning assumptions' for 1978/79 and 1979/80 allocated £14m to capital expenditure under joint financing in each year, and £15 and £20m respectively to revenue expenditure. These were not large sums—the revenue expenditure amounted to about half of one per cent of total NHS revenue expenditure—but at the local level they made it possible for buildings to go up and for staff to be employed a good deal sooner than would otherwise have been the case. In terms of effectiveness, joint financing compared quite favourably with exhortation. A study by the Central Policy Review Staff in 1977 of *Relations between Central Government and Local Authorities* identified joint financing (in the course of a fairly critical examination) as a 'striking and potentially important new development.'

Use of services in the late 1970s

Patterns of patient movement and health and social service utilization continued to change in the late 1970s, consolidating the trends that had become apparent earlier in the decade. The resident population of hospitals and wards for the mentally ill declined still further; by 1979 the average number of in-patients had fallen to 76,000, corresponding to only 55 per cent of the 1961 figure. The total number of admissions rose to a peak of 178,841 in 1976, and then dropped by two or three thousand a year to 169,310 in 1979. This was the smallest number of admissions recorded since 1967, but the trends over the decade had not been so clear-cut as to indicate firmly that a long-term falling off was probable. However, for conditions with a high relapse rate the total number of admissions in a given period do not mean a great deal in themselves. By disaggregating admissions during the late seventies we can see clearly that the pattern which had emerged earlier in the decade had intensified. The number of first admissions, which by 1975 had fallen to 57,376, declined still further to 49,237 four years later. As many as 120,000 of the persons admitted for in-patient treatment in the latter year were returning for a second, third, or subsequent spell; the ratio of readmissions to first admissions was now nearly two-and-a-half to one.

It would be of great interest to compare the diagnostic distribution of patients admitted for in-patient treatment in the late 1970s with that of their predecessors a decade or so earlier, in order to assess the extent to which changes in admission rates had varied between different types of psychiatric illness. Unfortunately however it is almost impossible to make a precise and detailed comparison, because of a change in the rules of classification introduced into the statistical returns in 1970. Until that year, it was necessary to classify depressive conditions either as depressive psychoses (ICD 296) or under the heading psychoneurosis (ICD 300). Under a new dispensation, psychiatrists were then allowed to avoid this dichotomy and to include depressions of uncertain status in a miscellaneous category together with undiagnosed and non-psychiatric conditions. Not altogether surprisingly, this escape route proved extremely popular. When we compare the admissions of 1979 with those of 1964, we find that more than one-quarter were allocated to this residual category in the later period; 15 years earlier only one per cent of all admissions

had been thus dealt with. However, if we make the rough and ready but plausible assumption that virtually all the cases in the residual category are in fact depressions of uncertain status, we may conclude that around half of all the 1979 admissions were for affective conditions of whatever type, a proportion quite close to that of 1964. But the sharp reduction in first admissions is observable in almost all diagnostic categories. It is only in the case of alcoholism (but not alcoholic psychosis) and personality and behaviour disorders that there is any increase in admissions. Even first admissions for senile and pre-senile dementia are down from 9100 to 5500, in spite of the increase in incidence that must inevitably have been associated with the changing age-structure of the population. But in 1979 there were nearly 1.5 readmissions for every one first admission for senile psychosis, indicating a pattern of care very different from that of 1964, when three-quarters of all senile admissions were first—and presumably terminal—admissions. First admissions for schizophrenia were impressively reduced, falling to little more than two-fifths of the 1964 figure. The readmission rate for schizophrenic patients however was extremely high; in 1964 the ratio of readmissions to first admissions had been little more than 2:1, but by the end of the seventies the ratio was in the region of 6:1. A closely similar balance of first and subsequent admissions could also be observed for those patients who were clearly diagnosed as depressive psychoses. That in-patient admissions were being made on a very much more selective basis was obvious, though it was less clear what the new principles of selectivity were. The fact that first admission rates had fallen markedly across virtually the whole range of psychotic and psychoneurotic conditions suggests that severity of illness was not necessarily the sole criterion.

The use of hospital day-care continued to grow during the late seventies, to an extent which could account for a large part though not all of the simultaneous drop in first admissions. In 1979 there were 5000 more admissions of new day-patients than in 1975; between these years the total number of day-hospital attendances exceeded three million for the first time, new admissions and attendances alike having doubled in the course of the decade. Out-patient referrals remained fairly constant from year to year during the late 1970s, although there was a small upward trend in the total number of attendances. These significant changes in the pattern of hospital-based services for mentally ill patients have implications for

the roles and responsibilities of the general practitioner services; these are discussed in chapter 8.

Outside the NHS, local authority social service departments continued to expand their day-care and residential services, now with added support under the joint financing arrangements. The number of places in hostels and group homes increased by 1000 between 1975 and 1979, and the number of day-centre places by 1200. If the guidelines set out in the 1975 White Paper had any validity, it followed that the gap between the levels of provision achieved and those attained by the end of the decade remained formidable. Day-centre places, at just under 5000, amounted to less than one-fifth of what would be required to provide 60 places per 100,000 population. Hostel provision had been divided, in *Better Services for the Mentally Ill*, into short-stay establishments with an emphasis on intensive rehabilitation, with a projected national goal of 2-3000 places, and long-stay residential accommodation in group homes and similar settings, amounting to somewhere between 7000 and 11,000 places. The White Paper had also referred to the need for residential accommodation in the community for the elderly mentally infirm, but had not attempted to quantify the level of provision. It should be recorded that local authorities had a long tradition (originally derived from the Poor Law under Part III of the National Assistance Act, 1948) of providing residential accommodation for old people. During the 1970s there were always at least 100,000 such places in England, and by the end of the decade about one-fifth of these were occupied by elderly mentally infirm clients. Joint finance notwithstanding, striking differences between local authorities persisted, with the Inner London Boroughs spending on average approximately twice as much per thousand population on residential services for the mentally ill and three or four times as much on day-services, as other types of local authority.

A new chapter opened in 1979, when a General Election brought to power an administration committed to severe restraint in public expenditure and with a strong belief in self-help. Perhaps less predictably, a concern for reform of the legal framework of the mental health services was also to become a major consideration in the new Parliament.

4

1979-83: *Moving resources*

Continuity of priorities

The Conservative administration of 1979 was dedicated to two principles that were potentially relevant to—among many other things—the development of community mental health services. There was an over-riding commitment to reduce public expenditure and lessen the burden of taxation. Secondly, there was a strong reaction against what was seen as an undesirable long-term trend towards over-dependence on and excessive regulation by central government. In the event, the old maxim that equally admirable objectives are not necessarily compatible with one another received further confirmation; in the hope of restraining profligate spending by local authorities, Ministers found themselves intervening to an unprecedented extent in local affairs and seeking additional powers to penalize recalcitrant councils. Overall, the most that can be said is that the rate of growth in public expenditure was slowed down, but it was neither reversed nor even halted. Many factors contributed to this failure to achieve more than marginal reductions, including the rising costs of unemployment and of retirement pensions and the manifest electoral hazards of any serious assault on health services, as well as explicit undertakings to increase spending on defence and police services. Over the four years of Mrs Thatcher's first administration, public expenditure increased by six per cent in real terms and the general level of taxation remained virtually unchanged.

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'Stop the cuts' was an emotive slogan among unionized social workers, but in truth the dominant emotion of many looking back over this period was one of surprised relief that so much of the edifice of the welfare state was still standing. Whether services for the mentally ill would have grown more rapidly under a government of a different political complexion is very doubtful. On the whole, one's sense is of undramatic progress along lines already well established.

A mildly critical note was struck very early in the life of the 1979 government in the report of the Royal Commission on the National Health Service. This had been established three years earlier, principally as a reaction to serious professional and political doubts about the wisdom of the recently completed reorganization of the NHS. (It might be argued that it would have made better sense to create such a body before embarking on reorganization rather than after carrying it through.) However, in its inevitably wide-ranging reports the Royal Commission, last of a dying breed, addressed the question of the future of services for the mentally ill. There had been disappointment, the Report said, in respect of both the pattern of hospital care and the creation of services by the local authorities.

It was hoped that the mental hospitals could be replaced by psychiatric units placed in DGHs, supported by small local in-patient units and generally by an enhanced provision of services in the community. The feasibility of this has not yet been demonstrated. The relatively small size of the DGH units, the lack of money to create many more of them, and the nature and extent of the patient populations which the psychiatric services have had to continue to look after have frustrated the departments' plans. Some DGH units have been selective either in their admission policies or about those for whom they would continue to care, and the mental hospitals have had to receive those patients whom the DGH units have thought were unsuitable in the first place or whom they had failed to cure. In-patient facilities in community hospitals and hostels have not materialized. As we have noted, little or no progress has been made in developing community hospitals, and we understand that only one district has a 'hospital hostel' for the long-stay mentally ill.

The departments' plans have depended heavily also on increased provision for community care by local authorities.

Despite a sustained drive to discharge to and maintain mentally ill people in the community, the build up of the necessary social services has been slow. The provision of day centre places in particular has fallen far behind expectations. The capacity of local authorities to develop services, and in particular residential accommodation, for those who are considerably mentally disabled or disturbed may have been over-estimated. Local communities have not always welcomed such developments. (paras. 10.57, 10.58)

The Royal Commission thought that the DHSS attitude towards the old mental hospitals was an ambiguous one. This was exemplified by the statement in the 1975 White Paper, which was said still to represent Government policy to the effect that '... our aim is not the closure or rundown of the mental illness hospitals as such; but rather to replace them with a local and better range of facilities.' Most of those who worked in mental hospitals expected them to be closed, although so far only one had in fact been emptied of mentally ill patients—and that had been converted to the care of the mentally handicapped. Meanwhile 'critics and pressure groups have been encouraged to believe that mental hospitals must have harmful effects on patients and should be abandoned' (para. 10.59); as a result, staff morale had been damaged and recruitment affected. The health departments, the report argued, should make it clear that there was a long-term future for all mental hospitals unless they were exceptionally isolated or dilapidated.

There is a tantalizing brevity about the Royal Commission's discussion of psychiatric services as of many other specialized topics. It is arguable that although earlier Royal Commissions whose work had a bearing on health services (such as that on the law relating to mental disorder twenty years earlier) had been given excessively narrow terms of reference, the Merrison Commission's remit was so broad that it had proved impossible to examine a number of complex areas in sufficient depth to justify definitive recommendations. In relation to the overall balance of hospital-based and community-based services, the Commissioners reported 'We have not been able to reach a firm judgement about whether the present balance between hospital and community care is correct,' but added nevertheless 'We think it right that the emphasis should be on the development of community services ... progress will necessarily be restricted.' (para. 6.31)

In respect of psychiatric services, Ministers made it clear in the first year of the government's life that they did not contemplate any significant change of direction and explicitly adopted the policies and objectives set out in 1975—suggestions of ambiguity notwithstanding. The state of affairs inherited by the government was usefully summarized by Sir George Young, replying in May 1980 on behalf of the Secretary of State to a series of questions tabled by Mr R. Kilroy-Silk. Quoting 1979 figures, he showed that 32 local authorities had reached the guideline figure for residential provision in areas of 'average need' and three had reached the recommended level for day-care places; in both cases the calculation included provisions made by voluntary organizations. The generous providers of day-care were the Boroughs of Islington, Tower Hamlets, and Newham, all in north-east London, while the list of authorities that were up to standard with residential services included only five (Dorset, E. Sussex, Kent, Liverpool, and Manchester) that were not London Boroughs. At the same time, there were another 32 areas which made no direct provision for day-care and a handful which had created no hostel or other residential services. Further progress, said Sir George, would inevitably take a considerable time, but could be assisted by imaginative use of joint financing. The government proposed to increase joint financing in 1980/81 by 16 per cent at constant price levels over 1979/80.

Development and innovation: new pressures

Two significant documents published by DHSS in 1981 examined aspects of services for the mentally ill among other client groups. *Care in Action: A Handbook of Policies and Priorities for the Health and Personal Social Services in England* was directed at the members of the new district health authorities and the members of local authority social service committees, who in prefatory letters were addressed in bluff, headmasterly terms by the Secretary of State ('... priorities which Ministers will look to you to follow in running the services for which you are responsible. We want to give you as much freedom as possible ...') From the opening page, a tension is apparent between a belief in the value of peripheral authorities responding individually and imaginatively to local needs and circumstances and the conviction that there were national goals of over-riding importance. Was the prized local freedom to be limited to

a free choice of means towards nationally determined ends? It was far from clear.

The document touched in very general terms on the key problems of the statutory services and their links with the voluntary and private sectors. The statutory obligation on health and local authorities to cooperate to 'secure and advance the health and welfare' of the population was emphasized. Not for the first time, the Department stressed the importance of enabling as many frail elderly, mentally handicapped, and mentally ill people as possible to live in non-institutional settings, though it was careful to point out that this was not necessarily a less costly alternative. As far as mentally ill people and their families were concerned, the uneven progress made by social service departments in providing maintenance, support, and rehabilitation facilities was indicated in the customary tactful terms: 'some local authorities are now playing their full part'—many others, by implication, are not. For these purposes, an understanding of the personal and family problems involved and a knowledge of relevant community resources were more important than large financial commitments.

Care in Action offered somewhat clearer guidance on the future of mental hospitals, taking on the whole a less positive view than the Royal Commission had recently done. If they were not 'well placed to provide a service reaching out into the community' they should be closed over the next ten years or so and their resources redeployed to support 'the new pattern of health services'—perhaps even to support social service developments. Some changes of emphasis in the role of local authority social workers were envisaged. Preventive work had been neglected in the past, and in future should be given as much priority as was compatible with the discharge of statutory responsibilities; nevertheless, 'local authorities are expected to conform to the Government's target for spending overall' and a reduction in total net expenditure was clearly expected from 1981 onwards. The notion of using professional workers to identify community resources—particularly voluntary resources—and build up supportive networks was seen as best put into effect in the 'patch' system, the allocation of a small group of social workers to a small area of territory. *Care in Action* did not ask how far the 'patch' principle, which implies a very strong emphasis on the social worker as general practitioner, could be reconciled with the 1975 White Paper's belief that there had been too much erosion of specialist skills in social work and that a

new corps of social work specialists in mental health needed to be built up.

The document in question had set out clearly some fairly familiar objectives, suggested some modifications, but not done a great deal to provide original ideas as to how these desirable ends might be achieved. Those to whom *Care in Action* was addressed, whether elected or appointed members of public bodies, could perhaps be forgiven if they were heard to murmur that sermons were always stronger at extolling virtue than in demonstrating the precise steps by which it could be attained. However, it was quickly followed by another DHSS publication with a confusingly similar name but a different purpose. *Care in the Community* was subtitled *A Consultative Document on Moving Resources for Care in England*, and canvassed a number of specific ways of removing existing obstacles to the transfer of resources from health authorities to the personal social services. The over-riding purpose of such transfers would be to 'enable people who do not need to be in hospital to be moved into the community.'

The response to the consultative document was generally favourable. Replies received were analysed and led to a number of Ministerial decisions. These were set out in a further circular *Health Service Development—Care in the Community and Joint Finance*, distributed in March 1983.

The most valued proposal was that greater flexibility should be introduced into the arrangements for joint finance; useful though this scheme had been, the provisions for transfer of financial responsibility to local authorities which were under increasing pressure to contain their expenditure were seen as excessively restrictive. It was decided therefore that District Health Authorities might make lump-sum payments or continuing grants for an unlimited period to local authorities or voluntary organizations to provide services for identified persons moving from hospital into community care, and that subsequent vacancies in facilities supported in this way could be filled either by new discharges from hospital or by people who would otherwise have required hospital admission. In due time these arrangements would be made permanent by means of a 'central transfer of resources'; meanwhile, joint finance could be made available on a 10 years basis at 100 per cent with 'tapering' over a further three years. Another proposal in the consultative document which was warmly welcomed and subsequently approved by Minis-

ters (and incorporated in the Health and Social Services and Social Security Adjudications Bill) was to enable grants to be made by District Health Authorities for housing and education purposes.

Other proposals in the 1981 document had a more mixed reception. The suggestion that hospital buildings might be transferred together with responsibility for alternative services for its patients was not generally found attractive because of the unsuitable design and locational features of the premises likely to be involved. Although joint consultation and joint planning were accepted in principle by peripheral authorities and strongly encouraged by Ministers, the suggestion that these might be carried to a logical conclusion by pooling funds for a particular client group and assuming shared executive responsibilities was more than most respondents could accept; some approved of the idea but thought the practical difficulties would be insurmountable. New legislation would of course be required; yet it is possible that only a full integration of the contributing agencies can ever ensure the development of comprehensively caring services for the vulnerable groups concerned. An alternative suggestion was that one authority should be given sole responsibility for the care of a particular client group, but this found even less support and was not pursued further.

By the time of the General Election of 1983, then, the annual allocation of joint finance was creeping up to £100m and imaginative new ways of creating effective working relationships between structurally separate bodies with closely linked areas of responsibility were ready for exploration. The value of the work of the voluntary sector, taken to include both formal voluntary organizations employing professional staffs and voluntary activity in local communities, was again endorsed. There was strong encouragement to set up a series of pilot projects to explore alternative ways of taking long-stay patients out of hospital; part of the central allocation for joint finance would be reserved for such projects, all of which would be monitored by DHSS and some evaluated in detail.

While all of this points to significant achievement, two reservations must be noted. First, the new proposals covered the handicapped and the elderly as well as the mentally ill. The Department made it clear that it wanted to see a range of projects relating to different client groups, but it is a matter for speculation how large a part will be allocated to provisions for mental illness. A good deal of emphasis is bound to be given, quite properly, to the care of the elderly in view of

demographic pressures, with the added incentive that the needs of this group are tolerably well understood and that meeting them has obvious presentational and electoral advantages. Mental handicap also is likely to be a major beneficiary of the new proposals. Taking and keeping mentally handicapped people, especially young ones, out of institutional care has recently become something of a crusade, as well-established research-based knowledge has provided ammunition for pressure groups of a kind not active in the field of mental illness. To this must be added the attraction that providing community-based services for mentally handicapped children is bound to have for social service departments and even more for voluntary organizations active in the child care field, recent enthusiasms for adoption and fostering having both substantially reduced the use of their traditional residential facilities for the care of children deprived of a normal home life and opened up new possibilities for resettling the handicapped.

A second restricting aspect of the 1983 proposals is that they focussed exclusively on the transfer of long-stay hospital patients. Twenty years earlier this would no doubt have been seen as a major issue in the development of a community orientation for psychiatric services, but by the 1980s it had largely given way to the more complex and subtle problems of providing a network of supportive services to reduce the risks of relapse and repeated hospital admission. Activities of this kind seem unlikely to fall within the scope of the 1983 proposals.

New legislation

In parallel with the planning of new initiatives to transfer resources away from the health services, a great deal of departmental and parliamentary time was devoted during 1981 and 1982 to the reform of the Mental Health Act, 1959.

The 1959 Act had been designed principally to ensure that legal procedures and formalities should not stand unnecessarily between the person in need of treatment and the medical services available. As subsequent trends in admission and discharge demonstrated, the Act was very successful in this respect; the problems reviewed in these chapters were—and remain—largely problems of organization and co-ordination in the planning and delivery of services, complicated by the changing roles and relationships of professional groups, and

not problems created by legal barriers and restraints. Although the use of compulsory powers to detain patients in hospital in particular circumstances continued after the Act, the use of most of the relevant sections declined steadily. By 1979 compulsory admissions accounted for 10 per cent of all hospital admissions for mental illness, compared with twice that proportion only 13 years earlier. Nor did most of these admissions lead to prolonged periods of detention. Only 5000 patients, 7 per cent of all those in hospital at the end of 1979, were held under compulsory powers.

Nevertheless persistent attacks on the 1959 Act were mounted in the 1970s on the grounds that it infringed the civil liberties of patients, depriving them of fundamental rights in the name of medical judgment. The attack was a particularly forceful aspect of a wide-ranging critique of the use of the treatment ethic to justify compulsory intervention in the lives of persons disadvantaged in one way or another, and it stemmed at least in part from the extensive and effective use made of the courts in the USA to overturn discretionary professional and administrative decisions. MIND, formerly the National Association for Mental Health, led a vigorous campaign against those sections of the Mental Health Act that gave compulsory powers to doctors or restricted the rights of detained patients. How much energy was thereby deflected from the promotion of other, perhaps equally valuable causes relevant to the welfare of the mentally ill can never of course be estimated.

In spite of rather general opposition from the psychiatric profession, the case for reform made progress; the need for some revision and updating within the overall framework of the Act came to be accepted. A consultation paper in 1976 led two years later to a White Paper *Review of the Mental Health Act, 1959* and in due course to the Mental Health Amendment Bill of November 1981.

The explanatory memorandum that accompanied the Bill made it clear that its scope was limited.

The Bill is about the status and legal position of those mentally disordered people who need special protection or control. It is not about the services for the much larger number of mentally ill and mentally handicapped people in hospital and in the community as a whole.

For the most part therefore the provisions of the Bill, which with certain modifications received the Royal Assent in November 1982,

are not directly relevant to our present concerns. The 'larger number of mentally ill people' were not affected by the Act's halving of the period that is required to elapse before a compulsory order is renewed or terminated, its improvement of access to Mental Health Review Tribunals or its establishment of a Mental Health Act Commission with a general protective function for detained patients. There were however some interesting innovations in the responsibilities allocated to social workers, and although these were formulated in terms that applied only to compulsorily detained patients, there is at least a possibility that they may have longer-term implications for the welfare of a wider range of mentally ill clients.

S.16(3) of the Act introduces the concept of 'the approved social worker', who will be required to interview patients before making an application for admission to hospital, so as to satisfy himself that detention in hospital is the most appropriate means of ensuring that the patient receives the care and treatment he needs. S.17 additionally provides that 'where a patient is admitted to hospital in pursuance of an application (other than an emergency application) made under Part IV of the principal Act (i.e. the 1959 Act) by his nearest relative', the local authority for the patient's home district shall 'arrange for a social worker to interview the patient and provide the managers (of the hospital) with a report on his social circumstances'. The approved social workers, who would take over their responsibilities two years after the passage of the Act, must be appointed in sufficient numbers by local social service authorities, and must be approved by the authorities as 'having appropriate competence in dealing with persons who are suffering from mental disorder'.

When these proposals were first made public, it became clear that the statutory responsibilities of the Central Council for Education and Training in Social Work had been embarrassingly overlooked. This omission was soon made good, and at the time of writing (June 1983) considerable progress has been made, mainly in CCETSW's initiative, on planning assessment procedures and appointing examiners. CCETSW will be responsible for the assessment of competence, though the training programmes themselves will be in the hands of the local social service authorities.

An amendment to the Bill, introduced in the House of Lords and incorporated in the Act as S.51, laid a duty on the District Health Authority and the local social services department to provide

aftercare services for some categories of detained patients when these were discharged from hospital care.

Whether these provisions of the Amendment Act will have wider repercussions can at present only be a matter for speculation. It is at least possible that the creation of a body of social workers in each area who have some specialized training in mental health matters will go some way towards redressing the balance of interests within social service departments. Those who are recognized as 'approved social workers' under the Act may not be content with specialized duties that relate only to compulsory admissions, but may exert pressure for a more wide-ranging social work contribution to the welfare of mentally ill people in the community. The compulsory after-care provision designates the health authority and social services authority as equally responsible, creating a need for agreement as to the allocation of responsibilities. Here too a development is projected that applies only to a small proportion of discharged psychiatric patients but which may conceivably provide a foundation for more extensive services for those leaving hospital psychiatric care. Though there are some grounds for hope, all our past experience should warn us against excessive optimism as to the likelihood, in the foreseeable future, of substantial growth in the social work contribution, however desirable that may be.

Lacunae

On reading the foregoing review of trends in community mental health services between 1959 and 1983, one is struck by two important areas of omission. First, there is a missing human dimension. In its emphasis on legislative and administrative developments and its concern with quantifiable changes in the levels of service provision, the review conveys little of the existential realities of mental illness for those who suffer from it or live with it or indeed work with it. The inevitably crude social and medical categories employed conceal a multiplicity of individual sufferings, tensions, and problems of relationship. Even our discussions of new or expanded services leave unanswered pertinent questions about the quality of life experienced by those for whose benefit these services are provided. We tend to think of hostel places or day-care provision as intrinsically superior to life in a hospital ward, although there are grounds for suspecting that institutionalization and neglect can take

shape in community-based facilities no less than in hospital wards, even if necessarily in less dramatic form. A whole range of qualitative questions remains unanswered, indeed scarcely formulated. The gaps in these chapters reflect in large measure the limitations of recent social-psychiatric research. Somewhere in the mid-sixties the impetus to build up a substantial research literature—as distinct from a polemical literature—on the human consequences of mental illness, or on the evaluation of community services, seems to have been dissipated. There has recently been research of very high quality in the ill-mapped borderlands of sociology and psychiatric epidemiology but little in the areas directly relevant to our narrative.

The second gap is one that can be filled in later chapters. In order to understand why community mental health services grew slowly and encountered so many obstacles during the period under review it is necessary to take account not only of structural factors and financial commitments, but also, it is suggested, of the changes that were going on at that time within and between the professions whose respective contributions were potentially significant. If opportunities were not seized, if initiatives were not pursued, if areas of responsibility were neither demarcated nor integrated, we may need to look beneath the apparatus of joint committees and consultative bodies and raise questions about the ways in which members of the professional groups involved perceived themselves and one another, and about the changes in patterns of work and of relationship that occurred over a period of some 25 years. Some aspects of these patterns and trends are better documented than others, but we can form some view of the vicissitudes of psychiatry, community psychiatric nursing, social work, and general medical practice during what for all of them was a period of crucial importance. Such an examination is no less necessary as a preliminary to suggesting hopeful lines of growth for the future. This is the subject-matter of the second part of this report, which also takes account of significant developments in the voluntary sector.

5

Stands Scotland where it did?

The review in the preceding chapters of developments in hospital and community services relates only to England and Wales. Scottish health and welfare services are governed by separate legislation, and the patterns of organization and service provision that have evolved both under the NHS and within local authorities are significantly if in most instances not profoundly different from those south of the Border. The care of the mentally ill is an interesting example of quite substantial Anglo-Scottish differentiation having developed on the basis of variations in professional and administrative attitudes rather than of legislative decisions.

The English Hospital Plan of 1962, which incorporated far-reaching proposals for the reduction of psychiatric hospital provision, was paralleled but not matched by the Hospital Plan for Scotland. The statistical projections of Tooth and Brooke had taken no account of data from Scottish mental hospitals, and the officers of the Department of Health for Scotland saw no need to apply their conclusions:

The advent of the new mental health legislation and the increasing emphasis on community care impart an element of uncertainty into this part of the hospital service. As the local health authority and other supporting services develop, and as the public understanding of mental illness grows, it is likely that some classes of patient hitherto admitted to hospital will be able to remain in the community or to return sooner. Consequently,

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the numbers and character of the hospital population may change somewhat. There is, however, little evidence yet in the Scottish figures of any very large run-down of the total hospital population. (Department of Health for Scotland, 1962a).

No standard ratio of psychiatric beds to population was therefore adopted, and no target figures for 1975 were set.

This caution was on the face of it commendable, but to set it in context we must recall that psychiatric in-patient provision in Scotland was at the time exceptionally generous. At the end of 1961 there were 19,672 mentally ill patients occupying hospital in-patient places, corresponding to 3·8 per thousand population or 15 per cent more proportionately than England and Wales. (Department of Health for Scotland, 1961). This was consistent with a traditionally stronger emphasis in Scotland on institutional forms of provision: institutions for the mentally handicapped, residential homes for children, and prisons all housed proportionately more inmates than their English counterparts. The heavy dependence on hospital care went hand-in-hand with a very low level of activity in the local health and welfare services. The English local authority scene was not at that time generally impressive in this respect, but the few attempts that had been made to develop or co-operate in imaginative services had no equivalent in Scotland. Indeed, over the period 1951/52 to 1961/62 local authority expenditure on mental health services remained constant—which is to say that in real terms it declined very substantially. (Department of Health for Scotland, 1962b). Such provision as was made was entirely in the field of mental handicap, and the expansion of local authority services during the sixties did not touch at all on the mentally ill.

The degree of stability of the Scottish psychiatric in-patient population is remarkable. The lack of any sign of a significant reduction, referred to in the Hospital Plan of 1962, suggests that the advent of tranquilizing drugs had had a minimal impact during the late 1950s on customary patterns of retention and discharge, in spite of a major exercise in the reclassification of patients which produced a steep fall in the number retained under compulsory powers. Changes in the next decade or more were minimal. During 1962 there was actually a growth in the in-patient population; by the end of that year there had been an increase to 20,159 residents—excluding those in the psychiatric wards of general hospitals. Although there was a slight fall thereafter, the total resident population fluctuated between

19,000 and 20,000 up to and including 1973. At the end of that year there were 18,632 in-patients in Scottish mental hospitals and a further 506 in psychiatric units attached to general hospitals. This 'prevalence' rate of nearly 3.7 per thousand population may be compared with the contemporary English occupancy rate of 1.9; Scotland, with little more than one-tenth of the population of England and Wales, had one-fifth of their number of psychiatric patients.

Throughout this period, annual rates of admission to mental hospitals were rising, from about 17,000 per annum in the mid-sixties to between 22 and 23,000 in the early and middle seventies. To these must be added the annual intake to general hospital psychiatric units, which remained fairly constant at about 2800. Taking one year with another, discharges and admissions were approximately equal; over the ten-year period 1968-77, there was a total of 241,000 psychiatric admissions and 241,000 discharges. In both mental hospitals and general hospital units, the ratio of admissions to residents was lower than in England, though in the general hospital case only marginally so; in 1975 the Scottish ratio of 1.3:1 for mental hospital admissions to residents compared with the English proportion of 16:1 for the same year, while in the general hospital psychiatric units the respective ratios were 7:1 and 8:1. One striking feature of the Scottish scene was the relative lack of expansion in general hospital provision for mentally ill patients. In the mid-seventies the latter accounted for one-eighth of all psychiatric admissions, a fraction only half that obtaining in England.

Several factors seem to have combined to maintain a relatively large population in in-patient psychiatric care in Scotland—a slow rate of decline in the established long-stay population, a tendency towards longer durations of stay for current admissions, a smaller provision of 'fast-moving' general hospital wards and not least a high overall admission rate. Admissions in the mid-seventies averaged 4.8 per thousand population, while the corresponding rate for England was 3.5 per thousand. There was a major contrast in first admissions, which throughout the 1970s were in excess of 10,000 a year, corresponding to 2 per thousand population, approximately twice the English first admission rate. Although the number of persons admitted annually who had had previous experience as in-patients was proportionately greater than in England, considered in relation to first admissions the risk of re-admission for Scottish psychiatric

patients was consistently lower—a consequence possibly of the longer average duration of the initial stay in hospital.

In 1974 the hospital population fell significantly to 17,600 but remained above 17,000 in each of the next four years. There was a further reduction at the end of the decade, and at the end of both 1979 and 1980 a census of patients indicated fractionally fewer than 16,000 residents. By that time however the corresponding English figure was only 76,000; north of the Border there remained proportionately twice as many people under in-patient care as in England.

A direct comparison of trends in admission rates for specific diagnostic groups is complicated by factors referred to in earlier chapters. It seems however that there were both similarities and differences between Scottish and English diagnostic frequencies. Both in the mid-sixties and at the end of the seventies, the first admission rate and the overall admission rate for schizophrenia in Scotland was very close to that in England. In 1964/65 the in-patient admission rate for senile dementia was slightly higher in Scotland than in England, but while first admissions (though not total admissions) fell steeply in England over the next 15 years, the corresponding Scottish rate rose slightly and total admission increased markedly. In both periods, admission rates for personality and behaviour disorders were approximately twice as high in Scotland, while in respect of admissions for alcoholism and alcoholic psychosis we find an approximately five-fold difference. Changes in diagnostic classification make it particularly difficult to assess trends over time in admissions for depressive conditions, but it does not seem that this major category was significantly more common among Scottish than among English in-patient admissions.

The heavy emphasis on in-patient care did not imply a failure to develop non-resident clinical provision. The expansion of out-patient services in hospital and peripheral clinics was considerable. Between 1964 and 1980 the annual number of new out-patients went up from 17,500 to more than 31,000, an increase of 77 per cent. This was very much greater than the overall rate of growth of out-patient services during that time, which was only one-third. What proportions of this work are respectively attributable to pre-admission assessment, post-discharge follow-up and ongoing treatment is unknown. Seen side-by-side with the data on hospital admissions and discharges, however, there is no indication that the out-patient

services have been providing an alternative service for those who would otherwise have been admitted to a psychiatric ward.

There are two respects in which the development of services for the mentally ill in Scotland has been almost insignificant compared with the position in England: the provision of hospital-based day-care and of specialized local authority social services—even though in the latter area at any rate the history of service development in England, has, as we have seen, fallen considerable short of earlier expectations. Day-hospital facilities for mental illness were unknown in Scotland before the mid-seventies, with the exception of units for children and adolescents which were dealing with about 500 cases a year. It was only in the last years of the decade that any day-hospital arrangements for the adult mentally ill became evident, with an average of 650 patients being admitted to this mode of care in the years 1977-1980.

The near-total failure of the local authority system is striking. The reorganization of the personal social services came two years earlier in Scotland than south of the Border (see chapter 6). The new unified social work departments begun from a smaller base of established professional activity, were more wide-ranging in their obligations (because of the abolition of the Scottish probation service and the creation of an entirely new juvenile justice system) and had imposed on them a general legislative commitment ('to promote social welfare') that was if anything even more open-ended than that of their English counterparts. In a land with seemingly intractable problems of poverty and urban deprivation, the demands on the personal social services have been heavy by any standard. Whence should come the initiative to create an entirely new range of services in the face of so many and varied demands that seemed able to absorb any additional resources than were made available? The Scottish Hospital Plan of 1962 implied that a run-down of psychiatric institutions should wait upon the appearance of new community services. But there has been no such manifestation in the public sector, and there is no very obvious reason why there should be. If in England the continuing emphasis on early discharge and the reduction of the established long-stay population created major problems for the individuals and families concerned, it also generated pressures on local social service authorities to which some at least were prepared to respond. To say this is not to condone a callous policy of emptying wards when no community alternatives are

available, but merely to make the cynical point that the maintenance of large hospital establishments makes it extremely easy for the administratively, financially and in many ways ideologically separate social work authorities to fail to acknowledge any responsibilities on their own part.

In 1982 there were in Scotland only 65 day-centre places for the mentally ill; only one centre, with 35 places, was directly provided by a local authority. One hundred and forty people were living in hostels or group homes provided by social work departments, with a further 40 residents in similar accommodation under the auspices of voluntary bodies. If the levels of provision in Scotland had matched those prevailing in England (and generally deemed inadequate) one would have expected to find between seven and eight times as many day-centre places and between two and three times as many residential places.

Even arrangements for the transfer of health service funds to local authorities to support community-based projects which would reduce the burden on the NHS were introduced more slowly in Scotland, and on a less generous basis. Co-operation between health boards and local authorities was enjoined by the National Health Service (Scotland) Acts of 1972 (s.20) and of 1978 (s.13). A Working Party on relationships between the authorities in question recommended in 1977 that joint liaison committees should be established as one way in which co-operation might be made more effective. Several such committees were set up, but there is no record of any significant developments in relation to mental illness arising from their work. It was not until March 1980 that the principle of 'support financing' was introduced in Scotland, with the same objectives as the 'joint financing' that had been brought into effect in England and Wales in 1976. The terms outlined were also similar. The upper limit of a Health Board contribution to the capital cost of a local authority project should normally be 60 per cent—but this contribution should be expressed 'in financial and not percentage terms', so that any additional costs that might arise in tendering or construction would fall upon the local authority. Financial support for running costs would be for 'a limited period only and on the understanding that the local authority will assume full financial responsibility as soon as possible.' The initial contribution to running costs should not exceed 60 per cent of the total and should be on a reducing scale over a period of not more than five years; a joint

review of arrangements after three years might however lead in exceptional cases to a decision to extend a contribution towards revenue costs into a sixth or seventh year. Projects proposed by voluntary organizations might be eligible for inclusion in joint financing arrangements, but no such proposal could be submitted to the area health board without the prior approval of the social work authority; and the final decision on all support financing proposals, wherever they originated, lay with the health boards (NHS Circular No. 1980 (GEN) 5). These belated plans for the limited use of NHS funds to support community developments seem to have aroused little enthusiasm among Scottish local authorities, and their impact on provisions for mental illness has been negligible. At the time of writing, there is no indication whether the more generous provisions recently introduced in England and Wales will be matched by more attractive Scottish proposals. Meanwhile, the manifest disparity provides an easy justification for continuing inactivity.

One surprising feature of the Scottish scene has been the absence of major public debate on the pattern of mental health services. Mrs Castle's White Paper of 1975 moved no mountains, but it discussed honestly some major deficiencies in the services and by laying down guidelines for the level of provision of particular facilities it stimulated greater self-awareness and some self-criticism on the part of local authorities. Neither that publication nor the more recent discussion document on care in the community had any Scottish equivalent. Two statutory bodies, the Scottish Health Services Planning Council and the Advisory Council on Social Work (the latter subsequently abolished) set up a joint sub-committee to examine services for the mentally ill, but its report, although completed in 1981, has never been published. It would no doubt be unreasonable, especially in recent and current economic circumstances, to expect Departments of State to be intensely active in promoting innovation in the public services, but it is hard to shake off the impression that in Scotland there has in this field of work been an excess of complacency and a lack of self-examination both in the central department and in the relevant professions.

Many questions remain to be answered before the distinctive features of Scottish mental health services can be explained and not merely described. Are there genuine differences in the incidence of particular psychiatric disturbances—other than those associated with alcoholic excess, where the case has been reasonably clearly

established? How far do disadvantaged social conditions create the perception of a stronger case for hospital admission or for longer duration of stay—and, if they indeed have a significant influence on professional decisions, how well-founded are the underlying assumptions? To what extent has there been a failure to recognize the hazards of institutional life? If there has been a somewhat too complacent conservatism, what are its roots and by what processes has it been perpetuated? Given sufficient official interest and professional curiosity, it would be possible to entertain ways of seeking solutions to these problems, all of which may be involved in varying degrees in the pattern of services described in this chapter; but the very lack of that curiosity may itself be part of the problem.

Whereas in England a policy of community care has been promulgated but only very incompletely and imperfectly carried through, in Scotland nothing has been promised and virtually nothing achieved. It could be argued that the Scottish position is not something deviant and discreditable that calls for special explanation, but rather that it represents a wise and realistic policy, working in the best interests of the mentally ill and their families. But this too would need to be demonstrated empirically and not merely be asserted; too much is known about the damaging effects of long-stay institutional care for that self-justifying claim to be accepted at its face value. If over the years between the Mental Health Acts the relevant services in England travelled hopefully in what was believed to be the direction of community care, but without maps or landmarks and with an unco-ordinated gait, their Scottish equivalents, we may suspect, have remained in very much the same place with little attempt to take stock of its limitations or to discern new goals. In the absence of fresh evidence the answer to Macduff's question must in this respect be—regrettably, yes.



*Social work:
From Younghusband to Barclay*

Social work in the nineteen-fifties

During the period under review the profession of social work underwent major changes in scale, in training, in the ways in which it was organized and deployed and in its place in public awareness. And although—indeed, perhaps because—the changes were in the direction of greater numbers, wider powers and more extensive influence, the period was marked by recurrent debate over the nature of the professional task and the place of social work in the broader context of social development. By an interesting coincidence, a major official report on social work appeared in the year of the Mental Health Act and another at the time of the Amendment Act.

In the 1950s a limited and reasonably well-defined range of personal social services was delivered by fairly small groups of workers, many of whom had received little or no professional training and who worked in a number of separate organizations or departments. These various groups had come into existence at different times in response to what were then perceived as specific social needs.

The probation service had been created by legislation as long ago as 1908, to 'advise, assist and befriend' offenders, and was linked primarily with the courts rather than the local government system. The Home Office was responsible for both the training of probation officers and the inspection of probation services. As a career, probation had always been able to attract a certain number of young

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men of good educational background and strong social conscience. At the risk of some exaggeration, we can say that their female counterparts were to be found in the child care services. The Children Act of 1948 was a reaction to revelations of casual incompetence on the part of local authorities in the handling and placement of neglected and deserted children, with some consequent tragic deaths that became *causes célèbres*. Henceforth, responsibility for the care of children 'deprived of a normal home life' was to be in the hands of a specialist officer, overseen by a separate committee of the local authority and inspected by the Home Office. A number of training courses grew up in the 1950s to meet the needs of this small but rapidly expanding corps of social work specialists.

Other social workers employed by local government generally had different educational—and probably social—backgrounds. The National Assistance Act, 1948, which finally brought to an end the life of the Poor Law, transferred some of its functions to the county and county borough councils. These were the provision of residential accommodation for the elderly and infirm who were in need of care and attention not otherwise available to them; the provision of temporary accommodation for homeless people; the promotion of the welfare of the blind and (optionally) of the deaf and the disabled. These responsibilities were generally discharged either by a separate welfare department of the local authority or by a specialist section of the public health department. Breaks with the past are commonly less decisive than new legislation and new structures might lead one to expect, especially when there is in effect a continuity of personnel. Just as 'Part III accommodation' was almost invariably provided in former work-houses, so most of the staff responsible for the new welfare services had previously acted as relieving officers or other employees of the Public Assistance authorities. The now defunct Poor Law was also a major source from which mental welfare officers were recruited; in a number of areas, their practices were combined with general welfare duties. Almost without exception, welfare officers and mental welfare officers alike neither held professional qualifications nor had had experience of higher education. The tradition of untrained staff inherited from the Poor Law was perpetuated by the practice of recruiting new intakes from the ranks of the clerical and related grades.

In the mid-1950s there were in Britain about 500 psychiatric social workers and about 1200 almoners (or medical social workers, as they

were beginning to be designated). All of these, by definition, were professionally trained and qualified, either through university-based courses or through the training programme organized by the Institute of Almoners. This latter group had come into existence early in the century and had initially been concerned principally with the assessment of patients' means; increasingly however they turned their attention to the provision of help and support for hospital patients whose medical condition was associated with or had brought in its train some personal or social difficulties, and after the creation of the National Health Service the abolition of fees in hospitals made it possible for almoners to concentrate exclusively on patients' needs rather than their possible liability for payment. The first British training course for psychiatric social workers was established in 1929 at the London School of Economics; thirty years later, three other university-based courses were also in operation. The majority of practising psychiatric social workers were employed in hospitals or out-patient clinics, with a substantial minority working in the child guidance services. Only a handful of either medical or psychiatric social workers were employed in the health and welfare services of the local authorities. A key element in the work situation of members of both these groups of social workers was a close relationship with medical practitioners, although few medical or psychiatric social workers would have claimed that there was a strong sense of impaired professional autonomy.

The Younghusband Report and its consequences

A working party set up in 1955 under the chairmanship of Miss (later Dame) Eileen Younghusband to enquire into 'the proper field of work and the recruitment and training of social workers . . . in the local authorities' health and welfare services . . . and in particular whether there is a place for a general purpose social worker with an in-service training as a basic grade' presented its report early in 1959. The central recommendation of the report was that three clearly demarcated grades of social worker should be recognized: welfare assistants with minimal training, who would deal with 'people with straightforward or obvious needs who require material help, some simple social service, or a periodic visit'; social workers with a general training in social work equivalent to two years full-time training, who would undertake the main range of work in local authority health

and welfare departments then being carried out by welfare officers, mental welfare officers and so on; and professionally trained and experienced social workers (almoners, psychiatric social workers, and family caseworkers) who would handle particularly complex cases and provide a consultation and supervisory service for other workers. 'Elitism' and 'elitist' were not at that time recognized terms of abuse.

From this principal recommendation flowed many others. The output of highly qualified and university-trained caseworkers should be expanded, and an increasing proportion should be attracted into local authority service. For the proposed middle grade of social worker, an entirely new training programme should be initiated. New courses should be established, mainly in the further education sector; a new national professional qualification should be created, and a national training council to issue the awards, promote and oversee courses, and maintain educational standards. Existing welfare officers and similar personnel over the age of 50 might be regarded as qualified by experience, but a significant proportion of younger workers in the health and welfare services should be encouraged to undertake the new training. There should be research into the nature of social needs and social work problems; and so on.

A Council for Training in Social work was in fact established by legislation of 1962, and within five years some 30 courses had been set up, mainly in colleges of further education, offering two-year training programmes for non-graduates. At the same time, a growing number of universities, both established and newly created, entered the field of social work education by providing qualifying courses at the postgraduate level. (Even in this period of rapid university expansion, the academic status of social work remained ambiguous. No chairs or independent departments of social work were created, although a few were to come into existence in the early 1970s. Social work training courses either occupied uneasy corners of departments of sociology or formed partnerships—sometimes mistrustful, sometimes tolerant, occasionally positively productive—with undergraduate departments of social administration.) By 1967 the annual output from professional social work courses of all kinds had reached 1000. Increasingly, local authorities and other employing agencies were both expanding their social work establishments and replacing retired staff with qualified practitioners; inevitably however unqualified social workers remained very much in the majority throughout

the 1960s. This was particularly true of the mental welfare services of the local authorities, in spite of some increase in the number of psychiatric social workers entering this field of employment. In this, certainly no less markedly than in other areas of practice, there were very large variations between authorities both in the scale and the quality of the services provided. But these developments in training and in service provision were overtaken, first by the emergence of new professional attitudes and ideologies and then by a fundamental critique of the whole current pattern of local authority personal social services.

Generic principles

The Younghusband Working Party had been set up to examine, *inter alia*, the possible role of a 'general purposes' social worker. In their report however they made it clear that they had felt obliged to discontinue the use of a term which had, it seemed, given rise to a good deal of confusion. Some of the organizations submitting evidence to the Working Party had assumed that the term referred to an 'all purposes' social worker (rather than, as was intended, one who could discharge a variety of functions within the local authority health and welfare services) and were inclined to dismiss this misconceived notion as highly unrealistic. That one individual could be expected to encompass the whole range of social work responsibilities seemed to verge on the absurd. Yet even in the late 1950s there were to be found some indications of interest in the concept of social work as a unitary activity, and the trend was to become increasingly powerful during the following decade. Social work education played a major role in encouraging this development.

Two or three university-based social work courses in the 1950s offered a standard programme of professional training to graduates who proposed to pursue careers in several different branches of social work. This did not apply in the further education sector, and even those who attended the university courses generally saw themselves as potential specialists of one kind or another. As university courses multiplied in the 1960s, they followed for the most part a generic pattern, and were commonly referred to as courses in 'applied social studies'. The unifying element was provided by the principles and practice of social casework, in the particular sense in which that term had come to be understood. That sense had quite a long pre-history,

but now in a fairly short space of time it came to provide a common philosophy for several different groups of social workers, justifying a 'generic' approach to professional training and ultimately—with, it may be argued, a certain amount of sophistry—a generic mode of practice.

Social workers, it was said, encountered clients in a number of different settings (hospitals, clinics, local authority offices), clients who fell into different age-group, administrative, or legal categories. But at a deeper level of analysis, it was claimed, the underlying problems were often similar; and there were also very important common features in the ways that trained social workers dealt with them. The client's presenting problems, though not necessarily to be pushed to one side as irrelevant, often—perhaps generally—were only the outward symptomatic expression of more profound difficulties. Frequently, the latter were rooted in the client's personality and his characteristic patterns of relationship. The social work encounter must therefore begin with a period of careful assessment, in which the worker elicited a personal history and attempted to assess the nature and significance of the underlying difficulties. Once identified, the pattern of cause and effect had to be made comprehensible and acceptable to the client; this was rarely a simple or brief task, given the strong dislike of caseworkers for simple didactic styles and their correspondingly positive emphasis on the need for client and social worker to work through difficulties together. How the problem was finally resolved would depend both on its own characteristics and on those of the client. If he or she could bring sufficient and appropriate resources to bear and if the problem was one susceptible to change, the emphasis should be on mobilizing those resources so as to effect a significant improvement in the client's circumstances; but if a problem was judged intractable or a client insufficiently strong, the social worker's objective should be to help achieve a more satisfactory adjustment to an apparently unchangeable situation. At each stage, the relationship between social worker and client was of crucial importance. How fully these principles were reflected in the actual practice of professional social workers is impossible to determine, but it seems probable that at any rate in the more prestigious areas of social work practice they constituted a set of ideal standards at which to aim and were not merely rhetorical.

It will be obvious even from this grossly over-simplified summary that casework theory has some affinities with the principles of

psychoanalysis. Although it might be unfair to see casework merely as an attenuated version of analytical theory and practice, it is improbable that this highly influential construction of the social worker's function could ever have evolved if Freudian and neo-Freudian writing and clinical practice had not flourished. Psychiatric social workers, on balance the best educated and most carefully trained of the social work specialists, enjoyed high prestige and played an important role as disseminators of ideas. These psychodynamically-oriented concepts had a key position in the more sophisticated social work courses and contributed significantly in the late fifties and early sixties to a growing sense of the common core of social work. Nevertheless, even those who argued forcefully for a recognition of a fundamental unity and the further development of a common framework of training did not at first see this as leading to a dissolution of the established specialisms which remained the foci of most social workers' professional loyalties.

Towards generic practice

The first official steps towards the creation of all-purpose social service authorities and as consequences, though not as inevitable corollaries, all-purpose social workers and universal generic training were taken in Scotland—doubly surprisingly, in view both of the customary practice by which Scottish Bills are drafted after the corresponding English legislation and of the relatively underdeveloped state of Scottish social work. North of the Border, the point of departure was the report in 1964 of a committee (the Kilbrandon Committee) whose remit had been to review and suggest possible improvement in the juvenile justice system. The report had recommended the creation of an entirely new system of lay 'juvenile panels' (or children's panels as they were later redesignated) and proposed that reports for the panels should be prepared, and supervision orders made by the panels should be carried out by a corps of specialist social workers attached to the education departments of the local authorities. Under the Labour administration that came to power in 1964, responsibility for dealing with the Kilbrandon report fell to an energetic junior minister in the Scottish Office (Mrs—later Dame—Judith Hart). Mrs Hart, who was a social sciences graduate and had some contacts with the world of social work, conceived the possibility of bringing about not merely a reform

of the juvenile justice system but a thorough-going reconstruction of the personal social services. She assembled a small and fairly informal team of advisers, consisting of two Scottish psychiatric social workers and an English professor of social administration. Although they carried out no research, assembled not even the simplest statistical information nor, as far as can be judged, thought through in any depth the likely problems of administration and consumer demand, they produced political results. If Mrs Hart's advisers wrote any report, it has never been published. What emerged with commendable speed was the White Paper *Social Work in the Community* (1966).

The defects of the current organization of local authority social work and welfare services were seen in the White Paper as arising from their piecemeal development in response to 'the identification at different times of certain groups of people who needed social help'. But the inter-relatedness of human problems, the body of expertise common to all social workers, the shortage of trained and experienced staff and the bewildering array of agencies all pointed to a single conclusion' . . . the local authority services designed to provide community care and support, whether for children, the handicapped, the mentally and physically ill or the aged, should be brought within a single organization.' There were sensible if superficial discussions of the importance of co-operation between the proposed new social departments and other statutory and voluntary agencies and of the value of preventive work. Social work services for the new system of children's hearings would be provided not of course by a department under the control of the Director of Education but by the staff of the new multi-purpose departments of social work, along with their many other obligations. The areas of responsibility of the new departments were briefly summarized; the main increase in cost, it was concluded, would be due to the appointment of Directors of Social Work and some regrading of other posts, balanced by savings resulting from the more efficient deployment of staff. Thus a report which had advocated the creation of a new social work specialism was unexpectedly transformed into the launching platform for a proposal that would entail—when all its essential features were incorporated in the Social Work (Scotland) Act of 1968—the rapid demise of all specialized social work services in the local authority setting.

Scotland then was already committed to a unified system of social

work provision when at the end of 1965 the Seebohm Committee was appointed 'to review the organization and responsibilities of the local authority personal social services in England and Wales, and to consider what changes are desirable to secure an effective family service.' There was no specific intention to bring the pattern of services in England and Wales into line with that planned for Scotland. Indeed, at least one major difference was clear from the outset. Kilbrandon had recommended, and the Scottish White Paper confirmed, that the probation service should be brought to an end, but the Seebohm Committee was explicitly precluded from considering the work of the probation and after-care service in England and Wales and making any proposals directly affecting it. Nevertheless, a shift towards unification seemed to be fairly clearly foreshadowed by the Committee's terms of reference.

The principal recommendations of the Seebohm Committee have been discussed in an earlier chapter so far as they affected the future organization of community mental health services. However, their long report contained much valuable information and a wealth of ideas about social work and it may be relevant here to examine some of the views expressed on practice and training.

There is a distinct contrast between the clarity and assurance with which the Committee expressed itself on certain issues and an ambiguity which appears from time to time in the report in relation to matters no less crucial. On the need for a unified social service department, for example, the conviction expressed is unwavering. It is almost impossible to read the chapter which reviews alternative patterns of organization suggested by various witnesses, and retain the belief that each variant was accorded the same degree of detached, scrupulous consideration. The advantages of models other than the unified department are mentioned, only to be brushed aside by a list of objections. The possible drawbacks of the unified departments are alluded to, only to be dismissed by a powerful recital of the gains to be expected. If the committee's collective mind was for long open on that fundamental issue, the fact is well concealed by the manner of drafting. When on the other hand the equally significant question of roles and responsibilities within the new departments is under consideration, there is in the report a notable lack of precision.

In general, it was argued that students embarking on social work courses should undertake a common training and that the prevailing pattern of specialization should be radically altered (para. 509). The

views of the British Medical Association to the effect that there was too high a degree of specialization early in the social worker's career were cited approvingly (para. 510), although they clearly did not point to an abolition of specialization. However, most of the evidence submitted on that score—and there does not seem to have been a great deal—agreed that it would be desirable for groups of specialists to be available within the unified departments, for reasons of administrative convenience, professional expertise and temperamental preference (paras. 511–515). 'We see force in these arguments' the report continues—in Seebohmese, a clear signal that the views in question are about to be ignored—but goes on to assert that '... a family or individual in need of social care should, as far as is possible, be served by a single social worker' (para. 516). There is a double *non-sequitur* in this conclusion; it implies, in the absence of evidence or detailed argument, that a department containing groups of specialists could not meet the requirement, and it assumes that the type of service advocated would necessarily do so. However, a recently qualified social worker might well '... pursue concentrations of interests' (para. 521), and some workers might be attacked to institutions such as schools or health centres '... on a fairly long-term basis' (para. 523). Further, 'Officers with specialized knowledge and experience, and in many instances further training will be required as consultants ...' Behind what seems to be a fair measure of equivocation on this subject there lies a perhaps surprising lack of capacity to see beyond organizational forms and to reconstruct imaginatively the ways in which work is actually carried out and decisions actually made within social systems.

On the question of social work training the Seebohm view was quite clear. Not only should training provision be greatly expanded, overseen by a single Council and tailored to a generic pattern at any rate at the basic qualifying level, it should also be freed from status differences. The Younghusband distinction between college-based and university-based training should be removed, and recognized professional social work qualifications, wherever obtained, should be of equal standing.

Although the Seebohm report gave a generous recognition to the potential contribution of research to the development of the personal social services, there is little indication of a detached research-mindedness as applied to the subject matter of its own deliberations. This is evident not only in the Committee's dismissal on rather

superficial grounds of suggestions that a period of planned experimentation might prove a useful means of identifying the merits and drawbacks of alternative systems of organization, but strikingly in their failure to acknowledge the researchable questions relevant to the debate on specialization in social work. What precisely are the special skills required in different areas of practice? What bodies of knowledge are needed to support the skills? How effectively can these be incorporated in training programmes which emphasize common principles and methods, or encompassed by a single worker with multiple responsibilities? There seems to have been a marked reluctance to contemplate propositions which were at least in part amenable to empirical enquiry, but which if taken seriously might have undermined the conviction with which the Committee's main recommendations were formulated.

The unified departments

In commenting on the rapidly changing picture of social work in the dozen years or so since the passage of the Local Authority Social Services Act we shall consider some of the implications of changes in the scale of the social work profession; the ideological debates in which social workers became caught up; and the problems of priorities from which the new multi-purpose social service departments have never been free. Although we can to some extent examine each of these trends in isolation, there are significant inter-relations between them.

The new departments had scarcely been established before they found themselves hopelessly under-resourced. The Seebohm Committee had thought it important that potential clients should be made aware of the social services' willingness to respond to their needs, but gave little consideration to the possibility that the very creation and promulgation of a new service might itself influence the ways in which people thought about their problems and the demands they would consequently make on the service. The concept of need is largely a subjective one and highly variable over time. What at any time are conceived of as needs justifying a demand for services depends on a complex state of public awareness which is in part influenced by the current state of professional opinion and the nature of service provision. In many urban areas in particular, the new service brought to light areas of need not previously recognized,

which created very heavy demands. Many of the new pressures stemmed from problems in which financial and environmental factors played a large part. Although the local authorities quickly began to improve their staffing levels, they were soon haunted by a sense that demand for services would expand so as to absorb whatever resources were available. The almost inevitable consequence was a heavy emphasis on work with crisis situations as they arose, rather than the carefully planned long-term preventive work to which reformers had looked forward.

Further pressures flowed from new legislation and, less directly but very powerfully, from the expectations of the non-client public, shaping both the explicit and the unspoken priorities of the new departments. The Chronically Sick and Disabled Persons Act, 1970, a well-intentioned Private Member's Bill regarded with barely concealed irritation and distaste by the social work advisory staff of the DHSS, laid upon local authorities heavy new specific responsibilities for the assessment of needs and the delivery of services. But it was above all in the field of child care that the attention of the public and the mass media came to be focussed sharply and critically on the activities of social workers.

It was in 1973 that Maria Colwell died at the hands of her stepfather, after being released from local authority care; and social work in Britain has never been the same since. It would be hard to exaggerate the cumulative effect that the short tragic list of children whose deaths might have been avoided but for an error of professional judgement, has had upon the unified social service departments or upon public attitudes towards them.

The intensity of present-day preoccupation with child abuse and child neglect might lead a visitor from another planet to suppose that these were problems somehow unique to our own times. In truth, the whole history of childhood is defaced by desertion, cruelty, suffering, and death. In the past half-century or so general standards of child care in developed countries have improved steadily and very significantly, but the level of our dominant, shared expectations has risen even more steeply. The common reaction to neglect, and even more to child cruelty, is one of horror because they clash so violently with our assumptions about the minimal natural entitlement of all children. The importance of this transformation of feeling and of the prevailing sense of what social justice demands should not be underestimated; well within living memory, millions of decent people took

it very much for granted that to be neglected was the natural fate of the children of the poor.

But this heightened sense of public concern does not in itself fully explain the intensity of indignation that has characterized reactions to the handful of publicized child deaths. Recalling the newspaper and television coverage of any of these tragedies, the evidence given to the enquiries set up in their wake, the reports of the enquiries and the reactions to those reports, one is forcefully struck by the strength of the criticism directed at the social workers in the case. Either they had failed to remove a child from its home, in spite of danger signals; or they had released a child from care back to a home not fit to receive it; or they had failed to visit as often or supervise as closely as they clearly ought to have done. Responsibility must be allocated, and social workers have sometimes felt that they were seen as more blameworthy than the parents or parent-substitutes who inflicted the fatal injuries.

The important factor in all this has been simply the emergence of the social services departments; an organization, that is to say, claiming to be comprehensive in its coverage of human problems, launched with promise of prevention and not merely crisis intervention, staffed largely by youngish people not without a certain bouncy assertiveness; and then, in the eyes of the public, falling down on a most fundamental responsibility. Hubris invites nemesis. We may turn back perhaps to the symbolic figures of the fairy tales in which child cruelty and abandonment are common—'Snow White', the 'Babes in the Wood', 'Hansel and Gretel'; here is social work claiming to be the Fairy Godmother—and when she waves her magic wand it snaps in two.

The Children Act, 1975, among many other things clarified and underlined the responsibility of local authorities to pursue enquiries into cases where neglect of or cruelty to children was suspected. At the same time, and in the aftermath of the Maria Colwell enquiry, strong encouragement was given to social service authorities by the central departments to review their procedures for the administrative management of known or suspected cases of non-accidental injury and to ensure that responsibilities were clearly defined and understood. Guidelines proliferated, safeguarding the local authority against public criticism and helping to hold management anxieties at bay as well as offering a framework for better professional practice. 'At risk' registers were created, sometimes on a scale so all-inclusive

as to be of no practical value; some writers have claimed—though admittedly with no supporting evidence—that in England and Wales such registers now contain a total of 50,000 names. In what rapidly became the most politically sensitive area of social work practice, basic grade workers with multifarious responsibilities were expected to give the highest priority to vigilance for signs of child abuse.

It is not difficult to see how a complex concatenation of circumstances has served to keep active interest in the problems of the mentally ill at a very modest level: a high proportion of relatively inexperienced workers; supervision of variable quality; the absence—or very limited presence—of specialist skills and knowledge; a heavy pressure of client demand; a consequent emphasis on work with the more explosive domestic crises; the imposition of statutory responsibilities and the emergence of some special concerns highly charged with professional and political anxiety. For the deteriorated schizophrenic or the recurrent depressive, provided that he or she did not come into sharp conflict with the law or create gross, publicly visible havoc with the lives of others, there were few social workers who would or could offer some service of value.

Professional expansion and professional controversy

Parallel to the early development of the social service departments has run the growth of the social work profession. In line with the recommendations of the Seebohm Committee, the Central Council for Education and Training in Social Work was launched in 1971 to promote social work training, review and approve courses and issue a standard qualification. In fact, established courses were expanded and new courses initiated at a rate which left little need for active promotion; before long a hundred institutions were offering programmes of social work education, including a substantial majority of British universities, almost all the polytechnics and some colleges of education. Several possible routes to the Certificate of Qualification in Social Work were recognized—one-year and two-year postgraduate courses, two-year courses for older non-graduates, and four-year programmes which combined a first degree with professional training. In 1972 a total of 2455 candidates embarked on CCETSW courses; this rose rapidly to 4000 in each of the peak years 1976 and 1977 and then fell slightly to around 3,700 a year in the late seventies and early eighties. Between 1972 and 1982 the ranks of

professionally qualified social workers swelled by nearly 35,000, just under half of whom were graduates.

Whether 'more meant worse' is of course a wholly unanswerable question, but almost certainly more meant different. For those writers who prefer to base their analyses on the findings of detailed empirical research, the paucity of material on trends in social work and its practitioners presents a daunting prospect; but when firm data are scanty or even non-existent, there is every justification for informed speculation. It seems highly probable, for example, that the social background of recruits to social work became appreciably broader. It is easy to exaggerate both the middleclassness of 'traditional' caseworkers and the degree of proletarianization that characterized the years of growth. But the increased opportunities for social mobility presented by the expansion of higher education—particularly if account is taken of the too readily neglected non-university sector—included access to social work among other professional and semi-professional occupations. Teaching, particularly primary school teaching, had long been a recognized avenue of occupational mobility for children of skilled working class background, and social work in a modest way took on a similar role. It is tempting to suggest that entrants to social work retained to a greater extent than recruits to teaching a sense of identification with their class of origin, but it is difficult to separate this out from a general increase in political radicalism among students, most notably in the social science disciplines, in the late 1960s and '70s. What is certain is that a significant proportion of recruits emphasized more strongly than their predecessors the 'social' in 'social worker', and were keenly motivated by a sense of concern for socially and economically deprived groups. This was most strikingly marked among those who moved to the practice of community work—though not always by way of conventional social work training—some of whom cherished near-Messianic aspirations for achieving social change. But social workers and community workers alike were intensely anxious to avoid modes of dress or speech that they felt might distance them from their clients, and as a result often generated very adverse reactions among members of the more staid professions with whom they came in contact. How the clients themselves perceived their social workers has unfortunately never been studied.

The whole question of the political implications of social work was a matter of lively controversy. Some writers in the mid-1960s had

criticized contemporary social workers for an excessive preoccupation with their clients' intra-psychic problems at the expense of their practical and material needs, and there was some consumer evidence from the same period to suggest that client expectations tended to be out of line with the treatment goals pursued by caseworkers. But critical observations such as these were mild in comparison with what came to be known as 'the radical critique' of social work and which was seen as a distinctive and flourishing school of thought for a few years around 1970. Its perspective was explicitly marxist, and the central assertion was that social welfare institutions in general and social work in particular were devices by which the hegemony of the capitalist system was maintained. The entire system of social security and welfare benefits was construed as a series of relatively minor concessions to the dispossessed classes by means of which the ruling elite and its agents were able to alleviate some of the worst symptoms of deprivation, blunt the edge of class conflict, and buy temporary social peace. This of course was not an entirely novel argument. The distinctive addition was the attack on social work for its role in allegedly damping the fires of discontent which might otherwise have fuelled revolution, by setting up spurious goals of 'adjustment' or 'adaptation', exerting pressure on clients to acquiesce in intolerable deprivations created by a fundamentally corrupt social and economic system. In cases where the client was put compulsorily into that role as the result of a decision by, for example, a law enforcement agency, the social worker who acted as supervisor was merely exercising a form of social control, thinly disguised by the rhetoric of welfare. Some defenders of traditional social work argued that even in the most just and equal societies that could be imagined, suffering would not have been abolished; people would still experience physical disability, bereavement, mental breakdown, the birth of a handicapped child, family stresses—and might justifiably look to the social work profession for help and support; the fact that the social work profession had not emerged in countries where marxism was the official ideology did not imply that human problems had been eliminated but rather that marxist governments could not afford to acknowledge their existence. Other opponents of the radical critique claimed that the dynamics of casework had been wilfully misinterpreted.

Radical social work as a coherent movement largely petered out after a few years, although marxist interpretations of social history

and analyses of issues in social policy continued to figure prominently in publishers' lists. Some writers have suggested that a fatal weakness lay in the failure to provide practical guidance for the radical social worker: how could he exercise his skills in ways consistent with the critical analysis he had accepted? He might attain a long-term and not particularly realistic aim of 'politicizing' his clients, but patiently explaining to someone seeking immediate help with personal problems that he was a victim of capitalism was unlikely to be much better received than offering to someone injured in a road traffic accident a lecture on speed limits and driver behaviour in place of surgical intervention. While this was a valid criticism, it was perhaps less significant than the fact that much of the radical critique had been absorbed into the mainstream of social work thinking, had become part of the conventional wisdom for a substantial proportion of young social workers. To the extent that that occurred, there developed an uneasy gap between theory and practice, with particular hesitation over the use of compulsory powers with involuntary clients. Even in the probation service, traditionally more identified with authority, deep rifts between basic grade officers and those in management positions became apparent over libertarian issues.

Educational dilemmas

Behind the uncertainties of this period, the heated correspondence in the professional weeklies and the striking of political attitudes, there lay a deep confusion over the role of the enlarged social work profession in the new multi-purpose departments and, in a broader sense, in society at large. Nowhere was this confusion more evident than in the vastly expanded training programmes for social workers. The problems confronting the CCETSW were manifold. Social work directors, local authority associations, trades unions and professional organizations had diverse and not always very explicitly or coherently formulated views as to what social work education and training should be about; against these had to be set the conviction of the social work teachers that they were the best judges of students' needs and that of the educational institutions which employed them that academic freedom constituted a valid defence against the intrusion of external influences on the curriculum. The Council's dedicated staff were able to insist, as preconditions for the recognition of courses, on

some requirements which ensured a reasonable balance between exposure to ideas and learning in practice settings. But with 140 courses leading to the CQSW via their own internal examinations there was no realistic possibility of maintaining a genuine comparability of standards.

If the social workers who staffed the courses were not always distinguished academically, they made up for this with extreme professional serious-mindedness. They were profoundly handicapped however by the absence of systematic basic information as to the working patterns and practices of the agencies for which students were being prepared; and very often, what they surmized about those practices left them in some doubt as to how adequately they reflected the professional principles that they themselves valued. They suspected that although the 'traditional' casework in which they had for the most part been trained might be defended on theoretical grounds by some writers and attacked on ideological grounds by others, what was being written about did not seem to resemble very closely the stuff of everyday practice in local authority area offices. Inevitably, a variety of compromises were struck, varying from one course to another, as did also the quality of theoretical teaching and of practice supervision. A recurrent feature of social work courses was an attempt to introduce students to most of what were judged to be the major areas of contemporary practice, coupled with an unhappy awareness that any one area, when examined closely, must be judged to be only superficially covered. The concept of transferability of skills between client groups and between setting has been and continues to be widely used, but we lack any empirical study of the realities of transfer, its potential and its limitations.

Surveying practitioners

There has been more than one reference in this chapter to the shortage of reliable and valid information on the nature of contemporary social work practice. It is essential therefore to give due recognition to the only large-scale study actually carried out in the period under review. Undertaken in the mid-1970s by two distinguished social work academics, Olive Stevenson and Phyllida Parsloe, the research reported in *Social Service Teams: The Practitioner's View* provides an invaluable commentary upon the state of practice, and is the more impressive because of the writers' ability to

balance a fundamental sympathy with and respect for social work practitioners with a capacity for analysis that can be sharply though not destructively critical.

One major limitation of the enquiry should be noted from the outset. The bulk of its raw material came from a qualitative study of the attitudes, satisfactions, and discontents of a sample of practitioners; over 360 staff were interviewed, in eight local authorities and two groups of hospitals. There was no attempt to record and quantify the actual activities pursued by the social workers. (It is an extraordinary comment on the state of our research-based knowledge of social work activity that the Barclay Committee, reporting in 1982, presented its introductory review of the current pattern of practice in terms no more sophisticated than 'A day in the life of Janet and John.') Nor for that matter did Parsloe and Stevenson undertake any research into the views of consumers. Within these limits however the report of this DHSS-sponsored enquiry presents a vivid and detailed picture of largely unplanned and frequently poorly organized responses to a multiplicity of demands from individual clients and other agencies, of great variety in the levels of skill required, of generally admirable intentions and of their frequent frustration by poor management or simply sheer lack of clear thinking.

The authors comment on specialization among many other aspects of practice, and argue that such formal and informal specialisms as have developed in area teams have arisen 'reactively' and not as a consequence of deliberate policies or management decisions. They describe specialization as '... a vital area for the future health of departments...' and carry the discussion to a logical if rarely considered conclusion by pointing out the dangers of expecting social workers not merely to deal with a variety of client groups but to be knowledgeable and competent in areas not traditionally part of social work at all—welfare benefits, for example, and aids and adaptations for the physically disabled; 'the profession runs the risk of losing credibility because of a reluctance to decide what is *not* social work.' In arguing for the extensive use of non-social workers in social service departments they aim to preserve the core of intensive casework, but they are non-committal on specific issues of specialization within social work.

Stevenson and Parsloe's summing-up is on balance disheartening to anyone interested in the possibility of encouraging new growth areas within social service departments. Their portrait, they report, is

'... generally one of commitment and hard work, of concern and sympathy... and of valiant efforts by many individuals...'; but these are often undermined by '... an overriding lack of clarity about objectives...' and a '... lack of imagination and creativity... to re-define objectives and roles... and to... facilitate innovation.'

Barclay and the community perspective

In spite of the ideological fusillade directed at them from the far Left, social workers did not look for quarter from the opposite end of the political spectrum. They fully expected hostility from the Conservative administration of 1979. Social work practice, it was thought, was philosophically unattractive to a party which emphasized the virtues of 'standing on one's own feet', while its practitioners believed that they were perceived as troublesome and strident militants. No-one was surprised when the Secretary of State for Social Services commissioned an enquiry '... to review the role and tasks of social workers... and to make recommendations' though there was a considerable element of relief that the task was to be carried out under the auspices of the National Institute of Social Work; there was little likelihood that the outcome would be wholly dismissive or destructive.

The Barclay Committee made a number of interesting points in its majority report—recommending a probationary year for newly qualified workers, for example, and the establishment of an inspectorate—deferred consideration of a statutory accrediting and regulatory body, and gave evidence of careful thought on the problem of defending clients' rights without producing convincing proposals for machinery to achieve this. For the most part however the report inhabits the intellectual no-man's-land reserved for official and semi-official documents on social issues, being neither rooted in the gritty realities of detailed social observation nor constrained by the disciplines of systematic research. Conjecture slides over into assertion, and recommendations with no specified means of implementation are put forward with a confidence undiminished by the lack of evidence or even of close argument. This is strikingly the case with the Barclay Report's central emphasis on 'community social work,' in spite of the claim that the conclusions are 'tentative' and do not constitute 'a blueprint'.

In presenting approvingly a particular model of community care

the Barclay Committee was developing a theme that had been adumbrated by Seebohm a dozen years earlier. Most social needs are 'met' without recourse to the official social services, by 'informal social care networks', usually family-based but sometimes more broadly neighbourhood-based. A substantial part of the professional social worker's task, Barclay argued, should be concerned not only with supporting these relatively fragile informal networks where they exist, but with actively promoting the development of new social care networks across local communities and thereby eventually reducing the demand for direct social work intervention. Social work education should be reoriented to take account of this new perspective. These views fly in the face of most of the available sociological evidence, which suggests that localities vary markedly in their capacity to meet their own inhabitants' social needs, and that the concept of the self-supporting community is peculiarly fictional in areas with a high incidence of personal and family problems. The Barclay Report asks no serious questions about the specifics of social need, the quality of the informal care provided, the human costs to the carers, the distinctive skills that may or may not be required to provide a more adequate response, the case for systematic experimentation focussing on the costs and benefits of alternative systems.

The Barclay Committee's position on specialization in social work is not clearly defined. The principle of post-qualifying specialist training is generally commended, but their discussion of organizational structures within which generalists and specialists might function together is brief, superficial, and unconvincing. Firmer opinions are to be found in the two minority reports, one of which extends the community dimension of the main report while the other sharply opposes it.

The first minority report accepts the general principle of 'community social work' but argues forcefully that such a model can flourish only if practice is decentralized from the area team and small groups of workers take responsibility for neighbourhoods of a few thousand population. Professor R. Hadley, one of the three signatories of this report, has written extensively on the 'patch' system of organizing social work resources. The 'patch' method, it is claimed, enables the professional workers to know their territory intimately, and puts them in a better position to mobilize local resources and make more effective use of volunteers. Like most innovations in social work, the

method is strenuously advocated by some and sharply criticized by others, without the benefit of much objective research evidence concerning its advantages and shortcomings. It is possible, for example, that it would fit well into well-defined communities with many long-established families and a dense network of established informal relationships, but be inappropriate for areas with shifting populations and weakly shared social norms and values. Possible, that is, but not certain; there is need, as always in the planning of personal social services, for detached and sensitive comparative analysis, but in relation to this as to other disputes substantial empirical evidence is hard to come by. Even when relevant research evidence exists, it is not allowed to diminish new enthusiasms. Thus, the 'patch' principle is usually seen as the apotheosis of genericism; the smaller the group of social workers that constitutes the effective operational unit, the less it is possible for any of them to work predominantly with a particular group of clients. Specialists will still be needed, but they will function at one remove from the neighbourhood team—this in spite of the fact that according to the Parsloe and Stevenson evidence area team social workers do not find specialist colleagues particularly useful unless they are also operating in the front line. There remains the question, scarcely touched upon throughout the Barclay report and the Hadley appendix, of the particular areas of responsibility which might call for specialist social workers. The treatment of this major question is characterized by a lack of any serious analysis—in spite of the title of the report—of roles and tasks; only mental handicap and work with the deaf are mentioned in passing as possible specialisms.

Barclay's second minority report, by Professor R. Pinker, is headed 'An alternative view', and it presents an impressive defence of what the author describes as an unfashionable position. Professor Pinker draws attention to the dangers of a continuing dilution of skills and diffusion of effort, and argues vigorously for the development of strong professionalism; this involves *inter alia* clear lines of accountability, a general social work council charged with the maintenance of professional standards, and a planned balance between genericism and specialism. That only one member of a working party of 18 came out in support of a model of social work that related it firmly and relevantly to traditional concepts of professionalism and professional responsibility is an alarming testimony to the potency of superficial but modish ideas.

Conclusion

Some established professions are excessively complacent, and it is arguable that their moral health would be improved by a measure of critical self-examination as well as by external assessment. There is a point however beyond which both introspection and outside scrutiny become counter-productive. Social work, it seems, is perpetually at the crossroads—a stance which inspires little confidence among other professionals or the public at large. It is too much to expect that the boundaries of social work can ever be defined with complete precision and clarity, and in such a way as to command universal agreement, but it is regrettable that so much confusion should still persist. Whether or not the scale and the rate of expansion have been too rapid, the processes of planning that growth and giving prior consideration to its implications have been profoundly inadequate. It might have made sense if an examination in detail and depth of the roles and tasks of social workers—as distinct from the promotional activities of the Seebohm Committee—had preceded rather than followed an increase in their trained numbers by 35,000. And at each stage, as indicated in this chapter, the enquiries that were actually carried out have had very little information of any substance to draw upon and have shown little intellectual rigour in their examination of issues. A persistent source of weakness has been a strain of anti-intellectualism which runs through social work and which has cumulatively contributed to the high degree of confusion that now prevails, through a failure to develop systematic understanding of client needs and relevant professional skills and knowledge as a means to the identification of the most effective ways of delivering services. That the client groups with which we have a particular concern have benefited little from the expansion of the social work profession is not in all the circumstances surprising. Although it is impossible to judge what practical consequences the Barclay report will have, current trends and fashions provide few grounds for optimism about a more creative contribution in the foreseeable future.



*Community psychiatric nursing:
Filling a gap?*

Mental nursing in the mid-1950s was beginning to emerge slowly from the depressed position it had long occupied. General nursing had made very significant strides towards professional recognition, but mental nursing faced obstacles that were not easily overcome: a high ratio of untrained to qualified staff, the lack of any foothold in the prestigious teaching hospitals, and a long association with the Poor Law as well as the obvious stigma arising from popular stereotypes of their work. With a relatively high proportion of male workers and a long tradition of local authority employment, mental nurses were more readily attracted to the trades union movement and were for some time outside the Royal College of Nursing.

As psychiatry, with the advent of psychotropic drugs and other physical forms of treatment came to take on more of the features of general medicine, so mental nursing became increasingly associated with general nursing principles and was no longer identified with the application of measures of restraint. The locus of mental nursing however remained the hospital ward, and it was not until after 1970 that there was anything resembling a substantial diversion of interest to extra-mural services. Factors that contributed to this development included changes in hospital admission and discharge practices as new patterns of drug use became consolidated, an interest in new professional outlets at a time of shrinking in-patient numbers and an awareness that there were major gaps in community care created by the dissipation of social work skills and energies.

References begin on page 197.

The importance of the 1970s for the consolidation of community psychiatric nursing should not be allowed to obscure the earlier initiatives of pioneers. The first community nursing service in Britain was established at Warlingham Park Hospital, Surrey, as early as 1954, when the orientation of psychiatric treatment in general was overwhelmingly institutional. It is not surprising that the concept at first developed very slowly. Only four new services were inaugurated during the following eleven years. In the late 1960s there was some increase in the rate of growth, and by 1970 a total of 22 community psychiatric nursing services had been established. Within a further four years however more than a hundred additional services had come into being, with a peak figure of 38 in 1974. Growth continued after that, but at a somewhat reduced rate: 86 further services were set up in the five years 1975-1979, but it was clear by the end of the decade that the period of expansion, at least in the sense of the creation of new district schemes, was effectively at an end.

It is possible that the figures quoted here for the inception of new services may have a margin of error, as they are drawn from the results of a survey of existing services carried out in 1980 by the Community Psychiatric Nurses Association, and would therefore not take account of schemes that had come into existence and been terminated for one reason or another before the survey date. Any such margin of error however is likely to be small, and not such as to affect the general accuracy of the pattern indicated. It is clear that by that date there were few health districts without some form of community psychiatric service. The response rate to the survey was 90 per cent; of the 242 health districts responding, 212 had a service based within the district, while all but six of the remainder had access to services supplied from another district. Although some form of community psychiatric nursing provision was to be found in almost all areas, intensity of coverage varied greatly, with a mean of 1 nurse to 40,000 population and a range of from 1:4000 to 1:150,000. The most common size of district service was five workers, but the range was from one to thirty members of staff: the existence of a probably limited number of large services raised the mean size to 7.5 workers. This very wide variation from district to district reflects the unplanned and *ad hoc* fashion in which these provisions developed, and necessarily has implications for the type as well as the volume of services offered. Wessex emerges as by far the best provided region, with a population per CPN figure of 20,000. North West Thames,

Oxford, South Western, West Midlands and North West regions all have population/CPN ratios of between 31,000:1 and 35,000:1. The lowest levels of provision are to be found in Northern Ireland (61,000:1) and Yorkshire (76,000:1) regions.

One interesting trend over recent years has been a marked shift towards community psychiatric nursing as a full-time activity rather than as one interspersed with work in the wards. A survey of 670 community psychiatric nurses reported in 1978 indicated that nearly half the respondents combined community visiting with ward nursing. According to the more comprehensive enquiry of 1980, however, about ninety per cent of those engaged in community psychiatric nursing were occupied on a full-time basis. A total staff complement of more than 1750 indicates a fairly substantial professional commitment, particularly if account is taken of the fact that about 1400 of those concerned were graded as charge nurse or above; staff nurses and state-enrolled nurses each accounted for less than ten per cent of the workforce. Against this however must be set the relative lack of specialist training. Only one in five of the registered mental nurses surveyed had completed or was attending a course recognized by the Joint Board of Clinical Nursing Studies as leading to a certificate in community psychiatric nursing. Evidence from the Joint Board indicates that more than 500 qualified nurses had at that time successfully completed one of the courses in question, suggesting a significant and unexplained loss to community practice amounting to about two-fifths of those receiving the specialist qualification.

The CPNA survey throws some useful light on the organization of the services in question. Half of the community services were based on a psychiatric hospital and a further 28 per cent had their main base in a psychiatric unit. Eight per cent were based on a day hospital or out-patient clinic and an identical proportion (18 services) on a non-psychiatric health centre. Although a substantial majority of CPN services saw themselves as part of a specialist psychiatric team, it was common practice to accept referrals from a wide range of sources. Only 27 per cent received referrals exclusively from consultant psychiatrists, while at the other extreme a similar proportion were open to referrals from clients and relatives as well as professional sources. The remaining CPN groups were accessible to primary health care teams as well as psychiatric specialists, and in a high proportion of cases to local authority social service departments and

other community agencies as well. Most of the services were oriented towards general psychiatry, but a minority (28 per cent) offered a specialist service in addition, usually in psychogeriatrics or in alcoholism and addiction.

After a short period of extremely rapid expansion community psychiatric nursing faces essentially qualitative issues rather than simple questions of scale, even though in the longer term the very uneven inter-regional pattern should not be ignored. As far as present considerations are concerned, there are matters relating to the range and types of services provided, the client groups who are the beneficiaries, the training of the relevant personnel and the relationships between community psychiatric nursing and other medical and social agencies.

In trying to identify the specific activities of community psychiatric nurses and the relative frequency with which different professional roles are adopted and particular types of service offered to clients, there inevitably arises the problem common to most examinations of professional and para-professional activities of differentiating rhetoric from reality. Detailed, large-scale and on the face of it rather pedestrian analyses of tasks performed and time allocated are necessary before it is possible to outline with any confidence the work-profile (or profiles) of a profession. The lack of the relevant data in relation to social work and the problems that this has created for professional education and training has already been touched upon. Although nursing is generally thought of as a less diffuse and perhaps more readily measurable area of activity, it must be said that the minutiae of the community psychiatric nursing at any rate are not really any better documented. An interesting example is provided by a recent long paper on the development of a community psychiatric nursing service in Mid Surrey. The authors (Merry and McCluskey, 1982) discuss in thoughtful terms the ways in which alternative models for such a service were considered, the arguments that led to the choice of a particular pattern for the deployment of staff, the growth in staff numbers and the associated changes in the utilization of hospital facilities. At no point however do they devote a single sentence to describing, let alone analysing critically, the work actually done by this greatly expanded service. An extensive review of the literature of community psychiatric nursing (Griffith and Mangen, 1980) suggests that accounts of the activities of the workers are more often formulated in terms of goals and objectives than of

actual procedures. The former type of statement makes it difficult to see where in practice the contribution of one profession ends and that of another begins.

In the absence of—to use an old-fashioned term—factual information, one is thrown back on the generalized and unquantified statements made by those who write with at least one eye to the advancement of the profession's interests. The temptation therefore is strong to give a perhaps undue emphasis to those activities which the writer sees as desirable components of the professional role or which carry status-endowing connotations by virtue of their presumed complexity or their association with other, established professions of high prestige. Thus Marais (1976) described a community psychiatric nursing service as one which 'seeks to identify and develop the potential of a person to solve problems within the framework of tradition and culture in a particular community'. This rather comprehensive statement reflects a general trend for definitions of the role of the community psychiatric nurse to shift over time—from an emphasis in the 1960s on fairly traditional nursing tasks, albeit in a non-institutional setting, combined with attention to predominantly practical needs, to a more global approach with a distinct psycho-social character. Murphy (1977), for example, summarized the objectives of community psychiatric nursing as: effective and total patient care in the community; a service which gives support to the patient and his family in times of crisis; preventing or reducing the effects of institutionalization; and the promotion of positive health in the community. Murphy further outlined a variety of roles for the community psychiatric nurse, namely, support (day-to-day care and after-care), primary, secondary, and tertiary prevention, and advice and guidance.

It is reasonable to suppose that in the background of this shift in the characteristic pattern of role definitions in the nursing literature lies an increasing orientation of nursing education, particularly in the growing number of degree-linked courses, towards psychological and sociological concerns. One might also speculatively but plausibly conclude that another factor in this trend has been a bid to fill the vacuum created by the disappearance of mental welfare officers and community-based psychiatric social workers. But it is still far from clear whether and if so to what extent the new role definitions put forward in the professional journals reflect changes in the realities of practice. For many years the principal *raison d'être* of

community psychiatric nursing was the administration of long-acting phenothiazines. How far this has given way to the roles of counsellor, caseworker, and psychotherapist is impossible to determine on the available evidence. In contrast to the more ambitious constructions of the professional task, Wooff, *et al.* (1983) in their review of trends in the Salford mental health service seem to define community psychiatric nursing simply as a drug injection service. No doubt different things happen in different places, but no-one is able to say with what frequencies.

Associated with this uncertainty are doubts about the kinds of patients, in diagnostic terms, who form the clientele of community psychiatric nurses. The 'basic' c.p.n. was concerned almost exclusively with long-term schizophrenics. There is little doubt that present-day involvement covers a wider range of diagnostic groups. Work with psychogeriatric patients plays a significant and probably increasing part, there is a minority interest in alcohol and addiction and evidence from more than one source of community psychiatric nursing contributions to the care of neurotic patients. Some nurses see themselves as practising behaviour therapy, and in a rare attempt at controlled experimentation, Paykel, *et al.* (1982) have carried out a comparative study of community psychiatric nursing and out-patient psychiatry. In this comparatively small-scale but well-planned investigation, 71 neurotic patients were randomly assigned for treatment to 'routine psychiatric out-patient care' or to 'supportive home visiting' from community psychiatric nurses. Over a period of 18 months they were each assessed at six-monthly intervals. The two modes of treatment were shown to be indistinguishable in terms of their effect on symptoms, social adjustment, and family burden. Community nursing resulted in a marked reduction in contacts with psychiatric and other professional staff at out-patient clinics, in a greater use of general practitioners for prescribing, and in more discharges. The level of patient satisfaction with treatment was higher among those seen by community nurses; this may be connected with the fact that the time available for each visit was several times greater than the time allotted for medical consultations. Although the patients included in this study were not rated as seriously ill or seriously socially impaired, and although the levels of improvement recorded were modest, the experiment must be considered encouraging. Yet even this otherwise well-defined study included no analysis of what the professionals in question actually

did when face-to-face with patients or members of their families. There is an obvious need for further comparative enquiries of this kind, taking into account different diagnostic groups and deliberately including detailed analyses of professional activities.

If community psychiatric nursing has embraced—or even merely has aspirations to embrace—functions which go a long way beyond traditional mental nursing skills, questions of the content and orientation of training become of crucial importance. An outline curriculum in community psychiatric nursing for registered mental nurses was first produced in 1974 by the Joint Board of Clinical Nursing Studies (since July 1983 incorporated in the National Boards for Nursing, Midwifery and Health Visiting). Two new outline curricula were published in 1979, by which time 439 nurses had obtained certificates after completion of one of the original courses. The revised curricula had some common components, but otherwise involved separate preparation for the nursing care in the community of the mentally ill and the mentally handicapped. By September 1983 a further 156 certificates had been awarded to those completing the course in community nursing of the mentally ill.

The revised courses, like their predecessor, are of 36–39 weeks duration. During the first 24 weeks of a course, at least two days each week must be spent in supervised fieldwork placements.

The outline curricula give evidence of thoughtful educational planning, differentiating between the skills, knowledge and attitudes relevant to the assessment of needs, the formulation of care plans and their implementation and evaluation. If they have a fault it is that they are somewhat ambitious in their coverage, aiming to develop skills in such areas as crisis intervention, family counselling, and behaviour therapy. The relevant body of theoretical knowledge is substantial in each case, while the skills in question can be acquired only under conditions of closely supervised practice. Whether the length and quality of supervised placements are adequate for this range of purposes is debatable, and the courses in community psychiatric nursing run the risk that their admirable objectives may be achieved only at a superficial level. Nevertheless, these courses take for granted a full basic training in mental nursing, and to the extent that the latter achieves greater sophistication in the behavioural sciences content and in training in psycho-social skills the task of the post-qualifying programmes becomes less daunting.

However, the fairly limited take-up of specialist training does not

reflect a belief that they lack depth but rather the opposite: the courses in question have been criticized as too long and of questionable relevance. In the hope of making some post-qualifying training available to psychiatric nurses who had moved into community practice during the phase of rapid expansion, and for whom there would be obvious difficulties relating to secondment, the Joint Board produced in 1982 outlines for short courses of 12-14 weeks duration. The centres approved to offer these programmes were unable to recruit a sufficient number of candidates in spite of their comparative brevity; their future is quite certain and it seems likely (September 1983) that they will be withdrawn and perhaps replaced by an even shorter updating course. It is clear that a large majority of present-day practitioners of community psychiatric nursing will effectively remain without specialist training; there is no reason why this position should change in the future. A ruling by the National Boards which made appropriate post-qualifying training a precondition for entry to community practice could begin to shift the balance, but there is no reason to suppose that any such requirement is under consideration. There does therefore seem to be a certain discrepancy between the all-embracing statements in the nursing literature as to the scope of community psychiatric nursing practice and the trained competence of most of its practitioners.

The unanswered questions about community psychiatric nursing concern role as well as functions. Its rapid and unplanned growth has served a number of different purposes—enabling psychiatric teams to maintain more patients in domiciliary settings, offering interesting new career opportunities largely free from the hierarchical controls of hospital nursing, and expanding—in theory at any rate—the frontiers of nursing to encompass activities more often associated with social work and clinical psychology. But for a proper assessment of the place of community nursing within the spectrum of the mental health services we need to take account of the location of this specialist provision, the degree of professional autonomy afforded to its practitioners and their operational relations with other groups. Some blurring of traditional role boundaries is to be welcomed, but beyond a certain point there are obvious dangers of confusion and conflict, with resources being used inappropriately and ineffectively.

In a helpful discussion of the need for policy and planning in this area, Mangen and Griffith (1982) refer to the possibilities of territorial conflict to the extent that community psychiatric nursing

develops specialist roles, particularly that of nurse-therapist, and discuss the advantages and disadvantages of attachment to primary health care teams. Although they claim that the minority of community psychiatric nurses with primary care rather than hospital attachments tend to complain of professional isolation, the case for attachments of the former type has been argued enthusiastically (Conway-Nicholls and Elliott, 1982). Discussing a service set up in one health district (North Camden) the authors describe a style of working in which hospital-based psychiatrists seem to play no part other than in psychogeriatric assessment. Clinical responsibility is vested in the general practitioner, and the large majority of referrals emanate from him or from other members of the primary care team. Although the diagnostic diversity of the patients seen is indicated, there is no discussion of the range of treatments undertaken; it seems likely that there is a substantial emphasis on administering drugs and observing their effects. It is claimed that the service has been accepted by local psychiatrists and that it is the district's policy for the continuing care of discharged psychiatric hospital patients to be taken over in due course by community psychiatric nurses based on primary care teams. How the nurses themselves perceive the balance of advantages and disadvantages associated with a primary care setting is not discussed.

Indeed, no information at all seems to be in existence concerning the views of the general body of psychiatric nurses as to alternative locations for their work; nor do we know much about the views of other mental health professionals. Psychiatrists in general are probably a shade more cautious in their endorsement of primary care placements than might be concluded from the North Camden paper. A discussion document produced (1980) by a working party of the social and Community Psychiatry Section of the Royal College of Psychiatrists (which included co-opted representatives of the Royal College of Nursing) described 'the most satisfactory pattern of working' as one in which 'the individual nurse works in relationship to a single psychiatric multi-disciplinary team and referrals are handled directly within the team'. It was seen to be important for the community psychiatric nurse to 'keep closely in touch with the primary health care workers' but obviously not to be one of them. There is an awareness in the document of possible problems of role definition and overlap, but no guidance is offered as to how such problems might be minimized. No one pattern of services can

justifiably be described as ideal, and the need for experimentation and evaluation is emphasized. The discussion paper concludes that although the expansion of this service is desirable, it should not grow at the expense of established hospital services.

Although the present and the possible future of community psychiatric nursing are neither as confused nor as contentious as those of social work, there is little doubt that its rapid and unplanned growth has raised many complex questions. If the striking expansion immediately after the creation of multi-purpose social service departments stemmed at least in part from an attempt to fill the gap created by the disappearance of mental welfare officers and community-based psychiatric social workers, it is extremely doubtful whether that objective has been achieved. There has been increasing use of the language of social casework and the language of clinical psychology, but the reality, difficult though it is to assess, seems to revolve much more around matters of medication and the monitoring of the effects of drugs. If there has been a failure to carry out a variety of social work tasks, that failure has not on the whole been made good by the activities of community psychiatric nurses. So at any rate it appears, in the absence of detailed revealing analyses. There is major scope for research which will examine in detail the specific features of a wide variety of local innovations, and evaluate the significance of different job-specifications and alternative modes of deployment. Such studies should take account of the gains and losses of different models from the standpoint of all the professional groups involved, and not least from that of the patients and their families.

8

General practice in transition

Discontents and early remedies

The struggle of general medical practice to achieve a distinctive identity and a professionally satisfying role has been and remains a recurrent theme in the history of the National Health Service. Although the growth of medical science and technology was already an important argument in the case for the initial establishment of a centrally-funded hospital system, it is the subsequent massive growth of specialization and of an associated hospital-based career structure that has been mainly responsible for the dilemmas and soul-searching of general practice. That is not to say that the early days of general practice in the NHS were relatively trouble-free; indeed, the first decade was particularly stormy as far as relations with central government were concerned. Every schoolboy knows that Aneurin Bevan undermined the opposition of the British Medical Association, representing principally general practitioners, to the proposed NHS by gaining the support of the Royal Colleges, with their high professional standing, social prestige, and almost ostentatious indifference to crude material considerations. One major consequence of that accommodation was a service which gave extraordinary advantages to the hospital consultants and singularly few, in the early days, to general practitioners. But although the tensions and recriminations over incomes and conditions of service gradually diminished as the pecuniary rewards of general practice came to be improved, more profound and intractable problems remained to be confronted.

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The quality of the service provided by general practitioners was sharply criticized within a couple of years of the inception of the service in a report by an Australian doctor who had surveyed a not very large but varied sample of practices (Collings, 1950). Country practice, claimed Collings, was 'the last outpost of family doctoring', but elsewhere, and especially in the large urban areas, the standard of general practice tended to be low, its methods unsophisticated, and its working conditions deplorable. Collings believed that the NHS had made a bad situation worse, placing additional burdens on an over-stretched and poor-quality service. The Collings report was received with some hostility and much defensiveness. It stimulated two major studies (Hadfield, 1953; Taylor, 1954) which argued for a more favourable verdict on the medical skills and personal dedication of the general practitioner. Yet a good deal of uneasiness remained, in spite of the more reassuring conclusions of writers such as Taylor and Hadfield; a sense among observers of general practice that the Collings cap, even if it did not fit perfectly, was not hopelessly askew, and among practitioners themselves a widespread conviction that their status had been diminished by the new health service and their professional isolation deepened. Their view of the supposedly contrasting past may have been nostalgically roseate, but their dissatisfaction with the present was unquestionably real.

It is of some interest, in passing, that these early commentators on general medical practice, writing before the large-scale development of psychotropic drugs, had little to say on the subject of psychiatric illness in the family practitioner's surgery except in terms of its nuisance value for the doctor. Stephen Taylor's customary breeziness of style degenerates, on this topic, into positive coarseness:

Types of neurotic illness varied similarly. In the countryside gross hysterics are still seen. In the slums, too, there are gross hysterics, as well as work-shy psychopaths. In suburban housing estates, whining anxiety hysterics predominate.

Perhaps the most important response to the frustrations of the early years of the NHS was the establishment at the end of 1952 of a College of General Practitioners. It would be quite excessively cynical to assume that its founders were motivated principally by considerations of status or prestige. Inevitably and admittedly, the social and professional standing and the wide-ranging influence of the Royal Colleges of Physicians, Surgeons, and Obstetricians were

prominent in the thoughts of the founding fathers. But their intentions were both more modest and at the same time more wide-ranging than those of the established Colleges. They did not aim, at any rate in the foreseeable future, to control entry to the ranks of principals in general practice by the award of a qualification equivalent to the College diplomas (MRCP, FRCS, MRCOG) which had become accepted as essential qualifications for appointment to consultant or even senior registrar posts. Instead, applicants for membership of the new College must already be experienced general practitioners, judged to be clinically competent and of good academic standing. While it was arguable that two of the Royal Colleges were in practice little more than examining bodies, the new body was concerned with maintaining and raising standards on a wide front, by scientific meetings, conferences and courses, the production of a journal, the establishment of regional faculties and the active encouragement of general practitioner research.

The praiseworthy emphasis that the College gave to issues affecting the quality of practice did much to build a new sense of professional self-esteem among its members. But that membership has never embraced more than one-third of all general practitioners, so that a majority have remained largely uninfluenced by College activities. Further, there was an obvious and inescapable price to be paid by the College for distancing itself from financial and organizational disputes, in terms of a loss of influence over developments that were in themselves potentially relevant to standards of practice and the shaping of professional identity.

It may be counted a minor tragedy that the concept of the health centre, which in the early planning stages of the NHS had been seen as the means by which family practitioner, specialist, and preventive services could be brought together at the local level, thereafter vanished almost without trace for the next twenty years. Most general practitioners showed little enthusiasm to become tenants of the local health authority, and the constructional extravagance of some of the early ventures frightened governments already deeply concerned at the escalating costs of the NHS. There was also possibly a sense in the central department that the rapid growth of consultative services in the hospitals made it unnecessary to duplicate diagnostic and other provisions in health centres. That the latter might take on a rather different orientation was not at that stage considered, and in spite of the work of the College most general practitioners remained cut off

from the mainstream of clinical advances, increasingly conscious of the impossibility of maintaining competence across the whole spectrum of medical practice, resentful at the prospect of becoming mere signposts to the hospital outpatient clinics, yet lacking any well-articulated alternative role.

At a more modest level, there was a steady move away from single-handed practice. Since general practitioners had consistently declined to entertain the notion of a salaried service—unlike the specialist, who had benefited massively in terms of conditions of work and the provision of ancillary personnel and technical resources, without any obvious loss of independence—central government could encourage the trend only by providing a variety of financial incentives; the pure theory of the independent contractor was greatly watered down in the process, but not wholly abolished. By 1964, only one general practitioner in four was working entirely on his own, but large groups were still not popular. Two-person partnerships were more common than those of any other size, and only three per cent of family doctors were to be found in group practices of six or more.

Partnerships and group practices have obvious advantages in terms of the organization of work: civilized arrangements can be made for handling night calls, weekend duties, annual holidays—even for free time during the working week, with the consequent agonizing choice between a day conference on recent advances in the management of Dunkelmayer's syndrome and a couple of rounds of golf. Group practice, carefully planned, might also present opportunities for the development of special interests—in a particular age group or in a range of conditions—which can be deployed across the whole practice; but given the relative lack of appropriate training it was not surprisingly unusual for these particular professional advantages to be grasped.

A much more radical view of specialization was put forward by McKeown. He argued (McKeown, 1965) that the all-purpose family doctor should give way to group practices consisting of four types of doctor, each responsible for a particular age or age/sex group—obstetrician, paediatrician, adult physician, and geriatrician. They would each function as a personal doctor, and be responsible for the hospital as well as the home care of their patients. This proposal, involving arrangements not unlike those that are common in the United States, has not been pursued energetically. It is far from

certain that it would be particularly attractive to general practitioners, and extremely doubtful whether it would find any favour with hospital consultants. Although no-one could benefit from the professional isolation of general practitioners, it does not follow that a dispassionate examination of patients' needs would point to a much stronger hospital orientation as the most effective way of meeting them.

Ann Cartwright, surveying general practice in the mid-1960s through the eyes of patients as well as of their doctors, reported distinctly high levels of patient satisfaction, but thought that behind these there lay 'an uncritical acceptance and lack of discrimination which is conducive to stagnation and apathy' (Cartwright, 1967). Lack of relevant comparable experiences and modest levels of expectation are nicely illustrated by a single finding. Questioned about appointments systems, those patients whose doctors had such an arrangement expressed satisfaction with them, while the patients whose doctors did not offer appointments thought that they were unnecessary. On the practitioner side there was less complacency. Although most of the doctors in the sample said that they enjoyed their work, they were critical about the number of trivial or unnecessary consultations, believed that much of their training was not being properly used, and wanted access—or greater access—to hospital beds.

In her conclusions, which draw on the results of a wide range of studies as well as her own survey, Cartwright draws attention to a prevailing lack of clarity about the role of the general practitioner and comments that although the (then) tripartite division of the NHS contributed to the difficulties associated with this uncertainty, the creation of a single health authority would not necessarily remove them. Disillusionment stemmed in part from 'an inappropriate medical education and . . . consequent unrealistic expectations'. It might be mitigated by postgraduate vocational training, but enthusiasm for this was not unlimited; two-fifths of the doctors in her sample had not been on any course in the previous five years. For some there was 'a barrier of incomprehension which prevents them from recognizing their patients' needs.'

The discrepancies between on the one hand the hospital-based and specialization-oriented training received by all medical students and newly qualified practitioners and the expectations of conditions of work, available resources and professional tasks that are thus

created, and on the other the ambiguities of the general practitioner's role and the broad spectrum of problems presented to him, with its substantial weighting of emotional and social difficulties, recur constantly in the general practice literature of this period. They are seen to generate a dual frustration: a lack of opportunity to make use of the diagnostic and treatment skills which are essential to the maintenance of the sense of professional identity he has acquired, and a sense of impotence when confronted with needs that he is not equipped to meet or sometimes even to appreciate.

In spite of acknowledged conflicts and dilemmas, the Royal Commission on Medical Education, which deliberated between 1965 and 1968, expressed firm confidence in the future of general practice. They believed that contemporary thinking on the relationship between bodily systems and on the importance of the social and material environment pointed to

... the continuing need for a first-line preventive, diagnostic and therapeutic service which can deal in general terms with the total medical needs of the patient and when necessary to guide him towards the appropriate specialized services... available to individuals and whole families as far as possible in the area where they live. . . . (para. 36).

The Commission was clear however that the future lay with 'larger units of organization'—groups of at least a dozen members, preferably working from health centres, with good administrative support and ancillary professional help. Doctors in such conditions could be expected to develop special clinical interests, as well as closer ties than in the past with both hospital medicine and preventive services.

All undergraduate medical students, it was argued (paras. 277-279) should be given 'an insight into general practice' as an integral part of a broadly-based medical education. It was essential for the student to understand that 'patients seen in teaching hospitals' represent a highly selected group and that many conditions, including 'emotional disturbances and minor psychoneurotic illnesses' are usually dealt with exclusively by the general practitioner. Universities should offer senior academic appointments in general practice—as some had already done—and practising family physicians should also make a major contribution to this aspect of the medical curriculum.

The submission of evidence to the Todd Commission in March

1966 must have been one of the first actions of the College of General Practitioners after the major advance in status signified by the grant of a Royal Charter. The Royal College claimed that entrants to general practice needed a systematized course of special postgraduate vocational training just as do doctors embarking on any other career in medicine. The minimum period recommended was four years after registration. Two of these should be spent in hospital posts relevant to the work of general practice—obstetrics and gynaecology, paediatrics, psychiatry, and geriatrics. The other two years should be general practice based, but preferably intercalated with hospital experience rather than treated as a single block, and not modelled on the traditional trainee assistant pattern. They should provide opportunities for a variety of learning experience, social and psychological as well as medical.

Dominating themes in these two years will be practice organization, early and pre-symptomatic diagnosis, management of disease at home, the management of anxiety, depression, and the many physical expressions of emotional disorder, the reactions of different types of people to disease, the doctor's own reaction to different types of people and stresses in families. (Royal Commission Report, Appendix 6)

The College thought it was essential to begin developing an organization in every region for this type of training.

The most important feature of this evidence was the assertion implicit in it that general practice was a specialty in its own right, requiring its own substantial and distinctive pattern of vocational preparation, and was not a residual category of medical employment for those who were unsuccessful at the quest for traditional hospital-based specialist qualifications and appointments. It was also a notable indication of developments in the direction of thinking, at any rate within the College, that a relatively heavy emphasis was placed on psychosocial problem areas.

The Royal Commission (paras. 114–123) clearly recognized the importance of postqualifying vocational preparation and in the light of the comparatively poor recent levels of recruitment to traineeship schemes argued that it should become obligatory. They thought however that three years of formal postregistration training would be adequate, made up of a series of six-month or twelve-month rotating appointments. Successful completion of this training should qualify

for membership of the RCGP. This would be followed by two years as an assistant principal, after which the doctor would be eligible for appointment as a principal in general practice and for inclusion in the vocational register which, it was proposed, should cover 'every doctor with a substantial measure of independent clinical or administrative responsibility' (para. 160).

The self-esteem of general practitioners as well as a detached assessment of the skills required for effective practice demanded that the long-remembered and deeply wounding dictum of Lord Moran that general practice was an occupation for men who had 'fallen off the ladder' should be decisively rejected. General practice must have its own training ladder if it was to hope for parity of esteem with the hospital specialities. Yet it was highly probable, on the basis of evidence collected on behalf of the Royal Commission that future recruitment to general practice would draw upon men and women for whom this had not been their first choice of medical career. A national survey of medical students carried out in 1966 showed that 23.5 per cent of final year students gave general practice as their first choice. The corresponding figure in a similar survey carried out five years before had been 27.4 per cent; if anything, active interest in general practice was declining. It was particularly disappointing that those medical schools which had done most to introduce students to general practice were no more successful in encouraging students to opt for it as a career. (Royal Commission Report, Appendix 19)

Psychiatric disturbance and the general practitioner

From its earliest days, the RCGP had laid stress on the importance of research in the context of general practice. Yet there were obvious limitations on the kind of research that could be pursued, given not only the restricted opportunities available to doctors with a round-the-clock responsibility for patients but also the specialized training, clinical material, and investigative resources required for most kinds of biomedical research. All of these prerequisites tended to be concentrated in teaching hospitals and general practitioners had neither appropriate qualifications nor right of access. The growing interest in epidemiological studies, however, opened up relevant new research opportunities for the interested general practitioner. Indeed, his access to unselected samples of the general population gave him positive advantages denied to the hospital physician, if the research

questions related to the frequency, social distribution, and environmental and biographical correlates of any but esoteric diseases. Such studies might be initiated by the general practitioners themselves, or perhaps more commonly developed in association with hospital-based clinicians and/or community medicine specialists. Psychiatric illness, which it was well recognized could not be adequately enumerated, let alone studied epidemiologically, simply on the basis of hospital admissions, presented research problems eminently suitable for investigation in the community laboratory of general practice.

Early studies in this field had been somewhat unprofitable. Global estimates by general practitioners of the proportion of patients presenting with some form of emotional disturbance displayed variations so wide that they could be explained only in terms of the personal philosophies of the doctors who made the judgements. Even counts of the frequency with which specified types of mental illness were observed in the course of a continuous recording of general practice morbidity (Logan and Cushion, 1958) had to be treated with some skepticism, given the lack of precise diagnostic criteria and the inclusion in the standard classification of diseases of some particularly vague residual categories. Obviously, greater confidence can be placed in studies which aggregate or average the conclusions reached independently by a large number of general practitioners, although there is no justification for regarding the findings of such studies as reflecting a 'true' or 'accurate' measure of the prevalence of psychiatric disturbance. The classic British study of this genre is that of Shepherd, *et al.* (1966), which brought together the diagnostic estimates of 76 London family doctors and placed 14 per cent of the population at risk in the 'psychiatric' category. The fraction is reasonably close to those emerging from other, broadly comparable surveys in Western countries.

There was a marked rise in the level of sophistication of studies in psychiatric epidemiology when around 1970 research psychiatrists moved beyond formal diagnostic labels and began to design specific measuring instruments with high reliability, suitable for application to large and unselected (except by virtue of co-operativeness) samples of the general population. These took the form either of standardized psychiatric interviews or questionnaires that included check-lists of symptoms indicative of emotional disturbance. The findings of studies using these clinical epidemiological methods have

been admirably brought together by Goldberg and Huxley (1980), who point out that there is of course no one 'cut-off point' which differentiates the mentally ill from the mentally healthy. However, it is possible to ascertain the numbers and the characteristics of persons in particular communities who are not in contact with psychiatric services but whose degree of symptomatology is comparable with that of patients receiving treatment.

It is clear that the former vastly outnumber the latter. While it seems that the large majority of people in this country who experience significant psychological distress do in fact consult their doctors, only a small proportion—perhaps one in fifteen—are referred by the latter to a psychiatric specialist. Goldberg and Huxley characterize the 'pathway to psychiatric care' in terms of a series of filtering processes, and identify from the research literature various social factors associated with filtering from one level to the next. Obviously, the manifest seriousness of the condition and its duration are significant factors. Most patients who consult their general practitioners have only relatively minor disturbances of mood and are very unlikely to be referred; but there is evidence (Shepherd, *et al.*, 1966) that even for seriously disturbed patients there is a substantial measure of non-referral. The general practitioners in the latter survey explained their retention of a high proportion of patients with symptoms suggestive of psychological disturbance in terms of the reluctance of the patients to become identified as psychiatric cases and of their own belief that the management of these cases was a proper responsibility of the family doctor.

It would be inadvisable to attach too precise a weighting to the factors shown in the research literature to be correlated with general practitioners' decisions about referral to psychiatric services. As we have seen in earlier chapters, the number of persons brought annually to the notice of hospital psychiatrists has changed markedly over the course of the past 25 years. This may be attributable in varying degrees to changes in the 'true' level of psychological disturbance within the community, to differences in the ways in which people interpret their own symptoms and consequently decide whether or not to consult a doctor, and to changing referral habits among general practitioners. The last-named is itself a complex variable, and may include shifts in the overall level of psychiatric perceptiveness and tolerance, a changing image of the functions of the psychiatric services and an increase—or conceivably decrease—

in confidence in the therapeutic methods immediately available. In so far as changes in the behaviour of general practitioners have contributed to rises and falls in the number of hospital-treated patients, it follows that there have been changes in the criteria consciously or unconsciously used in selecting patients for specialist referral. Because of the cost and operational difficulty of large-scale surveys of samples of the general population or of general practitioners, there is understandably no tradition of replicating enquiries at regular intervals so as to permit the examination of trends over time. In the absence of such data however we should beware of attributing timeless significance to patterns inferred from studies carried out in particular years. The filtering process is not merely complex but capable of quite marked changes over relatively short time-spans.

This academic reservation does not of course in any way challenge the truth of the broad generalization that most psychological disturbance is dealt with by general practitioners on their own. Here in a sense is community care in action, and on a substantial scale. To what extent it embraces the medical care of those patients who have been or are concurrently in touch with psychiatric specialists is not altogether clear. Goldberg's model of a filtering system relates essentially to 'new' cases, and ideally would need to be elaborated in a form which allows for the reverse flow into general practitioner and other community-based treatment (and non-treatment) settings of patients who have previously passed through out-patient or in-patient psychiatric care. Subject to some reservation because of the large measure of both secular and inter-practitioner variation and the uncertainty as to whether patients 'in the community' are or are not in receipt of treatment, Clare's summing-up is quite useful (1980):

... in a year, the average general practitioner will deal with 200 minor emotional illnesses; that twelve patients will present with severe depressions; that he will refer eleven patients for psychiatric advice and four to child guidance clinics; and ten of his patients will be admitted to psychiatric wards or hospitals. Fifty-five of his patients with recurrent or chronic mental illness will be living in the community. . . .

What treatment do the members of this heterogeneous group receive from their general practitioners? The question, once asked, almost answers itself: general practitioners prescribe drugs, and the overwhelmingly most common response to the presentation of

anxiety, depression, or any other disturbance of mood is the prescription of a psychotropic drug. In each year from 1970 to 1980 between 80 and 90 million prescriptions for such drugs were written by British general practitioners, amounting in recent years to just under one-quarter of all scripts. Sedatives and tranquillizers accounted for 24.4 million prescriptions in 1979, and antidepressants for another 7.6 million.

There is very little evidence of any other response to psychological disturbance, other perhaps than brisk reassurance, in the large majority of general practices. The prescription of drugs is of course entirely in line with the assumption about the doctor's role created by medical education and post-qualifying experience; many practitioners would say that it is also in harmony with the expectations of most of their patients. Yet few would claim that psychotropic drugs have more than a symptomatic effect; and while it may be entirely valid to commence a treatment process by bringing symptoms under control, it seems that only very rarely does the practitioner take advantage of the remission to explore any life-crises that may have precipitated the emotional disturbance. Instead, initial prescriptions tend to be followed by repeat prescriptions, and the problem becomes wholly medicalized without attention being given to any underlying problems of adjustment. How often the problems are themselves evanescent, how often patients develop a long-term dependency on psychotropic drugs, how often earlier psychiatric consultation might prove beneficial, are all questions on which one can do no more than speculate until the natural history of psychological disturbance is documented with both sensitivity and precision.

The foregoing generalizations are not valid for all family practitioners. There has for some time been a minority interest in the dynamics of the doctor/patient relationship and its therapeutic potential, an interest promoted principally by the late Dr Michael Balint. The seminars that he conducted for general practitioners, in which the significance of illness and the meaning of communications between doctor and patient were examined subtly and in depth (Balint, 1957) had a lasting impact on those who were involved in them. But inevitably their number, considered as a proportion of family doctors, was small; and while it is anything but disparaging to say that as a group they tended to have unusually strong intellectual and aesthetic interests, they clearly would not have qualified for the title of 'average' or 'typical' general practitioners—nor have wished

to do so. The practice of listening to patients, interpreting sensitively the nuances of their histories and symptoms, and moving non-directively so as to bring about improved ways of resolving or adapting to stressful life-situations, necessarily demands time that cannot be made available within the normal surgery consultation. However, it also requires a capacity for psychological awareness and an ability to put aside authoritative modes of professional behaviour, for which the undergraduate and postgraduate education of general practitioners has rarely, in the past, provided preparation of any value.

The re-shaping of general practice

For the present, it may be quite unrealistic to expect more than a very small number of family doctors to be actively interested in counselling or modified psychotherapy; most practitioners will prescribe psychotropic drugs, because this is in line with their conception of the role of a doctor, and most will claim that this is what their patients expect of them. But we need to think of the general practitioner not only as a personal doctor but also as one who can increasingly provide access to a range of professional resources through what has come to be called the primary care team. In the late 1960s and early '70s major changes were introduced into the structure and the reward system of general practice. These developments must be briefly summarized, as a preliminary to considering how they might affect the services provided for psychiatrically disturbed patients under the auspices of general practice.

Far-reaching amendments were made in 1966 in family practitioners' terms of service; in addition to a general improvement in the level of capitation fees, extra payments were introduced for seniority, for participation in group practice, and for work out of normal hours. The employment of ancillary staff was also encouraged under the terms of what was referred to as 'The GP's Charter', while in the following year the General Practice Finance Corporation was established, providing loans to set up new practice premises and to modernize old ones. In 1971 a report on the organization of group practice recommended full access by general practitioners to laboratory and X-ray services at general hospitals. The development of health centres was actively encouraged after years of neglect, partly in the hope that the building up of primary health care teams would

reduce the demand for acute hospital services. Between 1965 and 1980 the number of health centres in England and Wales went up from 28 to more than 1000 and the number of family doctors practising in them from not much more than 200 to not far short of 5000. The expansion of this service was however less marked in the large conurbations than in smaller communities. The typical new health centre was obviously a good deal smaller than earlier writers had pictured, and was perhaps only a special case of a general trend towards group practice. By 1980 only 14 per cent of practices were single-handed and 44 per cent of principals were working in practices of four or more partners. The total number of principals in unrestricted practice in the UK, having remained fairly constant around 23,500 from 1958 to 1970, rose in the next ten years to nearly 27,000. The average size of list fell to 2188.

There is no doubt that the public discontents of general practice were very much moderated in the wake of these developments. It does not automatically follow however that the quality of primary care was correspondingly improved, and indeed in the absence of any widely applied measurements of standards of practice or even of agreement as to what form such measures might take, it is obviously impossible to make any direct estimate of change. Much valuable information not involving the direct assessment of practice was gathered by Cartwright and Anderson (1981) in the course of a study carried out in 1977 which aimed to draw comparison with data assembled by Ann Cartwright in her 1964 survey. Their findings, as far as they are relevant to the matter of this chapter, are complex and only partially reassuring. More patients in 1977 than in 1964 expressed a desire for advice and reassurance, and more reported that they had in fact received advice or reassurance at a consultation. At the same time, there was a fall in the proportion of patients who thought that a general practitioner was a suitable person to talk to about domestic problems. There was however an increase in the proportion who reported that they would consult for a continuing feeling of depression. As far as the opinions of the two samples of doctors are concerned, we find no change over time in the percentage of consultations characterized as trivial or unnecessary, and a significant increase in the proportion of practitioners who thought it inappropriate that they should be consulted over personal or family problems. If, as might have been expected, medical education had developed in the period between the two surveys so as to give more

attention to psychosocial problems, there is no indication that this had had any positive impact on practitioners' attitudes; the youngest doctors in the 1977 sample were the most likely to express a lack of professional interest in their patients' personal problems. Taken in conjunction with such other inter-survey changes as a sharp fall in home visiting (though not to the American zero level) and a very considerable increase in the use of deputizing services, one is left with a marked sense of a diminution in the personal qualities of the doctor/patient relationship, with a growing movement of practitioners into work settings where better organization and greatly increased ancillary help are associated with limited availability and a more narrowly 'medical' definition of the physician's role.

Cartwright and Anderson speculate that the growth of social service departments may have led many general practitioners to believe that personal and domestic problems were no longer their concern. If this is true, it suggests a remarkable optimism in relation to the new agencies. Yet it is arguable that it is less important for practitioners to have a broad range of skills for the management of emotional disturbance, interpersonal relationship problems and environmental stresses than to have access to other forms of specialist help for their patients within the primary care setting. These considerations are at least as relevant to the situation of the former patient of a psychiatric unit, discharged to the care of a general practitioner as to a case of 'minor' emotional disturbance which is very unlikely ever to reach a psychiatric specialist. Wyld (1981), in a review of the literature on counselling in general practice, refers to different groups competing for a place in the general GP's surgery, each citing evidence of its own appropriateness and rarely acknowledging the contributions of others. There have been a number of enthusiastic accounts of the advantages of attracting one or more social workers to a general practice, and the descriptive studies of the late 1960s and early 1970s have more recently been supplemented by a controlled study (Cooper, *et al.*, 1975) of 'chronic neurotics' which indicated improved psychological and social adjustment, reduced numbers of prescriptions and less need for medical care among those who had received social work help. Corney and Biscoe (1977) compared local authority and surgery-based social work, and found that the latter brought in significantly higher proportions *inter alia* of patients with mental illness, emotional distress, and marital problems. In the past few years, clinical psychologists have come to offer a

range of techniques involving mainly behaviour modification, as well as counselling and traditional psychometric assessment. There is evidence—though without any statistical controls—of high rates of improvement consequent on behaviour therapy applied to anxiety-stress problems, habit disorders, and marital and other inter-personal problems, with a corresponding reduction in the prescription of psychotropic drugs (Koch, 1979; Ives, 1979). The Trethowan Committee (1977) recommended that the services of clinical psychologists should be widely available in community settings. In addition to the professional groups, there have also been a number of attachments of lay marriage guidance counsellors to general practices, with in many instances a carry-over of counselling work into emotional and interpersonal problems other than strictly marital difficulties (Cohen and Halpern, 1978; Waydenfeld and Waydenfeld, 1978; Heisler, 1979).

Reading glowing accounts of innovations, it is easy to forget how localized many of these are and what a very small fraction of the potential patient population is drawn into them. The Royal College of General Practitioners and the British Association of Social Workers jointly reported in 1978 that social worker attachments were the exception rather than the rule; mutual misunderstanding and failures of communication seemed to be the principal—and long-standing—causes. In Cartwright and Anderson's study, 23 per cent of the 351 doctors questioned claimed to have a social worker attached to their practice; nearly half of those who said they did not have such an attachment indicated that they would like one. Older doctors in single-handed practice were the most likely to say that they had an attached social worker. Recalling Irvine and Jefferys' finding (1971) that social workers were then attached to three per cent of general practices, Cartwright and Anderson clearly have some difficulty in believing their own figures. So it seems did the patients; only eight per cent of those whose doctor said there was a social worker attached to his or her practice realized this. Only three patients in the study; less than 0.5 per cent, said that they had had any contact with a practice-based social worker during the twelve months preceding the interview. The authors suggest that some doctors may have described as attachments arrangements which only involved liaison with the social services area team; is it also possible that some general practitioners included health visitors within their definition of social workers? No family doctor in the survey is reported as having an

attached 'psychiatric social worker' (though at that time there were in fact no such separately identifiable professionals) and one per cent had an attached marriage guidance counsellor. There were no separate questions about clinical psychologists, and it would obviously have been a matter of chance if one or two doctors in the sample had been involved in local experiments in the deployment of psychologists in community settings. Without doubt, the concentration of general practitioners on the use of psychotropic drugs in the management of problems ranging from minor emotional disturbance to severe psychiatric illness, without, in the large majority of practices, any attempt at systematic counselling, psychotherapy or behaviour modification, is not balanced by the provision of such services by other members of the primary health care team.

Conclusions

General medical practice has moved a long way from the 'cottage industry' described by some of its critics in the earlier days of the National Health Service. Family doctors now have better equipped premises, rarely work in professional isolation, have access to important hospital facilities, and are more effectively supported by receptionists, secretaries, and nurses. General practice has a place in every medical curriculum, academic departments of general practice are universal and the Royal College enjoys considerable esteem. Regrettably, and perhaps surprisingly, these developments seem to have produced no measurable changes in understanding of those aspects of ill-health which are not 'medical' in a very restricted sense of that term. There are few signs of a general orientation to care of the whole person as distinct from the treatment of specific symptoms considered in isolation, although in the writings of academic general practitioners and College activists this is seen as the defining characteristic of a rounded physician in primary care. In particular, one searches in vain for signs of anything more than a fairly small minority interest in the potential contribution of general practice to the community care of the mentally ill. Early days, of course; but it is a disturbing observation that so far as any trend is discernible it is in the reverse direction.

The Royal Commission on the National Health Service, while expressing its confidence in our family practitioner system, thought that there was room for improvement in the education and training of

the doctors concerned. In particular, they identified the two areas where further training was most needed as clinical pharmacology and the psychological aspects of practice. They looked forward to the implementation of the National Health Service (Vocational Training) Act, 1976, which would make three years of postregistration training a necessary preliminary to assuming the role of unrestricted principal in general practice, but believed it would be inadequate unless quality of performance was tested and competence demonstrated. The scheme came into effect in 1981/82, and requires registered medical practitioners to spend 'at least twelve months' as a trainee general practitioner and the remainder of the three years in 'educationally approved' posts in hospital or community medicine. These must include not less than six months experience in each of two of the following hospital specialties: general medicine, geriatric medicine, paediatrics, psychiatry, accident and emergency surgery or general surgery, obstetrics or gynaecology. At the end of each period of training a 'statement of satisfactory completion' must be provided by the consultant in charge, but there are no examination requirements or proposals for formal qualification. The scheme obviously calls for careful monitoring, which no doubt it will receive. How far it will affect the competence and confidence of general practitioners to handle major and minor mental health problems remains to be determined.

What seems to be missing from the scheme is any recognition that there may be specific learning needs for family practitioners relating to the psychological and social context of physical as well as of mental illness, the dynamics of doctor/patient relationships, the contributions of non-medical disciplines and the most effective ways of making use of them. Perhaps it is assumed that these cannot be taught or that the necessary understanding will be acquired by intellectual osmosis. In the light of past experience and in the face of the powerful role of traditional hospital-based specialties, the latter would seem an optimistic hope. The dominance of what Marinker (1974) calls the 'hidden curriculum' of medical education has been largely responsible for the failure of general practice to assume a central, co-ordinating role in the community care of mental illness; it would be deeply regrettable if an ambitious new vocational training scheme were to perpetuate that failure.

9

Psychiatry and the problem of identity

Achievements and anxieties

The 1959 Act was in an important sense a mark of public confidence in the profession of psychiatry. The decision to reform the law so as to ensure that no unnecessary obstacles should stand in the way of anyone likely to benefit from psychiatric treatment clearly entailed the recognition of significant therapeutic advances; and neither in the reported deliberations of the immediately preceding Royal Commission nor in the Parliamentary debates on the Mental Health Bill was there any serious questioning—indeed, any questioning at all—of the primary, central role of the psychiatric profession. This branch of medicine had travelled far since the establishment more than a century earlier of the Association of Medical Officers of Hospitals for the Insane with a membership of 44, and most of that distance had been covered in the last twenty years. The development of psychotropic drugs was an important, but not the only factor that had contributed to the improved status of psychiatry. The diverse activities of psychiatrists in the Armed Forces during the Second World War had gained sympathetic recognition; the incorporation of psychiatric hospitals together with general hospitals into the administrative structure of the National Health Service had done something to reduce the sense of isolation of psychiatrists from the general body of the medical profession; and the teaching of psychiatry was finding an increasing place in the undergraduate medical curriculum. Although there was still much to be achieved on that front,

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there had been marked progress since 1939, when Edinburgh and the Maudsley Hospital in London were the only sites of university-based teaching in psychiatry.

Nevertheless, a sense of insecurity was quite widespread. With very few exceptions, British psychiatrists strongly emphasized the essentially medical nature of their work. The impact of psychoanalytic and related ideas had been only marginal in the case of British—unlike American—psychiatry. A few corners had been invaded, but the greater part of all psychodynamically-oriented practice and theory was concentrated in a single establishment, and most psychiatrists adhered firmly to a model of mental illness that was rooted in organic concepts. Their general stance is well summed up in the introductory sentences of a major textbook of psychiatry of the period (Mayer-Gross, Slater and Roth, 1954):

This book is based on the conviction of the authors that the foundations of psychiatry have to be laid *on the ground of the natural sciences* (authors' italics). . . . 'There is in fact an immense body of evidence showing that in the major psychiatric disorders the specific factors in causation are those of a constitutional and physiopathological kind, and that in no psychiatric illness may these be left out of consideration'.

Indeed, so marked is the emphasis in this scholarly, humane, and infuriatingly complacent volume on the neurological and neuropathological foundations of psychiatry, and so patronizing and dismissive its attitude towards the disciplines of psychology and sociology, that the disinterested reader is left wondering whether a more plentiful supply of neurologists might not make psychiatrists redundant.

This claim that psychiatry worked wholly within the traditional framework of medical science was in one sense an assertion of respectability, but it entailed a significant if not very tangible cost. The careful dissociation of all but a handful of psychiatrists from psychoanalytic and related modes of thought had the advantage of avoiding both contamination by lay practitioners and involvement in the speculative hypothesizing that Mayer-Gross and his colleagues found so distasteful. It also meant that the psychiatrist, wholly committed to the treatment of mental illnesses that either demonstrably or presumably were of organic origin, could have little to say that was of interest to educated people who were not physicians.

There had been a brief, euphoric postwar phase when a few British psychiatrists with broad sympathies and transatlantic connections had managed to convey the impression that psychiatry might hope to offer solutions to seemingly intractable problems of industrial relations and international tension, but this was followed by a rapid reversion to a disease-bound perspective; and there has never in Britain been anything resembling the body of contributions made by Freudian, neo-Freudian, and Jungian writers in other countries to the interpretation of art and literature, history, and the social order—contributions usually speculative, sometimes perverse and occasionally profoundly illuminating. But it is not, after all, from intellectuals that doctors normally hope to receive recognition; and it is arguable that with the growth of the mass media of communication and their extraordinary capacity for vulgarization, psychiatrists were well advised to eschew interests and activities that could easily tempt them into the role of public purveyors of instant wisdom. What was—and remains—important to British psychiatrists as to all serious professionals was the recognition of their peers. And a recurrent problem for them has been the uneasy sense that they have not enjoyed parity of esteem with other medical specialists. The eager claim to be an integral part of medicine has not on the whole been reciprocated with equal enthusiasm; and it can be argued that the more psychiatrists restricted themselves to an emphasis on ‘organic’ mental illness the more difficult it was to break away from the stereotype of the ‘loony-bin doctor’. In the early 1960s, many of the status anxieties of psychiatrists in this country revolved around the question of the formation of a new professional body. Their concerns were similar to those that confronted general practitioners when the latter considered the establishment of a College, but they were not identical.

Towards a Royal College

The primary question was that of the formal qualifications appropriate for candidates for senior appointments in psychiatry. The standard requirement at the time in question was the possession of a Diploma in Psychological Medicine, awarded on the results of clinical and written examinations after an approved period of postgraduate study and clinical experience. In the postwar period such diplomas were awarded by a number of universities as well as, decreasingly, the Conjoint Board of the Royal Colleges. The most

highly regarded training was and is still that provided by the Institute of Psychiatry at the Maudsley Hospital, recognized as a school of the University of London. But there was a widespread feeling in psychiatric circles that no diploma could possibly equal in status the Membership of the Royal College of Physicians or the Fellowship of the Royal College of Surgeons, which had long been pre-requisites for appointment to senior registrar posts in general medicine (including neurology) and surgery respectively. It was of course open to any psychiatrist to submit himself for the membership examination, except that the College made no concessions to psychiatrists—or to pathologists, who had found themselves in a similar situation—and conducted that examination in internal medicine only. The Royal College of Physicians of Edinburgh allowed candidates to take one paper in psychiatry—or in one of a number of other specialist fields—in its membership examination, but in London this was seen as not *comme il faut*. Not surprisingly, the minority of English consultant psychiatrists who held the Membership or Fellowship of the Royal College of Physicians were with few exceptions to be found in academic departments or in teaching hospital appointments.

There was in addition a wider issue than that of formal qualifications. The numinous power and prestige of the Royal Colleges was if anything even more apparent to those effectively barred from sharing in them than to those members and fellows who effortlessly took them for granted. The Colleges, as well as conferring upon their members a generalized status that was recognized throughout the medical community, were also involved as collectivities in the highest councils of the profession and of the NHS; they were therefore in a position to contribute to important decisions and in some instances to influence the distribution of material rewards to the advantage of their own members. These points were eloquently made in particular by Dr J. G. Howells, at a tense meeting of the Royal Medico-Psychological Association in 1964. The RMPA was the lineal descendant of the Association of Medical Officers of Hospitals for the Insane, and had held a Royal Charter since 1926. It had for many years organized an examination leading to a certificate, but this had long been dropped in favour of the various DPMs; it was now essentially a learned society and published a journal of some standing. The question now was whether it should either give way to or, more probably, try to convert itself into a body of a different kind.

Dr Howells reminded his listeners that psychiatrists were not represented in their own right on the Joint Consultants Committee or on the General Medical Council; if psychiatrists were to be found there, it was because the Royal College of Physicians had condescended to allocate one or more of the places in their gift to College Members who happened to be psychiatrists. This applied even to the nomination of external assessors to the appointments committees of Regional Hospital Boards. There was equally no direct psychiatric representation on the Merit Awards Committee, and Dr Howells clearly thought it not wholly coincidental that only one consultant psychiatrist in seven received a merit award, compared to one-half of consultant physicians and surgeons. Apart from all these considerations, Dr Howells argued, there was a need for a single national specialist qualification rather than a variety of diplomas.

Psychiatrists in general were divided on this question, as contemporary correspondence in the medical journals as well as contributions to meetings such as this make clear. The decision was made more difficult by the fact that while a majority probably favoured the establishment of a new College, some of the profession's acknowledged and widely respected leaders saw no advantage in it. On the whole, it seems that those who were themselves well placed in the Royal College of Physicians were reluctant to throw their weight behind a move which if successful would somewhat narrow the range of the College's legitimate interests and might possibly reduce their own influence within it. A principal speaker against the motion for change was Professor (later Sir) Denis Hill, who emphasized the importance of drawing psychiatry closer to general medicine and argued that the creation of a new body would not in practice alter the question of representation 'in the councils of medicine'. In any case, he argued, the Royal College of Physicians was about to change its examination rules; another speaker referred to this as a 'death-bed repentance'—though to outside observers the College's demise did not seem to be close at hand.

The 1964 meeting did not end with a clear decision either way, but by the following year the desirability of a metamorphosis had been agreed upon. At the annual meeting of the RMPA in November 1965 it was 'agreed to continue with speed and vigour to take those measures which, it was hoped, would culminate in a Petition to the Privy Council for the change of title to the Royal College of Psychiatrists'. In the event the necessary processes proved to be quite

protracted, and it was not until 1971 that the change of designation was formally approved.

The seriousness with which the question of a qualifying examination was regarded is beyond dispute. It is not as if, having figured prominently in the preliminary discussions, it was relegated to a lowly position on the list of tasks to be accomplished once the desired goal had been achieved; on the contrary, the very first act of the newly recognized College, preceding even the appointment of a President or a Council, was to announce plans for a diet of examinations—and on a basis which evoked a chorus of protest from the entire body of trainee psychiatrists. What is more a matter for debate is not the sincerity of the concern but its significance. It was commonly claimed by those who wished to see a Royal College established that it would set higher professional standards through its examination requirements. There may well have been a case for change. Writing shortly before the inauguration of the new College, but without referring to it, Sir Denis Hill pointed out that the subjects in which would-be psychiatrists were examined had scarcely changed in the past 55 years (Hill, 1969). What does not seem to appear in the professional literature of the period, however, is any detailed analysis of existing training provisions or examination requirements leading to a review of their weaknesses in the context of the professional tasks confronting contemporary psychiatry and to specific proposals for reform. We turn later in this chapter to the views of training and examination that have been adopted by the Royal College. As far as the anticipatory debates are concerned, it is not easy to dismiss altogether the suspicion that the concern over qualifications was at least in part related to their symbolic and status-endowing properties.

It would be wrong to convey the impression that the profession of psychiatry was simply divided between those who defended the status quo and those who argued for a new collegiate body. There were a few who saw the whole debate as at most of marginal relevance to the problems confronting psychiatry at the time. Sharing in the embarrassment—to put it no more strongly—created by the current scandals arising in long-stay hospitals, it was by no means obvious to them that these could have been prevented, or could be avoided in the future, if the doctors concerned were submitted to more searching examinations in neuropathology. Looking at the range and trend of the mental health services, they wondered whether a strengthening of the links between psychiatry and some of

the non-medical disciplines and a rational consideration of the patterns of interprofessional relationships best calculated to raise the quality and effectiveness of patient care might not deserve as much priority as bids for a less marginal place within the broader profession of medicine. But this was a fairly small group, associated more with research on the social frontiers of psychiatry than with mainstream clinical activity, and the impact of their opinions did not significantly influence the direction of that debate.

Recruitment and training

Shortly after the major RMPA debate the Royal Commission on Medical Education was set up, (with a Professor of Psychiatry among its members), and long before the new College was established it had completed its deliberations and submitted its report. The Todd Commission's general philosophy of a more systematic and better co-ordinated approach to specialist training, combined with a system of vocational registration, was applied to psychiatry as to other branches of medicine. In arguing that '... the picture of psychiatric training ... still leaves a good deal to be desired' (para. 124) the Report looked forward to the development of '... national and regional programmes of specialty training in which university departments of psychiatry, the hospital service and the psychiatrists' own professional association will collaborate.' (para. 126). The approach to training being developed by the RMPA could, it was thought, be harmonized with the Commission's recommendations for general professional training. As far as the content of a formal training programme was concerned, the Royal Commission visualized less dependency on neurology and neuropathology, a better grounding in psychology and sociology, and opportunities to become familiar with psychopharmacology, psychotherapy and 'the conduct of community psychiatry'. Attendance at a formal course of instruction should be on two half-days a week throughout the three-year period of training, with the rest of the time spent in gaining clinical experience of different types within hospital settings.

The first examination proposals issued by the newly-fledged College in 1971 were neither well considered nor well received. Soon however a revised pattern emerged. This involved a period of training over three years, to be completed before applying for senior registrar posts; a Preliminary Test would be taken at the end of one

year and the MRC Psych. examination two years later. The former consists of an essay paper and a multiple choice question paper; these two types of paper re-appear in the Membership examination together with a clinical and an oral examination, though a research dissertation may be substituted for the essay paper. Psychology is one of five components in the Preliminary MCQ paper, while the community aspects of psychiatry and psychiatric epidemiology are included in the corresponding part of the Membership examination. The guidelines laid down for trainees mark a considerable advance towards a liberal view of the learning needs of psychiatrists in training. Trainees are encouraged to spend up to one year in study or research in a field associated with psychiatry, and psychology and sociology are specifically identified as among the relevant fields. Learning opportunities associated with clinical experience should include, it is recommended, 'the use of social services,' and the importance of ensuring continuing care for patients—'by working in liaison with general practitioners, psychiatric social workers, nurses and other colleagues.' 'Courses in clinical psychology, both diagnostic and therapeutic, should be provided, if possible by clinical psychologists.' It is salutary to contrast this last recommendation with Mayer-Gross, Slater and Roth's dictum, in their textbook of the 1950s, that the tendency of some psychologists to take over the functions of a doctor and engage in individual therapy is 'wholly to be deplored'.

These comparatively enlightened training requirements might be expected to attract a substantial number of medical graduates of high calibre to the practice of psychiatry. This does not seem to have been the case; psychiatry is not a popular career among British medical students and young practitioners. Fully one-half of the trainees presenting themselves for the examinations of the College appear to be the products of overseas medical schools. Perhaps more to the point is the fact that two-thirds of registrar posts in psychiatry in England and Wales and half of those in Scotland are at present filled by overseas graduates, many of whom did not come to this country with psychiatry as their preferred area of specialization. It implies no disrespect for the doctors of the Indian sub-continent, many of whom carry dispiritingly heavy burdens of clinical work in the least attractive hospital environments, to suggest that they do not on the whole provide the most hopeful means of shifting the emphasis of psychiatry away from an over-dependence on drugs and in the

direction of greater investment in individual and group psychotherapy and community-based initiatives in preventive and supportive services, all of which imply high levels of skill in personal communication and of sensitivity to cultural nuances. The College now insists on an English language test, but whether this guarantees a sufficient degree of fluency and ease of comprehension is questionable.

There is no single, fully convincing explanation of the reluctance of British medical graduates to embark on careers in psychiatry. Studies carried out in 1961, 1966, and 1977 agree that psychiatry is the expressed first career preference of perhaps five per cent of final year medical students (Martin and Boddy, 1962; Royal Commission on Medical Education, 1968; Parkhouse and Palmer, 1979). This constancy over time is in itself disappointing, for it suggests that the expansion and improvement in undergraduate psychiatric teaching that characterized this period had little impact on students' career preferences or—if we recall earlier discussion of trends in general practice—on attitudes to the psychosocial aspects of medicine in general. These studies also indicated that the career preferences in question are often held only tentatively, that change of direction after graduation is more likely to be away from psychiatry than towards it, and that interest in psychiatry as a career was markedly more common among students entering medical school than among those completing degree courses. Medical education seems if anything to reduce interest in this area of specialization rather than enhance it.

The problem of attracting a sufficient flow of able and highly motivated doctors to their area of practice must necessarily be a matter of serious concern to senior members of the psychiatric profession. The dismissive comments of the Royal Commission on the National Health Service (1979) cannot fail to have been deeply wounding:

Psychiatry is a shortage specialty. Though there has been a considerable expansion of the specialty in the last decade its staffing levels do not match the demands made upon it. Recruitment has recently fallen off: there are consultant posts unfilled and recruitment to the training grades has been deficient in both quantity and quality. Until the quality of recruitment improves it would be unwise to promote expansion of the specialty (para. 6.43).

Anthony Clare has reviewed thoughtfully the arguments that have been advanced in explanation of this failure (Clare, 1980). He questions the relevance of both Russell's argument that potential recruits are discouraged by the prospect of excessive pressures of work and Freeman's view that psychiatry's excessively biological emphasis is a deterrent to those who might more readily embrace psychoanalytic concepts and methods (Russell, 1973; Freeman, 1974). Clare himself believes that what is most likely to attract students to psychiatry is a brilliant exposition of its scope and potential; if he is right, it is a sad reflection on academic psychiatry that it seems to have done so little to illuminate the horizons of medical students.

Brook's finding that young psychiatrists see themselves as having been especially motivated in their career choice by curiosity about human emotions and behaviour is surely significant, and needs to be seen in the context of medical education as a whole (Brook, 1973). Becoming a medical practitioner involves a great deal more than the acquisition of scientific knowledge and technical skills. The most pervasive feature of medical education figures nowhere in the curriculum; it is a continuous process of socialization into a professional role and an associated concept of oneself as a doctor. The disciplines that dominate the curriculum and therefore the formation of that self-concept project an image of medicine in which behaviour and emotion play a minimal part. Injections of psychiatry, general practice, community medicine, and behavioural science seem to have little power, even collectively, to shift the central focus. For the student attracted by medicine's technological challenges, psychiatry can rarely seem an area of exciting opportunities. Those who remain obstinately curious about the human mind and its pathologies must develop an increasing sense of the marginality of their interests, of the difficulty of reconciling them with the mainstream conception of the doctor's role and functions. Many, inevitably, will be drawn towards a less peripheral area of work. For those who are neither deterred nor deflected from a career in psychiatry, there is sometimes a continuing inner need for a kind of over-compensation: a need to adhere particularly meticulously to a clearly 'medical' interpretation of one's role and functions. One consequence of this may have been a reluctance to promote a pattern of mental health services which is not hospital-based and which involves more open and less hierarchical relationships with

other professions than are characteristically found in medical settings.

Lay challenges

In the late 1960s and 70s any insecurities felt by psychiatrists about their status in relation to the medical world were intensified by claims to special expertise and to distinctive explanatory paradigms put forward from two disciplines outside the world of medicine: psychology and sociology.

During the period of our study, the position of clinical psychology changed quite dramatically. In the early phase, its place in the mental health services was small, circumscribed, and subordinate. Psychologists administered standardized tests to certain patients referred to them by psychiatrists, in the hope that the information provided might contribute towards a diagnostic formulation. But a major new impetus came from within the main body of academic psychology, in the form of the rapid development of learning theory. Many of the phenomena generally classed as indicative of psychiatric disturbance came to be reconceptualized as the consequences of failure or error in learning processes. This led to the development of a range of techniques for the modification of behaviour; they were applied with particular enthusiasm but not exclusively to anxiety states and phobias, although some critics claimed that the customary passion of psychologists for scientific confirmation tended to diminish when the question of evaluating their own therapeutic activities arose.

Armed with a considerable battery of treatment as well as of diagnostic methods, clinical psychologists, their numbers growing, began to seek a more autonomous role within the NHS. The right to receive direct referrals from general practitioners and in general to be seen as not merely providing an ancillary service for psychiatrists was eagerly sought. A sub-committee of the Standing Advisory Committee on Mental Health deliberated over the place of psychology in the health services for five years before reporting in 1977 (Department of Health and Social Security, 1977). The report was in general favourable to the aspirations of psychologists and recommended an increase in training opportunities and the creation of separate departments of psychology in health districts, offering services to a wide range of specialist departments and practitioners.

Although some psychiatrists have had little difficulty in incorpo-

rating behavioural techniques in their own therapeutic repertoires (Goldberg, 1982), and while clinical psychology now has, as we have seen, a recommended place in the training of psychiatrists, the vigour of this newly promoted specialty must be seen as something of a challenge to the unquestioned dominance of the medical profession; just how this will be resolved is still far from clear. What cannot be mistaken, however, are the signs of psychology, having freed itself from the dreaded dominion of doctors, mimicking some of the latter's least agreeable traits—pressing for the establishment of ever more senior posts, and carefully erecting institutional barriers against invasion by psychologists other than those designated clinical.

The second challenge came from sociology. It did not entail any claim to a therapeutic role, but put forward a closely argued system of explanatory concepts in relation to a substantial class of psychiatric disorder (Brown and Harris, 1978). This work emphasized in particular the role of identifiable life-events both in precipitating affective disorder of a degree severe enough to warrant psychiatric intervention and in increasing or decreasing vulnerability to stressful events. These were writings very different from those of the 'anti-psychiatry' school; what they lacked in literary panache was more than compensated by precise observation and a meticulous classification and detailed analysis of data. Theories about the baneful influence of stress had long been in circulation, but had rarely escaped from either circularity or anecdotalism; now the arguments demonstrated an unusually high degree of logical rigour and fidelity to the research material. Nor did the theory commit the error of claiming to embrace the entire range of psychiatric phenomena; a study of post-natal psychiatric disturbance, for example, showed the latter to be closely related to specific life-events, but acknowledged that these had no predictive value when psychotic indications such as thought disorders, delusions and hallucinations were present (Martin, *et al.*, 1982).

From the point of view of psychiatric and general medical practice, the importance of these sociological contributions lay in the critique they offered of a predominantly drug-oriented approach to treatment. Although the conclusions were not expressed polemically, the weight of the evidence indicating a major role for environmental factors in the aetiology of affective disorders clearly implied a need for a broader view of both treatment and prevention. Social and economic changes, it was argued, were potentially as relevant to

mental health as treatment measures of an obviously medical nature. Doctors might well argue that a case for social change, even if soundly based, did not contra-indicate the application of available treatment methods to alleviate suffering until such time as present imperfect gave way to a more perfect future. But Brown and his colleagues were able to make a case for 'social therapy' for the individual patient, designed to bring about changes in patterns of living and raise levels of self-esteem and the sense of positive achievement. There was little here that psychiatry was in principle incapable of absorbing—much, indeed, with which some psychiatrists would express themselves as being in general agreement. But to take these perspectives fully into account in thinking about professional roles and the future of mental health services would require a high degree of courage and self-assurance in breaking away from a safe and traditional concept of the place of psychiatry.

Conclusion

On the face of it, nothing would seem more obvious than that the profession of psychiatry should take a leading part—if not *the* leading part—in the development of mental health services in the community. Beneath the commonsense assumption that this is *par excellence* the profession dedicated to the care of the mentally ill there lies a deeper recognition of the many advances in standards of care that are properly attributable to the work of psychiatrists, from the abolition of locked wards to the spread of day-hospitals. One might speak also of major contributions to aetiological, epidemiological, and therapeutic knowledge, but this would be to go far beyond our present terms of reference. What is germane and scarcely disputable is that psychiatry neither took the initial lead in community care nor stepped in to fill the vacuum of leadership that by the 1970s had become painfully apparent. In the case of psychiatry, as of the other professional groups that have been discussed in preceding chapters, we must ask why this should have been so. To furnish an honest and convincing explanation of a complex sequence of happenings is difficult and problematic enough; to explain non-events is a truly daunting prospect, and it is often impossible to remain close to the data and avoid speculation.

The most obvious explanation is that the structure of the NHS simply does not provide a context for community involvement by

doctors other than general practitioners. Responsibility for the patient ceases at the point of discharge, when other agencies take over. Yet psychiatrists in general seem to have little confidence in either the efficiency or the clinical wisdom of the social agencies with which they are familiar, and indeed in many instances are well aware that they offer nothing at all. And although it is undeniably difficult to cross the gap it is not invariably impossible; it has been done, and effectively. Unquestionably, strong and persistent motivation is essential, but this has been apparent only in exceptional instances. The gravitational pull of the hospital is strong, while the rewards of work in community settings must seem too weak and its hazards discouraging. The principles of teamwork and interdisciplinary co-operation are generally applauded, but it is difficult for doctors to join teams except in the role of captain.

Even within the hospital that rank is open to challenge: such at any rate seems to be the explanation of a rather stiff statement on consultant responsibility adopted as College policy in 1977 (Royal College of Psychiatrists). The statement is to some extent an assertion of the principle of clinical freedom in the face of managerial intervention:

The Consultant represents ultimate medical authority within the Hospital Service for patients in his care. . . . The employer has no powers in this aspect of professional judgement. Once the appointment (of a consultant) has been made, the employer has limited control over the professional opinions of the individual Consultant.

But the document is also an affirmation of medicine's dominant role in relation to other professions in the clinical setting, and the delimitation of managerial authority is itself probably in part an expression of resistance to the administrative imposition of multi-disciplinary working arrangements. Drawing attention to the difficulties created by the hierarchical organization of nursing and social work, the document argues that

The . . . responsibilities of the medical profession cannot be delegated to a multi-disciplinary group when treating an individual patient. . . . Multi-disciplinary in this context, from the medical point of view, is a process of consultation, the final

decision resting with the Consultant on matters where the Consultant has the final responsibility.

If medical territory needed to be defended so tenaciously within the hospital ward, the prospect of the challenges and encroachments likely to be encountered in community settings must have served to deter many psychiatrists. Certainly the psychiatric profession has been no more ready than any other to champion the cause of mental health outside the hospital.

There are however some indications of possible change in the future. In a recent publication on psychiatric rehabilitation, the Social and Community Psychiatry Section of the College puts forward proposals for the multidisciplinary support of the chronically mentally ill inside and outside hospital, proposals which are constructive, collaborative in their intent, and notably free from dogmatic assertion of medical ascendancy (Royal College of Psychiatrists, 1980). How such proposals might contribute to new strategies for community mental health services is a matter for discussion in our final chapter.

10

The voluntary sector

The concept of MIND

The successes and failures in the development of services for the mentally ill have been presented almost entirely in terms of trends in the various statutory agencies and in the professions directly associated with them. Indeed, much of the recent history could be presented in the form of debate about the roles, responsibilities, and relationships of different professional groups. The contribution made by voluntary organizations seems for the most part to have been small by comparison, but it has not been insignificant, nor is it likely to be so in the future. This contribution includes direct service provision, centralized pressure group and lobbying activity, and the co-ordination at the local level of the activities of individual voluntary workers. The balance between these areas of work has changed significantly and quite rapidly during the period under examination.

The earliest forms of voluntary action in the field of mental illness were of the pressure group type, beginning with the protests against improper detentions organized by the Alleged Lunatics' Friends Society, established in 1845, and shifting in the 1880s to a campaign for reform of the lunacy laws, for which purpose the Friends Society transformed itself into the Lunacy Laws Amendment Association. Voluntary activity continued at a very low level however until after the First World War, although the Mental After-Care Association has an unbroken record of a century's work in this field and can

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justifiably claim to have pioneered ideas which are still significant. The decade after 1918 saw the creation of the National Council for Mental Hygiene, with strong interests in public and professional education, of the child guidance movement and of the first psychiatric clinics operating independently of the mental hospitals. During the 1930s there were concerted moves to bring together the various voluntary bodies that had come into existence to deal with different aspects of mental illness and mental handicap.

The Second World War delayed the establishment of the comprehensive national voluntary organization that a committee under Lord Favensham had recommended in 1939, but the Provisional National Council for Mental Health undertook extensive after-care activities at the request of the government. The National Association for Mental Health came into being in 1946. This was of course the year in which the legislation creating the NHS passed through Parliament, and there was a strong tendency to believe, in that period when a Welfare State was being enthusiastically created, that voluntary action would have little or no place in the new scheme of things; comprehensive state provision would soon make voluntary organizations—seen by many as tainted by the stigma associated with charity—a matter of purely historical interest. For some years the newly-formed NAMH remained uncertain of its scope and purpose (Jones, 1972; Anderson and Anderson, 1981).

From the early 1950s however the Association built up a substantial and varied programme of activities. It provided some direct services, including two 'community homes' for educationally sub-normal children, two approved schools and two schools for maladjusted children. It was also active in the field of public information and advice and was deeply involved in professional education, pioneering in particular the training of workers with the mentally handicapped. Another area of NAMH work was the encouragement of local mental health associations; this began slowly, but by 1971 there were 79 local groups in England and Wales concerned with fund-raising, local mental health education, befriending individual patients, and sometimes establishing local clubs or other social facilities. In all its work the NAMH throughout the 1950s and 60s maintained what in the jargon of the following decade would have been termed a low profile. It worked closely with the relevant professions and government departments, and was widely seen as a useful forum in which they could be brought together. It was

common for the speakers at NAMH annual conferences to include Ministers and distinguished professional and academic figures. It was in the very nicest sense something of an Establishment organization, and if it had a fault it was that it lacked a sharp cutting edge. That is not to say that it had no views of its own—indeed, NAMH as early as 1959 argued that it was essential for local authorities to be required and not merely encouraged to provide psychiatric after-care facilities—but rather that it tended to lay particular emphasis on quiet discussion and the achievement of some consensus of ideas. After a while, this fell out of fashion.

Through the 1960s, consumer movements became increasingly active. In the fields of social welfare and health, it was possible to distinguish between groups made up of persons suffering from a particular problem, often designated self-help groups; organizations of parents or other people with a long-term responsibility for the care of a specific group of patients or clients, the most notable example being the organization of parents of mentally handicapped children; and pressure groups which acted as advocates for a particular cause or class of persons, without any claim that it was their 'own members' for whom they spoke. Some of the groups in this last category made a very considerable impact. The Child Poverty Action Group and Shelter are outstanding examples of pressure groups which energetically promoted particular causes, drawing on academic research findings, collating and forcefully presenting supporting information, penetrating the mass media, capturing the imagination of sympathetic Members of Parliament and forcing themselves upon the attention of Ministers. Sometimes they were able to claim credit for specific pieces of legislation, and at the very least they helped to shape important sections of public opinion, ensuring greater receptivity to later legislative proposals.

During this period, when conditions in mental hospitals were coming increasingly under criticism, the NAMH began somewhat tentatively to adopt a more critical stance towards the mental health services and the professional groups involved in them, but it was not until 1970-72 that it embarked on a decisive change of identity. Under its new name of MIND and with a new director—recruited, significantly, from the National Council for Civil Liberties—there was to be an explicit emphasis on pressure group activities and on representation for patients and their relatives. In 1974 it was decided to expand regional and local activities, to transfer three of the

residential establishments to other bodies (a community home for ESN girl school leavers to a local authority and the two former approved schools to Barnardo's), and to strengthen the advisory service with particular reference to legal and welfare rights.

Although MIND continued to support a range of activities, albeit a range significantly narrower than in the past, it was its operations in the field of legal rights that gained the overwhelming share of public and professional attention. This was particularly the case after the appointment of an American lawyer to lead this work. There followed a series of court hearings which led to important changes in the status of psychiatric patients (including the recognition that voluntary patients had the right to vote, treating the mental hospital as their place of residence), challenges to official decisions taken to the European Court of Human Rights and a detailed critique of the workings of the 1959 Mental Health Act with particular reference to the rules governing the use of compulsory powers.

These assertive activities were extensively reported and undoubtedly produced some significant changes in the legal position of psychiatric patients. If credit for the Mental Health (Amendment) Act 1982 were to be allocated, a substantial share would have to be given to MIND. But inevitably some price was paid for these gains. Many psychiatrists, regrettably perhaps but not surprisingly, began to see MIND not as a friendly critic but as their enemy, questioning the good faith of medical decisions and placing what they believed to be an excessive weight on legal rights which many doctors were convinced were hollow—rights, they argued, to be untreated and neglected, rights to suffer and die. If over these years MIND made some new friends in the legal profession, it lost at least as many old ones in medicine. The fact that MIND's campaigns coincided in time with a number of other critiques of medical orthodoxy and traditional medical authority, whether from self-help groups, from the proliferating alternative therapies, from the women's movement, or from scholarly legal examinations of the appropriateness of medical dominance in certain crucial areas of decision-making, is a source of fascinating material for the social historian; in many of the psychiatrists at the receiving end it produced a bitter sense of being driven into a defensive position, as perhaps the most vulnerable members of a profession already harassed by persons and groups that seemed to have neither responsibility nor discernment.

Perhaps more important though less tangible than the resignations

and the angry letters was the opportunity cost of this high degree of concentration over several years on what was essentially a single issue. This is not to say that all the work of MIND ground to a halt. Routine activities were unaffected, and the development of local associations in particular was if anything intensified. But the strong emphasis of the London office on civil rights meant that the time and effort devoted to campaigning against injustices of unknown but certainly low frequency, even within that seven per cent of the hospitalized population potentially affected, was probably greater—and certainly more widely publicized—than that given to constructive criticism of the shape and direction of mental health services generally. It is arguable that whether as NAMH or as MIND, the largest voluntary organization concerned with mental illness has not succeeded in exerting a major influence on either the policy or the practices of the mental health services, having shifted from a position in which it did not have an individual and well-defined perspective on the development of services to a radically different stance in which an aggressive campaigning style was excessively narrowly focussed and succeeded in alienating many former allies.

Bernard Shaw observed that there were two tragedies in life: to fail to achieve one's heart's desire, and to achieve it. For MIND, the passage of the Mental Health (Amendment) Bill marked the end of a road. The campaign having achieved its objectives, it was by no means obvious where the organization that had committed so much to this enterprise should now turn. Further changes in personnel followed, and by 1983 there were clear indications of a more balanced prospectus, with a broadly based concern for the future of mental health services. Problems of prevention of mental illness and the monitoring and evaluation of services seem likely to figure prominently on the new agenda.

The steady growth of local mental health associations through the 1970s brought the total in England and Wales to 168 in 1982. The scale of this development is in itself a significant achievement, and some measure of a growing public awareness of and concern for mental health matters. There can be little doubt that the mass media of communication, and television in particular, contributed significantly to this trend. However varied the images of mental illness, mental handicap, and the relevant services that were portrayed—and that theme is itself one that would be worthy of investigation—they did much to increase the familiarity of mental disorder in the general

public and to stimulate activities that gave expression to the concern that was created. Little influenced by the polemics that reverberated in Central London, the local mental health associations embarked on a wide range of practical enterprises. Certain general problems confronted all of them: how to determine priorities for action; what relationship, if any, to try to build with the statutory services; whether to rely exclusively on voluntary activity or to employ one or more salaried workers; what balance to strike between 'clients' and others in the day-to-day activities and general control of the association; and how to obtain the financial support necessary for even the most undilutedly voluntary work.

The largest area of activity engaged in by local associations has been the provision of accommodation schemes, with a marked emphasis on small-scale group homes. In 1983 the local associations were directly responsible for more than 300 accommodation schemes, providing a total of 1600 places. Over 1100 of these places were in 254 group homes. There were also 17 hostels and halfway houses with 220 places, and 39 flatlet and bedsitter schemes providing more than 260 places. Outside the residential field the local groups ran 195 social clubs and 66 day-centres, as well as 41 projects specifically for mentally handicapped people. In addition, a wide range of other activities has been undertaken in different areas: mutual aid and support groups for persons with a particular mental health problem (agoraphobics, for example) or for relatives (those responsible, for instance, for the care of elderly people with severe mental illness), counselling services, befriending schemes for long-stay patients, holiday projects, and so on. About a quarter of the associations employ at least one salaried member of staff—as office administrator or as manager of residential schemes or of a day-centre. They are however a long way from being highly professionalized, although there has been an increasing awareness among the voluntary workers of the need to approach problems in a 'professional' way. Throughout these organizations runs a strong sense of the value of easy access and informality and of the dangers of condescension and patronage in the relations between helper and helped. The unobtrusive work of local MIND groups in a great variety of areas across England amounts collectively to a significant contribution to the development of community mental health services. Their responsiveness to perceived local needs and their involvement of local residents make the term 'community' a good

deal less perfunctory than is often the case. Some of these local projects are discussed in the following chapter.

Therapeutic communities

The concept of the therapeutic community was developed in the postwar years in the context of hospital psychiatric practice and has been applied there somewhat intermittently. Because the heavy demands that it makes on staff at all levels are particularly difficult to meet within large institutions where the degree of commitment is very variable and traditional definitions of staff roles are hard to modify, examples of successfully achieved therapeutic hospital communities have never been easy to come by (Jones, 1952 and 1962). But the concept is not a distinctively medical one, and indeed derives essentially from experimental work in social psychology. It should not therefore have occasioned much surprise when in 1959 an attempt was made to establish a therapeutic community for persons with a history of psychiatric illness, but outside the hospital environment and with no more medical supervision than was available to out-patients generally. There was however a good deal of mistrust at the time, and the early history of the Richmond Fellowship was a difficult one. The quality of its work gradually attracted favourable attention however, and by the 1980s the Fellowship had international connections and major educational commitments as well as responsibility for 40 establishments in Britain.

About half of the latter were designated halfway houses, providing places for about 350 people with a history of psychiatric disturbance including a substantial number for children, adolescents, and young adults; the remaining facilities were described as long-stay homes, community residences, and group homes. In recent years the number of admissions has been between 4 and 500 each year. The total number in residence at some time or other during the year 1980/81 was 831, and the average length of stay has been in the region of eight months. The formal diagnoses made by referring or supervising psychiatrists indicate a preponderance of personality disorders (about half of all recent residents), with psychoses outnumbering neuroses by almost three to one among the remainder.

The Richmond Fellowship is unusual both in its commitment to a coherent theory of organization and in the scale and sophistication of

a training programme which provides for visiting students as well as for its own staff. There is a positive approach to rehabilitation, which tries to avoid the notion of mentally ill clients as passive recipients of services. Instead, the intention is to enhance the competence of residents by creating an environment which encourages self-respect and self-expression. In addition to individual counselling (and medication as judged necessary by the resident's psychiatrist or general practitioner), there is a high degree of involvement in a variety of group activities. These are planned to increase awareness of oneself and of others, and in general to use the group of staff and residents as a resource for all its members. Since there is a temptation for all therapeutic communities to become excessively inward-looking, residents are encouraged to involve themselves as fully as possible in external affairs, either through employment or voluntary work. The model is a demanding one, requiring considerable care in the selection of staff and a large investment in subsequent training, but it represents an effective means of bridging the gap between psychiatric institutions and the open community.

A fellowship of sufferers

The barbs of 'anti-psychiatry' were not directed exclusively at the psychiatric profession. The portrayal of young schizophrenics as victims of intra-familial processes of distortion in relationships and in communications was not wholly original, having been prefigured by earlier speculations on 'the schizophrenogenic family' and by Bateson's concept of the double bind. But never before Laing had this incrimination of the parents of psychotic children been so eloquently formulated or so widely publicized. To many such parents it seemed an almost unbearable case of insult being piled upon injury. To have struggled, perhaps for years, with seemingly intractable problems of unpredictability, lack of communication, social withdrawal alternating with aggressiveness, to have seen the destruction of hopes and experienced the deepest anxieties for the future, and then to be assured by television programmes and paperback books that one was the author of these sufferings must to many parents have seemed the ultimate wound. Through newspaper correspondence there began a gradual drawing together of many parents of psychotic children who had previously coped as best they could with their problems in isolation from one another. Some early attempts to form groups

for mutual support and public enlightenment had limited success, but the National Schizophrenia Fellowship which emerged in 1972 has been increasingly active and has gradually expanded its membership to some 4000 families. Aided by grants from Departments of State and private donations as well as membership fees and the results of its own fund-raising activities, the organization operates on a variety of fronts. It has been active mainly through publications, in trying to raise the level of understanding of schizophrenia and its implications both in the general public and in relevant professional groups, has given evidence to official enquiries and responded to consultative documents and has sponsored systematic research. Apart from these activities of the Fellowship as a whole, important work is done by local groups—which are themselves also active in fund-raising and working for improved understanding on the part of local health, welfare and police services—in providing opportunities for families with a schizophrenic member to meet in order to share experiences and offer mutual support. This combination of self-help, low-key pressure group activity and support for the advancement of knowledge is an unusual and impressive one.

Miscellaneous provisions

Many other voluntary organizations have been concerned with the provision of mental illness services outside the hospital environment, though none can be said to have had a particularly powerful or pervasive influence. A few examples must suffice.

The Mental After Care Association is remarkable for its longevity. Founded by an asylum chaplain (Henry Hawkins) in 1879 as the After Care Association for Poor and Friendless Convalescent Insane, it can be said to have been the only provider of community care for the mentally ill in England for some 60 years. In spite of the recommendations of the Faversham Committee, the Mental After Care Association (a title assumed in 1940) did not sink its identity in the provisional wartime organization from which the NAMH emerged in 1946. It has since continued to operate independently, working on a fairly modest scale and in a relatively restricted geographical area. Two types of service are provided. There are eleven long-stay homes for middle-aged and elderly clients; almost all of these are situated in coastal areas of southern England, and they provide more than 300 places. There are also five hostels with about

130 residents; each offers a rather different mix of activities, and although their aim is rehabilitation and resettlement, there is no limit in the length of stay. Patients are carefully screened, and no-one with seriously disruptive behaviour, alcoholism, drug problems, or uncontrollable epilepsy is admitted. In addition, any psychiatrist referring a patient to MACA must give a formal undertaking to re-admit him or her to hospital if there is a serious recurrence of psychiatric symptoms. In general, the impression is of a caring, protective, fairly conventional and somewhat paternalistic organization that places a high value on its own independence and its preferred methods of working.

The Psychiatric Rehabilitation Association was first formed as a voluntary organization in a Surrey mental hospital serving the East End of London. It has since developed in several boroughs of North and East London. The PRA sets much store by groupwork methods, and uses them to encourage former psychiatric patients to take their place in the community, to help in providing and maintaining their own after-care facilities and to combat their own loneliness by visiting and encouraging other patients. It runs several evening discussion group meetings, two day-centres and an associated restaurant club, seven group homes (which can become places of permanent residence) and two industrial education units providing more demanding work situations than those of the day-centres. The PRA is also active in research and training and contributes in a variety of ways to furthering public understanding of mental illness and the problems associated with it.

The Jewish Welfare Board is an interesting example of a denominational welfare body of considerable longevity and some skill in adapting to changing social and economic circumstances. Founded in 1859 as the Board of Guardians of the Jewish Poor, with the intention of ensuring that impoverished immigrants did not become a burden on public funds, it rapidly diversified its functions. In recent years it has become highly professionalized, and is actively involved, *inter alia*, in providing both day-care and residential accommodation for psychiatrically disturbed persons of the Jewish faith.

Even a cursory review of the role of voluntary bodies in the mental health movement would be seriously incomplete without some reference to a number of organizations, minimally financed, which do not claim to be explicitly concerned with the mentally ill but in practice include many of them among their clients. Bodies such as the

Simon Community offer basic care and temporary accommodation, usually of a fairly rudimentary kind, to some of the most damaged social casualties: those not merely disturbed but homeless, friendless, and unsupported. A high proportion are or have been ill in a psychiatric sense; many are former patients of psychiatric institutions. The unrewarding work done, largely by volunteers, in the lower depths of our society is both a reminder of the destructive potential of some mental illness and a reproach to the formal services which have been unable or unwilling to prevent so much decline into degradation.

Conclusion

If we consider the development so far of community mental health services, it is evident that the contribution of the voluntary sector has been a substantial one. The emergence of well over one hundred local groups and the involvement of perhaps a few thousand private citizens in unpaid work in the field of mental illness is collectively an important achievement, the more so because of the element of spontaneous reaction to local problems and the absence of central direction. The voluntary movement has also displayed some of the pioneering qualities with which it is traditionally associated, having introduced more warmth and informality into the relations between helpers and clients than can always be counted upon in strictly professional relationships, and in at least one major example having put into effect on a considerable scale an innovative and theoretically sophisticated approach to psychiatric rehabilitation. What the voluntary sector has not so far provided is a powerful, independent agency operating at the national level, concerned with monitoring the scale and quality of community-based services, assessing changing needs, evaluating potential new models and identifying promising policy directions; it is suggested that the only body which might have discharged that function moved from an insufficiently critical stance to one that addressed an important but excessively narrow range of issues. There are signs however that this is changing.

There are two factors which limit the potential of the voluntary movement. First, there is its precarious financial position. The Department of Health is to be commended for its contributions to the care costs of major voluntary organizations, but neither these grants nor private donations and bequests can meet the costs of providing

direct services for clients. It is not easy to survive without local authority contributions, and local authority attitudes are sometimes mixed. Occasionally there is the politician's belief that all good things must be seen to flow from the town hall, and occasionally there is a streak of managerial imperialism that makes voluntary agencies fear a state of dependency which might end with their being wholly consumed. Even for well-intentioned local authorities, there is an irresistible temptation to scrutinize grants to voluntary bodies with exceptional care when expenditure has to be restrained. Without tolerance and generosity in the public sector, many voluntary organizations in the mental health field would be crippled.

The second factor is less tangible. The voluntary sector is not biddable. Its special virtues derive largely from its attempts to translate into action the hopes and visions of small groups of people. But its local, spontaneous, and sporadic qualities mean that it cannot be a vehicle of national policy. We can look to it for innovative, experimental, and pathfinding developments which in due course may be picked up by the statutory services. But it would be a contradiction in terms to see the autonomous voluntary sector as the principal means of implementing a centrally determined policy initiative. The statutory services are a long way from being a disciplined army, but the voluntary movements is made up of highly individualist guerillas. Whatever limitations that imposes, it leaves them free to lead by their example.

11

Local initiatives

Earlier chapters have drawn attention to the danger of treating the writings of the most enthusiastic and articulate members of any professional group as an accurate reflection of the current state of practice. It was not suggested that such writings were deliberately intended to create a misleading impression, but rather that their characteristically promotional style of presenting what the authors see as desirable modes of practice may inadvertently but very easily lead the uncritical reader to over-estimate the part they play in the day-to-day activities of the profession in question. But if there is a risk of allowing one's view of developments in the mental health and associated services to be coloured by too generous an interpretation of the scale and significance of innovative trends, there is also an opposite if not equal danger of permitting interesting and potentially valuable experiments to be obscured by the broad brushstrokes with which a period of largely frustrated expectations is depicted. The fact that a generally adverse climate does not make it impossible for collaborative community-based ventures to be launched and maintained is itself of some importance. Some of these developments need to be recorded in order to ensure a balanced account. It would be particularly valuable if there could be distilled from these accounts of local achievements some lessons for general application, but this would require not merely detailed investigation but also the development of methods and criteria by which the full costs and benefits of particular initiatives, as distinct from their face validity, could be evaluated. The absence of agreed criteria is discussed in chapter 12.

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At the level of descriptive information, a valuable service is performed by the Good Practices in Mental Health project, which was launched in 1977 to collect and disseminate information about good practices in the mental health field in the United Kingdom and elsewhere. Preventive provisions are considered as relevant as therapeutic and supportive services. Interested professional and lay groups and individuals are encouraged to identify examples of 'good practices' in their own areas and to prepare reports which the London-based GPMH office can make available for others to examine and perhaps build upon. Sponsored by the International Hospital Federation in co-operation with MIND, the Good Practices in Mental Health project has been supported by grants from the Department of Health and from charitable trusts. In its first six years 33 local GPMH studies were published, 29 from English districts, one from Scotland, two from Canada, and one from New Zealand; at the end of that period several more reports were in course of preparation. The present writer is greatly indebted to Mrs Edith Morgan, Director of GPMH, for providing much of the information about local initiatives drawn upon in this chapter.

Hackney

Hackney is a London Borough with marked social and economic problems and relatively high levels of psychiatric morbidity. A Community Psychiatry Research Unit was established at Hackney Hospital at the end of the 1970s, with support from the Mental Health Foundation, to explore the needs of people with long-term mental illness in the context of the slow development of local authority services. On the basis of a research study of the occupational and accommodation needs of therapy patients, a 'secretariat' was established to facilitate the provision of a range of supportive services. These were to include medical and psychiatric nursing, social and occupational, and personal (i.e., social work type) support, which were seen as essential complements to the residential accommodation that tended to be given priority by such local authorities as entered the field of community care for the mentally ill.

The Research Unit's working philosophy has been that the identification of needs by research should be followed by the provision of services to meet those needs. Because of the comparative rarity of research that is deliberately locally oriented, this approach is

not widely followed. The Hackney group have been fortunate in maintaining support for their care activities from charitable services—in particular, the Gatsby Foundation—and persuasive in involving statutory and voluntary agencies in the planning and delivery of services.

Several types of housing project are provided for groups of clients with different patterns of needs. The Vanguard Commune, a separately registered charity, is responsible for three houses used principally by residents who have not recently had a settled home and have either lost or never acquired the ability and skills to build up their own home and life-style. Some have come from hospitals, some from hostels, and some from lodging-houses. Many have quite serious psychiatric disabilities and lack the capacity to form relationships with others. Periods of depression and anxiety are common, as are both obsessional and anti-social patterns of behaviour. The communes are not generally considered suitable for residents who might benefit from more systematic rehabilitation, those using illegal drugs, nor those with serious drinking problems. Vanguard attempts to promote communal support in everyday living through its own staff and with help from other agencies, but does not offer personal care or rehabilitation. Length of stay is not limited and residents are encouraged to take part in decisions affecting day-to-day management. Some residents have moved on to independent council housing or to some other form of supported accommodation, and one or two have returned to hospital or hostel. Residents in these short-life houses will be offered places in one of three adjacent houses which have been purchased from the local authority and are being specially renovated; when completed in 1985 they will provide communal houses for 29 people, including two resident staff.

A 'flatshare' scheme offers permanent homes to clients who, because of past or existing mental illness, are unable to cope satisfactorily in totally unsupported accommodation but who would like to maintain their independence as far as possible. This scheme draws upon an allocation of flats made to the Community Psychiatry Research Unit and a small block of flats managed by the City and Hackney Association for Mental Health. Individuals receive support from the CPRU Support Network before, during and after moving; this covers practical and emotional problems and varies in intensity and duration according to personal needs.

A more structured pattern is followed in a large house owned by

the local authority and completely renovated by them to provide a permanent home for nine people who need a considerable amount of support; they will generally have had long periods in hospital and have difficulty in coping with day-to-day tasks and with normal housekeeping. All accommodation is let furnished and the weekly charge includes full board and lodging. A resident housekeeper with daily staff is responsible for all household management tasks as well as for keeping an informal eye on the welfare of residents. In the background, as with all the accommodation projects, is the Support Network based on Hackney Hospital, with its mixture of part-time and full-time staff—psychiatrist, social worker, social and occupational therapists—and additional back-up from voluntary workers. The small group provides intensive therapeutic and/or practical support to help sustain people within the community, not necessarily in connection with one or other of the accommodation schemes, and gives information and advice about local community psychiatric facilities.

Perhaps the most notable aspect of the Hackney developments has been the number of agencies involved. A charitable foundation has taken responsibility for most of the cost of the salaries of the basic CPRU team, but research grants have also been provided by the Regional Health Authority (North East Thames); the District Health Authority (City and Hackney) has made office accommodation and services available. The provision of various forms of housing would not have been possible without the generosity of the local authority, but both the Housing Corporation and the charitable trust have contributed to the costs of renovations and refurbishment of old property. A housing trust has been administratively responsible for much of the conversion work and the local mental health association manages some of the property as well as providing a range of voluntary services. The conventional assumption that the development of community mental health care requires a partnership between hospital service and local authority social services may need to give way to more complex organizational requirements.

Lewisham

The Mental Health Advice Centre in Lewisham (South East London) is also a recent development, but with a different emphasis from that of the Hackney team. Whereas the latter's main concern has been the resettlement of people with longstanding disabilities, the

Lewisham group has concentrated on linking psychiatric and psychological services more effectively with primary care. Mental health services in this socially mixed borough seem to have been inadequate by any standards; there were no psychiatric beds in the district hospital, no day-hospital, and only limited access to hospital out-patient facilities, while the psychiatric hospital serving the area was 12 miles away. An independent initiative by a small group of local professionals in the form of a limited domiciliary-based project for assessment and treatment gained the support in due course of the statutory authorities, and since late 1978 has worked from a suburban house in an easily accessible residential area of the borough.

The Advice Centre draws upon the services of professionals from a number of backgrounds—psychiatry, clinical psychology, community psychiatric nursing, psychotherapy, social work, and occupational therapy—backed up by a body of volunteers recruited by the voluntary service organizer attached to the mental hospital. Clients may present themselves without appointment and without referral; in practice the large majority are referred by general practitioners, though the number of self-referrals seems to be increasing. Children and elderly people are not accepted for treatment; and alcoholics and drug addicts are referred elsewhere for specialist help, but an attempt is always made to give advice and to point the client in an appropriate direction.

Volunteers act as receptionists, and introduce new clients to the professional on duty: only one will generally be available. This member of the team makes an initial assessment and contacts the client's general practitioner. The client is discussed by the whole team at a weekly conference, and if further help seems to be indicated a member of the group is selected as 'key worker', to maintain contact with the client and any other agencies involved and to co-ordinate any treatment programme. Treatment tends to emphasize a family therapy approach and makes use of volunteers working under professional supervision. A more recent innovation has been the creation of a crisis intervention team of psychiatrist, senior social worker, and community psychiatric nurse, using both health service and joint financing funds, to deal with emergency cases. This team work closely with general practitioners and the local authority's emergency social work team. Responding to calls by general practitioners, the team goes out to problems arising in domestic or

other settings (for example, police stations). Their initial task is to assess the need for emergency admission to hospital, but if this is not necessary alternative further treatment is arranged.

Well over 500 clients came to the Mental Health Advice Centre in its first two complete years, half of them falling within the age range 25–44. Young married women formed the largest client group, and the social class and ethnic distribution was fairly close to that of the borough as a whole, apart from some under-representation of social class I. Less than one-fifth of those seen had previously been psychiatric in-patients, although 44 per cent had received some form of psychiatric treatment, either from general practitioners or as outpatients; approximately equal numbers were and were not on some form of medication at the time of referral. Only a small proportion of the presenting problems (11 per cent) were considered to be indicative of specific psychiatric disorders; more than three-quarters of the clients however were experiencing emotional distress associated with a conflict in relationships, bereavement, or a similar problem. A diagnostic classification however suggested that there were few clients with no psychiatric abnormality, although psychotic disorders were uncommon; neuroses or 'transient situational disturbances' (ICD 307) were identified in half the referrals, and personality disorders in more than one-fifth. This general pattern was confirmed in psychometric assessments which tended to indicate relatively high overall levels of psychoneurotic disturbance and of depressive symptoms in particular. The staff in the Mental Health Advice Centre appear to have undertaken direct treatment with about half of all their referrals, in the form of either counselling at the Centre or, markedly less frequently, individual or group psychotherapy. Admission to a psychiatric hospital was necessary in only three per cent of cases, but 37 per cent of clients (as many as received counselling) were referred to out-patient clinics.

The staff of the Advice Centre claim that their work has made psychiatric services in the catchment area both more comprehensive and more readily available, and that the informality of the setting in particular has been appreciated by clients. They think it likely that their work is bringing about changes locally in the model of referrals outlined by Goldberg and Huxley, and suggest that the second and third filters described by these authors (the ability of general practitioners to detect psychiatric disorders and their referrals to psychiatric services) may 'simply be consequences of the present

service organization'. The staff are aware of the need for follow-up studies and for research to assess cost-effectiveness. (Bouras and Brough, 1982.)

Islington and Camden

The precise location of the Brecknock project has shifted in the course of its short history, and in doing so it has crossed borough boundaries betweenm Islington and Camden. Jointly sponsored by MIND and the Tavistock Institute of Human Relations as a community project initially emphasizing open access and mutual support, it had some affinities with the developments in both Lewisham and Hackney, but was significantly less oriented to professional treatment than the former and less involved in the provision of accommodation than the latter.

The project was launched in 1979 in Brecknock Road, where the intention was to provide 'an informal and unstructured community initiative', a setting where people with or without specific psychiatric difficulties could meet to share problems and solutions and where networks of mutual support could be generated as a means of dealing with stress, loneliness, and isolation, with the ultimate aim of aiding the integration into the community of people with some psychiatric disability. Local residents could attend as often as they wished, and take advantage of any of the services provided: information, advice, informal counselling, an outreach crisis service, and an alcoholic support group. Short-term overnight accommodation was provided for people needing a breathing-space away from their home environments. It is estimated that 400 people used the project in one way or another during its first year, but an enforced change of address to temporary premises in the King's Cross area led to some reduction in the scale and scope of activities.

An additional worker was appointed in January 1982 to develop schemes of a preventive nature in an area consisting approximately of Kentish Town and Tufnell Park. A survey of a local inter-war council housing estate indicated high levels of isolation and stress-related illness, and a series of interviews with local general practitioners not merely confirmed a high frequency of prescribing for tranquilizing and hypnotic drugs but also drew attention to considerable dissatisfaction among doctors with this mode of treatment and a wish for an acceptable alternative. This led the worker to focus on the

development of self-help groups for users of psychotropic drugs. The existence of such groups was brought to the notice of patients by their general practitioners; most of those who were interested had long-term personal problems and tended to be depressed, anxious, or lonely.

A third phase in the history of this project began in the spring of 1983, when new premises were found in the Dartmouth Park area. Two workers were appointed later that year, one with a nursing and one with a community work background, but most of the original activities were not resumed. Instead, the project built upon the more recent activities with drug-users and established itself as a resource centre for self-help groups whose concerns fall very broadly in the mental health area. General information and support are provided as well as premises for meetings, but the staff are not involved in anything that could be described as treatment. Their intention is to respond to problems that become apparent in the local community, and to that end they have drawn attention to their facilities through a door-to-door survey in the neighbourhood and the distribution of leaflets to a wide range of community groups in the two boroughs. At the time of writing, it is hoped to set up one group for discharged mental hospital patients, but otherwise to concentrate on preventive work by encouraging the formation of groups whose members share a personal problem (e.g., recent retirement or bereavement) which might potentially lead to some more serious emotional disturbance. Finance is provided in approximately equal proportions by an Urban Aid grant (via the local authorities) and an Inner Cities Partnership grant (via the area health authority). These grants are administered by MIND, one of whose senior social workers offers such professional advice as the staff feel the need for.

Solihull

Solihull, a Metropolitan District near Birmingham with a population of 200,000—that is to say, of the size of an average London Borough—has been the setting of a development involving unusually close co-operation between social services and health authorities and emphasizing training for independent living. The first step was the presentation by the director of social services, after the publication of the 1975 White Paper, of a proposal for a residential and day-attendance centre for the rehabilitation of

former psychiatric patients. There seems to have been a general will to co-operate, and a process of joint planning led to the construction of a purpose-built centre (Middlewood House). This was opened in 1980 under local authority auspices, with one-quarter of the building cost and three-fifths of the estimated first year's running costs being contributed by Solihull AHA under joint financing arrangements.

A clinical psychologist was appointed, also with the aid of joint finance, to help both to set up the new centre and to reorganize the rehabilitation unit in the feeder hospital. His role was seen not merely as one of liaison but also as to help ensure that the two systems developed a complementary relationship and a common approach to rehabilitation. The basis of this approach was the belief that the failure of former patients to cope successfully outside the psychiatric institution was often related to the lack of skills to deal with various facets of life in the community rather than to the illness itself. The emphasis was therefore on the acquisition of relevant skills through the provision in both centres of appropriate and realistic learning environments, with progressive movement towards less supervised settings and increasingly independent living. This involves the selective use of rehabilitation wards, a pre-discharge house, group accommodation, bedsits, and flatlets. The day-centres attached to both the hospital and the social services centre also provide a base for follow-up services utilizing two community psychiatric nurses and a social worker. Similar procedures for assessment, training, review, discharge, and follow-up are followed in both establishments, and some candidates for rehabilitation have been accepted on criteria other than psychiatric illness.

The rehabilitation process is not focussed solely on the individual rehabilitee, but is likely to include family and friends; since social factors are known to be significantly involved in readmissions to psychiatric hospital, there is an emphasis on trying to identify specific problems and work towards a solution. Under the heading of 'community living skills retraining', help is given in the areas of self-care (including cooking, cleaning, and laundry), basic social and leisure skills, and occupation; the latter takes account of the demands of getting and keeping a job as well as specific work skills. Because independent living is the primary goal, trainees are encouraged to cope with looking after themselves, even when occasionally they have psychiatric difficulties. The same approach also requires that

they should not be unduly protected from the consequences of their actions; it is assumed that the police (who appear to have co-operated helpfully with the project) should be called in to deal with seriously anti-social behaviour.

Many administrative and staff practices have changed to allow the realistic training. 'Institutional' cooking has given way to self-catering, and money is provided at both institutions so that trainees can budget, shop, and cook for themselves. The social services department provides the finance for this purpose for the preliminary unit at Middlewood, and all the other units there are classified by DHSS as independent accommodation, so that residents receive money for rent and food as part of their benefit. The working hours of staff are planned so that social and leisure skills training can take place in the evenings and at weekends.

Both establishments are concerned to develop strong links with the local community. These include regular meetings with the local authority's co-operative housing department, the establishment of social clubs in the community with the help of volunteers, the provision of advice and support to friends, relatives, landlords, and even the neighbours of former psychiatric patients, and the use of Middlewood as a community centre for groups ranging from the Brownies to the Elderly Club.

There is an active in-service staff training programme, and it is hoped to offer similar opportunities to a range of professionals with a general interest in rehabilitation. A transfer programme has enabled social services staff at Middlewood House to work at Hollymoor Hospital, and hospital nursing staff to work at the social services centre. Research is carried out into specific techniques of rehabilitation, in addition to studies to monitor the work of the two units. Data so far collected confirm the growing importance of the patient with multiple previous admissions, as against the classical 'long-stay' patient. In some cases, it seems, people are being admitted directly to the community facility who might otherwise have been admitted to the psychiatric hospital, but their management involves co-operation with the latter and with the neighbouring out-patient clinic. A major further innovation has been the opening (again with the help of joint finance) of a family unit at Middlewood House, making it possible to avoid a situation in which children are sometimes taken into care because their mother has been admitted to a mental hospital (O'Callaghan, 1982).

Tameside

An ambitious attempt to provide a comprehensive, community-based mental health service has been undertaken in a sector of Tameside AHA. The catchment area served extends from the edge of Manchester to the Peak District and has a total population of 75,000. It covers the districts of Hyde, Longdendale, and Glossop, with a socially and industrially varied population. Brindle House, described as the Community Mental Health Centre, is in the middle of the catchment area, and is backed up by a 14-bedded ward in the local District General Hospital five miles away. All psychiatric referrals, including self-referrals, are processed through Brindle House, which provides out-patient, home visiting, and day-care facilities; no distinction is made between day-centre and day-hospital. The Centre is financed on a 50/50 basis by the AHA and the social services department of the local authority (Tameside MB). A management team including officers of both authorities is responsible for operational policy, while on a day-to-day basis the Centre is managed communally by its staff team; no-one is designated as being in overall charge. There is a separate psychogeriatric service with its own consultant and day facilities.

The staff team consists of three-and-a-half social workers, three psychiatrists, and one psychologist, who share initial referrals, three day-centre therapists, two volunteer art therapists, one nursery nurse, and three clerical and administrative staff. Three-quarters of referrals come from general practitioners or the hospital. Only eight per cent are self-referrals; an open door policy is in operation, but the fact is not widely advertised. Initial referrals are shared between the 'key therapists'. It is not assumed that all new clients must be seen by a doctor, and in practice almost half are dealt with by a social worker. The entire team sees itself as having a psychosocial rather than a 'medical' orientation—that is to say, their emphasis is on understanding clients' problems rather than on diagnostic classification in disease terms. They aim to provide full assessment and intensive therapy as rapidly as possible after referral.

The day-centre is oriented towards active short-term treatment, and although avoidance of hospital admission is not seen as the principal objective of the community service the capacity for a rapid response and the provision of alternative forms of help has in fact had

the effect of reducing admission rates by 20 per cent (in the first two and a half years) and bed occupancy by 50 per cent. The programme of the day-centre is designed to facilitate a focus on 'problems'. Clients generally attend on two or three days a week, provide their own food, and arrange their own transport; no medication is prescribed at the centre. The records kept by members of staff are available to clients who may themselves contribute to them. Activities provided include individual and group psychotherapy, marital and family therapy, and art and drama therapy, as well as treatments based on home management and help for parents who have emotional difficulties with their children. Therapeutic work may also be carried on in clients' homes to complement that done at the centre.

Although work is planned to meet the needs of both acutely disturbed clients and those more chronically handicapped, it is recognized that the demands they make are different and not always easily reconciled. A programme emphasizing social skills training is being developed in the interests of clients with long-term disabilities. The principal concern however is with the provision of prompt and appropriate help to prevent acute problems and crises degenerating into chronic illness. The key role of general practitioners in identifying the need for such help at an early stage is clearly recognized, as is a marked variation in the abilities of general practitioners in that respect.

The staff of the Community Mental Health Centre would like to see a greater effort in the direction of early prevention by positively offering services to high risk groups, and are concerned to devise programmes specifically related to the needs of young people, for example, or of heavy drinkers. They recognize however that their identification as a psychiatric service may understandably deter many people who might be helped from accepting the status of clients. They think that on balance therefore preventive services are best offered through voluntary organizations or through official bodies not specifically defined as psychiatric, though they themselves can make valuable contributions to the planning of such services. Once again, the general practitioner's surgery is seen as the obvious focal point for diverting people with emotional problems away from formal psychiatric services.

Glasgow

In an area where the concept of community psychiatric services remains comparatively under-developed, the Glasgow Association for Mental Health has in a short space of time created a distinctive and significant role for itself. Unlike other projects discussed in this chapter, which try to meet particular needs within populations of at most 200,000, GAMH is the only organization of its kind in an area of about a million people; it does however have the advantage of close links with an extremely active Council of Voluntary Service. Like most small and medium-scale initiatives in the voluntary sector, it has to live with constant uncertainty over funding. Urban Aid, mediated through the Regional Council, provides some seven-eighths of its income; but Urban Aid funding cannot continue beyond seven years, and the likely future after 1987 is already a cause of anxiety. The Association sees itself as operating on a variety of principles—self-help and consumer representation on the one hand, and as an independent professional social and community work agency on the other. Its work has not been characterized by a high degree of involvement of the general public or of volunteers, and its role *vis-a-vis* the statutory bodies is inevitably problematic. The general view of voluntary activity which informs the Association's work is that 'the voluntary sector acts as a catalyst for producing change; as guardian of the interests of patients and their families; as a lobby to secure resources; as a provider of innovative services.'

Nine or ten 'LINK' social clubs are now active, serving local areas (some of them in nearby towns as well as in the city itself) and offering people with mental health problems social contact, recreation, discussion, and access to professional services. They meet once or twice weekly in community centres or hired rooms; a high proportion of members are self-referred. The Link Forum, to which each club elects representatives, has a number of co-ordinating roles. It helps with banking arrangements, for example, and has organized holiday schemes and educational and arts projects. Club members are encouraged to think of themselves as responsible and critical consumers of services and not as passive beneficiaries. They take part in discussion sessions with students and professionals and in 1982/83 formed a working party which produced a detailed response to the consultative document issued by the Scottish Home and Health

Department prior to the Mental Health (Scotland) Amendment Bill and actively campaigned for changes.

The absence of day-care facilities and of other community mental health services led the Association to develop a day-care service as a 'springboard' programme to promote recovery in a band of patients believed to have a high chance of achieving or regaining full independence. It was intended that the model should be independent of existing psychiatric facilities, be centrally located and use a group-work approach. It was important to identify realistic goals and to ensure that users had a strong voice in the running of the project. The principal objective of the programme was to allow individuals the opportunity, together with professional help, to create or rediscover their confidence in themselves and their ability to lead satisfying social lives. The programme differed from much day-centre activity in being fairly highly structured and of fixed duration. There have so far been six such programmes, each of three months duration and with a standard daily timetable. Using a workshop format and a variety of methods—discussion, role-play, drama, video, art-work, etc.—participants focussed on three major areas—social and interpersonal skills, housing and welfare rights, and work and leisure.

One hundred and seventy-four people were accepted for the first six programmes, and apart from withdrawals and early leavers 121 participated actively. The users included both former psychiatric hospital patients and some who had only been in primary health care. The workshop experiences had practical consequences. The activities of the housing workshop led to 27 tenancies of various kinds being obtained for members; the occupations workshop led to a number of opportunities for voluntary work and for full-time temporary employment—in total 73 jobs opportunities were provided, mostly funded by the Manpower Services Commission. Future workshops are likely to be somewhat longer but less intense, and there is some hope that the model may be drawn upon in the planning of day-care services by the statutory authorities. GAMH has also generated its own active housing association and is presently handling 27 tenancies while assessing the need for new commitments in the housing field.

The Glasgow Association has, unlike a number of community-based initiatives, begun to move into the psychogeriatric field. In conjunction with an area social work office of the local authority, the services of an existing day-centre for the elderly were expanded to

provide day-care on two days a week for eight elderly confused people at a time. This was thought of as a means not only of reducing the burden on relatives and other services, but also as providing some enhancement of morale and stimulation of memory. Costs have been kept low by using existing services wherever possible.

An important continuing aspect of the Glasgow Association's work has been a recurrent involvement in policy questions. Through conferences and working relationships with health and social service authorities a substantial effort has been made to raise the level of debate about the proper scope and organization of community mental health services.

Conclusion

The half-dozen local initiatives outlined in this chapter differ from one another in many respects—the precise focus of their work within the spectrum of psychiatric disturbance, the range of services offered, the extent of geographical coverage, the basis of funding, the balance involved between health services, local authority services, and voluntary organizations. Some features however are common to all these projects. Although none of them is committed to an ideology of 'anti-psychiatry', all work with a concept of mental illness and its management that is far removed from a model which emphasizes disease and its medical treatment. Associated with this guiding interest in personal problems and the therapeutic value of group processes is a fairly high degree of flexibility in the definition of professional roles. Those projects which involve psychiatrists are not dominated by them; psychologists and social workers in particular have equal voices in the care of clients and in project management. Finally, none of these initiatives has sprung fully-armed from the head of a statutory authority or voluntary organization. In each case there was a certain vision which led an individual or group to take a determined and perhaps unconventional initiative, and to be prepared to work through sometimes complex and demanding negotiations.

This short list of projects is neither random nor comprehensive. Many other initiatives could be listed, some very small or highly localized, others more ambitious. The object however has been to provide illustrations of interesting developments to set against a picture of national trends which in general have disappointed the

early expectations of a major shift in mental health care. For it must be emphasized that even if every attractive-seeming community-based mental health project were to be enumerated, they would be seen collectively to touch upon only a small fraction of all those who need help in order to live more harmonious and constructive lives. These illustrations are important as possible indicators of directions in which travel might be encouraged.

A final reservation must be noted. We can say of all these projects that they have admirable intentions and show interesting lines of development, but we are in no position to say unequivocally that they are successful. Success must be judged in terms of beneficial changes achieved in the lives of patients or clients and those around them, and cannot be inferred from statements of aims or even from the use of particular methods, unless the general effectiveness of those methods has already been satisfactorily demonstrated. The low priority given to evaluation and even to the definition of evaluative criteria is a widespread weakness of community mental health as of many other personal and social services. It will be more fully considered in chapter 12, which asks how we have reached our present position and what are the prerequisites for identifying and pursuing new national goals.

12

Loose ends

The missing champions

The principle of a major shift towards 'community mental health services' has been widely and increasingly accepted for a quarter of a century. When the prospect of a very substantial reduction in the in-patient population of the psychiatric hospitals was first outlined in the early 1960s, some writers expressed doubts as to the rate at which this could be achieved and others drew attention to the need for a commensurate development of community-based services, but there was little inclination to argue that a trend away from the large specialist hospital was intrinsically undesirable. The intensity of the emphasis upon active therapy as the *raison d'être* of the hospital service was occasionally qualified by a reference to a continuing need for asylum, in the literal sense of the word, but there has been no serious claim that the traditional model of hospital care should dominate the future pattern of provision. A scaled-down but therapeutically vigorous hospital service on the one hand and a developed community service on the other have been accepted almost without reservation as the essential and complementary components of a system of care for the mentally ill. Nor has the matter ever been politically contentious; Conservative and Labour administrations alike have embraced, probably with slightly different mixtures of motives, the notion that services for the mentally ill should increasingly be community-based.

There is therefore something of an anomaly to be explained. The

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targets for reducing psychiatric hospital bed provision took a little longer to reach than was originally forecast, but in the end the reduction went some way beyond the early prediction. Although not one large mental hospital has actually been closed, and although the number of in-patient beds in general hospital psychiatric units has failed to reach the expected level, it cannot fairly be denied that the goals laid down for the hospital service in England have been largely attained. By contrast, the development of community services has been slow and fitful, marked by considerable geographical unevenness, with a significant proportion of apparently interesting innovations occurring in the margins rather than the mainstream of service provision and conveying in general a marked sense of discrepancy between ambition and accomplishment.

Before considering why the policy of community care for the mentally ill has had such an undistinguished history, it might be appropriate to ask whether, at national level, anything that can accurately be termed a policy has ever existed. We have had rather vague and general statements of aspiration, but a conspicuous lack of clarity and specificity in formulating objectives. There have been numerous exhortations to co-operate, but little firm guidance as to the processes and structures by which co-operation could best be achieved. Official statements have been characterized neither by an imaginative awareness of the existential aspects of psychiatric disability nor—what might perhaps more realistically have been hoped for—by any quantitative rigour; the 1975 White Paper, for example, which laid down 'norms' for the provision of hostel and day-centre places in terms of units per thousand population, produced figures out of the air without any indication of the means by which they were calculated or the assumptions on which they were based. During the period under review prevailing conceptions of community care altered quite markedly, partly because of the changing pattern of psychiatric hospital usage, partly because of less tangible shifts in ideas about mental health problems in their individual and social contexts, but these trends made little impact on official thinking and writing. Whether ideals so loosely expressed and with no solid plan for implementation can properly be described as amounting to a policy is very much open to debate.

That debate however may be of only theoretical interest. Barbara Stocking, on the basis of an extensive review of innovations in health care which were taken up across the country with varying degrees of

speed and enthusiasm, concludes *inter alia* that the existence or otherwise of policy statements is unrelated to success. (Stocking, 1984). If we take into account the high degree of decentralization of decision-making within the National Health Service and the very considerable structural problems inevitably arising from the political, administrative, and financial separation of health care and local authority services, the undramatic nature of the problem and its lack of obvious popular appeal, it is clear that with or without central guidance, a major reorientation of mental health provision could only have been achieved on a nationwide scale if the cause had been vigorously and consistently promoted by influential groups within the medical and social care systems.

Students of industrial innovation, seeking to understand why some new developments are taken up enthusiastically while others of apparently similar promise seem to languish, have allocated a major role to the concept of the product champion (Schon, 1973; Rothwell, 1975). Since it was characteristic of large organizations to react against change and innovation of a potentially disturbing nature, it was essential, Schon argued, for new ideas to have 'champions'. 'The champion', said Schon,

must be a man willing to put himself on the line for an idea of doubtful success. He is willing to fail but he is capable of using any and every means of informal sales and pressure to succeed. No ordinary involvement with a new idea provides the energy required to cope with the indifference and resistance that major technical change provides. It is characteristic of champions of new developments that they identify with the idea as their own, and its promotion as a cause, to a degree that goes far beyond the requirements of their job.

Rothwell's studies in two major industries differentiate four types of role associated with such innovation and not necessarily mutually exclusive; one of these, the 'business innovator', the individual actually responsible within the management structure for the overall progress of the project, approximates most closely to Schon's conception of the product champion.

These and other studies all relate to entrepreneurial roles within single corporations; voluntary change within the health and social services is inevitably a much more diffuse affair, has none of the stimulus which may come from the expectation of profit and has to

contend with a more elaborate system of defences against change. It requires therefore a great deal more than an individual as product champion to help stimulate movement in a new direction. The concerted action of a professional group, or at any rate of a significant and vocal fraction, may be a necessary precondition of change; and in the case of community mental health services, this commitment has been conspicuously lacking over virtually the whole of the period in question. Earlier chapters which have reviewed trends in the history of the relevant professional groups between the late 1950s and the early 1980s have suggested that each had its own problems and its own priorities—either elected or bureaucratically imposed—which were at the least inconsistent with the forceful promotion of community mental health services or perhaps even militated against that role.

For psychiatry, by most criteria the central profession in this field of work, the period was a difficult one. The long-standing problems of status insecurity within the greater profession of medicine were confounded by waves of criticism directed successively from sociologists, from social workers, and from exponents of civil liberties. Professional groups which had traditionally accepted a subordinate position became less tolerant of long-standing hierarchies of esteem and defined accountability in terms of their own management. To venture into community settings was to expose oneself to challenges to one's authority in contacts where some blurring of roles, if not a gross confusion, was almost inescapable. The familiar setting of the hospital provided some reassurance, and an emphasis on intensive drug-based treatment, especially in a ward of the district general hospital, was clearly consistent with an acceptable construction of a medical role.

All hospitals, of course, are inward-looking, and perhaps it is unreasonable to expect psychiatric establishments to turn themselves inside out. We are unusual in Britain in having deliberately maintained a system of universal cover by more than 25,000 general medical practitioners; and it could be argued that the family doctor is the appropriate focal point for services for mentally ill people. In a narrowly statistical sense this is indeed the case. The research evidence shows clearly that the vast majority of people who consult their general practitioners about an emotional problem or a disturbance of mood are dealt with by the GP alone, although the standard treatment is the prescription and repeat prescription of psychotropic

drugs, which have long since ceased to be the prerogative of psychiatric specialists. Here, as in hospital practice but on a very large scale, we have powerful means of relieving symptoms. We may need to rewrite the hymn:

Art thou weary? Art thou languid? Art thou sore distressed?
Then valium shall comfort thee and librium bring thee rest.

But beyond that there is comparatively little to report. It is a sobering thought that, as in the case of psychiatry, the reform of medical education does not seem to have achieved the intended impact on general practitioners. Evidence from a variety of sources leaves one with a marked sense of diminution in the personal qualities of the doctor/patient relationship, with a growing movement of practitioners into work settings where better organization and greatly increased ancillary help are associated with restricted availability and a more narrowly 'medical' definition of the physician's role.

Although it was commonly assumed that the authority social services would provide the main operational basis for mental health services in the community, there have been few indications of a 'product champion' role developing in this area. The social work profession has grown too rapidly and has perhaps been subject to too many conflicting influences to have retained a firm hold on its own sense of identity. The submerging of specialisms has not led on to a widely shared understanding of the nature of the generic task and of the appropriate professional methods, but rather to a diffuse diversity of styles and attitudes. No one body speaks authoritatively for the profession of social work. Membership of the British Association of Social Workers (BASW) amounts to about 40 per cent of qualified practitioners. The National and Local Government Officers Association (NALGO) includes far more social workers among its members, but its concerns as a trade union quite properly do not extend to questions of professional priorities. But even if it were possible for a professional social work organization actively to promote the cause of community mental health services, it would not be in a position to commit its own members to any course of action. Virtually all social workers function within bureaucratic systems, the majority of them in large and complex ones. Major policy decisions are made by committees of elected local authority members, dependent though they may be on the advice of senior officers. The pressures of client-led demand and of statutory responsibilities have

combined to ensure a generally low priority for projects perceived by managers and councillors alike as essentially health service responsibilities.

Some of this resistance has recently been melted by joint finance, but it is fair to say of the social services as of the two relevant branches of medicine that throughout the period between the Mental Health Act of 1959 and the Amendment Act 23 years later their distinctive problems and priorities were at variance with the cause of community care for the mentally ill. There were to be sure significant exceptions: psychiatrists with the courage to accept the challenges posed by the complexities and ambiguities of multi-professional teamwork away from the security of the hospital setting, general practitioners who themselves acquired counselling skills or brought professional or volunteer specialists into their practices, social workers who were active in developing support networks for clients with mental health problems, and social service authorities which sanctioned imaginative collaborative ventures. But these *were* exceptions, and a consequence has been the marginal status of a high proportion of innovative developments. For the most part they have been tacked on to existing services; of the local initiatives described in chapter 11—admittedly not a random sample—it is interesting that only one involved the substitution of a new, comprehensive community-based service for the traditional pattern. Individual innovators in the role of product champion have been able to achieve localized advances in community provision, but it would have needed, as a minimal prerequisite, an impetus from at least one influential profession acting as a collective champion to bring about a substantial transformation of the national scene. And none of the relevant professions was either sufficiently secure or appropriately oriented to exert the necessary pressure.

New directions

A high proportion of locally-based initiatives in this field, including those discussed in chapter 11, were launched around 1979–80. It is a fascinating paradox that after two decades in which, in spite of regularly increasing levels of expenditure on both health and social services, the rate of growth of community mental health services remained exceedingly slow, a period of sharp financial restraint should have coincided with a significant rise in the number of local

innovations and a marked expansion of interest in mental health issues. No doubt to some extent economic necessity has stimulated invention. But it is also relevant to note the ways in which the climate of ideas was changing under a variety of influences. Prominent among these is what might loosely be termed the consumer movement. This does not refer to a specific group or body of persons, and perhaps consumerism would be a more appropriate term to indicate such trends as a diminished respect for professionals and a sense that too many aspects of human life are regulated or dominated by professional actions and judgements. In the health field this led to a proliferation of self-help groups and mutual support groups, usually focussing on a specific condition. An extremely important trend in relation to mental health has been a growth in awareness of the scale and significance of the minor emotional disturbances. This has been fed to some extent by a new interest in stress and stress-related disorders and has been associated with some reaction (which is not to say a massive revolt) against the treatment of human problems in terms of a narrowly medical paradigm. The women's movement has contributed on a significant scale to this new emphasis on self-awareness and self-help. Another alternative to a 'disease/treatment' model has been the striking growth in counselling activities, generally under the auspices of voluntary bodies, in relation to a wide range of problems; marital tensions, problem drinking, and bereavement are perhaps the best-known areas of application.

It is not altogether surprising that the two major documents on the future of mental health services which were published in 1983 were both prepared under the auspices of voluntary organizations. Following a debate on mental health services in the House of Lords on 31 March 1981, the Richmond Fellowship set up an enquiry into 'community approaches to the mentally ill' under the chairmanship of Lord Longford. It was perhaps unusual among modern committees of enquiry in including seven members of the Upper House in a total membership of fourteen; two of the Peers were medically qualified, one of them a former President of the General Medical Council, and another was a former Director of Social Services. The other members included two professors of psychiatry and a Past President of the Royal College of General Practitioners. The report was published in July 1983.

Later that year MIND published a report entitled *Common*

Concern, described as a 'manifesto for a comprehensive mental health service'. Of the nine members of the working group which had produced the report, six were members of the staff of MIND; the only medically qualified member was a psychiatrist who had been a pioneer of community psychiatry. Other contributors of material for the report included two senior psychiatrists and a general practitioner. The MIND and the Richmond Fellowship reports both looked to the future and attempted to outline likely future needs. An examination of the extent to which they agreed in their identification of problem areas and in their prescriptions for change may be a useful way of moving from the review of the achievements and, more noticeably, the failures of the past 20 years towards a consideration of desirable and potentially attainable goals for the future. This may also be an appropriate context in which to discuss the recommendations of the report on *Psychiatric Rehabilitation in the 1980's* produced three years earlier (and, obviously, with narrower terms of reference) by a working party of the Social and Community Psychiatry Section of the Royal College of Psychiatrists.

Reports and recommendations: the Royal College of Psychiatrists

This large working party (25 members and three observers) was by no means limited in its membership to psychiatrists. The 12 non-psychiatric members included representatives of nursing, clinical psychology, community medicine, social work, occupational and industrial therapy, and the voluntary sector. Two of the 13 psychiatrist members were associated with the later enquiries. Professor John Wing, chairman of the Rehabilitation Working party, was to be a member of the Richmond committee of enquiry, while Dr Douglas Bennett was actively involved in the group that produced the MIND report.

Unlike the later reports, the rehabilitation study was a response to a request from the DHSS. The College was asked to consider facilities for rehabilitating people, in and out of hospital, with chronic psychiatric disorders and to make recommendations; the organic psychoses of old age as well as mental retardation were excluded from the College remit. The working party reviewed the scale of the problem, but was not able to make any definitive assessment. Extrapolation from a district register (Camberwell) suggested that there were about 210,000 nationally who at the end of

1976 had been in touch with psychiatric services for more than a year, including a spell in some kind of residential or day accommodation. Slightly more than two-fifths of these would have been diagnosed as schizophrenic, but what proportion of the total or of clinical sub-groups might have been expected to benefit from some form of rehabilitation was unknown. The working group also recognized the importance of a large group with 'milder affective and neurotic conditions' but decided that their rehabilitation problems would require separate attention. The focus of the report therefore was to be essentially on those with chronic psychotic conditions leading to long-term social disablement.

Particular importance is attached to regular, detailed, and skilled assessment in realistic settings, in order to determine the disabilities present, to discover potential for development and specify short-term and long-term goals and set in train rehabilitative processes designed to achieve them. In summarizing the techniques of rehabilitation, the report sees medication as 'the ground on which the rehabilitation structure is built'; a wide range of techniques may contribute to that construction, including group methods and various forms of behaviour modification, as well as occupational therapy broadly defined, general education, and individual and group counselling. The report recognizes that rehabilitation is not an activity that embraces patients alone but should extend to work with relatives and friends and to health education addressed to key individuals in the local community and to the general public. The recommendations cover training of professional staff, the provision and staffing of rehabilitation services and some problems of co-ordination and planning.

The writers of the report believe that there should be a 'minimal network' of day and residential environments in every district and argue that particular priority should be given to some important elements which at present are rarely provided. These include experimental schemes for sheltered residential care, such as housing estates on hospital sites; hospital-hostels for those at risk of becoming long-stay in hospital; group homes with a high degree of day-time supervision, which could diminish the need for hostels; long-term sheltered occupation, some of it in the setting of a day-centre; sheltered working groups in open employment, and special support during the return to work. Since rehabilitation requires particular skills, the report recommends training for all those involved in the various facilities. Psychiatrists in training should all be able to obtain

experience in a service where rehabilitation is a major part of the clinical work, and although creation of a sub-specialty of psychiatric rehabilitation is not recommended, the report urges the appointment in each health district of a consultant with a special interest in and responsibility for rehabilitation. In addition, all rehabilitation units require the services of a clinical psychologist. As district rehabilitation services develop, all psychiatric nurses will need to have 'a community orientation with emphasis on rehabilitation procedures and services'. The training of social workers is seen as deficient and the creation of specialists in rehabilitation is recommended for the social services as well as the health service, with part of the practical apprenticeship and training of many basic grade professional staff being shared.

The working party recognized and deplored the lack of co-ordination between the various agencies concerned with rehabilitation, and added its voice to the many which urged health service and social service authorities to accept a joint responsibility for the chronically disabled. Within each health district, which should be regarded as the local unit for planning purposes, a multi-disciplinary rehabilitation group should be established with responsibility for case identification, planning to meet district needs and monitoring the progress of service development. The core members of the team would be a psychiatrist, a specialist social worker, and a psychiatric nurse, one of whom would act as rehabilitation co-ordinator. An identified key worker should be responsible for the ongoing care of every chronically disabled person, and to do so must be in a position, by prior agreement, to call upon the services of any agency working in this field, and should be available to give advice in emergencies to general practitioners, relatives, or others with legitimate interests. The report notes with regret the absence of any genuinely integrated mental health service, and recommends further study of ways of achieving this at local and national levels without arguing for or against any particular type of solution (Royal College of Psychiatrists, 1980).

In the context of the development of services and of ideas about services, perhaps the most significant feature of this report is its frank acknowledgement of the scale and seriousness of the problem. Without minimizing the therapeutic achievements of the previous quarter-century, the report by clear implication underlines their limitations. Residual disability, whether in a 'new' long-stay hospital

population or in a variety of community settings ranging from comparatively sheltered if potentially stressful family environments to homelessness and destitution, is seen as a major challenge, and one largely neglected. Perhaps—but this is not a point which the report makes—therapeutic enthusiasm always carries with it the danger that failures will be resented and ignored; there is a certain agreeable realism in accepting the importance of work towards quite modest rehabilitative goals, work which may sometimes be of value if it achieves no more than the maintenance of the status quo, the prevention of further deterioration. Most of the report's recommendations are sensible and familiar, and it is regrettable that some very basic requirements should still need to be reiterated in 1980. Some of the proposals are of particular interest, however. The notion of the designated key worker as the person who tries to ensure that the right services are available at the right time is an attractive one, and has also arisen in discussion of the complex needs of mentally handicapped and young chronically sick clients. The theory of general practice would suggest that the responsibility for mobilizing services should lie with the primary care physician. It is a measure of the gap between theory and reality that the report on psychiatric rehabilitation, although recognizing that the general practitioner can 'help to ensure continuity of care for patients as well as emergency help', does not see him as more centrally involved in the process. The notion of a unified mental health service makes an appearance in the report, but there is no discussion of how that desirable goal might be attained, given the present structure of services. It is also worth mentioning that the Department which commissioned the report has given no indication that it plans to act so as to achieve any of its recommendations (Wing, 1984).

Reports and recommendations: the Richmond Fellowship

The committee of enquiry set up by the Richmond Fellowship in 1981 took a broad if not fully comprehensive view of the problems of mental illness, and its report impressively blends detached clinical description and humane concern. Reviewing sensitively the principal types of psychiatric disturbance (other than those of childhood and of old age) and drawing attention to the patterns of human need arising from them, the report reaches conclusions that are not merely critical but damning: '... the age-long neglect of the mentally ill, although

ameliorated . . . is still a marked feature of present-day society in Britain'. The erosion of the former institutional base of the mental health services without completing the construction of a new one is viewed as ' . . . intolerable and . . . reprehensible'. 'We deplore the use of the term "community care" as a slogan that diverts attention from the real issues of quality of life for mentally disordered, distressed or disabled people, whether or not they are living in "institutions".'

The report's recommendations are accordingly wide-ranging, and go a long way beyond familiar exhortations for better co-operation. The obligation placed on local health and social services by previous legislation should be reaffirmed by statute, and a named Minister appointed to ensure that it is implemented. If it is indeed government policy to ensure the provision of services of good quality in each district, it must be recognized that this will not be achieved unless it is made mandatory. This will involve the provision of additional finance and the establishment of appropriate local machinery to make certain that minimum standards of care at any rate are obtained. The designated Minister should have control of a new Development Fund of unspecified size. This Fund would be earmarked specifically for the development of 'a wide spectrum of community services for the mentally ill', and should be administered under a Departmental Planning Board. It would parallel and not replace existing joint funding arrangements, but would not rest on the assumption that responsibility for the cost of services was in due course to be taken over by local authorities. Every district health authority and every local authority social services department should be required to specify in detail its expenditure on services for the mentally ill over the previous ten years, and would in general be expected at least to maintain that level over the next decade, excluding any contributions from the Development Fund.

To give substance to the concept of community care, the report argues, there needs to be local machinery for identifying needs, to provide specialist services, to ensure that the general run of community provisions are accessible and flexible and to help raise the level of public understanding, sympathy, and co-operativeness. On this last point, the authors of the report are realistically resistant to romantic notions of 'the community' as easily capable of coping with its own problems. A statutory organization is necessary in each health district. Recognizing that the present division of responsibility is fundamentally unsatisfactory, the report recommends as a means

of achieving greatly improved co-ordination in the foreseeable future the creation in each district of a *Joint Mental Health Development Committee* made up of senior representatives of social and health services and voluntary organizations. Led by a District Co-ordinator, who may have a background in psychiatry, social work, or nursing but whose standing and seniority must be beyond dispute, the Development Committee should be responsible for the operation of both existing joint funding arrangements and the proposed new development funds; ensuring that statutory services in both sectors are quantitatively adequate (at least at the level of the 1975 criteria); working towards improvements in the quality of services, scrutinizing budgets and comparing local services with those of other districts.

The Richmond report stresses the value of regular critical appraisal of local services. The Development Committees should be sensitive to the reactions of patients and staff organizations as well as to the findings of independent research. In addition, they should have the benefit of reports from a proposed new Inspectorate. The creation of such a body, responsible to the DHSS and preferably spanning both health and social services, is a potentially important recommendation of the report. Although the observations of inspectors would be widely distributed, the district Joint Mental Health Development Committees would have a particular responsibility for discussing these findings with staff teams. This is not seen as an isolated event, however, as district Development Committee would have a continuing role in considering together with practitioners how the scale and quality of all services could be improved.

In commenting on the scale and range of services that each district should be expected to provide, the report takes the guidelines of the 1975 White Paper as minimal requirements that should be made mandatory and argues that further innovations are called for: day-centres intermediate in level between 'occupational therapy' and 'sheltered workshops'; some high-level sheltered factories; rehabilitation units of various kinds, where preparation can be offered for independent living in group homes and bedsitters; and as a last resort hostels that are available for refuge rather than for treatment. The organization of staff teams within all operating units should allow for a high degree of continuity of personnel, a minimum of managerial hierarchy and clear and explicit policies for selection of clients, treatment regimes, and environmental quality. The District Co-ordinator and his or her colleagues would carry the major responsi-

bility for the demanding task of ensuring continuity and complementarity of services, and should be readily accessible to all staff participants. In order to make certain that the services in their turn are fully mobilized for the benefit of patients and their families, the Richmond report deliberately adopts the Royal College of Psychiatrists' proposal for the creation of district registers and the designation of key workers, with all that that implies in terms of access to and flexibility of response by practitioners of all kinds.

Administrative structures and financial provisions are valueless unless staff are knowledgeable, skilful, and properly motivated. The disadvantages of existing patterns of professional training are clearly recognized in the Richmond report—lack of knowledge in depth of mental illness and its management, a tendency to claim a monopoly over particular forms of assessment and treatment, and to undervalue the contributions of other professional groups, and a general lack of interest or skill in dealing with the 'mundane' problems that concern mentally ill people and their relatives. The idea of a new type of worker, a mental health professional, is not however seen as realistic; instead, the committee of enquiry urges strengthening the specialist aspect of academic training in all the relevant professions and providing apprentice training in multidisciplinary teams in accredited centres—a trend which obviously becomes easier to follow as more model services of the type outlined elsewhere in the report are brought into being. For social workers, the most hopeful route is seen as the expansion of specialist post-basic training in mental illness and its care, and the writers of the report find it '...astonishing that the principle of specialist courses for social workers is still not widely accepted'. The structure of nurse training is not thought to need substantial change. Community aspects of nursing can be incorporated with little difficulty in both basic and specialist courses for psychiatric nurses, and a good deal of relevant theoretical training could be undertaken jointly with social workers. The relative neglect of the principles and practice of community care in the training of psychiatrists, community physicians and general practitioners is commented upon, as well as the opportunities for advancing the understanding of a wide range of other professional and community groups (Richmond Fellowship, 1983).

The report of the committee of enquiry set up by the Richmond Fellowship is wide-ranging, authoritative, and a major challenge to central government as well as to the authorities directly responsible

for service provision. It draws from recent history the lesson that departmental encouragement, generalized sometimes to the point of platitude, cannot hope to overcome competing demands, inertia, and anxiety. It is clear in its assertion that new resources must be made available, specifically earmarked for mental health purposes, and that effective planning and monitoring systems capable of overriding sectional interests must be established both nationally and locally. It is not a report likely to prove popular among those to whom it is most obviously addressed. Demands for the injection of additional finances on an unspecified but necessarily substantial scale seem irreconcilable with the governmental priorities prevailing at the time of the report's production. The proposals for new machinery for the allocation of resources, the development of services and their oversight may evoke resistance from social service and health authorities jealous of their own autonomy and independence of one another, and may be unattractive to civil servants who dislike the creation of precedents. If services for the mentally ill are to be built up through an entirely new network of arrangements for planning, implementation, and monitoring, how, it may be asked, can comparable demands on behalf of other neglected client groups with a broad spectrum of needs be avoided or on what basis can they be refused? The imaginative ideas of the Richmond Fellowship report could lay the foundations for a thoroughgoing reconstruction of our health and welfare services, but this seems likely to guarantee them at least as many opponents as supporters.

Reports: MIND

The Report *Common Concern* is ambitiously entitled 'MIND's manifests for a new Mental Health Service'. Summarizing major recent trends in existing services, the report warns against the assumption that a slavish adherence to 'community care' concepts provides an adequate foundation for a comprehensive service. Hospital admission will continue to be necessary for some people, and for those severely disabled there will remain a need for asylum. The objective of change should be the creation of an improved quality of care, and the justification of community-based services should be that they will make for more effective care. The general aim should be to provide care in the least segregated or least restrictive environment, based on the requirements of the individual.

The services must attempt to enhance a mentally ill person's status as a citizen, to provide formal care networks which support the informal sector and which respond to changing needs.

The new service, it is argued, should be designed on the basis of a comprehensive assessment of needs rather than 'building on existing service descriptions or organizations'. This determination of needs should draw upon a very wide variety of sources of information, ranging from the epidemiological to the anecdotal and including contributions from patient groups and neighbourhood discussions as well as service providing agencies. Nevertheless, it is not suggested that new services can be designed on a *tabula rasa*; the new assessments will give rise to strategic objectives towards which change and development in existing services will be directed. The implementation of this plan will be the responsibility of a Mental Health Service Development Group, to be responsible for operational planning, budgeting control and management of the new service, and a Mental Health Service Development Committee responsible for strategic and policy development. There are obviously some affinities with the proposals of the Richmond Fellowship committee of enquiry. MIND's development groups would be more broadly based, including housing as well as social services representatives and of the local supplementary benefits office, of clients, of the community health council, and possibly of the trades unions. The development committees would be made up of the members of the development groups with elected members of the local authority housing and social service committees and members of the district health authority; this political involvement is seen as crucial in securing the necessary financial and organizational commitments. Funding would be obtained (but perhaps not immediately) as a unified budget, drawn as a precept from the appropriate health and local authorities. Additional funding from central sources will be required, but this is seen as essentially a transitional arrangement, to be secured through an extension of the joint finance budget.

In discussing the components of a comprehensive service, the report lists more than 160 possible elements and says that 'local requirements will be most effectively met by permutations of the list based on assessed local need': child and adolescent psychiatry, the psychiatry of old age, forensic psychiatry, alcoholism, and drug addiction are included among the headings under which the list is organized. Four problem areas are singled out for particular

consideration: chronic mental illness, mental illness in old age, the place of secure provision in a comprehensive service, and the mental health aspects of primary care, with a strong emphasis in discussion of the first three topics on *minimal segregation and flexibility of response to individual needs.*

The report's review of the staffing requirements of a reformed mental health service underlines the importance of a commitment to innovation at all levels and a readiness to move between different sectors of a comprehensive service in response to changing patient needs. It looks forward to a large expansion of community psychiatric nursing and suggests—unlike the Richmond Fellowship report—that there is a need for a generic mental health worker. Such workers could become the largest group within the mental health service. They might be recruited principally from community psychiatric nursing, but with an expansion of training that would enable them to take on some of the functions of social workers and of clinical psychologist. As far as existing professional groups are concerned, the report recognizes the twin dangers of excessive rigidity of roles and of excessive blurring; a distinction is made between the core skills of each of the major contributing professions and more generic skills (e.g., in family therapy) where the members of multidisciplinary teams may act interchangeably. No attempt is made to set out detailed proposals for training; the report does not clearly distinguish between basic professional and in-service training, but places a high value on learning in the work situation and insists that new approaches to training must be informed by the same general principles as underlie the authors' vision of a new mental health service. (MIND, 1983)

Perhaps the most valuable feature of this report is its firm adherence to the principle that all planning of services should be built upon a detailed assessment of the needs of the consumers and potential consumers of the services and should be responsive to changes in those needs. At the same time it does not assume that new services can be created in a vacuum; the problem is rather to juxtapose existing provisions against a model of a comprehensive service, and then to devise ways of moving at reasonable speed from the former towards the latter. The report's principal fault is a tendency to produce long lists of elements or components without giving much more than token recognition to the problems involved in selecting and combining items. No-one, for example, has devised a

methodology for carrying out an assessment of needs for a given district which draws into a meaningful whole such very varied sources of information as the report sets out. This is not to say, of course, that the task is impossible or that it should be the responsibility of the authors of a 'manifesto' to work out a very detailed and complex plan of campaign; but there is a danger that without some preliminary foray into the techniques of integrating data of different levels of abstraction and of precision, planners may be deterred by the appearance of an unmanageable task. Similarly, the listing of all (or about all) of the possible elements of a comprehensive mental health service is in itself an impressive undertaking. The report rightly recognizes that no one district could be expected to provide—or should need to provide—every service listed, and the authors probably see the catalogue as a means of stimulating comparisons and imaginative planning. Nevertheless, there is a danger that the heart may sink at the prospect of change on an apparently titanic scale. The authors are well aware that there are many middle ways between trivial tinkering with existing services and the pursuit of utopia as a short-term goal. But to identify realistic but worthwhile objectives is an exceedingly complex task, and those who might undertake it need and deserve help. The MIND report is best seen both as an admirable statement of principles and as a prolegomenon. It needs urgently to be followed by technical manuals which will explore the variegated terrain confronting service planners and chart some possible pathways through it. Terms such as monitoring and evaluation recur frequently in this report, but a great deal of guidance must be given if these are to be translated into the operational terms that are necessary if the manifesto's ideals are to be even partially realized.

A neglected dimension

All three reports outlined above give some recognition to the value of systematic research, particularly in the evaluation of health and social services. But it is arguable that its potential contribution is larger than is generally acknowledged, and that the small volume of relevant high quality research could be a major impediment to the creation of comprehensive services even if all other indications were favourable. We may consider the role of research in relation to both specific items of service provision and particular constellations of services in a geographic or administrative area.

Decisions about treatment—to use the term in the widest possible sense—should wherever possible be based on an understanding of the likely consequences of that treatment; this includes knowledge both of its effectiveness, according to agreed criteria, in curing, alleviating, or stabilizing the condition to which it is deemed relevant, and of any negative or damaging results that it may have. The decision whether or not to employ a specific treatment may involve a form of utilitarian calculation in which probable beneficial consequences are weighed against possible side-effects, having regard to the likely strength of each, the availability of alternatives, and the seriousness of the condition under treatment. Because it is now generally recognized that many forms of drug treatment can cause serious problems, careful methodologies have been developed for the laboratory and clinical evaluation of drugs, and any competent practitioner would expect to have full information on the results of such trials before deciding on the introduction of any new treatment. Where other forms of patient or client care are concerned, however, there may be little likelihood of harm resulting. Nevertheless, the question of efficacy remains relevant if limited human resources are to be deployed most productively; but there is still a marked shortage of reliable information as to consequences and a marked tendency for ideas about social and psychological care and treatment to be diffused on the basis of superficial attractiveness rather than demonstrated effectiveness. Within social work there is now a small body of evidence derived from controlled investigation into the use of different methods of intervention in relation to different client groups, but the coverage is not extensive, and it must be admitted that among most practitioners and managers there is still a fairly low level of sensitivity to research-based knowledge as a guide to action.

Current thinking about mental health services in the community provides many examples of apparently promising ideas which have been submitted to little or no investigation. It is not suggested that they do any harm, only that in most instances we know very little about their consequences one way or another. Self-help groups, for example, now enjoy a considerable vogue, but it is remarkably difficult to find any reliable information as to their usefulness or otherwise, let alone answers to more sophisticated questions as to the particular circumstances or combinations of circumstances that may be associated with varying degrees of effectiveness. There are of

course considerable methodological problems relating to self-selection, time-scale, the absence of control data and a prevailing lack of clarity about objectives and therefore about appropriate criteria for evaluation. Most problems of this kind can with goodwill and ingenuity be resolved at least in part, even if the study that finally emerges falls short of the rigorous standards of the controlled laboratory experiment. Even detailed descriptive naturalistic studies with no pretence of statistical precision could prove very enlightening in the examination of a range of possible provisions. There are basic questions that should be asked about any service, without necessarily raising fundamental issues about 'care'. Of a drop-in centre, for example, we might ask who uses it? What previous contacts they have had with other agencies? What benefits if any they feel they have derived from participation? Whether this seems to have any effect on their use of other services? and so on. As modest local studies accumulate, preferably with the use of some common methods, it should become possible—should have become possible before now—to form a general view of the uses and limitations of different types of provision.

Similar considerations apply, *a fortiori*, to whole patterns of provision area by area. Of course each district has its unique features and needs to develop its own blend of services. Nevertheless, the needs of people with particular clinical and social problems do not vary so fundamentally from one district to another that it is impossible for one to learn from the experience of another. In any case, information about the social context of a service—about general levels of deprivation, for example, or about population density—should automatically be taken into account in interpreting the findings of studies of service utilization and effectiveness. When we consider the whole constellation of services in a given area, we need to introduce a set of evaluative criteria different from those that would be appropriate for a study of a specific service component, even though information from the latter type of enquiry could also contribute usefully to an overall reckoning. It would be of great value to have a series of standard 'measures' that could be applied to any area services so as to provide a basis for tentative comparisons. These would not be measures of provision—the number of community nurses or social workers, for example, or the number of day-centre or hostel places—for it is precisely these that were being evaluated. Among the measures of outcome that would need to be gathered it

would be necessary to include the basic statistics of hospital in-patient admission and readmission rates, but these would be too crude and too unreliable to stand on their own. Changes if any in general practitioners' prescribing habits would be of interest, but probably less so than measures of the quality of life derived from direct study of clients and of members of their households. A gradual collation and evaluative comparison of results should begin to throw light on the advantages and drawbacks of different packages of services.

True experiments can rarely be conducted in the conditions of an open society, but with co-operative planning between authorities quasi-experiments are both feasible and valuable. As the MIND report clearly implies, there are very many different ways of selecting and combining services. To say that each district should emphasize those provisions particularly relevant to its own needs is not particularly helpful, as many districts have only a sketchy knowledge of their own needs, much need only becomes apparent when services are provided, there are no well-recognized ways in which the uniqueness or otherwise of a particular pattern of needs, if known, can be assessed, and until there is good evaluative research it is often impossible to judge what impact a specific service component is likely to have. A certain amount of operational scepticism might have a number of advantages over passionate conviction, especially if it were sufficiently widely shared for a number of district authorities with broadly similar demographic structure and socio-economic problems to co-operate in research. It would be profitable to begin by comparing areas which vary significantly in their current levels and types of provision of various community services in order to assess the human costs and benefits of each. Studies of this kind, by indicating areas of weakness, would also suggest priorities for the development of new services or the modification of existing ones. Research designed to accompany planned changes could estimate their degree of success in attaining their objectives as well as any unintended disadvantages that might accrue. If a general similarity of outcomes should be demonstrated as between ostensibly different patterns of mental health service, questions of cost-effectiveness could usefully be examined. It is not axiomatic that proliferation of services beyond a certain point leads to proportionate improvement in the quality of care, but the point at which diminishing returns set in has to be determined empirically.

Policy-makers have been known to argue that research has too long a time-scale to be of use to those obliged to make rapid decisions. The field of community mental health services provides a striking example of a field in which service development has been slow and sporadic and research, which would have had ample time to help define optimal patterns of provision, has scarcely been drawn upon at all. Because there is still so much leeway to make up, the potential contribution of research and experiment remains very substantial.

Regional reviews

The history of mental health services cannot, as we have seen, be adequately understood outside the context of the general systems of health and social care. In this final chapter therefore it is pertinent to consider briefly some recent innovations in health services management and to speculate what implications if any they are likely to have for the special cause of the care of the mentally ill. The first of these is the system of regional reviews implemented in 1982, the second the proposals for a new management structure outlined in the report prepared by a group under the chairmanship of Mr R. Griffiths.

The House of Commons Committee of Public Accounts had had many occasions to comment critically on the slackness of financial control and accountability in the NHS. In March/April 1981 senior officers of DHSS and of the Welsh and Scottish Offices were closely questioned by the Committee, which in its subsequent report (House of Commons, 1981) expressed some surprise that the central departments had limited powers of control over expenditure and resource use by the health authorities, that up-to-date information on staffing levels was available only in respect of doctors and dentists, and that systematic inter-regional comparisons were not undertaken. Later that year, a parliamentary question by the Chairman of the Committee as to how the Secretary of State proposed to ensure greater accountability elicited a reply indicating a new plan for a regular round of high-level reviews, region by region. This was followed by a DHSS 'Health Note' in January 1982 which set out ministerial intentions more fully. It has become accepted practice that in the course of a calendar year each NHS region is involved in a review by a team led by a Minister. The essential raw material for a review is a set of papers prepared by the region and discussed at DHSS headquarters between regional representatives (members and

officers) and a very senior DHSS group including, as well as the Minister, the Permanent Secretary and Deputy Chief Medical Officer. Issues for discussion are agreed well in advance of the meeting, and although regions are encouraged to propose ideas for discussion, it is made clear that Ministerial topics have over-riding priority, that only the most important strategic issues get on to the review agenda, and that regional reviews are not a forum for the discussion of general questions relating to Departmental policy; questions of accountability to the Secretary of State are of paramount importance. It is not the practice for regions to be visited.

In selecting issues for a regional review, the starting point is said to be a factual survey of the health needs of the region, the provision made to meet these and the region's plans to modify that provision. A check-list of areas of Ministerial priority is used to identify matters that may give cause for concern, and these are likely to be raised for discussion at the review meeting. The major headings of the check-list are services (including mental illness), use of resources (including hospital closures) and machinery (including collaboration with voluntary and local authorities). While the check-list is used selectively, all regional reviews in 1983 dealt with manpower questions, regional reports on their reviews of component districts and reports back on tasks agreed in the previous year's round.

The annual cycle is thus of crucial importance. Very soon after each review the Department prepares an Action Plan which sets out precise objectives for the region and is public property, in the sense that it is deposited in the House of Commons Library and is expected to be distributed by regional authorities to health districts, family practitioner committees, local authorities, and community health councils. If after about six months it becomes clear that a region is failing to meet the targets laid down in the Action Plan, this must be reported and explained and may lead to Ministerial intervention. At the following year's review the question of how effectively the region has performed in relation to the goals of the previous Action Plan head the agenda. There is a strong DHSS preference for quantifying objectives, performance and so on; unfortunately, there is not yet available an instrument for measuring the levels of anxiety generated in regional headquarters by the review process, but there is no doubt that it would need to be capable of recording exceedingly high readings. It is generally recognized that accountability, in the context of these exercises, is likely to include summary dismissal for the

chairmen of regional authorities which manifestly fail to meet Ministerial requirements.

This is not the place to savour the ironies of the emergence of a highly centralist style under an administration whose initial philosophy gave so much weight to maximizing the freedom of peripheral authorities. From the point of view of the problems with which this book is concerned, we may note the potential significance of the new *dirigisme* for strengthening the prospects of major policy initiatives launched from the Department of Health. The point of departure for the regional review system was concern over failure to restrain regional expenditure, in particular manpower costs. It has rapidly evolved however as a very wide-ranging audit of performance. How effective it might become in advancing community mental health services depends in part upon a number of factors which it should before long be possible to assess: the sensitivity of the indicators used, the difficulty of closely and sensitively examining a particularly complex area of care within a review system with a broadly strategic emphasis, and the absence of any inspectorial element. In any event, the review system does not overcome the obstacles created by the separateness of local government; although it could be used to encourage joint funding ventures, it can do nothing to enforce the co-operation of social service and housing authorities. Finally, the financial climate in which negotiations between the central departments and regional health authorities are carried out cannot fail to be highly influential. If economy is no longer the sole object of the exercise, it has certainly not been displaced in favour of encouragement to spend. Budgets are restrained, and regions are enjoined to make 'fairly pessimistic' assumptions about future resources in their planning activities. If therefore deficiencies in regional provisions are brought to light by the new procedures, any additional costs of making them good must presumably be met by corresponding economies elsewhere. The review system would of course have a very different potential in relation to mental health services if it went hand-in-hand with something like the development fund advocated in the Richmond Fellowship's report.

Corporate management

The philosophy that pervades the regional review system is carried a long step further in the 'recommendations for management action'

submitted to the Secretary of State in October 1983 by Mr R. Griffiths, who with a small team of business men had been asked earlier that year to 'give advice on the effective use and management of manpower and related resources in the NHS'.

The report refers to numerous faults in the processes by which the NHS is managed, some of them closely similar to limitations that have been pointed out earlier in this chapter in relation to a specific sector of health service activity: that precise management objectives are rarely set, that there is little measurement of health output, that evaluation of practices is by no means common, that effectiveness in meeting needs and expectations is rarely assessed. These failings, it is suggested, are related to 'the lack of a clearly-defined general management function throughout the NHS'. General management is defined as 'the responsibility drawn together in one person, at different levels of the organization, for planning, implementation and control of performance'. The review process is regarded as a valuable instrument, but one which to be fully effective needs to be backed up by a strong and coherent management system; the pressure of demands on Ministers and the most senior civil servants is such that they cannot be deeply and continuously committed to the process. Griffiths also believes that good general management would make it easier to achieve change and would accelerate all decision-making; at present the emphasis on interprofessional consensus leads to unnecessary delays or to 'lowest common denominator' decisions.

The solution proposed is essentially the creation of a corporate management structure which gives powerful support to the Secretary of State and instals a general manager at each level of the NHS. Within the DHSS and the existing statutory framework, a Health Services Supervisory Board and a full-time NHS Management Board are to be established. The former would in effect correspond to the Board of Directors of a very large commercial undertaking. It would be concerned with the overall direction of the Health Service, strategic resource allocation and other decisions, and general monitoring of performance. Chaired by the Secretary of State, it should include his most senior Officers and a small number of non-executive members. The NHS Management Board is described as small and multi-professional; its chief officer would function as general manager of the Health Service on behalf of the Secretary of State. This Board's responsibilities would be for planning the implementation of

agreed policies, to provide overall leadership and drive, and achieve long-term consistency.

Within the Health Service, the report recommends the appointment of a general manager 'regardless of discipline' at each level—the regional, the district, and 'the unit'—generally the individual hospital. Functional management structures at all levels should be reviewed and reduced, and the responsibility of functional managers to the appropriate general manager must be made clear. Nevertheless, clinicians must 'participate fully in decisions about priorities in the use of resources'. How the necessary consultation is to be achieved is not discussed in any detail, although it appears that small-scale studies have been undertaken in six hospitals at the instigation of the Griffiths team. But whatever the mode of consultation, there seems to be no doubt where the eventual responsibility for decisions will lie.

The report includes many other important recommendations, including the development of efficient information and reporting systems and the creation of a high-calibre personnel function, but the foregoing brief summary of its key proposals may be sufficient, in this final chapter, to indicate the direction that the NHS is about to follow and to permit speculation on the impact this trend is likely to have on community mental health services. The implementation of the proposals in 1985 is unlikely to be painless. Griffiths observes that the NHS is not strong enough to withstand the rigours of a further reorganization, but his recommendations, if taken seriously, do not amount to very much less than one. A new management system of this kind cannot be gently infiltrated without attracting anyone's attention. There cannot fail to be intense anxiety over appointments to general manager posts; these appointments will be 'regardless of discipline', but it will be surprising if a clinician is often seen as 'the best man for the job', and fears of lay control of professional activities will be rampant. When the tumult and the shouting dies, and the captains and the kings are installed, it will be a severe test of management ability to cut across the private empires that have needlessly proliferated while at the same time recognizing the valid aspects of professional independence and distilling the genuinely creative elements in professional loyalty. No management structures in public service systems are of the slightest value unless they make it possible to maintain a high level of professional motivation. Griffiths seems to acknowledge this, and it remains to be seen whether the

'thrusting' and 'dynamic' style of management he prefers is conducive to this end.

A striking feature of this report is its concentration on the hospital service. To the extent that questions of manpower and budgetary control are in the forefront, it makes obvious sense to give priority to that sector of the NHS that accounts for the bulk of capital and revenue expenditure. But it is hard to see how the new proposals could significantly affect the direction of family practitioner and other community-based health services. And, of course, the stumbling-block of divided NHS—local authority responsibilities remains unmoved. Those issues that have been crucial in the slow development of community mental health services will not be resolved by the installation of Griffiths-type management machinery. Indeed, there is at least a possibility of an adverse effect. The emphasis on obtainable goals and measurable achievements could well lead to an acceleration of programmed closures of mental hospitals, with a consequent increase in the number of psychiatrically disabled people 'in the community'. At the same time there are no signs in the new proposals of either structural innovations or professional incentives that might be deployed so as to strengthen the move towards community provision, the need for which is likely to be intensified.

Envoi

Inertia, lack of vision, and professional selfishness abound. So also do imagination, initiative, and compassion. In reviewing the chequered history and great contemporary unevenness of provision for psychiatrically disabled and emotionally distressed people there is a recurrent temptation to see it as a struggle between opposing forces—an uneven struggle, because the forces of neglect and complacency are better organized, more firmly institutionalized. It is a temptation that must be resisted; to construe the problem in value-laden terms does nothing to help the search for solutions.

The root of the problem lies in assumptions that have been made almost unquestioningly over a long period. Our health services and social services have to a striking extent been built up around the perceived needs and demands of particular professional groups. Human troubles sometimes fall neatly within the scope of a particular service. But those who are mentally ill (or mentally

handicapped, or old and infirm) cannot have their needs adequately met within the confines either of the health services or of the social services as those services are at present understood. At the level of the individual patient—who becomes a client when he crosses the boundary—there are major problems of ensuring appropriateness and continuity of care. At the planning level, the organization of patterns of care which can be responsive to individual needs regardless of administrative borders seems almost always to involve working against the grain. No-one could now seriously contemplate over-turning massive formal structures and powerfully entrenched interests in the hope of constructing new constellations of services dedicated to the needs of particular groups. In short, we do not have a comprehensive national mental health service, nor in the fullest sense is there hope of achieving one. The task is rather one of creating systems which while acknowledging existing divisions provide a framework for joint planning and joint action. To wait for the spontaneous emergence of cooperation in every district is to weight the scales in favour of the forces of inertia and give no encouragement to individual workers and groups of workers who are ready for change but feel themselves trapped within rigid organizational constraints. The concept of Joint Development Committees with clear powers and identified budgets, as outlined in some recent reports, has real potential. It must be reiterated however that political and administrative objections are inevitable, and the standard arguments are likely to be reinforced by the claim that this way of looking at service provision cannot easily be reconciled with present-day preoccupations with management which on the whole tend to emphasize the isolation of the NHS. But without a firm governmental commitment to the principle of active community-based mental health services and a corresponding recognition of the practical implications of the principle, the national scene will not have significantly improved by the end of the century; such advances as are achieved through small-scale local initiatives will be counter-balanced by the growing—and still largely ignored—problems of community and institutional care of the elderly mentally infirm.

Whatever structural changes are brought about, professional training will remain of paramount importance. The creation of an additional professional specialism, as suggested by MIND, is more likely to increase confusion than to dispel it. The shared learning experience advocated in the same report is however vital, as is

training of a quality sufficient to create genuine self-assurance and reduce defensiveness. Social work education faces a major task of reconstruction, needing to develop advanced training in the face of much employer indifference and even of ominous signs that levels of qualifying training may be lowered rather than raised. If the reform of medical education has failed to realize many of the hopes reposed in it, that is partly because changes introduced since the report of the Royal Commission have been marginal. But any discussion of its future must take account of a wide range of considerations, far wider than the requirements of mental health care which are the sole concern of this book.

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