

EVALUATING A COMMUNITY PSYCHIATRIC SERVICE

The Camberwell Register
1964-71

Edited by J.K. Wing and
Anthea M. Hailey

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*In the south suburbs,
at the Elephant,
Is best to lodge*

Twelfth-Night, Act III, Scene iii, 39-40

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The Camberwell Register relies for its information on the goodwill of contributors and record-keepers in a hundred different agencies. We cannot acknowledge them all, but we hope that this volume will demonstrate that the data are not just stored uselessly away like a miser's hoard but are actually used in evaluating and planning. The DHSS makes a substantial financial contribution to the upkeep of the Register, through the Medical Research Council. Our contacts with them, particularly with Dr John Brothwood and Mr John Cornish have always been cordial and, from our point of view, most satisfactory. Dr E. R. Bransby and Mr T. A. Dibley kindly made extra tables from the national statistics available.

Dr Lorna Wing first set up the Register in 1963 and it was her chief work for several years until running fairly routinely. She remains in clinical charge while the statistical work is carried out by Mrs Anthea Hailey. Mrs Cynthia Taylor of the MRC Computer Services Centre (Director: Mr Brendan Kelly) built up a library of routine programs for statistical analysis which have been maintained and

further developed by Mrs Brenda Oates. Updating of register files on the computer is supervised by Miss Paula Macmillan. Miss Ruth Sousa has undertaken the programming for the Salford Register. The chief clerical officer is Mrs Christine Hitchins, and her able staff comprises Mrs Eileen Stephens, Mrs Joyce Brown, and Miss Jennifer Drayton. Miss Elizabeth Hicks is the secretary for the Register. Mrs Lillian Astell the Unit Secretary, Miss Christine Durston, Miss Carol Perkins, and Miss Jill Brown, also contributed in many ways. Mrs Astell was responsible for clerical work on this book.

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The present book was edited by J. K. Wing, who wrote first drafts of twelve chapters and second drafts of six of the others. Lorna Wing edited Chapters 5, 23, and 24. Chapters 8, 11, 17, and 18 are very little changed from the first drafts. Chapters 12-15 are based upon work undertaken in partial fulfilment of the requirements for a degree of MPhil in psychiatry of the University of London. Nearly every chapter is based in some way upon the register and Anthea Hailey has been responsible for the tables and figures throughout. Doctors Bennett, Birley, and Isaacs read early drafts of the chapters and Dr John Brothwood commented on the

whole volume. Their comments were much appreciated. The extent of contribution of each author is given in more detail in the list of contents. The authors take full responsibility for their contributions and the views expressed do not in any way commit any of the hospital, local authority, or government departments mentioned. In particular, the plans put forward in Chapters 22 and 24 should not be read as hospital policy.

The book is designed to be read as a unity, in spite of the diversity of its material. We hope that it conveys something of the sense of corporate effort that lay behind the developments recorded, whether administrative, clinical, or evaluative. For our part, we think that the foundations for a model psychiatric service in this area of London are being laid and that the opportunities for further useful evaluative research are good.

JOHN WING
ANTHEA HAILEY

Camberwell, April 1972

PART ONE

INTRODUCTION

The Camberwell Register and the development of evaluative research

J. K. Wing

This book is an expansion of the annual report of the Camberwell Psychiatric Register for 1971. Such reports have tended to be compilations of statistics with a brief commentary, whose readership was not intended to be very extensive. The main point of setting up the Register, however, was that it should be used for scientific purposes; particularly for the evaluation and planning of the local sociomedical services. The MRC Social Psychiatry Unit, which established the Register, maintains and uses it as a form of scientific instrument. Its functions are to measure the extent and type of current use of services, to facilitate the examination of patterns of contact over time, to monitor changes accidentally or deliberately introduced, to allow the estimation of future trends, to indicate researchable issues and to act as a sampling-frame for more intensive studies. The Unit has a long tradition of undertaking scientific work in the field of social psychiatry and also of attempting to show how certain of the results could have practical application. The Register increased the possibilities both for strategic and for tactical research.¹ The present volume is intended to illustrate how a psychiatric case-register, when used by a research unit as a tool for scientific investigation, can illuminate a set of related problems and help to suggest solutions to some of them. All the work to be described has been made possible, in one way or another, by using the Register. Less than a third consists of the routine descriptive statistics which usually make up an annual report. It was hoped, in this way, to avoid altogether the common image

1. For a definition of these terms see the Dainton Report (1971).

of a register as a static collection of unusable and uninteresting facts.

The result, when the various research reports were put together, the statistics suitably translated into narrative, and the clinicians' accounts of changes in the services added, was a substantial monograph which appeared to be worth publishing because of its possible interest to a wider public than would ordinarily want to read a register report. What emerged, in fact, was a case-study of a community psychiatric service in transition from a very traditional origin towards a form which might perhaps, one day, be good enough to use as a demonstration model.

There are, of course, disadvantages in such an approach, the chief of which is the parochial nature of many of the issues discussed. Within the context, however, this also has advantages. Translated into everyday decisions, the most exciting intellectual conclusions, the most breathtaking scientific discoveries become commonplace. However brilliant, they are useless (except as entertainment) unless this transmutation can occur. It is to be hoped that some intellectual entertainment has remained but only the more applied studies relating to the provision of services have been included. We have not put in, for example, the preventive medication trials (Leff and Wing, 1971; Hirsch *et al.*, 1972), nor the study of communication deviances in the parents of schizophrenic patients (Hirsch and Leff, 1970), nor the work on standardization of diagnosis (Wing, Cooper, and Sartorius, 1972). Investigations currently going on and studies of services not based on the Register have also been left out.

The volume dedicated to Sir Aubrey Lewis by his former students contains seven chapters on the work of the MRC Social Psychiatry Unit between 1948 and 1967 and a brief account of the Unit's origins (Shepherd and Davies, 1968). The combination of a strategic with a tactical scientific approach is well illustrated by these contributions. Very little of this work was carried out at the Maudsley and Bethlem Royal joint hospital, in spite of the fact that the Unit was situated in the associated Institute of Psychiatry. This was because a busy teaching hospital, without responsibility to a catchment area and with relatively less interest in social methods of treatment since most patients were short-stay and living outside the local district, did not provide an ideal environment in which to test hypotheses concerning the influence of social factors on the onset, course, and outcome of psychiatric disorders.¹ Such research work did, however, go ahead elsewhere and, by

1. It will be clear from the references in the rest of this book how much evaluative work had, nevertheless, been done.

1963, it was clear that it would be advantageous to set up a register of all contacts with psychiatric services in a defined geographical area, in order to solve some of the methodological problems, particularly those connected with sampling, met when carrying out investigations in several hospitals and communities in different parts of England.

It was decided that Camberwell would be chosen as the area of interest, in the belief that the intellectual and professional resources of the Maudsley and Bethlem Royal joint hospital were such that the advantages of a postgraduate teaching hospital taking responsibility for a district would come to be appreciated. The idea of a teaching community would replace that of a teaching hospital. Model services would eventually be set up and the processes of change would allow opportunities for evaluation, experiment, and the testing of theories of social treatment. Camberwell would become a kind of social laboratory.

This was taking something of a risk since, in those days, the idea of a teaching hospital (let alone a postgraduate teaching hospital) taking a catchment area was novel and, to many people, unwelcome. Nevertheless, the possibility of success provided a certain motivation in itself. Although the work done in the Unit was highly satisfying, since it constituted an addition to knowledge, solved some complicated intellectual problems and, in addition, was occasionally taken up and put into practice in various centres, the possibility of more systematically influencing the planning of local services was of additional interest.

The Department of Health and Social Security was approached and made funds available to the Medical Research Council to establish the Register, which became part of the Social Psychiatry Unit. The Register was set up by Dr Lorna Wing during 1964 and began running formally on the 1 January 1965.

This book is about the evaluation, and to a lesser extent about the planning, of psychiatric services. It is fair to say that many of the subsequent changes in the local services have been planned on the basis of data from the Register or of research studies carried out by Unit staff. The conjunction of evaluation and planning has been as close as could reasonably have been expected or desired, but most of the work of planning is recorded only in the minutes of committee meetings and it is not yet time to tell that side of the story in any detail.

The reason why people outside south-east London might be expected to take an interest in the changes that occurred in Camberwell's psychiatric services, and in the way these changes were planned and evaluated, is that essentially similar problems are

being faced in most areas in the United Kingdom, without the benefit of detailed research. Even in countries where the structure of services is quite different, such as the USA, or where services are much less plentiful, as in Nigeria, the questions posed in this book will be present and will require an answer. The more specific problems of extrapolation can be helped to a solution by the use of case-register comparisons.

It will be noticed that the point of departure for most of the work described is the existing hospital service. This is where most of the impetus to change has come from. If there is a sequel to this book in five years' time, describing the plans, developments, and further evaluations that have taken place the focus may well lie outside the present hospital services and a majority of the authors may not be medical. Much depends on the new social service department of the local authority and on how the new area health boards work. For the moment, however, we are deeply concerned with questions such as how many beds are needed, where they should be placed, how much consultant time should be devoted to specialized psychotherapy, and what form of supervision is needed by chronically handicapped psychotic patients living in the community?

Because little has yet been done to plan the Camberwell psychiatric services for children or adolescents, or for alcoholics and other addicts, and because there has been less concern with health education and promotion in the area, these topics do not loom large. They are problems for the future. The book is mainly concerned with services for the adult mentally ill since this has been the presenting problem.

The principles of evaluative studies are briefly discussed in Chapter 2. The basic aim is to determine whether the services decrease morbidity or contain it at the lowest possible level. A discussion of the concept of morbidity in psychiatry is therefore required. The fact that many psychiatric treatments are social in nature gives rise to special problems in measurement which are also discussed. The main methods used in evaluative studies are described, and a strategy of research applied to the special problems of local district services is outlined.

Chapter 3 contains an account of the social and demographic characteristics of the Camberwell population and of the development of services for the mentally ill up to 1964. Camberwell at that time did not have a high-quality service. Most of the major advances (except the building of the Maudsley itself) had taken place elsewhere. There was, however, considerable potential for advance.

The background of national and comparative local statistics is

discussed in Chapter 4. The context is one of steadily decreasing numbers of occupied beds in mental hospitals but of increasing numbers of admissions, although it looks as though the rate of increase is beginning to level off. The comparative statistics of children's services are briefly considered in Chapter 5.

This concludes the introductory Part One. Part Two (Chapters 6-10) is concerned with the statistics of change during the years 1964-71.

Some of the administrative and clinical innovations introduced between 1964 and 1971 are described in Chapter 6, illustrated by figures from the Register. Considerable attention is given to the deliberate attempt to redistribute admissions so that nearly all patients should be admitted to hospitals within Camberwell and cared for by a Maudsley-Bethlem consultant. The clinicians most involved contribute an account of the thinking behind these policy changes. The extent to which long-stay patients still accumulate is considered.

Chapter 7 presents statistical data describing the extensive out-patient facilities of the area and the less ample day-hospital and day-centre services. The increase in number of long-stay day-places is striking.

Chapter 8 deals with the special problems of King's College Hospital, an undergraduate teaching hospital whose small psychiatric department is faced with rising referrals from the general wards and out-patient clinics. Particularly pressing are the needs of those who attempt suicide and those with psychosomatic illnesses.

Chapter 9 is concerned with statistical projections, although appropriate warning is given not to take these too seriously. The rather slow run-down of the 'old' long-stay population is balanced by the fact that the 'new' long-stay only build up in numbers for a period of about three years, after which the numbers remain fairly constant. Camberwell uses rather more short-stay beds than other parts of the country, no doubt due partly to the special requirements of a postgraduate teaching hospital. The results of extrapolating recent trends to 1980 are presented with appropriately strong reservations.

Chapter 10 contains a discussion of the statistical, clinical, and administrative material described in Part Two. This is already more than most planners have to work on, nevertheless it is certainly not enough. Certain conclusions stand out clearly. The problems caused by dementia need to be considered separately from those of other psychiatric disorders. The deliberate effort made to implement the first principle of planning, to care for most

patients within the boundaries of the area for which the service is responsible, has been successful except for a trickle of long-stay patients still going to Cane Hill Hospital. Calculations of future bed usage based on recent trends suggest that fewer beds will be utilized in 1980, particularly for long-stay patients, but the predicted figure still comes out very much higher than that recommended by the DHSS. However, the assumptions that have to be made in order to believe these extrapolations, seem unreasonable, except for the 'old' long-stay group. It is more than likely, at least in Camberwell, that alternative services will be made available. Moreover, rather higher numbers of short-term beds are being used than elsewhere in London and fewer day-hospital places than might be considered feasible. The trend towards the use of long-stay day-centres and hostels is, for the moment, markedly upwards. Rather than planning on the basis of guesswork, several more intensive studies are suggested. The process of admission to hospital itself needs investigation, both for the small group admitted under order and for the large majority. Why did the admission rate go up? Is admission always really necessary? Why do long-stay patients still accumulate, even though in relatively small numbers?

A chapter is devoted to each of these matters in Part Three, where the results of specific studies are presented and tentative conclusions are reached. Chapters 11-15 do not finally answer the questions posed by the data presented in Part Two but they give sufficient extra information to enable a plan to be drawn up for the next decade of modifications to the Camberwell service.

First, however, the problems of patients who are not living in hospital need to be considered and this is done in Part Four (Chapters 16-20). There are two main groups; those suffering mainly from chronic psychotic conditions, many of whom would, in the past, have become long-stay, and those with more transient or less-handicapping conditions. Chapter 16 deals with out-patients, one group of whom received specialized psychotherapy, the other, supportive treatment. The issues raised here are fundamental, but the treatment is statistical and the questions remain unanswered for the moment. Chapter 17 considers whether those patients who previously contacted services because of psychotic conditions but who then dropped out of contact, had more or fewer problems than similar people who kept up regular attendance. From a clinical point of view there was little evidence that more specialist services were required; clinical needs were being met. This was by no means true of social needs; a theme that recurs in several of these studies. Chapter 18 contains an

account of the thinking that went into the establishment of a rehabilitation workshop for the chronically handicapped psychotic patient. This introduces Chapter 19, which deals with an epidemiologically based experimental study of a rehabilitation workshop. This again raises fundamental issues concerning the relationship between in-patient and day-patient care. In particular, the fact that patients outside hospital may not wish to attend an official unit and thus fail to benefit from a structured environment, raises interesting questions for services. Chapter 20 begins a consideration of the problems of social work.

Part Five (Chapter 21) deals with the Camberwell Reception Centre. Although strictly speaking 'extra-territorial' so far as the district services are concerned, this institution casts a shadow over all the other agencies in the area. It is impossible, in Camberwell, to forget the gaps in the welfare system, through which it is so easy to lose the awkward and the unco-operative patient. The relationship between Chapter 19 and Chapter 21 is uncomfortably close.

Part Six (Chapter 22) contains some suggestions, based on all the foregoing material, for planning the Camberwell services for the mentally ill and those suffering from dementia during the next ten years. There is an excellent chance that part of this plan will actually be put into operation.

Chapters 23 and 24, which constitute Part Seven of the book, deal with services for the mentally retarded. The scale of treatment is necessarily limited since less attention has been devoted to this important subject than to mental illness, an imbalance which ought to be remedied in future. The principles of evaluation and planning remain the same.

Thus the book covers some aspects of the psychiatric services of a local area fairly systematically and comprehensively; a few in greater depth and many rather superficially. What has been selected for study has been to some extent arbitrary. Scientific social psychiatry barely yet exists and this book is a contribution to a very young subject. It is hoped that the reader will gain an understanding of the necessity for evaluation and of its usefulness, even from this rather patchy compilation, and that he or she will catch a little of the interest and enjoyment, as well as the travail that is to be found in this field of scientific work.

J. K. Wing

I. Evaluation and planning

I. I. INTRODUCTION

Planning consists of anticipating the problems which are likely to arise when trying to achieve a given aim, and of working out in advance some means of solving them. In planning sociomedical services, the aim is to decrease or contain morbidity in the population, and to decrease mortality as far as possible. The problems are likely to be complex, varied, continuously arising, and often unexpected, so that the organizational framework for dealing with them must be correspondingly flexible and long-term. The more systematic and intelligent the anticipation, the more effective the decisions are likely to be. Rational, as opposed to *ad-hoc* or instant planning requires the acquisition and use of the most relevant and up to date information concerning the probable effects of each of the alternative courses of action available. Planners' own decisions will be part political, part administrative, and part clinical, but they always contain this element of value. There is no difference in principle between national and local planning except that the former is rather more concerned with decisions of policy, that is of value, while the latter deals with decisions of implementation. At both levels, much planning is still of the instant variety. Services develop on the basis of the political philosophy of the time; feudal, *laissez-faire* capitalistic or welfare-state-managerial, but without much appreciation of what a scientific consideration of the processes affecting the level of morbidity in populations could contribute.

On the other hand, scientists have tended to be rather scornful of what they call 'operational' research. This is perhaps because much operational work is descriptive rather than analytic; any evaluative element involved being left to the administrators who consider the results. Thus a study of the length of waiting-lists in out-patient departments carries the assumption that, within reasonable limits which are fairly obvious, patients should not have to wait very long. It is a technical matter to discover what is actually happening in a given service, and it is an administrative matter to decide what to do about it. This sort of work is understandably not of great interest to scientists. Nevertheless, scientists often develop lines of work which are potentially of great value in deciding planning problems. For example, a theory concerning the way schizophrenic symptomatology varies in different social environments (such as an understimulating hospital ward or an overstimulating family setting) may be very relevant to the way services for schizophrenic patients should be run. Such scientific research is 'strategic', while the work concerned with its applicability in practice is 'tactical' (Dainton, 1971). Some scientists will find the combination of strategic and tactical elements in an over-all programme of evaluative research directed towards the problems of reducing morbidity in a population an attractive one.

Planners are often unaware of the implications of such lines of work until quite a late stage in development. They would not have suggested the research in the first place, since they are concerned with more obvious problems, and they may not be in a position to judge the applicability of the results. Even the question of what issues are 'researchable' needs quite complicated scientific assessment. On the other hand, central and local government is properly concerned to decide which problems have high social priority and to promote research into those problems (Rothschild, 1971). The relationship of planning to evaluation is therefore a crucial one. Planners make decisions but they must be prepared for independent evaluation of the results: they cannot evaluate their own services. Evaluators are concerned with the quality of those decisions (do the services carry out their function of reducing or containing morbidity?) but they cannot make the decisions themselves. Philosophies of planning are fundamentally political while philosophies of evaluation are fundamentally scientific. Outstanding individuals may still attempt to span both points of view, in the tradition of Sidney and Beatrice Webb, but they can only do so successfully by moving constantly from one role to the other. The roles themselves remain distinct. What makes co-operation possible is that the ultimate aims of evaluators and planners are the

same. In addition, each planner, if he is to be successful, must be a bit of an evaluator and each evaluator must be a bit of a planner.

It follows that the administration of funds for evaluative research is a matter both for planners (who must be able to decide on areas of high social priority) and for evaluators (who must insist on a scientific independence which is visible as well as actual). We are fortunate in the UK that much research is already funded on a long-term basis so that the balance between strategic and tactical research is well kept.

1.2. PLANNING AIMS

What most national or local planning committees have immediately available to them as the basis for planning is limited. They have their own experience of administering services, the advice of clinicians and administrators, government directives and circulars, certain data from national and local statistics and, above all, the actual current structure of the services as they stand at the moment; a set of institutions and agencies developed by trial and error, handed down from the past complete with traditions and prejudices. This last element cannot be over-emphasized. Bureaucracy has a built-in obsolescence because of a built-in resistance to change, whereas the whole point of the interplay between evaluation and planning is that the process of change itself must be built-in. Voluntary agencies to some extent fill the gaps and provide the impetus to develop new kinds of service but this is a very haphazard way of ensuring that fresh ideas are tried out.

Certain principles are generally accepted in the UK as governing the local provision of services for the psychiatrically ill. These principles have subsequently been adopted by the US Mental Health Center programme.

1. Health service authorities should accept responsibility for the whole of a geographical area, coterminous so far as possible with that of a local government authority. Everyone needing treatment should be able to obtain it. Services should be geographically accessible from all parts of the area and should usually be sited within it. There must, however, be freedom of choice within reason, so that services should not be completely area-bound.

2. Health services should be comprehensive and varied, including for example in-patient and partial hospitalization units, out-patient clinics, domiciliary and other consultation, and an emergency service. The number of places should be adequate. The staff should be well trained and have reasonable time to devote to their clients. The health services should overlap with those concerned

with the provision of social and welfare services, vocational guidance, and protected environments of various kinds, including hostels and workshops for the permanently handicapped.

3. These area health services should not only be comprehensive, they should be integrated. This principle assumes that there should be no delays in transfer and no sudden changes in the level of social performance demanded. Communications should be free so that staff in each part of the service know what is available elsewhere and can readily take over when a patient is transferred.

4. The chief aim of the health services is to decrease or contain morbidity, first in the patient, secondly in the patient's immediate family, thirdly in the community at large. Each agency has a combination of diagnostic, therapeutic, rehabilitative, and preventive functions. Prevention is better than cure. Primary, secondary, and tertiary preventive methods should be used to stop disease occurring in the first place, to detect illness at an early stage, to limit development of chronic disabilities following an acute illness, and to prevent the accumulation of secondary handicaps if clinical disabilities are unavoidable. This is what is meant by the 'containment' of morbidity. Since much psychiatric handicap is chronic, many patients are likely to remain in contact with services for a long time. Fairly large numbers will therefore accumulate and the development of secondary handicaps will need special attention. If fully put into practice, these principles should ensure that morbidity is reduced as much as it can be.

1.3. AIMS OF EVALUATION

Just as the planner has to start with his own unique area, with the services already available, the attitudes, capabilities, and inter-relationships of the existing staff, the persistence of traditional ways of doing things and the special characteristics of the local population, so the evaluator must do the same. Evaluative studies can be carried out at as many different levels as the clinical or administrative procedures being assessed. However, of the four basic principles of planning local services, the last, to decrease or contain morbidity, is the most fundamental. The main aim of evaluative studies, therefore, is to discover whether the service or procedure under investigation actually does this. Studying whether the other three basic principles, responsibility, comprehensiveness, and integration, are put into effect is a second aim, but the assumption that their application decreases morbidity needs to be checked. A third aim is to discover the most economical and efficient ways of decreasing morbidity. This stage logically follows the first two, in

which the basic diagnostic, therapeutic, and preventive methods are evaluated and it is ascertained that a comprehensive and integrated network of services makes them available to all in the local population who need them.

Thus evaluative work may involve studying the organization of community services, the management of a particular institution (including its committee structure), the morale of staff, the provision of various types of service such as day-hospitals or rehabilitation units, the attitudes of local residents towards placing a psychiatric hostel in their road, or the carrying out of specified clinical functions such as diagnosis, treatment, rehabilitation or prevention (see also WHO, 1970).

If need for services is defined in terms of reduction or containment of morbidity, evaluative studies may be elaborated in the form of six questions, which outline a basic research strategy (Wing, Wing, and Hailey, 1970). There is no implication that all research groups should adopt such a pattern, simply that these are the questions that planners and evaluators will want answered.

1. How many people are in contact with the various services that already exist, what patterns of contact do they make, and what are the temporal trends in contact rate?
2. What are the needs of these individuals and of their relatives?
3. Are the services at present provided meeting these needs effectively and economically?
4. How many other people, not in touch with services, also have needs, and are these needs different from those of people already in contact?
5. What new services, or modifications to existing services, are likely to cater for unmet needs?
6. When innovations in service are introduced, do they in fact help to reduce need?

In each case, the criterion is firstly whether the service reduces or contains morbidity and secondly, whether it does so efficiently and economically.

The first question can be answered by the use of descriptive statistics, particularly those provided by case-registers. The second requires the definition of morbidity and its measurement in individuals who are already receiving services and also the definition of treatment: the relation of one to the other gives an estimate of need. The third is the question of value; do the existing services meet the needs of those in touch with them? The fourth is

an extension of the second but requires surveys of the population not in touch with existing services. The fifth involves planning innovations on the basis of the answers to the earlier questions. The sixth returns to evaluation, this time of the innovations. Thus a cycle of evaluation-planning-re-evaluation-replanning is set up, and the possibility of learning from trial and error, which is still an excellent evaluative technique, is incorporated.

This strategy proceeds from the known to the unknown; from the routine collection of statistical data concerning services which already exist, to morbidity in the general population and the planning and evaluation of new services. The major problems for implementation therefore are (i) to define and measure morbidity, (ii) to define and measure the treatments carried out by services, and (iii) to choose appropriate designs for studies which will test the effect of services on morbidity. These problems will receive consideration in sections 2, 3, and 4.

2. Morbidity and disablement

2.1. DEFINITIONS

Clear and economical definitions of the basic terms 'need', 'demand', and 'utilization' have been given, in a purely medical context, by Matthew (1971).

A need for medical care exists when an individual has an illness or disability for which there is effective and acceptable treatment or care. It can be defined either in terms of the type of illness or disability causing the need or of the treatment or facilities for treatment required to meet it. A demand for care exists when an individual considers that he has a need and wishes to receive care. Utilization occurs when an individual actually receives care. Need is not necessarily expressed as demand and demand is not necessarily followed by utilization, while, on the other hand, there can be demand and utilization without real underlying need for the particular service used.

Matthew goes on to consider some of the ways in which need can be measured and methods of meeting need evaluated. His discussion can be applied, in principle, to the evaluation of psychiatric as well as of general medical services, but many of the problems met in the psychiatric field are very complex and require separate consideration. The term 'need', for example, must be defined in terms of concepts of 'illness and disability' which can be much less confidently left undefined. Moreover, *social* needs as well as *medical* needs must be considered.

Several components in morbidity have to be distinguished, each

of which has its own implication for evaluating psychiatric services. In the first place, there is illness or injury, recognized by the presence of biological or psychological abnormalities, sometimes persisting as chronic 'primary' impairments (slowness or thought disorder in schizophrenia, for example). In the second place, there are the attitudinal and behavioural reactions which accumulate as 'secondary' handicaps whenever primary impairments are present (for example, lack of confidence in ability to obtain a job, maladaptive attitudes or personal habits. Institutionalism is largely a matter of secondary reactions). These two elements together constitute morbidity due to illness. This is the much-maligned 'medical model'. For a more detailed discussion, see Wing, Cooper, and Sartorius (1972). A third element, consisting of handicaps which exist independently of any illness, such as a lack of occupational or social skills due to poverty or a poor education, or a lack of 'coping ability', must also be considered because it is intimately linked to the other two.

The combined effects of these three types of handicap on the social performance of an individual creates a condition which may be variously named but will here be called 'disablement' (Richardson and Weir, 1956). Disablement is defined in purely social terms, according to the degree to which the individual falls short of the level of social performance which is generally expected within a given society and by the individual concerned. It is therefore possible for someone with an obvious primary impairment (for example, a stiff little finger), to be in a condition of disablement if he is a violinist but not if he is a machine-minder (Harris, 1971). Similarly, someone who appears disabled in one society may not necessarily appear so in another. Secondary handicaps will be as much related to the expectations of society, particularly of the important people in the patient's social environment, and to pre-existing social handicaps, as to primary impairments.

Although, strictly speaking, morbidity only consists of primary impairments and secondary handicaps, in practice it is often impossible to disentangle the latter from any social handicaps which antedate the illness or injury. For practical purposes, therefore, all three elements may be considered together, and the term 'morbidity' will often be used in this less strict sense. Morbidity lowers activity and social performance, but the level at which the condition becomes defined as disablement depends upon local cultural or sub-cultural norms.

One further point needs to be emphasized. Purely social handicaps often occur without any primary or secondary handicap due

to illness. In such a case, disablement is not caused by morbidity. This case is important because of the difficulty of defining some psychiatric disorders (particularly the personality disorders) in terms of purely biological or psychological abnormalities. Strictly speaking, the term 'illness' should not be used if the abnormalities present can only be defined in social terms. However, many people are referred to medical services because of a condition of disablement which is not, strictly speaking, due to illness. Confusion is caused because such people are often referred to as 'sick' or 'ill' even by doctors. Some sociologists have come to write as though illness can only be defined in this way (Scheff, 1963; Goffman, 1961). Mechanic (1969) presents a more balanced view, differentiating 'illness' from the 'sick role' and 'illness behaviour'. This is the only way to resolve the semantic part of the issue. In this chapter, 'illness' refers only to conditions which are defined in terms of biological or psychological abnormalities. There is no social component in definition, although there are social causes, social treatments and social effects. 'Disablement', on the other hand, is purely social in definition, although there are biological and psychological causes, treatments, and effects. Disablement which has only social causes often presents as a practical medical problem, but this is no reason to confuse the concepts of illness and disablement.

It is particularly important, in a work which is devoted to the psychiatric services, to specify these limitations in the use of the medical model. The claims made by psychiatrists who define illness in social terms can be very wide. Practically any discontent may be regarded as an aspect of neurosis or psychosis when these terms are not strictly defined, and may be put down to such features of modern civilization as the psychiatrist happens particularly to dislike. The reaction by some anti-psychiatrists is correspondingly sweeping.¹

This brief discussion of the concepts of illness and handicap is intended to clarify the first aim of evaluative studies, which is to assess sociomedical services in terms of their success in reducing morbidity. The term 'morbidity', although given a restricted definition, is not limited only to the manifestations of acute

1. Consider, for example, the argument that 'modern life is so "abnormal" that resistance to its demands might be a mark of health and sanity, and that success might be the mark of ill health, a sharing of a neurosis hidden because it is shared by the (apparent) majority' (O'Connor, 1963). The terms 'abnormal', 'health', 'sanity', 'ill-health', and 'neurosis' are in fact basically moral, although they appear to be medical. The writer would probably obtain wider agreement for his thesis if there were agreed definitions for such terms, so that the meaning could be expressed with greater clarity and precision.

illness, nor only to biological impairments. Decreasing morbidity means decreasing illness or handicap due to illness. 'Need for services' is then defined in terms of the type and severity of illness and handicap in the population.

Morbidity in relatives carries the same connotations as morbidity in patients. The term 'burden on the community' contains two components; one relating to morbidity suffered by patients or induced in relatives, the other relating to the economic cost to the community. 'Burden' may be subjective or objective. For example, if it is proposed to open a hostel for chronically handicapped people in a residential area, the degree of burden imposed on neighbours may amount to no more than subjective distress at the anticipation of problems that in fact will not occur. On the other hand, the burden may be objective even though no distress is felt. The two components usually occur together however.

2.2. MEASUREMENT

The crudest measure of illness is to make a diagnosis, stating whether the illness is present or not. Thus the 'psychiatric morbidity rates' in general practice described in detail by Shepherd, Cooper, Brown, and Kalton (1966) were based entirely upon the diagnoses made by the family doctors concerned. These are the essential descriptive statistics which form a first basis for evaluation but they clearly conceal a considerable variation in type and severity of morbidity and include an unknown proportion of patients who have presented medically but who have no illness so far as present medical knowledge can ascertain. These matters have been considered in other studies by the general practice unit (Cooper, Eastwood, Goldberg, Shepherd, and Sylph, 1970).

Measurement of the various components in morbidity and disablement presents complicated problems which can only be solved by moving across disciplinary boundaries. Full discussion of the problems of standardizing the processes of recording and classifying psychiatric symptoms and primary disabilities may be found in Wing, Cooper, and Sartorius (1972) and exemplified in the case of the functional psychoses by the reports of the International Pilot Study of Schizophrenia (WHO, to be published), and the US-UK Diagnostic Project (Cooper *et al.*, 1972). Such techniques have not yet been used on a considerable scale in evaluative studies though, when they are, the resulting gain in comparability and communicability is considerable (Leff and Wing, 1971; Hirsch *et al.*, 1972; cf. also several of the studies reported in Parts Three and Four). Behavioural indices are described by Wing (1961); one of these, social withdrawal, may be

useful as a measure of severity in schizophrenia (Wing and Brown, 1970).

Secondary handicaps present quite different problems of measurement since they consist of attitudes and personal habits, formed in response to the patient's experience of illness and primary impairment, to pre-existing social handicaps, and to the reactions of important individuals in his own social circle (relatives, employers, professional workers, etc.). Edwards (1957) has considered the problems of attitude scale construction in some detail. Attitudes towards discharge (Wing, 1962) and towards work (Wing, 1960), and self-confidence in ability to work (Wing, 1966), have been measured during studies of the effects of therapeutic environments on secondary handicaps.

Disablement has to be measured in terms of activity and social performance. The former criterion was used by Harris (1971) in the UK and Sullivan (1971) in the USA in surveys of general populations but the measures used were necessarily crude. Within western societies, there is a general agreement that men (and many women) should be self-supporting in congenial employment and that most people should live in small family groups. Although these are very general dimensions, and changes in social aims can occur rapidly in terms of a historical time-scale, occupational and domestic criteria constitute the most readily measurable and accessible indices for determining whether individuals are in a state of disablement. More complex measures of social performance are needed to measure the subtle effects of psychiatric impairments, but the problems have not yet been fully solved (Stevens, 1972; cf. also Chapters 13, 15, 17, and 19).

Finally, contact with a medical service may be regarded as an index of morbidity or disablement although, strictly speaking, it need be neither. Thus the fact that admissions to mental hospitals per 100,000 population appear to be reaching a plateau, after having been increasing steadily for several years (see Chapter 4), might seem to indicate that the need for admission was decreasing. Svendsen (1952) has discussed the factors (which he divided into 'nosocomial', 'threshold-affecting', and 'prevalence affecting') which are responsible for changing admission rates, and social scientists have also paid a good deal of attention to the selective factors determining 'the path to the hospital' (Goffman, 1959; Mechanic, 1969).

There is considerable evidence that administrative indices such as length of stay or readmission rate cannot be used as measures of morbidity; mildly handicapped individuals may stay a long time and severely handicapped people a short time (Wing, Carstairs,

Monck, and Brown, 1964; Brown, Bone, Dalison, and Wing, 1966; Wing and Brown, 1970; Brown, Birley, and Wing, 1972). Clearly it is safer, whenever possible, to make a direct assessment of morbidity and disablement, and to separate out the various components involved. Rates of contact with medical services will then be designated precisely for what they are, 'contact rates', until the term 'morbidity rates' can be correctly applied.

3. Measuring the process of treatment

3.1. DIRECT MEASURES

Medical treatment may be defined as any procedure which directly results in a decrease in the severity of symptoms or in the prevention of an increase in symptoms. Rehabilitation may be defined in terms of the long-term treatment or containment of primary and secondary handicaps. Biological treatments such as drugs or electro-shock and psychological treatments such as conditioning are very familiar and trials of their efficacy are well established. Social treatments are less familiar and there have so far been few trials, although there is now little doubt that the social environment does have a direct and marked effect upon the course of many psychiatric illnesses, including some such as schizophrenia, which formerly were thought to have an inviolable natural history. The significance of this fact for any work concerned with the evaluation of services is that a distinction has to be made between the ward or unit providing the treatment and the processes which make up the treatment itself. This is clear enough in the case of psychological treatment as, for example, in Bartak's comparative study of three schools for autistic children (Bartak and Rutter, 1971); he was not so much interested in the schools as in the different teaching methods that were being used. It is not so obvious when the treatment is itself social, as for example in trials of the 'therapeutic community' or of 'social milieu therapy', in which exposure to the treatment ward is also regarded as exposure to the treatment.

In some cases, very specific processes seem to be involved. Wing and Freudenberg (1961) showed, in a controlled study, that increase or decrease in social stimulation given by nurses could have an immediate effect upon certain severe and chronic symptoms of schizophrenia. A therapeutic environment for such patients is one in which there is a steady but emotionally neutral stimulation to perform up to individually attainable levels. If allowed to do nothing, however, such patients will become inactive and socially withdrawn. The term 'social treatment' is therefore

immediately applicable. Since it may have to be kept up over a long period of time, just like drug treatment of schizophrenia, it becomes part of rehabilitation and management as well. It is a sound principle of rehabilitation to give exercise to functions which have become diseased following illness or injury, in the hope that partial or complete recovery may eventually occur.

Many such processes of social treatment and rehabilitation are at work in any complex therapeutic environment. Another important category of processes affect secondary rather than primary handicaps, that is, attitudes and personal habits. For example, the longer a patient has been in hospital the more likely he is to want to stay there and the less likely he is to have realistic and constructive plans for the future (Wing and Brown, 1970). Patients who are moderately handicapped from a clinical point of view may nevertheless remain in hospital simply because of these secondary problems. Quite a different set of ideas and methods is needed to help them regain a sense of independence and self-confidence.

Naturally these two kinds of handicap interact with each other and also with the third. Schizophrenic patients are particularly vulnerable to institutionalism in the social conditions found in many mental hospitals. Institutionalism, in schizophrenia, may be largely due to the fact that patients with a tendency towards apathy, because of the illness, do not use all their faculties spontaneously and, in crowded and understaffed wards, it is difficult to give the attention which would keep residual mental and physical functions at an optimum level. The necessary characteristics that a community should have in order to make it 'therapeutic' for such patients can be fairly precisely specified. Evaluation then consists in making the appropriate measurements of morbidity in order to see whether the aims are achieved. It would be useless, however, trying to test these ideas in a 'therapeutic community' set up for a completely different group of patients.

The therapeutic and harmful aspects of the social environment were directly measured by the use of nurses' attitude scales, time-sampling of nurses' and patients' behaviour, and other techniques. Simply being in the ward or the workshop was not the criterion. In these cases, the social factor was expressed in the behaviour of a single individual towards the patient.

The use of 'jigs' which enable a physically handicapped individual to complete a task in spite of his impairment provides an exact analogy with some of the techniques used in the education or the rehabilitation of the psychiatrically handicapped. Methods of operant conditioning of autistic children, or of manipulating the

social environment of chronic schizophrenic patients, for example, do not necessarily cure the handicap, but they enable the individual to function at an optimum level as long as they are maintained. Such methods improve the individual's 'coping' ability. As Mechanic (1962) pointed out it is the inability to cope with some problem which the individual is expected to be able to deal with which produces stress. Any increase in coping ability means an increase in confidence and improvement in attitude towards other problems.

However, secondary handicaps such as underconfidence (particularly in people who tend to be rather anxious about their performance anyway) may also be influenced directly by the use of group methods. In several studies of psychiatrically and physically handicapped people at an industrial rehabilitation unit, it was shown that various aspects of the environment affected the entrants' attitudes and behaviour in an advantageous manner. Precisely which aspects of the environment were involved, however, could not be demonstrated although they could be hypothesized. Very precise controls are required for this kind of work, but it is difficult to set up, for example, a highly motivated group and a poorly motivated group within the same unit, in order to observe their effects in selected individuals, since one group affects the other. King, Raynes, and Tizard (1971), however, have approached the problem of the management of severely retarded children with a high degree of ingenuity, demonstrating quite clearly that certain procedures are more effective than others and that certain kinds of professional training are more conducive to applying the more effective procedures. This work opens up a new line for evaluative research.

Investigating the 'therapeutic community' may be analogous to investigating another very complex treatment, 'psychotherapy' (Cawley, 1971). A feasible technique may be to reduce the complexity by dissecting out various simpler therapeutic elements and to evaluate each one separately. Further consideration is given to this matter in section 5 on the use of theory.

However, although it may be ideal to isolate and measure the therapeutic social procedures within the over-all experience of being in a particular unit, it is not entirely valueless to consider the unit as a whole. It is true that most units tend to use a multiplicity of treatment procedures, biological, psychological, and social, but if an experimental design is used it will be possible to discover whether *something* about the experience in the unit is advantageous, even though it will not be possible to specify precisely what. The unit's distinctive mode of treatment (that is, the one for which it is

best known, or the one on which it most prides itself) may not be the most useful technique at all, as Hyman *et al.* (1962) pointed out. Nevertheless, a first case will have been made and further investigations will be worth while.

Treatment and rehabilitation involve also diagnosis, supervision, management, and prevention. Each of these functions may be worth investigating and therefore measuring. Enough has been said, for the moment, on the subject of diagnosis. Supervision and management are aspects of rehabilitation and present similar problems. Prevention presents a special problem for measurement since it is the sum of innumerable other procedures and is probably best assessed in terms of its effects. The partial effects have been mentioned already. Gruenberg's (1966) demonstration of a decreasing rate of 'social breakdown syndrome' in a general population is the best study of an over-all effect, although it is difficult to be sure what processes were at work to produce this result.

The other point is that it may be useful to classify the agencies which carry out these functions. One way is to divide them into two main groups according to whether they provide residential accommodation (hospital ward, hostel, hotel, lodgings, home) or day-time occupation (day-hospital or centre, rehabilitation or sheltered workshop, open employment). Another way is to divide according to the main type of function carried out: medical (diagnosis, treatment, nursing, etc.) or social (assessment environments, attitude changing environments, handicap containing environments, etc.). Another way is to classify agencies according to the extent that they are structured like ideal models of hospitals, factories, schools, prisons, clubs, churches, or army units; or according to their social functions: coercive, utilitarian, or normative (Etzioni, 1961). Such classifications have been little used in scientific work as yet but as research becomes more sophisticated it will become essential to develop them.

3.2. INDIRECT MEASURES: EFFICIENCY OF SERVICES

Each element in a comprehensive service has to be organized and managed in such a way that the effectiveness of therapeutic and preventive techniques is maximized. This is true of a hospital ward, a day-hospital, a workshop, an out-patient clinic, or a hostel. These units themselves have to be co-ordinated into an efficient service and, ultimately, precisely the same criteria must be applied to an area health board. At each organizational level there are management problems and how these are decided will help to determine the effectiveness of treatment.

Thus efficiency itself can become a measure of treatment. The

extent to which a local service takes its area responsibility seriously, is truly comprehensive and truly integrated, is a measure of the effectiveness with which therapeutic procedures are made available to those who need them. Indirectly it is a measure of the therapeutic procedures themselves (Lawrence, 1966).

At the simplest level, the leader of a unit determines its policy, its morale, and the efficiency of its organization. At its most complicated, there is a complex committee structure, with several professional hierarchies represented, and a wide distribution of personal responsibility, so that it is difficult to identify the unit with any particular individual. This is most clearly true of an organization such as the joint Bethlem-Maudsley Hospital, with its associated Institute of Psychiatry. But even beyond this level, there are problems of co-ordination; between different hospitals, between the hospital and other medical services (for example, GP and local authority), and between medical and other services (for example, social service, education and children's departments of the local authority, Department of Employment services, voluntary services, and so on).

It is at these higher levels that evaluation procedures are most likely to lose their way and miss their ultimate goal of assessing reduction of morbidity.

This book will not, in general, be concerned with efficiency for its own sake, only with efficiency of organization and management in terms of the principles set out in section 1. Each of these principles involves decisions which affect the health or welfare of patients or relatives. Transfer between agencies, for example, if not carried out efficiently, can involve a patient relapsing or an intolerable load being placed upon a relative. If services are not comprehensive the same result can occur.

One inevitable consequence of evaluating the service given by specified units, particularly small ones, is that identified members of staff must feel themselves under investigation. When Wing and Brown compared the policies and social treatments of three mental hospitals in 1960, they considered that the three physician superintendents who had been influential in determining those policies during previous years were, in many ways, 'representatives' of their institutions. Knowing the superintendents, one knew a great deal about the hospitals. This is a gross over-simplification, as anyone familiar with hospital administration will be aware, and interpreting the direction of cause and effect is at least as complicated as for any other correlation. Nevertheless, the three doctors in charge at the time of the investigation knew that, in some sense, they as well as their hospitals were on trial. They co-operated generously and

never attempted to influence the conduct of the investigation or the interpretation of the results (Wing and Brown, 1970). This was a happy collaboration but there are obvious risks which need always to be weighed before starting an investigation.

Methods of assessment must vary according to the type of unit being studied. Hyman's (1962) account of the principles of evaluation is written principally from the point of view of the scientist concerned with assessing the functions and effects of specified agencies. The only extra matter to be considered, apart from the general principles already covered in this chapter, is the policy of the agency itself. Hyman assumes without question that the problem is merely one of getting clear what the agency's objectives are, though he devotes attention to the problems that arise when these objectives are ambiguous or unstated, and makes it clear that the evaluator should try to take into account the unanticipated effects of the agency's policies. The logic of the argument in the present chapter goes further, however, since the final aim of any sociomedical service must in the long run be to diminish morbidity. Whatever its stated aims and policies, therefore, the evaluator must set up his own criteria against which to measure success, as well as including criteria based upon the agency's stated or implicit goals (Wing, 1970).

Finally, the indirect assessment of treatment procedures demands an evaluation of numbers of staff, their training, morale, and function, and the extent to which they are actually carrying out their duties. Some of the most fundamental problems facing the helping professions are likely to be discovered when the roles of psychiatrist, psychologist, social worker, nurse, occupational therapist, occupational supervisor, house parent, hostel warden, teacher, and GP are contrasted, compared, and evaluated. King, Raynes, and Tizard (1971) have pointed the way in their comparison of house mothers and nurses looking after mentally retarded children.

4. Methods of evaluation

The basic model for evaluative studies is simple. Criteria of morbidity are set up, the treatment to be given (and any other aim of the service) is specified, and groups of patients are assessed before and after treatment in order to see whether morbidity is reduced and any other specific aim achieved. A comparison group is used to indicate the likely outcome if the treatment is not given. The problems of defining and measuring morbidity and treatment methods have already been considered and the present section will

deal with the design of evaluative studies. The simplest and most limited technique is to describe what is going on; this provides a first basis for comparison and for monitoring change. If carried out systematically, it may provide knowledge which cannot be obtained in any other way and reveal facts about the workings of the services which are by no means obvious, even to staff who have been running them for years. Descriptive statistics, and one form of them in particular, psychiatric case-registers, also provide a basis for more fundamental studies.

4.1. DESCRIPTIVE STATISTICS

It is never possible to be purely descriptive. In effect, all routine statistics are judged in the context of clinical or administrative experience, against norms laid down elsewhere, or in the light of what is regarded as good practice in areas with exceptional services.

Thus it is useful to know how many beds are in use per 100,000 population, what proportion of discharged patients have follow-up consultations, the ratio of day-places to in-patient beds, the numbers of hostel places, and so on, because local planners have some idea already of what these numbers should be. Routine statistics can also be used to describe the age, sex, and diagnostic pattern of referrals or admissions and to indicate which patients stay longest in hospital or have a high death-rate (Kramer, 1969). Trends over time may also be useful, so long as they are used only to inform policy-making and not to determine it. This illustrates the major limitation of descriptive statistics: the mere observation of a figure or a trend over time gives no information as to whether it is useful. It merely summarizes the cumulative results of clinical and administrative decisions without indicating whether they are the right ones. For example, the paper by Tooth and Brooke (1961), describing a short-term decrease in mental hospital bed-occupancy and projecting the trend into the future, or the paper by Baker (1969) describing a psychiatric unit which appeared to manage with only 50 beds per 100,000 population are not evaluative. They can be used to illustrate a trend, but not to justify it.

Statistics relevant for planning may be collected at three main levels; that of the general population itself by means of sample surveys, that of the first diagnostic and treatment service (the GPs), and that of the specialist services. So far, however, general population surveys have not provided useful information concerning the need for specialist psychiatric services, since the type or severity of psychiatric disorder which requires specialist rather than generalist attention has not been defined. No population surveys

have yet been made using standardized methods of diagnosis and estimates of morbidity vary widely.

Some surveys have taken the view that anyone who can be shown to have even the most minor psychiatric incapacity requires specialist help (Srole *et al.*, 1962). This is to equate need with morbidity (albeit morbidity defined in rather a loose fashion). Matthew's definition is sterner than that; it defines need in terms of morbidity for which there exists an acceptable and effective treatment (and, in parenthesis, which will not get better reasonably quickly on its own).

Probably the best data on morbidity in the general population have come from surveys of general practice in the NHS of the United Kingdom (Taylor and Chave, 1964; Hare and Shaw, 1965; Shepherd *et al.*, 1966). Shepherd and his colleagues estimate that some 15 per cent of the population have a form of psychiatric disorder during one year. Only about 5 per cent of patients are referred by GPs to hospital but a substantial proportion (perhaps one-third) of patients with psychiatric disorders are not detected by the family doctor (Goldberg and Blackwell, 1970). It is not yet possible to pick out in any precise way which people would actually benefit from referral to a psychiatrist. A few studies have pointed out the differences, for example in diagnostic composition, between the psychiatric clientele of GPs and psychiatrists (Shepherd and Cooper, 1964; Hughes, 1969). It is clear that psychiatric morbidity of a relatively minor kind is very common in the general population; minor, that is, compared with schizophrenia, dementia, or severe intellectual retardation. The latter conditions are easily recognized and they tend, eventually, to come into contact with specialist services. Eastwood (1971) has pointed out the difficulties involved in screening a population for psychiatric illness, particularly the neuroses; the criteria adopted for assessing a screening programme in other fields of medicine (Wilson, 1971) could certainly not be met. There are no valid ways of detection at a pre-symptomatic stage, the value of early treatment has not been securely established and the proportion of false positives or false negatives is unacceptably high.

Thus, although the 'path to the hospital' usually lies through the GP's surgery, it is too early yet to say, from general practice studies, which patients will get more effective and acceptable treatment from a specialist than from the family doctor. Matthew's criteria of need are not, therefore, met. This very fundamental problem is even more general, because it can be asked, not only of the specialist, but of the GP himself. There are others, social workers and psychologists in particular, who might like to share

this work and might be just as good at some of it. We have hardly yet begun to study these matters but, when we do, the results may be surprising. The principles of evaluative research will remain true, however, whatever type of study is undertaken.

So far as the more severe psychotic disorders are concerned there is less likelihood of cases being missed in areas with reasonably good services. Some of the most sensitive indices of unmet need are indicators of various forms of social deprivation; homelessness in particular. Among the destitute population, who sleep 'rough' or live in common lodging houses or reception centres, there is a remarkably high rate of untreated morbidity, particularly alcoholism, schizophrenia, and personality disorder (see Chapter 21). This is due, in part, to gaps in the existing services, particularly in aftercare facilities and in sheltered accommodation (what used to be called 'asylum'). Some areas are therefore likely to contain more patients than others and knowing the characteristics of a local population (particularly its housing) can give a clue as to which types of morbidity can be expected to be most prevalent. An inner working-class urban area from which the slums have only recently been cleared will have and will need a different pattern of services to a middle-class commuter suburb or a rural county.

Projections of population numbers will also need to be considered. For example, in England and Wales the number of people aged 65 and over is expected to increase by more than 13 per cent and those over 75 by nearly 20 per cent during the next decade.

National data are routinely available concerning patients admitted to psychiatric hospitals. For each admitted patient, a mental health inquiry form is completed. Data include identification, date of birth, occupation, sex, marital status, diagnosis, and information concerning previous contacts. Statistics are now published annually in the DHSS's Statistical Report Series. Control of quality in data-collection is inevitably difficult. Nevertheless, gross changes over time do show up and will be discussed in Chapter 4. Tooth and Brooke (1961) wrote a famous paper drawing attention to the unexpected decrease in mental hospital bed-occupancy rate since 1954 and giving an estimate of how far it might go. This calculation illustrates the dangers of such predictions and will be considered again in Chapter 9. Summary figures concerning out-patient attendances are also collected annually and published in the CMO's reports. Patients are not identified and collation with other service data is not possible.

The extent to which statistics are routinely collected about local services varies considerably. Regional boards and individual

hospitals have their own figures. The joint Bethlem Royal and Maudsley hospital has published a useful volume triennially. By and large, however, local statistics are not at the moment a very sound basis on which to plan local services.

Nevertheless, routinely collected statistics could be used to determine whether certain of the aims of a service were being attained. For example, if a redistribution of contacts is being attempted (for example, from one hospital to another, or from in-patient to day-patient care), or a new service is being added to cater for a specified type of client, or an old service is being closed down, reliable statistics are needed to monitor the change. It is a very familiar situation to research workers to find that a claimed alteration in the way a service operates has not, in fact, been implemented (Kessel and Hassall, 1965).

There is an obvious temptation to make the collection of descriptive statistics an end in itself. This is exemplified by the trend towards the construction of mathematical models of 'health service delivery systems'. To the extent that such models include no component representing morbidity, but only the ebb and flow of unvalued events, they can only be of technical use; in summarizing large quantities of data, for example, or bringing out underlying trends. Curnow (1970), in discussing the data collected by Ashford and Pearson (1970) on general practice and hospital contacts in Exeter, asked whether such material could really 'increase our understanding and facilitate the control of disease'. His own view was that:

We need to establish priorities between the provision of different services and priorities for different individuals needing the same particular service. All this involves personal judgements. We need to give more thought to who should make these judgements and how we can obtain some consensus of views . . . I am far from convinced about the usefulness of general data collection. . . . What is the (mathematical) model for? . . . The data are descriptive rather than analytical and would seem to me to have a built-in obsolescence. . . . My priorities, and they are 'subjective', are for special studies of crucial areas where changes in the provision of care are imminent. The effects of the quality of care are difficult to estimate and we may need to rely almost entirely on subjective, but informed judgements.

Subsequently in the same discussion, Matthew (1970) suggested, in effect, that descriptive data could be used evaluatively. This is true only when the question under study has a fairly obvious answer; for example, when waiting times in an out-patient department are being studied. The point of view developed in the present volume is close to that of Curnow, except that rather more reliance

is placed upon the apparatus of evaluation as described by Hyman (1962) which goes some way towards reducing and controlling the subjective element in evaluation. Curnow is correct in believing that, in the last resort, the basis of decision-making must be a subjective judgement of value. The person who makes that judgement must, however, be a planner, not an evaluator. Evaluators provide the information which clinician and administrator require in order to make good decisions. Operational research, descriptive statistics and mathematical models may provide part of this information but only in so far as they are already clearly relevant to administrative or clinical problems (Cornish, 1971). In every other case, they must be transmuted by the evaluative process, that is, they must have been weighed against the criterion of decreased morbidity. Operational studies can only say what is happening, never whether it *should* be happening. Evaluative studies are intended to provide material which will facilitate the value-judgement.

The following subsections, on psychiatric case-registers and on methods of evaluation, summarize very briefly the ways in which descriptive can be turned into evaluative research.

4.2. PSYCHIATRIC CASE-REGISTERS¹

The principles of case-registers have been described in detail elsewhere (Wing and Bransby, 1970; Baldwin, 1971). Their chief function is to facilitate the evaluation and planning of local services although they have many other uses as well. The following account is based upon the Camberwell Register but is broadly correct for most other psychiatric registers as well.

The Camberwell Psychiatric Case-Register is a data-linkage system which began running formally on 31 December 1964, with a census of all Camberwell residents who were psychiatric in-patients or day-patients, or in a spell of contact with psychiatric out-patient clinics on that day. From 1 January 1965 information has been continuously collected concerning all contacts with psychiatric services made by Camberwell residents. Both adults and children are reported and mental subnormality and local authority psychiatric services are included; some of these agencies are within the Camberwell area but many are located further afield. Demographic characteristics of the patient, and the clinical diagnosis, are recorded on the Register, together with each service contact. All in-patient admissions to psychiatric hospital, and corresponding discharges, are monitored as are out-patient attendances, emergency clinic visits, and other types of contacts

1. This subsection is adapted from Wing, Wing, Hailey, and Taylor, 1970.

with a psychiatrist, for example domiciliary visits. The data are collected by a trained clerical team and are coded and computerized. Reliability checks are built into the Register system, and stringent precautions taken to ensure the confidentiality of the material. Computer techniques and programs have been developed, which now produce a reliable and routine output. Statistical reports are produced regularly.

The Register is essentially a research instrument which can be used to study many kinds of problem; biological, psychological, or social. In order, for example, to study the effect of social influences on the course of schizophrenia, it is useful to be able to determine the incidence and prevalence of the condition in various subgroups of a given population, to have a sampling-frame so that a representative group of patients can be studied, and to know the types of services available and used by patients and their relatives. The Register supplies these data. More high-powered measuring instruments can then be applied to samples selected according to specified criteria in order to test hypotheses about the relationship between social events and outcome. The same sort of considerations apply to other psychiatric conditions such as mental subnormality or dementia. A very wide range of issues can be studied in such a context, from complex problems of evaluation and future planning to comparatively simple ones, such as the systematic description of a redistribution of beds when hospital policies change.

As a research instrument, a case-register has both limitations and advantages. The advantages can be summarized under three headings, the first of which is the avoidance of selection biases and duplicated counts. By including all agencies which provide psychiatric care for the area, and including only those patients who reside in the area, the Register avoids the bias of a study based on one single hospital. The wider the variety of agencies which report to the Register, the easier it is to avoid bias and to draw representative samples. For conditions like schizophrenia and severe mental subnormality, which have a high 'visibility' in an area with well-developed services, the administrative prevalence is probably fairly close to the true prevalence. Another useful feature of collating the data from many agencies is that unduplicated counts can be made. Many patients contact several agencies during the course of one year but all this information is brought together in the Register so that no individual is counted twice.

The second advantage is that the Register is based upon a defined population so that it is possible to enter census data to calculate rates in a way that cannot be done with the figures of any

single agency or service. The triennial statistics of the Maudsley Hospital, for example, although for a long time almost the only detailed information available about psychiatric out-patient services in this country, could never be referred to a known population and it was therefore impossible to say how far the results could be generalized, or compared with those of other hospitals. There are now registers in many parts of the world, so comparative studies are at least tentatively possible.

The third advantage is that the Register is cumulative. The path of a patient can be traced through contacts with many agencies, the pattern of first contacts can be compared with the pattern of re-contacts, changes in pattern of contact over a time can be observed, and the effect of introducing new services into an area can be followed. One of the most important planning problems at the moment concerns the effect of the new policies of early discharge on the accumulation of psychiatric patients. Mental hospital bed-occupancy is decreasing in many areas but how far the patients who used to remain in hospital are now accumulating on the books of other community agencies is still not known with any accuracy. This is the kind of problem which registers can be used to illuminate.

These three advantages interact. Each of them can be achieved singly, in an *ad-hoc* manner, without setting up a register. But in order to conduct a research programme in social psychiatry over a period of years, and to advance beyond a certain point in methodology, the Register is an economical and irreplaceable tool.

It is important to recognize that there are limitations inherent in the register method, as well as advantages. The Camberwell Register covers a small part of a large conurbation. The area is not a 'community': rather it comprises many communities, each with an individuality and flavour readily recognizable to those who live locally but apparently anonymous and colourless to strangers. Camberwell is defined geographically and administratively, not socially. Geographical mobility is an important problem (6.1 per cent of the population had moved into Camberwell during the year before the 1961 census). However, from the point of view of services this is as much an opportunity as a problem, since half the population of the country lives in a conurbation and services must be planned accordingly.

The most obvious limitation stems from the fact that many people with psychiatric conditions do not contact psychiatric services and are therefore not reported to the Register. Various surveys put the number of psychiatrically disabled people in the community at about 15 per cent. The reasons why some attend

psychiatric services during a given period of time while others do not are complex but it is clear that the services could not cope with very much more than the present load. The register technique is most readily applied to problems of local planning, to statistical and epidemiological investigations of the kind that have hitherto been chiefly carried out using hospital statistics, and to the study of conditions, like schizophrenia, dementia, and mental retardation, which usually bring the patient into contact with psychiatric services sooner or later. For these purposes it is more suitable than either of the obvious alternatives: population or general practice surveys on the one hand, and national statistics on the other. A population survey cannot be used to study schizophrenia in any depth; it would be necessary to screen 25,000 people to find 100 cases. National statistics often cannot be applied to local problems without introducing large errors. The register method does not, however, replace these other techniques, in fact, it can be used very profitably in association with them; for example, to investigate trends shown in the national figures and to provide a sampling-frame from which groups can be drawn for intensive study and comparison with samples from a general population survey.

No doubt it will eventually be possible to add data from general hospitals and even from selected general practices in a really comprehensive record-linkage scheme, but it seems wise to show the value of registers on a small scale first.

4.3. DESIGNS FOR EVALUATIVE STUDIES

At the most superficial level, straightforward comparisons of service statistics may lead to useful hypotheses. Case-registers are particularly helpful in this respect since data are collected in comparable fashion with much attention to the control of quality. The study by Wing, L., *et al.* (1967), for example, indicated rather similar one-year reported prevalence rates in three areas (Aberdeen City, Baltimore, and Camberwell), though the distribution of contacts with different services varied considerably. Indeed all the case-registers that have so far reported an annual prevalence have given a figure of approximately 1.5-2 per cent of the total population. Such comparisons are usually too uncontrolled to be more than suggestive.

More useful comparisons can sometimes be made by taking advantage of the fact that two or more services have developed along different lines in some specifiable respect. The difficulty is that it is impossible to be sure that the same processes are at work in selecting individuals for treatment in the services being compared, even with retrospective or prospective matching. Short of a

controlled experiment, however, this design is often the best available (Sainsbury and Grad, 1966; Brown, Bone, Dalison, and Wing, 1966; King, Raynes, and Tizard, 1971). It is particularly useful if a longitudinal self-controlled comparison can also be incorporated. For example, Wing and Brown (1970) studied three mental hospitals thought to provide different social environments for long-stay schizophrenic patients. Measurement showed this to be the case and also indicated that the clinical condition of the patients differed in accordance with the hypothesis that social environment caused clinical improvement or deterioration. Further studies did not indicate that selective features could have been responsible for the differences but these could not, of course, settle the question. Follow-up of the three cohorts of patients indicated that the social environments of the hospitals changed in different ways during the eight years after the first investigation. In every case, change in the social environment was accompanied by the hypothesized changes in clinical condition (even when these changes were in different directions in different hospitals). Thus a strong case was built up for a causal connection between social and clinical events.

Such a combination of a comparative design with a prospective longitudinal study is quite a powerful design and can be recommended when advantage can be taken of differences which have developed between services which are highly relevant to some medicosocial hypothesis and further changes in the service are possible.

The follow-up design, whether prospective or retrospective, even by itself, occasionally offers a useful way of studying services (Robins, 1966; Brown, Birley, and Wing, 1972).

Another partial design is to contrast subgroups with each other; for example, entrants to an industrial rehabilitation unit were divided, according to an objective and a subjective criterion, into those who were confident in their ability to obtain and hold down a reasonable job and those who were unconfident. Four weeks later their confidence was again measured. Nearly all entrants fell into three groups; those who began confident and remained so, those who began unconfident but became confident and those who began unconfident and remained so. The first two groups had the best chance of success on leaving the IRU but, in particular, the second group had a better outcome than the third, suggesting that improvement in confidence is a valuable consequence of an IRU course. Other hypotheses, concerning the type of entrant most likely to respond to the course, and the features of the social environment most responsible for the improvement, could also be

tested (Wing, 1960, 1966). The lack of a control group of people with equivalent handicaps, who did not go to an IRU, is of course a major disadvantage of such a study, but the design does allow the partial test of hypotheses linking a particular kind of environment with an aspect of morbidity (in this case a secondary handicapping factor).

Hyman (1962), Borgatta (1966), and Matthew (1971) have discussed the use of the controlled trial, familiar during the past twenty-five years as the most effective design for testing the therapeutic effectiveness of new drugs (Bradford-Hill, 1971). It has been used for testing the effectiveness of psychiatric services as well (Meyer and Borgatta, 1959; Wing, 1960; Wing and Freudenberg, 1961) but by no means on a large scale because of the difficulty of meeting the requirements of the design. None of the difficulties need be insuperable but all of them appear to loom larger than in drug trials. The ethical problem of random allocation appears greater because clinicians are not so used to questioning the value of, say, a rehabilitation procedure, as they are that of a new drug. The treatment itself is more difficult to define. More relevant variables need to be matched in advance. It is usually impossible to fulfil double-blind conditions. The criteria of outcome cannot be symptomatic and may be difficult to specify. Administration of the trial may be very complicated. None of these problems is insuperable, several are characteristic of other designs as well but have not prevented them being used, and difficulties have sometimes been exaggerated.

The other major type of design is the epidemiological, in which the interrelationship between relevant variables is studied in samples which are related in a known way to a total population. The best-known examples are concerned with the investigation of possible causes of illness but the method is well suited to evaluative work. Registers of various kinds provide sampling-frames from which appropriate groups can be drawn for study, according to the hypothesis being tested. Psychiatric case-registers provide excellent opportunities for such work, since they cover most kinds of psychiatric service and are cumulative.

A particularly powerful design is given by the combination of the epidemiological and the experimental methods, an example of which is given in Chapter 19. Different combinations of these basic designs will suit different hypotheses and different circumstances but, whichever of them is chosen, the nature of the field and the multiplicity of the variables is such that replication will always be worthwhile. The best possible confirmation is to show that the same results hold when the study is repeated independently.

5. The value of theory

Theories useful to evaluators may be classified into three groups: biological or psychological, for example, theories concerning the nature of disease, or concerning psychological treatments; sociological, for example, theories concerning the nature of human groups; and interactional, for example, theories concerning the interaction between biological or psychological events on the one hand and social events on the other.

The third of these types of theory is most characteristic of social psychiatry but is most conspicuously lacking at the present time. Thus most of our social prescriptions are empirical. Theories of social causes would enable us to take rational preventive measures; theories of social influences on symptomatology would allow us to plan social treatments, and theories of the production or amelioration of primary and secondary handicaps by social factors would indicate better methods of rehabilitation and resettlement. The planning of sociomedical services would benefit immeasurably if it were possible to appeal to well-validated theories rather than to *ad-hoc* hypotheses. While we have no means of primary prevention and only partial and empirical methods of treatment, one of the most important kinds of theories to develop is one dealing with management of chronic handicaps. How does one advise patients and relatives about the best way of living with chronic schizophrenia: how to anticipate crises, interrupt the sequence of behaviours and reactions leading to a crisis or, where this is impossible, cope with a situation in which not only the patient but the patient's relatives need expert help (Brown, Bone, Dalison, and Wing, 1966)? Techniques have been worked out, and seem at least partially successful, for spastic children (Finnie, 1968) and autistic children (L. Wing, 1971*b*) but there is nothing equivalent for schizophrenia and other adult conditions. The essence of such methods is that they use manipulation of the social environment in order to minimize handicaps and maximize assets. The theory linking different types of social stimulation with different types of symptomatic response in patients with chronic or relapsing schizophrenia is a case in point, since it suggests that certain types of structure and certain ways of functioning of supporting services would be superior to others in the prevention of morbidity (Wing and Freudenberg, 1961; Wing and Brown, 1970; Brown, Birley, and Wing, 1972). It also suggests a considerable social component in phenothiazine treatment (Wing, Leff, and Hirsch, 1972). There is even a link with psychophysiological work (Venables and Wing, 1962).

Murphy has summarized the evidence that the incidence rate of schizophrenia is relatively high in the Tamils of southern India, the southern Irish, and the north-west Croats, and has taken the analysis further in his studies of Canadian mental hospital admissions (Murphy, 1965, 1968*a*, 1968*b*). He finds that Catholics appear to be particularly susceptible but that culture has an evocative rather than a merely distributive effect. Murphy's work is particularly interesting because of his attempt to link epidemiological with laboratory work, an attempt which has parallels with the theories mentioned earlier.

Social psychological theories also come within this category in so far as they deal with secondary attitudinal or behavioural factors, for example, Festinger's adaptation of reference group theory to explain attitude change in social groups (Festinger and Kelly, 1951). Such theories can be used to predict which entrants to a rehabilitation unit will most benefit from exposure to the environmental regime (Wing, 1966). The work by Goffman (1959, 1961) on the moral career of mental patients or the characteristics of total institutions, though it is literary rather than scientific, comes within this general category. King, Raynes, and Tizard (1971) tested a limited form of the theory in their study of different types of institution for severely retarded children. They also showed that the main reason for the difference between the institutions depended to a considerable extent on the professional training of the staff (nurses in one case, house-mothers in another), thereby improving considerably upon Goffman's formulation, both in specificity and empirical validity. Wing and Brown (1970) tried to separate environmental influences on primary impairments from those on secondary handicaps; theoretically, this is possible and may on occasion have practical importance.

The scientist who tries to evaluate sociomedical services is operating on the borders of three disciplines; biology, psychology, and sociology, each with its own strong theoretical and methodological traditions. To the extent that he forsakes the exclusive use of any one of these traditions and uses, in addition, the theories and methods of the other two, he becomes suspect in his home territory. Nevertheless, this is what he must do in order to contribute to a discipline which will serve his own purposes and those of the patients for whom alone the services are set up in the first place.

It will be plain enough from what has been said throughout this chapter that, however ill-developed the social sciences are now, their theories and their methods are essential for the solution of evaluative problems. One further point may be made, which is not so evident; that is that, as in other fields of science, basic theories will

advance because of the necessity to solve practical problems. The community psychiatric service may be as good a place to develop theoretical sociological insights as the armchair.

6. Conclusion

Evaluation is no different from any other scientific work except that its results may sometimes be immediately useful to administrators, and this introduces special problems. Much of it is long-term and strategic, and administrators will only become aware of any practical value towards the closing stages of the research. The immediacy of contact with planners carries opportunities and dangers. The danger is that freedom of inquiry and criticism may be limited, even if unconsciously, in the circumstances of investigating services which engage the energies and emotions of planners, administrators, and professional staff and whose success means a great deal to all concerned. When a scientist is undertaking a laboratory experiment he can remain objective in the face of his own desire to get a certain result, if only because he knows the experiment will be repeated elsewhere. In evaluative work the pressures are greater and the likelihood of independent replication considerably less. The need for visible independence and objectivity is therefore proportionately the greater. Another danger is that there will gradually be a shift of balance from strategic to tactical research, which would be tantamount to killing the goose that lays the golden eggs. The opportunities outweigh the dangers. The greatest of them is that we shall be able to make progress towards the establishment of a science of social psychiatry.

Camberwell and its services before 1964

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1. Characteristics of the area

(J. K. Wing)

Camberwell, in Chaucer's day, was hardly yet a suburb. The small villages of Peckham, Camberwell, and Dulwich did not begin to acquire a suburban status until the seventeenth century (Dyos, 1961). It was an area of market gardens at the foot of the Surrey hills which supplied London with fresh vegetables. A few of the rich owned villas in the area, because it was healthy and the drinking water was clean. Charles II installed Nell Gwynne here. In 1800, Dr Lettsom used to ride each day to the City to visit his fashionable patients.

Then came the expansion of the industrial revolution; beginning quietly (the population rose from 20,000 in 1800 to 55,000 in 1850) but accelerating rapidly, so that a peak of 260,000 was reached by 1910. This rate of growth was out of comparison faster than that of the total population of the country. Camberwell, together with the rest of the inner ring of London suburbs, was virtually created during the second half of the nineteenth century. During the single decade 1871-81, the population increased by more than 75,000 people. Dyos (1961) calculates that nearly 40 per cent of the immigrants came from the adjacent areas of Middlesex, Surrey, and Kent, about 28 per cent from other south-eastern counties, and most of the rest from an area south of a line between the Severn and the Wash. Relatively few, 12-16 per cent in any decade, came from the north or from Ireland. Within the area, too, there was prodigious movement. Charles Booth com-

mented, 'North of the Peckham Road is a large district becoming steadily poorer as the fairly comfortable move South and immigrants from Walworth arrive'.

Dyos points out that the suburb was the growing point of Victorian society. To this day, Camberwell looks Victorian to its core. The railways that run through it; the dried-up canals; the erratic course of the streets, following the boundaries of some former market garden or country estate; the rows of terraced houses in dirty but everlasting yellow 'engineering' brick (illustrations of whose façades can be seen in textbooks written for the jobbing builders of the time, penny plain and twopence coloured); the public houses with their coloured glass panels; even perhaps the inhabitants themselves, whether deserving working class or gangs of bully boys; all give off a faint odour, indefinable but instantly recognizable, of Victoriana, as though they had been preserved by some cosmic Betjerman for a nebular Victoria and Albert Museum, and insufficiently dusted.

Despite a certain drabness and decay, it is not a totally ill-looking area. Here and there, where the dirt has been removed and the paint has been renewed, it looks positively handsome. Certainly, little of the building that has come since has shown any distinction. Neither the great cliffs formed by the blocks of flats along Denmark Hill nor the rows of middle-class houses opposite provide any improvement. The new high-rise blocks, the office towers around the Elephant and Castle, and the small private estates with their picture windows staring at closed cul-de-sacs, are representative of what must be one of the least distinguished periods in British building. Only the cheap Victorian terraces, at least on a sunny day, and perhaps the stockbroker's Georgian on the Dulwich College estate, reflect an occasional image of a period of architecture which could legitimately be called both native and inspired.

Driving from north to south in Camberwell, from the remains of the old Surrey canal down to Alleyn's College of God's Gift, the Picture Gallery, and Dulwich Park, one can observe the marks of successive waves of in and out-migration. Up by the river, the former LCC boroughs of Southwark and Bermondsey were already, in 1800, part of London, together with the City, Westminster, Stepney, Holborn, Finsbury, and parts of Bethnal Green and Shoreditch. The northern most part of Camberwell had been occupied by 1850, leaving the remainder still mainly fields and farms. But as hordes of working people flooded in from the north, so gentfolk retreated south, a movement which has continued with less impetus until very recently, when it has been to some extent reversed.

No one would call Camberwell a community. No more than any other area of its size in London can it be regarded as having a population whose members are closely linked historically, administratively, commercially, or socially. Nevertheless, those who think that a fragment of a great conurbation must necessarily be socially isolated and anomic would be wrong. Camberwell can now be defined only in geographical terms, but it does share a character with the districts around it, such as Lambeth and Lewisham, and within it there are smaller areas where a community spirit prevails.

2. Southwark compared with other GLC boroughs

(J. K. Wing)

In April 1965, Camberwell was amalgamated with two other London county boroughs, Bermondsey and Southwark, to form a new Greater London borough, which took the name of Southwark. Camberwell can still be identified in the census statistics by combining certain electoral wards. To start with, however, the latest census figures (from the 10 per cent sample census of 1966) will be used to indicate the relative position of the new borough of Southwark within the GLC scheme of things, according to selected descriptive indices (GLC, 1968*a*). There are 32 GLC boroughs, excluding the City of London which has special characteristics; 12 Inner London, and 20 Outer London boroughs (see Fig. 3.1). Each has a population of approximately a quarter of a million people.

In terms of density, Southwark, with a population of 304,000 on 30 June 1966, living in 7,100 acres, has 43 persons to the acre; eighth highest of the 32 boroughs. The highest is Kensington and Chelsea, with 73 to the acre, while the lowest is Bromley, with 8 to the acre.

Table 3.1 shows that the Southwark population is slightly younger than that of Greater London; it is second in rank order for number of boys under 5, and fourth for girls in this age-group. At the other extreme, Westminster has the lowest proportion aged 0-4.

Certain types of census index have been shown by Sainsbury (1955) to have a special relevance for social and psychiatric morbidity. Indices of low socio-economic status (poverty, unskilled and semi-skilled occupation, unemployment, overcrowding) were not associated with suicide rates, while indices of social isolation and disorganization (persons living alone, immigration, birth outside UK, divorce) were. Stein (1957), studying first admission rates for schizophrenia, showed that they were higher from West

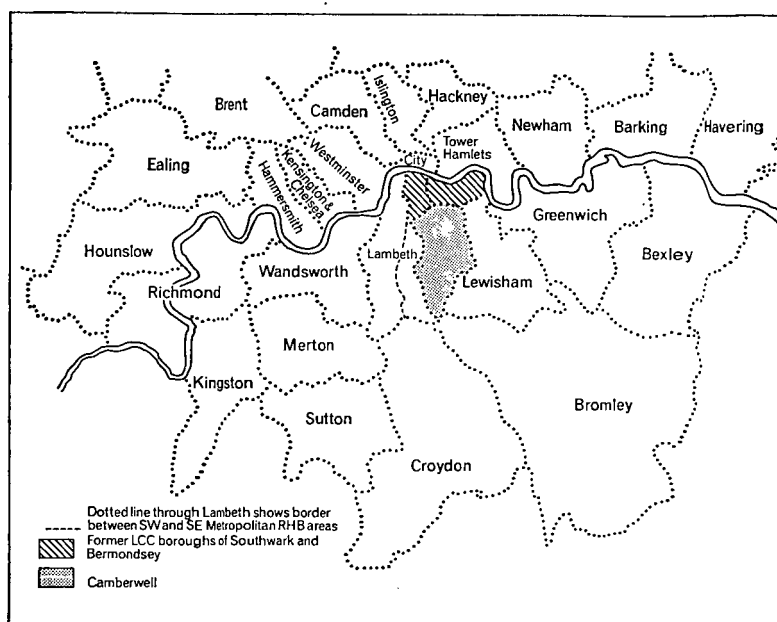


FIG. 3.1. Greater London boroughs showing Camberwell.

London (relatively more socially isolated) boroughs than from East London boroughs, once occupational class had been allowed for.

Hammond (1970) calculated rates of first admission for schizophrenia and other conditions, and for total admissions of patients from the 32 GLC boroughs. He used one socio-economic index (proportion of male population in semi-skilled and unskilled occupations) and one of general population mobility (proportion of population born outside the British Isles). Both indices are closely correlated with a range of other social, economic, and demographic variables. For example, the percentage of immigrants also acts as an approximate indicator of the proportion of single-person households, prevalence of shared dwellings and degree of overcrowding in each borough.

Table 3.2 gives the two indices mentioned by Hammond and three others that might possibly be relevant to admission rates; the proportion of population aged 65 and over, the proportion of households with exclusive use of hot water, fixed bath, and inside WC, and the change in population from 1966 to 1971. Table 3.3 presents Hammond's figures for schizophrenia admission rates

Table 3.1. Percentage of population in sex and age-groups (census, 1966)

Age-group	Southwark		Greater London		Westminster	
	M	F	M	F	M	F
0-4	9.3	8.3	8.2	7.2	6.0	5.0
5-14	14.5	13.2	13.2	11.7	8.2	7.3
15-19	8.3	7.6	7.9	7.3	6.0	6.6
20-44	34.0	31.6	34.4	31.8	41.4	36.5
45-64	25.6	19.7	26.9	20.9	28.2	21.8
65-74	5.7	13.8	6.4	15.1	6.9	16.8
75+	2.6	5.9	2.9	6.0	3.2	6.1

Table 3.2. Demographic, socio-economic, and social mobility indices (Greater London boroughs, 1966) (percentage)

Greater London boroughs	Unskilled or semi-skilled manual workers*	Born outside British Isles	Aged 65+	Households with exclusive use of hot water, fixed bath, and inside WC	Change in population 1966-71
Barking	33	1.8	10.3	80.5	- 3.9
Barnet	16	11.4	13.5	81.4	- 1.7
Bexley	19	3.0	10.5	85.7	+ 1.1
Brent	15	15.4	11.8	63.3	- 1.4
Bromley	16	4.0	12.1	85.7	+ 2.9
Camden	25	19.9	13.1	50.2	- 7.5
Croydon	17	6.4	13.4	77.0	+ 2.9
Ealing	22	10.7	12.4	72.0	+ 2.3
Enfield	19	4.4	13.4	75.0	+ 0.8
Greenwich	28	4.1	12.7	69.8	- 4.6
Hackney	29	14.3	12.1	45.1	- 11.3
Hammersmith	28	13.0	13.5	42.0	- 9.0
Haringey	23	14.2	14.3	47.1	- 3.9
Harrow	15	6.5	11.6	90.3	- 0.6
Havering	21	1.8	8.5	91.0	- 0.1
Hillingdon	21	4.9	9.0	91.3	+ 3.0
Hounslow	23	6.9	11.9	75.6	+ 2.8
Islington	23	16.5	12.0	32.9	- 15.4
Kensington and Chelsea	20	26.3	13.1	55.4	- 9.2
Kingston upon Thames	15	5.2	13.5	81.9	- 1.3
Lambeth	28	12.7	12.8	54.3	- 5.7
Lewisham	25	7.1	13.2	61.7	- 4.9
Merton	18	6.1	14.0	79.0	- 2.3
Newham	36	5.7	12.2	41.0	- 7.6
Redbridge	16	4.2	13.4	79.7	- 2.9
Richmond upon Thames	17	7.0	15.4	57.7	- 0.3
Southwark	35	6.7	12.7	48.9	- 12.1
Sutton	15	4.0	13.7	85.5	+ 2.2
Tower Hamlets	39	8.9	11.8	51.1	- 16.2
Waltham Forest	23	4.1	14.5	58.7	- 0.4
Wandsworth	24	10.7	14.0	53.2	- 6.3
City of Westminster	25	24.9	14.2	55.5	- 11.2
Greater London	24	9.3	12.6	65.6	- 3.8

* Percentage of actively employed males.

Table 3.3. *First admissions for schizophrenia in men and women, total first admissions, and total admissions (rates per 100,000 population, Greater London boroughs, 1966)*

Greater London Boroughs	First admission rates for schizophrenia		Total first admission rates	All admissions
	M	F		
Barking	10	18	99	302
Barnet	18	21	129	369
Bexley	16	19	123	317
Brent	19	15	105	339
Bromley	11	17	131	387
Camden	21	23	126	373
Croydon	23	33	177	408
Ealing	19	19	128	357
Enfield	15	17	106	263
Greenwich	23	29	161	418
Hackney	17	18	99	386
Hammersmith	27	21	116	377
Haringey	26	33	204	569
Harrow	8	14	104	310
Havering	9	24	104	298
Hillingdon	2	15	119	294
Hounslow	23	29	122	333
Islington	44	54	203	507
Kensington and Chelsea	43	55	216	694
Kingston upon Thames	7	13	111	327
Lambeth	14	19	111	432
Lewisham	17	19	117	316
Merton	12	16	91	310
Newham	21	25	115	343
Redbridge	19	23	150	407
Richmond upon Thames	20	12	145	415
Southwark	11	13	88	396
Sutton	18	15	117	383
Tower Hamlets	21	23	128	528
Waltham Forest	21	21	129	346
Wandsworth	42	41	243	675
City of Westminster	22	34	109	352
Greater London	20	24	134	395

(male and female), total first admission rates (all diagnoses), and total admission rates per 100,000 population.

The matrix of correlations between these variables is shown in Table 3.4. There is a considerable degree of correlation between the four admission rates, as might be expected. The proportion of employed men in semi-skilled or unskilled manual jobs shows little association with any of the admission rates, but the other index of class (proportion of households with various amenities), is moderately correlated with all of them, as well as with the other social indices. The proportion of population born abroad is moderately correlated with all the clinical and social indices apart from occupational class. The proportion of population over the age of 65 has only rather low correlations with the other variables. The percentage change in population between 1966 and 1971 shows moderate correlations with the clinical rates (except total first admissions) and also with the other variables (except proportion over the age of 65): for example, the greater the decrease in population the higher the total admission rate.

Four regression analyses were carried out using each of the admission rates in turn as criterion and the five social variables as predictors. The multiple correlation coefficients were:

Male first admission rate (schizophrenia)	0.72	$p < 0.01$
Female first admission rate (schizophrenia)	0.61	$p < 0.05$
Total first admissions	0.48	NS
Total admissions	0.60	$p < 0.05$

In the case of the male first admission rate, only one of the five social variables remains significantly correlated when the effect of the other four has been partialled out. This is the proportion of households with hot water and other amenities (partial correlation coefficient -0.41 , $p < 0.05$). In the case of the other two admission rates with a significant multiple r , no variable remained significantly correlated once the effect of the others had been allowed for.

These results do not suggest any clear-cut hypotheses linking social variables to schizophrenia or to total admission rate, though it is clear that certain rates are predictable to a moderate extent.

Hammond also included an index representing 'the degree of use made of local authority services in the field of mental health and welfare' but found that it bore no relationship to total first admission rate.

Table 3.2 shows that Southwark is third highest among London boroughs according to the proportion of actively employed men who are semi-skilled and unskilled manual workers (35 per cent). Only Tower Hamlets and Newham have a higher proportion

Table 3.4. Product-moment correlations between four admission rates per 100,000 population and five social variables: GLC boroughs

	1*	2*	3*	4*	5	6	7	8	9
1.* First admissions for schizophrenia (M)	—								
2.* First admissions for schizophrenia (F)	0.87	—							
3.* Total first admissions	0.81	0.80	—						
4.* Total admissions	0.79	0.72	0.85	—					
5. Proportion unskilled/semi-skilled	0.10	0.09	0.12	0.15	—				
6. Proportion foreign-born	0.58	0.57	0.34	0.51	0.08	—			
7. Proportion aged 65+	0.39	0.10	0.29	0.32	0.16	0.29	—		
8. Proportion of households with hot water, etc.	0.62	0.43	0.31	0.51	0.59	0.59	0.39	—	
9. Change in population, 1966-71	0.46	0.42	0.15	0.47	0.68	0.55	0.12	0.79	—

* Correlations with the first four variables were tested for significance by analysis of variance for the linear regression. Those in *italic* were significant beyond 5 per cent level.

Table 3.5. *Socio-economic groups of economically active males; three GLC boroughs and Greater London (census, 1966) (percentage)*

<i>Socio-economic groups</i>	<i>Tower Hamlets</i>	<i>South-wark</i>	<i>Greater London</i>	<i>Harrow</i>
Professional	1	2	6	10
Higher executive	4	6	12	18
Lower executive	5	4	4	4
Other non-manual	14	18	24	26
Skilled manual	37	36	30	27
Semi-skilled manual	20	18	15	10
Unskilled manual	19	16	9	5

Table 3.6. *Birthplace of population; three GLC boroughs and Greater London (census, 1966) (percentage)*

<i>Birthplace</i>	<i>Barking</i>	<i>South-wark</i>	<i>Greater London</i>	<i>Ken-sington and Chelsea</i>
British Isles	98.2	93.3	90.7	73.7
New Commonwealth*	0.9	4.9	4.8	8.5
Old Commonwealth	0.1	0.2	0.5	3.3
Other countries	0.7	1.5	3.9	14.5

* Asia, Caribbean, Africa, Mediterranean.

Note: Details of Southwark immigrant population: Commonwealth: Asia 1,180, Caribbean 8,410, Africa 1,030, Mediterranean 3,880, elsewhere 620. Non-Commonwealth: 4,530.

while, at the other extreme, Harrow and Kingston upon Thames have only 15 per cent. On the other hand, Southwark ranks sixteenth out of 32 boroughs in terms of the proportion of its population born outside the British Isles, and has a proportion (6.7 per cent) substantially below the average for Greater London (9.3 per cent). Barking has the lowest proportion born outside the British Isles and Kensington the highest. Tables 3.5 and 3.6 give further details.

Camberwell constitutes the southern two-thirds of the new borough of Southwark and is rather better off in respect of amenities such as parks and open spaces, quality of housing, provision of hot water, etc., than the northern one-third. The socio-economic and other census indices given earlier for Southwark do not, of course, entirely fit Camberwell (particularly those relating to poverty) but Table 3.7 shows that there is not much in it.

Table 3.7. *Socio-economic groups of economically active males; Camberwell (census, 1961) and Southwark (census, 1966) (percentage)*

<i>Socio-economic group</i>	<i>Camberwell</i>	<i>Southwark</i>
Professional, executive and managerial	10	12
Skilled non-manual	20	18
Skilled manual	40	36
Semi-skilled manual	17	18
Unskilled manual	13	16

Sainsbury, who studied morbidity rates in the former LCC boroughs, and therefore gave data for Camberwell separately, showed that it was approximately average on measures of poverty and delinquency and considerably better than average on measures of social isolation (persons living alone, persons living in hotels, number of lodging-house keepers) or social mobility (proportion of immigrants, proportion London-born, proportion foreign-born, persons moving in and out of the borough daily). Divorce was also less common than in most other boroughs. Camberwell ranked twenty-fifth out of 29 LCC boroughs on suicide rates during 1919-23 (8.6 per 100,000 population per year), twenty-fifth during 1929-33 (11.4 per 100,000), and twentieth during 1940-4 (11.1 per 100,000). The latest figure is 12.8 per 100,000 Camberwell population (1969 and 1970); very little different from what it had been twenty-five years previously.

Thus Camberwell is a relatively stable working-class area, with 57 per cent of its male population in skilled or semi-skilled manual occupations. It is not characterized by great poverty, social isolation, or social mobility. Consonant with this, its rates of delinquency, schizophrenia, and suicide are all average or below. It is no paradise and it is definitely not the most exciting part of the conurban London scene (one might even call it dull), but in certain places and on a sunny day, its residents might reflect that they could do very much worse than stay where they are.

3. Camberwell wards

(J. K. Wing)

Camberwell has twelve electoral wards, shown in Fig. 3.2. As was suggested in the introductory section, the successive waves of immigration from the north, each reaching further into the area and finally beyond it, have left their marks. The spate of public

Table 3.8. *Five social indices, by ward (percentage)*

<i>Ward*</i>	<i>Unskilled manual</i>	<i>Free school meals</i>	<i>Born in new Commonwealth</i>	<i>Resident outside borough one year ago</i>	<i>Single person households</i>
Consort	19	18	8	12	19
Burgess	18	15	4	9	18
Friary	16	17	7	8	19
St Giles	15	18	8	10	21
Brunswick	1	3	5	8	20
Bellenden	13	15	11	12	28
Waverley	13	7	5	9	20
Alleyne	13	13	8	11	20
Lyndhurst	8	17	4	14	21
Rye	7	8	2	11	22
Ruskin	5	4	3	13	18
College	5	2	1	14	14
Population	Economically active males	Primary school-children	Total	Total	Households

* In rank order according to proportion of unskilled manual workers.

and private building during the post-war years has altered the landmarks but not the character of the distribution, since the new Council blocks and estates are mainly in the north and east, while the private developments and the new buildings on the Dulwich College estate are concentrated in the south.

The GLC Research and Intelligence Unit has produced a useful volume of census indices, by ward, for all the Greater London boroughs (GLC, 1968*b*). Rates for schizophrenic patients aged 15-64 first admitted to hospital during 1965-70, were calculated per 100,000 total population using figures from the Camberwell Register. Rates for boys aged 10-17 first attending juvenile courts during 1965-9 were calculated from data collected by kind permission of the former Children's Department of the Borough. The proportion of primary schoolchildren who were granted free school meals during 1969 was obtained from a joint paper by the Southwark Community Project and the borough Planning Department.

Fig. 3.2 shows that there was a gradation in the proportion of economically active men in each ward who were engaged in unskilled manual occupations, from north-east to south-west. None of the other indices presented in Table 3.8 shows such a clear gradation. Uptake of free school meals (an apparently clear-cut measure of poverty) and proportion of residents born in new Commonwealth countries show a difference as between the northernmost and the southernmost wards.

The rates of first admission for schizophrenia and the rates at

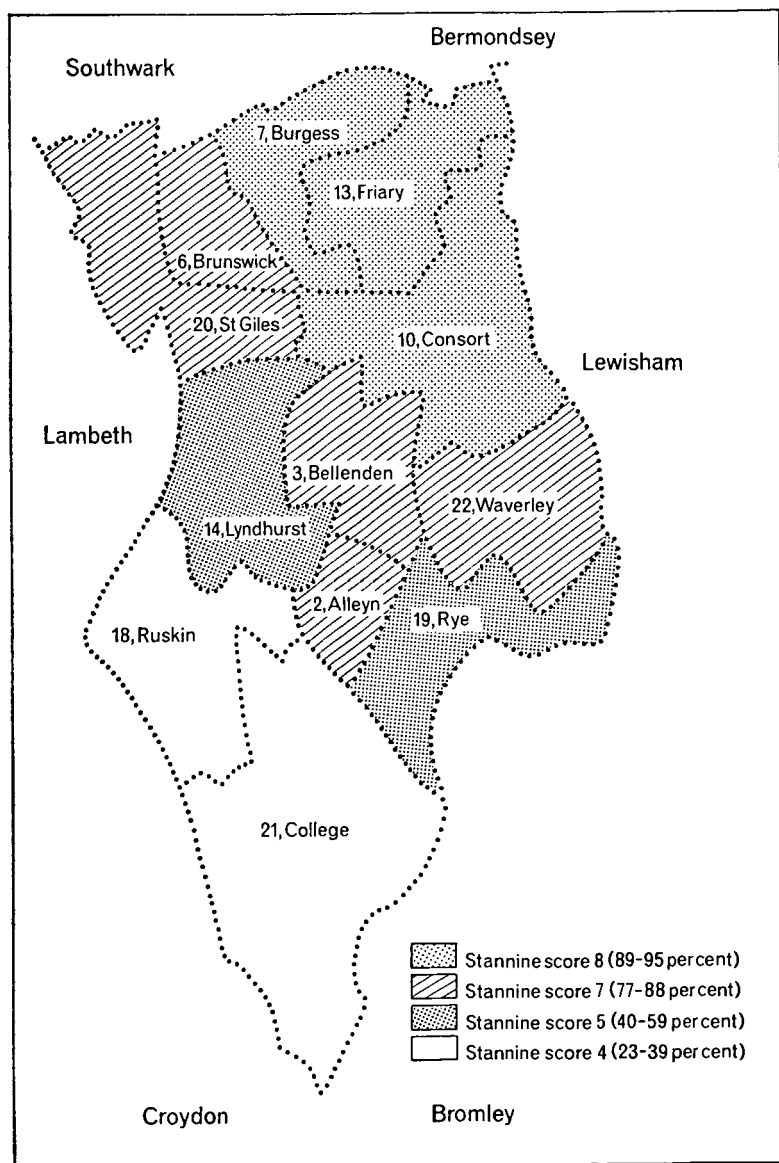


FIG. 3.2. Socio-economic groupings in Camberwell wards. Proportion of economically active men in unskilled manual occupations.

which schizophrenic patients begin a new episode of contact (after at least three months out of touch with psychiatric services) show no significant relationship to the geographical distribution of socio-economic indices but they tend to be lowest in the southern-most wards. Rates for juvenile new offenders, however, appear to follow more closely the pattern established for unskilled manual workers and uptake of free school meals. These figures are given in Table 3.9.

Table 3.9. *Three indices of morbidity; by ward*

<i>Ward*</i>	<i>Juvenile first offenders 1965-9 (per 1,000 total population)</i>	<i>Schizophrenia first admissions during five years (per 100,000 total population)</i>	<i>Schizophrenia new episodes during five years (per 100,000 total population)</i>
Consort	7.11	117	155
Burgess	5.82	50	170
Friary	7.58	95	202
St Giles	7.69	102	327
Brunswick	6.67	83	197
Bellenden	4.74	43	252
Waverley	6.52	43	79
Alleyn	7.10	142†	201
Lyndhurst	6.02	59	271†
Rye	2.50	70	150
Ruskin	3.16	39	178
College	4.91	19	130
Mean rate	6.02	72	196

* In rank order according to proportion of unskilled manual workers.

† Mainly concentrated in one polling district (M. Radford, unpublished data).

It appears that College and Ruskin wards tend to have low scores on all indices, both those relating to social conditions and those relating to morbidity, except for in-migration. A high proportion of the population of these two wards were not resident in the borough one year before the census day.

The relative homogeneity of the borough is, however, fairly obvious. In Scott's pilot analysis of enumeration district data from the 1961 census, Camberwell was fairly homogeneous on most variables. Norman's subsequent cluster analysis confirmed this homogeneity. On the six-fold classification of the Centre for Urban Studies, 44.6 per cent of ED's were grouped as 'stable working class', 28.3 per cent as 'almost suburban', 22.5 per cent as 'local authority housing', and 4.6 per cent as poor. The other two categories, 'bedsitter' and 'upper-class', were not used. Since then, the proportion in 'local authority housing' has probably increased at the expense of 'stable working class' and there might be a small representation of 'upper class'. Otherwise these proportions fit very well the impressions gained from driving through Camberwell.

The more recent cluster analysis of ward data (GLC, 1971) does not add much to these conclusions.

4. Age and sex distribution of the population

(Anthea M. Hailey)

By relating Register statistics to the population of the area, it is possible to compare results for services in Camberwell with those in other areas and in the country as a whole. When figures are given which show changes in the number of contacts over a number of years, it is essential to adjust for any population changes which may have taken place over the same period. For these reasons, we have calculated annual estimates of the Camberwell population for use in the Register tables in this volume, but in doing so we have encountered a number of problems.

Figures from the 1961 population census show that Camberwell had a population of approximately 175,300. In 1965, the area became part of the London borough of Southwark, and published figures from the 1966 10 per cent sample census do not give Camberwell as a separate unit; however, it has been possible to obtain figures for the original borough, with the help of the Research and Intelligence Unit of the GLC. They are subject to sampling errors, since the whole population was not included. A second problem is underenumeration which is known to have occurred, particularly in Inner London. Official estimates suggest that the over-all result of these two possible biases is that the census figures are about 2.3 per cent below the 'true' level. Applying this factor to the 1966 census data for Camberwell gives a population of approximately 172,000.

This demonstrates the gradual decline of population in Camberwell, a trend similar to that in other Inner London boroughs. A comparison by age and sex shows a differential rate of change between various groups within the population. Children aged under 15 years increased in number very slightly, and comprised 22.4 per cent of the population in 1966 compared with 21.9 per cent in 1961. In the adult age range, an increase in those aged 15-24 years from 14.1 per cent to 15.5 per cent of the total in 1961 and 1966 respectively was offset by a corresponding slight decrease in the age-group 25-64 years. The proportion aged 65 and over remained the same at each census, 11.5 per cent. Analysis by marital status shows a decrease in the proportion of the adult population (aged 15 or over) who are 'married', from 65.0 per cent, partly due to the relatively higher number of young adults aged 15-24 years, of whom less than one-quarter are married. The annual

Table 3.10. *Annual estimates of Camberwell population*

	Total all ages			Age 0-14			Age 15+		
	M	F	Total	M	F	Total	M	F	Total
1961 census	83·66	91·65	175·30	19·43	18·95	38·38	64·23	72·70	136·93
1962	83·32	91·34	174·65	19·45	18·94	38·39	63·87	72·40	136·27
1963	82·97	91·04	174·01	19·46	18·94	38·40	63·51	72·10	135·61
1964	82·63	90·74	173·36	19·48	18·94	38·42	63·15	71·80	134·95
1965	82·28	90·43	172·71	19·50	18·94	38·44	62·78	71·50	134·28
1966 census, corrected	81·93	90·14	172·07	19·52	18·94	38·46	62·41	71·20	133·61
1967	81·57	89·85	171·42	19·53	18·94	38·47	62·04	70·90	132·74
1968	81·22	89·55	170·78	19·54	18·94	38·48	61·68	70·60	132·28
1969	80·88	89·25	170·13	19·56	18·94	38·50	61·32	70·30	131·62
1970	80·52	88·96	169·48	19·57	18·94	38·51	60·96	70·00	130·96

estimates used in the tables in this volume are shown in Table 3.10, where figures from the two relevant censuses are used to construct a linear trend.

Table 3.11 shows the Camberwell data from the 1966 population census, corrected for underenumeration by 2·3 per cent.

It is difficult to forecast future population size because of uncertainty concerning developments in housing and employment policies. The GLC Research and Development Unit has made forward estimates, by applying local birth, survival, migration, and death-rates to 32 separate age and sex cohorts from the 1966 census. The RIPA report on hospital needs in south-east London (Saalmans, 1970) adapted the GLC forecasts for use in their study of the services provided by Guy's, King's College, and Maudsley Hospitals. For King's College Hospital's 'primary catchment area' (roughly, East Lambeth and Camberwell), it was calculated that

Table 3.11. *Camberwell population, 1966, by age and sex (corrected for underenumeration)*

Age	M	F	Both sexes
0-4	7,710	7,350	15,060
5-9	6,300	6,180	12,480
10-14	5,510	5,410	10,920
15-24	12,990	13,700	26,690
25-44	22,240	21,990	44,230
45-64	20,320	22,510	42,830
65-74	4,610	7,580	12,190
75+	2,250	5,420	7,670
0-14	19,520	18,940	38,460
15+	62,410	71,200	133,610
All ages	81,930	90,140	172,070

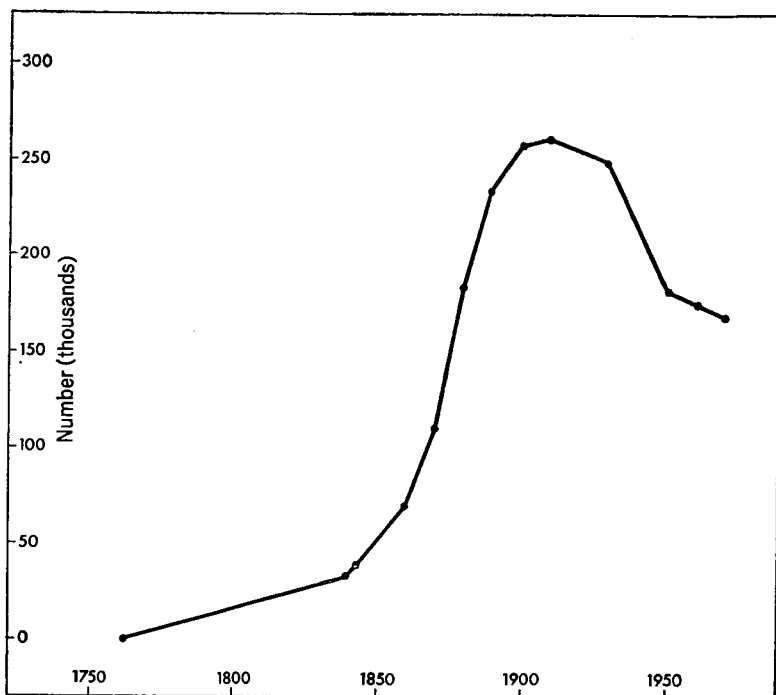


FIG. 3.3. Population in Camberwell, 1761-1971.

there would be a small increase in the age-group 0-14, little change in the age-groups 15-39 and 65+, but a considerable decrease (34 per cent) in the age-group 40-64, between 1971 and 1986. This may unduly emphasize some specific migration trends during the year 1965-6, which could well be halted or even reversed, nevertheless it does emphasize the necessity to keep a watch on population trends as an indication of possible changes in demand for services.

Fig. 3.3 shows that the trend has been continuous since 1910. The greater part of this movement is voluntary. Areas outside Greater London have relative advantages in employment, housing, and other amenities. Unless, therefore, the spate of new building can be kept up and, above all, new industries can be created in south-east London which will attract and hold a substantial work force, the decline is bound to continue.

The only exceptions have been the small influx of people from the Caribbean, now dried up, and of middle-class commuters who have wearied of the long journey into London.

5. Development of hospital and local authority psychiatric services

5.1. THE EARLY DEVELOPMENT OF A MENTAL HOSPITAL SERVICE (A. D. Isaacs and J. K. Wing)

The evolution of the present-day Camberwell psychiatric service reflects the social, clinical, legal, and administrative developments which have occurred during the past hundred years. The social philosophy of the Victorians was to provide for the deserving poor, including the handicapped, as a matter of charity. Preferably they should be out of sight, and not too much encouragement should be given to idleness. Institutions of various kinds were set up; for the deaf and the blind, for the physically handicapped and chronic sick, for the mentally ill and subnormal, for the orphaned, for the old. During the past century this philosophy has gradually changed, and that of the welfare state has taken its place. The change in point of view was summed up in the Minority Report of the Poor Law Commission of 1909. Beatrice Webb, who was mainly responsible for this great Report, worked upon two main principles; that prevention of poverty and destitution was better than trying to relieve it and that the social services should be professionally rather than charitably run. So far as the first aim was concerned,

the existing Poor Law could only tackle such social evils as disease and drunkenness at the point at which they had already done, if not their worst, something nearly approaching to it. . . . To take the responsibility away from *relieving* bodies and Relieving Officers, and to put it squarely on the shoulders of authorities responsible for public health, would, the Report maintained, be in the long run a strictly economic policy . . . The indiscriminate and uncoordinated charity of persons anxious to buy themselves a comfortable conscience at a low fee was harmful and demoralizing (Cole, 1945).

Looking back with hindsight, it can be seen that advance was proceeding throughout the period under review. Firstly, the institutions were made as humane as possible and some of the dangers of institutionalism began to be realized. Later the individual's, the family's, and society's reaction to disadvantage or disability was recognized as being of an order of importance, so far as future progress was concerned, quite as great as that of the disability itself. Institutionalism was not the only source of secondary handicap. Finally, the model became one of prevention. Institutions and other services should only be used as means to prevent the development of secondary handicaps and to protect the disabled individual against stresses which he could not withstand himself.

They should not be primarily a means of segregation, nor even of asylum unless that seemed to be the only resource left and the individual strongly wanted it. This progression can be seen in the history of all the sociomedical services. It is very incomplete, as the legacy of Victorian institutions constantly reminds us, but the direction is clear.

Up to the middle of the seventeenth century 'Toms o' Bedlam' (discharged patients with a recognizable badge giving them a license to beg) were a familiar sight. During the eighteenth century 'pauper lunatics' were the responsibility of the parish overseer and those who were found elsewhere than in their legal place of settlement were treated with the utmost severity (Jones, 1955). The general assumption in post-feudal times was that the condition of the able-bodied unemployed or destitute was their own responsibility. They were not really interested in work and, if they congregated together in poor areas, 'that was because they were attracted by the prospect of charitable handouts' (Jones, 1971). Even in the nineteenth century, when whipping was no longer ordered for vagrancy by statute, punishment by degradation was still the official policy, receiving its classical formulation in the principle of less eligibility: the pauper's condition must be less attractive than that of the lowest-paid labourer. Under the Poor Law, the workhouse system was designed to recover what profit might be had from poor people, extracting as much work from them as possible while giving them the minimum subsistence.

Under the 1834 Poor Law Amendment Act, everyone receiving public assistance had to be in a workhouse. Congregated among the destitute were the handicapped, the chronically sick, and the old. The accommodation which was set aside for them in the workhouse became a system of public hospitals many of which are still in use today. St Giles's and St Francis's hospitals in Camberwell are examples. That the conditions described in *Oliver Twist* were no exaggeration is amply shown in the history of Newington Lodge, written by Mr B. G. Morley of the borough of Southwark's welfare department. Mr Morley quotes a letter from one of the inmates which appeared in a local newspaper on 12 February 1862.

There were about 40 sick beds for the 'out-door poor' and not enough it seems for the inmates—'we have men lying about in the damp day halls because there is no room for them in the sick wards'. Rheumatic, bronchitic and bad-leg cases were confined to a shed at the rear which was also used for chopping wood. This shed, on the edge of the open sewer, had only the damp earth for a floor: the choppers were rusty in the morning after being used the previous day.

This institution actually became a workhouse infirmary for about ten years after 1877 (Morley, 1969).

There was an attempt to set up a voluntary hospital system supported by charity to care for this group of chronic sick people but already in the seventeenth century St Thomas's had restricted its admissions to short-stay cases. Doctors 'wanted to show results in terms of cure, and they were naturally reluctant to surround themselves with cases which showed the limitations of their professional skill. Doctors who taught particularly wanted to demonstrate successes.' In fact, after St Thomas's Hospital had excluded incurable cases, 'one of its governors (Mr Guy) founded, with money he had made in speculation, a sister hospital specifically for incurable and mental cases. But the early decision of the governors of St. Thomas's hospital to concentrate on curable cases proved to be an important precedent. It was not many years before Mr. Guy's hospital began to exclude the type of patient it was founded to treat' (Abel-Smith, 1964). This problem of the best means of caring both for acute and chronic conditions has still not been solved today.

Specialized hospitals were also set up for infectious diseases and yet another category, the county asylums, for the mentally ill. Before 1845, there was no single code for the treatment of the insane. Subscription hospitals such as Bethlem Royal were run as charities by their trustees. Private asylums (developed out of private madhouses) were inspected by the Metropolitan Commissioners in Lunacy. County asylums were managed by committees of magistrates appointed at quarter sessions. Many of the insane remained in prisons and workhouses, under the Criminal or the Poor Law. It was estimated that, in 1828, 9,000 such people were housed in workhouses. In addition, there was an unknown number of 'single' lunatics confined, often at home, under the care of an attendant, with no formal supervision or control at all.

The use of bleeding, purging, intimidation, straight-jackets, and other forms of restraint was generally discredited and the pioneers of moral management, Tuke, Charlesworth, Gardiner Hill, and Conolly, were the inspiration of a generation of psychiatrists. At the time that the first county asylums were set up, the medicolegal process of admission was regarded as being primarily for the benefit of the patient. The mentally sick individual appeared in need of protection from exploitation and physical ill-treatment, and admission ensured this, together with a minimal standard of living. The justices were involved because they were the managers of the asylum and because they were empowered to charge the patient's maintenance to his parish. Patients were regarded as

unable to look after themselves but it was not assumed that mental illness was incurable. On the contrary, the discharge rates from some county asylums were as high as those reached today, and many of the axioms of 'moral treatment' put forward by the psychiatrists of the time would be accepted now (Deutsch, 1949; Bockhoven, 1956; Rees, 1957).

However, the other major aim of the early legislation was to ensure that improper detention could not occur. The Lunacy Acts of 1890 and 1891, which codified and systematized the various legal restrictions on the freedom of the mentally ill, required at least one certificate of unsoundness of mind or mental defectiveness and an order by a justice at the time of admission.

This had two important results. The first was that no patient could be admitted without a firm medical diagnosis of a mental disorder and social conditions serious enough to justify powers of detention. The law envisaged no gradations between 'unsoundness of mind' and sanity, and no doubt about the possible causes of retardation of a child's development. A person could not be admitted to an asylum until his unsoundness of mind, as strictly interpreted by medical tradition, was established beyond reasonable doubt and often, in those days, beyond hope of cure. A child might not be taken into a mental deficiency institution for a period of prolonged observation before a definite diagnosis was made. An order for a defective's admission to hospital could not be made unless he was 'subject to be dealt with' under the circumstances specified in the Mental Deficiency Act. The other important point was the association between admission to mental or mental deficiency hospitals and the justices of the peace (Report of the Royal Commission, 1957).

These conditions not only attached an inevitable stigma to the process of admission, but ensured that only severely, often chronically ill patients were admitted. Much of the impetus towards the development of a comprehensive psychiatry, based on the principles of social treatment, was lost.

Prior to 1889, most of South London was included in the county of Surrey. Until Cane Hill Hospital was built in 1882, the county was served by Surrey County Asylum (built in 1841; now Springfield Hospital) and Brookwood Hospital which soon became seriously overcrowded. Responsibility for the provision of asylum accommodation rested at that time with the county justices and, to relieve overcrowding, in 1878 they purchased 148 acres of land which formed part of Portnalls' Farm in Coulsdon (15 miles from Camberwell), for the cost of £23,000, under the provisions of the Lunatic Asylums Act of 1853. On this site was developed Cane Hill Asylum which was constructed in a little over a year and was

opened on 4 December 1883, with an initial capacity for 1,124 patients. It was intended to serve those districts which extended south from London Bridge and the first patient to be admitted to the hospital from the community came from the St Olave's Union, an area that was subsequently to become the Metropolitan Borough of Bermondsey. This association of the hospital with South-east London continues to the present time.

In the first year of its existence 1,120 patients were admitted, most being transferred from various other asylums. Amongst them were 19 patients who were transferred from Bethlem Royal Hospital, thus provoking a special comment from the Medical Superintendent who observed that 'many of these are troublesome cases. I would suggest that the Removal Officer be requested to take more active steps towards obtaining the transfer of these cases to the asylums of their own Counties.' Of the patients admitted directly from home however, 33·5 per cent were discharged as recovered within a year, and half were in hospital for less than three months. To achieve this recovery rate in 1884, £89 was spent on drugs. By 1970 when approximately four times as many patients were admitted the drug bill had risen to £24,000.

At this early stage it seemed that every effort was made to provide meaningful occupation for patients, 200 men being employed on the attached farm and gardens as well as in such occupations as shoemaking, tailoring, coal-carrying, and ward domestic work. Female patients were occupied with needlework, kitchen work, and various household duties on the ward. Recreational activities were also developed and each ward was provided with chess sets, dominoes, and other games. The early reports refer to the presence of pianos and billiard tables in certain wards and regular fetes and outings were arranged for the patients, the first of the latter being in 1887 to celebrate Queen Victoria's Jubilee. What was considered to be a good library was available and there was a wide range of entertainments including dances, concerts, and various open-air attractions. To care for 1,000 or more patients, there were three doctors on the staff; one of whom was the Medical Superintendent, who was 'the paramount authority in the asylum'.¹

During the first five years of its existence the hospital remained under the supervision of the county justices and the majority of patients were admitted directly from home. By 1889 the recovery rate was reported to have risen to 40 per cent of patients admitted.

1. Dr Walk comments, 'This system was recommended and then enforced by the commissioners in the 1840s-1850s because, before then, confused and divided responsibilities had led to neglect and ill-treatment of patients, for example, at Bethlem in 1852.'

After these first five years, with the passing of the London Government Act, responsibility for administering the hospital was transferred from the county justices to the newly formed London County Council. At this time Cane Hill was one of five hospitals appropriated to the new county and the majority of patients admitted still came from the South London boroughs of Bermondsey, Southwark, and Camberwell.

Some of the disadvantages of treating patients so far from their homes were fully appreciated at this early stage. The Visiting Committee noted that patients' friends suffered 'great inconvenience from fatigue and exhaustion in walking the long distance from Purley station (over two miles) and remaining in conversation with the patients'. This resulted in the provision of light refreshments to ease the burden of visitors. Within a few years, 'Coulsdon and Cane Hill' (now Coulsdon South) station was opened and cheap fares were provided for visitors.

The high standard of humane care emerges clearly from the annual reports. However, the factors affecting all asylums at the time must have been at work. The early asylums had been small; Lincoln, built in 1820, had only 50 beds. But the size rapidly increased and Cane Hill, already large even when it was opened, was further enlarged to accommodate 2,000 patients by 1892.

5.2. THE LONDON COUNTY COUNCIL ERA, 1889-1948 (A. D. Isaacs and D. H. Bennett)

Between 1898 and 1914 six additional mental hospitals were built by the LCC and patients were allocated from a central office (run by the Metropolitan Asylums Board), largely according to the vacancy position. Camberwell patients were scattered throughout these LCC hospitals, although there was a certain geographical preference, vacancies permitting; and a significant proportion continued to be admitted to Cane Hill. The aftermath of this policy remains today, since 41 per cent of all the present long-stay patients, who were originally admitted to mental hospital from an address in Camberwell, are not living in Cane Hill Hospital but in one of the other hospitals that used to be administered by the Metropolitan Asylums Board; all even further away from their homes than is Cane Hill.

In these circumstances, the building of the Maudsley Hospital by the LCC, on the initiative of an eminent psychiatrist, Sir Henry Maudsley, was an enlightened and progressive step. It was opened in 1915, was used as a war hospital (particularly for cases of 'shell-shock') and became a postgraduate psychiatric medical school in 1924. Patients could be admitted voluntarily and they

could be treated as out-patients. Dr Edward Mapother was appointed Medical Superintendent of the Hospital for War Neuroses and subsequently of the Maudsley Hospital and occupied the first Chair in Psychiatry, instituted in 1936 (Lewis, 1969). Under his guidance, and that of his successors, Sir Aubrey Lewis (1946, who created the associated Institute of Psychiatry) and Sir Denis Hill (1966 to date), the Maudsley has become a national and international centre for treatment, teaching, and research.

The success of the Maudsley played some part in the drafting of the 1930 Mental Treatment Act under the provisions of which 'voluntary' patients could be admitted to mental hospitals. This Act allowed for the development of out-patient clinics at general hospitals but in the London area, apart from the undergraduate teaching hospitals, most psychiatric out-patients were seen at the Maudsley Hospital whence they were admitted to one of the LCC hospitals as required. The tendency to admit Camberwell patients to Cane Hill continued under this arrangement and it seems likely that the presence of the Maudsley in South London made the development of additional out-patient clinics at the local general hospitals seem unnecessary.

There was one further place in South-east London where a mentally ill patient might be admitted. In 1890, the Lunacy Act introduced a summary reception order, allowing a constable or relieving officer to remove a pauper lunatic who required immediate care to a workhouse for three days. Before 1930, each Poor Law Union had its own observation ward at one of its workhouses. Nearly all the patients admitted to Cane Hill Hospital came through the Constance Road Institution which opened in 1894, and belonged to the Camberwell parish. It also provided accommodation for the elderly and chronic sick. It was taken over by the LCC in 1930 and later renamed St Francis's Hospital, though its former functions were retained. The LCC laid down the policy that all patients needing certification or temporary admission should go to an observation ward first.

Professor Mapother thought that a correct system of care for the mentally ill should include the mental hospital, the observation ward, and the psychopathic clinic. In his report for 1932-5 he described the development of 'a co-ordinated system for dealing with mental and neurotic disease of all kinds and degrees and at all stages'. He felt that the Board of Control still favoured traditional mental hospital care and were jealous of the encroachments of the observation centre and the psychopathic clinic. Certainly the Board's attitude as reflected in their report for 1935 showed caution and suspicion. They were disquieted that, in some obser-

vation wards, newly admitted patients were mixed with chronic cases and low-grade defectives. They wondered whether the staff of the wards had adequate training and expressed their belief that, once it was clear that patients required treatment for mental illness, 'no time should be lost in transferring them to the mental hospital which in general is the only place able to provide specialized experience and the therapeutic resources necessary for successful treatment'. The Board was anxious lest observation wards which were improved might succumb to the temptation of giving 'active treatment': an aim inconsistent with the main purpose of such wards, which was the diagnosis of doubtful cases.

A judicious leading article in the *Lancet* in 1936 discriminated between an observation ward staffed by people without psychiatric experience which was 'used as a common dumping ground for diverse categories of the mentally ill and mentally deficient' and one that 'is at once the reception hospital for acute or dangerous mental illness, the distributing and diagnostic centre, and the place of treatment for very transient conditions such as some toxic and symptomatic psychoses'. There seemed little reason to retain the former but most authors argued for the latter type of observation centre; at least in the Metropolitan area. In the old Constance Road Institution the resident medical officers were not psychiatrists, but in 1937 Professor Mapother began to attend St Francis's observation ward twice a week. His visits were in the nature of a clinic, rather than a ward round. He saw only cases of interest or difficulty or those who were likely to become voluntary patients.

He still saw the 'psychopathic clinic' (Maudsley) as the pivot of the system providing care for a type of patient who would not approach an ordinary asylum. He felt there was no substitute for such clinics and said that wards in general hospitals could no more replace them, than cottage hospitals could replace the medical schools. The observation wards on the other hand provided the acute cases for study or undergraduate and postgraduate training; cases which could not be found elsewhere. At this time a pattern of care was set which was to continue for thirty-five years. The quiet voluntary 'patient' went to the Maudsley while St Francis received the objecting and objectionable but curable 'cases' and the mental hospital took the 'chronics'.

Pentreath and Dax give a vivid picture of St Francis's observation unit in 1937. Its eighty-two beds were disposed in two similar male and female blocks, which had been renovated before they took over the work of several smaller wards in other London institutions and hospitals. The rest of the old workhouse had by

this time become a large general hospital institution for the chronically sick. In each block new cases were admitted to a ward of ten beds for preliminary observation. There were two shuttered siderooms, two warmed and lighted padded rooms, and a bathroom with a continuous bath. Pentreath and Dax commented that padded rooms were 'often condemned but they proved especially useful in this work for really violent and restless senile patients. Moreover they diminished the staff who would otherwise be required to keep the cases in bed, and saved the extensive bruising which is bound to arise if this is done, besides avoiding an atmosphere of antagonism and unrest which is always bred by constant skirmishing.' They went on to say that 'padded beds with high sides, as used in certain of the LCC observation wards, covered in by netting if necessary, had much to recommend them, if they were used in addition to, rather than in place of, padded rooms'. They should be used in a single room to avoid disturbing and perhaps frightening other patients. Such beds, they added, do not 'constitute a form of mechanical restraint'.

Another larger ward was reserved for quieter bed cases. A recreation room with facilities for table games, a wireless set, and a piano was decorated with framed copies of pictorial railway posters. It was said that the nursing staff did 'most valuable work encouraging light handwork and various forms of useful employment on the Medical Officers' advice'.

While patients were admitted on a three-day order this was often extended by the magistrate for a further fourteen days. A few years later Butler felt that it was important to maintain 'the mild and most humane course possible in disposing of the patient'. He thought certification should be avoided whenever possible. The patient should be allowed to go home rather than to go as a voluntary patient to a mental hospital. Like Pentreath and Dax, he felt that whatever the Board of Control might say about early transfer to the mental hospital, relatives and patients still looked askance at mental hospitals, even if, since the Mental Treatment Act, admission was on a voluntary basis. All agreed that the transfer of a patient from the observation ward to a mental hospital should be delayed until the patient had been fully investigated. Butler said: 'I am convinced that this is justified, and I regard summary certification in the same light as I would summary execution.'

5.3. THE NATIONAL HEALTH SERVICE (J. K. Wing and A. D. Isaacs)
The National Health Service, introduced in 1948, was based on four fundamental principles:

1. It should be financed by taxes and contributions paid when people are well rather than by charges levied on them when they are sick.

2. It should be national in the sense that the same high quality of service should be provided in every part of the country.

3. It should provide full clinical freedom to the doctors working in it.

4. It should be centred on the family doctor team, the idea being that the different parts of the service should be co-ordinated in health centres.

There is no doubt that the new service resulted in a marked improvement in hospital standards and that neglected areas of medicine, particularly those dealing with chronic illness and psychiatry, benefited considerably. The service brought together hospitals with totally different histories and traditions; former workhouse infirmaries such as St Francis's and St Giles's, former county asylums such as Cane Hill, well-endowed private hospitals such as Bethlem Royal, unique postgraduate specialist hospitals such as the Maudsley, and 'voluntary' teaching hospitals such as King's College and Guy's.

One of the principal results of this long overdue integration was an increase in funds available to the psychiatric hospitals, with a consequent improvement in buildings and standard of care, a steady rise in numbers of staff and a marked improvement in morale.

Cane Hill Hospital was transferred from the LCC to the Ministry of Health. Its catchment area contained some 600,000 people and covered much of south-east London and the adjacent part of Kent. The Metropolitan borough of Camberwell was included in this area. Out-patient clinics staffed by Cane Hill doctors were established for the first time at local general hospitals such as St Giles's in Camberwell and St Olave's in Bermondsey. An additional link was established when the medical superintendent of Cane Hill was appointed an honorary member of the consultant staff of St Francis's observation ward; to which he paid regular visits, selecting patients who seemed to be suitable for transfer to Cane Hill. Links with the Maudsley Hospital were also established at this time, with the appointment of a Cane Hill psychiatrist as Honorary Associate Physician to the Maudsley as well as the secondment of postgraduate doctors to Cane Hill as clinical assistants. A Maudsley consultant acted as a clinical tutor to these groups and conducted case conferences as well as other teaching.

Before the year 1948, the Bethlem Royal Hospital (the longest-established mental hospital in the world) had been an active well-endowed private hospital with 250 beds, set in extensive grounds at Beckenham. It was closely connected with the City of London and governed jointly with Bridewell Royal Hospital.

At the time of the NHS, Bethlem Royal and the Maudsley were merged into one joint hospital. They served as the teaching hospital for the Institute of Psychiatry, one of the constituent institutes of the British Postgraduate Medical Federation.

The undergraduate teaching general hospital associated with King's College in the Strand, also had a well-established tradition of concern for the psychological aspects of medicine.¹ A chair in psychological medicine had been instituted by the Council of King's College in 1871, the first occupant of which was Dr Edgar Sheppard, Medical Superintendent of Colney Hatch Asylum. When Sheppard retired in 1890, he was succeeded by Dr E. W. White, Superintendent of the City of London Asylum, Dartford, who in turn was succeeded in 1909 by Dr R. H. Steen. Clinical teaching had consisted of lectures together with visits to the professor's mental hospital but Steen was an advocate of psychiatric out-patient clinics in teaching hospitals and he was appointed Out-patient Physician for Mental Diseases. Eventually he came to head a sub-department at King's College Hospital. He retired owing to ill-health in 1923.

Edward Mapother was appointed Lecturer in Psychological Medicine at King's College Hospital in 1922 so that he could give practical instruction at the Maudsley to King's College Hospital students. In 1923 he succeeded Steen as out-patient physician for psychological medicine. No appointment was made to the chair, and there has been no professor of the subject at King's since that time. In 1932, a 35-bed ward at King's (Pantia Ralli) was made available to Mapother and staffed and controlled for a time by the Maudsley (Lewis, 1969). Thus there has been a long tradition of intimate collaboration between the Maudsley and King's College Hospital.

The integration of all these hospitals into the NHS was a tremendous step forward but the tripartite structure of the new service (hospital doctors, local authority medical officers, and GPs being given separate hierarchies and continuing their different traditions) represented a victory for various special lobbies and a serious impediment for the future (Willcocks, 1962). A further

1. The following information was kindly supplied by the Department of the History of Medicine, King's College Hospital.

problem concerned the line drawn between the health and welfare services.

The Royal Commission on the law relating to mental illness and mental deficiency pointed out that

one aim of the reorganization of health and welfare services in 1948 was to distinguish between the social welfare functions and hospital functions of the public assistance institutions, which under the new legislation were divided between the new hospital service and the new local authority welfare service. But no similar attempt was made to distinguish between the hospital and social welfare functions of the mental hospitals, the mental deficiency institutions or those parts of the public assistance institutions set aside for patients detained under Section 24 of the Lunacy Act, 1890. All of them were transferred into the hospital service, although all of them, particularly the mental deficiency institutions, had always to some extent served both purposes. The mental deficiency institutions had always provided residential care not only for patients needing active training or continual nursing but also for many whose main need was a permanent home with some supervision. Mental hospitals, and even more the parts of the public assistance institutions in which persons were detained under the Lunacy Act, were accustomed to give more or less permanent 'asylum' to some patients, especially the elderly, who no longer needed active medical treatment but had no suitable home to which they could be discharged (Report of the Royal Commission, 1957).

The tripartite division of the NHS may be solved eventually by a new reorganization, putting all three components under one area health board (Green Paper, 1970) but throughout the period covered by the present work it complicated all attempts to plan a comprehensive service.

5.4. THE MENTAL HEALTH ACT, 1959 (A. D. Isaacs)

The period between the beginning of the NHS and the implementation of the Mental Health Act in 1960 was one of rapid change. The ideas of social treatment (rehabilitation and resettlement, the therapeutic community, early discharge and after-care, day-hospitals, domiciliary visiting, and a community service) swept through psychiatry, solidly backed by the introduction of the phenothiazines and later the antidepressant drugs. Some hospitals acted as pioneers, others lagged behind, but none was unaffected. Many had already developed 'dedesignated' admission units, to which patients could be admitted without any kind of legal restriction (even the signing of the 'voluntary' form). The Mental Health Act of 1959, allowed for admission without formality to any hospital and the special designation of mental

hospitals was ended. Compulsory admission became a matter for the judgement of medical practitioners; magistrates were no longer required to sign the order. The legal responsibility for patients was transferred from the medical superintendent of the hospital to the consultant psychiatrist who looked after the patient. This permitted psychiatric hospitals to adopt the administrative system of general hospitals in which responsibility is shared between a lay administrator, the medical committee, and the chief nursing officer. This system was soon adopted at Cane Hill (Hutchinson, 1963) and medical teams were established with responsibility for patients of both sexes. Against this background the community-based facilities underwent further development. In 1964 a short-stay in-patient unit was established at the same hospital thus providing the basis for a comprehensive psychiatric service for patients living in the former borough of Bermondsey and the adjacent part of Southwark (Oldham, 1969). At this stage Cane Hill relinquished responsibility for this part of its area, retaining, however, responsibility for Camberwell.

The Maudsley day-hospital opened in May 1953, accommodated in part of a large Victorian house within the grounds (Harris, 1954, 1956, 1957). The ideas behind its establishment and further development are discussed in Chapter 7. Another day-hospital was opened at Bethlem Royal Hospital in 1956 and one at St Olave's in Bermondsey in 1960.

5.5. HOSPITAL SERVICES OF CAMBERWELL IN 1964 (J. K. Wing)

The situation in 1964, when the Camberwell Register was first set up, was one of a rather traditional London service modified by the presence of an undergraduate and a postgraduate teaching hospital. Cane Hill, 15 miles away, was still responsible for the area, although it had only one out-patient clinic per week there, at St Giles's Hospital. Its consultants also conducted two sessions at St Francis's Hospital and one at King's College Hospital, mainly in order to select and facilitate the transfer of patients.

St Francis's observation ward admitted patients from all over London; treating a few, discharging many, and transferring the rest elsewhere. Very few patients were local. The observation ward and St Francis's geriatric hospital formed an isolated administrative unit. The observation ward was staffed medically by the joint Bethlem-Maudsley Hospital (Kenyon, 1968).

Maudsley and Bethlem Royal Hospitals provided an in-patient service for acutely ill patients in the early stages of illness, most of whom had a good prognosis. Patients came from all over the world but particularly from Greater London and the Home

Counties. Camberwell patients in this category were admitted, but if they had chronic or frequently relapsing illnesses they tended to be sent to Cane Hill. The joint hospital could provide an excellent rehabilitation service for a few individual local patients. There were night hospital places, a social club, prolonged follow-up, and a generous staff-patient ratio. A wide range of specialist units was also available (epilepsy ward, neurosurgical unit, adolescent and children's units, psychotherapy units, metabolic unit, and forensic unit), but these served patients from a very wide geographical area, including Metropolitan London, the Home Counties, and, to a lesser extent, the rest of the UK and overseas. Together, these units accounted for 229 of the joint hospital's beds; 246 being available for general purposes.

The Maudsley out-patient department, on the other hand, was very substantial and covered a large proportion of the needs of the area as well as a service for much of the rest of London. In particular, the emergency clinic and its twenty-four-hour service was much appreciated by GPs all over London from the time it was first set up in 1951. King's College Hospital also provided an out-patient service which had the attraction of no 'stigma', since the appointment was made to a general hospital and the patient did not need to identify which department he was attending. A few patients were also referred to Guy's Hospital at London Bridge.

5.6. LOCAL AUTHORITY SERVICES (J. K. Wing)

The local authority mental health services had their origins in the Poor Law system. We have seen that, before the passing of the National Health Services Act, the LCC was also responsible for the mental hospitals. Until 1948, the Relieving Officer was the person 'duly authorized' under the 1890 Lunacy Act to take proceedings in the case of certification. After 1948, a form of joint appointment was common, 'the duly authorized officer also being responsible for welfare services under part III of the National Assistance Act. Most of the DAO's had an excellent background of work in an administrative setting, but little social work experience, since the previous context of their work had been one in which principles and practice were somewhat rigidly laid down by higher authority' (Lawson, 1966).

The main duty was to see those referred to the mental welfare department as in urgent need of care and attention, for their own welfare or that of others, in order to decide whether admission to an observation ward on a three-day order was justified (Lawson, 1966; Miles, Loudon, and Rawnsley, 1961; Rehin, Houghton, and Martin, 1964). The mental welfare departments provided a

twenty-four-hour service. There were 22 duly authorized officers (16 full and 6 assistants) working for the LCC.

The Younghusband report on social workers (1959) pointed out that, over the country, no fewer than 623 DAOs had no qualifications, except (for some), length of service; 210 had the relieving officer's certificate; 96 had a degree or diploma in social science; 65 had mental nursing qualifications, and the remaining 95 had secretarial, administrative or clerical backgrounds, a total of 1,089 officers. London was rather worse than this record suggests, since its officers lacked training during their employment, except that they joined the staff as assistant, learnt what was expected of them on the job and were then promoted to full officer status.

However, with the implementation of the recommendations of the Younghusband Report (1959), the standard of training gradually rose.

At the time the Mental Health Act 1959 came into force, three categories of mental health social workers were employed by the LCC. There were a few fully qualified psychiatric social workers, mostly concerned with the child guidance service, and the duly authorized officers, exclusively men, to whom reference has been made above. The third category comprised the local assistant organizers, all women, who dealt with the bulk of the social work connected with the operation of the Mental Deficiency Acts. These three groups of workers were brought together in teams within the local authority health departments, which reduced specialization and widened the scope of the work. Former duly authorized officers were no longer responsible only for compulsory admissions but were able to develop a more therapeutic relationship with clients and their families. Further discussion of the role of local authority and hospital social workers will be found in Chapter 20.

The long tradition of service for the mentally retarded will be described in Chapter 23. The development of services for the mentally ill, apart from the social work functions mentioned above, was rather slower and less complete. The LCC set up a day rehabilitation centre near the Elephant and Castle and the borough a day-centre in Benhill Road, both mainly for patients who had been chronically ill. Several social clubs were run and recuperative holidays were provided in special cases. No residential hostels for the mentally ill were administered by the borough, although a few places were available in a hostel run by the neighbouring authority. Details of developments after 1964 will be found in Chapter 6.

The development of local authority services for the elderly also followed a prolonged and progressive course. In the earlier part of the nineteenth century, when children became a charge on the

parish owing to their parents deserting or becoming paupers, they were sent out to work with local farmers and businessmen. Following a public outcry in 1849 due to 150 such children dying from cholera, neglect, and starvation, 55 acres of an estate near Crystal Palace were acquired by the LCC and the North Surrey District School was built. This served as a school until 1937. After the Second World War, it was converted to take 318 homeless old men under Part III of the National Assistance Act, and a number of younger physically handicapped men, being renamed Orchard Lodge. The building has several times been due for demolition and it is now scheduled to remain only until 1975. Meanwhile the number of places is being run down. This is true of all the old-fashioned ex-public assistance institutions.

New premises are being built or acquired, under Part III of the National Assistance Act, to provide accommodation for old people. Most of those in Southwark are new, containing 60-100 places; some have accommodation in flatlets. There is also a holiday home at Bexhill, open all the year round. Some sheltered housing with a warden service is also available.

There is only one hostel specifically for mentally infirm old people (for example, with symptoms of mild dementia). This is Evelyn Coyle House. Inevitably, many people in Part III accommodation do develop such symptoms and physical diseases in addition. Formerly, there were small infirmaries attached to the larger public assistance institutions and transfers between the 'house' and hospital were arranged at the discretion of the matron, whose husband was usually the master of the institution. No hospital beds now remain. Welfare and hospital accommodation have rarely been planned together since they ceased to be under the same authority and there are inevitable complications in making transfers between them.

Other welfare services, such as domestic help, home laundry, 'meals-on-wheels', domiciliary occupational therapy, and so on, are fairly well-developed though the supply is limited and demand could theoretically outrun it very considerably if everyone who was entitled to a service asked for it.

These local authority welfare services have been discussed in rather more general terms than those which concern the health department, since they are of less immediate relevance to psychiatric problems. It should, however, be emphasized how very wide the range of local authority and voluntary social and welfare services is. The NHS provides opportunities for health care which do not exist in many developed countries but it could not have become as effective as it is if the social and welfare services had not

also been well developed. Other important local authority services, connected with the care of children, with education (including the state schools for educationally subnormal, maladjusted, aphasic, and physically frail or handicapped children) and with housing have not been discussed at all. To take one small example, those attending special schools or classes for autistic children are given free transport between home and school and an escort is provided free.

5.7. AREA HEALTH BOARDS AND LOCAL AUTHORITY SOCIAL SERVICE DEPARTMENTS (J. K. Wing)

The present chapter is not intended to describe changes which took place after 1964. Certain subsequent chapters contain an account of developments up to 1971 (see, for example, Chapter 6 for developments concerned with hospitals and hostels, Chapter 7 for developments concerned with day-care, and Chapter 23 for mental retardation services). However, it is necessary to mention the Seebohm Committee's (1968) recommendations which were implemented by the Social Services Act 1970, and the green papers on the reorganization of the NHS (1969-70). The borough of Southwark's Social Services Department began functioning on 1 April 1971. It includes the former welfare and children's departments and the social work functions of the health department. The remainder of the health department will in due course be incorporated within an integrated area health service, comprising hospital, local authority, and GP components. This service may cover several GLC boroughs.

Although the work described in this volume does not go beyond 1971, there will be considerable discussion of its relevance for the future, and the future may well be dominated by this separation between the social and the medical aspects of what clearly ought to be a joint sociomedical service. It is too soon to say how the social service will operate and the area health boards have not yet even been set up. Planning has to continue in spite of such difficulties and this volume would be less useful than it might be if such problems were not identified at the beginning.

6. Services for the destitute: Camberwell Reception Centre

(D. Tidmarsh)

The Camberwell Board of Guardians acquired the site of the present Reception Centre in 1866 from the Sisters of Nazareth House Convent, the building of the London, Chatham, and Dover

railway over the 4-acre site having made their way of life impossible. The buildings were adapted for use as an auxiliary workhouse and by 1877 housed 110 aged and infirm paupers many of whom were former tradesmen of the parish (Blanch, 1877). A casual ward and a new mixed workhouse were added in 1879 (Neate, 1971).

Under the 1834 Poor Law Amendment Act, with its insistence that no pauper should be better off than any independent labourer, the regime for both the mixed workhouse and the casual ward was harsh, the work soul-destroying, and the food appalling. In the 1890s it was softened somewhat by the introduction of toys for the children, tea and tobacco for the adults, and trained nurses for the sick. At about this time pauper uniforms were abolished. At the turn of the century the marginally improved but still harsh conditions in the casual ward, designed as they were to be worse than those of the workhouse, were described by Jack London.

The Royal Commission on the Poor Law, set up in 1905, initiated a gradual improvement culminating in the Poor Law Act 1930 by which the functions of the boards of guardians were divided between the public health and public assistance committees of the county and borough councils. The Camberwell Institution, as it was renamed, was administered for the LCC by its Public Assistance Committee, which dealt with the able-bodied, the healthy aged, and the infirm. The inmates of all the LCC's twenty-six institutions were classified and in the next decade transferred to the institution most suited to their needs. From 1930 to 1932 part of the Camberwell Institution was used as a non-residential training centre for suitable able-bodied paupers on outdoor relief (Neate, 1971). The conditions in casual wards, however, remained harsh and one such is described from his own bitter experience by George Orwell.

The LCC had plans to close the Camberwell Institution in 1939 because its buildings were thought to be too old and unsuitable for their purpose but the war intervened during which it was used for refugees. In 1946, a circular from the Ministry of Health laid down a set of new policies for vagrants, designed to abolish the casual ward and discourage wandering. However, the numbers of residents continued to rise.

In 1948, the National Assistance Act placed the executive responsibility for casuals and vagrants (now to be known as 'persons without a settled way of living') on the National Assistance Board, a central government agency, in place of the LCC which was to act only as agent. The Board's remit was 'to make provision whereby persons without a settled way of living may be influenced to lead a more settled life' and to 'provide and maintain centres, to

be known as reception centres, for the temporary board and lodging of such persons'.

Sick bays were instituted and a visiting medical officer appointed. Psychiatric problems were increasingly recognized and men referred to local clinics. Welfare officers were appointed and there was a resident representative from the local employment exchange. One of the dormitories was run as a hostel with better amenities for men who had found work. The regime remained strict, drab, and impersonal and the food was such that in the early 1950s men who had been dependent on it were found to be suffering from severe malnutrition (Hewetson, 1964).

Over this period the average number of men accommodated each night fluctuated between under 150 and 650. It is clear that the staff could not have classified, let alone done much to rehabilitate or resettle this great case-load of men with such intractable problems.

It has long been recognized that mental illness and poverty are associated. Thus Blanch (1877) records that, in 1675, 'a poor woman was reported to the parishioners in vestry assembled, to be lunatick and out of her wits for more than one yeare past'. Her disposal sorely puzzled them but she was eventually sent to the 'Hospitall of Bethlem' which cost the Parish of Camberwell 5s. a week, a sum for which an additional tax on the parishioners had to be levied.

Whiteley (1955), compared 48 men admitted to St Francis's observation ward from the Camberwell Reception Centre with 52 from a common lodging house. He found a higher proportion of schizophrenics amongst the Reception Centre admissions and commented on the high admission rate in this population. In a further study (Whiteley, 1958) he found that the admission rate for schizophrenia was some eight times that of the male population of London and that this excess was made up of readmissions. The few first admissions were of men who had only recently become destitute, suggesting that it is the mental illness which causes the social decline rather than vice versa. In 1964, Pamela Page worked as a psychiatric social worker at the Centre for four months. She found a large proportion of mentally ill men and felt that the impersonal setting was a sure method of encouraging degradation and deterioration. She saw men with schizophrenia, depression, alcoholism, epilepsy, and severe personality disorders as well as many physically handicapped and old. She commented on the lack of all kinds of after-care facilities and the need for long-term accommodation (Page, 1965).

A similar picture was presented by the visiting medical officers

to the Centre (Hewetson and Ollendorff, 1964). They contrasted the falling number of admissions to tuberculosis sanatoria with the rising number admitted to mental hospitals. An analysis of 417 psychiatric cases seen at the clinic revealed the following figures: schizophrenia 24 per cent, depression 21 per cent, alcoholism 17 per cent, epilepsy 14 per cent, neurosis 12 per cent, personality disorders 6 per cent, and miscellaneous conditions 6 per cent. Their figures show the preponderance of the severest forms of mental illness in this population.

In 1965 a census of one night's intake was conducted (Edwards *et al.*, 1968). Although the main emphasis of this exercise was on alcoholism, it was found that mental illness and alcoholism were each represented by some 25 per cent of the population. For the first time information was recorded on criminality; that 59 per cent of the clients were found to have served a prison sentence gives some indication of the problem these men present to society. It was concluded that the Centre was having to function simultaneously as an old people's home, a lodging house for the itinerant labourer, an alcoholism rehabilitation centre, a mental after-care hostel, a halfway house for discharged prisoners, and perhaps in a dozen other ways.

Thus at the time when the changes to be described in Chapter 6 began, the Camberwell Reception Centre was still a large Victorian institution for destitute men, coming from all over the country, with an enormous turnover and an almost unbelievable morbidity rate. It was suggested by the visiting medical officers that many of the mentally ill entrants were there because of the failure of mental hospitals to provide after-care for patients discharged from hospital while still handicapped. The 'early discharge policy' was then in full swing.

It can hardly be said that the Reception Centre was part of Camberwell's services: the rest of the borough wanted nothing to do with it. But, situated as it was and still is, right in the centre of the area, it serves as a reminder that the national statistics presented in the next chapter, and the descriptive statistics of the local mental health services given in Chapter 6, do not give the whole story. A recent survey of mental illness in the population of the Reception Centre will be described in more detail in Chapter 21 and, at this point, the implications for planning the mental health services of the future will be discussed in more detail.

*The statistical context:
comparisons with national
and local statistics*

*J. K. Wing, E. R. Bransby,
Anthea M. Hailey, and T. Fryers*

1. Introduction

(J. K. Wing)

The data in this chapter are all derived from the Mental Health Enquiry of England and Wales (which is concerned mainly with patients in psychiatric hospitals) or from the statistics of the Camberwell, Nottingham, Salford, and other registers. The purpose is to place Camberwell into context and to show how far its services are similar to those provided in other areas. Data from the Salford Register are now being collected to Camberwell specifications and it will in future be possible to produce identical tables. The material presented here allows only a sketchy comparison but this is sufficient to show some of the main similarities and differences between Camberwell and elsewhere.

Shepherd *et al.* (1966) estimate that approximately 10 per cent of people who attend a GP during a given year can be given a psychiatric diagnosis and approximately another 5 per cent have some associated condition of psychiatric significance. This estimated 15 per cent of the population with a psychiatric condition is much lower than the proportion indicated in some other work but it has the merit of being definable and it has a defined context. Only about 5 per cent of such patients are referred to a psychiatrist. The figures used in the rest of this book refer to *reported* prevalence, which is concerned only with patients in contact with those psychiatric services reporting to national and local registers.

Table 4.1. *One-day and one-year reported prevalence rates in four urban areas (rates per cent of population aged 15 and over)*

	<i>One-day prevalence</i>	<i>One-year prevalence</i>
Aberdeen City	0.854	1.775
31 December 1964		
Baltimore City (white)	1.156	1.998
30 June 1963		
Camberwell	0.861	2.051
31 December 1964		
City of Nottingham	0.838	1.964
30 September 1967		
Salford 1 January 1968	0.817	

Note: Data are taken from L. Wing *et al.* (1967), from the DHSS Statistical Report Series no. 13 and from Fryers, Freeman, and Mountney (1970).

Parts One to Six will refer only to mentally ill or disabled people, excluding the mentally retarded¹ who are considered in Part Seven.

2. Reported prevalence

(J. K. Wing, Anthea M. Hailey, E. R. Bransby, and T. Fryers)

Comparative one-day and one-year reported prevalence figures for five register areas are given in Table 4.1. These show that approximately 1 per cent of the adult population are in touch with psychiatric services on a given day and a further 1 per cent begin contact during the following year, making approximately 2 per cent in all during a given year. The figures are remarkably similar in the five areas, although one (Baltimore City) has a completely different service structure to the others. Figures for the Rochester, New York, Register, one in North Carolina and another in Hawaii (Bahn *et al.*, 1966), although not strictly comparable, also indicate this order of reported prevalence.

The age- and sex-specific rates for the one-day prevalence in Camberwell and Nottingham City are compared in Fig. 4.1. The prevalence comprises those who were in hospital or attending day-hospital on the given day, or who attended out-patient clinics before and after the day with a maximum gap of three months between visits. The remarkable similarity between register patterns.

1. The DHSS uses the term 'mentally handicapped' as a synonym for the WHO term 'mentally retarded'. This usage is most confusing and it is to be hoped that the DHSS will adopt international practice. The mentally handicapped are not, of course, all intellectually retarded.

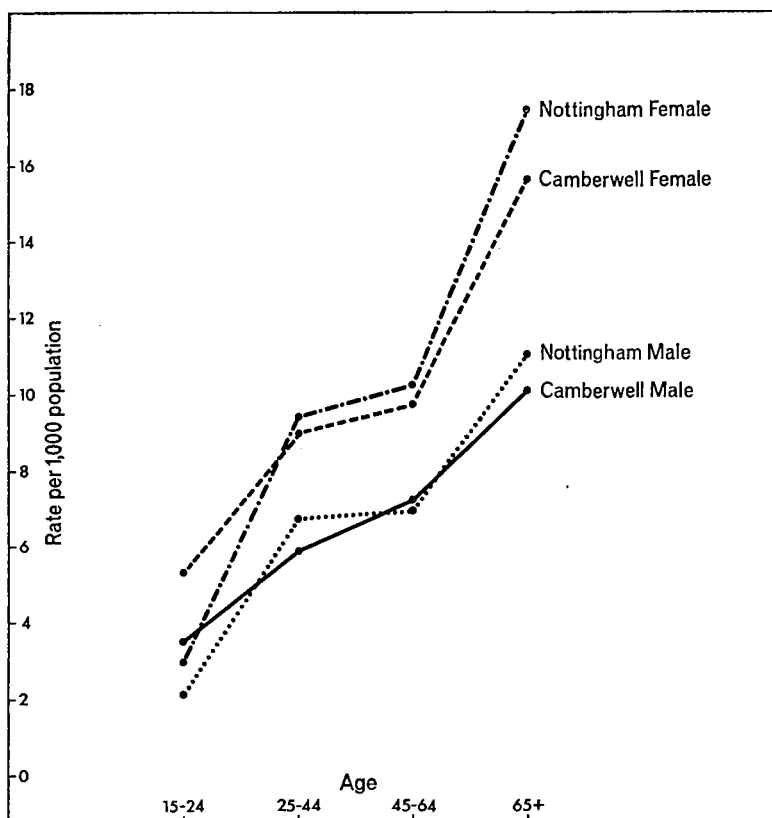


FIG. 4.1. One-day reported prevalence of patients on Camberwell Register (31 December 1968) and Nottingham Register (30 September 1967) (age- and sex-specific rates per 1,000 population).

already noted above, is shown in these graphs. It is also seen if the patterns are compared over several years. In general, one-day prevalence rises with age and is higher in women than in men.

The equivalent graphs for one-year prevalence are presented in Fig. 4.2. Although the patterns of contact are in general the same, the figures for people over the age of 75 are clearly much lower in Camberwell, suggesting that many of those with dementia who are cared for by psychiatric services in Nottingham are looked after in other facilities in Camberwell.

The comparative paper by L. Wing *et al.* (1967) indicated that, although the over-all one-year prevalence was similar in the areas studied, the detailed distribution in terms of various psychiatric services was rather different. Camberwell, in particular, used fewer

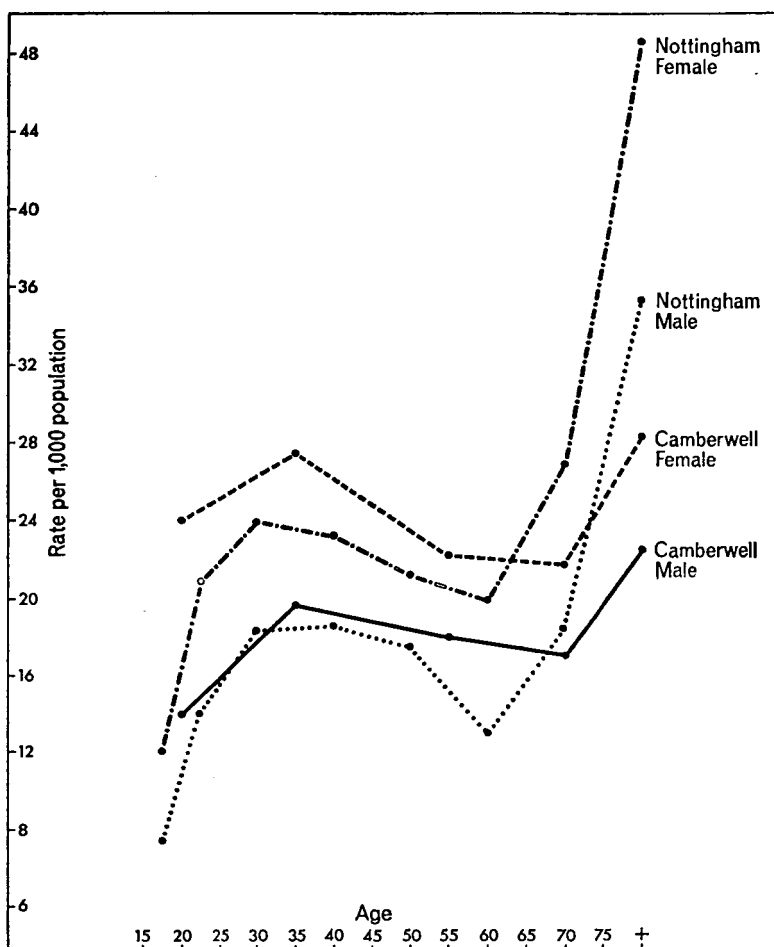


FIG. 4.2. One-year reported prevalence of patients on Camberwell Register (mean for 1968, 1969, 1970) and Nottingham Register (mean for 1967, 1968, 1969) (age- and sex-specific rates per 1,000).

hospital beds and more out-patient facilities than Baltimore. The changes in distribution over the years give a good idea of the dynamics of a service and Table 4.2 shows the context of change in Camberwell, which will be examined in detail in subsequent chapters. Comparative data for the Nottingham and Salford Registers will shortly be available. The general pattern is one of decreasing dependence on beds for long-stay patients, increasing numbers of day hospital places and increasing numbers of patients in a spell of out-patient contact.

Table 4.2. *Camberwell patients in different types of service contact on three census days (rates per 100,000 total population)*

Type of contact	31 December 1964	31 December 1968	30 June 1971
Population	173,360	170,780	169,480
In-patient:			
More than 1 year	240	205	172
2 months-1 year	40	58	45
Less than 2 months	47	46	45
Day-patient	8	12	20
Out-patient	264	314	354
Total one-day prevalence	599	635	636

Table 4.3. *Diagnostic categories assigned to Camberwell patients contacting psychiatric services during the years 1965, 1968, and 1970 (rates per 100,000 total population)*

Diagnosis*	1965	1968	1970
Schizophrenia	284	284	296
Affective psychoses	260	277	311
Organic psychoses	86	90	89
Depressive neuroses	404	473	453
Other neuroses	135	141	161
Other conditions, not known and no abnormality	287	384	431
Total	1,456	1,649	1,741

* For ICD equivalents of these diagnostic groups see Appendix. Note: Patients in hospital on the last day of the previous year included.

Table 4.3 summarizes the changes in Camberwell between 1965 and 1970 in terms of diagnostic categories (see Appendix for classification). The prevalence of schizophrenia and of organic psychoses does not much change over this six-year period but there is a moderate increase in the rate of all the affective disorders. The largest increase occurs within the category of 'other conditions' and is accounted for mainly by an increase in the number of patients with conditions classified as personality disorders, alcoholism, and marital problems. The over-all one-year reported prevalence increased from 1.5 to 1.7 per cent of the total Camberwell population.

Of more interest, however, is to consider these rates in terms of three components: (a) those in hospital at the beginning of each

year, three-quarters of whom are long-stay (see Table 4.2); (b) those admitted during the year; and (c) those who are treated only as day-patients or out-patients. Table 4.4 gives these separately for each diagnostic group using 1965, 1968, and 1970 by way of illustration. The rates are unduplicated; that is, they can be summed for each diagnostic condition within each year. Thus the total rate for schizophrenic psychoses reported in 1965 was 284 per 100,000 population, in 1968 it was still 284, and in 1970 it was 296. The proportion of patients in hospital on the three census days had decreased, the proportion admitted during the course of each of the three years had remained the same, and the proportion attending day-facilities or out-patient clinics had increased, so that the over-all reported prevalence remained much the same. This important observation needs to be checked over a longer time period and in other areas.

The changes in distribution of the organic psychoses (mostly senile dementia) are similar; there is a decrease in the number of in-patients and an increase in the number of day-patients and out-patients, the over-all one-year prevalence remaining much the same in 1970 as it had been in 1965. On the other hand, the affective disorders (the affective psychoses and the depressive and other neuroses) have shown an increase both in admissions during the year and in out-patient episodes, the over-all prevalence being higher in 1970 than in 1965. However, the largest increase has taken place in the category of 'other conditions', both in terms of admissions and of out-patient episodes.

In 1970, the one-year prevalence (1.7 per cent of the total population), was divided into 17 per cent schizophrenia, 5 per cent organic psychosis, 18 per cent affective psychosis, 26 per cent depressive neurosis, 9 per cent other neurosis, and 25 per cent other conditions (10 per cent personality disorders, alcohol, and other addictions).

Data concerning marital status may be found in L. Wing *et al.* (1967, 1970) and the DHSS Statistical Report Series no. 13. All registers show higher episode rates for single men and women than for married except in the youngest age-group, and for divorced compared with widowed or still-married people. L. Wing *et al.* (1967) showed that schizophrenic patients beginning a new episode of contact (i.e. after a period of at least three months out of contact) during 1965-7 were more likely to have been working in unskilled manual occupations than would be expected from the distribution of occupations in the general Camberwell population (a rate of 402 in class V compared with the over-all rate of 284 per 100,000). The same was true, however, of all other diagnostic

Table 4.4. Camberwell residents receiving in-patient care or receiving only out-patient or day-patient care during 1965, 1968, and 1970, by diagnosis (rates per 100,000 total population)

DIAGNOSIS*	1965 (pop. 172,710)			1968 (pop. 170,780)			1970 (pop. 169,480)		
	IP during year			IP during year			IP during year		
	IP on	Not IP on	IP	IP on	Not IP on	IP	IP on	Not IP on	IP
Schizophrenia	160	63	61	141	60	83	144	61	91
Affective psychoses	49	78	133	46	84	147	41	99	171
Organic psychoses	47	31	8	52	19	19	34	22	23
Depressive neuroses	18	68	318	20	88	365	26	69	358
Other neuroses	8	5	122	3	16	122	5	18	138
Other conditions, not known and no abnormality	47	50	190	53	64	267	41	78	312
Total	329	295	832	315	331	1,003	291	347	1,093

* For ICD equivalents of these diagnostic groups see Appendix.

conditions apart from the 'other neuroses'. In fact, 3 per cent of the unskilled manual population, compared with 2.3 per cent in the semi-skilled manual class (IV), 1.6 per cent in the skilled manual class (IIIB), 2.4 per cent in the skilled non-manual class (IIIA), and 1.4 per cent in classes I and II, began a new episode of contact during that period, irrespective of diagnosis. The same authors showed that patients born in the West Indies had high rates of schizophrenia while those born in Eire and Northern Ireland had rates equivalent to those in the native-born population; those born in other parts of the world also had high rates. Alcoholism, on the other hand, was high in the Irish but low in the West Indians; other rates were much the same whatever the birthplace.

Finally, an account of the statistical context in which the studies to be described in the rest of this book were made would not be complete without the presentation of the age and sex profiles of the major diagnostic categories. The rates used in Fig. 4.3 are inception rates, that is, first contacts with the Camberwell Register, during the five years, 1966-70, per 1,000 of the specific population. These rates should be divided by five to obtain the mean annual rate. The inception rate is not the same as the first-ever contact rate, which is the statistic one would like to present. However, most registers do not produce a first-ever contact rate for comparison, mainly because the proportion of 'not knowns' is so high. A patient may have had a first contact with a psychiatric service twenty or thirty years before first being reported to the register; or, if he has only recently moved into the register area he may be reported for the first time although this contact is, for him, only a continuation of a series which took place in the previous area. The Camberwell Register, which does collect this information, has a high proportion of not knowns and, in any case, the numbers in some of the age-sex cells are too small to calculate stable rates. The inception rates are therefore considerably larger than the first-ever contact rates. Even so, they have to be given for rather broad age-groups in order to obtain sufficient numbers. The inception rate includes patients who first make contact with out-patient or day-patient services, so that the first admission rate forms only a part of it.

Fig. 4.3 shows the age-sex profiles of six diagnostic groups in terms of five-year inception rates. Men only have a clear predominance in the schizophrenias, at least up to middle age. In nearly all the other conditions, females are predominant, except for the residual group which contains the personality disorders and addictions, where there is little difference. The age-patterns of the diagnostic groups are highly characteristic although there are some interesting sex differences, particularly in the affective psychoses

and depressive neuroses. The contrast with the age-patterns of prevalence rates (L. Wing *et al.*, 1967) is striking, since only dementia and affective psychosis in men show an increasing inception with age, while the other conditions reach a peak in early or late middle age or are the prerogative of young people. When another couple of years' data can be added it will be possible to examine these patterns using more detailed age-groups and more specific diagnoses.

The next two sections will be largely devoted to the admissions statistics for England and Wales collected by the DHSS, so that Camberwell can be seen in the national context.

3. Use of hospital beds

(J. K. Wing and Anthea M. Hailey)

3.1. RESIDENCE RATES

In 1969, 31 per cent of all the hospital beds in England and Wales were used by patients with mental illness, while a further 15 per

Table 4.5. *Patients in psychiatric hospitals on annual census days, 1954-69*
(Rates per 100,000 total population)

	Occupied beds per 100,000 total population	
	England and Wales* (31 December)	Scotland† (31 March)
1954	344	410
1955	339	412
1956	335	406
1957	328	408
1958	325	406
1959	315	400
1960	306	393
1961	299	386
1962	291	381
1963	283	373
1964	278	366
1965	269	368
1966	263	361
1967	256	355
1968	248	362
1969	238	356
1970	231	339

* DHSS Statistical Report Series no. 12.

† Baldwin (1971) and Heasman, M.
(personal communication).

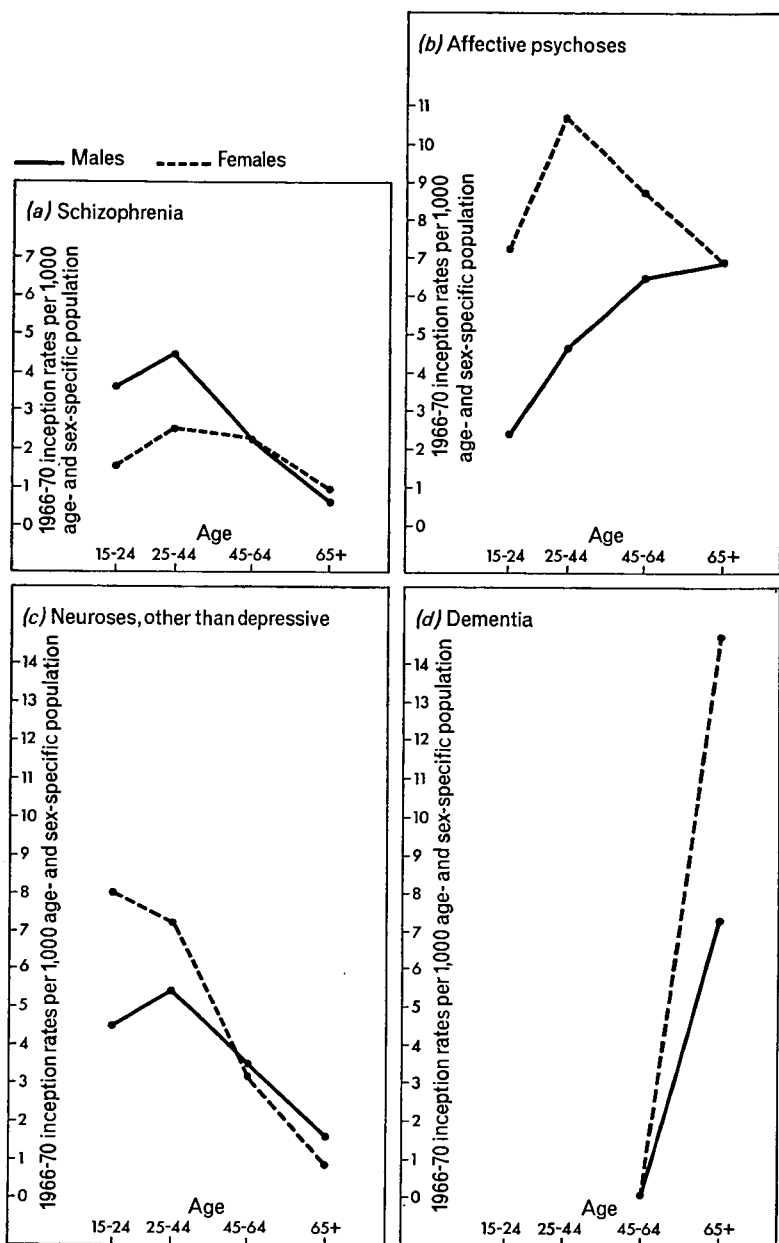


FIG. 4.3. Age-sex profiles of six diagnostic groups (five-year inception rates).

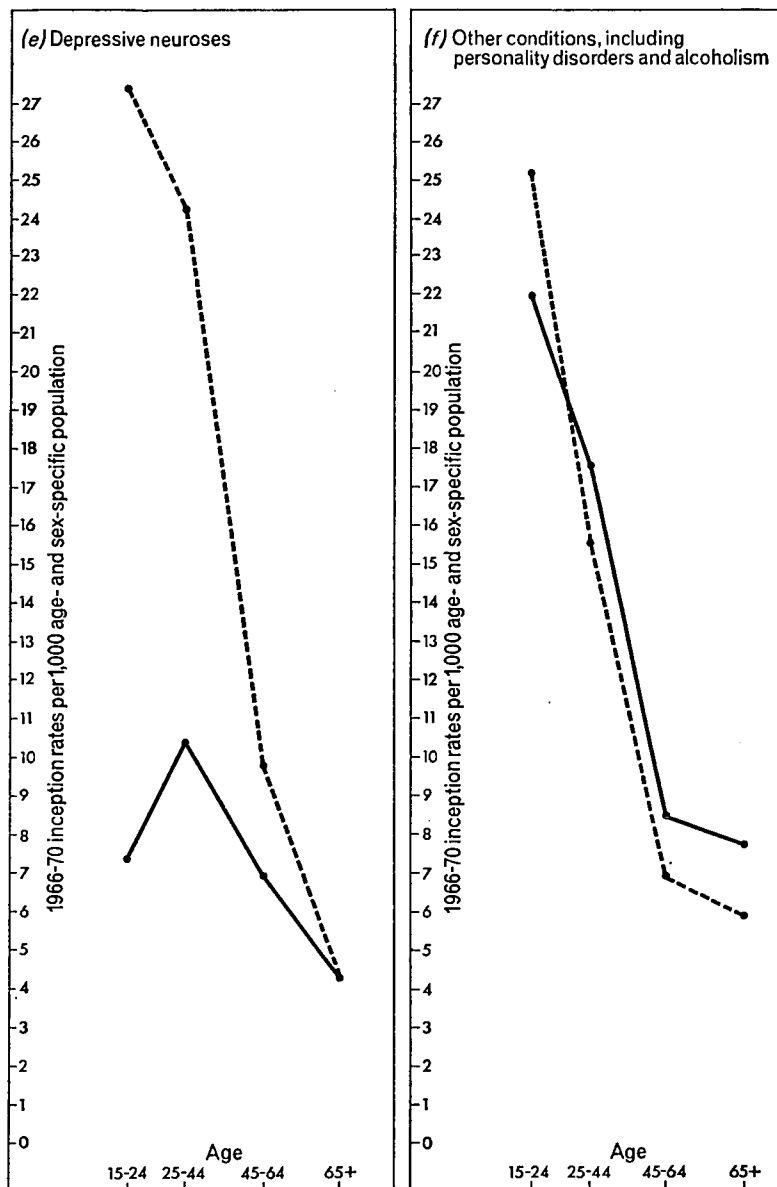


FIG. 4.3 (cont.)

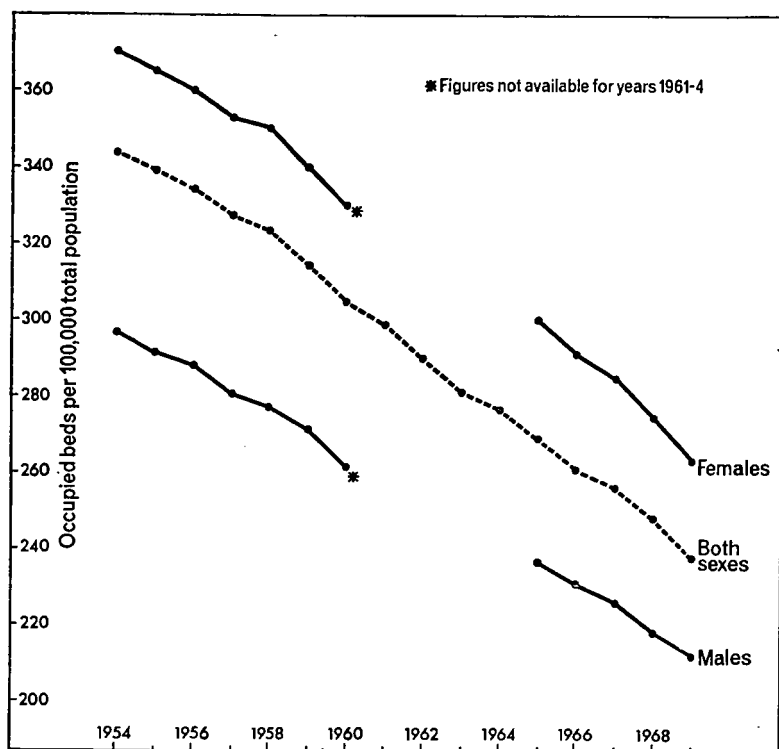


FIG. 4.4. Occupied beds in regional board hospitals, England and Wales, 31 December 1954 to 31 December 1969 (estimated rates per 100,000 total population).

cent were used by the mentally retarded; 46 per cent in all. On the other hand, only 2.5 per cent of all new out-patient referrals were attributable to psychiatric patients and only 4 per cent of all attendances (DHSS Annual Reports). It is clear, therefore, that the very high proportion of all hospital beds occupied by the mentally ill and retarded is due to the slow accumulation of long-stay patients over a long period of time. In fact, the number of beds in mental hospitals steadily increased throughout the whole of this century up to 1954, but then it quite unexpectedly began to decline. Table 4.5 gives the annual rates for England and Wales, compared with those of Scotland, during the period since then. In England and Wales the decline in numbers has been very steady, from 152,197 in 1954 to 116,275 in 1969. Fig. 4.4 shows that the trends are similar for men and women, though there have always been more beds for women patients. In Scotland, however, far

more beds are used than in England and Wales, and the drop is less spectacular and less sustained (Baldwin, 1971). In Denmark, there was little change in rate from 1957 to 1967, approximately 220 beds per 100,000 total population being available (Juel-Nielsen and Strömrgren, 1969).

Table 4.6. *Short- and long-stay residence rates on 31 December 1969: England and Wales, four Metropolitan regions, and Camberwell (sex-specific rates per 100,000 population)*

AREA	LENGTH OF STAY				TOTAL	
	Under 1 year		Over 1 year			
	M	F	M	F	M	F
England and Wales	55	74	156	190	211	264
Metropolitan regions	60	81	174	224	234	305
Camberwell	58	133	151	234	209	367

At the same time, both in England and Wales and in Scotland, the proportion of the authorized number of beds actually occupied has also gone down (in England and Wales, from 96.2 per cent in 1954 to 87.4 per cent in 1969).

There is considerable variation in different parts of England and Wales (Statistical Report Series no. 3). The Liverpool Region has the highest residence rate (303 per 100,000 in 1969) and the Oxford Region (157) the lowest. The four Metropolitan regional areas, covering London and the surrounding counties, also have a relatively high rate (271).

About three-quarters of the beds are occupied by patients who have been in hospital longer than one year. Women have higher rates than men, both in this long-stay group and in the shorter-stay. Table 4.6 compares the rates of long-stay and shorter-stay bed occupancy in England and Wales, the four Metropolitan regions and Camberwell. The Camberwell rates for men are in line with those of the Metropolitan regions and England and Wales but the rates for women are higher even than those of the Metropolitan area.

The age and sex-specific rates of patients occupying beds in regional board hospitals in England and Wales are given in Fig. 4.5 for men and in Fig. 4.6 for women; in each case separately for the years 1954 and 1969. Both graphs show very clearly the reduction in beds occupied. It has affected all age-groups except the very young and very old but is particularly striking in the age-groups 25-74.

The increase in rate with age which has always been a feature of

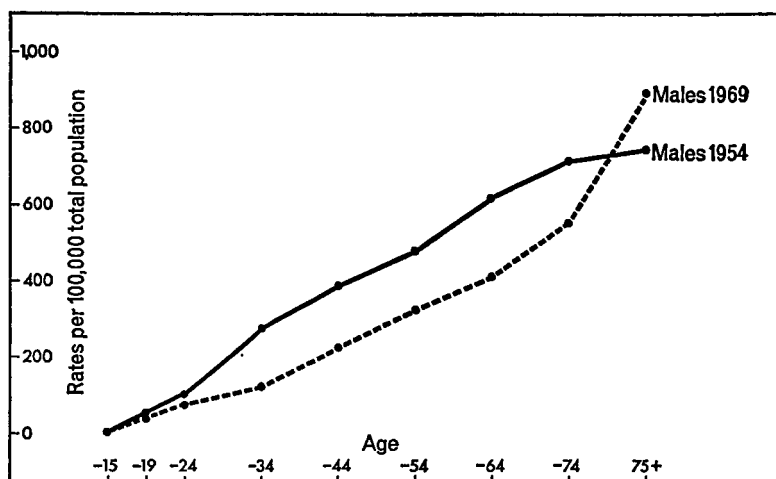


FIG. 4.5. Male patients occupying beds in regional board hospitals, England and Wales, 1954 and 1969 (age- and sex-specific rates per 100,000 total population).

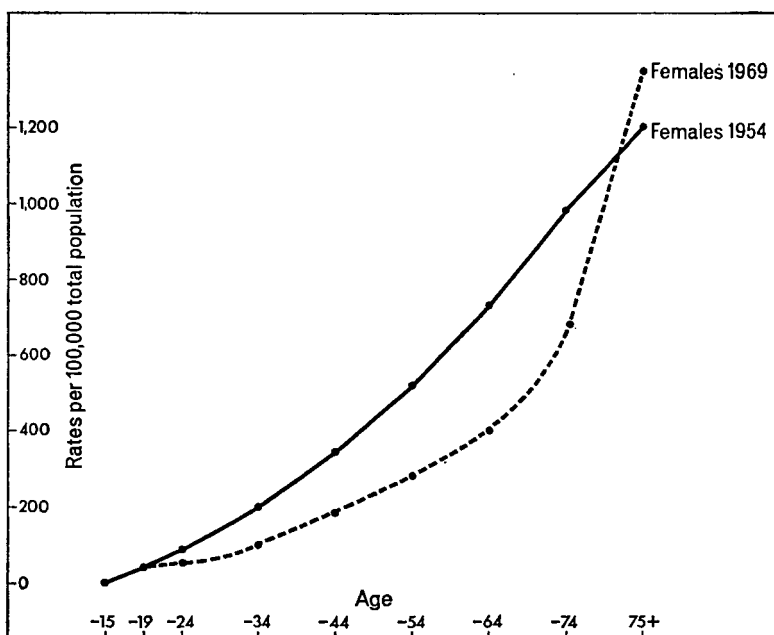


FIG. 4.6. Female patients occupying beds in regional board hospitals, England and Wales, 1954 and 1969 (age- and sex-specific rates per 100,000 total population).

psychiatric hospital residence rates was very obvious in 1954, but in 1969 it has become even more exaggerated, since there are fewer patients throughout most of the age-range and actually *more* over the age of 75. This increase goes against all the other trends, which are towards a decrease in bed usage. As the DHSS point out (Statistical Report Series no. 12), 'in the next decade the population of persons aged 65 and over will increase by almost one million and of these about half a million will be aged 75 and over; if the current pattern of hospitalization and trends continue, these would require an extra 8,000-9,000 beds mostly for persons aged 75 and over. Again, on the basis of existing trends, by the end of the next decade almost two-thirds of the patients in mental illness hospitals might be aged 65 and over.'

There is also a small increase in the numbers of beds provided for children under 15, from 183 in 1954 to 549 in 1969.

3.2. ADMISSIONS TO HOSPITAL

Fig. 4.7 shows that during the period 1954-69, in spite of the decrease in number of occupied beds, the rate of first admissions to psychiatric hospitals in England and Wales almost doubled. The rate for women was considerably higher than that for men and increased more rapidly. There was some indication, however, towards the end of the period, that the rate of increase was slackening off.

Fig. 4.8 gives the equivalent information for patients readmitted to hospital during each of these fifteen years. In this case, a definite plateau was reached by 1964 and there has been little change since then. Again, rates for women have stabilized at a considerably higher level than those for men.

The first admission rate for Camberwell was almost constant over the years 1965-9, between 140 and 150 per 100,000 total population, a figure which was considerably lower than the national rate. Readmissions increased steadily over the period, reaching 350 per 100,000 by 1969; this rate was a good deal higher than that for the whole of England and Wales. The explanation for this difference between national and Camberwell rates lies in the fact that the definition of 'first admission' is very much more strict for the Camberwell than for the national statistics. Brown, Parkes, and Wing (1961) found that 14 per cent of patients recorded on Mental Health Enquiry forms as first admissions to three mental hospitals in 1951 and 1956 had in fact been admitted previously. There were also many cases in which nothing was entered in the appropriate space so that the appropriate classification would have been 'not known' rather than 'first admission'. Approximately one-

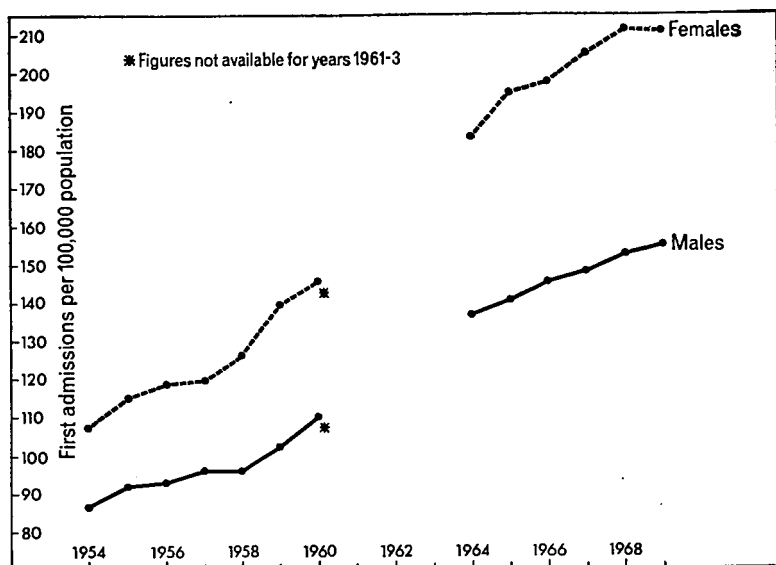


FIG. 4.7. First admissions to regional board hospitals, England and Wales, 1954-69 (rates per 100,000 total population).

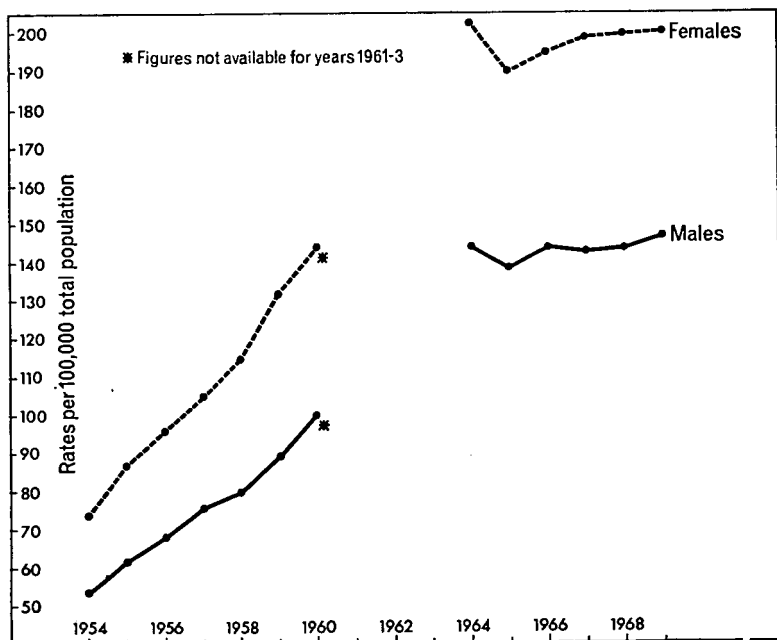


FIG. 4.8. Admissions, other than first, to regional board hospitals, England and Wales, 1954-69 (rates per 100,000 population).

third of such cases reported to the Camberwell Register have been previously admitted. It is likely, therefore, that the national first admission rate is too high and the readmissions rate too low. The national rates for 1970, which have been calculated by a different method, do show a closer approximation to the Camberwell figures (125 first admissions per 100,000; DHSS, 1971). Table 4.7 shows the Camberwell and national figures for 1970.

Table 4.7. *First admissions and readmissions in 1970. Camberwell and England and Wales. Numbers, and sex-specific rates per 100,000 total population.*

Type of admission		Camberwell		England and Wales†	
		M	F	M	F
First admissions	N	97	146	21,173	38,379
	Rate*	120	164	114	153
Readmissions	N	238	377	44,925	65,686
	Rate*	296	424	189	261
All admissions	N	335	523	66,098	104,065
	Rate	416	588	303	414

* Camberwell rates calculated using population figures shown in Table 3.8.

† Mental illness hospitals and units under regional hospital boards, all ages, England and Wales.

Source: Figures for England and Wales were kindly supplied by the DHSS.

A crude index of turnover may be calculated from the data given in Tables 4.6 and 4.7 which gives a figure for England and Wales of 5.5 for men and 5.6 for women. The equivalent figures for Camberwell are 7.2 and 4.4, which suggests that men stay a shorter period of time and women stay longer. In fact the index cannot be used in this crude way. A rough comparison of lengths of stay of Camberwell patients admitted during 1969 and followed for one year, with patients discharged from hospitals in England and Wales during one year who had stayed for less than 12 months, shows that the proportions staying under 1 month, 1-3 months, and 3-12 months were much the same for Camberwell men but considerably weighted towards a longer stay in Camberwell women. More detailed analyses need to be made using precisely comparable indices, which are not at the moment available for the national statistics, but it is very likely that men to some extent and women to a considerable extent tend to stay for longer periods in Camberwell hospitals. A considerable part of the difference, but not all, is probably due to the numbers staying for less than one month.

In 1970, 59,552 patients were admitted to regional board hospitals in England and Wales for the first time, and 110,611 on a

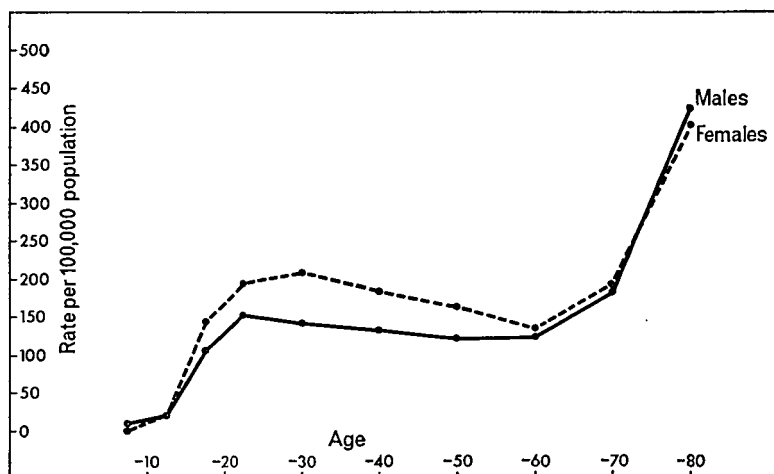


FIG. 4.9. First admissions to mental hospitals in England and Wales, 1970 (by age and sex). (Data kindly supplied by the DHSS.)

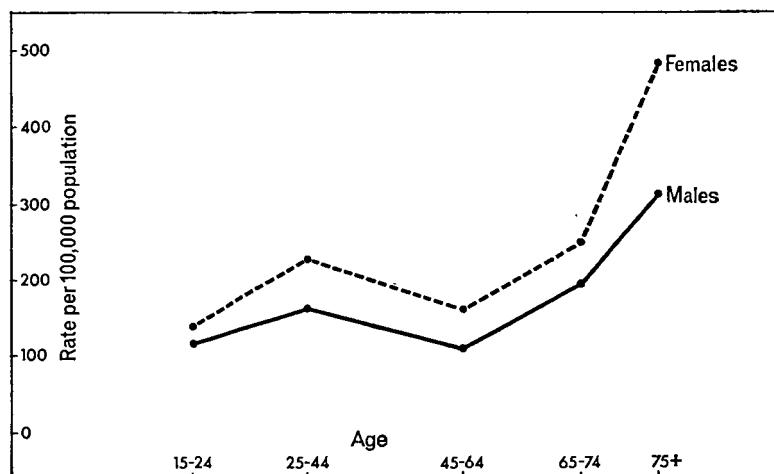


FIG. 4.10. First admissions from Camberwell (age- and sex-specific rates) (average for 1965-7).

second or subsequent occasion. The age- and sex-specific rates of first admitted patients are shown in Fig. 4.9. Rates for females are consistently higher than for males, except in children and in both sexes increase to a peak in young adulthood (25-34 in women, 19-24 in men), then decline somewhat in middle age and increase again sharply after 65 to a high peak at 75 years of age or more.

Table 4.8. *New* patients entering psychiatric day-hospitals, 1961-9. England and Wales.*

<i>New patients</i>		<i>New patients</i>	
1961	5,700	1966	16,340
1962	8,840	1967	17,350
1963	11,304	1968	18,743
1964	12,120	1969	20,730
1965	14,043		

* Patients who had not attended previously at the day-hospital during that year.

This is a very characteristic curve for contact data. It is very similar in the Camberwell data shown in Fig. 4.10 and is found also in data from the Nottingham Register (see Diagram 4 of Statistical Report Series no. 13).

Of patients admitted to psychiatric hospitals in 1969, only 17 per cent were under any kind of legal restraint. Sections 25 and 29 of the Mental Health Act, which are both short-term provisions, were most commonly used. The equivalent proportion in the four Metropolitan regions was 19 per cent, and in Camberwell was 14 per cent.

The commonest diagnostic group allocated was depressive psychosis (38 per cent). Schizophrenia accounted for 21 per cent, psychoneurosis for 13 per cent, personality disorders for 6 per cent, and alcoholism and other addictions for 5 per cent.

A gradually increasing proportion of patients is being admitted to units other than mental hospitals. In 1969, for example, 14 per cent of psychiatric patients were admitted to units in non-teaching general hospitals and 4 per cent to teaching hospitals.

4. Day-hospitals and out-patient clinics

(J. K. Wing and Anthea M. Hailey)

In 1956 there were 14 psychiatric units in England and Wales admitting day patients. Two years later there were 38. The increase in number of first referrals to day-hospitals during recent years has approximately paralleled the increase in first admissions to hospital, from 9,000 new referrals in 1962 to 20,000 in 1969 (CMO's Report for 1970). The figures are given in Table 4.8.

In 1967, a survey of fifteen selected day-hospitals was carried out by the DHSS (Statistical Report Series no. 7). The annual number of patients attending day-hospital for the first time per 100,000 local population varied from 16 to 132. Nearly all had previously received psychiatric care and most were referred from

the local psychiatric out-patient or in-patient departments. About one-third of men were given a diagnosis of schizophrenia, one-quarter affective (mainly depressive) psychoses, one-sixth personality disorders, and one-eighth neuroses. Among women, depressive psychoses accounted for almost one-half, neurotic disorders for about one-fifth, and schizophrenia one-sixth.

It is clear that, although day-hospitals are used for most kinds of patients, including those with acute and those with chronic conditions, there is as yet little uniformity of practice and some units tend to specialize mainly in one kind of patient. There are three main models; one based on the ward for acutely ill patients, one based on the longer-term rehabilitation unit (with workshops or at least some industrial work) and one combining both functions. The DHSS has suggested that 65 day-patient places are needed per 100,000 population, a figure which is beyond what is available in most areas at the moment even though about half of the places are for patients in wards. (Camberwell had 12.4 conventional day-hospital places per 100,000 at the end of 1971.)

There has been a tremendous increase in the numbers attending out-patient departments. A graph of the figures for first referrals and total attendances is given by Hill (1969). The trend is still continuing. First referrals increased from 319 per 100,000 population in 1966 to 359 per 100,000 in 1969, while total attendances went up from 2,083 to 2,309 per 100,000 between these two years. There was considerable variation between hospitals. There was an equivalent increase in new referrals and number of attendances at all out-patient clinics in regional board hospitals, not only psychiatric. Over-all, new psychiatric out-patients remained stable at about 2.5 per cent of all new referrals while all psychiatric attendances remained at about 4 per cent of the total. Teaching hospitals undertook more out-patient work than others.

The out-patient services available to Camberwell patients are considerably more extensive than the national figures would suggest. During 1969, there were 5,822 attendances per 100,000 population; some two and a half times the national rate.

Data given by the DHSS (Statistical Report Series no. 10) indicate that number of day-hospital attendances is linked to number of occupied beds, hospitals with relatively few occupied beds tending to have a high rate of day-patient attendance and vice versa. There is some evidence that rate of first referral to out-patient departments, and total out-patient attendances, are linked in a similar way, though the association is less striking. It seems reasonable to suppose that hospitals which are furthest from their catchment areas can provide less in the way of out-patient and day-

patient facilities and that they will have tended to accumulate more long-stay patients in the past. Moreover, day places can probably be substituted directly for in-patient beds to some extent.

These matters can usefully be studied on an international level (WHO, 1970) but the data are not yet precise enough to indicate clear answers.

5. Implications for planning

(J. K. Wing and Anthea M. Hailey)

In summary, the national statistics show a pattern of steadily increasing admissions both on first and subsequent occasions (though this is now levelling off), increasing use of out-patient facilities (both by new patients and by those who have been in contact before) and increasing referral to day-hospitals. Concomitantly, the number of beds used in psychiatric hospitals is steadily decreasing. Long-stay beds are particularly affected. However, there is a marked increase in the proportion of beds used by patients aged 75 and over. Similar trends may be observed in Scotland although there were many more mental hospital beds to start with and the trend towards a decrease was slow to get started. It is not yet certain how far it will proceed. In Denmark, there is no trend towards a lower residence rate but fewer beds were used to start with. There has been a much greater capital expenditure in Denmark on new units based on district general hospitals. Between 1948 and 1966, annual admissions more than doubled (from 13,000 to roughly 29,000). Day-hospital facilities were also extended. In 1967, there were 219 beds in all types of psychiatric hospitals per 100,000 population. Juel-Nielsen and Strömngren (1969) conclude 'that there is little reason to expect a decrease of pressure on Danish psychiatric institutions even if radical plans concerning a highly desirable development of out-patient facilities are carried into effect'.

It is very tempting to project any obvious statistical trends into the future. Tooth and Brooke (1961) made estimates of the rate of attrition in the long-stay (over two years) mental hospital population at the end of 1954, based on the run-down of the cohort during the following five years. By assuming a simple linear reduction, it appeared that these patients would all be dead or discharged after sixteen years (i.e. by 1970) and that, by then, a new long-stay group would have built up, amounting to 90 beds per 100,000 population (over two years stay). They also calculated that another 90 beds per 100,000 would be required for shorter-stay patients (under two years) making 180 per 100,000 in all. This

figure was adopted in the *Hospital Plan for England and Wales* (1962). It is clear from Table 4.5 that this prediction was off the mark. Basically, this was because the calculation assumed a linear rather than a curvilinear decrease of numbers in the long-stay group (Norton, 1961; Lindsay, 1962), leading to an overestimate in the rate of attrition. (This point will be referred to again in Chapter 9, section 2, when the Camberwell data are discussed.)

However, although statistical projections have been heavily criticized on such technical grounds, the chief reason for treating them with caution was stated by Baldwin (1969): 'The correct application of the projective technique in respect of the mental hospital plan would have been to determine the consequences of the decision to adopt a particular bed-population ratio not to determine the ratio.' In other words, residence statistics can only show what the trend is, not what the trend ought to be, and it is the latter question that planners need to answer. Further problems of over-all statistical projections have been examined by Rehin and Martin (1963) and Baldwin (1971), in particular the difficulty of dealing with regional variations and the complexities inherent in allowing for the development of competing or alternative services. From both points of view, bed-population ratios seem to represent only one element, and not necessarily the most central one, in a complex matrix of factors which planners need to take into account.

Finally, of course, there is the major difficulty that statistical projections may be used not only to learn what might be expected in the future but to justify the adoption of a policy that, if it works, will inevitably fulfil the prophecy. To some extent this is bound to occur if the prediction fits the planners' own ideas of what ought to happen. However, this involves another dimension of planning altogether; one based upon administrative and clinical value judgements rather than on evaluative research.

Just where mental health service planning in this country falls between these two extremes (unsubtle and rather rigid statistical projections on the one hand and *ad-hoc* administrative decision-making on the other) is not very clear. The figures most recently recommended from the DHSS are not accompanied by a detailed justification. It is suggested that only 50 beds will be needed for mentally ill adults per 100,000 population, together with 65 day-places and 'adequate' local authority services. The basis for these plans is most probably clinical judgement. The Chief Medical Officer wrote in his annual report for 1968: 'Experience in a number of areas, both in London and in the provinces, has suggested that a minimum provision of 0.5 beds per 1,000 may be

sufficient for adult mental illness.' These could be placed in district general hospitals and 'totally replace the old mental hospitals'. Three papers supporting figures of 0.35, 0.5, and 0.7 beds per 1,000 population were quoted in the annual report for 1970. All were by clinicians who felt understandably proud of the achievements of their own services. Their papers do not contain enough detail to allow an evaluation of the services described; in particular, to assess what strains are felt by patients and relatives. Nor do they give grounds for confidence concerning the provision of supporting services or staff (Downham, 1967; Baker, 1969; Oldham, 1969). None of the work which has attempted to evaluate these matters independently was mentioned.

The disadvantage of arguments based simply on what it is *possible* to do in selected areas is that no attention need be given to the quality of the service offered. The only way to clarify the concept of 'need' is to consider the functioning of all the community services, not only the in-patient facilities, in the light of their effect on the disabilities, behaviour, and attitudes of patients, social factors such as poverty and overcrowding, morbidity in relatives, and the general burden to them and to the community. These matters can be investigated, and it was suggested in Chapter 2 that it is an essential part of evaluative work to study them. Equally, planning must take them into account as well. The present volume is mainly concerned with the development and modification of services in one small area of London, and with statistical data describing these events. How far these statistics accord with the DHSS's plan will become clear in subsequent chapters, particularly Chapters 6 and 9. Wider questions concerning matters of value and evaluation will be left for Chapters 22 and 25 but there they will be discussed in detail.

APPENDIX

The equivalent *ICD* (8th revision) groupings for the Camberwell Register ten-fold classification are as follows:

Register classes	<i>ICD</i> numbers
1. Affective psychoses	296, 298.0, 298.1
2. Schizophrenia	295
3. Other functional psychoses	297, 299, 298.2, 298.3, 298.9
4. Depressive neuroses	300.4
5. Other neuroses	300.0-3, 300.5-9, 305
6. Alcohol and other addictions	303, 304
7. Senile and presenile dementia	290
8. Other organic conditions	291, 292, 293, 294, 309
9. Personality disorders	301, 302
10. Other, not known, and no abnormality	306, 307, 309, 310-15

The use of child psychiatric services in three urban areas: an international case-register study

*Lorna Wing, J. A. Baldwin, and
Beatrice M. Rosen*

1. Introduction

1.1. PREVIOUS STUDIES

The use of adult psychiatric services in Aberdeen in Scotland, Baltimore in Maryland, and Camberwell in London was compared on the basis of one year reported prevalence data from the case registers covering these areas by Wing *et al.* (1967) (see Chapter 4). Although certain differences in sex-, age-, and diagnosis-specific rates were found, the similarities were more striking, the one-day reported prevalence in all three areas being about 1 per cent of the adult population at risk with a further 1 per cent reported during the subsequent twelve months.

Children aged under 15 years were omitted from the earlier study since psychiatric conditions in this age-group present particular difficulties in diagnostic classification and in making valid comparisons, numbers are smaller than for adults so that a longer time period may be required to amass an adequate number of cases for analysis, and the points of interest differ from adult psychiatry. This chapter completes the comparison of the three areas by focusing on the 0-14-year age-group.

Some work on children and adolescents from both Baltimore and Aberdeen has been reported already. Bahn, Chandler, and Eisenberg (1962) studied the course of out-patient clinic care in relation to psychiatric diagnosis in 5,000 admissions of Maryland residents aged under 20 during eighteen months from 1 July 1958. They demonstrated differences between diagnostic groups in

respect of number of diagnostic interviews, referral to hospital care, amount of out-patient treatment and rate of improvement. Bahn and Oleinick (1966) followed 5,000 adolescents aged 12-17 years over an average of eighteen months after first admission to the Maryland Register. About 16 per cent had multiple admissions and could be distinguished in terms of residential area, type of care, diagnosis, and referral agent from those having one completed admission and those having an unterminated admission of over a year's duration.

Using the register, Baldwin (1968) studied reported incidence in children and Adolescents from the North-East Region of Scotland and showed sex- and age-specific rate patterns associated with diagnosis, urban and rural residence, social class, referral agent, and type of service entered. In an extension of this study Baldwin, Robertson, and Satin (1971) showed that the combined annual incidence of deviant behaviour reported from psychiatric, guidance, and probation services, when overlap caused by reporting the same patient from more than one service had been eliminated, was over 1.8 per cent of males and 0.6 per cent of females aged 2-16 years in the population at risk, whereas the rate for psychiatric services was about 0.4 per cent of males and 0.25 per cent of females.

1.2. THE THREE REGISTER AREAS

The Maryland and North-East Scottish register areas were described by Wing *et al.* (1967), and fuller descriptions have been published (Baldwin and Millar, 1964; Bahn, 1967). As in the comparative study of adult services, only the three urban areas will be considered in this chapter. Camberwell is the smallest of the three, but is part of the Metropolitan area of London. Aberdeen city is a university and marketing centre for the agricultural north-east of Scotland and is only slightly larger than the Camberwell district. Baltimore is an industrial city of almost a million, having large slum areas, high rates for many physical disorders, and up to 40 per cent non-white population.

The populations at risk of entering the psychiatric services in the three areas close to the reference period of the study are shown in Table 5.1. Baltimore had the youngest population with nearly 31 per cent under 15 years old, whereas Aberdeen and Camberwell had 24 and 22 per cent respectively. The proportions in the 0-4 and 5-9 age-groups were notably high in Baltimore. Presumably the lower proportions with increasing age in Baltimore and to some extent in Camberwell reflect out-migration of families with school-age children in these areas, contrasting with the lack of

Table 5.1. Population estimates for Aberdeen, Baltimore, and Camberwell

AGE	ABERDEEN			BALTIMORE			CAMBERWELL		
	(1966 10 per cent sample census)			(7 Jan. 1965 estimate)			(1966 10 per cent sample census corrected for under-enumeration)		
	M	F	Total	M	F	Total	M	F	Total
0-4	7,340	7,110	14,450	51,060	51,120	102,180	7,710	7,350	15,060
5-9	7,510	7,210	14,720	50,058	50,122	100,180	6,300	6,180	12,480
10-14	7,290	7,040	14,330	39,472	39,408	78,880	5,510	5,410	10,920
0-14	22,140	21,360	43,500	140,590	140,650	281,240	19,520	18,940	38,460
15+	62,960	77,610	140,570	300,900	335,610	636,510	62,410	71,200	133,610
Grand total	85,100	98,970	184,070	441,490	476,260	917,750	81,930	90,140	172,070

Note: The figures used in all the tables include the white and the non-white population and patients of no settled address as well as residents of the area.

mobility in Aberdeen. The sexes were fairly evenly balanced in the childhood age-groups in all three areas, but Baltimore was distinctive in having more females than males in the two youngest age-groups. Males were slightly more numerous in all childhood age-groups in Aberdeen and Camberwell, and in the 10-14 group in Baltimore. Females predominated among adults in all three areas.

1.3. PSYCHIATRIC SERVICES FOR CHILDREN

(a) *Aberdeen*

Child psychiatric services in Aberdeen were centred on the children's hospital where there was a child psychiatric out-patient clinic and a 10-bed in-patient unit. Child psychiatric consultation was provided to the city education authority child guidance clinic, the only guidance service in the area. These services were staffed by a full-time consultant psychiatrist and one other full-time psychiatrist in training. Another consultant psychiatrist also conducted clinics at the child guidance centre part-time. Children, particularly in the 10-14 age-group, were also often seen in the Ross Clinic, a regional treatment centre mainly for adults, but were very rarely admitted to the mental hospitals (Baldwin, 1968). The education authority child guidance clinic operated an extensive programme of psychological testing, mainly in relation to learning difficulties. Only the small fraction of children who, in the opinion of the guidance staff of psychologists and social workers, evidenced emotional disorder were referred to the visiting psychiatrists (Baldwin, Robertson, and Satin, 1971). Only children actually seen by a psychiatrist were included in the register. There were no private child psychiatric facilities and very few children went outside the area for treatment.

(b) *Baltimore*

In Baltimore there were 9 clinics for children and adolescents only, and 16 serving all age-groups, all run by psychiatrists. There was also a large programme of psychological testing and counselling in the public (i.e. state) school system taking between 5,000 and 10,000 children a year. Only a small proportion reached psychiatric services, and the programme may have had the effect of lowering rates obtained from the psychiatric case-register. There was a separate programme for retarded children. Private mental hospitals, general hospital psychiatric in-patient services, and private out-patient psychiatric clinics reported to the register. Private practitioners did not. Their number, and the number of cases they treated, is not known.

(c) Camberwell

In Camberwell, the great majority of the children referred to a psychiatric service attended either the Maudsley children's department, or the child guidance clinic at Belgrave Hospital, which is part of King's College Hospital. A smaller number attended the Inner London Education Authority child guidance clinic at Peckham (out-patients only) and a very few were seen at other London teaching hospitals, especially Guy's Hospital and the Hospital for Sick Children at Great Ormond Street. Educational psychologists employed by the Inner London Education Authority saw some schoolchildren with learning problems, but the size of this service was much smaller than the psychological service in the state school system in Baltimore, or the education authority's child guidance clinic in Aberdeen. As in the other areas, only children actually seen by a psychiatrist were included in the tables given in this paper. Investigations made when the register was set up indicated that the number of children treated privately was negligible.

The presence of child assessment, guidance, and counselling services with no clearcut relationship with psychiatric services introduces an important element of uncertainty in estimates of rates of child psychiatric disorder. In each of the areas studied it seems likely that rates based on register data, which represent only specialist treated morbidity (excluding private psychiatric practitioners' patients in Baltimore), are marked underestimates of true morbidity levels. This indeterminacy must be kept in mind in interpreting the results of the study presented in this chapter, which can only reflect at all accurately the use of the specified psychiatric services. Comparisons with results of community studies of psychiatric morbidity in children may be helpful in assessing the extent of the underestimate and are considered in the discussion.

2. Method

The comparisons to be discussed below are based on the two-year reported prevalence rate of contacts with psychiatric services in the three areas. A two-year period, instead of the more conventional one year, was chosen in order to ensure that the numbers were sufficient for valid comparisons.

In this chapter, one-day reported prevalence rates for patients currently in contact with a psychiatric service are given for 31 December 1964 (Aberdeen and Camberwell) and for 30 June 1964

(Baltimore). Other patients, not counted in the one-day census, who began a new episode of contact in the subsequent two years are dealt with separately. The two groups of figures were summed to give two-year prevalence rates. All rates are given per 10,000 of the appropriate general population. (For Camberwell, the population base used was the 1966 10 per cent sample corrected for under enumeration [see Table 5.1].)

The definition of current contact with a psychiatric service used to obtain one-day census rates in general included everyone who was an in- or a day-patient on the specified day and all out-patients who had been in contact with the services during the previous three months. However, there were minor variations between the registers. In particular, in Baltimore, a patient who had had his final clinic interview might, for clerical convenience, have been kept on the list of active cases until three months after his last contact. This would have the effect of inflating the one-day prevalence rates in Baltimore in comparison with the other areas.

3. Results

3.1. COMPARISON OF PREVALENCE RATES FOR CHILDREN AND ADULTS

Table 5.2 compares the reported prevalence rates obtained from the three registers for children and adults. It gives these for a one-day census, for new episodes over two years, a two-year prevalence, and for patients admitted to in-patient care in the course of two years.

Table 5.2. *Adults and children in contact with psychiatric services: age and sex (age- and sex-specific rates per 10,000)*

AGE	ABERDEEN			BALTIMORE			CAMBERWELL		
	M	F	Total	M	F	Total	M	F	Total
<i>One-day prevalence</i>									
	31 Dec. 1964			30 June 1964			31 Dec. 1964		
0-14	27.10	11.70	19.54	32.25	15.87	24.04	25.10	11.08	18.20
15+	78.46	85.43	82.31	121.99	103.43	111.72	79.64	96.91	88.84
<i>New episodes during two years</i>									
	1 Jan. 1965-31 Dec. 1966			1 July 1964-30 June 1966			1 Jan. 1965-31 Dec. 1966		
0-14	95.30	43.54	69.89	73.39	37.17	55.29	130.63	72.34	101.92
15+	148.67	189.28	171.09	170.16	108.70	137.75	175.29	247.19	213.61
<i>Total two-year prevalence</i>									
	31 Dec. 1964-31 Dec. 1966			30 June 1964-30 June 1966			31 Dec. 1964-31 Dec. 1966		
0-14	122.40	55.24	89.43	105.63	53.04	79.33	155.73	83.42	120.12
15+	227.13	274.71	253.40	291.14	212.10	249.47	254.93	344.10	302.45
<i>Number of patients admitted for in-patient care during two years</i>									
	1 Jan. 1965-31 Dec. 1966			1 July 1964-30 June 1966			1 Jan. 1965-31 Dec. 1966		
0-14	8.58	4.21	6.44	10.46	4.48	7.47	2.56	4.75	3.64
15+	53.21	69.32	62.10	136.72	75.00	104.18	61.21	86.52	74.70

The reported prevalence rates for adults (which included white and non-white residents and those with no settled address) were considerably higher than those for children in all three areas. The difference as seen in the one-day prevalence rates was even more marked than in the new episodes. The most striking discrepancy was in the rates for in-patient care, which varied from ten times higher in adults than in children (Aberdeen) to twenty times higher (Camberwell).

The rates for boys were higher than for girls in all three areas. The reverse was true for men and women in Aberdeen and Camberwell, though not in Baltimore. Even in Baltimore, however, the male:female ratio was much higher for children than for adults.

3.2. TOTAL PREVALENCE RATES FOR CHILDREN

The one-day census rates for the three areas were fairly similar, with Baltimore highest, then Aberdeen, closely followed by Camberwell. The picture was quite different for the new episodes over two years. Here Camberwell's reported prevalence rate was much the highest, with Aberdeen second and Baltimore lowest. The discrepancies in this second measure were so large that the descending order of Camberwell, Aberdeen, and Baltimore was preserved in the total two-year reported prevalence rates. The rates for in-patients, however, showed that Baltimore was the highest, with Aberdeen second, and Camberwell lowest.

Table 5.3. *Children in contact with the Baltimore psychiatric services: ethnic origin (age- and race-specific rates per 10,000 population) (two-year prevalence).*

	<i>White</i>	<i>Non-white</i>	<i>Total</i>
0-4	20.43	19.53	19.96
5-9	98.72	77.66	87.54
10-14	132.71	161.30	145.79
0-14	81.59	77.12	79.33

Table 5.3, giving the ethnic origin of the Baltimore children, shows that the rates were slightly higher for the white as compared with the non-white children, but the differences were too small to explain the low two-year reported prevalence rate for this area.

3.3. DIFFERENCES IN PREVALENCE RATES FOR BOYS AND GIRLS

Table 5.4 shows that the boy:girl ratio was roughly 2:1 in all three areas. In general the rates for both sexes increased with age.

Table 5.4. *Children in contact with psychiatric services: age and sex (age- and sex-specific rates per 10,000 population) (two-year prevalence)*

AGE	ABERDEEN			BALTIMORE			CAMBERWELL		
	M	F	Total	M	F	Total	M	F	Total
	31 Dec. 1964-31 Dec. 1966	31 Dec. 1964-31 Dec. 1966	31 Dec. 1964-31 Dec. 1966	30 June 1964-30 June 1966	30 June 1964-30 June 1966	30 June 1964-30 June 1966	31 Dec. 1964-31 Dec. 1966	31 Dec. 1964-31 Dec. 1966	31 Dec. 1964-31 Dec. 1966
0-4	39.51	21.10	30.45	24.87	15.06	19.96	76.53	24.50	51.13
5-9	174.43	59.64	118.21	117.66	57.46	87.54	190.43	100.31	145.83
10-14	152.26	85.23	119.23	194.82	96.68	145.79	226.88	144.14	185.91
0-14	122.40	55.24	89.43	105.63	53.04	79.33	155.74	83.42	120.12

The only exception was that for the boys aged 5-9 in Aberdeen, who had the highest rate for any age-sex group in that area.

3.4. DIAGNOSIS

It is not possible to make valid comparisons of diagnostic categories between the three areas. In Aberdeen, some of the children's diagnoses were classified according to the *International Classification of Diseases*, 7th revision (WHO, 1957), but in most cases a private system, recommended in 1966 by the RMPA Child Psychiatry Section, Scottish branch, was used. (This was based on six main groups, namely, organic, psychosomatic, behaviour disorders, psychosis, subnormality, and other.) Classification of diagnosis in Baltimore was according to the American Psychiatric Association's system (American Psychiatric Association, 1965; Spitzer and Wilson, 1968). The Camberwell Register used a system of its own based on the suggestions made by the WHO committee on classification of children's psychiatric conditions (Rutter *et al.*, 1969) and by Wing (1970).

Table 5.5 gives the nearest approximation possible to a diagnostic comparison. Despite the discrepancies between the systems of classification, it is clear that the largest single category in each of the areas was that covered by the label 'behaviour disorders'.

The rate for 'neurosis' in Aberdeen was considerably higher than that in the other areas, but this was likely to be due to the inclusion of some of the conditions which, in other areas, would be classified as behaviour disorders.

4. Discussion

4.1. COMPARISON OF PREVALENCE RATES FOR CHILDREN AND ADULTS

In Aberdeen and Baltimore, the two-year reported prevalence rates for children were approximately one-third of those of the adults in the same areas. In Camberwell, the children's rate was almost half that of the adults. The significance of these ratios depends upon the

Table 5.5. Children in contact with psychiatric services: diagnosis (sex-specific rates per 10,000 population (two-year prevalence))

DIAGNOSIS	ABERDEEN			BALTIMORE			CAMBERWELL		
	M 31 Dec. 1964-31 Dec. 1966	F 31 Dec. 1966	Total	M 30 June 1964-30 June 1966	F 30 June 1966	Total	M 31 Dec. 1964-31 Dec. 1966	F 31 Dec. 1966	Total
Behaviour disorders	73.17	27.62	50.80	63.49	31.59*	47.55*	113.22	63.89	88.92
Neuroses	25.75	12.64	19.31	4.90	4.23	4.54	9.73	5.81	7.80
Psychoses	0.90	0.94	0.92	2.50	1.31	1.90	4.61	1.58	3.12
Organic disorders	6.32	2.81	4.60	5.97	2.31	4.14	10.76	5.81	8.32
Mental deficiency	2.26	2.81	2.53	6.83	3.32	5.08	—	—	—†
Other	7.23	3.28	5.29	0.38	0.20	0.29	12.30	1.58	7.02
No psychiatric disorder	2.71	2.81	2.76	2.31	0.81	1.56	4.61	3.17	3.90
Not diagnosed	0.90	0.47	0.69	13.28	5.24	9.27	0.51	1.58	1.04
N/A N/K	3.16	1.87	2.53	5.97	4.03	4.98	—	—	—
Total	122.40	55.24	89.43	105.63	53.04	79.33	155.74	83.42	120.12

* Children with the diagnosis 'personality disorder' and 'transient situational personality disorder' were included here.

† The Camberwell children attending psychiatric clinics who were mentally retarded were variously classified under 'organic disorders', 'other', and 'psychoses'.

true prevalence of psychiatric conditions in the total population, concerning which there is only a limited amount of information.

Rutter, Tizard, and Whitmore (1970) calculated from the results of screening the entire 10- and 11-year-old population of the Isle of Wight that, in this group, the one-year prevalence of clinically significant psychiatric conditions (affecting the child's emotions, behaviour or relationships) was 6.8 per cent. A previous survey in Aberdeen (using questionnaires only) produced a very similar figure (Rutter, 1967; Rutter *et al.*, 1970). However, Rutter (1972) and Berger and Yule (1972) also examined a sample of the 10-year-old school population in Camberwell and the results suggested that the rates for Camberwell were more than twice those for the Isle of Wight. The rates for Baltimore City are likely to be nearer to those of Camberwell than for the rural Isle of Wight.

With regard to the true prevalence rates for adults, Shepherd *et al.* (1966) found that, in the course of one year, 10 per cent of people registered with the general practices in Greater London that were studied saw their family doctor because of a psychiatric condition.

The various figures given above can be applied only tentatively to the three areas, and, in the case of the children's studies, they refer to a very small age range, but they do suggest that children with psychiatric conditions are less likely to be referred to clinics than are adults.

The problems shown by children referred to psychiatrists are, in the main, different from those seen in adults. Neurotic behaviour disorders and conduct disorders together formed by far the largest group in the three areas studied here, and Rutter *et al.* (1970) noted similar findings in their study of true prevalence. Wolff (1967) reported significant differences between children referred to a child guidance clinic and a control group of non-referred children, especially in the high prevalence of antisocial behaviour, soiling, and enuresis in the clinic group. However, Shepherd *et al.* (1971) were able to match a group of school-age children referred to child guidance clinics (from which were excluded children with epilepsy, psychosis, or brain damage, those in residential care, and those referred by the courts or probation officers) with children who had similar disturbances but who had not been referred to a psychiatrist. Differences in severity between the matched pairs were not significant and the major factor seemed to be that the mothers of the clinic children were more likely to worry about their children's problems and to seek advice. The ability of some parents to tolerate behaviour problems may be important in reducing the prevalence rate for children as compared with that for adults. Other possible factors include lack of recognition of the nature of psychiatric problems in children, lack of awareness of the existence of clinics, and differences in willingness to seek psychiatric advice related to cultural background. The effect of the school psychological services mentioned in the introduction must also be taken into account. In addition, many children with behaviour problems are placed in special schools, or, if they come into conflict with the law, are dealt with by the probation or approved school services.

Consideration of reported prevalence rates raises a number of questions. Are there enough clinics to cope with the potential demand? Would expansion of the services be effective in reducing morbidity among children? Does the very small number of in-patient places for children follow from a limited need, or is there a larger need which is not being met? Shepherd *et al.* (1971), found that just over three-fifths of both clinic and control children had improved over a two-year period and that certain behaviour problems seemed to be related to stages of development, so the answers to these questions are not at all clear.

4.2. TOTAL PREVALENCE RATES FOR CHILDREN

As can be seen from the discussion in the previous section, the differences between the three areas in the total two-year reported prevalence rates are probably due to a variety of factors. The

effects of administrative differences between the areas are likely to be of most importance, especially the larger contribution of the school psychological service in Aberdeen and Baltimore and the non-reporting by private practitioners in Baltimore.

The higher one-day prevalence rate in Baltimore and the lower rate for new episodes suggest that fewer children are seen for a longer time in this area than in the others. However, as explained in section 2, a slightly different rule for terminating cases in Baltimore would also tend to inflate the one-day prevalence rates.

4.3. DIFFERENCES IN THE PREVALENCE RATES FOR BOYS AND GIRLS

The predominance of boys among children referred to the clinics in all three areas is similar to that which has been reported in other studies of children's psychiatric services (Baldwin, 1968). Difficult, especially aggressive, behaviour is commoner in boys than in girls (Rutter and Graham, 1966) and some parents find this difficult to manage (Shepherd *et al.*, 1971; Wolff, 1967). However, the sex difference cannot be explained away by selective referral to clinics. In the present study the excess of boys was found in most of the other diagnostic categories, as well as in the behaviour disorders. Rutter *et al.* (1970), in their study of a total population of 10- and 11-year-old children, also found that more boys had clinically significant psychiatric problems, the ratio being nearly two to one. Neurotic disorders were somewhat commoner in girls than boys, but the conduct disorders, and mixed conduct and neurotic disorders were much more frequently seen in boys. Shepherd *et al.* (1971) found a higher prevalence of antisocial behaviour (destructiveness, stealing, lying, wandering) in boys, in their 10 per cent sample of children attending local authority schools for normal children and special schools. The reason for the higher rates of psychiatric problems in boys, and the marked change in the sex ratio by the time of adult life (Baldwin, 1968) is unknown (see discussion in Rutter, 1970).

4.4. DIAGNOSIS

Data concerning diagnosis were presented because this is such an important variable, but very little could be made of the comparisons because of the lack of a common system of classification. The problem in the children's field is far worse than for adult psychiatry where a workable, if not completely satisfactory, system is available in the *International Classification of Diseases* (WHO, 1967). The eighth revision of the *ICD*, however, does not give any subdivisions at all for psychiatric disorders in children. A triaxial system which gives (i) any underlying organic cause (if known),

(ii) a description of the overt behaviour, and (iii) the level of intellectual functioning, as suggested by Rutter *et al.* (1969) for use in child psychiatry, seems the most satisfactory suggestion that has been made. The sub-classification of the behaviour disorders is an important problem in diagnosis. The work of Robins (1966) and Pritchard and Graham (1966) suggests that the division into 'antisocial' and 'neurotic' subgroups has prognostic significance.

It is to be hoped that agreement will be reached in later versions of the *ICD*, and that this will be used internationally even if diagnoses are coded in various local systems as well. A detailed glossary is particularly necessary because of the lack of a common diagnostic tradition.

Once interim agreement has been achieved, further work can be done on reliability of diagnosis and prognostic implications and this can lead on to useful comparisons of different areas within or between countries. At the moment, no conclusions concerning epidemiology can be drawn.

4.5. OTHER VARIABLES

It was not possible to present data on social class, referral agent, or country of origin, because the criteria used in the three areas were so different. This affected both the recording of data concerning patients and census data for the whole population which are needed for the calculation of rates.

The attempt to compare the three areas highlighted the difficulties of this kind of work which arise from a lack of internationally agreed standards as well as from differences in the organization of services. It also emphasized the great need for evaluation of the work of children's services, so that rational plans can be made for the future.

PART TWO

STATISTICS OF CHANGE 1964-71

*Residential services
for the mentally ill:
developments, 1964-71*

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1. General developments

(J. K. Wing and A. D. Isaacs)

Many of the developments to be described in this chapter were planned only in the sense that, seen in their historical context, they were inevitable. We have illustrated in Chapter 3 that the psychiatric services of the area had been in constant flux and that, on the whole, the evolution was progressive. Such developments have occurred all over the country and, it is to be hoped, will continue in the future. What made Camberwell, in a sense, unique, was the juxtaposition of a postgraduate psychiatric hospital and institute of the status of the Bethlem-Maudsley and Institute of Psychiatry, with all their resources, ideas, and scientific and clinical skills (even though these were remote from immediate community problems), with a somewhat traditional service focused largely on an out-of-town mental hospital. If the two could be brought together, the opportunities appeared to be tremendous.

There were several reasons why they should be brought together. In the first place, there was beginning to be a general feeling that every teaching hospital should take responsibility for servicing a local catchment area. It was generally assumed that the local service might in this way be improved and become a model or demonstration of the way in which a service should be run. In the second place, doctors and other members of the helping professions would be trained in community, as opposed to hospital, medicine. In the third place, the readiness to experiment and

critically evaluate new techniques, associated with universities and research units, could perhaps be applied to organizational, administrative, and social problems as well as to biological ones, leading to a progressive improvement in service provisions as the results from several areas accumulated and as theoretical knowledge grew.

These considerations applied particularly to undergraduate teaching hospitals but they seemed to apply with special force also to the complex of Bethlem-Maudsley Hospital and Institute of Psychiatry. Such a group ought to be in the forefront of developing new ideas in community psychiatry. Because of its educational programme it was uniquely placed to offer a training in the epidemiological, social, and community basis of psychiatry (in particular, of course, to train the future teachers). Finally, because of the long tradition of research in these subjects in the institute and hospital, and the presence of the MRC Social Psychiatry Unit with a long-standing interest in this field, it seemed likely that the opportunity would be taken of rationally planning, evaluating, and learning from any developments that occurred.

The main innovation, therefore, that took place during these years, apart from those that would have occurred in any case in the backwash of progress elsewhere, was that the Bethlem-Maudsley Hospital did gradually come to adopt the view that community responsibility for a local district was not only a legitimate, but a necessary and urgent means of achieving its aims as a teaching hospital.

The MRC Social Psychiatry Unit had begun in 1964, in anticipation of this change, to set up a psychiatric case-register covering the area of Camberwell and this started running formally on 1 January 1965. While the first discussions and negotiations were proceeding, a base-line of data was being collected so that, by the time the first decisions were carried into effect, it was possible to monitor the subsequent changes.

The main negotiations took place with Cane Hill Hospital (South-West Metropolitan Regional Board) and King's College Hospital. The latter became responsible for supplying general hospital services to the area of Camberwell and East Lambeth and, in order to carry out this commitment, incorporated Dulwich, St Francis's, and St Giles's hospitals into its group. Responsibility for the psychiatric services of Camberwell was delegated to the joint Bethlem-Maudsley Hospital which continued to provide the medical staff for St Francis's observation ward. There was, however, an important proviso, that forty-five Camberwell patients could still be admitted each year to Cane Hill Hospital by joint hospital staff.

This agreement came into formal operation on 1 April 1970. However, in anticipation of it, several other developments took place which will be described in more detail in the following sections. The most important of these was that St Francis's observation ward was closed for three months in the summer of 1967 and then reopened after some reconstruction as a district treatment unit. There had already been a joint consultant arrangement between Cane Hill and St Francis's, but the number of sessions was increased and the Cane Hill consultant was also appointed to the Bethlem-Maudsley Hospital. By a reciprocal arrangement, sessions were made available at Cane Hill Hospital for a Maudsley clinician, thus providing the basis for continuity of clinical care between these components of the community service.

An adequate number of beds was set aside at the joint hospital to provide, in association with the new psychiatric wing at St Francis's, for all the anticipated short-stay requirements of the area. Camberwell patients were given priority for admission to these beds.

The Maudsley Day Hospital began to concentrate more than hitherto on local patients and a new rehabilitation workshop was opened in 1967 with the aid of a grant from the DHSS.

Close collaboration was established between the Borough of Southwark's health department and the newly integrated hospital service. Two consultant psychiatrists working in the community service at St Francis's, Maudsley, and Cane Hill hospitals were appointed to the Medical Officer of Health's Psychiatric Advisory Committee. Several social workers were appointed jointly by the local hospitals and the local authority and, in general, collaboration between the Mental Health Department and the hospitals was close. There was a considerable expansion of local authority day centre provision and industrial work was introduced into two of the centres.

The beginnings of integration could also be seen in the service for patients suffering from dementia, many of whom had hitherto been admitted to Cane Hill Hospital. From 1967, twenty beds were made available in the geriatric unit at Bethlem Royal Hospital for the short- and medium-term assessment and treatment of elderly patients suffering from psychiatric disorders including dementia. In June 1970 an experimental psychogeriatric assessment unit was established in one of the geriatric wards at St Francis's. This comprised six beds for female patients who were jointly assessed by a psychiatrist and the geriatric physician, the latter retaining clinical responsibility (Department of Health circular, HM 70/11). It was agreed that the assessment procedure

should be completed in four weeks. To ensure free communication between all concerned, monthly meetings were held in which the participants included the medical and nursing staff as well as representatives of the local authority Social Services Department. The two psychiatrists involved in the unit were given free access to the short- and medium-stay beds at Bethlem Royal Hospital and long-stay beds at Cane Hill. This joint staffing arrangement again facilitated the integration of a district geriatric and psychiatric service. The principle of pre-admission screening has been practised by both the geriatrician and the psychiatrist and this has reduced to a minimum the number of patients requiring in-patient assessment of this type.

This is a brief and general account of the changes brought about in the Camberwell in-patient services during the years 1967-71. The record of progress is substantial and, in many ways, the local community service is beginning to be as good as that provided in the best centres elsewhere. There are, however, many gaps and deficiencies, some of which will need radical solutions. Moreover, several fundamental developments (the new social service departments of the local authority and the envisaged area health boards, for example) are likely to give rise to major opportunities. During the remainder of this chapter, however, attention will be directed to a consideration in detail of the progress which has been made recently. The aims of the clinicians and their impressions will be set against the hard statistics of the Register in a preliminary attempt to evaluate what actually happened. One particular development, the closing of St Francis's observation ward and its reopening as a district treatment unit, will be considered in special detail.

2. St. Francis's: observation ward into district treatment unit

2.1. OBSERVATION WARD: ST FRANCIS'S BEFORE 1967 (D. H. Bennett)
Lawson said of the observation ward, as it was in 1959,

All doors are locked and there is no immediate treatment apart from essential sedatives and similar immediate necessities. The nursing staff has a largely custodial role, and use of the padded rooms on each side was not unusual. There was no occupational therapy, as it was considered that the patients stayed so short a time that they could accomplish very little. The purpose of a ward as a place to which any person presenting an 'emergency psychiatric' problem could be taken was obvious in its lay-out and day-to-day organization. Patients were held compulsorily for not more than seventeen days, diagnosed and dis-

charged, either to another hospital for treatment, or to home or elsewhere in the community. The locked doors, for example, resulted from the legal and compulsory nature of its admissions rather than from any conviction on the part of the staff that this was the best way to run an observation ward. . . . St Francis still operated only as an observation unit, and had no voluntary patients or treatment facilities. Even so the staff at St Francis might suggest, if the patient was coming from North London, that the Duly Authorized Officer should try elsewhere. If he could not succeed, however, it was extremely unlikely that St Francis would refuse to take the case. [It was] the only observation ward unit still fulfilling the true function of such a unit in receiving, diagnosing and discharging or transferring patients who constituted psychiatric emergencies as recognized by the Duly Authorized Officers or the police and admitted by them in the London area (Lawson, 1966).

At that time, even before the introduction of the Mental Health Act, admissions to St Francis's, particularly of patients admitted with a diagnosis of organic condition, were declining. On the other hand, patients with personality disorder and alcoholism were increasing in proportion (Kenyon, 1968). Following the Mental Health Act, informal patients were admitted for the first time and the number of police admissions began to go down. Reserpine was introduced in 1959 and chlorpromazine shortly afterwards; as treatment improved, the need for control diminished. Padded rooms were little used after 1961 (Moran, 1962).

Thus, as the therapeutic attitude towards recurrent psychosis changed, patients with these conditions were more readily accepted into psychiatric hospitals, leading both to a decreased use of the observation wards and to a higher concentration among admissions of those with alcoholism or personality disorders, for whom they were still seen as the most suitable place for 'disposal'. Table 6.1 illustrates this trend.

Table 6.1. *Comparisons of diagnostic groups in St. Francis's observation ward at different times (after Kenyon) (percentage)*

Diagnostic group	1936 N = 518		1947-9 N = 3,351		1957-8 N = 3,006		1962-3 N = 2,517	
	M	F	M	F	M	F	M	F
Affective	15.7	30.3	18.0	29.3	27.4	43.8	25.4	41.4
Schizophrenia	17.5	16.8	20.8	18.0	33.3	33.8	27.3	31.3
Personality disorder	4.0	4.5	9.9	3.8	22.1	9.7	38.7	19.2
Organic	54.7	47.0	43.2	38.7	15.4	10.7	7.3	6.5
Subnormal	3.6	0.8	2.5	0.5	1.7	1.9	1.2	1.5
Other	4.5	0.6	5.6	9.7	—	—	—	—

Some changes at St Francis's were related to the unit's close association with the Maudsley Hospital and its emergency clinic, viz. the increase in the number of admissions from the locality which rose from 35.5 per cent in 1957-8 to 56.7 per cent in 1962-3. Other changes were determined by administrative fiat. The LCC, for example, decided at one time that old people were blocking the observation ward beds. An instruction was issued to duly authorized officers that they were to admit only those old people whom they found to be acutely ill (Lawson, 1966). This change in policy accounts, perhaps, for the reduction over the years of persons admitted with an organic diagnosis. Similarly, a policy change negotiated with the Metropolitan Police, contributed to the reduced numbers of police admissions in recent years (Eilenberg and Whatmore, 1961).

In 1966, St Francis's Hospital became part of the King's College Hospital group. Many people by this time had concluded that observation wards were an anachronism (Kenyon, 1968) and a vigorous debate took place as to the best way to proceed. Discussions were held between representatives of the South-East and South-West Regional Hospital Boards, King's College Hospital, Cane Hill Hospital, and the Bethlem-Maudsley joint hospital. It was decided that by far the best solution would be to close the observation ward for a period of renovation, while the nursing staff took part in a refresher course. When the unit reopened it would be an integral part of the district services for Camberwell and East Lambeth. Short-term hospital treatment would be given, in particular, to patients with chronically handicapping or frequently intermittent illnesses whose main long-term need was for rehabilitation and community care.

While these discussions were proceeding, and before a decision had been taken, a survey was made of the attitudes of the nursing staff. The findings will be briefly reviewed here, since they are of considerable interest for students of the sociology of institutions.

2.2. SURVEY OF NURSES' ATTITUDES, APRIL 1967 (J. K. Wing)

The aim of the survey was to describe the attitudes of observation ward nurses, most of whom had worked there for many years, to the changes being proposed, in the hope that the knowledge gained would be useful both to those planning the changes and to the nurses themselves.

All the 25 nurses of staff rank or above were interviewed with the exception of 8 who were missed because of sickness or holidays. The interview was conducted with the aid of a schedule drawn up after consultation with the 3 senior nurses. Most of the questions

were open-ended and followed by extra probes, so that a content analysis of replies could be carried out. In only one case was it necessary to cut an interview short because the nurse was getting worried.

The most evident result of the survey was that there were two fairly definite but opposing views about the lines future development at St Francis's should take. Seventeen nurses were interviewed, 12 of them female and 5 male. Three of the men and 3 of the women were against St Francis's changing its functions. These nurses looked back to a time when there had been a high morale among the staff of the observation ward, due to the fact that they were carrying out a job which though socially denigrated, was distinctly socially useful and demanded exceptional experience and skill. 'This city needs a unit for emergency purposes, day and night.' 'I should hate to feel we are going to be boxed into Camberwell.' The acutely ill psychotic patient could be humanely cared for and transferred to the appropriate mental hospital without ill-effect since relationships were good. Incorporation of St Francis's into the local services would have a claustrophobic effect, administration would become more remote and time-consuming and patients would have to be turned away. It was felt that a local service would be too constricting; the only limitation on admissions should be that fewer patients with alcoholism or personality disorders should be admitted. Less cogent arguments were that Cane Hill Hospital had the advantage of country air and a lovely view and that patients improved more rapidly if they were not kept too long in one place.

The other point of view, held by ten of the nurses (one was doubtful), was that the ward should be converted to a district treatment unit. The main reason was that patients should not be transferred elsewhere for treatment. Both their interests and those of the nursing staff would be served if they could be treated in the unit, even if this meant a longer stay and therefore fewer admissions. These nurses felt that they would be more interested and better able to exercise their professional skills in such a setting. They felt they could devote more attention to social needs, could come to understand the patients' environment and its effects better, and that the whole atmosphere of the unit would improve. Greater freedom could be allowed, day-patients could come in, there would be a greater emphasis on rehabilitation and less on supervision. Staff could get to know patients and would take the responsibility of an area seriously.

These two attitudes summed up many years of debate over the best organization of psychiatric services: on the one hand, the

feeling that there will always be patients who have just hitched a lift into London on a long-distance lorry, who need to be treated somewhere in town by humane and experienced professional staff and that this is specialized work; on the other hand, the desire to build up a service with local roots and a long-term responsibility for people who, though possibly chronically handicapped, should stay within the community if this is at all feasible. It seemed to everyone impossible to combine both functions in the same unit. A choice had to be made.

Opinions were evenly divided as to whether it would be better to be attached to the Bethlem-Maudsley or to Cane Hill Hospital (the other alternatives had few adherents). In favour of the former were its excellent reputation, its wide range of facilities, its proximity, the long tradition of association and the fact that it needed the extra dimension of experience that St Francis's could provide. In favour of Cane Hill was its size (there was a ward appropriate for every type of problem), its willingness to accept all comers, its familiarity with the difficulties experienced by St Francis's nurses and its country situation.

Many detailed suggestions were made concerning the unsatisfactory buildings. Thus the half-doors on the toilets 'like horse-boxes' attracted particularly unfavourable comment. These were passed on and some of them were rectified during the period of renovation. Serious reasons for dissatisfaction remained, however, since the problems were inherent in the bricks and mortar, which were redolent of the era of the Poor Law. There was too little room for the care of restless and disturbed patients and too little possibility of separating different groups. This was particularly true of young antisocial patients and those with dementia, who had to be nursed together. Both groups unsettled the less-disturbed patients. The stairs were very awkward, particularly for elderly patients, and there were no lifts. In one of the wards the outside door had to be locked in order to keep one patient from wandering. The two wards were physically distant from each other and both were far from the occupational therapy facilities (which, in any case, were too sparse). The offices were badly sited; patients had little opportunity for privacy; there was little room for patients to move about and little storage space.

On the whole, the nurses were ready to accept change. Eleven were in favour of having male and female staff on the same ward, 3 were doubtful and only 3 were opposed. Two more were doubtful about mixing patients. Everyone was in favour of having a single co-ordinating doctor in charge of medical care and decision-making. Most wanted to see day-patients on the wards, to place

more emphasis on rehabilitation and home-visiting, and to foster a socially therapeutic atmosphere in the unit. It perhaps goes without saying that old-fashioned nursing methods were universally condemned and that there was no disagreement about open doors. Everyone wanted student nurses to be accepted in the unit and thought it had an important part to play in training.

An attempt was made to measure morale among the nurses, with interesting results. Two aspects were considered, following Revans (1964). Inquiry was made concerning the guidance, support, consultation, and attitudes of those higher in the hierarchy and the helpfulness, support, and competence of those lower down. It was surprisingly easy to ask these questions and assess the answers. In general, dissatisfaction was greater among men than among women, among the older rather than the younger nurses, and particularly among those who had been there longest. Both male and female sides had their specific problems. It is clear from the attitudes towards the future of St Francis's summarized earlier that one point of view looked back to a time of high morale, when there was a feeling that an excellent job was being done in spite of public indifference or disapproval; the corollary being that that period was drawing to a close. Some of the more detailed points about morale cannot be brought out in a publication of this kind and, in any case, the numbers were too small to allow confident interpretations. There was, however, a strong impression that the female nurses were readier to accept whatever changes lay in the future and perhaps were less ready to put forward policy ideas of their own.

The general impression was that, on both sides, there were excellent professional workers who would, whatever their current views, have no difficulty in adapting to a new regime and making it work. It would be expected that morale would improve considerably once the main change had been made and the opportunity to implement and decide new policies arose.

Finally, the nurses were asked to describe their own attitudes towards St Francis's, and to estimate what public attitudes would be, on ten-point scales of kindness, helpfulness, permissiveness, integration with the community, and hospital rather than prison-like qualities. The results are summarized in Fig. 6.1. There is remarkable unanimity about the nurses' own views, even among those who were most critical. St Francis's was regarded above all as a kind place, also as helpful, unlike a prison, permissive and integrated, in that order. 'Integrated with the community' was least regarded as a justified description. On the other hand, nurses felt that public attitudes were quite different, that people outside

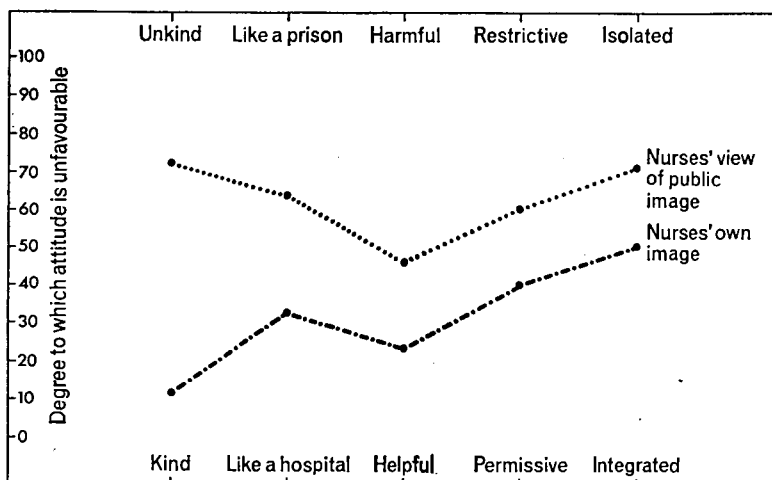


FIG. 6.1. Attitudes of nurses to St Francis's and nurses' estimate of public attitudes.

would regard the place as unkind, prison-like, restrictive, and isolated. Some shrewd suggestions were made for putting the public image right. 'Once we begin a treatment unit it will be different. Until then it can't be put right.' 'If you change the attitude of the Maudsley to St. Francis you will change the public attitude.' 'Advertise for voluntary helpers.' 'Put articles in the local press.' 'Let them come and see. Show them there is nothing to be afraid of.' But there was, of course, a school of thought which could see little chance of change unless something really radical were done. 'The name sticks. People don't realize it has changed since it was Constance Road Institution. They say, "Once you get in there, you won't get out".' 'You've got to shift it altogether.' 'Pull the place down.'

2.3. DISTRICT TREATMENT UNIT: ST FRANCIS'S AFTER 1967 (D. H. Bennett)

The observation ward was closed in May 1967. Structural changes were made and the whole place was redecorated. 'A' ward, which had dealt exclusively with men became an admission and short-stay ward for patients of both sexes. The former 'D' ward, for female patients, also accepted both men and women, but took on more of a rehabilitative function. On both wards, male and female nurses worked together. St Francis's psychiatric wing reopened in September 1967 with a reduced complement of 62 beds. For the first time, all forms of psychiatric treatment could be given and

patients could be compulsorily detained on Section 26, but it was decided that the maximum duration of stay would be six months.

A part-time psychologist and two full-time occupational therapists were appointed, while the social work establishment was filled by the appointment of two workers jointly with the borough of Southwark.

A programme was provided both for admitted alcoholics and for those who had left the ward. Alcoholics Anonymous held meetings on three nights a week. In 1968 an industrial workshop was opened, a limited number of day-patients were accepted and a nurse-centred supportive follow-up was established. This latter service provided contact for discharged but invalid patients with the nursing group who, in terms of both their careers and their siting, are less mobile than doctors or social workers. Their duties are arranged on a twenty-four-hour pattern, best suited to meet the needs of those former patients who are disabled, unreliable, and unable to keep regular appointments. Such patients attend when they wish, and see the nursing staff on duty who undertake their direct care under the supervision of a senior registrar (Watson, Bennett, and Isaacs, 1970).

Although the former Poor Law buildings still stand, and the institutional atmosphere seems to have been built in with the very mortar, the functions of St Francis's are now radically different, both in theory and in practice, to anything which its original creators can have conceived. The buildings are quite unsuitable in numerous ways and plans have been tentatively drawn up against the possibility that a modern building might eventually be constructed.

All services are moulded as much by their history and traditions as by the energy and ideas of those who operate them. Each of the hospitals serving Camberwell has its own peculiar social structure and social flavour. The nurses of St Francis's were well aware of the characteristics of their own unit and those of other hospitals. Since St Francis's reopened there has been a marked change in its organization, and it has taken its place within a set of services which is beginning to be integrated simply by reason of the fact that relatively few psychiatrists and social workers are involved and all have been concerned with the major policy decisions. Mapother's distinction between the psychiatric clinic and the observation ward has already been eroded and must in time disappear.

The next section deals with data from the Camberwell Register which illustrate the changes taking place in the distribution of short-stay hospital beds during the years 1964-71, of which the innovations at St Francis's constituted such an important part.

3. Short- and medium-term hospital care

(J. K. Wing and Anthea M. Hailey)

3.1. SHORT- AND MEDIUM-TERM BED USAGE, 1964-71

By 'short- and medium-term' is meant periods up to 365 days. The term 'mental illness' includes dementia. Fig. 6.2 shows the probability of leaving hospital by length of stay in months of all patients admitted to hospital over a three-year period. It can be seen that after two months the probability drops sharply, suggesting two months' stay as a suitable point at which to subdivide the under one-year group. Six months is another possible point; 90 per cent of patients have been discharged by that time and only another 6 per cent are discharged during the next six months. Each has its uses. For most purposes, three periods will be used throughout this part of the book; 0-60 days ('short-term'), 61-365 days ('medium-term'), and more than 1 year ('long-term').

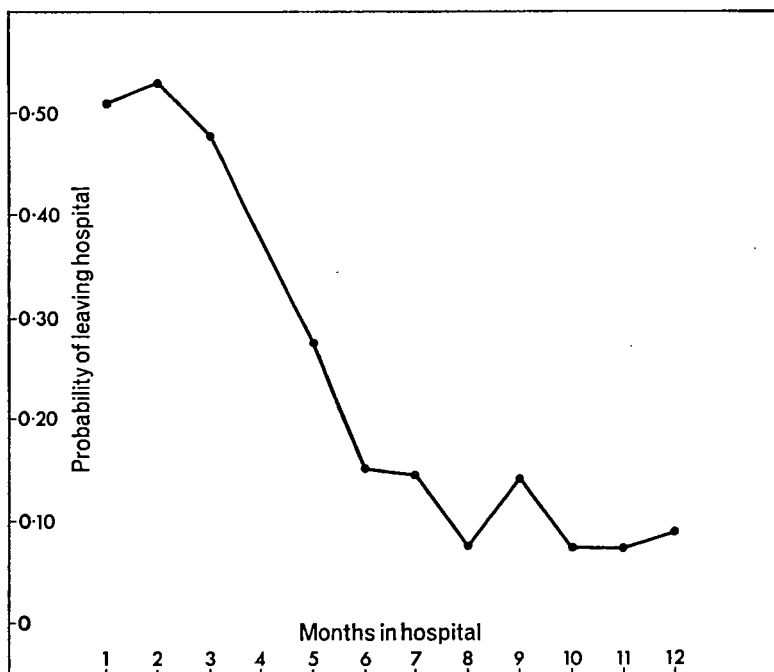


FIG. 6.2. Camberwell residents: admissions 1965-7. Probability of discharge or death, by month.

Table 6.2 shows the numbers of hospital short- and medium-stay beds occupied by Camberwell patients¹ on six-monthly census days over a period of six years. (Beds are allocated by short-term or

Table 6.2. *Short- and medium-term bed usage on six-monthly census days, 1965-70 (Camberwell residents aged 15+; mental illness beds)*

Year	30 June	31 December
1964	—	151
1965	150	125
1966	132	117
1967	150	158
1968	192	178
1969	173	166
1970	165	170
1971	154	—

long-term groups according to the length of time that each patient has been in hospital on the census day.) The numbers of short- and medium-term beds used varied a good deal (naturally enough, the number of short-term beds is usually lower on 31 December than on 30 June), but it seems to have settled down towards the end of the period at 150-70 beds (approximately 1 per 1,000 total population).

Table 6.3. *Number of patients admitted to hospital per year, and number of admissions, 1965-70*

Year	Number of persons admitted		Number of admissions	
	N	Rate*	N	Rate*
1965	555	321	730	423
1966	520	302	672	390
1967	564	329	724	422
1968	618	362	815	477
1969	639	376	855	503
1970	651	384	858	506

* Rate per 100,000 total population, using annual population estimates shown in Table 3.8.

Table 6.3 shows the numbers of patients admitted per year, and the numbers of admissions, during the same period. It can be seen that the impression given in the previous table, that bed usage went up to some extent during the period under review, is con-

1. Patients from the Camberwell Reception Centre are not counted in any of the tables unless specified.

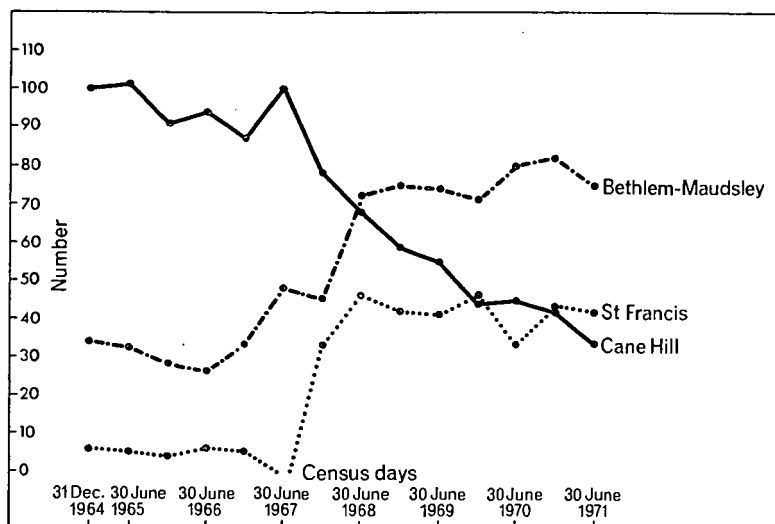


FIG. 6.3. Short- and medium-stay in-patients on six-monthly census days. By agency (Camberwell residents aged 15+; mental illness beds).

firmed by the admission figures. This finding deserves further study since it suggests that the threshold for admission to hospital might have been lowered. A more detailed investigation is reported in Chapters 11 and 12.

3.2. REDEPLOYMENT OF SHORT- AND MEDIUM-TERM BEDS

The basic aim of the plan for redeployment of beds was to ensure that patients no longer had to be admitted to a hospital outside the area. 'Camberwell beds' were set aside for this purpose at the Maudsley Hospital and patients from Camberwell given special priority on waiting lists. St Francis's observation ward was converted to a district treatment unit as described earlier. Fig. 6.3 shows the effect of this policy. The number of patients in short- and medium-stay beds at the end of 1964 and in mid 1971 were as follows:

	31 Dec. 1964	30 June 1971
Cane Hill and other mental hospitals	110	33
Bethlem-Maudsley	34	75
St Francis's	6	42
King's College Hospital, St Giles's	1	4
Total	151	154

These numbers, in conjunction with Fig. 6.3, indicate that redeployment has indeed taken place. Cane Hill and other mental hospitals, which originally provided the large majority of the shorter-term beds, now provide less than one quarter while Bethlem-Maudsley and St Francis's have increased their contribution from one-quarter to three-quarters of the total. The aim was to reduce the number of patients admitted to Cane Hill to at most 45 per year from 1 April 1970, and it was expected that these would be either patients suffering from dementia or other patients who had stayed at St Francis's or Bethlem-Maudsley for a year or longer. Fig. 6.4 shows the quarterly number of admissions to Cane Hill Hospital, St Francis's psychiatric wing, the Bethlem-Maudsley, and all other hospitals during the six years. Here, other mental hospitals are separated from Cane Hill. In order to illustrate the changes between the three main agencies, Guy's, King's College Hospital, and St Giles's, are included with these 'other hospitals', and account for most of the admissions in the later years. The graph tells a similar story to Fig. 6.3, but it does not suggest that the numbers of admissions to Cane Hill had decreased to the expected rate during the last three quarters of 1971. This is not a matter of the difference between number of persons and number of admissions.

Table 6.4. *Number of patients admitted to various hospitals in 1965 and 1970 (Camberwell residents aged 15+; mental illness beds).*

<i>Hospital</i>	<i>1965</i>	<i>1970</i>
Bethlem-Maudsley	173	348
St Francis's psychiatric ward	94	189
St Francis's psycho-geriatric assessment unit	—	11
King's College Hospital and St Giles's	5	36
Guy's, St Thomas's	1	4
Cane Hill	278	86
Other mental hospitals	66	39
Total	555*	651*

*Unduplicated. Some patients had an admission to more than one agency.

Table 6.4 shows the number of patients admitted to various hospitals serving the area in 1965 and in 1970. Eighty-six patients were admitted to Cane Hill in the latter year (on 98 occasions), a marked decrease but well above the target figure.

The figures for the first year of the commitment, i.e. 1 April 1970 to 30 March 1971, were therefore considered. Altogether, 74 patients were admitted to Cane Hill during this period, on 82 occasions. Of

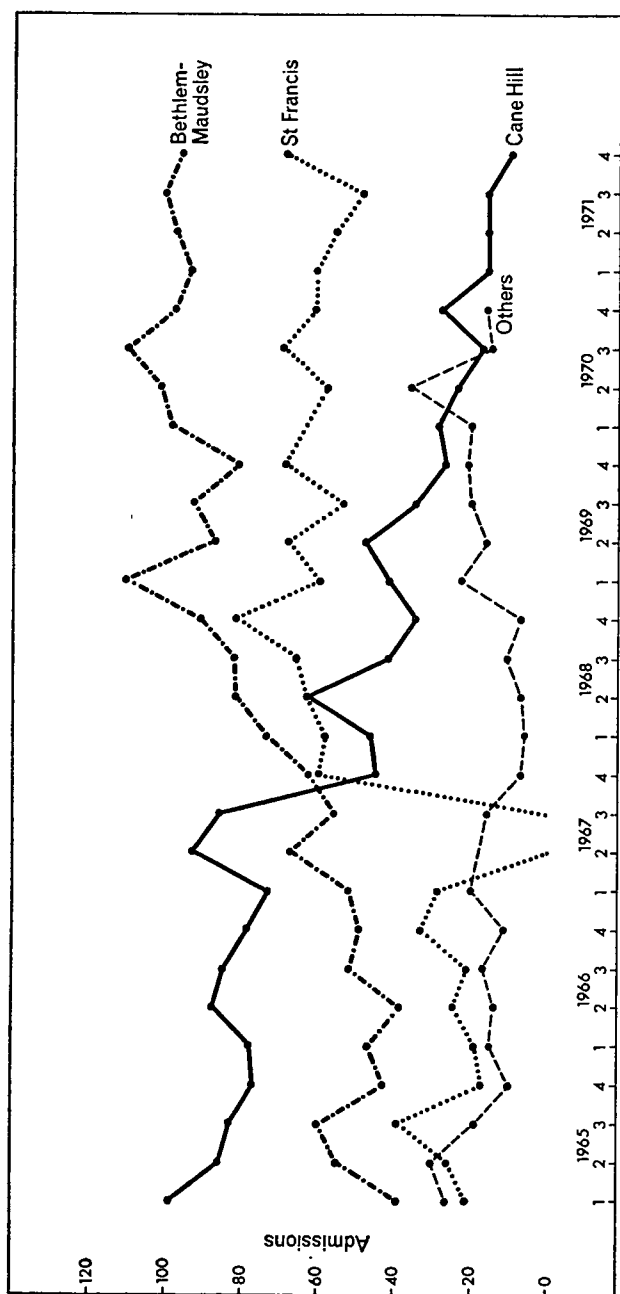


FIG. 6.4. Quarterly admissions by agency.

these 82 admissions, only 27 were arranged by the two consultant psychiatrists who were appointed to all three hospitals (Cane Hill, St Francis's, Bethlem-Maudsley); in 10 cases the diagnosis was dementia, in 8 chronic schizophrenia, and in 9 other conditions. Thus, so far as the Camberwell community service could ensure it, the commitment was not only met, but more than met. The other 45 admissions to Cane Hill could probably be absorbed into the community service with little difficulty, since in only 9 cases was the diagnosis dementia and in only 6 cases with other diagnoses did the patient stay more than six months. Even if *all* 15 had been referred to the two community psychiatrists and still admitted by them to Cane Hill (which is highly improbable), the upper limit of 45 patients in the year would not have been exceeded.

In addition to the Cane Hill admissions, there were 87 to local hospitals other than St Francis's and the joint hospital, mainly to St Giles's (part of the King's College Hospital group), where a new psychiatric ward had been opened. This trend will need to be observed but it gives rise to no special concern since it means that an alternative service is available to Camberwell patients.

This matter has been considered in some detail because an important planning principle is involved. The existence of an arrangement whereby patients can still be admitted to a mental hospital miles away from the catchment area, means that there is a back door through which the population of long-stay patients could be replenished. Forty-five patients a year may not sound many, but if they all stay three years, 135 patients have accumulated. This is how long-stay populations have built up in the past. The extent to which 'new' long-stay patients did actually build up during the years 1965-70 will be considered in the next section.

4. Long-term hospital care for the mentally ill

(J. K. Wing and Anthea M. Hailey)

4.1. THE 'OLD' LONG-STAY

No plans were made for dealing with the 416 patients who, on 31 December 1964, had been in hospital for more than a year. Most of them (59 per cent) were in Cane Hill Hospital; the others were scattered around all the former Metropolitan asylums. It is perhaps a commentary on our values that these patients were left out of consideration; on the other hand, a case can be made that many are too handicapped for resettlement or do not wish for it (Catterson, Bennett, and Freudenberg, 1963), or that the priorities for allocating scarce resources do not allow it (Macmillan, 1970).

Numbers gradually declined during the seven years under consideration. By the end of 1971, only half (208) of the starting cohort of 416 remained in hospital. Details of the composition of the group are given by Hailey (1971). In summary, 64 per cent of the 416 patients were women and 36 per cent men. About one-third had been in hospital 2-10 years, about one-quarter 11-20 years, and the remainder for more than 20 years. By far the commonest diagnosis was schizophrenia (58 per cent).

The extent to which the attrition rate during these six years can be extrapolated into the future will be considered in Chapter 9.

4.2. THE 'NEW' LONG-STAY

Patients with dementia will be considered separately in section 5. The numbers of patients with other diagnoses admitted during the years 1965-70 who eventually stayed longer than twelve months are shown in Table 6.5. In spite of an increase in numbers admitted there has been no increase in the proportion becoming long-stay.

Table 6.5. *Numbers of patients admitted to hospital annually, with conditions other than dementia, and proportion remaining in hospital as long as twelve months, 1965-70 (Camberwell residents aged 15+; mental illness beds)*

<i>Year admitted</i>	<i>Number admitted</i>	<i>Number becoming long-stay</i>	<i>Percentage long-stay</i>
1965	500	22	4.4
1966	479	21	4.4
1967	522	16	3.1
1968	583	25	4.3
1969	603	25	4.2
1970	616	24	3.9

4.3. RUN-DOWN AND BUILD-UP OF LONG-STAY POPULATION

The two processes described in sections 4.1 and 4.2, the run-down of the 'old' long-stay population and the build-up of the 'new', together with changes in the shorter-stay population, make up the over-all trend in bed ratios. The numbers in the 'old' and the 'new' long-stay groups (of patients without dementia) are shown, for annual census days from 31 December 1964 to 31 December 1971, in Fig. 6.5. Two cohorts of the 'old' long-stay are shown. The first, beginning on 31 December 1964 was running down in curvilinear fashion from the initial 367 beds and had reached 199 beds by 31 December 1971. The second, beginning on 31 December 1967 was approximately parallel to the first and had run down from 314 to 225 within four years.

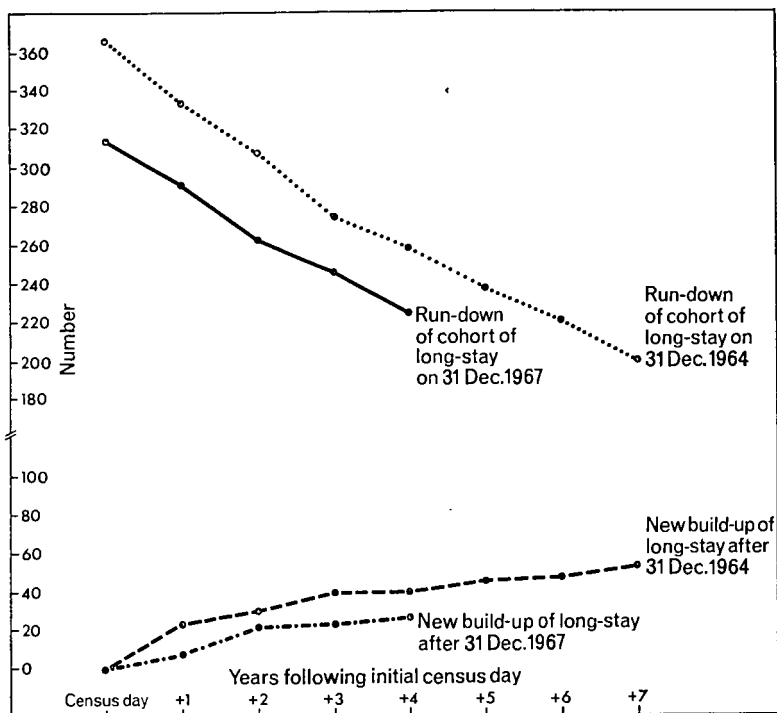


FIG. 6.5. Camberwell patients with diagnosis other than dementia. Run-down and build-up of long-stay numbers on annual census days, 1964-71.

The equivalent build-up of new long-stay cohorts after these two census days is also shown in Fig. 6.5. In the seven years after 31 December 1964, there was a build-up to 53 beds. In the four years after 31 December 1967, the build-up was definitely smaller. Plotting equivalent figures for cohorts beginning on the intermediate census days confirms both the curvilinear nature of the run-down and the tendency for the build-up to become rather slower. Since the numbers achieving 'long-stay status' each year remain steady at approximately 20-25 per year (see Table 6.5) it is clear that some patients are only staying for a year or two in hospital and are then being discharged again.

The dynamics of the 'old' and 'new' long-stay populations are therefore complex and statistical projection of future bed use is hazardous. This matter is discussed further in Chapter 9.

Certain characteristics of the 'new' long-stay patients admitted between 1965 and 1970 are shown in Table 6.6. Among those aged less than 45, men predominate and schizophrenia is the commonest

Table 6.6. *Characteristics of patients admitted 1965-70 who remained for more than one year in hospital (diagnosis other than dementia)*

Age at admission	Schizophrenia		Affective psychosis		Neurotic depression		Other neuroses		Other conditions		Total	
	M	F	M	F	M	F	M	F	M	F	M	F
<25	10	2	—	—	1	2	—	—	1	2	12	6
25-44	18	14	2	4	1	2	2	1	4	1	27	22
45-64	4	10	1	9	2	3	1	—	4	2	12	24
65+	1	2	2	13	—	4	—	—	1	7	4	26
All ages	33	28	5	26	4	11	3	1	10	12	55	78
Total	61		31		15		4		22		133	

diagnosis. Among those aged 45 and over, women predominate and the commonest diagnosis is affective psychosis (mainly, of course, depressive). Patients with dementia are omitted here also.

Figures from the Salford Register were kindly made available by Dr T. Fryers which allow a comparison of the rate of run-down of an 'old' long-stay cohort and the rate of build-up of a new one in Salford and in Camberwell. The data are presented in Fig. 6.6, using rates per 100,000 population in each year. It is clear that the 'old' long-stay group is considerably higher in Salford than in Camberwell and also that the new build-up is more rapid and continues longer.

5. In-patient services for patients with dementia

(J. K. Wing and Anthea M. Hailey)

Table 6.7 shows the numbers of patients admitted to hospital in successive years who were given a diagnosis of dementia (the age is calculated on 31 December of the previous year). A small proportion are under the age of 65 and the diagnosis is Pick's or Alzheimer's disease or other conditions giving rise to severe and irreversible brain damage. Apart from 1965, there is little fluctua-

Table 6.7. *Number of patients with dementia admitted to hospital during the years 1965-70.*

Years of age	1965	1966	1967	1968	1969	1970
<65	7	3	3	2	1	4
65-74	14	18	21	14	10	8
75+	35	21	20	19	25	27
Not known	—	—	—	—	1	—
Total	56	42	44	35	37	39
Number out of cohort staying 1 year	19	15	14	12	9	9
Percentage	34.5	36.6	33.3	34.3	25.0	25.7

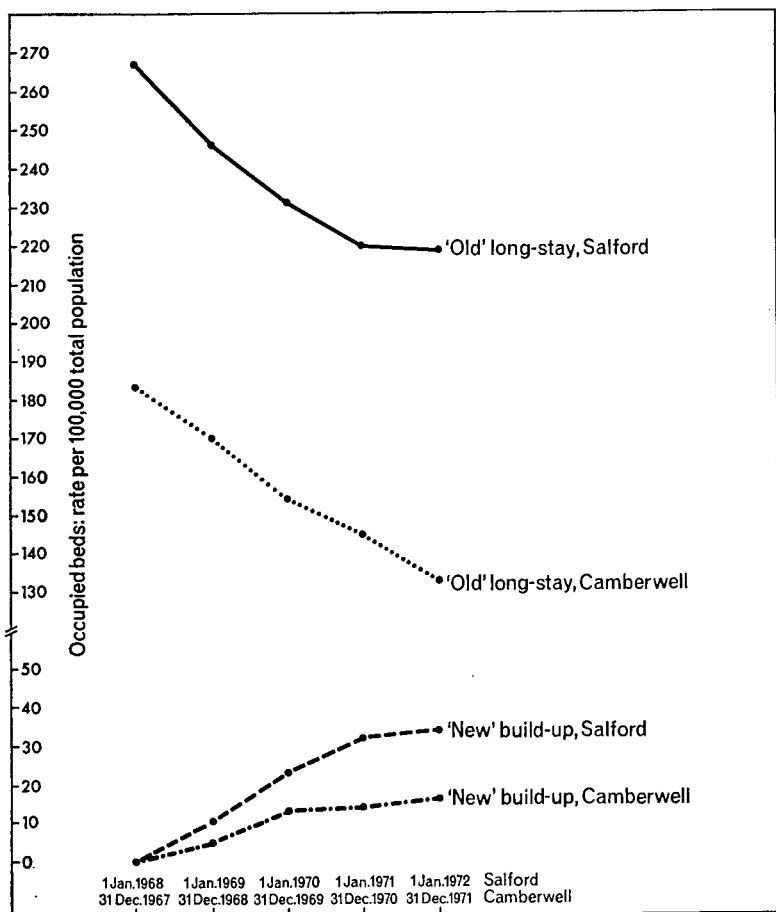


FIG. 6.6. Patients with conditions other than dementia (long-stay patients only), Salford and Camberwell cohorts compared. (Note: Total population in appropriate year used in calculating rates.)

tion in the numbers. For 1970, the admission rate for dementia is 0.5 per 1,000 population aged 65-74 and 3 per 1,000 population aged 75+.

Table 6.7 also shows the number of patients in each year's cohort of admissions who stay in hospital as long as one year, i.e. who become long-stay. The proportion is approximately one-third; very markedly higher than the equivalent figure for other conditions (see Table 6.5). From 40 to 50 per cent die before they have been in hospital one year.

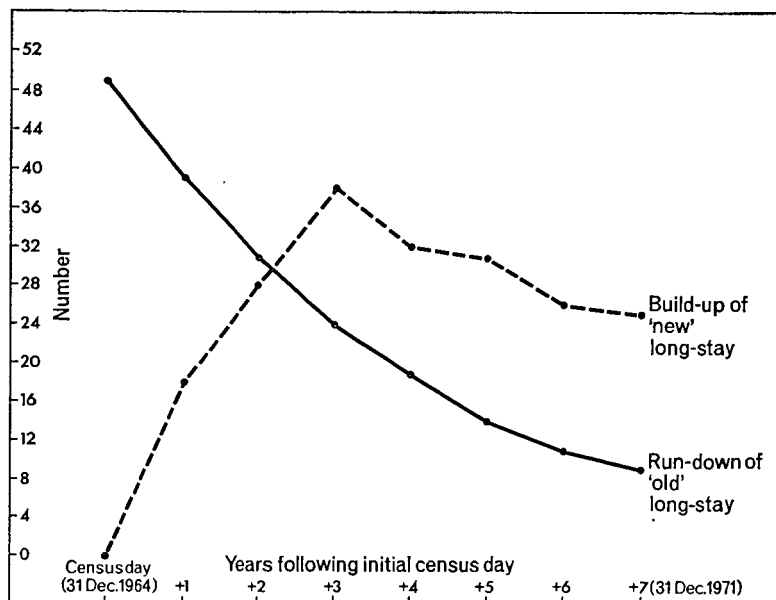


FIG. 6.7. Run-down of 'old' long-stay cohort (31 December 1964) and build-up of 'new' long-stay group. Patients with dementia only.

The run-down of the 'old' long-stay cohort in hospital on 31 December 1964 is shown in Fig. 6.7. The gradual nature of the run-down is surprising, but is due to the fact that some of the patients were admitted with dementia due to brain damage before the period of the senium and have grown old in hospital. The new build-up reaches a peak (38 beds) after three years and then there is a decline to 25 beds. A check is provided by the data in Fig. 6.8 which show a somewhat faster run-down of the 31 December 1967 cohort and a build-up to only 20 beds in four years (the equivalent in the build-up after 31 December 1964 was 32 beds after four years). The Salford build-up after 31 December 1967 (given as the numbers expected on the basis of the Camberwell population) reaches 15 beds after four years; the difference is due to the fact that Salford does not include dementia starting before the age of 65 in the figures whereas there are a few such patients in the Camberwell data (and they tend to stay the longest time since the mortality rate is lower).

The number of shorter-term patients with a diagnosis of dementia has been decreasing. On successive annual census days from 31 December 1964 to 31 December 1970 the numbers were

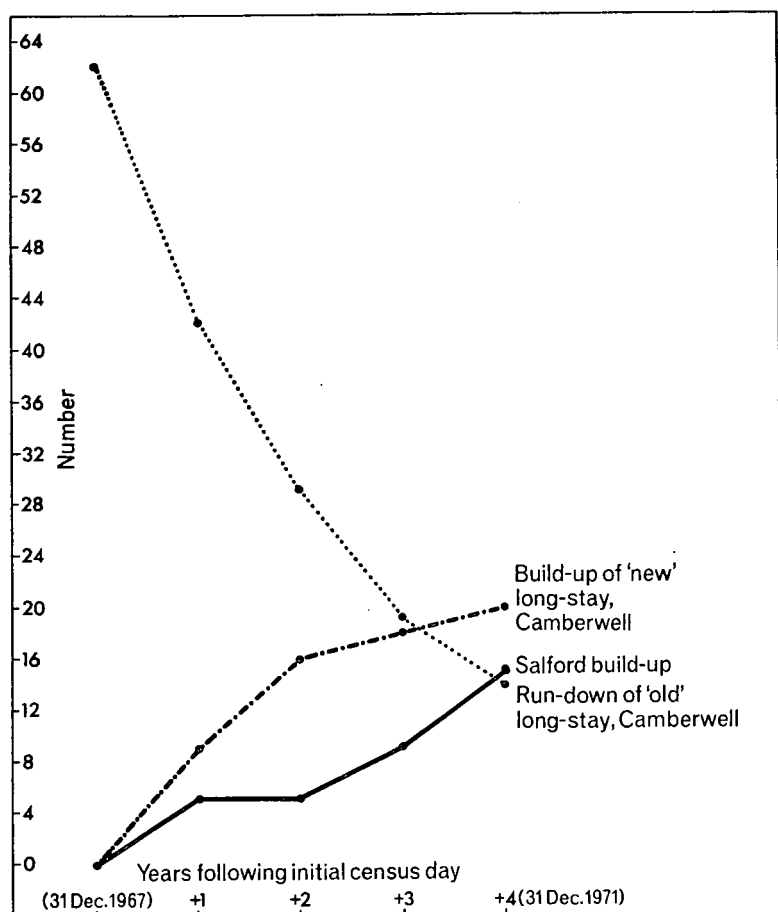


FIG. 6.8. Run-down of 'old' long-stay cohort (31 December 1967) and build-up of 'new' long-stay group. Patients with dementia only. Camberwell and Salford compared. (Salford numbers are those expected in the Camberwell population.)

as follows: 33, 31, 20, 28, 17, 15, 15. It must be remembered that another considerable group of patients with dementia are not included on the register; these are the patients admitted to the geriatric wards at St Francis's with physical illness and varying degrees of dementia in addition. A special survey of this group, subsidized by the DHSS, has shown that 48 per cent of all patients over 65 years of age entering St Francis's geriatric wards from addresses in Camberwell are suffering from significant degrees of dementia, that is they have cognitive symptoms well in excess

of those consistent with normal ageing, whereas only 30 per cent of admissions in the same age group to psychiatric facilities were so affected.¹

A few patients with 'mental infirmity' attend Evelyn Coyle House on a day basis (three, at the end of 1971) and a few attend St Francis's psychiatric wing (one, at the end of 1971). The geriatric day-hospital is not covered by the register.

6. Hostels

6.1. STATISTICS, 1964-71 (J. K. Wing and Anthea M. Hailey)

The number of places provided in hostels can be very simply described since there are so few of them. In fact, for the mentally ill the local authority provides only a short-stay hostel (Evelyn Coyle) which opened in 1969, with twelve beds for the 'elderly mentally infirm', that is, patients suffering from mild dementia who do not need very much supervision, particularly at night. A few places are available in a hostel maintained by the neighbouring borough of Lewisham (Honor Lea) and a few in the longer-stay hostels of the Mental After-Care Association or other voluntary organizations none of which is in Southwark. The numbers of places occupied on successive census days were as follows:

	Evelyn Coyle (<i>mentally infirm</i>)	Honor Lea, MACA, and other hostels
31 December 1965	—	6
31 December 1966	—	10
31 December 1967	—	12
31 December 1968	—	14
31 December 1969	2	12
31 December 1970	2	10

Since the number of places for the elderly mentally infirm is so small very little more remains to be said. Other places available in Part III accommodation are certainly used by people suffering from dementia overlapping in severity with that found in in-patients. This accommodation is not covered by the register and no estimate can be made at the moment of the size of the overlap. Kay, Beamish, and Roth (1962) found that 42 per cent of patients first admitted to a geriatric ward, 29 per cent of those first admitted to welfare homes for the aged and 49 per cent of patients first

1. J. Copeland, personal communication. This study forms part of the US-UK project.

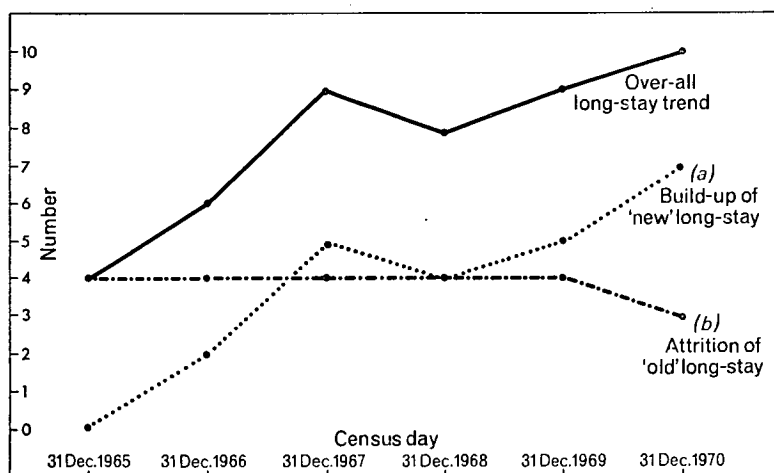


FIG. 6.9. Number of long-stay patients in psychiatric hospitals on annual census days, 1965-70 (Camberwell residents aged 15+, mental illness places).

admitted to mental hospital geriatric wards, from defined areas in Newcastle upon Tyne, were suffering from well-developed dementia.

The accumulation of long-stay patients is shown in Fig. 6.9 which is comparable with Fig. 6.5 for in-patients. The contrast with long-stay hospital bed trends is striking, since the build-up of new long-stay places more than balances the attrition of the old long-stay, with a consequent increase in total number of long-stay places.

Table 6.8 presents the data on which Fig. 6.9 is based and includes the numbers of short- and medium-stay places.

Table 6.8. *Numbers of patients in hostels on six annual census days*

	Annual census days					
	31 Dec. 1965	31 Dec. 1966	31 Dec. 1967	31 Dec. 1968	31 Dec. 1969	31 Dec. 1970
Short-stay <2 months	1	1	2	1	2	—
Medium-stay 2 months <1 year	1	3	1	5	3	2
Total, <1 year	2	4	3	6	5	2
Long-stay, 'old'	4	4	4	4	4	3
Long-stay, 'new'	—	2	5	4	5	7
Total, >1 year	4	6	9	8	9	10
Total	6	10	12	14	14	12

A summary of the hostel places available at the end of 1970 by length of stay and diagnosis, is given in Table 6.9.

It illustrates the lack of places for dementia: only one such patient was in a hostel on that day. These will be ignored in the statistical projections of bed-numbers that follow in Chapter 9.

Table 6.9. *Hostel places available on
31 December 1970, by length of
stay and diagnosis*

	<i>Dementia</i>	<i>Other conditions</i>
Under 1 year		
Honor Lea	—	—
Evelyn Coyle	1	1
MACA, etc.*	—	—
Over 1 year		
Honor Lea	—	4
MACA, etc.	—	6
Total	1	11

* Mental After-Care Association and other nursing homes or long-term hostels.

6.2. WINDSOR WALK HOUSING ASSOCIATION (J. L. T. Birley)

In an attempt to meet part of the need for hostel places, the Windsor Walk Housing Association was set up. This is a charitable organization whose aims are to establish and maintain houses to accommodate people suffering from psychiatric illness. A large Victorian terrace house has been acquired, with accommodation in bedsitters for about 8-10 people, a manageress-housekeeper lives locally. It is expected that this first house will be fully occupied by the spring of 1972 and that further houses will be acquired as seems necessary.

Non-residential services for the mentally ill, 1964-71

*D. H. Bennett, J. L. T. Birley,
Anthea M. Hailey, and J. K. Wing*

1. Day-hospitals, day-centres, and workshops

1.1. GENERAL PRINCIPLES (D. H. Bennett)

While the functions of observation wards and mental hospitals were changing, new developments in psychiatric care were being initiated elsewhere. Reformers attempted to treat the mentally ill with less restraint and less coercion. Mental hospitals and observation wards opened locked doors and accepted more and more patients without legal commitment. At the same time general, private, and university hospitals, which provided treatment for less ill or disabled patients, discovered that even the restraints of full-time admission were unnecessary. They began to admit patients for only part of the twenty-four hours or for part of the week. Some private hospitals admitted individual day-patients. Between 1948 and 1953, day and night hospitals were established in independent or university clinics in Canada, in England, and the United States. This new form of treatment was well received, not only by patients and their relatives, but by administrators, who appreciated that by these means, hospital care could be provided for less cost. 'One shift of personnel was needed, not three; one meal a day was supplied, not three. It provided care for a fraction of the capital, or initial cost of a new hospital. More people could be treated in less space and for less money' (Farndale, 1961). The advantages of partial hospitalization were especially apparent in those countries which lacked adequate facilities for in-patient admission. So partial hospitalization came into being when it was realized that the restraints of full admission to hospital were no

longer necessary, and its growth has been favoured in Britain by practical and economic advantage.

Day- and night-hospitals are no longer associated solely with general or university hospitals. Many mental hospitals now provide day care either within the main hospital or in attached centres. Of the many forms of partial hospitalization, day-treatment seems to be that most favoured and the first British day-hospital was opened by Bierer in 1948 (Bierer, 1951).

The Maudsley day-hospital opened in May 1953 and was accommodated in part of a large Victorian house within the grounds of the hospital (Harris, 1954). Its separate entrance opened on to the street. Rooms in the basement, on the ground, and first floors were used as a day-hospital while for a time the second floor functioned as a night-hospital. Harris, who had pioneered this development, at first admitted only twenty women. He had the assistance of a full-time registrar and one or two clinical assistants. Nursing care was provided by a doubly qualified ward sister and two junior nurses. The part-time services of a clinical psychologist, a psychiatric social worker, and an occupational therapist were also available (Harris, 1957). Harris believed (1956) that nurses found the work in the day-hospital congenial because a reduction in administrative duties, and the single shift working, enabled the sister and nursing staff to give more of their time to the patients. Their feeling that they were in close contact with the whole of the patient's life increased their sense of responsibility.

At one time patients were selected for the Maudsley day-hospital according to clearly stated criteria. Harris believed that patients must be so ill as to need admission to a hospital bed if the day-hospital did not exist. On the other hand the patient should not be too disturbed to come to the day-hospital or to manage at home, which should not be more than half an hour's journey away, at night. Patients who were alcoholic, suicidal, addicted to drugs or who showed psychopathic behaviour, were excluded. Harassed overworked housewives were said to do badly and to require in-patient admission in the end. At that time sensible affectionate relatives, willing to play an active, supporting role were preferred, although it was recognized that success had been achieved in less favourable family situations. Harris's criteria and those of Tobin (1958) reflect a preoccupation with the patient's psychiatric condition and his control of his behaviour and the demand for an ideal domestic situation. Suitability for day-hospital treatment was seen in terms of the patient and his illness. The family was considered only in terms of its capacity to care for the patient, and to bring him to, or fetch him from, the day-hospital. No attention

was given to the ways in which family relationships might influence day-hospital treatment or how day-treatment might affect the family itself.

Today, most psychiatrists would find it more difficult to say who may and who may not be suitable for day treatment. 'It is clear that day-hospitals follow their own individual policies both as regards patients admitted and treatment policies, both presumably being adapted to local needs and circumstances' (Statistical Report Series no. 7). The indications for admission are determined not only by the day-hospital's size, by its location, and the number and experience of staff, but also by the treatment available. The uncertain basis of selection is reflected in a study of patients admitted to Fort Logan State Hospital over a period of six months (Kraft, 1964). Equal numbers of day-patients and in-patients were compared on fifty items which included aspects of their behaviour, mental state, diagnosis, and previous treatment. Comparison showed that the only absolute bar to day-hospital admission was a patient's legal commitment. In-patients as a group were more disturbed and impaired in their behaviour, but many day-patients were no less disturbed. Although the two groups could be differentiated on a number of items, they could not be distinguished on such factors as 'danger to self', 'danger to others', 'previous suicidal attempts', 'distance from home to hospital', 'disturbance of relationship with family', or 'history of difficulty with the law'.

Later the Maudsley day-hospital admitted both male and female patients up to 30 at a time. Over 100 patients were admitted annually and another day-hospital was opened at the Bethlem Royal Hospital in 1956. At the Bethlem Royal and Maudsley day-hospitals in the triennium of 1955-7 there were 4 women patients to every male patient. In the triennium 1961-3 there were 5 women patients to every 3 male (Hare, 1959, 1965). By 1969 there was one male patient to one female patient in the Maudsley day-hospital (Statistical Report Series no. 7). This change in the proportion of male to female patients probably reflects a change in the unit's therapeutic aims and its admission criteria, and in the understanding by psychiatrists and others of the unit's purposes. Many psychiatrists and social workers still see the day-hospital as a social facility for the support of lonely or inadequate people. They make no distinction between day-hospital treatment and day-care. *Day-hospital treatment* is given in units which provide every form of treatment usually available in a psychiatric hospital. *Day-care* is provided in day-centres independent of a hospital and consists of social and occupational help with limited medical consultation.

From 1964 onwards it has been recognized that sooner or later, the Maudsley Hospital would come to provide a local service for the population in the old Metropolitan borough of Camberwell. We saw in the previous chapter how St Francis's Hospital had increasingly provided services for patients in Camberwell and contiguous areas of south-east London. It seemed clear that, as a district service for Camberwell developed, St Francis's observation unit and the Maudsley day-hospital would have to accept an increasing responsibility for the more disabled, more chronic or longer-staying patients. This meant that the day-hospital and St Francis's would have to be increasingly concerned with the rehabilitation of disabled patients. Between 1953 and 1969 there has been a decrease in the proportion of depressed patients admitted to the day-hospital while the proportion of those with schizophrenia and personality disorders has increased. The increase in the numbers of patients with schizophrenia followed the opening of the rehabilitation workshop in 1967 but that of the personality disorders was a steady, slow growth over the years. The day-hospital, in combination with a workshop, is a very useful rehabilitation facility. It also has an important part to play in a district psychiatric service as a link between patient, family, hospital, and social services (Sheldon and May, 1967). Rehabilitation and the principles underlying the establishment of the workshop are discussed in Chapters 18 and 19.

Much has been said about the administrative advantages of day-hospital care but the social advantages are no less important. Roles are complementary and that of the sick person will have an important influence on the roles of others with whom he lives and works. The less deviant the role, the less disturbing to family and society.

Erikson (1957) drew attention to the difficulties facing the mental patient who committed himself to a role similar to that of a physically sick person. In such a role the mental patient is exempted by society for a limited period of time from social obligations as long as he co-operates in treatment and recovers quickly (Parsons, 1951). If quick recovery does not occur, he may become anxious that any demonstration of social competence on his part will deprive him of his role and status as a 'patient'. There is every chance that he will decide that to continue as a 'patient' is the most satisfactory solution of this conflict. The individual then embraces the sick role, not as a temporary shelter from stress and conflict but as a permanent adaptation to society. Erikson recognized that the day-hospital could resolve a patient's 'dilemma' by separating the two aspects of his role; that of being sick enough to require help and that of needing some exemption from social responsi-

bilities. The day-hospital patient is able to obtain help as a sick person, while he still retains something of his status as a husband or father at home. In another article, Erikson (1962) showed that in-patient units which sought to control deviant behaviour might only perpetuate it when they gathered patients into highly segregated groups which reinforced their alienation from the rest of society. In the day-hospital, on the other hand, the patient is not removed from his place in society, nor is he forced to accept a totally deviant role which cannot be reversed. In this way the day-hospital can play a very important part in the rehabilitation of the psychiatric patient. While physical rehabilitation seeks to enable the disabled to perform physical tasks in a physical environment, psychiatric rehabilitation seeks to aid the psychiatrically disabled to perform social roles in a social environment. The day-hospital plays an important part in the patient's clinical rehabilitation by neither removing him from his role in society, nor forcing him to play a totally deviant role.

At present the day-hospital accommodates forty male and female patients every day. Some have acute treatment problems, some come daily from the wards of the St Francis's and Maudsley hospitals for rehabilitation, some live in the former borough of Camberwell and some come from outside this area. It has never been possible to provide enough day-places for all the Camberwell patients suitable for this form of care. So it has been impossible to estimate the extent to which day-hospital treatment can be applied to the care of the total psychiatric population of the area. Fox, Rutter, and Smith (1960) having examined 273 patients who were seen over two months in the Maudsley Hospital emergency (walk-in) clinic, considered that 109 (40 per cent) could have been admitted to the day-hospital by Harris's (1957) criteria. The patients examined were from a preselected hospital population and the estimate could not be tested. Kraft (1964) found that about 50 per cent of patients admitted to Fort Logan Hospital could be treated as day-patients. Zwerling and Wilder (1964) arranged that acutely ill psychiatric patients attending the Bronx Municipal Hospital Centre could be assigned at random to in-patient or day-patient care, once the decision to admit had been made. Of a random sample allocated to day-hospital care 66 per cent were accepted. Of the 34 per cent rejected, a half were suffering from acute or chronic brain syndromes. Two-thirds of those accepted were treated entirely in a day-hospital. The number treated solely in the day hospital approximates closely to the estimates of Fox, Rutter, and Smith (1960) and a little less closely to those of Kraft (1964). A further 27 per cent were treated in the day-hospital, but with a

short period of in-patient treatment not exceeding one week. In 1965, 638 patients were admitted to a number of hospitals serving the Camberwell area, and 64, or 10 per cent were admitted to day-hospitals. This figure shows that at present we might only be providing about a quarter of the day-hospital places needed.

Of course the clinical condition of day-patients fluctuates from day to day, and so too, may their family circumstances. Patients fail in their attendances or may leave the hospital suddenly. All members of the staff must make decisions at short notice. They cannot delay, cannot wait until tomorrow, cannot put the patient to bed, and sometimes cannot even wait to summon the doctor. Such situations increase the staff's feelings of anxiety. These often reach a peak in the late afternoon or at weekends when staff have to decide whether the patient is well enough to go home. How staff meet the recurring crises will depend on how they work together and this, in turn, will depend on how their work is organized. In a bureaucratic organization decisions are made by senior members of the hierarchy who issue instructions to junior members of the staff and not only tell them what they have to attend to, but also what they do not have to bother with. Hierarchical systems of this type do not meet the needs of a day-hospital which has to deal with more disabled and less predictable patients. Instead it requires an 'organic' system of staff organization (Burns and Stalker, 1966). Such a system allows any staff member who has knowledge of the immediate situation to become the centre of control and communication. All staff members must become part of a team which shares a common, or at least, compatible goal. They should also share a common code of conduct towards patients, their families, and other staff members, as well as a common language.

All that has been said points to one firm conclusion. There is no place, eventually, for a rigid distinction between day-treatment and in-patient treatment. They may complement each other or they may follow each other. No single treatment environment can meet the needs of any one patient over a period of time, and no single environment can meet the needs of all patients. There will have to be a closer integration of home, out-patient, in-patient, night- and day-care. Rigid distinction between types of care and administration by separate, isolated authorities means that patients are forced to circulate through various facilities. This is neither constructive nor therapeutic. The readmission of patients, 'the revolving door', has been accepted with a cynicism which disregards the rights of the revolving patient or the distress of those children who, when a parent becomes an in-patient, have to be taken away from their families.

Kraft (1964) has shown how different forms of treatment can be combined. This is a realistic situation. In most mental illnesses the period of crisis requiring in-patient admission is surprisingly short. Probably 40 per cent of the psychiatrically ill who are at present admitted can be treated as day-patients alone. If in-patient and day-treatment is combined, many more, possibly another 25 per cent can be treated with a very short period away from their homes. Before we make our plans we shall need more exact knowledge of the effects of day-treatment on families. In planning for the future we shall have to think more of day-*patients* and less of day-*hospitals*. The day-hospital is only a temporary expedient but one which can teach us valuable lessons by the reorganization of services for the mentally ill in the future design of psychiatric hospitals.

It will also be necessary to bring the day-centre very closely into relationship with the other services. The borough of Southwark has two centres which serve Camberwell patients. One, Castle Day-Centre, provides more active care, with the aim to return patients to employment eventually, while the other, Camberwell Day-Centre, provides longer-term care. Some industrial contract work is included. Psychiatrists from the joint hospital continue to treat their own patients while they are in day-care, but at the present time, no single psychiatrist is specifically concerned with either centre. Just as with in-patient wards, there is a great deal to be said for one co-ordinating doctor exercising clinical and administrative 'milieu' functions within each unit.

Apart from the Maudsley rehabilitation workshop, which operates in close association with the Maudsley day-hospital (see Chapter 18) there is a small privately run workshop-day-centre and a few psychiatric patients work in nearby Remploy factories.

1.2. STATISTICS, 1964-71 (J. K. Wing and Anthea M. Hailey)

Table 7.1 shows the increase in the number of day places provided. On the whole, the Maudsley day-hospital has not yet increased its proportion of local patients. The rehabilitation workshop, however, had provided 15 extra places by the end of 1970 and the policy of accepting day-patients at St Francis's, described in Chapter 6, section 2, also brought up the numbers considerably. Local authority day-centres steadily increased their provision throughout the period. Thus the numbers in all types of day-care had risen from 36 at the end of 1964 to 122 by the end of 1971. Of these, only 21 (12.4 per 100,000) were conventional day-hospital places.

The complementary Table 7.2 provides information on the numbers of admissions to day units during the six years under review.

Table 7.1. *Numbers of Camberwell residents in day-hospitals, day-centres, and workshops on census days. By agency*

<i>Agency</i>	<i>31 Dec. 1964</i>	<i>31 Dec. 1965</i>	<i>31 Dec. 1966</i>	<i>31 Dec. 1967</i>	<i>31 Dec. 1968</i>	<i>31 Dec. 1969</i>	<i>31 Dec. 1970</i>	<i>31 Dec. 1971</i>
Maudsley day-hospital	13	21	9	18	18	15	19	21
Maudsley workshop (not attending day-hospital)	—	—	—	5	12	9	16	15
St Francis's day-patients*	—	—	—	—	3	4	14	17
St Olave's day-hospital†	1	2	—	—	—	—	—	—
Local authority day-centres	16	24	32	37	50	50	59	62
Private workshops	6	10	12	15	13	12	9	7
Total	36	57	53	75	96	90	117	122

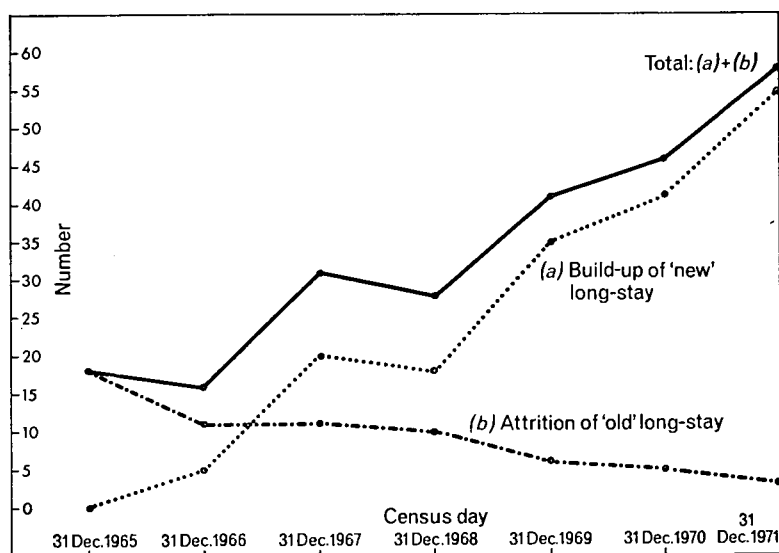
* In a spell of contact; not all would attend on any given day. † Not collected after 1966.

Table 7.2. Numbers of Camberwell admissions to day-hospitals, day-centres, and workshops, 1965-70

	1965	1966	1967	1968	1969	1970
Maudsley day-hospital	65	58	63	62	61	81
Maudsley rehabilitation workshop	—	—	8	25	26	31
St Olave's day-hospital	15	4	10	*	*	19
Local authority day-centres	27	33	32	42	41	45
Private and voluntary day-centres	5	4	5	3	1	1
Total admissions	112	99	118	132	129	177

* Information not collected routinely.

Fig. 7.1 presents data comparable to those in Fig. 6.5 and 6.9. The attrition of long-stay places in day-hospitals, day-centres, and workshops provided at the end of 1965 is contrasted with the build up of 'new' long-stay places. The picture is similar to that of hostels but, being based on rather larger numbers, is more reliable. It provides a complete contrast to the situation shown in Fig. 6.5, in which the 'old' long-stay group was steadily decreasing while a 'new' long-stay group was not replacing it, so that the over-all picture was of a run-down of long-stay beds. For day places, there

**FIG. 7.1.** Number of long-stay patients in day-hospitals, centres, and workshops on annual census days, 1965-70.

is only a very slow attrition of 'old' long-stay places but a steady build-up of 'new', with no sign of a plateau being reached. Taken together with Fig. 6.9 which shows a similar pattern for hostel places even though very few are available, the conclusion is inescapable that a new build-up of long-stay patients is taking place, only this time it is in the community instead of in hospital.

Table 7.3. *Numbers of patients in day-hospitals, day-centres, and workshops on annual census days (Camberwell residents 15+, mental illness places)*

	Annual census days						
	31 Dec. 1965	31 Dec. 1966	31 Dec. 1967	31 Dec. 1968	31 Dec. 1969	31 Dec. 1970	31 Dec. 1971
Short-stay <2 months	16	14	14	27	13	32	26
Medium-stay 2 months-1 year	23	23	30	41	36	39	49
Total, <1 year	39	37	44	68	49	71	75
Long-stay >1-year							
'old'	18	11	11	10	6	5	3
'new'	—	5	20	18	35	41	55
Total >1 year	18	16	31	28	41	46	58
Total	57	53	75	96	90	117	133

Table 7.3 presents the data on which Fig. 7.1 is based and includes the numbers of short-stay and medium-stay places as well.

Further data on the value of the new rehabilitation workshop for chronically handicapped psychotic patients will be given in Chapters 18 and 19. Table 7.4 gives a diagnostic breakdown of patients

Table 7.4. *Patients admitted to day-centres or day-hospitals, during 1965-70. Diagnosis.*

Diagnosis	Day-centres		Day-hospitals including rehabilitation unit	
	N	%	N	%
Schizophrenia	64	30	88	25
Affective psychoses	33	15	72	20
Organic psychoses	31	14	14	4
Depressive neuroses	36	17	98	28
Other neuroses	13	6	22	6
All others	37	17	61	17
Total*	214	100	355	100

* There is some overlap between the two groups of patients.

admitted to day-hospitals during the years 1965-70, and compares this with patients admitted to day-centres during this time (patients admitted to the rehabilitation workshop all spend a period in the Maudsley day-hospital first).

More patients with schizophrenic or organic psychoses are admitted to day-centres than to day-hospitals (44 per cent compared with 29 per cent) and fewer with affective disorders.

2. Out-patient facilities

2.1. GENERAL PSYCHIATRIC OUT-PATIENT DEPARTMENTS (J. K. Wing, J. L. T. Birley, and Anthea M. Hailey)

Shepherd, Cooper, *et al.* (1966) compared the distribution of the main psychiatric diagnostic categories in groups of first admitted in-patients, out-patients, and general practice patients. Among first admissions, the psychoses accounted for 72.3 per cent, the neuroses for 18.1 per cent, and the character disorders for 5 per cent. Among out-patients the equivalent proportions were 24.5, 43.6, and 23.2 per cent. In general practice the proportions were 4.2, 63.4, and 3.9 per cent (the remainder had other conditions). The factor of selection can plainly be seen at work; what tends to be called 'the path to the hospital'. At each stage, a screening process is at work, the nature of which varies at different times and in different localities. This process is partly in the hands of the doctor and partly of the patient.

There are, of course, other types of service intermediate between the GP's surgery and the out-patient clinic, notably the domiciliary consultation and the casualty or emergency clinic. Contact between family doctor and specialist may be made directly, for example by telephone. Consultations can also be arranged privately with psychiatric specialists, outside the NHS, though this is comparatively rare.

The first function of these out-patient facilities is to make a clinical and social diagnosis, on the basis of which the patient and family doctor can be advised concerning further action (often called 'disposal'.) This may take the form of admission to full or partial hospitalization, further out-patient attendance or immediate discharge. Occasionally a purely 'social' disposal is made, for example to a hostel or other social agency. The second function is that of treatment, short-term or long-term; including behavioural therapy, psychotherapy, supportive, and pharmacotherapy. Long-term management often includes much attention to the social milieu of the patient. At all stages, there may be transfer between in-patient, day-patient, out-patient, and social care. (For an

analysis of a surgical out-patient clinic, see Williams and Wiseman, 1972.)

Carstairs and Bruhn (1962), discussing the differences between British and American practice, suggest that

in the former, short-term treatments with relatively brief interviews and much reliance on drug therapy is the rule; in the latter, relatively long-term treatment, with an emphasis on extensive psychotherapeutic interviews is the preferred approach. British practice approximates rather closely to that of the busy doctor's surgery, or of the crowded medical or surgical out-patient clinic, both in its concentration upon somatic symptoms and somatic remedies and in its tendency to neglect the time-consuming but vitally important task of taking a full social history and appraising the patient's current personal problems. . . . The British clinic is thus relatively well equipped to deal with functional and organic psychoses, that is with those conditions where psychiatric practice most closely resembles physical medicine. In the familiar transactions of medication and of physical treatment both doctor and patient feel at home. It is only the psychosomatic, the mildly depressed and the inadequate patients who fail to profit from this approach. . . .

Three important assumptions are made which might be questioned. In the first place, comparative register studies do not indicate that, when the services of a whole area are considered (as opposed to the highly selected groups attending certain clinics), American patients receive more out-patient treatment than British (L. Wing *et al.*, 1967). Out-patient services are only now coming to be provided on a community scale, through the mental health centres, and the most severely handicapped patients do not yet attend even these centres to the extent that was envisaged (Cumming, 1968; Goldberg, 1971). Secondly, it is not yet clear to what extent the two approaches described as typical of British and American psychiatry do actually differentially benefit neurotic patients. Finally, there is no mention of long-term social treatments, including rehabilitation and management, which may well also differentiate the practices of the two countries.

Comparative out-patient studies are very much in their infancy; it is too soon to make generalizations about the practices of total services, as against those of specific agencies. However, it is true enough that, measured by treatment rates per 100,000 population, psychotherapy is a most uncommon treatment in the NHS. Further details of a special study of specialized psychotherapy and supportive treatment, based on the Camberwell Register, are given in Chapter 16.

Camberwell residents and their doctors have a wide range of out-patient services at their disposal. During 1969, patients

attended psychiatric out-patient and day emergency clinics on approximately 10,000 occasions (a rate of 5,822 per 100,000 population, compared with a rate of 2,544 for all regional hospital boards in England and Wales and of 4,293 for the four Metropolitan regional boards and teaching hospitals). There is virtually no waiting-list.

Table 7.5. *Numbers of patients making contact with out-patient and emergency clinics during the years 1965-70, and numbers of contacts made. By agency*

Agency	1965	1966	1967	1968	1969	1970
Maudsley, St Francis's						
Contacts	5,115	5,476	5,958	6,799	7,782	7,859
Patients	1,049	1,147	1,280	1,355	1,535	1,543
King's College, Guy's, St Thomas's						
Contacts	1,189	1,207	1,262	1,201	1,168	1,134
Patients	287	284	321	289	288	316
St Giles's (Cane Hill)						
Contacts	1,747	975	1,367	1,310	1,046	996
Patients	413	334	390	372	311	276
Other						
Contacts	146	115	56†	28†	12†	58†
Patients	41	31	30	10	12	14
Total*						
Contacts	8,197	7,773	8,643	9,338	10,008	10,047
Patients	1,729	1,743	1,964	1,970	2,089	2,080

* Unduplicated total of patients within each separate year.

† Information not collected routinely.

Table 7.5 shows the numbers of patients attending various hospital clinics during each year from 1965 to 1970 and the number of contacts they made. There was an increase from 1,729 patients making at least one contact in 1965 to 2,080 in 1970. This increase took place mainly at the Maudsley Hospital's clinics. There was also some increase at King's College Hospital's out-patient department, though the data for new referrals (not only from Camberwell) given in Chapter 8 suggest that the rate of increase of referrals to out-patients may be levelling off compared with former years.

It is difficult to calculate a figure equivalent to bed-ratio to indicate the 'capacity' of an out-patient service (in effect, the number of patients who can be dealt with at a given time). One approximation to 'capacity', however, is the number of patients who are in a spell of contact on any given day. A spell of contact is defined operationally as that period of time during which a patient is making contact with out-patient services with a maximum gap of three months between contacts. If the patient is out of contact for

three months, the spell is terminated from the date of the previous contact. A spell of out-patient contact can thus be dealt with statistically in the same way as a spell of in-patient or day-patient contact: one-day or one-year reported prevalence can be obtained, mean length of spell can be calculated, numbers of spells can be counted, and so on. According to the definitions used by the Camberwell Register, 'spells' are limited to one kind of service contact (in-patient spell, out-patient spell, etc.) while two or more consecutive spells of different kinds of contact make up an 'episode'.

Table 7.6. *Numbers of patients in a spell of out-patient or emergency clinic contact on six-monthly census days*

Census day	Maudsley	King's College		St Giles's (Cane Hill)	St Francis's	Total
		Guy's St Thomas's				
31 Dec. 1964	250	58	149	—	—	457
30 June 1965	312	76	156	—	—	544
31 Dec. 1965	322	68	136	—	—	526
30 June 1966	358	79	72	—	—	509
31 Dec. 1966	347	77	106	—	—	530
30 June 1967	336	79	104	—	—	519
31 Dec. 1967	361	77	113	8	—	551
30 June 1968	383	70	115	12	—	580
31 Dec. 1968	384	55	84	13	—	536
30 June 1969	422	78	94	11	—	605
31 Dec. 1969	409	82	89	22	—	602
30 June 1970	390	70	97	30	—	587
31 Dec. 1970	368	62	100	24	—	554
30 June 1971	402	82	83	33	—	600

The numbers of patients in a spell of contact with out-patient and emergency clinic contact on six-monthly census days from 31 December 1964 to 31 December 1970 are shown in Table 7.6. There has been a considerable increase during this period, particularly at the Maudsley and St Francis's, while the numbers at St Giles's (Cane Hill) have tended to decrease. At the end of 1970, 327 per 100,000 population were in a spell of out-patient contact, while 24 per 100,000 were in a spell of day-hospital contact and 282 per 100,000 were in-patients, making a total unduplicated one-day prevalence of 633 per 100,000.

An index analogous to 'turnover' may be calculated by dividing the number of patients seen in out-patient departments during a given year by the number in a spell of contact on 30 June of that year. According to this index, the 'turnover' remained much the same at all three types of hospital, when 1965 and 1970 were compared (Maudsley, 3.4 and 3.7; King's College Hospital and

other undergraduate teaching hospitals, 3.6 and 4.5; St Giles's, 2.7 and 2.9).

Of all the patients seen in out-patient departments during 1970, 33 per cent attended only once, 44 per cent on 2-5 occasions, and 18 per cent 6-12 times. Those who attended more than 12 times during the year accounted for only 5 per cent of all out-patients. There was very little difference in frequency of contact between those (31 per cent) who were given a diagnosis of a psychotic disorder, and the rest.

A study of diagnostic distribution in out-patients attending during 1969 indicates the expected predominance of non-psychotic conditions. Only 11 per cent of patients had a diagnosis of schizophrenia, 1 per cent of organic condition, and 19 per cent of depressive psychosis. Neurotic depression constituted 35 per cent and other neuroses 13 per cent of the total. The diagnostic distributions were much the same at the Maudsley and King's College Hospital but the clientele at St Giles's was more likely to be diagnosed schizophrenic and less likely to be diagnosed neurotic.

Kaaser and Cooper (1971) have reported a study of 183 patients referred to the Maudsley out-patient department, 110 to the emergency clinic, and 73 to routine out-patient clinics. One-quarter had been referred at their own instigation or that of their relatives. The authors interviewed GPs soon after the patient had been referred and again three months later, when they also interviewed the patients. They found that the great majority of the GPs expected the patients to be taken on for treatment. However, of those about whom the family doctor only wanted advice, two-thirds were not, in fact, referred back. The hospital took 'on care' the large majority of the sample, mainly in the out-patient department, only 139 being admitted.

The care provided appeared in some respects inadequate. Three months after the patients had first been seen, 31 per cent had lapsed from attendance and another 26 per cent had been discharged, but there was no difference in outcome between the two groups. The GPs' opinions of the service remained broadly favourable; so did the patients', but over half (53 per cent) were nevertheless unable to remember the name of any psychiatrist they had seen. The process of referral of a substantial group of patients might, therefore, be regarded as purely ritualistic. A more managerial interpretation might suggest that a good deal of trial and error selection goes on, by patient, GP, and consultant, and that early termination in half the cases is a satisfactory solution, since it allows more intensive care to be concentrated on the remainder.

As will be seen in Chapters 16 and 20, the evaluation of out-

patient and social work services has hardly yet begun but it raises fundamental questions concerning the most effective and the most economical forms of care for many patients who are at present referred to consultant services.

Another important function of an out-patient service is the further treatment and supervision of patients who have been discharged from in-patient care. In 1965, patients discharged from the joint hospital stood a considerably better chance (79 per cent) of attending at least once in the out-patient department during the subsequent three months than did those discharged from Cane Hill (50 per cent), and also more chance of being seen three times or more (54 compared with 37 per cent). This may reflect the fact that Cane Hill patients included a larger number of socially disorganized people who would not be able to keep set appointments. Watson, Bennet, and Isaacs (1970) therefore devised a 'ward follow-up system' at St Francis's Hospital to cater for such patients as they were taken over by the Camberwell community service. It was assumed that they would be more likely to return to a ward setting with which they had already become familiar, and to nurses whom they knew, than to the relatively strange and impersonal atmosphere of an out-patient department (see Chapter 6). Further evaluative work needs to be done to determine the success of this procedure.

2.2. EMERGENCY SERVICES (J. L. T. Birley and Anthea M. Hailey)

Several workers in this country (Whiteley and Denison, 1963; Mountney, Fryers, and Freeman, 1969) and in the United States (Ungerleider, 1960; Weisz, Houts, and Straight, 1970) have analysed the kind of patient who uses the emergency clinic, and have pointed to the wide range of functions that can be undertaken, from 'disposal' alone to a full course of treatment as well.

The Maudsley Hospital has run an emergency or 'walk-in' clinic since 1951 (Fox, Rutter, and Smith, 1960; Varley, 1963; Brothwood, 1965; Birley, 1967). It provides a no-waiting service for patients referred by themselves, their GPs, or other medical services or social agencies. To some extent it acts as a stop-gap for the inadequacy of other services, both within the joint hospital (cancelled out-patient clinics, patient's doctor not available, long waiting-lists for routine appointments) and outside it (lack of 'psychiatric cover' for general hospital casualty departments particularly at night, or for other urgent referrals from general hospitals or for domiciliary visits). Camberwell patients have accounted for some 15-20 per cent of the work of the clinic; a

proportion which has not changed much over the years since the Register was set up except for night and weekend emergencies, which have increased markedly.

Domiciliary visits made by psychiatrists at the request of GPs or mental health social workers are usually also emergency calls. As with emergency out-patient visits, what is mainly required is a social and medical diagnosis and 'disposal', that is, a decision concerning the immediate action to be taken. One consultant psychiatrist at the joint hospital is in general charge of the out-patient arrangements for Camberwell patients and a roster of consultants ensures that someone is always on call for domiciliary visits. The emergency clinic is, of course, much less wasteful of the consultant's time, though most psychiatrists regard their domiciliary work as an important part of their professional experience, since it gives them a chance to observe family reactions to psychiatric crises at first hand.

Table 7.7. *Numbers of patients contacting Maudsley out-patients, emergency, and domiciliary services during each year from 1965 to 1970*

	1965	1966	1967	1968	1969	1970
Out-patient department (routine)	906	1,011	1,170	1,192	1,372	1,363
Day emergency clinic	434	365	392	496	455	410
Night emergency clinic	11*	82	135	257	322	308
Domiciliary visits	24	23	29	29	45	87

* Not collected in full in 1965.

Table 7.7 shows the numbers of patients attending the Maudsley out-patient department's routine clinics, and the day and night emergency clinics. The numbers visited at home on domiciliary calls by joint hospital psychiatrists are also shown. (Cane Hill psychiatrists also undertake some of the domiciliary work.) This shows the increase in numbers of patients and of contacts over the period, which is partly at the expense of the Cane Hill service at St Giles's but is largely due to extra patients being referred. The increase in night emergencies is particularly striking.

Approximately 15-20 per cent of patients seen on emergency contacts are admitted to hospital. The proportion is rather higher for self-referred patients and those referred by social agencies than it is for those referred by their general practitioners.

One function which might be expected to be performed by the emergency services is suicide prevention. Mindham and Birley (1972), in a study of 140 patients attending the emergency clinic, found that a considerable proportion could be regarded as suicidal

risks. One-third had made at least one previous attempt or gesture and nearly half were preoccupied to some extent by suicidal thoughts. One-third had talked about suicide to other people. Only 27 (20 per cent) could be said to be severe risks and, of these, only 10 were admitted to hospital. It is difficult to evaluate how far suicide was, in fact, prevented, but the rate for 1969 and 1970 was little different to what it had been previously; if anything, there was a slow increase in rate. However, less than a quarter of those who committed suicide were known to the psychiatric services (on the whole, these were the younger ones). Data concerning a follow-up of patients who attempted suicide, which possibly indicate a more successful preventive role for out-patient supervision, are mentioned in the next chapter.

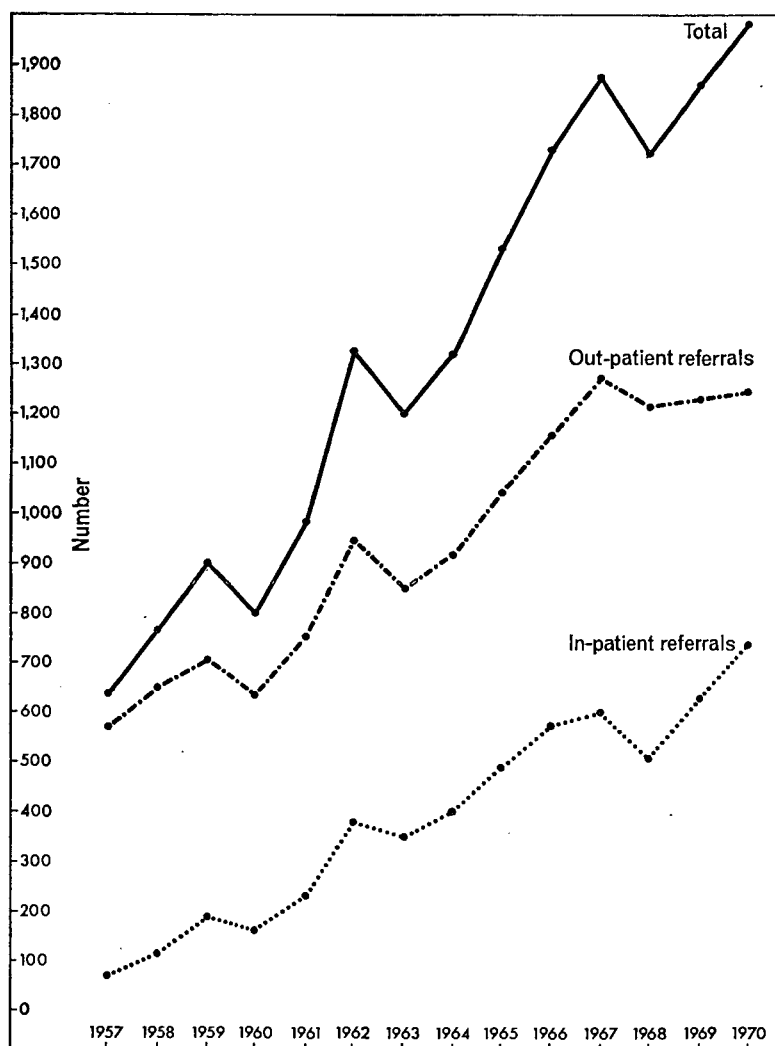
One of the main conclusions of this chapter must be that systematic evaluation of the effectiveness of out-patient services remains to be carried out and should receive high priority.

The department of psychological medicine at King's College Hospital

S. Greer and D. W. Liddell

The early development of a department of psychological medicine at King's College Hospital was briefly summarized in Chapter 3. During the 1930s, a 35-bed ward at King's was made available to Mapother and the Maudsley Hospital, at a time when none of the eleven other London teaching hospitals provided any accommodation for psychiatric in-patients. When this lapsed, with Mapother's retirement, it was many years before any teaching hospital again admitted psychiatric in-patients. The Mental Health Act encouraged the development of such units but the response was wary and slow. Thus, even in 1962, all twelve teaching hospitals between them provided only 72 NHS psychiatric beds on site, although they were prepared to establish in-patient units at associated hospitals some miles from the parent hospital (Curran, 1964). This tendency to place psychiatric units some distance from the main site cannot be explained entirely on the grounds of convenience and may be, in part, a reflection of persisting Victorian attitudes.

However that may be, it is clear that some progress has been made. The need for establishing adequate psychiatric services has now been accepted by teaching hospitals as part of their recent commitment to provide comprehensive district health services. These major changes in policy have, of course, drastically increased the workload of general hospital psychiatric units. Some indication of these changes is provided by the data contained in Fig. 8.1, in respect of the psychological medicine department of King's College Hospital.



G. 8.1. New patients referred to King's College Hospital, 1957-70.

Between 1957 and 1970, the number of new patients seen in the department trebled, from 639 to 1,990; this is accounted for by an approximately two-fold increase in out-patients, from 572 to 1,249, and more than a ten-fold increase of referrals of patients from medical, surgical, and other wards, from 67 to 741. These figures, it must be emphasized, only go up to 1970 and do *not* include the

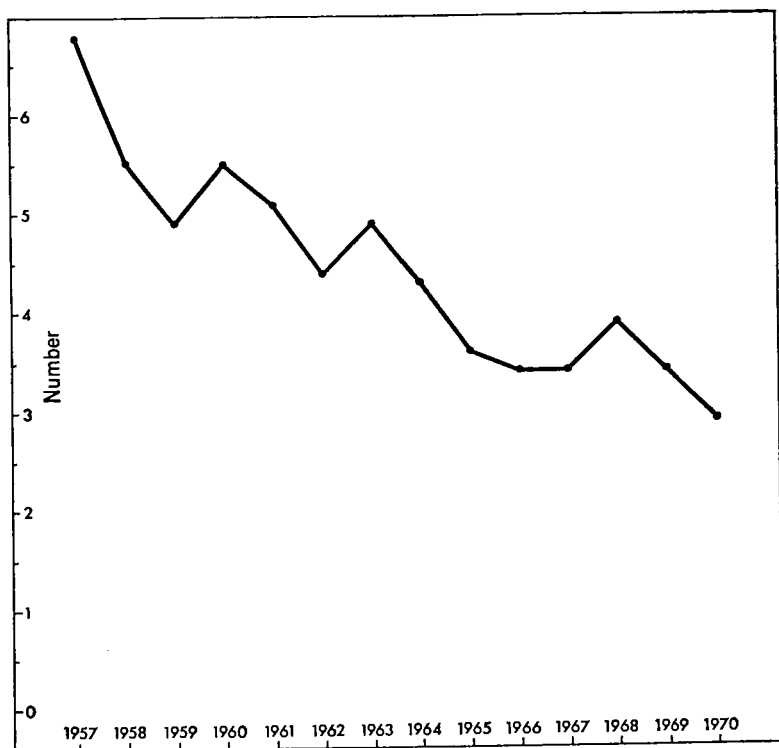


FIG. 8.2. Average number of occasions on which out-patients were interviewed during each year, 1957-70: King's College Hospital psychiatric out-patient department.

extensive additional work involved in taking over district psychiatric services in 1971. The district allocated to King's is Camberwell and East Lambeth. The Maudsley is coping, by agreement, with the Camberwell area, leaving East Lambeth for the King's College Hospital department of psychological medicine. How, then, has the department coped with the increased volume of work? A useful, though admittedly crude index is provided in Fig. 8.2.

Whereas in 1957 each new out-patient was seen on average 6.8 times, by 1970 each patient was seen only on an average of 2.9 occasions. The fall in the number of treatment sessions cannot be attributed to any dramatic advances in therapy; on the contrary, it indicates a decline in the quantity of psychiatric attention to individuals which is balanced by an increase in the quantity of

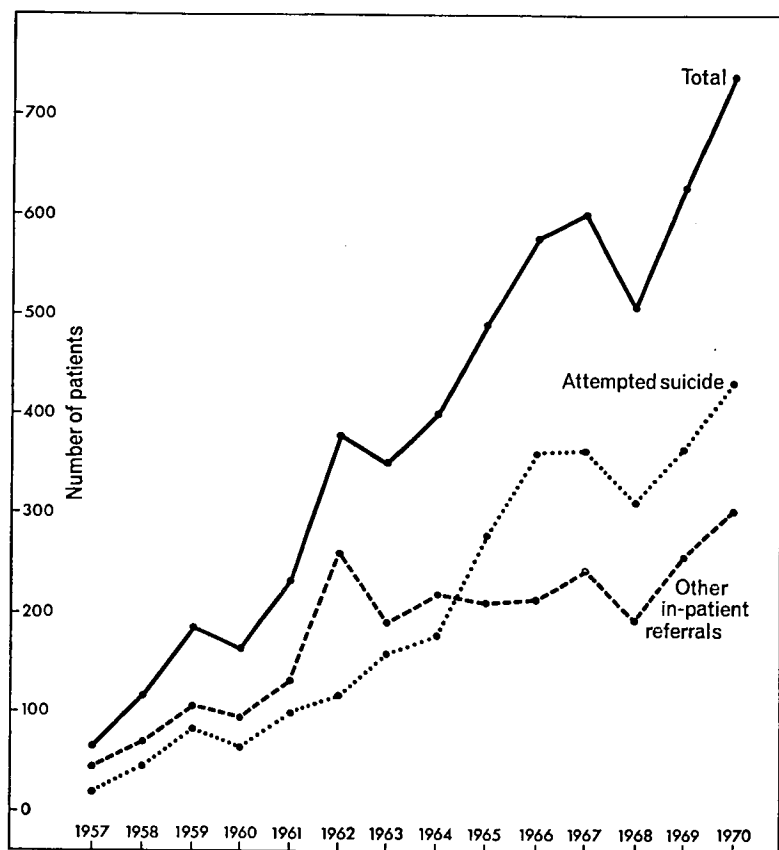


FIG. 8.3. In-patients on general wards referred for psychiatric assessment, King's College Hospital, 1957-70.

work in general; in other words, what the psychiatrist has to offer is spread more thinly.

The rise in new patients referred to the department between 1957 and 1970 was, as shown in Fig. 8.1, rather steeper among in-patients than among out-patients. The in-patients from medical, surgical, and other wards at King's who were referred for psychiatric assessment increased ten-fold. Further analysis (Fig. 8.3) indicates that this increase was accounted for by a twenty-fold rise in referrals for suicidal attempts and a smaller rise in other in-patient referrals.

The enormous increase in referrals for attempted suicide is, of course, partly attributable to changes in medical policy. Thus, in

1961, when suicidal behaviour ceased to be a criminal offence, the Ministry of Health sent a circular to all hospitals recommending that any patient attempting suicide should be seen by a psychiatrist before discharge (Ministry of Health, 1961). The implementation of that recommendation as well as the establishment of a district accident service at King's in 1965 contributed to the steep rise in attempted suicide admissions. There can be little doubt that a real and substantial increase in attempted suicide rates has also taken place; such rates are rising by probably as much as 10 per cent each year (Aitken *et al.*, 1969; Bagley, 1970). The incidence of deliberate self-poisoning has, according to a detailed official report, reached 'epidemic proportions' and presents a serious public health problem (Scottish Health Services Council, 1968).

The influx of admissions for attempted suicide was unforeseen and created serious problems at King's for the casualty department, for medical firms which admit these patients and, of course, for the psychological medicine department. Pressure of work, long waiting-lists for medical beds, and inadequate facilities in all these overburdened departments, led some casualty officers and medical registrars to send home a proportion of these patients before they had been seen by a psychiatrist. This was unfortunate: a subsequent follow-up study showed that 39 per cent of such patients repeated their suicidal attempts and 4 per cent killed themselves within eighteen months, whereas those seen by a psychiatrist made significantly fewer suicidal attempts (Greer and Bagley, 1971). But psychiatrists' gratification that their efforts produced some tangible results must be tempered by the knowledge that their standards, too, fell short of those expected from a teaching hospital department. Thus, only 54 per cent of the patients who attempted suicide referred to the department could be offered any kind of continuing psychiatric or social help; the remaining patients had only the briefest contact with psychiatric services, amounting to one or, at the very most, two interviews. The cited study reveals that, in 1968 at any rate, the management of attempted suicide patients by casualty doctors, physicians, and psychiatrists alike, was unsatisfactory. Although some of the deficiencies have been rectified, there remains a striking contrast between the excellent medical facilities provided for the physical resuscitation of these patients and the inadequate psychiatric and social services available for their after-care.

This state of affairs provides a good illustration of the problems faced by psychiatric departments in general teaching hospitals. In the inevitable competition within the hospital for the limited funds available, psychiatry usually fares badly, competing as it

does with older, more established disciplines as well as with newer, more glamorous, and vastly more costly medical activities such as organ transplantation. Psychiatry, like geriatrics and medical services concerned with care of the chronic sick, remains low on the list of priorities. Yet there are indications that society is becoming more willing to spend money on these neglected areas of medicine, a trend which is increasingly reflected in the policy of King's and other teaching hospitals. McKeown's (1958) vision of a balanced hospital community is being translated into reality and with it a psychiatric department which is closely integrated with the rest of the hospital on the one hand and with community services on the other.

Statistical projections of service utilization

J. K. Wing and Anthea M. Hailey

1. Introduction

At the end of 1954, there were 152,197 patients in the psychiatric hospitals and units of England and Wales; 344 for every 100,000 people in the population. This was the turning point. After increasing steadily throughout the century, the number of beds began to go down. On 31 December 1970, there were only 113,127 beds; 231 per 100,000. Nearly three-quarters of the patients were long-stay, that is, they had been resident for more than a year, while about 65 beds per 100,000 were used by shorter-stay patients. Most attempts to estimate how many beds will be needed in future are grounded partly on the observation of statistical trends and partly on value judgements as to how far the trends should be allowed, or provoked, to go (Wing, 1971).

So far as statistical trends in conventional bed numbers are concerned, the calculation has three components: the number of beds at present occupied by patients who have been in hospital longer than a year (the accumulation from the past); the number of beds needed for patients who will become long-stay in the future; and the number of shorter-stay beds. These three components will first of all be considered separately and then brought together in a general discussion of trends in bed usage. However, it should be emphasized that a central thesis of this book is that statistics in themselves are very little use to planners. They are of value only when considered in the light of other kinds of information. Some of the clinical and administrative ideas shared by those responsible for planning the Camberwell services have already been discussed and are of paramount importance. For example, it would not

matter very much if the trend were towards the provision of fewer hostel places; the policy would remain that *more* should be provided. As it is, trends in hostel provision can hardly be calculated since the numbers are so low, but decisions must still be made. Similarly with hospital beds; it is not to be assumed, simply because the trend is towards less use of hospital beds that this is what *ought* to continue to happen in future. Statistical indices are no substitute for value judgements. Some of the further data necessary for informed judgements will be presented in Parts Three and Four and recommendations will be left until then. Meanwhile, the statistical projections are presented as an important but by no means decisive contribution to the pool of information needed for planning.

Table 9.1. *Run-down of long-stay beds (percentage)*

	<i>Discharged</i>	<i>Died</i>	<i>Remaining</i>
<i>31 Dec. 1964, N = 416</i>			
1965	2.6	7.7	89.7
1966	2.4	6.5	80.8
1967	1.7	7.5	71.6
1968	0.7	4.1	66.8
1969	1.9	4.3	60.6
1970	0.7	4.1	55.8
1971	1.7	4.1	50.0
<i>31 Dec. 1965, N = 414</i>			
1966	4.6	8.0	87.4
1967	2.4	8.7	76.3
1968	0.7	5.1	70.5
1969	2.2	5.5	62.8
1970	1.2	3.9	57.7
<i>31 Dec. 1966, N = 397</i>			
1967	3.0	10.3	86.6
1968	1.5	6.8	78.3
1969	2.3	6.5	69.5
1970	1.5	4.3	63.7
<i>31 Dec. 1967, N = 376</i>			
1968	4.3	7.2	88.5
1969	3.2	8.0	77.4
1970	2.1	4.8	70.5
<i>31 Dec. 1968, N = 350</i>			
1969	4.6	8.3	87.1
1970	2.6	6.3	78.3

2. The 'old' long-stay

The first component in the calculation is the number of beds required for patients who have already become long-stay. Figs. 6.5 and 6.7 together show the rate of attrition over a six-year period in the cohort of 416 beds occupied by long-stay patients on 31 December 1964. Table 9.1 presents data for each such cohort in successive years. For the reasons given in Chapter 6, section 5, the 'old' long-stay group with a diagnosis of dementia can be included with the rest.

If the proportions of each cohort remaining at the end of successive years are plotted on a graph it will be seen that, in each case, the result is a curve rather than a straight line. For a detailed discussion of methods see Lindsay (1962), Baldwin and Hall (1967), and Hailey (1971). How these curves are to be projected into the future is guesswork. Everything depends, for example, on

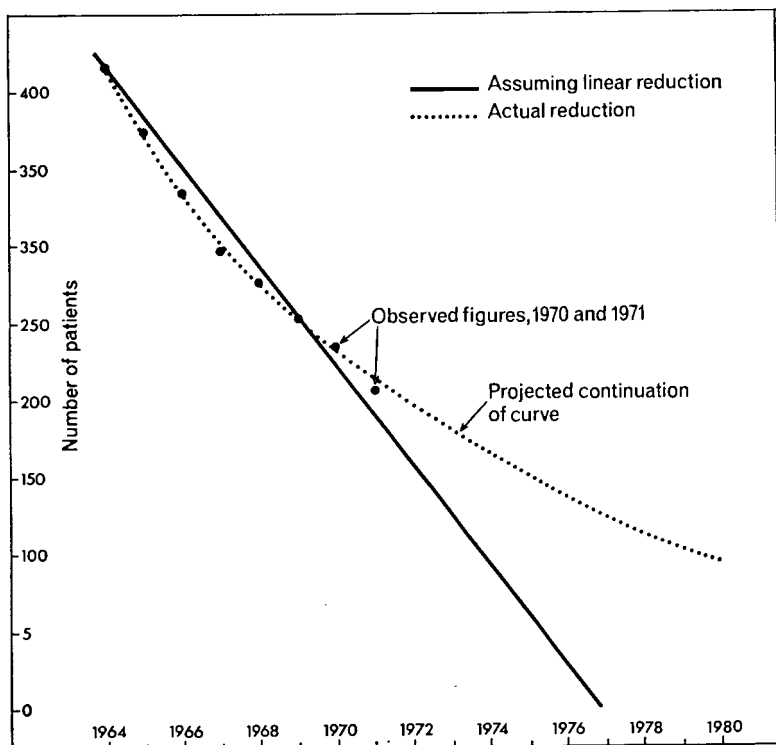


FIG. 9.1. Reduction of long-stay population: Camberwell residents in hospital more than one year on 31 December 1964.

whether an energetic reformer decides that the patients are to be discharged or transferred to other accommodation, or whether the climate of opinion changes against community care. It may be observed, however, that attrition is due mainly to deaths and not to discharges.

The effects of applying straight-line and curvilinear projections to the long-stay cohort remaining at the end of 1964, based on observed trends until the end of 1969, are shown in Fig. 9.1. The simple method of Tooth and Brooke (1961), assuming a linear trend which will continue until all the cohort have left hospital, leads to a prediction that none will remain after thirteen years, that is, by the end of 1977. Tooth and Brooke's formula assumes that the cohort will be reduced by the same number each year, that is $x_{n+1} = x_n - c$ where c is a constant.

Lindsay used the Tooth and Brook data to show that what in fact seems to happen is that the cohort loses a similar *proportion* each year. An appropriate formula would be $x_{n+1} = x_n - (1/c)x_n$ where c is a constant. In so far as it is possible to predict at all, this curvilinear trend seems more convincing. Using the figures for the run-down of the 31 December 1964 cohort during the five years to the end of 1969 as a basis on which to draw a curve, the observed figures for the end of 1970 and 1971 lie very close to its projected continuation.

3. The 'new' long-stay

The second component in the calculation of future bed use is an estimate of the extent to which new long-stay patients are accumulating to replace the old. Fig. 6.5 showed for patients with conditions other than dementia, that during the period from the end of 1964 to the end of 1970, the new build-up comes nowhere near replacing the losses due to attrition of the 'old' long-stay group.

Table 9.2 shows the number of patients admitted during successive years, who remained in hospital as long as one year. Patients with dementia are shown separately from the rest and figures are given for each of the sexes. Thus, 25 patients suffering from dementia (19 of them women), and 20 with other conditions (11 of them men), were admitted to hospital during 1964 and remained there for at least one year. The rate of 'recruitment' to the long-stay group showed a definite fall off over the years for patients with dementia, though not for the other patients. Only 9 patients with dementia, out of the 1970 cohort of admissions (all of them women), became long-stay. This may well have been due

Table 9.2. *Numbers of patients recruited to become long-stay, out of successive annual cohorts of admissions: by diagnosis and sex (Camberwell residents, 15+)*

ADMITTED DURING THE YEAR	NUMBERS BECOMING LONG-STAY			
	Dementia		Other conditions	
	M	F	M	F
1964	6	19	9	11
1965	2	17	4	18
1966	2	13	8	13
1967	2	12	5	11
1968	1	11	14	11
1969	1	8	12	13
1970	—	9	12	12

to the increasing attention paid to the community care of elderly patients during this period (see, for example, Table 4.4).

Table 9.3 shows the run-down in the numbers of beds for long-stay patients recruited from the 1964 cohort of admissions. Twenty-five patients with dementia and 20 with other conditions, who were admitted during 1964, remained in hospital at least a year.¹ Following their progress from the time they became long-stay, it can be seen that only 3 patients with dementia remained in hospital six years after they became long-stay (most of the others have died), and that only 3 patients with other conditions (all of them men) have remained continuously in hospital throughout the following six years.

It may be assumed, on the basis of Table 9.2, that the starting cohorts of patients recruited to the long-stay group will be somewhat smaller in future, at least for patients with dementia, since the

Table 9.3. *Attrition in numbers of long-stay patients from 1964 cohort of admissions*

Patients remaining at end of:	Dementia		Other conditions	
	M	F	M	F
One year	6	19	9	11
Two years	5	16	7	4
Three years	3	13	5	3
Four years	2	10	3	1
Five years	1	8	3	1
Six years	1	2	3	1
Seven years	1	2	3	—

1. The figures are based upon each patient's personal follow-up period, one year, two years, etc., from the date of admission.

trend is in that direction. Table 9.4 shows the possible accumulation, over a ten-year period, of 'new' long-stay patients. If only 15 patients with dementia and 20 patients with other conditions become long-stay each year, it can be estimated that approximately 60 long-stay places would be needed for patients with dementia (51 of them women) and approximately 65 long-stay places for patients with other conditions (42 of them men).

Table 9.4. *Build-up of 'new' long-stay group if recent trends are continued and policies do not change: by diagnosis and sex.*

	Dementia		Other conditions	
	M	F	M	F
Starting cohort	3	12	10	10
After two years	3	10	8	3
three years	1	8	5	3
four years	1	6	3	1
five years	1	5	3	1
six years	—	4	3	1
seven years	—	3	3	1
eight years	—	2	3	1
nine years	—	1	2	1
ten years	—	—	2	1
Accumulation	9	51	42	23

There is, of course, no reason to suppose that the attrition observed in the cohort of 'new' long-stay patients recruited from 1964 admissions will hold for future cohorts. In fact if the attrition observed in the 1965 cohort were used, rather different figures would result (45 beds for patients with dementia but 85 beds for patients with other conditions). A very crude check can be made by comparing these figures with the current bed occupancy for patients on a given day who have been in hospital more than one but less than ten years. Long-stay bed occupancy within this group reflects the policies of the recent past rather than those of the future but the assumption that these will remain stable underlies all projections. On six annual census days, the numbers of patients with dementia who had been in hospital more than one but less than ten years varied between 40 (1964) and 53 (1967), with a mean of 47. Comparing these figures with the estimated build up of 60 patients using the 1964 figures or 45 patients using the 1965 figures, perhaps it is reasonable to settle on a round number of 50.

The equivalent comparison for the group of patients not suffer-

ing from dementia is less helpful. The numbers in hospital from one to ten years on annual census days have been steadily falling, from 114 in 1964 to 78 in 1968. It seems likely that this decline will have continued, in which case 65 beds (the 1964 forecast) might be realistic and 85 beds (the 1965 forecast) too high.

As a final check, the data in Figs. 6.5 and 6.7 should be considered. They show the actual numbers of long-stay patients using beds on annual census days who had accumulated since the end of 1964. At the end of 1971 there were 25 patients with dementia plus 53 with other conditions. These numbers are very much smaller than the 50 plus 65 calculated above. The period of accumulation was, of course, only seven instead of ten years, but the interesting thing to notice is that the trend in both demented and non-demented groups was for a rapid build-up in numbers over two or three years after which a plateau was reached, or only a very slow increase. This suggests that, according to the most recent trends, the estimates made earlier may be too high.

However, it also shows how fluctuating the situation is and that further policy changes could well affect it either way. It is not sensible to take figures of this kind too seriously; they should be used as a statement concerning the present and immediate future and as a guide to evaluation rather than to prediction.

4. Short- and medium-stay beds

The third component in the calculation of future bed use deals with short- and medium-stay beds. Table 6.2 showed that 155 beds were being used, on average, during the years 1965-71. The numbers used by patients with dementia decreased during this period and, towards the end, only about 15 were being used (Chapter 6, section 5).

The other 140 shorter-stay beds were used by patients with conditions other than dementia. Although this is a higher number than would be calculated on the basis of the national figures, it is not out of the way for a teaching hospital. However, it will be shown in Chapter 13 that not all these patients needed to be admitted to hospital.

5. Projected bed usage, 1980

The three components in the calculation of future bed usage are summarized in Table 9.5. If the purely statistical considerations discussed in this chapter are any guide and assuming that current policies will persist unchanged for the next ten years (which is

unlikely), 155 short- and medium-stay beds, 115 'new' long-stay beds and 98 'old' long-stay beds would then be in use, a total of 368. It is not feasible to calculate a rate from this figure, because of the difficulties of defining the denominator where very long-stay patients are concerned. The rate for short-stay beds for the 140 patients not suffering from dementia, based upon the 1970 population, would be 82.6 per 100,000, or 121 per 100,000 if the 65 'new' long-stay beds for equivalent patients were added. The rate for the 15 short- and medium-stay patients and the 50 long-stay patients with dementia, amounts to 38.4 per 100,000 total population (or 3.27 per 1,000 population over the age of 65).

Table 9.5. *Projected bed usage assuming no changes in recent trends*

Type of patient	Diagnosis		Total
	<i>Dementia</i>	<i>Other conditions</i>	
Short- and medium stay	15	140	155
'New' long-stay	50	65	115
Total	65	205	270
Rate per 100,000	38.4	121.0	159.5
'Old' long-stay	—	98	98

If the population of Camberwell continues to decrease at the rate of 650 per year, as it has done between 1961 and 1971, it will be down to 163,000 by 1981 and the absolute numbers of beds needed would be about 4 per cent fewer.

Rates calculated in this way cannot be compared with those recommended by the DHSS since information from more intensive evaluative studies needs to be considered before it can be decided how far current policies should be altered. Information from these studies, and the effect on plans for psychiatric services during the next decade, will be discussed in Chapters 11-25.

J. K. Wing

The marked changes taking place in the Camberwell psychiatric services between 1964 and 1971 have been monitored by the Camberwell register and described in Chapters 6-9. In the background are the same general trends that are seen in the national statistics; a decrease in number of beds occupied, particularly by the long-stay, an increase in the number of admissions which, however, may now be coming to an end, an increase in the provision of day-places and alternative residential accommodation, and an increase in out-patient attendances. Camberwell has more resources at its disposal than the average but the general pattern of provision and the general trends are not essentially dissimilar. The one figure which stands out as markedly different is that for short-stay beds occupied by women patients, which is nearly twice the national rate.

In 1964, the Camberwell services were based upon an out-of-town mental hospital; in 1971 the change-over to a local community service was well under way. So far as figures are concerned, the plan has operated reasonably well. In particular, the aim to restrict admissions to Cane Hill to 45 or fewer per year has been achieved and surpassed so far as joint hospital physicians are involved. This point should not be missed because it appears simple; without some method of monitoring it is very easy to claim results which are not, in fact, being achieved. Some of the papers which make claims concerning the numbers of beds used by local services are based on figures which have not been independently collected or checked. Obtaining high-quality statistical data about

local services is not as easy as may appear. So far as Camberwell is concerned, however, the redeployment of short- and medium-stay beds is going well and the immediate objectives have been attained.

Many problems remain, one of the most important of which concerns the extent to which some patients, particularly women, need to be admitted to hospital as opposed to being treated in a day setting or in the out-patient department. It is necessary to go beyond statistical data in order to solve this question, although more detailed analysis (cf. Chapter 11) can provide certain clues to the answer. A series of more intensive studies was therefore planned. The first concerns the reasons for the increasing admission rate, which are not necessarily the same in Camberwell, with its much higher rate of admissions, as nationally. It may, in fact, be that the Camberwell situation anticipates what may later occur nationally as the changeover in function from the mental hospital to the district general hospital gets under way. This question is examined in Chapter 12. A second study is concerned with the reasons why patients are admitted to hospital at all. This raises some fundamental issues, which are considered in Chapter 13. An analogous, though numerically smaller, problem has to do with the question of compulsory admission. Although only 14 per cent of Camberwell patients are admitted on order (compared with the national rate of 19 per cent), the possibility of coercion lies behind any consideration of admission to hospital and it is important to know why such provisions are actually used. This is dealt with in Chapter 14. A further component of the over-all question concerns the outcome after discharge from a brief period in hospital; to what extent do patients remain handicapped in the community? This will be dealt with in Part Four. Finally, there is the problem, described in Chapter 8, of the new groups of patients referred by the other departments in general hospitals. Patients who have attempted suicide compose a large proportion of these, but there are also many referred for psychosomatic disorders or other psychological problems.

A second large problem has to do with the new accumulation of long-stay patients; those suffering from dementia and those with other conditions needing to be considered separately. The figures given in Chapters 6 and 9 indicate that the new build-up is most unlikely to reach the present level of bed-occupancy. How much short it will be depends not only upon recent trends, which are themselves changing, but upon measures introduced in the future. These measures themselves should depend upon a consideration of present trends and on the results of investigations such as those to be described in Chapters 11-15. Chapter 15, in particular, contains

an account of the reasons why recently admitted patients stay as long as six months in hospital. Another important component for consideration is the extent to which hostel places can be used instead of hospital beds. Chapter 15 begins the examination of this question but since so few places are as yet provided for Camberwell patients it is impossible to speak from direct experience. Such places as are available, however, already show a pattern of occupancy which indicates an accumulation of 'new' long-stay patients. The same pattern is seen in day-place occupancy. Clearly, the evaluation of any trend towards increasing numbers of long-stay places outside a hospital setting must be examined very carefully, without any preconception that such places must inherently be less prone to induce institutionalism than mental hospitals were.

Until these two problems have been dealt with, the projection of beds likely to be in use in 1980 is of little value. The figures that emerge from the statistical exercise, 140 short-stay and 65 long-stay beds for patients not suffering from dementia, making 121 per 100,000 total population, are more than twice as large as the recommended 50 per 100,000. They cannot in themselves, be taken seriously as a basis for planning since they make no allowance for possible changes in trends. Further consideration will be given to the problem of forward projections in Chapters 22 and 25.

The third large problem concerns the provision of day-care. Whether this is in a conventional hospital setting (acting, as Harris suggested, as a direct substitute for in-patient care), or in a rehabilitation workshop, or in a longer-term day-centre, or in the new type of setting provided at St Francis's Hospital, where the day-care has some of the features characteristic of day-hospital, day-centre, and follow-up supervision in the out-patient clinic, there is no doubt of the upward trend. How far can it or should it be encouraged to go? Should day-hospital and day-centres specialize, on the analogy of the variety of functions formerly undertaken by mental hospitals? Should there be, at the very least, treatment units, rehabilitation units, units providing mainly sheltered accommodation and work, geriatric units, and so on? Should the mainly medical aspects of the work be carried out in association with hospital wards or should the day environments be completely separate? How should doctors, nurses, occupational experts, social workers, wardens, divide the labour? Some of these questions are considered in Part Four.

Out-patient provisions also raise large problems, some of them quite fundamental. Who should undertake the basic follow-up supervision and support? Does specialized psychotherapy offer anything that social workers or GPs could not provide? What use is

repeated out-patient contact anyway? Can the 'disposal' function of a diagnostic or emergency clinic be carried out more rationally? What proportion of the large number of patients who are found, in general hospital non-psychiatric out-patient clinics, not to be suffering from any ascertainable physical illness, should be referred to a psychiatrist? There is some *prima-facie* evidence that patients who have attempted suicide benefit from such support (though it might possibly be equally effective if provided outside a medical setting).

The problem of dementia needs separate consideration. The total number of beds used in 1980, calculating from existing trends, would be 15 short-stay and 50 long-stay; 38.4 per 100,000 total population or 3.27 per 1,000 population over the age of 65. This figure is somewhat higher than that suggested in the latest DHSS circular (2.5-3.0 per 1,000) but precisely the same reservations need to be made as for beds for the mentally ill. Present trends may be misleading or they may be undesirable. The value of alternative accommodation has not been assessed, nor have the needs of patients not now cared for in hospital.

Finally, there is the large problem of the 'old' long-stay. Even in 1980 there are likely to be about 100 patients in mental hospitals, particularly Cane Hill, who were admitted from Camberwell before the present changes were thought of. If Cane Hill Hospital were to close by that time, what would happen to the 60 Camberwell patients there?

Thus a discussion of the statistical material presented in Chapters 6-9 leads to the formulation of a set of further questions, which require more detailed information for their solution. This illustrates one function of a case-register and adumbrates another, since most of the projects now required must be based on samples from the Register so that the data can be related in a realistic way to the needs of the area.

Part Three of the book will deal with those issues which are concerned with admission to hospital.

PART THREE

ADMISSION TO HOSPITAL

factors causing an increase in numbers. Subsequent chapters in this section will report studies designed to elicit some of the reasons for changing admission patterns. Table 11.1 compares Camberwell with England and Wales for the year 1965, the first full year of the Register operation. The rates for Camberwell are higher than for England and Wales for all age and sex groups except elderly males; female rates are substantially higher, the ratio of female to male being 1.56 in Camberwell, 1.32 for the country as a whole.

Table 11.2 gives figures by age and sex for numbers of admissions from Camberwell, 1965-70. The rise in numbers is seen for

Table 11.2. *Camberwell admissions to psychiatric hospitals and units, 1965-70. Age and sex*

Age in years	1965			1966			1967		
	M	F	Both	M	F	Both	M	F	Both
15-24	39	48	87	37	47	84	37	60	97
25-44	115	197	312	131	149	280	143	176	319
45-64	77	124	201	68	140	208	64	132	196
65 or over	31	99	130	24	76	100	33	79	112
Total	262	468	730	260	412	672	277	447	724

Age in years	1968			1969			1970		
	M	F	Both	M	F	Both	M	F	Both
15-24	63	75	138	48	81	129	50	68	118
25-44	138	172	310	132	147	279	161	175	336
45-64	99	147	246	118	189	307	101	165	266
65 or over	37	84	121	43	94	137	23	115	138
Total	337	478	815	342	513	855	335	523	858

both sexes. The striking increase in male admissions over the age of 45, between 1968 and 1969, has slackened in 1970; a similar picture is seen for females admitted below the age of 25. The over-all picture is of an increase in 1968 and 1969 in all sections except the 25-44-year-old group; in 1970 the trend was halted or reversed. As was described in Chapter 6, it was at the end of 1967 that the district service was begun, when St Francis's became a district treatment unit and the joint hospitals increased their commitment to Camberwell. Fig. 6.4 showed the dramatic change in admission patterns between the main agencies serving the area, and we now see that there was a substantial increase in the number of admissions in the next two years. By 1970, the situation seems to have stabilized somewhat, perhaps in association with the adoption of almost full catchment area responsibility by the Bethlem-Maudsley group on 1 April 1970. It is helpful, in what

follows in this chapter, to consider the Camberwell data in the light of these changes: 1965-7 are a baseline, against which to consider the effect of changes in 1968-9 and of the final resolution of the transitional period in April 1970 and thereafter.

National figures for 1965-70 show an increase in all age- and sex-groups except 35-44 years, and 55-64 years, where for both males and females the trend seems flatter or fluctuating. (Figures were extracted from the DHSS Statistical Report Series nos. 4, 5, 11, and 12.) Interestingly, the national figures for 1969 and 1970 show a slowing in the rate of increase, such as is seen for Camberwell for 1970; whereas each year from 1965 to 1968 there were around 4,000 more admissions than in the previous year, for 1969 over 1968 this dropped to 2,000 and for 1970 1,500. The ratio of 1970 to 1965 admissions was 1.17 for Camberwell, 1.10 for the country as a whole; the increase has thus been of the same order in Camberwell as nationally. Provisional register figures for 1971 show a decline to about 800 admissions.

Table 11.3. *Camberwell admissions 1965-70 by previous history of in-patient care, and number of patients admitted each year*

	1965	1966	1967	1968	1969	1970	% 1970/1965
First admission	251	231	248	243	253	243	- 2.2
Readmission	479	441	476	572	602	615	+28.3
Total	730	672	724	815	855	858	+17.5
Number of patients	555	520	564	618	639	651	+17.3

Table 11.3 shows Camberwell admissions each year according to whether they were first or readmissions,¹ and gives the number of patients who experienced them. The number of first psychiatric admissions seems to have been unaffected by the reorganization. The increase is in admissions of patients who have had previous in-patient care: the number of patients each year increases in corresponding proportion (see the last column of the table). The services are not providing extra in-patient care for people who have never had any before, but are providing more for those who have been admitted before.

It is not possible to compare trends in national first admission

1. Some admissions for 1968-70 are coded on the Register with previous in-patient history not known. A special check had been done of those in 1965-7 not known, from which it was found that 70 per cent were in fact first admissions. The 'not knowns' have been divided in this ratio between first and readmissions for 1968-70.

rates, for reasons given in Chapter 4, but figures were given in Table 4.7 for 1970 which show that first admissions comprised 37 per cent of all admissions nationally, and 28 per cent of all Camberwell admissions.

In order to examine the increase in 1968-9 in more detail, Table 11.4 divides each annual cohort according to six broad diagnostic groups. Depression is divided into 'severe' (the affective psychoses)

Table 11.4. *Camberwell admissions 1965-70. Diagnosis*

<i>Diagnosis</i>	<i>1965</i>	<i>1966</i>	<i>1967</i>	<i>1968</i>	<i>1969</i>	<i>1970</i>
Schizophrenia	178	157	138	159	157	190
Affective psychoses	205	179	225	213	230	242
Organic psychosis	61	47	54	43	45	43
Depressive neuroses	160	143	153	205	211	161
Other neuroses	17	30	27	39	42	45
All others	109	116	127	156	170	177
Total	730	672	724	815	855	858

and moderate (depressive neuroses). The 'organic' group comprises mainly senile and presenile dementia. There has been a reduction in the number of admissions for organic psychosis; one possible reason for this is the provision of alternative forms of care outside the psychiatric services for elderly patients with dementia, but these other services are only just beginning to be used and they are not yet within the terms of reference of the register. No clear trend is discernible for schizophrenia or severe depression, although they have tended to increase with time, especially in 1970. The 1968-9 increase is most marked in the two groups of neurosis, 'moderate depression' and 'other neuroses', and in the residual category, 'all others', which includes personality disorders, addictions, and a few other conditions.

Again, it is possible to make broad comparisons with national trends over the same period, and to discover that the only diagnostic groups which have not shown an increase nationally are senile psychoses (as in Camberwell). The highest proportional increase for England and Wales has been in 'personality and behaviour disorders', and 'alcoholism and addiction'.

There could be many reasons, clinical and social, for an increasing rate of admission to psychiatric hospital. Chapter 12 is concerned with this question. Here, it is worth pointing out that, from the statistical point of view, Camberwell's rising admission rate would simply indicate a higher turnover of patients (that is a shorter length of stay) if the number of beds available to the area

were fixed. However, before the reorganization of in-patient care, there were no 'Camberwell' beds as such, and patients could be admitted to any of several hospitals in south London. Since the end of 1967, beds at Bethlem-Maudsley and at St Francis's have been allocated for Camberwell; the number of beds occupied by patients from the area has fluctuated around a rather higher figure. Fig. 6.3 demonstrated the increase in numbers of short- and medium-term beds.

It is pertinent, therefore, to examine the length of stay distribution of admissions each year, to determine how much of the increase might be due to a high turnover of short-stay patients. Table 11.5 gives the figures. The increase over time is most striking in the 1-2 months, and 3-6 months groups. The percentages show the proportion of all admissions who were discharged before reaching the length of stay indicated. There has been a slight shift towards longer stay over the years: in 1965-7, 40 per cent of admissions lasted less than one month, 79 per cent less than three months. By 1970 the corresponding figures were 36 and 75 per cent. This means that average length of stay has increased over the period. (We have not calculated an arithmetic average, since the distribution by length of stay is so skewed that such a measure is inappropriate and virtually meaningless.)

It was seen earlier that the increase in 1968-9 was largely in the neuroses (including depressive neuroses) and the residual group of diagnoses. It is useful, therefore, to examine the various diagnostic groups by length of stay to elicit more detail. In Table 11.6 admissions lasting a year or more have been omitted, as they were considered in Chapter 6 as 'new' long-stay patients. Short-stay admissions for schizophrenia (i.e. less than one month) decreased until 1970, when there was a sudden return to the 1966 level. The groups which show a marked inflation of the number of short in-patient spells are the neuroses, and 'all others'. The neuroses also show an increase in numbers staying three to six months, as do schizophrenia and severe depression; perhaps with more beds available, allocated to Camberwell, there is less pressure for discharge. It is noticeable that there has been no change for organic psychoses; the reorganization seems to have had no effect here. We shall return to this point in the discussion of redistribution between the various agencies, which follows.

During 1965, 10 per cent of admissions from Camberwell were to hospitals other than the catchment area hospital, Cane Hill, or the local hospitals Bethlem-Maudsley and St Francis's. Patients went to Tooting Bec, or to Belmont Hospital, or one of the other big mental hospitals to the south of London. A very few had in-

Table 11.5. Camberwell admissions 1965-70. Length of stay. Numbers, and cumulative percentages

Stay in months	1965		1966		1967		1968		1969		1970	
	N	%	N	%	N	%	N	%	N	%	N	%
< 1	303	41.5	268	40.0	287	39.6	308	37.8	306	35.8	311	36.2
1 < 2	184	66.7	174	65.9	175	63.8	198	62.1	218	61.3	207	60.3
2 < 3	87	78.6	88	79.0	112	79.3	108	75.3	116	74.9	130	75.5
3 < 6	78	89.3	82	91.2	86	91.2	122	90.3	126	89.6	123	89.7
6 < 9	23	92.4	12	93.0	28	95.1	28	93.7	36	93.8	42	94.7
9 < 12	14	94.2	12	94.9	6	96.0	14	95.4	19	96.0	12	96.2
12 or more	41	100.0	36	100.0	30	100.0	37	100.0	34	100.0	33	100.0
Total	730		672		724		815		855		858	

Table 11.6. *Camberwell admissions 1965-70. Diagnosis and length of stay for those staying less than one year*

<i>Diagnosis</i>	<i>1965</i>	<i>1966</i>	<i>1967</i>	<i>1968</i>	<i>1969</i>	<i>1970</i>
<i>Schizophrenia</i>						
<1 month	74	59	42	43	36	59
1<3 months	68	66	62	69	63	73
3<6 months	12	15	16	24	31	30
6<12 months	11	7	10	12	16	20
<i>Affective psychoses</i>						
<1 month	80	72	87	74	71	81
1<3 months	82	70	96	88	106	109
3<6 months	28	29	27	35	36	36
6<12 months	10	6	9	11	13	7
<i>Organic psychoses</i>						
<1 month	12	12	12	10	11	16
1<3 months	15	12	12	13	12	9
3<6 months	8	6	11	5	8	3
6<12 months	7	2	5	3	5	6
<i>Depressive and other neurosis</i>						
<1 month	77	63	80	101	104	71
1<3 months	71	83	71	90	92	87
3<6 months	21	20	20	39	38	33
6<12 months	6	4	8	10	13	12
<i>All others</i>						
<1 month	60	62	66	80	84	84
1<3 months	35	31	46	46	61	59
3<6 months	9	12	12	19	13	21
6<12 months	3	5	2	6	8	9

patient care at a London teaching hospital, mainly King's College Hospital. Fewer people each year were admitted other than to the three main hospitals, particularly after the reorganization, until 1970 when a new in-patient ward was opened by King's College Hospital, and a few more patients were admitted to St Olave's Hospital situated just beyond the northern tip of the Camberwell area.

Fig. 6.4 showed the main features of the redistribution of admissions. Table 11.7 gives the data upon which the graph is based, and reveals that the joint hospital, together with St Francis's, now takes the vast majority of short-stay admissions and copes with an increasing proportion of longer-stay patients. These figures show the district service in operation.

Table 11.7. *All Camberwell admissions 1965-70. Agency, length of stay.*

	<i>Bethlem-Maudsley</i>	<i>St Francis's</i>	<i>Cane Hill</i>	<i>Teaching hospitals</i>	<i>Mental hospitals</i>	<i>Total</i>
<i>1965</i>						
<1 month	44	94	138	—	27	303
1<6 months	145	9	156	6	33	349
6 months or more	8	—	51	—	19	78
<i>1966</i>						
<1 month	42	78	126	2	20	268
1<6 months	134	19	163	6	22	344
6 months or more	12	—	41	—	7	60
<i>1967</i>						
<1 month	60	72	122	9	24	287
1<6 months	164	51	134	8	16	373
6 months or more	14	5	41	—	4	64
<i>1968</i>						
<1 month	82	149	63	2	12	308
1<6 months	227	104	85	2	10	428
6 months or more	20	16	38	—	5	79
<i>1969</i>						
<1 month	102	116	51	31	6	306
1<6 months	236	116	71	24	13	460
6 months or more	34	19	30	—	6	89
<i>1970</i>						
<1 month	125	115+5*	28	15	23	311
1<6 months	250	119+6*	42	28	15	460
6 months or more	35	18	28	—	6	87

* Admissions to St Francis's geriatric assessment ward, which opened in July 1970.

The reorganization has been differentially effective in respect of the various diagnostic groups discussed above. Fig. 11.1 shows quarterly admissions by agency for four main groups. For schizophrenia (Fig. 11.1*a*) the results were somewhat delayed but the district service was coping with the majority of admissions by 1970; the effect of redistribution was more immediate for admissions for affective psychoses (Fig. 11.1*b*). The situation remained unchanged for organic psychoses; (11.1*c*); Cane Hill was the main agency until the middle of 1970, when a geriatric assessment ward opened at St Francis's to take cases from Camberwell. It is too soon to show the effect of this on admission patterns.

The fourth graph (Fig. 11.1*d*) concerns the milder disorders, and illustrates the increase in admissions to the Bethlem-Maudsley for

--- Bethlehem-Maudsley St Francis — Cane Hill - - - Others

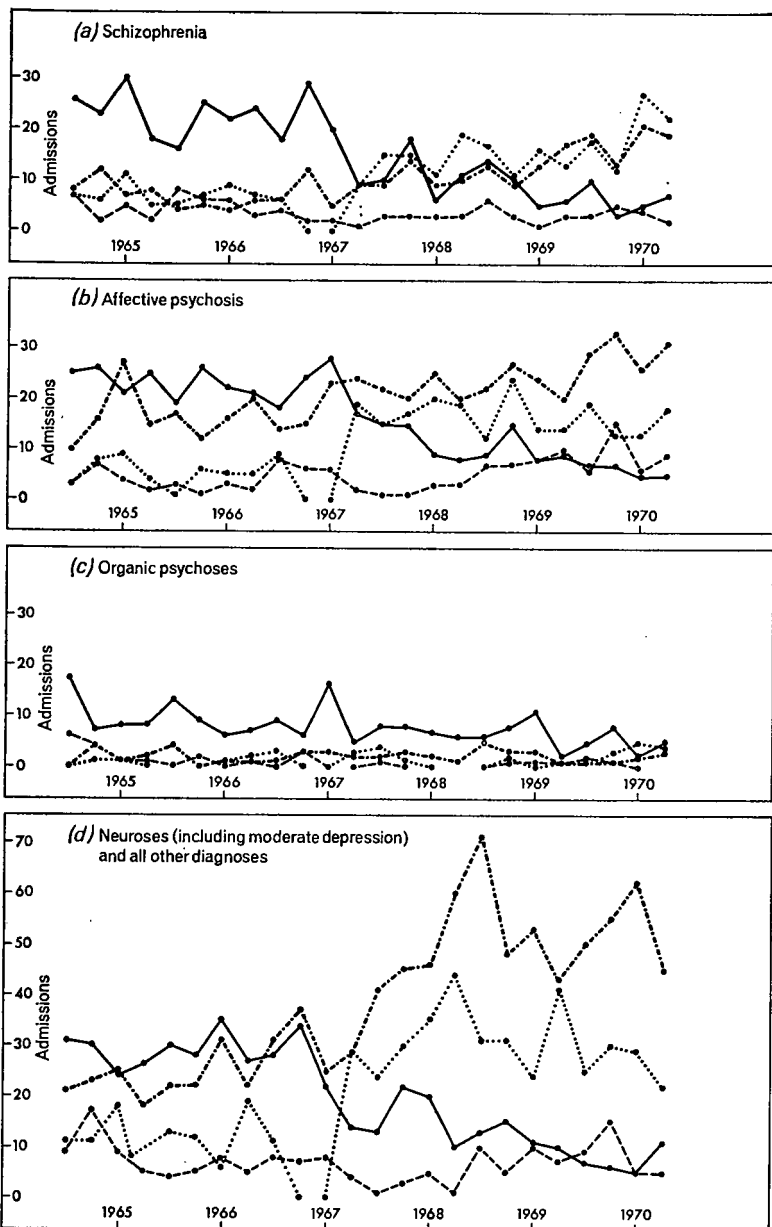


FIG. 11.1. Quarterly admissions from Camberwell by agency.

these disorders during 1968-9. This group emerges as of paramount importance in evaluating the effect of developing a district service, and has been the subject of a special study which is reported in the next chapter.

Reasons for the increase in admissions

C. Godber

1. Introduction

It was shown in Chapter 11 that Camberwell had followed the national trend in showing an increase in admission rates to psychiatric hospitals despite a gradual fall in number of resident patients. Between 1965 and 1969 this increase was of the order of 17 per cent, representing an extra 125 admissions in the latter year. Most striking was the increase among the non-psychotic disorders, where the increase was just over 30 per cent. This group comprised less than one-third of all admissions but contributed well over half the total increase. Svendsen (1952) divided the factors contributing to such increases into 'nosocomial' (those affecting the actual capacity of the service, for example, number of beds available), 'threshold-affecting' (those affecting the readiness of patients or others to use the service) and 'prevalence-affecting'. It is apparent from the work of Ødegaard (1952), Fremming (1951), and Bremer (1951), before and during the war, that hospital censuses used to underestimate the prevalence of the psychoses in the community. The longitudinal trends demonstrated by Harris and Norris (1954) and Svendsen (1952) indicate how an increase in admissions can be due to the extension of psychiatric care to these previously unrecognized psychotic patients.

These increases in admissions did not appear to result from the expansion of the hospitals *per se*, and the relative unimportance of nosocomial factors has been documented in the wartime studies of Ødegaard (1954), Svendsen (1952), Lewis (1942), and Hopkins (1943), as well as that of Norris (1959) in three London mental

hospitals. The importance of demographic factors in determining the likelihood of hospital admissions has been emphasized by Norris (1956), Lawson (1966), Hare (1955, 1956), and Cooper (1961, 1966), among many others. More recent surveys, such as those of Shepherd *et al.* (1966) and Rawnsley and Loudon (1962), have indicated the extent to which patients with neuroses and personality disorders are dealt with in general practice without referral to hospital. The main impression from these and other studies, is that the largest factor in the gradual rise in admissions has been the increasing readiness of patients and their relatives to accept admission, as the stigma attached to psychiatric hospitals has declined and the therapeutic possibilities have improved.

This is particularly important in view of the emphasis in this country on the transfer of psychiatric in-patient care to general hospitals. It is likely that this will further reduce stigma with the result that the pressure on beds could be increased still further. The trends in Camberwell are therefore of particular interest since the change from Cane Hill to the local service based on the joint hospital and St Francis's Hospital should result in considerably less stigma.

The recent statistics from the joint hospital have shown how the ratio of in-patients to out-patients has tended to increase among patients diagnosed as having personality disorders, while falling or remaining static for other diagnostic categories. This increasing prominence of the diagnosis of personality disorder among in-patients is noticeable also in the reports in the community care-oriented services at Chichester (Sainsbury and Grad, 1966), Oldham (Rehin and Martin, 1968), and St Mary Abbott's (Baker, 1969); the reversal of this trend at Blackburn may reflect the criteria for psychiatric involvement laid down by Silverman (1968).

The frequency of admissions under the diagnosis of personality disorder has certainly increased in Camberwell in the period of surveillance by the Register. This may, of course, have reflected a change in diagnostic habit on the part of the doctor rather than any real change in character of the clientele. Nevertheless, this period has seen an increase in the representation of the 'milder' disorders among admissions, with a particular rise in patients diagnosed as having personality disorders admitted to St Francis's and the joint hospitals, coinciding with the assumption of an area responsibility by these hospitals. The possible implications for 'general hospital' psychiatry make it important to investigate this trend to discover whether nosocomial or threshold-affecting factors have played any part. Some study of the paradox of the marked increase of 'milder' disorders among in-patients during a period in which the Camber-

well out-patient services have undoubtedly been strengthened, is also warranted.

2. Design and method

Two cohorts of patients were chosen for investigation; one admitted during 1965 and one during 1968 (Godber, 1971). The distribution of diagnoses in these cohorts has been discussed in Chapter 10. Most of the increase in numbers between 1965 and 1968 took place in the non-psychotic groups, and these (with the exception of the small group of addictive conditions) were chosen for further investigation. Since there were nearly 400 cases altogether, a sample of one half of each cohort was selected at random; 84 in 1965 and 111 in 1968. The mean length of stay was 62 days in the former year and 75 in the latter. The number of beds used by the samples during the year was estimated at 40 in 1965 and 60 in 1968. The change in pattern of admission from Cane Hill and other mental hospitals (43 out of 84 patients admitted in 1965, 23 out of 111 patients admitted in 1968) has already been described.

The register diagnoses of the non-psychotic patients in the two samples, checked by reference to the case-notes, are shown in Table 12.1. There is provision for a first, second, and third diagnosis to be entered on the register for each patient and three groups are shown in Table 12.1: (i) first diagnosis of personality disorder, (ii) first diagnosis of moderate depression or neurosis with a second or third diagnosis of personality disorder, (ii) first diagnosis of moderate depression with no associated personality disorder. It is clear that the increase from 1965 to 1968 is entirely in the group with some mention of personality disorder, whether as a first diagnosis or not.

The case-notes of the two samples of patients were then examined. Information on demographic data, previous psychiatric

Table 12.1. *Diagnosis of patients with neuroses and personality disorders admitted to hospital in 1965 and 1968*

<i>Diagnosis</i>	<i>1965</i>	<i>1968</i>
Neurotic condition, no personality disorder mentioned	59	59
Neurotic condition, personality disorder given as second or third diagnosis	17	36
Personality disorder first diagnosis	8	16
Total	84	111

history, mode and route of admission, result of hospital stay, and outcome one year after admission was recorded. Two scales were constructed for rating patients on the basis of the case-notes; one mainly concerned with the severity of any psychiatric illness present, the other with social disorganization.

The items used in the scale of severity of illness were as follows:

1. Depressive symptoms.
2. Other symptoms such as anxiety, delusions, etc.
3. Disturbed behaviour, including for example antisocial behaviour, and disinhibition or wandering due to dementia.
4. A history of earlier depressive or other illness or a positive family history of psychiatric illness.
5. Intensity of treatment given while in hospital.

Duplication of scoring for symptoms was avoided. Item 4 on the history was designed to correct for underscoring if patients were admitted early in order to anticipate a breakdown predicted on the basis of past illnesses. Each item was rated on a five-point scale. Various combinations of these scores were used during the analysis but the sum of the five ratings seemed to produce similar results to the others and was much the simplest so that only these results are presented. A higher score indicates a more severe degree of illness.

The items used in the social disorganization scale were:

1. Accommodation.
2. Domestic isolation.
3. Rate of change of jobs and time unemployed during the previous two years.
4. Financial solvency.
5. Extent of the individual's dependency, or that of his family, on social service agencies.
6. Marital stability.
7. The extent to which the patient still had responsibility for children under 16 years of age.
8. Delinquency.

Each of the items was rated on a four-point scale. Several of the items were difficult to rate because only scanty information was recorded in the case-notes. Bearing in mind West's observation (1969) that the most disorganized individuals are often the least well documented, it was felt desirable to discard as few cases as

possible on the grounds of scanty information. The proportion discarded was in fact 5 per cent. There was more correlation between certain items than others; thus divorced patients often had low scores on marital stability and also on accommodation and isolation. Again, the sum of the eight ratings was the most convenient composite index and seemed as suitable as any of the others tried. A higher score indicates greater social disorganization.

3. Results

The mean scores of the total group of 195 patients were 5.8 ± 2.61 on severity of illness and 3.2 ± 3.9 on social disorganization. The mean scores in various subgroups are shown in Table 12.2. A low score on severity of illness and a high score on social disorganization were linked with the following variables: male sex, age

Table 12.2. Mean scores on 'severity of illness' and 'social disorganization' scores in various subgroups of the total series

Category	N	Mean score: severity of illness scale	Mean score: social disorganization scale
Total series	195	5.8	3.2
1968 admissions	111	5.6	3.8
Age under 40	92	4.2 ($p < 0.001$)	4.2 ($p < 0.01$)
Men	61	4.8 ($p < 0.001$)	—*
Broken marriage or single	93	5.2	4.4 ($p < 0.001$)
Social class V	31	4.8 ($p < 0.05$)	6.3 ($p < 0.01$)
Suicidal threats or attempts	58	4.8 ($p < 0.05$)	4.2 ($p < 0.05$)
Personality disorder (first diagnosis)	24	3.7 ($p < 0.001$)	6.5 ($p < 0.001$)
Cane Hill or other mental hospital admissions	66	6.1	5.0 ($p < 0.001$)

* Not applicable, since a different standard of scoring was adopted for women.

under 30, unskilled manual occupation, downward social mobility, suicidal threats or gestures prior to admission, brief duration of symptoms, less satisfactory outcome at discharge or one year after admission, poor use of hospital follow-up facilities but use of multiple social agencies. These characteristics were frequently linked with a diagnosis of personality disorder. Patients admitted to Cane Hill or other area mental hospitals were more socially

Table 12.3. *Distribution of high and low 'severity of illness' scores in 1965 and 1968.*

'Severity of illness' score	1965	1968	Total
0-5	37	57	94
6+	47	54	101
Total	84	111	195

disorganized than those admitted elsewhere but their severity of illness scores were much the same.

Table 12.3 shows the distribution of numbers of patients with high and low scores representing severity of illness. Most of the extra patients in 1968 are in the group with low scores. Table 12.4 gives the equivalent information about social disorganization scores. Here the increased numbers in 1968 are all in the higher scoring group; a chi-squared test on this distribution reached a level of significance of <0.05 .

Table 12.4. *Distribution of high and low 'social disorganization' scores in 1965 and 1968*

'Social disorganization' score	1965	1968	Total
0-2	54	52	106
3+	30	59	89
Total	84	111	195

The mean severity of illness scores of patients with high and low social disorganization scores are shown in Table 12.5. Patients with a greater degree of social disorganization show a significantly lower severity of illness score than the rest both in 1965 and 1968 ($p < 0.01$). There is no significant change over time in either the high or low social disorganization group taken alone.

Table 12.5. *Mean 'severity of illness' scores of patients with high and low 'social disorganization' scores in 1965 and 1968*

'Social disorganization' score	Year	N	Mean 'severity of illness' score
0-2	1965	54	6.15
	1968	52	6.22
3+	1965	30	5.33
	1968	59	5.08

Tables 12.6 and 12.7 show the mean illness and social disorganization scores of patients in the two samples with and without a diagnosis of personality disorder. Analysis of variance discloses a significant difference between diagnostic groups according to the disorganization score both in 1965 and in 1968 ($p < 0.001$), while there is very little difference between the 1965 and 1968 scores within the groups. Similarly, the severity of illness scores are lower, the less personality disorder is in evidence ($p < 0.01$) but there is no difference between the two cohorts.

Table 12.6. Mean 'severity of illness' score of patients in three diagnostic groups, 1965 and 1968

Diagnosis	N	1965 Mean score	N	1968 Mean score
Neurotic condition no personality disorder mentioned	59	6.3	59	6.1
Neurotic condition, personality disorder given as second or third diagnosis	17	5.4	36	5.9
Personality disorder first diagnosis	8	4.0	16	3.6

Table 12.7. Mean 'social disorganization' score of patients in three diagnostic groups, 1965 and 1968

Diagnosis	N	1965 Mean score	N	1968 Mean score
Neurotic condition, no personality disorder mentioned	59	2.2	59	2.3
Neurotic condition, personality disorder given as second or third diagnosis	17	3.8	36	4.5
Personality disorder first diagnosis	8	6.0	16	6.8

4. Discussion

Thus, while it is true that the increase of admissions is accounted for mainly by non-psychotic illnesses, taken presumably from the large reservoir of such people in the community who would not previously have been so readily admitted, it is not due at all to the 'easier' neurotic conditions (particularly neurotic depression), which are no more represented in 1968 than they were in 1965, but to the more difficult group of people with personality disorders (most of whom have a neurotic depression as well). The similarity between patients admitted to the joint hospital and those admitted

to the mental hospitals, in terms of mean scores on severity of illness, suggests that there is not a lower threshold of admission to the joint hospital. Although there was a small decrease in severity from 1965 to 1968, this would not be sufficient to suggest a change in threshold. It is rather that the group with personality disorders has grown in size.

The change cannot be accounted for in terms of diagnostic habit, since the diagnosis of personality disorder is validated, as compared with that of neurosis without personality problems, by a high social disorganization score, a low illness score, and familiar clinical and social characteristics, both in 1965 and in 1968.

Several threshold-affecting factors may nevertheless be at work. One of these is the frequency of suicidal threats and gestures in the group with a diagnosis of personality disorder. Such behaviour is on the increase. It was shown in Chapter 8 that referrals for attempted suicide to the psychiatric department in King's College Hospital were rising very markedly. This may simply be part of the national rise in admission rate. There may also be more readiness, in general, to enter a psychiatric hospital than there used to be. Finally, a concomitant increase in the unemployment rate may explain some part of the extra admissions, since the associated economic difficulties would be expected to affect socially disorganized individuals most. Economic stresses would presumably undermine social adaptation in such people rather than precipitating further psychiatric morbidity.

The nosocomial factor cannot be omitted, however, since the number of beds theoretically available to Camberwell patients was not defined but the involvement of the joint hospital and St Francis's nevertheless increased the pool of beds available. Admitting doctors at these hospitals could more confidently admit patients to their own services than they previously could to those of a hospital some fifteen miles away whose consultants were less familiar.

It should, of course, be pointed out that the fact that admissions for the more severely depressed group had not increased may well be evidence that the community care services are now in touch with most such patients; that is, there is no large reservoir of uncared-for psychotic patients. The next development might actually be a decrease in such admissions.

Finally, it should be mentioned that the case-records of patients admitted to hospital with a diagnosis of personality disorder (whether or not associated with a neurotic condition) did not suggest that the services were well-equipped to cater for this new clientele. The decision to admit seemed in many cases a recogni-

tion of the failure of other forms of care rather than the deliberate choice of an effective method of management. The outcome both in hospital and one year after admission was relatively less good than for other groups.

The value of a medically oriented setting for the treatment of this type of patient has been questioned. A subgroup of patients in this sample was studied more intensively and the conclusion was reached that greater provision of day-care and short-term hostel accommodation might well have obviated the need for admission in half the cases. This is in agreement with the findings of Brothwood (1965) and Fox *et al.* (1960) on patients admitted to hospital from the Maudsley emergency clinic. The need for greater social work facilities was also abundantly clear.

A more specific study of reasons for admission to hospital is described in Chapter 13.

Reasons for admission to hospital

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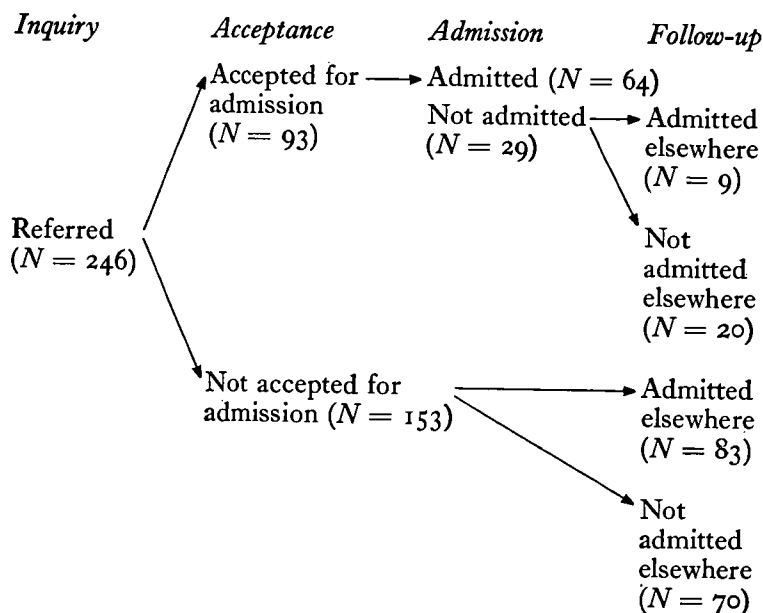
1. Introduction

It was shown in Chapter 4 that Camberwell has an admission rate well above the national average, particularly for readmitted women. Although the readmission rate is not at the moment continuing to increase, it is of special interest to consider whether the high rate is justified since, if it is, it suggests that other areas of the country should be providing more in-patient facilities. If it is not, there are lesser but still important implications for planning the Camberwell services.

Svendsen's division of the factors affecting admission rates into those determining prevalence in the community, those affecting the threshold of admission and those influencing the number of beds available has been mentioned in earlier chapters. Godber showed in Chapter 11 that an increase in the number of admissions between 1965 and 1968, might be accountable in terms of all three factors. The personality disorders, which were mainly responsible, might have become more numerous, both relatives and staff might have become more ready to admit, and the number of beds available was not specifically restricted. Nevertheless, there had *not* been much of an increase in the organic functional psychotic or neurotic conditions. As in the national figures, the rise in admission rates in Camberwell has now levelled off.

Whether to admit a patient or not is one of those decisions of value discussed in Chapter 2, and there is a considerable literature on the subject. Mishler and Waxler (1963) examined referrals to two psychiatric hospitals over an eleven-week period, dividing

them into four groups; those who were accepted for admission and those who were not accepted, and within each of these groups, those who were actually admitted and those who were not. The groups were formed at four decision points, as follows:



The significant factors in making the decisions were the source of the referrals, who made the decision, the extent of previous hospitalization, the presence of relatives, the time of day that the decision was made, and the sex of the patient. The follow-up data are not applicable to British services since there was a good deal of 'shopping around' to other hospitals accounting for the relatively high proportion of patients admitted after the initial decision had been against admission. Patient variables such as diagnosis and type and severity of behaviour were not examined.

Tischler (1966) did study clinical variables. He divided a group of 143 psychiatric patients seen at a general hospital psychiatric emergency clinic into those admitted and those given follow-up appointments. It was found that those admitted were older than the rest. The most marked clinical discriminating factors were general appearance, stream of thought, mood, sensorium, and diagnosis of psychosis. Some two-thirds of the families agreed with the doctor's decision to admit compared with 87 per cent when the decision was not to admit. If the doctor thought the patient both

likeable and interesting, he was more likely to be treated as an out-patient.

Scheff (1963) makes the point that an underlying rule in clinical medicine is, 'when in doubt, continue to suspect illness'. This rule may have advantages and disadvantages, depending on the relative importance of false negatives and false positives. In the psychiatric clinic an extension of the rule may suggest that the more junior the clinician the more he might want to be on the safe side and admit rather than not admit; perhaps also, that the more staff involved, the more likely admission will be. Twaddle and Sweet (1970), evaluating the decisions of doctors admitting patients to a general hospital, found that over half need not have been admitted. Most of those false positives were due to factors in the patient but some, no doubt, were due to doctors erring on the safe side.

Family tolerance is obviously an important factor influencing the decision to admit. Grad and Sainsbury (1966) showed that severe burdens felt by families were relieved equally in a 'community care' and in an 'admission-oriented' service: both services, however, admitted equal proportions of suicidal or aggressive patients, and probably the most severely affected families were relieved by the admission of the patient in both services. So far as lesser degrees of burden were concerned, the 'admission-oriented' service gave somewhat more relief.

Freeman and Simmonds (1959) found that relatives asked for patients to be readmitted mainly because of the reappearance of bizarre symptoms and not because of dissatisfaction with the general level of performance. Brown, Bone, Dalison, and Wing (1966) in a five-year follow-up study of discharged schizophrenic patients in three areas with community services developed to differing degrees, found that the most community-oriented service was characterized by the highest readmission rate, possibly because of a greater awareness by doctors and social workers of the morbidity exhibited by patients after discharge. Behaviour disturbance did not necessarily lead to readmission however; in fact the degree of severity of behaviour disturbance recorded in the social worker's case-notes was not related to whether or not the patient was admitted following a crisis.

One of the most important factors governing admission policies will be the availability of alternative types of service. The studies of Markson, Kwoh, Cumming, and Cumming (1971) in the USA and Pasker and Ashley (1971) in this country suggest that considerable numbers of elderly patients need not be admitted to hospitals. There has been no equivalent work with psychiatric patients, in which the views of doctors, relatives, and patients were all con-

sidered, except for work on long-stay patients (Rawnsley, Loudon, and Miles, 1962).

The possible alternatives range from brief emergency admission to hospital or use of hostels, through admission to day-hospitals or other day facilities, to domiciliary care with out-patient supervision. None of these has been adequately investigated. Weisman, Feirstein, and Thomas (1969) described a policy of emergency admission for a few days only with appropriate transfer to other services. There has been almost no study of hostels as a substitute for hospital admission, perhaps because the admitting doctor is usually a member of a different hierarchy to those who can make decisions concerning hostel admission. There are, however, several studies concerning day-hospitals. Fox, Rutter, and Smith (1960), who considered 273 emergency clinic patients, thought that 40 per cent were suitable for day-care. Hogarty *et al.* (1968) tried to establish criteria differentiating in-patients, day-patients, and out-patients (though they fell into the trap of equating descriptive with evaluative work). Zwerling and Wilder (1964), and Wilder, Levin, and Zwerling (1966) selected alternative patients, at random, for day- and in-patient care, after deciding that one or the other was needed and could be accepted by the patient. (The criteria for making this initial decision to admit were not, however, given.) Of 189 patients assigned to the day-hospital, 39 per cent were treated there without transfer. Another one-third were transferred only for very brief in-patient treatment and otherwise could be managed in the day-hospital. Guy *et al.* (1969) randomly assigned 137 patients to out-patient or day-patient treatment and found a greater over-all improvement in the latter (particularly an increase in the accessibility of schizophrenic patients) with fewer and shorter periods of readmission. Depressed patients treated in the out-patient department seemed, however, to improve more quickly.

Kessel *et al.* (1965, 1971) describe a service in Plymouth whose organization was specifically designed to prevent much admission to hospital. Morrissey (1966) describes a similar attempt in Worthing. Both were based on an increased use of day- and out-patient facilities. The Plymouth study failed to show any effect on numbers or on length of stay. The Worthing study did show a decrease in number of admissions towards the national average. Grad and Sainsbury (1966, 1968) evaluated the subsequent extension of the Worthing policy to Chichester by comparing patients referred to the Chichester service with those referred in a very similar cathedral city, Salisbury, where the admissions policy was more conventional. The results of this complex evaluation are not yet fully available.

It is clear that this mixed bag of studies allows no definitive answers to the questions; why are people admitted to hospital and is this the most effective and economic means of giving care and treatment? Each study is too much bound to the specifics of a given service and each uses methods which are not quite comparable with all the others. This is inevitable in any developing science. Eventually, uniform techniques will be adopted and acceptable generalizations will be made. There does, however, seem to be an agreement that a substantial proportion of admissions could be prevented.

Meanwhile, studies will continue to be done to answer specific local questions. The present investigation is one such, the aim being to discover why patients were being admitted to hospital from the Camberwell district and to evaluate the policy. It was thought that a longer and more definitive study would be mounted if the present pilot work seemed promising.

2. Design and method

2.1. SAMPLING

The study population comprised all Camberwell residents who made contact with a psychiatric service during the first six months of 1971. Three groups were excluded: those aged less than 15 or more than 64, those with a diagnosis of drug or alcohol addiction, and those with a diagnosis of organic brain disease. It was decided to collect information concerning approximately 50 recently admitted patients, 40 patients who might have been admitted but actually were not and 10 admitted to the day-hospital.

Since this was a pilot study and impeccable sampling was not essential, only admissions to the Maudsley, St Francis's, and Bethlem hospitals were included. These three hospitals accounted for 618 out of 855 admissions in 1969 (see Table 11.7) and it was calculated that, allowing for the exclusion categories, there would be 188 eligible admissions in a six-month period, so that a one in four sample should be sufficient. All patients satisfying the criteria who were admitted on each successive fourth day therefore constituted the series. A few would be included twice through being readmitted again during the six-month period.

Most contacts are with out-patient services; some 11,000 a year from Camberwell, most of whom are not at risk of being admitted. A high-risk group was therefore defined, comprising patients seen at the emergency clinic, at the routine out-patient clinics of three consultants who were mainly concerned with Camberwell patients or at the St Francis's follow-up clinics (including partial day-care

as described in Chapter 6), who were considered by any relevant person as possibly in need of admission but who were not actually admitted. Domiciliary visits by the same three consultants were also sampled. Another source of high-risk patients was the follow-up clinic at King's College Hospital for those who had been admitted after an attempt at suicide. It was estimated that a one in two sample of the emergency clinic and out-patient groups would produce 24 patients and a one in four sample of the King's College Hospital group would produce 10. Some six domiciliary visits to patients satisfying the selection criteria would be included. Thus in all 40 patients would be accepted for the high-risk but non-admitted group.

Finally, the patients admitted to the Maudsley day-hospital who were not transferred from the wards or admitted for rehabilitation would also be included in the series.

2.2. MEASUREMENTS

(a) *Decision to admit or not to admit*

A questionnaire was designed to cover the various factors likely to be considered by the clinician who had to decide whether or not to advise admission to hospital. The main headings were availability of beds or alternative services, the needs of patient and family, the attitudes of the various parties concerned, and the amount of relevant information at the clinicians' disposal. Time of day and day of the week were also taken into consideration.

The other schedules used mainly served the function of obtaining additional information about the patients and their families in order to throw light on the decisions actually taken by clinicians.

(b) *Present State Examination*

The ninth edition of the PSE was used in order to elicit symptomatology at the time of examination and during the month before interview with the patient, which took place as soon after admission as possible. The symptom and behaviour ratings were unavoidably made hours and occasionally days after the decision by the admitting doctor. Although in many cases the symptomatology will not have changed, the chances of a change in behaviour are considerable.

(c) *Behaviour schedule*

A list of types of descriptive behaviour was drawn up, comparable to that used by Leff and Vaughn (see Chapter 17). Most of the questions concerned behaviour during the month before the key

decision, but for aggressive and suicidal behaviour it was decided to include any manifestation during the previous year.

(d) Social performance

The schedule used by Mann and Sproule (Chapter 15) Leff and Vaughn (Chapter 17), and Wing *et al.* (Chapter 19) was adapted to allow ratings of change in performance during the past month relative to what the informant regarded as the patient's normal performance. The areas rated were occupation, marriage, child care, sociability, heterosexual adjustment, and leisure activities. Simple five-point scales were rated on the basis of data obtained in each area, according to whether adjustment was much better, unchanged, worse or much worse than normal. The patient was asked in each case what he thought the relative's attitudes were and questions were also inserted to make a rating of insight possible.

(e) Relative's schedule

The sociologist devised and administered a partially standardized interview which covered the aspects of social performance described above, the behaviour of the patient and any recent changes, the circumstances of the home and the events leading up to the point of decision. Ratings were made which could be compared with those made on the basis of information obtained from the patient.

(f) Basic data

A basic information schedule, in general use in the unit, was completed from the case-notes and from the interviews with patient and relatives.

(g) Reliability

The first five interviews conducted by each psychiatrist were tape-recorded and independently rated by the other. When the most important items from the behavioural and social performance schedules were selected for comparative examination (abnormalities of behaviour during the month before the point of decision, for example), the over-all yes-no agreement was 81 per cent, while the agreement on other items was 73 per cent. The sociological data will be presented separately (Hewett, work to be published). Stevens (1972) gives more detailed information concerning the reliability of the social performance schedule as used in the studies by Wing *et al.*, and Leff and Vaughn.

(h) Judgement concerning need for admission

After all the information about any one patient had been collected the three authors and another psychiatrist (J.W.) met to discuss and decide on the need for admission to hospital. A patient was allocated by agreement to one of four categories:

1. No alternative but admission to hospital.
2. Very little choice but admission; the patient might conceivably be kept out of hospital but this would seriously stretch any average service; for example, by getting a skilled nurse to spend several days and nights at the patient's home.
3. A case could be made for admission but, on balance, even an average service could probably cope without admission, for example, by use of day-care, etc.
4. The research team could see very little reason why the patient should be admitted.

This judgement clearly had advantages and disadvantages. The research team had much more information available, they were not under pressure and they were taking no risk. On the other hand, they were not in the situation that existed at the time the real decision was made and they could only hypothetically re-create it. They did not, however, consider events that occurred after the clinical decision had been made and their judgement was conservative, i.e. if in doubt they opted for admission.

2.3. PROCEDURE

The two psychiatrists interviewed the patients and the sociologist the relatives, friends, and other informants. The patient's permission was always obtained before seeing the relatives. The response rate was generally good; only 8 out of 92 patients and 11 out of 82 available informants could not be interviewed. The clinic doctor was asked to complete a questionnaire, indicating the decision he made about admission and the reasons he came to it.

Two practical problems arose. One was that the numbers of high-risk patients attending the emergency clinic, etc., were not sufficient to maintain the expected contact rate and it was therefore necessary to include patients from outside the Camberwell area as well. Only 30 high-risk non-admitted cases could be collected in the course of the six months, and 17 of these came from outside Camberwell. Four of the 12 day-hospital patients were not Camberwell residents. The second problem was that the out-patient department closed for alterations and redecoration on the

day the study was due to begin. This entailed a good deal of confusion and extra work but, on the whole, it did not affect the results of the study.

Thus the three groups finally accepted into the series constituted 50 admissions, 30 high-risk but non-admitted patients, and 12 day-hospital patients.

3. Results

3.1. DEMOGRAPHIC FACTORS

Age, sex, occupational class (RGO), ethnic group, education, present marital status, and present family status were distributed in a similar way in the three groups. Of the 50 admitted patients, 36 were women.

3.2. PREVIOUS ADMISSION TO HOSPITAL

Of the 50 patients admitted to hospital, 38 (76 per cent) had had a previous admission compared with 26 of the 42 others (62 per cent); a non-significant difference. However, of the 13 patients who had previously been admitted under order, 12 were in the admitted group; a very highly significant difference.

3.3. CLINICAL CONDITION

The diagnosis of each patient in the series is shown in Table 13.1. The admitted patients were significantly more likely to be suffering from psychotic conditions (and, of these, schizophrenia was commoner than affective psychoses).

Table 13.1. *Diagnosis of patients in three comparison groups*

<i>Diagnosis</i>	<i>Admitted patients</i>	<i>High-risk non-admitted patients</i>	<i>Day-hospital patients</i>
Schizophrenic psychoses	18	3	1
Affective psychoses	13	5	2
Neuroses	9	14	6
Personality disorder	10	6	2
Transient situational disturbance	—	2	1
Total	50	30	12

There was complete agreement on diagnosis between the clinician and the Catego computer classification, based on PSE ratings of present state and history (Wing, Cooper, and Sartorius,

1972), in 74 out of 92 cases (80 per cent). Scores can be derived from the PSE representing numbers of psychotic and neurotic symptoms. When these scores are compared within diagnostic groups there is little differentiation, as Table 13.2 shows.

Table 13.2. *Mean numbers of psychotic and neurotic symptoms in three comparison groups*

Diagnosis	Admitted patients		High-risk non-admitted patients		Day-hospital patients	
	P	N	P	N	P	N
Schizophrenic psychoses	18.1	12.5	17.3	23.3	3.0	13.0
Affective psychoses	7.1	21.8	11.7	19.0	—	20.0
Neuroses	—	26.4	—	25.0	—	23.2
Personality disorders	—	32.1	—	26.8	—	25.5

Behaviour during the previous month as reported by the patient was compared with behaviour reported by the relative. Agreement was in general good but patients tended to under-report certain kinds of behaviour (particularly withdrawn and irritable behaviour) compared with relatives and the latter reported more disturbance. These differences occurred in all three groups, however, and the comparative results will be reported here mainly as given by the patient. Severe behavioural disturbance was significantly commoner in the admitted group. Severity was judged according to the nature of the abnormality (thus violence was regarded as severe disturbance while laughing to self was not), and according to the extent to which the behaviour impinged on children or neighbours rather than on adult relatives such as parents or marital partners. Of the 50 admitted patients, 34 described severely disturbed behaviour, while only 15 of the remaining 42 patients (36 per cent) did so ($X^2 = 9.6$, $df = 1$, $p < 0.005$).

Condition at the time of PSE interview could be compared by using the score on the behavioural sections, including observed abnormalities of speech, affect, and behaviour. The mean score in the admitted group was 4.3, compared with 1.2 in the high-risk non-admitted group and 2.0 in the day-hospital patients ($F = 9.94$, $p < 0.01$).

3.4. SOCIAL PERFORMANCE

Data on social performance will be reported elsewhere but, in general terms, there was only a non-significant trend towards a higher degree of impairment in the non-admitted patients.

3.5. NECESSITY FOR ADMISSION REPORTED BY CLINICIAN WHO MADE DECISION

The admitting doctor recorded his impression of the clinical and social requirements of the patient at the time the decision to admit or not to admit was made. Nineteen possible needs of the patient or relatives were presented as a checklist and Table 13.3 shows their

Table 13.3. *Need of patients for various treatments or forms of care*

<i>Need for:</i>	<i>Admitted patients (N = 50)</i>	<i>High-risk non-admitted patients (N = 30)</i>	<i>Day-hospital patients (N = 12)</i>
Treatment which cannot be given as out-patient	17	3	2
Specialized therapeutic environment	12	4	10
Special clinical investigations	4	1	—
Medical and nursing observation and assessment	31	1	3
Basic nursing care	5	1	—
Protection of patient from:			
self-neglect	15	1	2
consequences of own behaviour	12	3	1
suicidal intentions	16	10	1
self-injury	11	6	2
environmental stress	24	11	3
Patient's own insistence	3	3	—
Protection of relatives and public from:			
patient's aggression and destructiveness	15	6	1
patient's embarrassing behaviour	11	1	—
other aspects of behaviour	6	2	—
Respite to those providing care	14	15	—
No-one to look after patient	8	4	2
Relatives' over-concern	3	3	—
Lack of sufficient information	2	2	—
Other	3	1	2

distribution in the three comparison groups. If the needs which most obviously indicate admission are considered separately (need for treatment which cannot be given as an out-patient, need for protection from suicidal intentions, need of protection from aggressive behaviour), two-thirds of the admitted patients have such need compared with one-third of the rest.

The attitudes of various parties concerned with admission, as reported by the admitting doctor, are shown in Table 13.4. There was a considerable consensus of views for or against, but the patient was more likely to be uncertain one way or the other or to disagree with the decision. It is perhaps not surprising that the doctor's views are most in accordance with what actually happened.

Table 13.4. *Admitting doctor's impression of attitudes of the various people concerned towards the patient's admission*

Party concerned	For or strongly for		Unsure		Against or strongly against		Not known or not applicable	
	Admitted	Not admitted	Admitted	Not admitted	Admitted	Not admitted	Admitted	Not admitted
Patient	24	6	11	10	11	10	4	4
Relative	33	8	—	2	—	4	17	16
GP	17	7	1	7	—	1	32	15
Psychiatrist	46	9	2	4	1	15	1	2

In one-quarter of the patients ($N = 23$) some form of alternative care was suggested (nearly always non-residential) instead of admission but only three of these patients were in the admitted group.

3.6. DAY AND TIME OF ADMISSION

Out of the total series, 48 patients were attending the emergency clinic when the decision to admit or not was made. There was no difference in time of arrival between those who were admitted and those who were not. Only 5 of the 48 were seen during the weekend, but 4 of these were admitted.

3.7. URGENCY OF NEED FOR ADMISSION AND AVAILABILITY OF A BED

Two-thirds of the admitted patients were thought to need admission the same day and most of the others could only wait a couple of days. In every case, throughout the whole of the six-month period, a bed was available.

3.8. RESEARCH TEAM'S JUDGEMENT CONCERNING NEED FOR ADMISSION

Table 13.5 shows the judgement made by the research team concerning each patient's need for admission. It was thought that admission could have been avoided in about one-third of the cases in the admitted group (17 out of 50) but that in 5 of these cases it would have been necessary to go to considerable lengths in order to keep the patient out of hospital. In 12 cases out of 50 (24 per cent) it should theoretically have been a fairly simple matter to make alternative arrangements. Ten of these 12 were women.

Table 13.5. *Judgement of research team as to degree of necessity for admission*

<i>Research team's judgement</i>	<i>Admitted patients</i>	<i>High-risk non-admitted patients</i>	<i>Day-hospital patients</i>
Should be admitted	33	2	—
Should only be treated outside hospital under special circumstances	5	4	1
Admission unnecessary if other routine services available	10	2	—
Admission unnecessary	2	21	11
Total	50	29	12
Not known	—	1	—

Flexible and simple arrangements for rapid admission to the day-hospital, which is still geared to admission from a waiting-list, would have avoided admission to a ward in most of these cases. This may be due partly to the small size of the day-hospital and partly to the traditionally sedate admission policies of a teaching hospital. On the other hand, 6 of the 30 non-admitted patients and 1 of the day-patients were thought to have shown a need for admission (5 of them from the emergency clinic). Since the admitted group constituted a one in four sample, while only half the non-admitted group were from Camberwell and these constituted all the eligible patients, it is clear that the main problem is one of over-admission, if the research team's judgements are taken seriously (some examples are given in the Appendix to this chapter). On the basis of these sampling fractions, it can be calculated that the admission to hospital of some 92 patients could be avoided during the course of a year by a rearrangement of services, while 6 perhaps ought to be admitted instead of treated outside hospital; a net reduction, within the limits of the inclusion criteria, of 86 admissions, approximately 70 of them women. This number may be compared with the estimated annual number of 376 admissions during 1970 who met the inclusion criteria at the hospitals concerned. If the appropriate adjustments are made to the over-all admission rates they look more like the national rates and would be very close indeed if the assumption could be made that an equivalent proportion of patients not represented in the sample, particularly those aged 65 or more, need not be admitted.

Brief notes concerning the 12 patients who were not thought to

need admission, together with a case-summary for several other illustrative patients, are included in the Appendix to this chapter.

3.9. PATIENTS ADMITTED COMPULSORILY

Nine patients were admitted under order; section 25 ($N = 4$), section 29 ($N = 4$), section 136 ($N = 1$). The nature of these orders is explained in Chapter 14. As a check on the findings in that chapter, the ratings of insight were examined. In five cases the patients were rated as showing no insight and in one who refused interview it appeared that insight was probably absent. Two patients were said to have moderate or partial insight; one was put on order while in a general hospital and the other while in a convalescent home. The other patient was said to show full insight at the time of the research interview but the situation leading to admission had been a violent one and there seems no doubt that insight was lacking at that time.

All patients except the last were placed into the category of definitely requiring admission but all nine refused to be admitted voluntarily. The last patient had a long history of problems, both social and emotional, and it was thought that she might have stayed out of hospital if a whole battery of services (such as nursing supervision at home) had been available.

4. Discussion

Many expectations concerning reasons for admission are confirmed by these results, although the numbers are small and it is not possible to undertake a sophisticated statistical analysis. The four main types of reason were disturbed behaviour, pressures from relatives and professionals, availability of beds, and lack of alternative forms of care.

Disturbed behaviour is by no means an absolute indication for admission. One-third of the patients with aggressive or destructive behaviour were not admitted. A diagnosis of schizophrenia was more closely associated with admission and affective psychoses were more frequently found in in-patients than the rest. An interaction between behaviour and diagnosis was apparent. Thus expressed suicidal intentions in a depressed patient were taken more seriously than in a patient with personality disorder. Information concerning the patient's behaviour is given to the doctor by various informants. The patients themselves tended to under-report certain symptoms, compared with their relatives' account. It is shown in several other chapters in the present book that they also tend to report less disability. Relatives give a fuller account

but 18 per cent of admitted patients and 27 per cent of the others were unaccompanied. Admitting doctors tended to overestimate the degree of agreement of relatives with their decision to admit. GPs expressed an opinion about admission in only one-third of the admitted cases but on the three occasions on which they brought the patient to the clinic personally, admission always took place. Local authority social workers were only involved in 14 out of 92 cases. On the basis of the information obtained, the doctor had to make his decision and give his advice; only 9 patients out of 50 were placed on order. The main reason for admission was given as self-neglect in one-third of cases, protection from suicide in one-quarter, and need for skilled observation and assessment, need for special clinical investigations, or need for a therapeutic environment in the rest. Only in one case did the admitting doctor feel the need for alternative facilities, which would have enabled him to advise a different action than admission.

In fact, there were always beds available to the admitting doctor, a situation which is not found in much of the health service. The doctors were often relatively junior and it is quite likely that some patients were admitted simply for the reason that the doctor was too inexperienced to take the responsibility of advising otherwise, in the face for example, of a conflict of evidence over an expression of intent to commit suicide.

There were no facilities for brief admission followed by rapid transfer to the day-hospital, nor could direct admission to the day-hospital be arranged in an emergency, since there was usually a waiting-list for vacancies. It was thought that about a quarter of all the patients admitted to the wards could have been dealt with in this way. There would be many implications for the day-hospital as at present constituted (see Chapter 6). It would need to be larger in size and part of it would take on the functions of an ordinary acute ward. These functions are already carried out but the administrative arrangements are not geared to the needs of patients requiring urgent admission in a situation of crisis. The proportion of 25 per cent is smaller than that given by Zwerling and Wilder (1966) and it may be a conservative estimate.

There is no local authority hostel available for the adult mentally ill in Camberwell. Apte (1968) showed that a hostel can be a realistic alternative to hospital admission in some cases. A co-ordinated hospital and local authority service would undoubtedly provide opportunities for reducing the number of admissions to hospital, by using a wide range of hostel services.

A further service which could have been of considerable use is an emergency domiciliary assessment service. In fact, social

workers at the joint hospital do occasionally make emergency home visits and local authority social workers often do so, but some of the fifty admissions might have been prevented if such a service had been more readily and routinely available. Domiciliary nursing care might also have been helpful in a few cases though the economics of such a service are somewhat doubtful.

The essentials of a service in which no patient was admitted to a hospital ward unless absolutely necessary, would be a round-the-clock assessment service (including domiciliary assessment when necessary), directed by experienced and responsible consultants whose advice was readily available at all times, which would have a full range of alternative overlapping facilities at disposal. Regular follow-up conferences would ensure that the consequences of decisions made in the emergency or out-patient clinic would be fed back to those responsible so that continuous learning could take place.

Scheff's point that doctors tend to assume illness unless the contrary can be proved is not necessarily borne out by this study but a minor variation of the rule, that it is safer to admit if there is any doubt, certainly seems to have been adopted. In the circumstances the rule is justified but with an expanded assessment service and with a full range of services available it would be unnecessary.

APPENDIX

Illustrative case-summaries

A. Patients admitted to hospital who were thought by the team not to need admission (all twelve cases summarized).

1. *Mrs A* was a 47-year-old married woman living with her family not far from the hospital. She had been under treatment for several years as an out-patient at another hospital. She was a difficult patient to manage, being dependent and histrionic. She was having a difficult period at home adjusting to her two teenage daughters growing up. The husband said she was referred to the Maudsley because the psychiatrist at the other hospital found her a 'pain in the neck'. The patient was not keen on admission, and the family could not see how it would help. She stayed only four days.

2. *Mrs B*, a 42-year-old woman with travel phobia, became more depressed and a friend suggested she take a mini-cab to the emergency clinic. She broke down and cried and was admitted. She had been going to work regularly and had not attended the out-patient clinic for two years. She did not want to come into hospital but was persuaded by the doctor ('I'd do anything he said') and her man-friend was amazed that she was admitted.

It is doubtful that she needed admission to hospital. Both she and her friend would have been willing for her to attend as a day- or out-patient.

3. *Mrs C* was a 19-year-old housewife. She was moderately depressed, finding the housework and children difficult to cope with. She was taking tablets from her GP. She told a visiting probation officer that she had an impulse to take them all at once and was advised to go up to the emergency clinic. She had good insight into her condition and had never been in hospital before. She was quite willing to have attended as a day-patient and there seemed no indication for admitting her as an in-patient.

4. *Miss D* was a 32-year-old single person. She lived alone and had always felt very isolated. She had a depressive personality and had had two admissions during the past three years. On this occasion the symptoms may have been precipitated by the 'A'-level examinations she was soon to take. Her doctor felt she needed more support than he could give her as an out-patient. She had wanted to get into a hostel, but none was available within reach of work. This would have been a better resolution of the situation: admission to a hostel, the patient felt, would have solved her problem of isolation. It is possible it would also have helped prevent further relapse of her illness.

5. *Mr E*, returned to this country six weeks before admission from Australia where he had gone to live with his family. He had been repatriated here on account of mental illness. He returned to London to his parents' home where he and his wife and her two children, not only had to share the same room, but also the same bed. The only place he could talk to his wife in confidence was outside her place of work during the lunch hour. He was depressed, angry, and resentful. He was admitted to hospital for one day and then discharged himself.

6. *Mrs F* was 36, married with six children, and had suffered recurrent panic attacks for years, for which she had had out-patient treatment at another hospital. She had attended at the Maudsley since 1969. She had been seen on domiciliary visits and had attended the emergency clinic several times.

The main pattern of her illness seems to have been an acute anxiety state with depressive features precipitated by physical or psychological stress with a rapid response to supportive help and Diazepam. Recently she has had panic attacks with palpitations, sweating, feeling of inability to cope, eventually retiring to bed. This had occurred following diarrhoea and vomiting for three days which her children had too. She had recently finished menstruating, and said that this was usually her worst time.

The patient's husband had given up his trade as painter and decorator in order to be near his wife, a financial catastrophe from which they never recovered. They have a mentally retarded daughter, who requires a lot of supervision. She is soon to leave school or training centre and there is the worry about what she will be able to do.

There seemed to be no special indication for in-patient treatment and, in fact, the patient left hospital after a few days.

7. *Mr G* was a divorced man aged 34 living with his parents. He had first become ill in 1965, with paranoid schizophrenia. His marriage broke up and he had a series of jobs each requiring less skill than before (originally he had been a draughtsman). He had been discharged from hospital six weeks before the key admission; on that occasion he had been in hospital for a year. He felt that he was not wanted at home and that he was being edged out of the jobs he had started by Freemasons. He took an 'overdose' of phenothiazines and went to bed but woke up without ill-effect next morning. He told his parents what had happened

and they brought him to the casualty department from which he was admitted. Day-hospital care was not considered but the parents would have been against it.

It was thought that immediate day-hospital treatment together with a subsequent hostel placement would have avoided the need for further admission of a patient who was already in danger of institutionalism.

8. *Mrs H* was a 33-year-old housewife who had been having rows with her husband over his suspected infidelity, which he denied. She felt that she had no support or affection from him. He had suggested a separation, following which she took an overdose of tranquillizers and was admitted for one day to King's College Hospital (her life was not seriously in danger). She remained weepy and depressed and was referred to the emergency clinic at the Maudsley from which she was admitted. The main problem was a marital one and, although the research team thought the patient needed support, for example through the hospital, the indication for admission did not seem strong.

9. *Mrs I* was a 41-year-old housewife who had had a puerperal psychosis at the age of 24. She had since been admitted on four occasions for catatonic schizophrenia. Two weeks before the key admission, her daughter was admitted to St Francis's Hospital. The patient became restless and agitated, talked incoherently, and neglected the housework. She was not disturbed at night. Her husband had considerable sympathy for his wife's condition and would have been content if she had been admitted to the day-hospital.

10. *Miss J*, a 25-year-old single woman, had been brought up by her grandmother in Ireland, as her father, an alcoholic, left her mother who then took up work in England. Miss J came here aged 16, was married at 18, but the marriage was annulled after eighteen months. Recently she had been working as a clerk, living in digs, and not on very good terms with her mother. Also recently her relationship with her boyfriend deteriorated and she found herself lacking concentration at work. On day of admission, a friend of the patient's telephoned her mother who went over to see her and her landlady. Mother was told that employer said she was in trance-like state at work, that she had refused to work for one week, being irritable, refusing to let the landlady into her room, behaving in a strange manner, being frightened in the street and thinking 'there is something in the tea'. Attending GP for five years since annulment (for non-consummation); he found her difficult and suggested she be admitted for psychotherapy.

The landlady, on the other hand, said that the patient was a quiet reserved girl, who gave rise to no problems. The landlady denied that the patient locked herself away in her room. Picture quite at variance with that presented by the mother. Patient had a tendency not to eat proper meals and landlady often failed to coax her.

It is difficult to reconcile these conflicting stories. If an emergency domiciliary visit had been possible, admission might have been avoided.

11. *Mrs K* was a 57-year old widow who lived in her own house, letting the top floor to a quiet middle-aged couple. She was well-known to the hospital having had some twenty admissions in the past. She first came into the study as a control patient about a month before this visit. On that occasion she had had a typical episode of depression, with a hysterical presentation: a great deal of weeping, saying how she could not carry on, showing loss of confidence. The GP had wanted her admitted because she was a difficult person to help. The emergency clinic doctor who saw her at that time was very experienced. He saw no need to admit her once he had spent some time with her and she had responded to his support. When seen at interview a few days later she was back to her 'normal self' and made a point of saying how pleased she was that she had not been admitted.

She had been a widow for many years. She had few friends. A patient who was kind to her during her previous admission asked her for money to help in a business he had. She lent him £300 and he disappeared. She had had a man visitor for a few years. He came to see her regularly each Saturday for two hours; she never went to see him. He had promised her that he would marry her when he retired. Two weeks before the second visit to the emergency clinic he retired and he also stopped visiting her. This undoubtedly precipitated the second episode. It was an identical bout of depression: both according to the GP's letters and emergency clinic notes. However on the second occasion she was seen by a doctor new to the clinic with little experience who decided to admit her.

Though this patient had need for immediate support and community care she already knew the MWO well and could have been put in touch with him. Admission to hospital served no useful purpose.

12. *Mrs L* was a married woman with two grown-up children, now married for the second time, who had been admitted eight times during twelve years for paranoid or schizo-affective disorders. Her last previous admission had been for depression. For two or three weeks she had been depressed and weepy and thought her husband who was in good health, was seriously ill. It was thought that she could have been treated in the day-hospital and that many of her previous episodes could have been dealt with in this way if she had been treated early enough each time, before more serious symptoms developed.

B. Patients admitted to hospital who were thought by the research team to need admission (two case-summaries)

1. *Mrs M*, a 51-year-old housewife, had been well for about fourteen months, attending the out-patient department and maintained on Largactil. Previously she had been in hospital on four occasions in the last five years with manic depressive psychosis, manic type, and mixed affective disorder and hysterical personality.

She was more irritable before Christmas and when her family came to stay there was a flare-up; she became excited and hostile, particularly towards her husband and to her two married children who packed up

and left. She then became depressed, but blamed everything on her husband. She was admitted to hospital for a few days and then discharged herself. Two days later she woke early in the morning and told her husband to get some coal. When he went for it she locked him out and he had to smash a window to get in. He became angry and the patient ran to the police station in fright. She was brought up to the hospital by the police when they learnt she had recently been an in-patient.

The husband displayed considerable tolerance of this very long-standing condition in his wife. He had changed his job so that he could devote more time to her. He spoke very highly of his grown-up children.

He saw the main problem as his wife's lack of insight and unwillingness to admit that there was anything wrong with her. He felt no one could share his problem with him and that the doctors had no helpful suggestions to make to relatives, to help them deal with the situation.

2. *Mrs N*, a 52-year-old Greek woman, had her first (known) psychiatric illness on her way to this country in 1946 to join her husband whom she had married sometime before in Greece. Initially, the diagnosis was mania but this was later changed to catatonic schizophrenia. She had a standard prefrontal leucotomy in March 1968 and was discharged in September 1948. There was a similar illness in 1958, otherwise she was fairly well until last Autumn when she visited her family in the USA. She was upset by her sister-in-law's treatment of her brother; the illness began with ideas of reference and she developed delusions of persecution. In January she left her job and became restless and excited. There was pressure of talk and overactivity at home, even at night. She did not complete anything she started and her husband found it impossible to calm her. On the day of admission she rushed out of the house without her coat or money.

C. Patients not admitted to hospital who were thought by the research team to need admission (two case-summaries)

1. *Mrs O* was brought to the emergency clinic by her husband on 15 March. She had had three previous admissions for manic-depressive and depressive illness and her husband thought she needed to be admitted again. The doctor advised against admission and suggested they wait to see the effect of chlorpromazine. Mr O took time off work to look after her. She did not improve and was admitted three days after coming into the control sample.

The husband was very upset when talking about wife; near to tears and self-critical. Mr O was sure she was ill for a week or two or perhaps five weeks before this but described how hard it is to know whether to insist on the patient seeing the doctor: it may be a false alarm and 'you do more harm than good'. She accuses him of 'carrying on' and he hates this more than anything else. She also has a fantasy that the television repair man is the father of one of the children: she has told the eldest boy this, which worried Mr O. He believes she will never be really well again. He has lost confidence in her GP and thinks Maudsley doctors were deceived (at last routine check) by her being 'high', they thought she was well but

in fact she was manic prior to depression. He blamed himself for not going with her to point this out.

2. *Mr P*, a young man of 20, youngest of two sons living in a poor tenement flat together with his ill parents and brother. He has been in hospital five times for disturbed behaviour in the last two years. He left hospital three months ago but did not return to work because he did not feel well enough. He sat at home, brooding on what was to become of him, that he did not have any man or girl friends. Listened to records and went for walks with his brother. He experienced hallucinations and felt tense, but kept quiet except for an outburst during which he broke a couple of windows. His GP was called and the patient was referred to the emergency clinic, but admission was not advised. The housing situation was very poor, both parents were in poor health, the mother diabetic and the father with a chest complaint. Both sons had schizophrenia. Nobody in the household was working.

D. Patients not admitted to hospital who were thought by the research team not to need admission (two case-summaries)

1. *Mr Q*, a 48-year-old electrician, has been doing union work for two years. For some months now he has been bringing home problems from work. Five weeks ago he broke his left shoulder and he has been off work since. He has been getting irritable, edgy, thinking continually about work, getting depressed, waking at 2-3 am, and getting up to do his work. He is worried about his fracture. He started to drink to calm his nerves. His wife worried and went to see the GP about him. She wrote a letter to Maudsley emergency clinic. He himself denied there was anything wrong and refused admission.

Both patient and wife were very co-operative and think that *Mr Q* broke down because the worry of organizing a compensation claim for work mates in an accident was too much for him. A quiet family, they 'keep themselves to themselves', the sons have no girlfriends and go everywhere together and with their father. Out-patient treatment was accepted.

2. *Mr R* was a young bachelor of 19 who lives with his parents in an opulent flat. He worked as a trainee accountant in industry. He had had difficulties with girlfriends.

The present one had been unsatisfactory in various ways, particularly by not keeping dates. She had then told him she might be pregnant. He would have liked to marry her but she wanted an abortion. He was worried about getting money for this and also for a holiday he had planned to get away together. On the day of admission, she let him down, they had a row, and he went for a drive and returned home; 'things were building up'. He went upstairs to listen to records. He could not see any solution to it so he took some tablets; fifty Hypon. He lay down for a while and then he got scared and told his mother. Treatment as an out-patient was arranged.

Reasons for compulsory admission

H. Dawson

1. Introduction

Society has always established means of segregating those of its members whose behaviour for one reason or other has become intolerable to the majority. Before Shaftesbury's reforms in 1848, those people exhibiting what the majority would now call mental illness were incarcerated as 'lunatic vagrants' in prison or the workhouse. Subsequent legislation embodied in the Lunacy Act (1890), the Mental Treatment Act (1930), the National Health Service Act (1946), and finally the Mental Health Act (1959) have more and more brought humanitarian ideals to bear on the problem of compulsory admission to mental hospital, avoiding the routine involvement of the magistrate except in special circumstances when criminal acts or the police are directly concerned.

Most workers agree that the statutory removal of patients from the community is a regrettable but unavoidable necessity, whereas other more radical thinkers feel that such an act represents society's own madness projected on to a scapegoat (Cooper, 1967).

Certainly in the USA there is some evidence that 'the commitment process has the form of due process of law, but is actually vacuous since the decision tends to be predetermined' (Mechanic, 1969). In this country Lawson, investigating the working of compulsory admissions under the then new Mental Health Act (1959), found that many of the factors associated with compulsory admission were merely of an administrative nature: 'nosocomial' factors, such as availability of beds or length of waiting-list, and 'threshold-affecting' factors such as time of day, age of patient, and

so on. This suggested that many compulsory admissions could have been avoided by introducing administrative changes.

Since 1959, the national rates of compulsory admission have been dropping. In Camberwell, although the numbers on order have come down to a small proportion of all those admitted during the course of a year (14 per cent in 1969, as against 19 per cent in the four Metropolitan regions, and 17 per cent in England and Wales), it looks as though no further decrease is taking place. It is therefore important to consider whether patients still being admitted compulsorily do in fact need to be treated in this way or whether some other method of managing whatever problem has led to certification might not be more satisfactory and at least equally effective (Dawson, 1971).

2. Design and method

Fifty patients, consecutively admitted under order to the mental hospitals serving Camberwell between April and December 1970, formed the series for investigation.

The following sections of the Mental Health Act were used:

Section 25 ($N = 17$). Admission for observation. The patient's relative or a mental health social worker applies for admission and the recommendation of two doctors is required stating (a) that the patient is suffering from mental disorder of such a nature or degree that warrants detention in hospital for observation (with or without treatment) and (b) ought to be so detained for his own safety or for the protection of others. One of the doctors should be approved by the local health authority. The patient may be detained in hospital for observation for twenty-eight days.

Section 26 ($N = 1$). Admission for treatment. The conditions are similar except that the two doctors' recommendation is for detention in hospital for treatment.

Section 29 ($N = 29$). Admission for observation in case of emergency. The conditions are similar to those for Section 25 except that a statement is necessary in the application that the procedures involved would cause considerable delay. Only one medical recommendation is required. The patient may be detained for observation for only seventy-two hours but this period may be extended to twenty-eight days if a second medical recommendation is given before the seventy-two hours expire.

Section 136 ($N = 3$). Police orders. The application for admission is made by a police officer.

Two other sections of the Act were not used:

Section 60. Admission under court order.

Section 65. Admission under court order with the proviso that only the court can discharge the order.

It should be noted that Sections 25, 26, and 29, accounting for 47 out of 50 orders, require two conditions to be satisfied; an application by a relative or (if none is available) a social worker, and one or two medical recommendations. The responsibility is thus shared. The focus of interest in this chapter will be on the justification for an order being made at all rather than on the administrative question of which type of order is most appropriate.

A comparison group was set up by including for every patient on order the next voluntary admitted patient to the hospital for the same sex, diagnostic category, and approximate age. This matching was successful in producing equal numbers of the sexes and a closely similar age and diagnostic distribution. Ninety per cent of the patients in the comparison group were within five years of the matching patient. The diagnoses of the two groups are shown in Table 14.1.

Table 14.1. *Diagnoses of patients in compulsorily and voluntarily admitted groups compared with those of admissions in 1969 (percentage)*

<i>Diagnostic group</i>	<i>Compulsorily admitted*</i>	<i>Voluntarily admitted*</i>	<i>All admissions in 1969</i>
Affective psychoses	36	36	49
Schizophrenic and other psychoses	46	46	28
Alcohol and drug addictions	8	8	8
Dementia and other organic conditions	4	4	4
Personality disorders and other conditions	6	6	12
Total number	50	50	855

* It can be seen that the two groups were exactly matched for diagnostic group.

Schedules were drawn up to guide the interviews with each patient and with those most closely concerned with arranging admission. These included the hospital doctors concerned with admission and treatment, the GP, mental health social worker and any other professional involved with the admission, voluntary workers such as officers of the Salvation Army, the police, relatives, and members of the public such as landlords, tenants, neighbours, friends, colleagues, or strangers who happened to become involved.

All interviews were completed as soon as possible after the time of admission, while the incidents were still fresh in informants' minds.

3. Results

Co-operation was readily forthcoming from all patients and informants and no replacements had to be made.

There were 35 women and 15 men in each group; a ratio of 2.3 to 1. The equivalent ratio among all patients admitted from Camberwell during 1969 was 1.5 to 1 (see Chapter 11), a non-significant difference. It can be seen from Table 14.1 that the only sizeable discrepancy in diagnostic distribution between the patients in the series of compulsory admissions and all those admitted during 1969 is that schizophrenia has a substantially higher representation in the former group, accounting for nearly half the patients. The age distribution of the investigated series was closely comparable to that of all patients admitted during 1969, except that only 15 per cent of compulsorily admitted patients were aged 15-24, while 30 per cent of voluntarily admitted patients fell into this age-group. The difference is not significant.

The distributions of certain easily measurable clinical and social factors in the compulsorily and voluntarily admitted series were compared and found not to differ significantly. These included birthplace (Irish and foreign-born versus others), marital status (ever married versus others), occupation (skilled versus unskilled), time of day when admitted (inside or outside office hours), whether previously admitted to a psychiatric hospital, and whether currently attending an out-patient clinic.

The influence of factors measured on the basis of interview ratings was then considered: these were burden on the family, relatives' knowledge of the services available, fear or dislike of mental hospitals, social isolation, denial of illness, and disturbance of behaviour.

3.1. BURDEN

A three-point scale assessing the degree of burden or stress on the family was rated on the basis of the subjective feelings of relatives and the account given by any professional workers involved. Much the same degree of burden was indicated by the two indices (little or none: 10 per cent family, 10 per cent professionals; moderate: 58 per cent family, 54 per cent professionals; severe: 32 per cent family, 36 per cent professionals). No significant differences were found between the two series of patients.

3.2. RELATIVES' KNOWLEDGE OF SERVICES

The relatives of 42 per cent of patients admitted on order were thoroughly familiar with the available services compared with only 29 per cent of the families of voluntarily admitted patients ($p < 0.05$). Such knowledge appeared to be acquired during contact with the services concerned.

3.3. FEAR OF MENTAL HOSPITALS

Judged by the patients' own opinions and by relatives' views of the patients' opinions, there was no difference in attitudes between the two series. A rating of marked fear or dislike, on the part of relative or patient, was only made in 6 per cent of cases (4 per cent in patients, 6 per cent in relatives, and 4 per cent in both).

3.4. SOCIAL ISOLATION

Ratings of social isolation (minimal, moderate, or marked) were based upon recent contacts with relatives at home and with people outside the home. There were no statistically significant differences between the two series.

3.5. DENIAL OF ILLNESS

Insight is a concept fraught with epistemological complexity (Lewis, 1934). According to one common but sometimes unspecified usage, insight involves acceptance by the patient of the general views on mental illness held by the professional people who are making the assessment of insight. Since psychiatrists themselves often disagree as to the nature of mental illness in any particular case this type of definition tends to be self-defeating. 'Denial' of illness is conceptually simpler (Weinstein and Kahn, 1955), though it contains elements of the same confusion. Denial was assessed on a three-point scale (minimal, moderate, marked) on the basis of the interview with the patient and the accounts of his behaviour given by the other informants. Table 14.2 shows the distribution of ratings in the two series of patients. The compulsorily admitted group denied that they were ill to a much greater extent; this was the most significant finding of the study ($p < 0.001$). It goes

Table 14.2. *Denial of illness.*

<i>Degree of denial</i>	<i>Compulsorily admitted</i>	<i>Voluntarily admitted</i>
Minimal	6	38
Moderate	7	7
Marked	37	5

without saying that none of the compulsorily admitted group was prepared to enter hospital voluntarily, while all the voluntarily admitted group did so. Table 14.2 shows that there were six people who did not really deny they were ill but who nevertheless refused to be admitted.

3.6. DISTURBED BEHAVIOUR

Glasscote (1966) and Scheff (1964) view the management of psychiatric emergencies solely in terms of deviance from or threat to social norms of conduct. In the present study, the patient's behaviour was rated on a five-point scale of frankly dangerous behaviour (whether to self or to others). Two separate ratings were made; in the first place on the basis of the most disturbed behaviour reported by witnesses, and in the second place on the basis of the behaviour reported by the patient or occurring during the examination by the doctor who recommended compulsory or voluntary admission. Violence or threats *after* the decision to admit were not taken into account. There was no significant difference between the groups on either scale. Table 14.3 gives the details. When the two sets of ratings are compared with each other, it is found that the doctors' reports of behaviour during examination or reported by the patient contain significantly less evidence of violence or threats than do the reports of witnesses. That is to say, the admitting doctor must necessarily rely on the accounts of informants. This is true of compulsory and of voluntary admissions.

Table 14.3. *Disturbed behaviour before admission*

Degree of disturbance	Compulsorily admitted		Voluntarily admitted	
	<i>Reported by witnesses</i>	<i>Reported by admitting doctor</i>	<i>Reported by witnesses</i>	<i>Reported by admitting doctor</i>
None	—	—	—	—
Eccentric or odd, e.g. talking to self	3	6	6	12
Disturbed behaviour, e.g. gross delusions, overactivity	19	28	14	26
Seriously disturbed, e.g. screaming in public, threats of violence or suicide	23	15	25	12
Aggressive or destructive to self or others	5	1	4	—

3.7. CLASSIFICATION OF CASES

On the basis of all the reports, a rough classification of the types of disturbance leading to admission was made. Six groups were set up:

1. Patients considered by their relatives to be disturbed in behaviour but not suspected of being a danger to themselves or to others, though in need of observation or treatment.

2. Patients who created a public nuisance but who were not suspected of being a danger to themselves or to others, though in need of observation or treatment.

3. Patients who came by chance into contact with mental health services and who were not regarded as a danger to themselves or to others, but who needed observation or treatment.

4. Patients considered by their relatives to be a danger to others.

5. Patients who had harmed themselves or who had seriously threatened to do so.

6. Patients who appeared dangerous to members of the public.

Table 14.4 shows the numbers of patients in these six categories. Some brief case-summaries are presented in the Appendix. The distribution is much the same in the compulsorily admitted as in the voluntarily admitted series. Only thirteen patients were compulsorily admitted because of danger to themselves or others (groups 4, 5, and 6); most of these as Lemert (1951) pointed out, were recognized and initially dealt with by the family. Most of the others were in urgent need of observation or treatment.

Table 14.4. *Classification of patients admitted compulsorily or voluntarily*

<i>Informant</i>	<i>Group Behaviour</i>	Compulsorily admitted	Voluntarily admitted
1. Relatives	Disturbed, not dangerous	23	25
2. Public	Nuisance, not dangerous	11	9
3. Self	No danger	3	—
4. Relatives	Danger to others	6	6
5. Relatives and others	Danger to selves	4	6
6 Public	Danger to others	3	3

4. Discussion

On almost all the factors studied, there was little difference between the patients who were admitted compulsorily and those who were admitted voluntarily. Only the factor of denial of illness differentiated between them plus the fact that the compulsorily admitted patients all refused to enter hospital voluntarily.

The apparent reasons for making an order were many and varied. In some cases, admission was enforced in order to forestall anticipated social or family disruption or future violent behaviour. Such decisions were based on the pattern of past events. In other cases the decision turned on the hardship and suffering caused to the patient's family which, although not amounting to physical violence, nevertheless went far beyond the limits of what is ordinarily regarded as tolerable. In other cases, again, the decision was based upon socially embarrassing behaviour in public, such as wandering naked in the street. An example of each of these three types of reason is given in the Appendix. In all cases a clinical syndrome was readily apparent to the admitting physician, and only twice was there any difficulty in arriving at a specific diagnosis, although in both cases it was obvious that the individual was seriously mentally disturbed.

However, since these reasons for admission occurred quite as often in the voluntarily admitted as in the compulsorily admitted group, they provide no explanation why an order was necessary, whether or not violence had occurred or been threatened. In fact, by far the most dangerous individual in the whole group was admitted voluntarily.

The only reason for an order appeared to be that the patient did not agree that admission was necessary. In such a case, the doctors concerned had to make up their minds, on the grounds of prevention of present or immediately predictable suffering, or of harm to the patient or of seriously embarrassing behaviour in public, caused by a mental disorder. Such decisions are matters of value as well as science. The responsibility is shared by the relative or social worker who applies for the patient's admission.

When the investigator made his own judgement, on the basis of what the doctors, patients, and other informants had to say, only two cases appeared in any way doubtful; even here, no alternative to hospital admission seemed possible even if only to clarify an ambiguous situation.

So far as the organization of services is concerned, conditions had clearly improved greatly since Lawson's time. There was close liaison between the local authority mental health department and the various hospitals, due to the fact that each of them had at least one social worker with a joint appointment to both types of authority. There was also a good deal of consultation about patients who might at some future time need admission to hospital on order. An efficient screening system of domiciliary visits also contributed. In only one case would earlier communication and co-operation (in this case between the police and the mental health

department) have averted a situation of potential violence developing.

It is not clear that any specific improvement in the psychiatric services would reduce the number of occasions on which patients were admitted under order. The only arrangements which appear likely to produce a definite decrease in the rate of compulsory admission would be those which themselves prevented relapse of illness occurring. Discussion of such changes, particularly in family management, takes us outside the scope of this chapter. Wider changes still, for example in the attitude of members of the general public when they suddenly and unexpectedly come across socially embarrassing behaviour, or in the tolerance of those who have psychiatrically handicapped relatives, are also difficult to plan for, though they could be expected eventually to have an effect.

Meanwhile, the number of compulsory admissions is likely to remain at roughly the present level. One modification in procedure should, however, be considered. The merits of compulsory admission as a day-patient rather than as an in-patient were not considered but, in the light of the results of Chapter 13, it is clear that some patients would be better treated in this way.

APPENDIX

Illustrative case-summaries

A. Elective orders

These two orders were in order to avert social crises which were not yet apparent but were thought to be imminent.

Mrs A was a 46-year-old woman with a long history of paranoid schizophrenia. Over the past year she had deteriorated gradually. The chief complaint was that she continually accused her daughter of being a prostitute and that her husband used to bring people into the home to have sexual relations with her for money. More recently the number and hostility of these accusations had undermined the confidence of her husband who now began to feel that his own mental health was beginning to suffer. His daughter had also begun to allow some signs of emotional disturbance. *Mrs A* was becoming more slovenly in the home and was cooking very badly whenever she cooked at all.

Mr A called a psychiatrist and admission under section 25 was recommended in the light of her previous history, as on previous occasions she continued to deteriorate until she was admitted to hospital. She denied any necessity for admission.

B. Orders applied to patients on account of intolerable burden to relatives, etc., although no violence occurred ($N = 14$)

Mr B, 63, an English working-class man living with his wife and daughter had previously been diagnosed schizophrenic on a compulsory admission ten years earlier. Recently he had become more withdrawn and eccentric. He hoarded vast quantities of junk in the house making living space unbearably small. All day he spent cutting out orange skins and applying them to his scrotum as a support. His 'workshop' became full of curious objects which were probably of sexual significance. In the days before admission he had been making suggestive remarks to his daughter about having sexual relations with her. He had also expressed

bizarre thoughts of a paranoid nature. Crisis was reached when his wife threatened to leave, taking their daughter with her. He took to locking himself in his 'workshop', a shed in the garden, whereupon the GP was called who advised compulsory admission.

C. Orders used because of public embarrassment ($N = 5$)

Miss C, 42, a middle-class English spinster secretary went to her doctor complaining of stomach trouble which she had experienced for some months. The GP ordered a Barium meal. On presenting herself for the X-ray she was anxious, overactive, and importuning to other patients to the extent that they complained to the out-patient nursing sister who discovered that the patient had lately been in hospital with a hypomanic illness. She arranged for a psychiatrist in the out-patient department to see her, who recommended compulsory admission on the grounds that she was again in a severe hypomanic phase.

D. Orders used because of actual violence ($N = 6$)

Mr D, a drama student due to take his exams, became overactive at a party one evening and later walked uninvited into the flat of two fellow girl students, making suggestive remarks to them. They eventually persuaded him to leave in the early hours of the morning. He later made a minor assault on a stranger in the street and was apprehended by the police. The police surgeon noted pressure of talk and religious delusions, and advised compulsory admission.

E. Orders used because it was obvious to relatives and examining doctors that the patients were psychiatrically disturbed enough to warrant in-patient treatment ($N = 23$)

Mrs E, 40, an Irish housewife had recently received a letter from her husband who was serving a long sentence for grievous bodily harm. She had been very upset by the contents of the letter and had been expressing paranoid thoughts; staying up all night with the children and neglecting them. She was persuaded to go to the out-patient department by her mother-in-law. When she presented at the Maudsley emergency clinic, she was garrulous, overactive, and verbally aggressive to the doctor who felt that the severity of the disturbance warranted admission under order.

Sheila Mann and Jane Sproule

1. Introduction

Chapter 6 contains details of the numbers of patients who still stay in hospital as long as a year. The numbers achieving 'long-stay status' each year are small; only 34 during 1969, for example, of whom 9 were suffering from dementia. Nevertheless, a steady accumulation of this kind over the years would mean the retention of sizeable institutions. It was pointed out in Chapter 10 that predictions based on recent statistical trends are hazardous. Forward planning requires more data than that. In particular, it would be useful to know whether recently admitted patients who stay a relatively long time, do so because of clinical factors such as severity of symptoms or primary handicaps which require medical and nursing attention, or whether social factors such as a lack of desire to leave or an absence of alternative accommodation are more important. Much of the published work on long-stay patients deals with the 'old' long-stay, who have accumulated from the past. Catterson, Bennett, and Freudenberg (1963), for example, who studied such a group after ten years of an intensive rehabilitation programme had resulted in the successful discharge of many patients, found that those who remained tended to have marked primary or secondary handicaps which made discharge unsuitable or problematic. Wing and Brown (1970) confirmed this general picture so far as such active hospitals were concerned, while noting that hospitals where rehabilitation procedures had only more recently been introduced would continue to find it possible to discharge such patients for some time to come.

The problems of the 'new' long-stay are likely to be quite different. They have not stayed long enough to become institutionalized but it might be thought that their clinical condition should have stabilized by the time they had been in hospital for six to twelve months, so that the pattern of primary and other handicaps should have become clear.

There could even be a new kind of long-stay patient, with different diagnoses and problems to those seen in the past. The statistics of case-registers in the USA indicate that the commonest single diagnosis on admission is alcoholism; other categories, such as brain damage in young people, or personality disorders, are also becoming more prominent. Although there is no evidence of this kind in the figures quoted in Chapter 6, it is doubtful how far most of the published studies can be relied upon to indicate present problems.

Magnus (1967) looked at the 'new chronics'; all new patients admitted to Glenside Hospital in Bristol during 1961-4 who remained resident for one year or more and were still in hospital at the time of review. Nearly half of the 178 patients had been given a diagnosis of schizophrenia and a further 23 per cent had organic conditions, mostly dementia. Magnus concluded that 50 per cent still needed to be in hospital for psychiatric reasons, 11 per cent required geriatric care, and 29 per cent required after-care (although the local authority tended to interpret their responsibility in this respect somewhat more narrowly).

The present study was intended to assess the primary and secondary handicaps of patients who stayed in hospital as long as six months and to discover from the relatives what their views were concerning discharge, with the aim of tentatively estimating the need for long-stay hospital places and for possible alternative accommodation (Mann, 1970). The problems of patients with mainly organic handicaps, particularly of patients with dementia, are relatively specific and may better be considered with those of geriatric and chronically physically sick people, so that this group was not included. Otherwise, the resources of the Camberwell Register were used to derive a representative sample of 'new' long-stay patients.

2. Design and method

The series was composed of all Camberwell in-patients aged 16 and over who, on 1 October 1969, had been resident from six months to three years, together with those who attained a stay of six months during the period 1 October 1969 to 30 June 1970.

Those with progressive cerebral disease were excluded. Patients who were out of hospital for less than two weeks before readmission, and those transferred from one hospital to another, were counted as having a continuous stay.

Six months was chosen as the lower limit because of the evidence of Fig. 6.2 that the chance of death or discharge begins to level out at this point. Three years was chosen as the upper limit in order to exclude the 'old' long-stay population. After obtaining the permission of the consultant in charge, each patient was interviewed shortly after the census day, or within a week or so of the date on which he or she had stayed in hospital for six months. After assessing the patient's current clinical condition with the aid of the Present State Examination (Wing, Cooper, and Sartorius, 1972), a series of questions was asked in order to elicit the patient's current social performance, attitudes, and plans for the future. The sociologist interviewed the appropriate relative or other informant, with the patient's permission, in order to rate behaviour and social performance before admission and attitudes and expectations concerning the future if the patient were discharged. The views of consultant and (where appropriate) social worker were sought and recorded and the case-notes were abstracted for basic social and demographic information. Twenty-one consultants were involved in all, eighteen of whom completed brief questionnaires about their patients. A brief case-summary was prepared and the research psychiatrist made a uniform diagnosis in each case after discussion with the medical and nursing staff looking after the patient.

On the basis of this material the psychiatrist and sociologist decided on an 'ideal' disposal for each patient, under eight different headings.

One patient was discharged before the interview could be undertaken and in one case the consultant thought that the patient should not be interviewed as she was taking part in psychotherapy which had reached a crucial stage. In one further case the patient refused to be interviewed. In the second and third cases full information was obtained from other sources and thus only one person out of those selected had to be excluded from the study.

3. Results

3.1. GENERAL CHARACTERISTICS OF THE SERIES

Table 15.1 shows the hospital in which the 62 patients were interviewed, the numbers in the two length-of-stay groups and the sex distribution.

A first analysis was undertaken in order to discover whether the patients interviewed as they reached the six-month point had different characteristics to those who had been in hospital for 7-36 months on 1 October 1969. The two groups were very similar and such differences as were found related to the longer stay of the

Table 15.1. *Characteristics of patients in hospital from six months to three years*

Hospital	6-7 month group		8-36 month group	
	M	F	M	F
Maudsley and Bethlem Royal	1	10	4	4
St Francis's	5	5	3	2
Cane Hill and other mental hospitals	4	5	6	13
Total	10	20	13	19

second group; they were older, had been unemployed longer, were less confident of their relatives' welcome or of their future plans, etc. It was therefore decided that the two groups could be considered together.

The age-range was 16-83 years. The same proportion as in the general population of Camberwell was immigrant, 10 per cent. In 14 cases, no relative or other informant was seen, either because the patient or relative did not wish it or because illness or distance prevented it. In only one case was no relative known. A high proportion of the relatives (82 per cent) had been in contact with a social worker, although the quantity and quality of the work done varied greatly. Social worker questionnaires were completed in 49 cases. Only 4 patients were not in the joint hospital, St Francis's or Cane Hill, in each case for good reasons. The patients seen appeared to be representative of the general population with regard to residential stability, only 12 had lived for less than one year at the address from which they entered hospital, and 20 had been at the same address for more than nine years. Twenty-nine patients had at one time been married although at the time of interview only 13 were living with their spouses. The educational level ranged from 6 patients with A-level or higher qualifications to 5 patients with estimated IQs below 80. Eleven out of 20 men and 11 out of 29 women had been unemployed for two years or more before they were admitted to hospital although they would have been expected to be working. Only 5 men and 10 women were within two years of the first contact with psychiatric services when they were interviewed.

3.2. CLINICAL CONDITION

The distribution of diagnoses is shown in Table 15.2. Schizophrenia accounted for nearly half the cases (14 out of 23 men) and affective disorder was the second largest group over-all (the largest among women: 16 out of 39).

Table 15.2. *Distribution of diagnostic groups, by sex*

<i>Diagnostic group (ICD group)</i>	<i>M</i>	<i>F</i>	<i>Total</i>
Schizophrenia (295, 297)	14	13	27
Personality disorder (301 excluding 301.1)	4	3	7
Affective disorder (296, 298.0, 298.1, 300.4)	3	16	19
Addiction (303, 304)	—	2	2
Depression and personality disorder (301.1)	2	3	5
Other neuroses (300 excluding 300.4)	—	2	2
Total	23	39	62

Fifty-eight of the 62 patients were interviewed using the PSE. Two were excluded as explained earlier and two could not be interviewed, one owing to deafness, the other owing to hypomanic excitement. The symptomatology present classified according to the Catego procedure (Wing, 1970) was as follows:

Schizophrenic symptoms	22
Manic or psychotic depressive symptoms	3
Other psychotic symptoms, further classification doubtful	4
Borderline psychotic symptoms	10
Neurotic symptoms	19

These were, of course, residual clinical pictures. Nevertheless, active psychotic symptoms were still present in half the cases.

Only 13 of the 62 patients were admitted under order.

3.3. PATIENTS' ATTITUDES

Twenty-eight patients stated that they definitely wished to stay, two were indifferent, 15 had some wish to leave although they were vague and undecided, 6 had a quite unrealistic wish to leave (for example, a 56-year-old married man, with a diagnosis of schizophrenia, who for seven years had experienced hallucinations. He had a well-developed delusional system involving his neighbours which caused him to black out all the windows of his house, thereby forcing his family, who shared his delusions while he was present, to lead a markedly abnormal life. His symptoms had failed to

respond to intensive treatment, but he was anxious to return to his previous environment.) The remaining 7 wished to leave hospital and had realistic plans for doing so. Four were not interviewed.

Attitude to discharge was not related to length of stay, as would be expected in much longer-stay populations (Wing, 1962; Freeman, Mandelbrote, and Waldron, 1965) and the proportion wishing to stay (48 per cent) is high for such a short-stay group, no doubt due to the very high degree of selection which now takes place before a patient stays even as long as six months.

Twenty-three patients thought that they were not ill or handicapped in any way at the time of the interview, 11 thought they were slightly, 9 that they were moderately, and 14 that they were severely handicapped. The self-assessments varied from the completely unrealistic to one schizophrenic patient who was aware of his condition and who anticipated that a future breakdown was possible.

Patients' attitudes to their relatives will be considered at the same time as their relatives' attitudes towards them. The largest group wanted to return home to the relative with whom they had previously been living (22 out of 58) and thought the relative would welcome them.

The realism of patients' plans for the future was assessed by the research psychiatrist and the relatives. In many cases the patient had no plans at all and in others no relatives were interviewed. Just over one-third had two estimates, one by the psychiatrist and the other by the relative, and in these cases there was considerable agreement: the psychiatrist thought that 15 out of 24 were fairly realistic, and the relatives thought that 13 out of 24 were fairly realistic. The patients' drive to achieve readaptation was similarly estimated and a similar agreement between psychiatrist and relative was found. Patients with no plans for the future were included (mostly rated as having little drive) so that the numbers are somewhat larger. The psychiatrist thought that 21 out of 30 had little or no drive; the relative thought that 20 out of 30 had little or no drive.

3.4. RELATIVES' ATTITUDES

In 12 cases the patient's spouse was interviewed, in 21 cases the parent, in 12 cases another relative, in 4 cases a friend or landlady, and in 13 cases there was no interview.

The background situation before the patient was admitted to hospital was discussed with relatives. Only 17 of the 49 informants had felt no marked distress; in 19 cases the distress had been severe and prolonged over several weeks. However, in only 14 out of 47

relevant cases was there a 'social crisis' (defined in terms of dangerous or embarrassing behaviour or intervention by non-professional officials such as the police). Fifteen relatives described no problems such as sleeplessness, poor appetite, worry, tension, and nervousness; 23 had had moderate problems, and 7 severe problems of this kind.

Concerning the housing situation, 9 relatives had no room for the patient, in 3 the patient would have to sleep on a sofa, in 14 cases the patient would share a room and in 18 would have a room of his own. If the patient were to return home, 21 relatives thought there would be no financial difficulties and 12 that there would be (in the remaining 29 the question was not relevant or the answer not known).

The longer the patient had been in hospital the fewer contacts they had with the outside world. This was exacerbated by the geographical situation, since the longer-stay patients were in hospitals remote from Camberwell.

The patients' and relatives' answer to a question concerning the degree of welcome home is shown in Table 15.3. The patients regarded themselves as considerably more welcome than was justified by the relatives' response ($p < 0.05$). A similar finding was recorded by Wing, Carstairs, Monck, and Brown (1964). Similar differences were found in answers to questions about how confident the informant would be about the patients' ability to remain out of hospital for at least a year after discharge.

Table 15.3. *Estimates of the welcome a patient would receive if he returned home after discharge*

<i>Degree of welcome</i>	<i>Patient's estimate</i>	<i>Relative's estimate</i>
Definite	20	12
Doubtful	12	6
None	10	24
Not known or not applicable	20	20

3.5. RECOMMENDATIONS CONCERNING ALTERNATIVE ACCOMMODATION

On the basis of all the information collected, including the comments of patient, relative, consultant, social worker, and other informants, a judgement was made by the research psychiatrist and sociologist and a third rater (JKW) concerning the most satisfactory type of accommodation for the patient at the time of examination. These judgements were necessarily clinical and not

scientific but they were made more systematically and in a more informed manner than would ordinarily be possible, and they were made according to the same criteria. Eight groups were formed as follows:

1. *Further hospital treatment required* ($N = 17$)

Patients in this group required further in-patient treatment but were thought likely to be discharged within a year at latest and not to need special precautions regarding security. For example, a 16-year-old girl had been taking part in psychotherapy in a special ward for nearly two years (the diagnosis was personality disorder). She was intelligent and had benefited considerably from treatment. At the time of examination she was continuing her studies at a Day College returning to the ward in the evening and for the weekends. It was thought that she could be discharged in a few months' time. Although her parents were pleasant and helpful it was thought that the patient would best go to the students' hostel.

The group could, in fact, be divided into those who needed further long-term in-patient psychotherapy ($N = 3$) and those who required other forms of treatment ($N = 14$). An example from the second subgroup is a 45-year-old married woman who had been admitted to hospital on at least ten occasions, the first following the death of her son. The episodes of illness had taken the form of severe depression or mania. At the time of examination she had only mild depressive symptoms. Her husband and two children were willing to receive her home when she was better, although they found the recurrent illnesses a considerable burden. It was thought that she would recover sufficiently to go home after a period of further treatment.

2. *Further treatment in a special ward required* ($N = 4$)

In a few cases, the patient's behaviour had been, and remained, such that considerable supervision appeared necessary because of the possibility of danger to self or others. For example, a 24-year-old man had been admitted several times since the age of 16 years, with a diagnosis of schizophrenia. The condition had not responded well to treatment and was unchanged for several months before the time of examination. He alternated between states of apathy and of violence; in the latter condition he had left hospital and attacked his mother. She was concerned about him and visited him regularly in hospital but was unwilling for him to be at home. He, on the other hand was unwilling to go anywhere else. It was thought that this patient and two other young schizophrenic men with similar difficult relationships with their mothers needed to remain

in hospital under supervision, at least for several more months. The fourth patient in this group was a 47-year-old married woman who was addicted to barbiturates and alcohol. In addition, she had an anxiety state and a long-standing personality disorder. She had been in trouble for forging prescriptions. Her present admission to hospital was the twentieth since 1948. Her third husband (a younger man with his own personality difficulties) thought she should be in an addiction unit, but this had already been tried without success. He thought that she should not return home until further treatment had been successful. On the previous occasion that she had gone home for the weekend she had forged a prescription for barbiturates.

As well as these four patients, there were five others in group 3 described below, who might well qualify for this group but who, it was thought, should stay for a trial period in a supervised hostel. If this did not succeed a supervised hospital ward might well be necessary.

3. Supervised hostel (N = 17)

A rather heterogeneous group of 17 patients (including the 5 just mentioned above) were thought to require accommodation in a hostel where some medical and nursing supervision and support were available. The hostel would not need to be run as a hospital ward but supervision would be needed at night and the overriding consideration would be continuity of treatment and support, both medical and social. The patients' problems varied from recurrent self-injury, or irresponsible behaviour (e.g. uncontrolled promiscuity and reckless spending) to frequent relapse of a schizophrenic illness. Relatives, in general, were unable to cope with the patient or to offer the support needed and were unwilling to offer a home unless the behaviour changed markedly. Because of the heterogeneity of the group it is difficult to find a single example. One 56-year-old single man with a schizophrenic defect state had been reasonably well apart from brief episodes of in-patient care until his mother, who had always looked after him and coped with him, developed dementia. He was self-neglectful and was a danger to himself (he had on one occasion set fire to a bed, probably accidentally), had a poor employment record and no idea of what he might do after discharge. In contrast, a 47-year-old single woman who was addicted to amphetamines had been in hospital on seven previous occasions and had lived in various hostels for five years. She had always been aggressive in manner and resentful of criticism and had a very poor employment record. She had been in prison twice for vagrancy.

The latter patient was one of five who, it was thought, might be tried in a supervised hostel but who might later need to be admitted to a supervised hospital ward. She did, in fact, later go to a hostel but did not stay and had to be readmitted.

4. *Part III accommodation for elderly people* ($N = 5$)

Four elderly patients needed the accommodation provided under Part III of the National Assistance Act (1948). For example, a 73-year-old widow had recovered from a first attack of affective disorder which had begun three years previously. Her relatives were unable to provide a room and she felt that she was too frail to live alone; this was probably correct. The fifth patient was a 57-year-old single woman who had previously lived in a Part III hostel. She had been admitted several times to hospital with schizophrenic illness but at examination was symptom-free. Her 73-year-old stepmother was the only relative and could not offer any accommodation.

5. *Hostel or lodgings with some supervision* ($N = 7$)

Seven patients were thought to need hostel or lodging accommodation without medical or nursing supervision but with some degree of social supervision. A sympathetic landlady, for example, who understood something of the patient's problems and who was in touch with the patient's social worker would probably be an ideal person to provide lodgings for certain patients. For example, a 21-year-old man had recovered from a manic-depressive illness and was working well from hospital. He had been living alone in lodgings before admission but did not wish to do so again. His relative refused to have him at home (his mother had committed suicide and his relations with his father had always been poor). This patient did later leave hospital and was found digs with a motherly landlady.

6. *Other specified accommodation* ($N = 5$)

Five patients required a specific form of accommodation; one for the blind, one for the deaf, one for the chronic sick, one for the severely retarded, and one patient wished to be repatriated.

7. *Unsupervised lodgings* ($N = 4$)

Four patients could have lived alone in lodgings or shared a flat with friends. For example, a 42-year-old married man who had recovered from schizophrenia remained on friendly terms with his wife although they lived apart. He had greatly damaged his own flat before admission as a result of delusional beliefs. At the time of

interview he was awaiting the completion of repairs before returning home.

8. Home with relatives ($N = 3$)

Patients were only allocated to this group when both they and their relatives were agreeable. For example, a 60-year-old widow had had several recurrent affective illnesses during the previous seven years from which she usually recovered quite well. She could have returned to live with her daughter but the housing conditions were inadequate and she was hoping for a transfer. This was later arranged, at which time the patient did go to live with her daughter.

3.6. SUMMARY OF ACCOMMODATION NEEDED

Table 15.4 summarizes these recommendations. In brief, there were three groups: group 1, who required further treatment ($N = 17$), groups 2 and 3, who needed medical and nursing supervision ($N = 21$) and groups 4-8, who had largely recovered from their psychiatric condition and could have been discharged if the alternative accommodation had been available ($N = 24$).

Table 15.4. *Suggested accommodation required by sixty-two patients who had been in hospital from six months to three years, by sex and diagnosis*

TYPE OF ACCOMMODATION	DIAGNOSTIC CATEGORY					
	Schizophrenia		Affective disorder		Other	
	M	F	M	F	M	F
1. Hospital treatment	1	5	0	6	0	5
2. Supervised ward	3	0	0	0	0	1
3. Supervised hostel	5	4	0	1	5	2
4. Part III hostel	0	2	1	2	0	0
5. Less supervised accommodation	3	1	1	1	1	0
6. Other specified accommodation	1	0	1	3	0	0
7. Unsupervised accommodation	1	1	0	1	0	1
8. Home	0	0	0	2	0	1

On the whole, those in groups 2 and 3 were younger, more often male, saw themselves as less handicapped, were seen by their relatives as more handicapped, were more often living with parents, more often rated as showing personality abnormalities before the onset of illness, less realistic about future plans, less in contact with their relatives, less welcome at home, more likely to give rise to a financial burden at home, and less likely according to the con-

sultant to be discharged within a year, compared with those in the other groups. All these associations were statistically significant.

4. Discussion

It should be emphasized that the judgements involved in allocating these sixty-two patients to the various accommodation categories were clinical. They may have been wrong. They could not, in many cases, be tested, since the suggested accommodation (particularly in supervised hostels and lodgings) was not available. Many patients in the supervised hostel group, for example, might eventually need more secure accommodation. However, the aim of the study was to assess the reasons for staying as long as six months in hospital and to try to suggest alternatives where practicable.

In about a quarter of cases the patient still needed further hospital treatment but it seemed likely that this would not continue indefinitely. It could perhaps be argued in several cases that treatment could have continued while the patient was at home or staying in some other type of accommodation, but on the whole, the placement seemed satisfactory. In parenthesis, it should be noted that long-term in-patient psychotherapy is an unusual form of treatment in NHS hospitals which, if it proves successful and popular, would attract many more patients and considerably raise the numbers of beds needed.

In a further one-third of cases the patient still seemed to need some nursing supervision because of symptoms resulting in disturbed behaviour which it would be unreasonable to expect relatives to cope with unless they actually wished to do so. In fact, several relatives of patients in this group were quite prepared to accept the patient at home if advised to do so, though in most cases they had reservations.

Two related problems arise concerning the patients in this group; one to do with future hospital bed needs, the other to do with the extent to which such patients would be willing to accept hostel life and not return home.

If only the four patients thought to need treatment in a supervised ward are considered, the question of accumulation becomes one of length of stay. Three of them were in the nine-month sample of patients staying as long as six months. If they all stayed as long as three years and the rate of accumulation remained steady 12 such patients would be expected to accumulate during this time. Since all the patients who had stayed up to three years were examined, this assumption could be checked and, in fact, only 9 had done so. If the 5 patients who were optimistically placed 'on trial' into the supervised hostel group are considered, it might appear that this

early accumulation rate for 3 long-stay cases per year needing a secure hospital environment is too low; that patients are being discharged too early, since they are certainly not going to hostels. Studies of the present kind cannot answer such questions, only pose them. Supposing, however, that about 4 patients a year will accumulate over a five-year period, and that no patients will need to stay in hospital for longer than that period, some 20 long-stay beds in a supervised ward, for patients who should not leave hospital except under supervision, would be required (12 per 100,000). This is a guess rather than an estimate, made in order to stimulate further work using larger numbers of patients.

The other problem has to do with the extent to which patients are willing to accept hostel life. The recommendation for a supervised hostel was sometimes based upon the judgement that the patient might not return home because of the adverse attitudes or moderate coping skills of relatives, because of his own attitudes or previous behaviour, or because recent experience had made it plain that the burden on relatives would be too great. It is well-known (Clark and Cooper, 1960) that the lack of constraint in hostels makes it difficult to be sure that patients will stay, even though it is thought that they should. This set of recommendations, therefore, is hypothetical at this stage. All that can be stated is that, had such a hostel been available, 12-17 patients might well have been discharged to it. Twenty-eight out of 58 patients (48 per cent) definitely wished to stay in hospital; after only six months to three years in hospital, they had become institutionalized. Wing and Brown (1970) found, in their 2-10-year 'old' long-stay group, that only 23 per cent wished to stay. The present series is much more highly selected since the pressures are nowadays all towards discharge and the 'new' long-stay patients are more likely to remain because they wish to do so. It is possible that patients who wished to stay in hospital might be more prepared to stay in a long-term hostel but only further study under realistic conditions (i.e. with a hostel available) can determine the answer to this question.

The five patients recommended for Part III accommodation do not raise problems of this kind. The consultants concerned were quite clear about the necessity and the only question was the length of the waiting-list.

The remaining recommendations are fairly straightforward although the accommodation suggested was often not available. It was not thought that the family care system used in Norway would be applicable to London conditions but the idea of patients attending a day-centre from sheltered lodgings, as at Beilen in Holland (Wing, 1957) does seem feasible.

PART FOUR

NON-RESIDENTIAL SERVICES

Specialized psychotherapy and long-term support in the out-patient department¹

J. K. Wing and Lorna Wing

1. Introduction

The importance of psychotherapy, as one of the commonest and most distinctive methods of treatment used by psychiatrists, is hardly disputed, although the definition, theoretical basis, and effectiveness of its various forms are subject to much debate. In the present article we are concerned with psychotherapy only as a form of service available to NHS patients. Our aims are: (1) to calculate the numbers of patients, living in an area with relatively good services, who are receiving two operationally defined types of psychotherapy, (2) to estimate the numbers of local patients already attending out-patient clinics who might be referred to a specialized psychotherapy department if certain rules of selection were applied, and (3) to discuss the relevance, if any, of these data for planning local psychotherapy services. The limitations of the material will be obvious and the calculations crude, but they should be adequate to open the subject to realistic discussion.

The statistics of the out-patient services available to Camberwell patients have been described in Chapter 6. The Maudsley Hospital has a large specialized psychotherapy department to which patients can be referred after being seen by a consultant in one of the many general clinics. Most of the group and individual treatment is undertaken by psychiatrists in training under the supervision of a consultant psychotherapist.

1. Based upon the paper 'Psychotherapy and the NHS: an operational study', *Br. J. Psychiat.* **116** (1970), 51, by kind permission of the editor.

2. Design and method

There were four parts to the study. In the first place, we enumerated all the Camberwell patients who were receiving 'specialized psychotherapy' during 1965. In practice, this included anyone who was intended to be seen at least weekly, for a minimum of six months, by a psychiatrist who was either a trained analyst or analytically orientated, and who devoted himself mainly to psychotherapy. All patients seen in the psychotherapy department at the Maudsley, plus those said by selected consultants to be receiving psychotherapy, were included. The definition has the merit of being clearcut and relevant to the psychotherapy services available in the NHS. Since the number was predictably small, we next proceeded to a consideration of all the patients receiving treatment during 1965 in the psychotherapy department at the Maudsley Hospital, whatever area they lived in. In this way, we could determine whether Camberwell patients receiving specialized psychotherapy were typical of the larger group.

Thirdly, we used the Camberwell Register to enumerate all patients receiving 'supportive treatment' according to an operational definition, whereby anyone who made an out-patient contact in 1965 and was then seen at least twenty times before the end of 1966 was included. At the very lowest frequency of contact, such patients were seen nearly once every month for at least two years, whereas at the highest frequency they might be seen weekly for at least twenty weeks. This definition seemed to rule out any possibility that patients were attending simply for the supervision of medication. Two brief case-summaries are given in the Appendix (section A).

Fourthly, we scrutinized the case-records of Camberwell patients who contacted out-patient clinics during the month of March 1965 in order to make a rough assessment of how many might have been referred to the psychotherapy department if facilities had been available and the consultant psychiatrist had been willing. One case-summary of a patient thought suitable, and one thought unsuitable, and one of a patient actually receiving psychotherapy at the time, are presented in the Appendix (section B).

3. Results

During the year 1965, 41 Camberwell patients were receiving 'specialized psychotherapy' according to our definition (15 at the Maudsley, 16 at King's College Hospital, and 10 at the Tavistock

Clinic) a prevalence of 29.9 per 100,000 of the population aged 15 and over. This figure, small as it is, is nevertheless too high, since many of the patients did not, in fact, attend as frequently or for as long a period, as was hoped. It represents 2.8 per cent of the 1,264 Camberwell patients who attended only out-patient clinics during 1965 (that is, who did not spend any part of the year in hospital). Twenty-one patients actually began 'specialized psychotherapy' during the year, so that the 'incidence' is just over half the prevalence; 15.3 per 100,000 Camberwell population aged 15 and over.

Certain characteristics of these 41 Camberwell patients were compared with those of all 258 patients attending the Maudsley psychotherapy department during 1965. There was no difference in diagnostic distribution. Seventy-two per cent of Camberwell patients had non-manual occupations compared with 83 per cent of those attending the psychotherapy department. Camberwell residents were rather older (24 per cent as against 37 per cent under 25) and therefore rather more likely to be married. None of these differences is statistically significant, but they are consistent with the differences between Camberwell patients in general and those attending the Maudsley Hospital. There was no difference in sex distribution.

Thus, in order to describe the characteristics of patients receiving 'specialized psychotherapy', it is fairly safe to take the larger group of 258 patients. Of these, 113 actually began treatment during 1965 and 63 during the previous year. The rest had been receiving psychotherapy for longer periods and had made their first contacts at the Maudsley two to fifteen years previously.

3.1. CAMBERWELL PATIENTS RECEIVING 'SUPPORTIVE TREATMENT'

Of the 1,878 Camberwell patients who attended an out-patient clinic during 1965, 143 (7.6 per cent) attended on twenty or more occasions before the end of 1966. This number included 16 who were already receiving specialized psychotherapy or who were accepted for it, leaving 127 'supported' patients. The prevalence of 'supportive treatment' is 92.7 per 100,000 Camberwell residents aged 15 and over per year, compared to the 'specialized psychotherapy' prevalence of 22.9 per 100,000 (a ratio of 4.0:1).

The highest number of contacts was 87. 'Supported' patients made contact, on average, 28 times, while the 16 psychotherapy patients made contact, on average, 37 times each, during the period of investigation.

3.2. COMPARISON OF PATIENTS RECEIVING 'SPECIALIZED PSYCHOTHERAPY' AND THOSE RECEIVING 'SUPPORTIVE TREATMENT'

Twenty-six per cent of patients receiving 'specialized psychotherapy' at the Maudsley came from south-east London postal districts compared with 41 per cent of the general run of Maudsley out-patients. Conversely, 26 per cent of 'specialized psychotherapy' patients came from the Home Counties compared with 15 per cent of general patients.

Patients receiving 'specialized psychotherapy' were significantly less likely to be over 45 years of age (5 per cent) compared with patients receiving 'supportive therapy' (35 per cent), and significantly more likely to be male (48 per cent compared with 31 per cent). 'Specialized psychotherapy' patients were significantly more likely to be single (57 per cent compared with 26 per cent) in accordance with their younger age.

If housewives, students, and retired people were omitted, there was a very highly significant excess of patients in the Registrar-General's classes I and II (41 per cent of the 'specialized psychotherapy' patients compared with 4 per cent of the 'supportive therapy' patients). Even when all categories were included the difference remained remarkable (31 per cent against 3 per cent).

'Specialized psychotherapy' patients were significantly more likely to have been given diagnoses of personality disorder (25 per cent) than 'supported' patients (6 per cent), while the latter category contained more diagnoses of psychosis (32 per cent versus 3 per cent). Each group contained about the same proportion of neurotic disorders, but sexual disorders of various kinds were commoner in the 'specialized psychotherapy' group (17 per cent compared with 2 per cent).

3.3. HOW MANY PATIENTS ARE 'AVAILABLE' FOR 'SPECIALIZED PSYCHOTHERAPY'?

A print-out was taken from the computer of all the 547 Camberwell patients who attended any psychiatric service during March 1967. Every alternate patient, in number order, was included in the sample ($N = 273$). Thirteen had moved out of the area and were excluded, leaving 260 patients. We then excluded patients in a number of other categories: those over 60, those with psychotic or organic conditions, those with addictions or antisocial personality disorders, those with severe mental subnormality or with no fixed address, and those who had been admitted to hospital within the previous three months. All this could be done on the computer print-out, and it left 121 'possibles': 83 at the Maudsley, 6 at

Dulwich Hospital, 20 at King's College Hospital, and 12 at St Giles's Hospital. Because of the greater detail contained in the Maudsley case-records, we decided to collect more specific information only for the 83 Maudsley patients, in order to determine which of them might be regarded as definitely unsuitable for 'specialized psychotherapy'. Twenty-six were aged between 45 and 59, and 6 were already receiving psychotherapy. In 5 cases information was inadequate for any decision to be made. In the case of 15 of the remaining patients, it seemed very unlikely that they would have been referred to the psychotherapy department by even the most enthusiastic protagonist. The reasons varied widely, from low intelligence or poor verbal skill, through disinclination or inability to keep appointments, to rapid recovery or the presence of features (such as psychotic symptoms or gross physical handicap) which had not been mentioned on the Register report form. Length of contact with services was not regarded as a possible ground for exclusion, since so many of the patients already attending for 'specialist psychotherapy' had very long histories. This left 31 patients out of 83 who, so far as we could tell from the case-records, could quite as easily have been referred to the psychotherapy department as any of those who were already attending there, and whose age, sex, and diagnosis were very similar. Their social class distribution was the same as that for Camberwell patients attending the Maudsley psychotherapy department. This does not, of course, mean that these patients would have been accepted if referred and a place had been available, nor that the consultant in charge would have agreed to refer them; only that the case-notes of 31 patients seemed very little different from the case-notes of patients already attending the psychotherapy department. (The ratio of 31 'available' patients, to 6 actually receiving psychotherapy, is 5.2:1.)

We could not make the same judgement on the case-records of 'possible' patients attending the other hospitals, but on the assumption that an equivalent two-thirds of the 5 St Giles's, 6 Dulwich, and 9 King's College Hospital patients aged 45 or under could have been referred for psychotherapy, the total becomes 44 possible Camberwell patients out of a total of 273 (16 per cent). Any consideration of patients aged between 45 and 59 would increase this proportion by up to a further one-third.

When related to the 1,264 Camberwell out-patients who attended during the year and were not admitted to hospital, it can be estimated that 202 patients might have been referred for specialist psychotherapy, although only 41 at most actually received it; a ratio of 4.9:1. Not only does this omit all patients

aged 45 or more, but it also excludes any patient admitted to hospital in 1965. Nevertheless, almost the entire case-load of the psychotherapy department could have been taken up by these Camberwell patients alone. A ratio of 5 to 1, multiplied by the 'incidence' rate of 15.3, suggests that about 75 patients per 100,000 adult Camberwell population might have been referred for 'specialized psychotherapy' each year if facilities had been available and the consultant psychiatrists willing. This is a minimal estimate. What the numbers would be if residents of Camberwell who had not been referred to a psychiatrist at all, but who had psychiatric symptoms during 1965, were considered, cannot even be estimated.

4. Discussion

This study suffers from the usual limitation of operational research in that no clinical conclusions can be drawn from the statistical data presented. The fact that more patients could have been referred for psychotherapy does not mean that more *should* have been. Quite a different series of studies would be required to answer this question, based on the evaluation of morbidity in patients and their relatives and on a comparison of the effectiveness of the service given by different types of therapist or agency. It is, however, possible to calculate some of the consequences of an increase in referral for psychotherapy.

We can calculate that the Camberwell out-patient services provide at least 15 hours of 'specialized psychotherapy' per week.¹ In addition, at least 11 hours are devoted to 'supportive treatment'.² At a conservative estimate, these services might be expanded four-fold, using a further 78 hours a week, or 43 hours per 100,000 population. Since a consultant employed full-time by a regional hospital board or board of governors puts in 11 sessions of about 3½ hours each, per week, this calculation alone suggests that one further full-time consultant would be required for every 100,000 of the population in England and Wales.

The data in this article were first published early in 1970. Several references since then have suggested that, in spite of the explicit disclaimer, it was taken to recommend the appointment of a con-

1. Of the 41 patients receiving psychotherapy during the year, about one-half were in groups—three groups are therefore needed. If 5 of those in individual treatment were seen twice weekly and the rest once weekly, for one hour each visit, and if about half of the 41 were receiving treatment at any one time, 15 hours of psychiatrist time per week seems a minimal estimate.

2. The 127 patients made 3,496 visits. If half of these took place during one year and each lasted 20 minutes, 583 hours would be required, or 11 hours per week.

sultant psychotherapist for every 100,000 of the population. It may therefore be worthwhile repeating that we made no such suggestion. Our recommendation is for evaluation of the functions of the psychotherapist and for examination of the extent to which they can be carried out by GPs or social workers. The outcome of such studies remains an open question.

APPENDIX

A. Brief case-histories of two patients receiving 'supportive treatment' in 1965 and 1966

Mr A, aged 22, single. Intelligence average. Admitted to St Francis's Hospital and thence transferred to the Maudsley when aged 20: diagnosis, 'acute non-specific psychosis' and 'abnormal personality'. Stayed six months in all. Admitted to day-hospital for four months in 1964 and then sent to industrial rehabilitation unit for two months. Seen twenty times in the out-patient department during 1965 and eight times during 1966. 'A solitary man, who needs regular support in order to keep going, and liable to further breakdowns.'

Mrs B, aged 42, married to second husband, one child. Intelligence average. First referred to Maudsley out-patient department in 1965: seen twelve times during the course of 1965 and also seen by psychiatric social worker because of problems connected with the child's upbringing and with marital tensions. In 1966 she was seen eight times and in 1967 three times. Treated with phenelzine and chlordiazepoxide. Diagnosis: "Tension state in a mildly obsessional personality."

B. Examples of patients thought suitable and unsuitable for referral to psychotherapy department, and of one receiving psychotherapy in March 1965

Mrs G, aged 36, married with one child. Intelligence average. First referred to out-patient department in 1965. History of sudden onset of phobic anxiety state in August 1962. Seen ten times in 1965, eight times in 1966, and twelve times in 1967. Treated with antidepressants and chlordiazepoxide, behaviour therapy, and relaxation. Could have been referred to psychotherapy department.

Mr D, aged 36. Married, with two children. Dull average intelligence. (Mill Hill IQ 92, WAIS 89, but he went to an ESN school.) Admitted to a mental hospital in 1962 after an attempt at suicide: diagnosis, reactive depression in a man of hysterical personality. First seen in Maudsley emergency clinic in May 1965: depressed, inadequate, mildly obsessional. He was admitted to the day-hospital for much of 1966 and a considerable amount of social case-work was carried out. In 1967 he was seen six times and the possibility of readmission to the day-hospital was being considered. Unsuitable for referral to the psychotherapy department.

Mrs E, aged 27, married, with no children. Intelligence average. First referred to Maudsley emergency clinic in 1958 when she was 18, and given a diagnosis of 'affective reaction'. Was given supportive psychotherapy at approximately ten visits per year till 1960 when the symptoms cleared up. A second episode began in 1964, shortly after her marriage. She began psychotherapy in 1965 and attended twenty-five times that year. In 1966 she was seen ten times and in 1967 four times, then being discharged to the care of her GP. This patient was actually receiving psychotherapy in March 1965.

*Psychiatric patients
In Contact and Out of Contact
with services: a clinical and
social assessment*

J. Leff and Christine Vaughn

1. Introduction

In an ideal psychiatric hospital service sick people would be cared for as in-patients until they were able to be discharged altogether or to be looked after by the community services, which would then take over smoothly, ensuring that any burden on the relatives would be kept to a minimum. It is of practical interest to investigate how far a particular service falls short of this ideal. One way to do so is to follow up patients who have lost contact with the hospital services for a specified period and evaluate their clinical state and their adjustment to life in the community. In such an investigation, the relatives of patients should be considered as much clients of the services as the patients themselves. Consequently their opinions on the patients' clinical status and social functioning and on the adequacy of the services need to be sought.

There are considerable difficulties involved in any follow-up study, particularly one that attempts to trace patients who are out of contact with services. This probably explains why a thorough search of the literature using a computerized information retrieval service (MEDLARS) revealed few studies with any relevance to this problem. Röder (1970) followed up all 246 schizophrenic women discharged from a mental hospital serving Copenhagen, during the decade 1951-60. He compared the average number of days of readmission for those who attended the after-care clinic for altogether more than one year and those attending for less than one year, over the five-year period 1955-9. He found that those attending for a total period of less than one year had significantly fewer

days of readmission than the others. He drew no conclusions because in the early years of the clinic's existence the patients selected for attendance were those with prolonged admissions or readmissions, indicating that their prognosis was poor. By contrast, Orlinsky and d'Elia (1964) and Sheldon and Jones (1967) found that psychiatric after-care reduced the readmission rate. In the latter study the patients were randomly allocated to psychiatric or to GP after-care. It was found that, in both forms of supervision, good attendance was accompanied by a significantly lower readmission rate than poor attendance but that no special benefit accrued from specifically psychiatric help. This indicates that self-selection by patients for attendance at clinics may be as important a link with outcome as selection by the psychiatrist. Furthermore, the use of readmission as an index of morbidity is dubious because it can be influenced so strongly by administrative policy and other factors unrelated to the illness itself.

In addition to the work discussed above, studies of patients in contact with services suggest areas of interest for any assessment of the effectiveness of such services. In a study of schizophrenic patients admitted to Mapperly Hospital in 1956, it was found that those in an episode of contact with psychiatrists or mental welfare officers five years later were not necessarily the most ill, disabled, or socially impaired. Even in an area where there was considerable emphasis on after-care, severely disturbed patients and families with problems were not more likely to be in contact with community services than others, (Brown *et al.*, 1966). The results of another study suggest that the relatives of patients in a community care service experience more distress and subjective burden than do families in a traditional hospital-based psychiatric service (Grad and Sainsbury, 1968). Consideration of the issues raised by these studies makes it essential to seek out the patients who are no longer in contact with the psychiatric services and to interview them and their relatives to obtain information about their clinical status and social performance and any burden felt by the relatives.

This was the aim of the present study, which must be regarded as a preliminary venture into this field. The intention was to locate and interview all patients with a diagnosis of functional psychosis who were living in the Camberwell area and who had been out of contact with the psychiatric services for a year. Similar patients who had been in contact with the services in the previous year would act as a comparison group. The null hypothesis was that there would be no difference between the In Contact and Out of Contact groups in terms of the severity of their clinical condition, the degree of their social disability, and the burden on relatives.

2. Design and method

2.1. SELECTION OF SAMPLE

In selecting patients for this study, the Camberwell Register served as a sampling frame. Two groups of patients were selected. An In Contact group consisted of persons who contacted the services of Maudsley, St Francis's, or Cane Hill hospitals during the year prior to being sampled with a diagnosis of a functional psychosis. Included in this group were persons visited regularly by psychiatric social workers or receiving regular injections of fluphenazine decanoate who were otherwise not in contact. The Out of Contact group was limited to persons out of contact with services for one year, but in contact during the year before that on account of a functional psychosis. Excluded from both the In Contact and Out of Contact groups were patients with organic brain disease and those persons who were in-patients at the date of selection. A lower age-limit of 16 years was stipulated.

Sampling procedures differed for the two groups. An In Contact sample was drawn every three months from a Camberwell Register computer print-out. This list included all those patients with eligible diagnoses and gave their amount of contact for the year preceding the date of selection: for instance, the length of out-patient episodes, the frequency of contact within episodes, and the types of other contacts (such as in-patient admission or MWO supervision) during the previous year. By means of random sampling, six patients were chosen for each of the three facilities: Maudsley, St Francis's, and Cane Hill. If contact could not be made with a particular patient, he was replaced by the next person on the list whose last attendance was at the same facility. Previously sampled patients were excluded from later print-outs.

Each month the file cards of all patients out of contact with the services for thirteen months were selected by Camberwell Register staff. The master cards were then checked so as to eliminate all those with a diagnosis other than functional psychosis. There was no question of sampling the final number of eligible patients in this Out of Contact group, as the numbers were invariably so small that it became necessary to interview every eligible patient who could be contacted.

After eliminating patients who were found to have resumed contact with the services or who were known to have left the area, 73 eligible patients remained. In 18 cases out of these 73 (25 per cent) one particular consultant refused permission to interview (no patient was interviewed without first contacting his last consultant). Fourteen patients (19 per cent) had moved to an unknown

address, and it was possible that some were still in the area. Attempts were made to trace them by contacting the last known local doctor, the NHS Register (deaths), and the Department of Health, which has information concerning in-patient admissions up to the end of the last calendar year. However, no additional patients were traced by these methods. These two groups represent a possible source of bias, particularly if any had remained within the area, as they are unlikely to be representative of the whole sample. It seems probable, however, that most had left the area. The remaining 41 patients (56 per cent) formed the Out of Contact group. Only one of these patients refused to be interviewed. The 40 patients who were interviewed were compared with the 50 patients in the In Contact group.

2.2. INTERVIEW PROCEDURE AND INSTRUMENTS

The first stage in data collection involved abstracting basic data about each patient from hospital case-records. This provided general demographic data as well as information about past contacts with psychiatric services, symptoms, and events leading to any previous admissions. The interviewers were a psychiatrist and psychologist who called on the patient in his home, separately interviewing the patient and relative, preferably the spouse if married, the mother if unmarried. If either the patient or relative was absent, a return visit was arranged. We did not try to talk to relatives of patients who lived alone unless the relatives saw the patient very regularly. Five patients in each group lived on their own or in a hostel.

As a result of a pilot study it was decided not to send a letter before calling on the patient. Patients out of contact with the services can be wary and sometimes frightened by the idea of follow-up. Those selected for the pilot study usually either refused to be interviewed or managed to be away from home at the designated date and time if they were given advance notice by letter. An unannounced visit has its disadvantages for researchers: on average at least one unsuccessful visit was necessary for every successful contact, but this direct approach resulted in all but two of the patients contacted agreeing to be interviewed. Emphasizing confidentiality, we told each patient that we were interested in his or her view of services received and of any present needs or problems as such information would help to plan more effective services.

Four schedules were used for assessment. They comprised a Present State Examination (PSE) schedule, separate Attitudes to Contact schedules for patient and relative, and a Social Perfor-

mance schedule. The PSE could only be administered by the psychiatrist, while the other three could be given either by the psychiatrist or the psychologist, whichever was most convenient. Ten pilot interviews were carried out to test the adequacy of these schedules and to establish inter-rater reliability between the two interviewers. The schedules were used to guide structured interviews with open-ended questions and pre-coded responses: the respondent answered in his own words and the interviewer recorded the response using a coded rating. Definite items of information were to be collected. If there was any sign of ambiguity the questioning continued until the interviewer was able to make a rating, in an attempt to reduce response error.

The interview procedure with the patient was as follows. First, the patient was given the PSE. This is a standardized clinical interview limited to symptoms occurring during the previous month, which has been described in previous publications (Wing, Cooper, and Sartorius, 1972). A second schedule was used to explore the patient's attitudes to contact and the services, and to termination of contact. Finally, the Social Performance schedule was administered, a standardized interview which attempts to measure the adequacy of the patient's social functioning in the community. It is worth describing this questionnaire in some detail.

The questionnaire was constructed from general questions, around which the interviewer is free to elaborate. It is divided into the main areas of social functioning, such as sociability and use of leisure time. Some are obviously mutually exclusive, such as employment and unemployment. Others are not always applicable, such as household duties and marital relationship. There are ten sections in all, nine covering specific areas, and the final one involving a general assessment of the patient's confidence and drive. In each of the nine specific sections there are five questions requiring factual information and one question which is aimed at the informant's satisfaction with the performance in that section. A score of + indicates a positive asset, 0 is given to a noncommittal answer, and 1 and 2 are degrees of impairment. In each section, the figures can be simply added to give an impairment score and the number of plusses can be summed to give an asset score. The scores on dissatisfaction are not included in either of these sums, so the handling of the scores is very simple. The schedule takes from a quarter of an hour to an hour to administer, with the majority occupying about half an hour.

The main problem in scoring the schedule is one of norms. Ideally an assessment of social performance involves a knowledge

of the norms of the patient's social group. At the present time such knowledge is not available, and in its absence raters are constrained to apply their own individual norms. A prior unpublished study of reliability revealed a need for raters to agree on and stipulate the norms for each item in advance, since individual norms for areas of social functioning tend to vary considerably. The interviewers in the present study did this, and consequently inter-rater reliability was very high. Results of studies of internal consistency indicated that the individual sections of the questionnaire were dealing with distinct functions, and that most of the individual items in each section correlated highly with each other and with the section total. A few did not, and sections will be later reorganized accordingly. On present evidence this Social Performance schedule can be a useful instrument, but its preliminary nature needs to be taken into account in appraising the results obtained (see also Chapters 13, 15, and 19).

The same Social Performance schedule, with minor modifications in the phrasing of questions, was given to the patient's relative. In a second structured schedule the relative was asked about the patient's clinical condition during the past year and month, and about his own attitudes toward the services and contact. In an attempt to assess family burden, the psychologist also asked the relative about the effects of the patient's illness on his own health, work, leisure time, finances, and on any children in the household.

After all the data had been collected, coded and tabulated, comparisons both within and between the two groups under study were carried out, using chi-squared and *t*-tests where applicable.

3. Results

3.1. INTER-RATER RELIABILITY

Both interviewers simultaneously rated the schedules for the first five patients in the study. Their reliability as determined by correlation coefficients was over 0.9 for virtually all the measures.

3.2. COMPARISON OF IN CONTACT AND OUT OF CONTACT PATIENTS

The null hypothesis stated above was tested by comparing the In Contact patients with the Out of Contact patients using all the measures employed in the study. In the presentation of the results the probability levels are given with each measure on which a significant difference between the groups was found.

Information derived from the psychiatric history showed that the In Contact patients had been admitted to hospital more times than the Out of Contact patients (5 per cent) and had made a greater number of visits to out-patient clinics (1 per cent). A greater proportion of them were receiving drug treatment (0.1 per cent).

Few patients in either group showed many symptoms on clinical examination and only one measure distinguished between the groups. More of the In Contact patients showed affective flattening than the Out of Contact patients (5 per cent). The relatives' account of the patient's clinical condition revealed more differences than the PSE for two reasons. Firstly because more prominence is given to the patient's behaviour in the relative's questionnaire than in the PSE, which is only concerned with behaviour during the interview, and secondly because the former covers one year while the latter covers only one month. From the relatives' account the In Contact patients had exhibited more symptoms both in the previous month (5 per cent) and in the previous year (1 per cent) than the Out of Contact patients. The relatives of the In Contact patients had experienced greater (2 per cent) and more persistent (1 per cent) distress than the relatives of the Out of Contact patients and had also felt less physically fit (2 per cent).

On social measures the In Contact patients were less occupationally stable (5 per cent) as indicated by the duration of the longest job they had ever held. The In Contact patients who were employed showed fewer employment assets than their Out of Contact counterparts (5 per cent). By contrast, however, the unemployed In Contact patients showed more assets (5 per cent) and less impairment (1 per cent) in respect to their unemployed status than the unemployed Out of Contact patients. It is noteworthy that this was the only measure, either clinical or social, on which the In Contact patients had an advantage over the Out of Contact patients.

In terms of their relationship with their relatives, the unmarried In Contact patients showed fewer assets (0.1 per cent) and more impairment (5 per cent) than the corresponding Out of Contact patients. The In Contact patients showed more impairment (5 per cent) in their ability to look after the household, and their relatives were less satisfied with their performance in this sphere (5 per cent). The relatives were also less satisfied with the heterosexual activity of these patients (5 per cent).

The two groups were not distinguished on any other social measures.

3.3. EFFECT OF DIAGNOSIS

It was thought to be of interest to determine whether any particular diagnostic group was responsible for the differences detailed above. Patients were classified according to the diagnosis in their case-notes into two groups, 'schizophrenia' and 'manic-depressive psychosis'. It was recognized that some of the information in the case-notes was scanty, but in no case was it necessary to alter the clinician's diagnosis substantially. The category 'schizophrenia' included all patients with first rank symptoms and those with paranoid delusions in the absence of predominant affective symptoms. The distribution of the diagnostic groups according to various social and demographic items is shown in Table 17.1.

Table 17.1. *Some characteristics of patients in contact with services compared with patients out of contact for a year*

	IN CONTACT (<i>N</i> = 50)				OUT OF CONTACT (<i>N</i> = 40)			
	Schizophrenic		Manic		Schizophrenic		Manic	
	<i>M</i>	<i>F</i>	<i>M</i>	<i>F</i>	<i>M</i>	<i>F</i>	<i>M</i>	<i>F</i>
Number of patients	21	19	1	9	10	17	5	8
Mean age in years at follow-up	42.0	46.0	—	41.0	45.5	42.1	51.8	39.2
Marital status:								
Single	10	3	1	1	5	1	—	2
Married	8	12	—	6	3	12	4	6
Separated/widowed/divorced	3	4	—	2	2	4	1	—
Employment status								
Employed	9	6	1	4	5	8	4	5
Unemployed	12	8	—	3	4	6	—	3
Not applicable (housewife or retired)	—	5	—	2	1	3	1	—

There were 40 (80 per cent) schizophrenics in the In Contact group and 27 (67.5 per cent) in the Out of Contact group. In general, more of the schizophrenic patients had an abnormal premorbid personality (5 per cent) than the manic patients, whether they were in or out of contact. They also showed more impairment and had fewer assets than the manic patients in most areas of social functioning. The data from the PSE, however, showed that the In Contact and Out of Contact schizophrenics hardly differed at all from the corresponding manic patients in terms of number of symptoms, such as auditory hallucinations and paranoid delusions.

This is accounted for by the small proportion of patients in all groups who reported active symptoms in the month covered by the PSE.

In considering the differences revealed by the general comparison between In Contact and Out of Contact patients, the schizophrenics accounted for the more intensive out-patient care given to the In Contact patients. Both diagnostic groups contributed to the worse clinical condition of the In Contact patients in the previous year as described by their relatives. However, the manic patients were largely responsible for the greater and more persistent distress felt by these relatives.

The greater occupational instability of the In Contact patients was due to the manics, but virtually all the differences in social performance between the two groups were attributable to the schizophrenic patients. In particular they were responsible for the one measure on which the In Contact patients were at an advantage namely their attitude to unemployment. However, this advantage only appears in the patients' ratings and not in the relatives' assessment. Furthermore, these In Contact schizophrenics were rated by the interviewer as being more overconfident (2 per cent) than the Out of Contact schizophrenics, so that this difference in the area of unemployment should be viewed with caution.

3.4. PATIENT-RELATIVE DISCREPANCIES

As the Social Performance schedule was virtually the same for both patient and relative, the scores could be compared to reveal any significant discrepancies. It was found that the In Contact schizophrenics accounted for all the discrepancies between the patients' and relatives' accounts and in all cases the patients saw themselves as less impaired than did their relatives. This finding corroborates that of Pearman and Gunn (1967) who found that male schizophrenic out-patients tended to present a much more favourable outlook for the future than did their relatives. It is also in accord with a similar finding in the rehabilitation study (Chapter 19).

3.5. EFFECT OF DRUG TREATMENT

Data were collected as to whether patients were being maintained on psychotropic drugs. This enabled us to compare a group of Out of Contact patients receiving regular maintenance therapy with a group not on drugs. The same comparison was not possible among the In Contact patients as virtually all of them were on drugs. The group of Out of Contact patients on drugs was largely made up of schizophrenics, who contributed all of the differences between the two groups. The schizophrenics on drugs were less irritable than those not on drugs (5 per cent), but complained more of lack of energy (1 per cent). Those on drugs were better off in a number of areas of social functioning than those not on drugs. These

comprised marital assets (5 per cent) and satisfaction (1 per cent), assets with regard to sociability (5 per cent), and attitude to unemployment (1 per cent).

3.6. MODE OF TERMINATION OF CONTACT

Data were also collected as to whether the doctor or the patient terminated the last period of contact with the services. The patients who terminated contact themselves were younger (2 per cent), had suffered more side effects from drug treatment in the past (2 per cent), and voiced more complaints of service inadequacies (5 per cent). They also had fewer assets in the areas of marital relationship (5 per cent) and household tasks (2 per cent). Apart from the lack of marital assets, all these differences were attributable to the schizophrenics.

3.7. INTENSITY OF CONTACT

The effect of intensity of contact was examined among the In Contact patients who had not been admitted in the previous year. We looked for any difference in clinical and social measures between those with a greater and those with a lesser number of out-patient contacts during the year. Correlation coefficients were calculated between the number of out-patient contacts and the mean social asset and impairment scores derived separately from the patient and relative interviews. The relationship was also analysed between the number of out-patient contacts and the patient's clinical condition obtained both from the interview with the relative and from the PSE. None of these associations was found to be significant.

4. Discussion

With the exception of a single measure, the results disproved the null hypothesis and showed that both clinically and socially the patients who had been out of contact with the services for a year were better off than those still in contact. The one measure that supported the null hypothesis was the more positive attitude of the unemployed In Contact schizophrenics to their lack of employment, compared with their Out of Contact counterparts. Although there is some suggestion that the overconfidence of these patients may have contributed to this result, it indicates that the ten unemployed Out of Contact schizophrenics need special consideration.

The data collected on maintenance therapy provided two groups, one on drug treatment and the other not on drugs. The

patients in these two groups were not matched in any way, but it is worth noting that the schizophrenics being maintained on drugs were functioning better socially than those not on drugs. This finding supplements that of Leff and Wing (1971) that maintenance therapy with phenothiazines reduces the clinical relapse rate in acute schizophrenic patients. Another finding of Leff and Wing that is supported by the present study is that patients who terminated contact with the services themselves were significantly younger than the others. They were also more dissatisfied with the services and more impaired in some aspects of their social functioning. The social impairment was particularly evident in those who did not receive maintenance therapy from their general practitioners after terminating contact with the hospital services.

One of the principal aims of this study was to determine whether the existing psychiatric and social services were meeting the needs of patients. In term of the patients' *clinical* status the services could be said to be functioning effectively. Few patients in any group had active symptoms and those out of contact with the services were clinically better than those in contact. The few Out of Contact patients with serious psychotic symptoms were mostly suffering from chronic paranoid delusions, which are known to be relatively resistant to phenothiazine treatment. One manic patient had become psychotic again shortly before we interviewed her and as we left her house we met the mental welfare social worker arriving to arrange her admission. Apart from this patient, only two others were thought to need hospital supervision on account of their symptoms. Both suffered from paranoid delusions and were resistant to the idea of seeking further medical help. We discovered later that one was subsequently admitted to hospital while the other committed suicide.

The services were much less adequate in coping with *social* needs. Of the In Contact group 16 patients were in need of help from the housing department and other social agencies, irrespective of whether they were being seen by social workers. Seven of these patients were currently not in contact with the psychiatric services, contact having been terminated in the course of the key year. Twenty Out of Contact patients were in need of similar help. An additional 9 In Contact and 7 Out of Contact patients were not receiving rehabilitation when it would have seemed appropriate, but all save 2 of these patients resisted taking part in a rehabilitation programme (see Chapter 19). Three of the patients in each group who required rehabilitation were women who could reasonably have been expected to be employed. Adding all these patients together 25 (50 per cent) of the In Contact group and 27

(67·5 per cent) of the Out of Contact group were in need of some kind of social service.

Patients' and relatives' complaints reflected the disproportionately greater social than medical needs. Only 1 patient and 4 relatives in the In Contact group and 1 patient and 3 relatives in the Out of Contact group complained of inadequate in-patient or out-patient care, whereas in the case of all the patients with social needs complaints were made by the patient, the relatives, or both.

We will consider in detail some of the patients with the greater needs, the In Contact and Out of Contact unemployed schizophrenic males, and then survey the general social problems encountered in the study.

The 12 unemployed schizophrenic males in the In Contact group constituted 24 per cent of the total In Contact sample and fell into four distinct subgroups. Four of the 12 men were in day-centre or rehabilitation programmes and using the services to the full. Two were too ill for rehabilitation and required further hospitalization, which was later effected. Four had actively resisted all attempts at rehabilitation, appeared to have no interest in working and refused to participate in any programme directed towards this end. The remaining two patients were the only ones who could be described as having service needs that were not being met, in that they were eager to work and desired rehabilitation. One of these men was a control patient for an ongoing rehabilitation study, which explains why he was not in a programme at the time of interview.

There were only four unemployed schizophrenic males in the Out of Contact group (10 per cent of the total Out of Contact group), and all four resisted the ideas of rehabilitation and employment. Such resistance to rehabilitation, as well as to other services, is characteristic of many impaired patients and has been well documented.

In considering the needs of the total sample of patients we found housing to be a particular problem, reflecting both the housing shortage in the general population and the hostel shortage in the psychiatric population. Eight In Contact patients (16 per cent) and 11 Out of Contact patients (27·5 per cent) badly needed alternative accommodation. At least 4 of these patients (3 In Contact, 1 Out of Contact) required accommodation in a hostel or convalescent home. In 2 of these cases the relatives felt they had reached breaking point, and questioned how much longer they could provide twenty-four-hour supervision and care without irreparable damage being done to their own mental and physical health. Both relatives were being treated for depression by their

local doctors, and one relative (the patient's brother) found the situation so unbearable he regularly contemplated suicide as an escape. 'She's ruined whatever life I might once have had. I wouldn't care if she walked out in the street and never came back.' This patient had been offered accommodation but had refused. The two patients concerned were both severely handicapped chronic schizophrenics, ill for fifteen and twenty-five years respectively. The third patient, a 76-year-old widow with florid paranoid delusions, was living alone and attending a psycho-geriatric day-centre at the time of interview. She was the recipient of numerous services (Home Help, Meals-on-Wheels, visits by a social worker), and would have been helpless without this attention and assistance. Because of her rapidly deteriorating physical and mental condition, everyone concerned with her felt it to be imperative that she have some kind of sheltered accommodation. Unfortunately she had resisted all attempts to provide her with such accommodation, and short of forcing a move (an undesirable alternative), there seemed no solution to the problem. Certainly the services were doing everything possible to remedy the situation. The fourth patient was a 57-year-old male chronic schizophrenic who lived in slum conditions and showed signs of extreme self-neglect. His case is described in the Appendix.

Most of the other patients in need of alternative accommodation were on council housing lists but had been waiting many years for rehousing, meanwhile living in appalling circumstances. In some instances overcrowding was the main problem, with as many as five persons sleeping in one room. Conditions of cold and damp, collapsing ceilings and floorboards, and inadequate or absent plumbing facilities were also common. Repeated requests for repairs had been ignored or put off by the local council or private landlords, especially if rehousing was believed to be 'imminent'. In the worst case encountered, the 87-year-old mother of the patient described how the house was infested with rats. Their nights were disturbed both by these pests and by the leaking ceiling which dripped water on to their bed. In view of the desperate conditions under which this family of an aged mother and two subnormal daughters were living, a recommendation had been made for immediate transfer. They rejected two offers, the first because it seemed too far away (although only a few miles distant, Lewisham seemed like a foreign country to them), the second because it was a fourth-floor flat in a building with no lifts, and the mother could not climb stairs. In this particular example a rehousing problem was complicated by the special needs and disabilities of a family with multiple handicaps.

In addition to their housing problems, 4 In Contact patients (10 per cent) and 6 Out of Contact patients (15 per cent) had other needs as well, for example, a day nursery, visits from a social worker, financial assistance, Home Help, or a social club. A further 8 In Contact patients (16 per cent) and 9 Out of Contact patients (22.5 per cent) with adequate housing could have benefited from other services such as the above.

Included among those with service needs were 9 patients (4 In Contact, 5 Out of Contact) who had multiple handicaps. In addition to being mentally ill they had one or more physical impediments, such as blindness or epilepsy.

It is interesting to note that virtually all of those patients with multiple handicaps were schizophrenics, as were other patients who were in need of a variety of services. The few manic patients with service needs (1 In Contact, 3 Out of Contact) needed only to be rehoused, and only 1 required hostel accommodation or rehabilitation. Some of the In Contact and Out of Contact patients with multiple needs had approached the services without success. Others were unaware of the existing facilities and had never been informed as to their availability. Only four patients resisted attempts by the services to reach them, a problem which has already been encountered in the area of employment and rehabilitation. These persons included the above-mentioned widow who lived alone without being able to look after herself, and one of the chronic schizophrenics in need of hostel accommodation in order to relieve the relative's burden. Two other female patients had rejected the idea of attending a day-centre, preferring to stay at home with their parents.

It has been demonstrated that many patients show marked impairment in social functioning, whether or not they are clinically ill, and that this is particularly true of the schizophrenics. Whether patients are in or out of contact, a large proportion of social needs are not being met.¹ It is most important that patients with these needs be reached, either by the mobilization of existing resources, particularly in the areas of housing and social work, or by the creation of new services, such as psychiatric hostels.

1. Case-histories of patients with particular kinds of needs may be found in the Appendix.

APPENDIX

Illustrative case-summaries

Unfulfilled need for rehabilitation

A timid, shrinking young man of 19, intelligent and a good worker but unable to keep a job for more than a few weeks because he can't bear being with more than two or three persons at once. He had been diagnosed as a schizophrenic but the only symptoms on interview were self-consciousness, a lack of confidence, and excessive worrying. He finds Melleril helpful but is not attending an out-patient clinic at the moment. His parents are critical of his out-patient care, feeling the doctors did little. Despite the fact that the doctor terminated his treatment, the patient might well benefit from therapy, a rehabilitation course, or a programme involving retraining in social skills. Both the patient and his parents are enthusiastic about the idea of rehabilitation.

Multiple social problem

A 47-year-old female chronic schizophrenic who once spent eighteen years continuously in hospital. She has now recovered except for some slowness and apathy, but has many severe social problems. Both she and her husband are unemployed and lead a borderline existence on his £8 National Assistance. She expresses interest in working but lacks self-confidence and is limited by her psychiatric history. Her husband recently spent twelve months in prison for sexually assaulting their twin daughters over a long period of time, and now is encountering the usual difficulties of ex-prisoners in obtaining jobs. Regular visits to the employment exchange and applications for interviews have been unsuccessful. He was offered a place on a rehabilitation course in Croydon, which would eventually entail his living there. Both he and the patient reject the idea of moving to Croydon, since it is so far from their three children in care. The parents visit the children weekly and are under the impression that the courts will allow them home if the parents show

they can provide a good home. This is unlikely to occur. The patient and her husband pay £3 weekly for a tiny single room and are living in a disturbed household. The rows between the landlord and his own mentally ill wife are so distressing that the patient is desperate to move to a new place, but the Housing Department has not been encouraging and she doesn't know where to turn next. The social worker is supportive but doesn't seem able to help with the husband's unemployment and housing, which seem to be the two major problems. The patient has not been in contact with the psychiatric services for a year but is thinking of attending out-patient's again. 'Perhaps they can do something, what else can we do?'

Need for sheltered accommodation

A 57-year-old schizophrenic patient in need of hostel or other supervised lodgings. Apart from some eccentricities of manner and appearance he shows no mental pathology but there are signs of extreme self-neglect, for example, a diet consisting almost entirely of tea, sugar, jam, and bread, and he has not worked in seventeen years. He and his brother live together in squalid conditions and seem to coexist in a wary interdependence with no other social contacts. The house is the only one in the road which has not been demolished (the electricity was knocked out in 1944 when a bomb fell and was never re-established) and appears to be unfit for habitation. There is some conflict between the PSW and the housing inspector about this. The PSW has a good relationship with the patient, but he has rejected her suggestions of a day-centre and Meals-on-Wheels. He is nostalgic about his time in hospital and probably functioned better there than at any time in his life in the community, playing the role of an orderly and helping the nurses in any way he could. He says his main wish is for a flat of his own, and certainly he needs some form of alternative accommodation. But he might derive the greatest benefit from some more structured setting, such as a hostel, which would provide supervised opportunities for rehabilitation.

Principles underlying a new rehabilitation workshop

D. H. Bennett

1. Community versus hospital rehabilitation

The mental hospital, like the observation ward, is now often regarded as an obsolete and, perhaps harmful, institution. Many believe that with energy, imagination, adequate staff, and facilities, it should be possible to treat most mentally disordered people in the area where they live.

When the Mental Health Act became effective in 1960 there was a rapid and dramatic reduction in the legal commitment of the mentally ill. In 1963 only 7.5 per cent of patients resident in mental hospitals were 'certified', compared with 75 per cent five years before. Because most patients admitted compulsorily are on short-term orders, less than 4 per cent of the mental hospital population in England and Wales is so detained today. Only a small proportion of patients in most hospitals are restrained by locked doors.

Yet when legal restraints were removed and hospital doors unlocked, it was found that unconsidered obstacles still prevented patients from leaving hospital, although they needed no treatment and were no danger to society. Many who were discharged experienced the same difficulties in adjusting to life outside the mental hospital which Henry Maudsley had noted a century before. Maudsley, at that time the young superintendent of Cheadle Royal Hospital, said that 'it might seem a painful thing to deprive of liberty persons who appear so little ailing, were it not that repeated experience had shown it to be vain folly, if not a positive cruelty to send them forth into the trials of life, where they are

utterly unable to encounter them' (Lewis, 1953). It was not recognized that such patients were 'disabled' and that it was their disabilities which made it impossible for them to encounter or adapt to the trials of life with any hope of success. When this was appreciated rehabilitation activities were introduced in some mental hospitals.

At that time most mental hospital patients had long-standing and massive primary disabilities. So rehabilitation effort was directed to the modification or prevention of secondary disabilities. Since these secondary disabilities had been partially caused by institutional life some psychiatrists sought to prevent the patient's hospital admission or to encourage his early discharge. This they called 'community care' although, in fact, it was 'anti-institutional care'. They assumed that since disabilities were a result of mental hospital admission they would not occur if patients were not admitted to hospital or only stayed a short time. Those who accepted this view equated rehabilitation with the discharge of patients from the old style mental hospital. Many doubted whether, with the closure of mental hospitals, there would be any need for hospital rehabilitation services. They thought that any necessary rehabilitation would be provided outside the hospitals by local authority social service departments or by the Department of Employment. In practice these services provide excellent facilities for the last stages of the psychiatrically disabled patients' resocialization and preparation for employment. But naturally they do not have staff with the necessary skills to undertake the earlier stages of rehabilitation.

At present, psychiatric rehabilitation is in a period of transition. It is no longer a routinized mass-produced process for large numbers of long-stay mental hospital in-patients. Nor are the general social changes in mental hospital wards any 'substitute for specific social treatment aimed at the individual and based on a detailed knowledge of his handicaps' (Wing and Brown, 1970). At the same time we are being asked to rehabilitate fewer patients with schizophrenia and a long mental hospital stay. Instead we have to provide for those psychiatrically disabled persons who, although they have never been hospital in-patients, have failed to respond to psychotherapy, physical treatments, or behaviour therapy. Many fall into that difficult group of people with personality disorders referred to by Godber in Chapter 12. There is no evidence that the need for rehabilitation will decline or that we shall be able to replace the skills of the hospital psychiatric rehabilitation team with those of other services.

There is a growing tendency to centre psychiatric rehabilitation

in day-hospitals while the rehabilitee continues to live in his natural environment. This has certain advantages. One comes, for example, to understand not only the person's handicaps but also how they are related to the requirements of the social environment in which he has to adapt. It can be argued too, that the day-hospital and family situation provide a more stimulating and demanding setting for the rehabilitation process than some socially deprived and unstimulating hospital wards. While the rehabilitee, like a soldier, may learn some social drill on the mental hospital parade ground, he will only learn to cope with the unexpected and harsh demands of everyday life on the battle course of his natural environment.

Yet when the rehabilitee continues to live in his home environment he may well be subject to influences from family and others which conflict with and undermine the rehabilitation activity of the day-hospital. It is probable that one cannot undertake intensive socialization without separating the subject from such influences. On the other hand, too much separation, as in prolonged mental hospital admission, may make it difficult for the rehabilitee to carry over what he has learned into everyday life.

So it is likely that those disabled persons who require the most intensive rehabilitation will still need an initial period of in-patient socialization during which they are separated from their family for most of the week. Of course there is little point in making this separation unless active resocialization is provided for the in-patient. This is not easy in a ward where staff have to meet patients' differing needs and where other patients, like the family, may impede rehabilitation efforts (Talbot *et al.*, 1964).

The use of paid work introduces some of the expectations of normal life, balanced by the appropriate rewards. But it is impossible to mimic other aspects of everyday life within the institution. Occupational kitchens, for example, offer a housewife the chance to perform a limited number of her instrumental tasks. But one cannot hope to reproduce a situation where she is cooking a meal, having a row with a neighbour about one of the children, pacifying the two other children, and reassuring her aged father.

Except in those situations where there is active family interference, rehabilitation is best undertaken in the day-hospital. The disabled person is only a partial patient and can maintain many of his other roles in society. While his disabilities are corrected, his abilities improved, he or she can practise their adaptation in the environment where they live or are going to live. Rehabilitation is the key to successful 'district' or 'community' psychiatry. It will not only prevent the accumulation in hospital of those sadly

disabled patients whom we knew in the past. It will also provide a more useful way of helping all those many patients whose disabilities are still unrecognized or who, having failed to respond to treatment, do not know where to turn for help.

2. The Camberwell rehabilitation service

In the Camberwell service, rehabilitation is provided for in-patients at Cane Hill and Bethlem Royal hospitals, and for in-patients and day-patients at the Maudsley and St Francis's hospitals. The day-hospital area at the Maudsley and St Francis's hospitals is the most active centre for the assessment and readaptation of patients, for co-ordinating the rehabilitating team and for maintaining links with the Maudsley rehabilitation workshop.

Local authority social service departments, the Department of Employment, and other agencies all make a most important contribution to patient rehabilitation but, at present, they are unable to assess either psychiatric disability or its effect on social competence. Since psychiatric rehabilitation is likely to become more, rather than less, complicated in the years ahead, it is not a question whether we should use hospital or extra hospital services for rehabilitation. All the present resources will be required and more besides.

Patients may enter the Camberwell rehabilitation service at several points and in many ways. They may be referred directly to the day hospital from the out-patient department or after having been in-patients at the Maudsley, Bethlem Royal, St Francis's or Cane Hill hospitals. They are referred by GPs, hospital consultants, the Department of Employment or local authority social workers. Both the Maudsley and St Francis's hospitals provide primary occupational assessment units where occupational therapists assess the ability of the recovering patient to undertake at least fifteen hours' effective paid work in a week. If a patient can do this he is usually transferred to the Maudsley day-hospital. While attending the day-hospital he lives at home, in lodgings, a hostel, or in the hospital ward.

The resocialization aims of rehabilitation can be divided into what Bidwell (1962) calls role socialization and status socialization. By role socialization Bidwell means the training and preparation for the performance of specific tasks. By status socialization he refers to a broader pattern of training which prepares the rehabilitee to resume a more generalized status in life. Vocational or educational training are examples of role socialization while participation in groups, the daily life of the ward or advice from doctors or

social workers are examples of status socialization. In the day-hospital we are concerned with status socialization and we try, in groups, by various means to improve the patient's performance of social roles at work, at home or elsewhere. Attempts are made to make some mutual adjustments between the disabled person's performance and the expectations of his society. At the same time efforts are being made to prepare the disabled person for role socialization. His hours of paid work are increased slowly from twenty to thirty hours per week, while we note the degree of improvement in his social performance. We are less interested at this stage in the person's work capacity than in his growing responsibility, confidence, and willingness to accept a work role. For some psychiatrists and social workers the day-hospital's emphasis on work is suspect. They would accept that people desire to be certain of what is expected of them and recognize that they are upset when their activities do not lead to the fulfilment of their expectations. Yet these professional workers fail to recognize that 'in our society some major factors relevant to our capacity to predict are our ability to maintain our income, to preserve and develop our status with others, the state of our health, the type of person we associate with. . . . Work is central to all of them—a man's job often dictates his income, his status, to some extent his friends and even perhaps his health' (Williams and Blackler, 1971).

3. A rehabilitation workshop .

This means that role socialization is quite as important as status socialization, for if both are not accomplished, rehabilitation is incomplete. To provide for this we have established a small workshop, run on industrial lines, next door to the day-hospital. This workshop is similar in some ways to an industrial rehabilitation unit (IRU) as run by the Department of Employment and it serves roughly the same purposes. It enables the staff to assess the patient's abilities as well as his disabilities. The patient can also compare himself with other handicapped persons and can judge his performance against the background of a work situation reminiscent of his previous employment outside hospital (Wing, Bennett, and Denham, 1964). Both the disabled person and the staff begin to concentrate on performance and skill rather than on disabilities or symptoms.

The hospital rehabilitation workshop seems to have certain advantages over the traditional IRU, due to its siting and policies. Being near the hospital and the patient's home there is less risk of the premature termination of rehabilitation; a risk which grows

as the distance between the rehabilitee's home and the IRU increases. One can also admit individuals whose chance of future resettlement in open employment seems uncertain or even improbable. Although such candidates are not accepted in the Department of Employment's rehabilitation services, many eventually do well. The duration of the ex-patient's industrial rehabilitation can be adjusted in the workshop to suit his needs, while in the IRU he attends for a relatively fixed course.

While it is recognized that the goals of role socialization and status socialization are complementary, the staff in the day-hospital and workshop have differing backgrounds as well as different attitudes and aims. A certain degree of conflict is inevitable and perhaps necessary. But when the two programmes are geographically and socially close, it is easier to resolve the inevitable conflicts of view to the benefit of the rehabilitee. Certainly the presence of a realistic workplace so close to the wards makes the hospital staff more conscious of their obligation to prepare the patient as fully as possible before he goes to the workshop.¹

The staff in the rehabilitation workshop expect the new entrant to have been working thirty hours a week and to be reliable and regular in attendance and timekeeping. He should also be relatively independent and able to manage such matters as travelling, his finances, medication, and his sick certificates before transfer. Most importantly he should have made the sometimes difficult decision to give up the patient role for that of a worker.

The day-hospital staff assure themselves that the candidate can meet these requirements before applying for his admission to the rehabilitation workshop. When the patient is transferred, his previous psychiatric history and diagnosis are not communicated to the manager, since the workshop staff feel that such information might bias their attitudes. Of course, information about circumstances which might cause any danger to the individual, other workers, or staff, is given to the manager.

The workshop was opened in 1967 in two Victorian houses which were converted into one building by opening the separating walls in the basements, ground, and first floors. The building is commonly referred to as the 'rehabilitation unit' or 'rehabilitation workshop'. It is not a rehabilitation 'unit' since a large part of rehabilitation takes place before the patient is admitted. Nor is it only a 'workshop', for it provides research, clerical, secretarial, graphic, and data-processing experience for up to ten rehabilitees

1. The Maudsley rehabilitation workshop was established in 1967, with the aid of a grant from the DHSS, on condition that evaluative work should be carried out.

on the top two floors. In the basement and ground floor there is machine work, extrusion plastic moulding, offset printing, electrical assemblies, soldering, and other assembly work for about twenty-five workers. It has been an important discovery that such a variety of work can be provided within a small unit. This provision, and the effectiveness of the workshop, depends on the capability and experience of the industrial staff. The manager is a skilled toolmaker with two assistants also recruited from industry. The office work is organized and supervised by an occupational therapist who first developed this work in the day-hospital. The staff's expectations in the unit are those of the world of work. Entrants work a thirty-eight-hour week, clock in at 8.30 am, and out at 5.30 pm, five days a week, with an hour for lunch and recognized tea breaks. They see their psychiatrist or social worker as 'out-patients', outside working hours, or by arrangement with the workshop manager. They are paid piece-work rates, except the office workers who are paid an hourly rate. A special training scheme (approved by the DHSS) allows those who earn more than they receive from sickness or supplementary benefit, to relinquish the latter from a fixed period and take their earnings instead. Only a few elect to do this but the others can earn the £2 which social security 'disregard' when paying benefits. There are usually thirty-six individuals in the workshop; many are not Camberwell residents but ex-patients of the Bethlem and Maudsley hospitals, whose homes are elsewhere.

The aim of rehabilitation is to resettle the disabled person in economic employment and this is achieved for about 35 per cent of the patients going to the workshop. A further 45 per cent achieve partial resettlement in Remploy, day-centres, or in domestic life. The remainder discontinue attendance, are discharged by their psychiatrists, or suffer a clinical relapse. For some years the average duration of stay was three months. This has increased recently, due to a significant national rise in unemployment. Naturally the staff are reluctant to discharge the disabled until they have a job, or a place to go to in a sheltered workshop or day-centre.

Over the years there has been a slow accumulation of a small number of severely disabled men and women who are almost, but not quite, capable of open employment. Many have had shorter or longer periods of economic employment but have had to return to the workshop. They need a sheltered workshop in the community which would enable them to make more of their abilities than they would if they were simply discharged from hospital. There are numerous local authority day-centres which play an invaluable

part in the continuing rehabilitation of the most disabled persons. But the gap between day-centre occupation and open employment is very wide. A sheltered workshop would help to bridge it.

4. Conclusion

Psychiatric rehabilitation aims to help the disabled to make the best of their abilities and to play the most normal role possible in society. If they are to meet these demands they must be helped to work and earn as well as to cope with their emotional conflicts. They must be able to manage stress and be motivated to do so. These aspects of rehabilitation are complementary. Recovery of the ability to work increases confidence and diminishes anxiety and depression, just as recovery from depression and anxiety increases the ability to work.

While one of the workshop's main purposes is the resettlement of patients in employment it is not its only contribution to rehabilitation.

The visibility of the demands of work feeds back into the wards and occupational therapy department. Doctors, nurses, and occupational therapists develop a more realistic understanding of the contribution they must make if patients are to be resettled. The workshop also provides a realistic assessment of a patient's capacity to meet the stresses and requirements of everyday life. This avoids the disappointment and frustration which hospital staff, employers and Department of Employment, and the patients themselves feel, when they are misplaced in situations for which they are unsuited and unfit.

It seems that in spite of the traditional administrative dichotomy in the provision of clinical and industrial rehabilitation, and in spite of the natural conflict in their aims, they should, in the future, be more closely integrated.

*An epidemiological and
experimental evaluation of
industrial rehabilitation of
chronic psychotic patients in
the community*

*Lorna Wing, J. K. Wing, Barbara Stevens,
and D. Griffiths*

1. Introduction

A good deal of attention has been given to the rehabilitation and resettlement of long-stay patients in mental hospitals, with fairly encouraging results so far as those with clinical handicaps of moderate severity are concerned. Most of these patients have suffered from a form of schizophrenia. Apart from the common negative symptoms such as flatness of affect and poverty of speech (which become evident to employers as lack of initiative, slowness, and social withdrawal), there are usually secondary handicaps as well, particularly unfavourable attitudes to work and to discharge, the development of which has been fostered by a long stay in hospital.

In one fairly thorough study, 45 long-stay schizophrenic patients from two mental hospitals, with clinical handicaps of only moderate severity, attended a course at an industrial rehabilitation unit while still living in hospital. All were under 60 years of age and the average length of stay was $8\frac{1}{2}$ years. The preparation in one of the hospitals had been prolonged and systematic, while the other was only just developing its rehabilitation services and patients went to the IRU with rather little preparation. One year after the course ended, 24 of the 45 were employed, 10 of them in sheltered work (for example, in Remploy factories). Except for 3 men, their work adjustment was satisfactory. The other 21 patients were unemployed. Seventeen patients were living outside hospital: in 8 cases adjustment was satisfactory, in 6 cases there were definite problems, and in 3 cases adjustment was very precarious.

Even in the most successful cases, the patients remained handicapped in some way and needed a certain amount of supervision. It was quite clear that preparation within the mental hospital prior to the IRU course was very helpful, by decreasing the adverse reactions so common when there is a marked change in a schizophrenic patient's environment, by decreasing the need for maintenance of phenothiazine medication and by improving attitudes. A change in unfavourable attitudes to work outside hospital proved to be one of the most important consequences of attending the IRU. Attitudes to discharge did not change nearly so much and this aspect of resettlement was far less satisfactory (Wing, Bennett, and Denham, 1964).

Nevertheless, it was thought that the patients studied were representative of about 6,000 schizophrenic patients in mental hospitals throughout England and Wales, some 1,500 of whom could have been resettled in open employment and another 1,450 in sheltered work of the Remploy type, if the necessary facilities in the hospital and IRUs, the skilled medical and nursing staff, and experienced social workers and DROs had been available.

These were quite encouraging results and they were matched in several other studies, in which the principles of rehabilitation began to be established in some detail, but they came at a time when clinical interest was becoming more and more committed to the problems of patients who did not stay in hospital long enough to become institutionalized. The hope was that, by preventing institutionalism and thus avoiding the development of the secondary handicaps associated with it, the need for complex hospital rehabilitation procedures would be considerably diminished.

It is interesting to compare the results of the study of long-stay patients, carried out in 1959 and 1960, with those of a study of schizophrenic patients admitted to Mapperley, Netherne, and Severalls in 1956 and followed up in 1961 and 1962. About one-quarter of those first admitted, and about one-half of those re-admitted, in 1956, were severely handicapped five years later, though very few of them had become long-stay. While the outcome for first-admitted patients was very satisfactory in more than half the cases, the over-all results were in some ways disquieting. Out of 142 men, 42 were unemployed at the time of follow-up and 35 were in hospital. Out of 169 women, 42 were unemployed or, if housewives, were severely disabled, and 29 were in hospital. This means that, over-all, 48 per cent were functioning poorly according to these crude but easily measured indices.

The results were not very different when the three areas were compared, although one of the hospitals had pioneered the early

discharge policy and there was an integrated local authority and hospital after-care service. Community rehabilitation facilities, whether hospital, local authority, or Department of Employment and Productivity, were little used in any of the areas. Many severely ill patients were not even in contact with psychiatric services at the end of the follow-up period. The course of schizophrenia all too often appeared to be one of discharge from hospital, a longer or shorter period of remission followed by a relapse, a consequent social crisis leading to readmission, and then discharge with the cycle beginning again. It is true that relatives did not complain very much. They had not complained very much in the days when most patients became long-stay. It did not mean they had nothing to complain about (Brown, Bone, Dalison, and Wing, 1966).

The moral was drawn from these two studies that the skills and experience in rehabilitation which have been built up over the years in mental hospitals might be just as relevant for schizophrenic patients in the community. The work of Wing and Brown (1970) confirmed this view.

The data presented in Chapter 17 suggest that psychotic patients attending out-patient clinics frequently present difficult social problems, as well as the familiar clinical ones. The question arises whether rehabilitation methods are as appropriate for the chronically handicapped in the community as they appear to be for equivalent patients in hospital. It was decided to use the Camberwell Register to derive a sample of patients living in the community, who had been given a diagnosis of psychosis and had been unemployed for at least a year, and then to test the value of rehabilitation with an experimental design, thus allowing the maximum generalizability of the results.

2. Design and method

2.1. THE SAMPLE

The 380 patients reported to the Register during 1968 who were aged 18–54 and diagnosed as suffering from a form of organic or functional psychosis or epilepsy were considered for the study. Table 19.1 shows the relationship of this sample to other patients with the same diagnoses who were also known to the Register. The 504 patients aged 55 or more were not considered, nor the 261 patients aged 18–54 who contacted during 1956–7 but not in 1968, nor the 69 patients in the same age-group who had been long-stay in hospital at the beginning of 1968, nor over 4,000 people with non-psychotic diagnoses. Finally, only residents of Camberwell

Table 19.1. *Camberwell adults contacting services 1965-8, diagnosed psychotic and non-psychotic. Numbers and crude rates per 100,000 total population*

	AGED 18-55			
	Psychotic		Non-psychotic	
	N	Rate	N	Rate
Patients contacting in 1968	380	221	1,428	830
Patients contacting 1965-7, but not 1968	261	152	1,887	1,097
Patients in hospital one year or more on 31 December 1968	69	40	16	9
Total aged 18-55	710	413	3,331	1,936
Aged 15-17	9	5	96	56
Aged 55-64	178	104	440	255
Aged 65+	326	190	354	205

were included, leaving out homeless and destitute people such as those attending the Camberwell Reception Centre, and people who moved out of Camberwell during 1968. One patient whose only contact with the Register was that she committed suicide during 1968 was also omitted. She would have been in the study group if she had not died.

The present study therefore began with 380 psychotic patients, aged 18-54, who were reported as attending during 1968 and who were still in the area at the end of that year. Their case-notes were examined in order to apply an operational criterion of psychosis (a history of delusions, hallucinations, stupor, severe excitement, or overactivity). Fifty-six who showed no evidence of a psychotic illness according to these criteria (most of them depressed) were excluded. Next, the employment record was considered. Patients who had been unemployed for a year or more (excluding periods during which they had been acutely ill) were included. A total of 170 patients were employed during 1968, 75 were fully occupied as housewives (we were not able to apply a strict criterion as to competence), 2 were unemployed only when acutely ill and 2 were too physically handicapped to work. This left 75 eligible for the study, a rate of 44 per 100,000 total population.

2.2. DESIGN

Of the 75 eligible patients, 1 died and 2 left the country in 1969 before they could be interviewed. In 4 cases, the consultant in charge did not give permission for the patient to be seen. The remaining 68 patients were contacted and asked to attend for interview. Fourteen did not wish to come, leaving 54 who were seen. Of these, 11 did not wish to take part in rehabilitation, 9 had

already been in the rehabilitation unit, and 6 were thought unsuitable by reason of severity of symptoms, aggressive behaviour, or likelihood of poor attendance. This left 28 who were suitable and willing to take part. These were divided at random into an experimental and a control group of 14 patients each. The former were admitted to the Maudsley day-hospital and subsequently to the rehabilitation unit for as long as seemed necessary. The latter were not admitted but the consultant was free to arrange any other rehabilitation programme he wished. Table 19.2 summarizes the numbers eligible and the numbers taking part.

Table 19.2. *Selection of experimental and control groups*

	<i>Number found from case-notes</i>	<i>Number interviewed</i>
Experimental group (E)	14	14
Control group (C)	14	14
Already receiving active rehabilitation (T)	9	9
Unsuitable for rehabilitation (R)	10*	6
Patient refused (R)	25	11
Died before interview arranged	1	—
Left country, 1969, before interview arranged	2	—
Total	75	54
Rate per 100,000 total population	44	

* Including 4 patients whose consultant did not want the patient to be included.

Patients in the experimental group and their relatives were interviewed at the beginning of the study, at least once during their stay in the day-hospital and rehabilitation unit and at the time of discharge. They and their relatives were again seen at a follow-up interview nine months after discharge. A final check was made on social and employment status, using the case-notes, in January 1971, two to three years after the first service contact in 1968.

Patients in the control group and their relatives were similarly interviewed at the beginning of the study and again one year later. A final case-note check was made early in 1971 as for the experimental group.

All the other patients in the sample and their relatives were

interviewed at the beginning of the study and again one year later if they were willing to co-operate. Information was obtained from the case-notes concerning all patients at the final two- to three-year check-up.

Thus a group of 75 patients was selected, comprising all the psychotic patients aged 18-54 who attended psychiatric services during 1968, were not long-stay and had been unemployed for a year or more.

2.3. INFORMATION COLLECTED AND METHODS OF ASSESSMENT

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

Those who were interviewed were seen by a psychiatrist and a psychologist. The former used the Present State Examination (Wing *et al.*, 1967) to make a diagnosis, and completed a role performance schedule concerning relationships with spouse or relative, sociability, and leisure activities (for details and information on reliability see Stevens, 1972). The psychologist gave intelligence and aptitude tests, and assessed the patient's confidence concerning his ability to obtain and hold a job, his attitude to work and his attitude to unemployment (Griffiths, unpublished). A sociologist interviewed the patient's relatives where possible, and rated the relatives' account of the patient's role performance (as above), the problems presented by living with the patient, and the attitude of the relative to the patient. These measurements and ratings were all repeated in the follow-up interviews.

3. Results in the whole group

3.1. INITIAL CHARACTERISTICS

The characteristics of the 74 people in the sample (excluding the one who died in 1969) will now be described.

1. *Social and demographic*

There were 51 men and 23 women. Forty-three patients were aged 18-39 and the rest 40-54. The patient's previous occupation is shown in Table 19.3. There had been considerable decline in occupational status and most patients' recent work had been semi-skilled or unskilled manual. Eight patients had been unemployed for only one year, 19 for only two, 16 for three to five, and 26 for more than five; information was not known for the other 5 patients. Only 26 patients had been married and only 19 had had children. At the time of the study, 8 were still living with a marital partner,

Table 19.3. *Patient's previous occupation*

<i>Occupation</i>	<i>Best jobs</i>	<i>Most recent jobs*</i>
Non-manual	20	15
Skilled manual	9	5
Semi-skilled manual	26	19
Unskilled manual	16	32
Not known	3	3
Total	74	74

* All the patients had been unemployed at least a year.

38 with parents or other relatives, and 16 in lodgings or hostels. Eighteen were immigrants (mostly from the 'new' Commonwealth), 35 had a history of personality abnormality before the onset of illness, 13 had below average school attainment, and 11 had a history of petty crime. Out of 52 for whom the results of an intelligence test were available, the IQ was below 90 in 41 (79 per cent). Griffiths will describe these results in detail.

2. *Clinical*

About half the patients had been ill for more than ten years; two-thirds had been admitted to hospital three or more times. Twenty-three had been in hospital for a year or more at some time previously. None of them had received any specialized rehabilitation. Table 19.4 shows the diagnostic composition of the group in terms

Table 19.4. *Clinical diagnosis and Catego classification*

<i>Catego class</i>	<i>Schizophrenia</i>	<i>Clinical diagnosis Paranoia or psychosis</i>	<i>Mania</i>	<i>Epilepsy</i>	<i>Total</i>
Schizophrenia (S+)	37	2	—	—	39
Schizophrenia (S?)	1	—	1	—	2
Paranoid psychosis (P+)	5	1	—	—	6
Paranoid psychosis (P?)	5	—	—	—	5
Other psychoses (O+)	1	—	—	—	1
Other psychoses (O?)	6	—	—	—	6
Mania (M+)	2	—	—	—	2
Mania (M?)	—	—	2	—	2
Psychotic depression (D+)	1	—	—	—	1
Psychotic depression (D?)	1	—	—	—	1
Retarded depression (R)	1	—	—	—	1
Barbiturate psychosis	—	1	—	—	1
Epilepsy	—	—	—	4	4
Not known	3	—	—	—	3
Total	63	4	3	4	74

of the Catego system (Wing, Cooper, and Sartorius, 1972) rated on the basis of the case-notes, using PSE data when available, and also in terms of the clinical diagnosis. Forty-one patients had shown symptoms characteristic of schizophrenia such as thought insertion, broadcast or withdrawal, delusions of control, or non-affective auditory hallucinations (Catego classes S+ or S?). Eleven had shown other non-affective delusions, in 5 cases of rather a fragmentary kind (classes P+ and P?). One had clear catatonic episodes (class O+). Six others had had episodes of odd behaviour which, as described in the case-notes, did not allow a clear-cut classification; one man, for example, became increasingly slow and self-neglectful at the age of 20, was seen again twenty years later when he was affectively flat and slow to speak, and was rated at interview as showing only these two symptoms (Catego class O?). All but 1 of these 59 patients had been given a diagnosis of schizophrenia, paranoia, or paranoid psychosis. The one exception was a man given a diagnosis of recurrent mania; the difference in classification turned on the nature of the auditory hallucinations which he had, at one time, experienced; these were not clearly described in the case-notes. The clinical diagnosis may have been correct. Of the remaining 15 patients, 3 had insufficient information in the notes to make any classification but the diagnosis was schizophrenia, 4 were suffering from epilepsy, and 1 had a phobic anxiety state which at one time had been complicated by a barbiturate withdrawal psychosis. Of the 7 classified as affective psychosis by the Catego system only 2 were given a clinical diagnosis of mania, the rest were diagnosed as schizophrenic. In the case of 3 out of these 5 discrepancies, the further clinical history was compatible with an affective rather than a schizophrenic disorder; in the other 2 the diagnosis remained in doubt. Since the Catego classes were derived by a standard method, and allow a greater differentiation than the clinical diagnoses, they will be used in describing the results of the study.¹

Fifty-four patients were interviewed, using the PSE schedule, at the time of entry into the series. Eleven had no symptoms, 24 were moderately impaired, 12 were actively deluded, 2 had marked incoherence of speech, 4 were characterized by severe blunting of affect and poverty of speech but not by more florid symptoms, and

1. The London series of the International Pilot Study of Schizophrenia (WHO, 1972) allows a rough comparison to be made, although patients from outside Camberwell were included and patients with 'residual schizophrenia' (many in classes O+ and O?) were excluded. Patients in that series were admitted to hospital during an acute psychotic episode; the same operational definition of psychosis and the same Catego classes were used as in the present series. Approximately the same proportions of patients were found in the schizophrenic, paranoid, and affective psychotic classes.

I was mute. This enables comparison to be made with the system used in studies of long-stay in-patients (Wing, 1961). Table 19.5 shows that the present series were not as impaired clinically as long-stay schizophrenic patients of similar age in three mental hospitals (Wing and Brown, 1970) but that more were severely impaired than in an earlier rehabilitation experiment (Wing, Bennett, and Denham, 1964).

Table 19.5. *Classification of severity and type of symptom shown at interview: present series compared with long-stay schizophrenic patients in three mental hospitals and with long-stay schizophrenic patients attending an industrial rehabilitation unit (percentage)*

Clinical group	Present series		Three mental hospitals, 1960	IRU, 1960
	Total group	Experimental group		
Moderately impaired				
1a. No symptoms	20	21	11	42
1b. Moderate symptoms only	37	43	18	
1c. Moderate symptoms apart from severe blunting of affect	7	7	5	
Severely impaired				
2. Coherent delusions predominant	22	21	11	9
3. Incoherence of speech predominant	4	—	15	—
4. Poverty of speech predominant	7	7	26	—
5. Mute	2	—	15	—
Total	54	14	273	45

3. Social performance and attitudes

Ratings on the social performance schedule indicated considerable impairment of social and leisure activities. The schedule provides for both assets and impairments to be rated. In the area of heterosexual relationships 41 out of 53 patients had no assets rated at all, while 37 had scores indicating severe impairment (a score of 6 or more out of a possible total of 10). In the area of sociability the equivalent figures were 37 and 29, while in the area of leisure activities the figures were 40 and 38.

Comparing the ratings of performance made on the basis of the separate accounts of patient and relative showed considerable agreement (Stevens, 1972) but the relatives expressed a good deal more dissatisfaction (one-third of them were very dissatisfied compared with only 3 per cent of the patients). The degree of satisfaction or dissatisfaction expressed about the relationship between the patient and relative, when considered from the two

points of view, is shown in Table 19.6, which speaks for itself. A similar result has been found in many studies (Wing, Carstairs, Monck, and Brown, 1964; Chapter 13; Leff and Vaughn, Chapter 17).

Table 19.6. *Dissatisfaction about relationship between patient and relative*

Patient's degree of satisfaction	Relatives' degree of satisfaction				Total
	<i>Positively satisfied</i>	<i>Content</i>	<i>Dissatisfied</i>	<i>Very dissatisfied</i>	
Positively satisfied	2	2	4	3	11
Content	—	5	4	3	12
Dissatisfied	—	—	1	4	5
Very dissatisfied	—	—	1	1	2
Total	2	7	10	11	30

A self-confidence questionnaire was administered in order to measure each patient's confidence in his or her ability to obtain and hold down a suitable job (Wing, 1966). The mean score on 46 schedules was 22.8, which compares with 20.3 among 183 entrants to an IRU (most of whom were physically handicapped). The present series contained 8 schizophrenic patients who had unrealistically high scores. These patients had also been represented in the IRU series but in much smaller numbers.

The attitude to rehabilitation was rated by the psychiatrist in 50 patients. It was thought that 7 were positively in favour, that 20 would passively accept a course if offered, that 11 might accept but would be likely to attend rather irregularly, and that 12 would probably refuse.

The psychiatrist and psychologist made ratings of constructive drive and realism of plans for the future at the time of the initial interview. Neither rater thought many patients had much drive to achieve a resettlement, but in many cases this seemed quite realistic in view of their handicaps. In terms of an over-all rating combining the two aspects the psychiatrist thought that 18 out of 53, and the psychologist 27 out of 51, had some fairly realistic drive.

3.2. OUTCOME

Two outcome measures were used. The first was based on the social condition of patients at the time of follow-up two to three years after first contact in 1970. Many patients did not change at all, so that this is not a measure of improvement. Clinical condition as such was not considered unless it caused social problems. Six outcome groups were distinguished:

1. The first consisted of 10 patients who were working at the time of follow-up and who appeared to be satisfactorily resettled, considering the severity of their initial impairments.
2. The second group comprised 21 patients who were attending a day-centre and whose domestic arrangements seemed, in the circumstances, to be satisfactory. Eight, however, were precariously adjusted and it would only need the death of an aged parent or the closing down of a common lodging house for serious problems to arise.
3. The third group contained 9 patients who, although unemployed, were unwilling to attend a day-centre. Four were living in lodgings, they were shabby and down-at-heel, unwashed, ragged, and generally neglected. The other 5 were living with relatives who preferred to have them at home because they became so agitated when expected to perform to a higher standard, as in a day-centre. They caused no great burden but in one case the mother, aged 88, was very worried as to what would happen when she died.
4. There were 12 patients in the fourth group, whose adjustment in each case was unsatisfactory. One young man committed suicide during the follow-up period and a young woman shortly after the time of follow-up. Another patient died of coronary thrombosis but at the time of his death he had been a considerable burden to his very frail and handicapped mother. One patient was in a reception centre with her child, one was aggressively domineering towards his mother, one was inclined to behaviour such as lighting a candle under a lampshade, one was almost completely inert and needed to be totally cared for by his grandmother aged 70, and so on.
5. Thirteen in-patients at the time of follow-up constituted the fifth group. All had been unsatisfactorily adjusted at the time of admission to hospital. One later committed suicide.
6. Finally, the outcome was unknown in 9 cases since the patients had left their previous addresses and could not be traced. In 2 cases the patients left the country before they could be interviewed. Five of the others refused interview and 2 were seen. In addition to these 9, 1 other patient had committed suicide early in 1969 before he had been selected for the series.

The second measure of outcome was based on a consideration of all the changes that took place during the two years. Out of 65 patients for whom a judgement could be made, the largest number (31) did not change at all. Eighteen improved transitorily,

for example by attempting a job, even though they could not keep it up. Another 11 made more solid progress, while 5 became worse. The relationship between the two measures is close, as can be seen from Table 19.7. Three patients who were in hospital at the beginning and end of the study had shown some improvement in the interim.

Table 19.7. *Relationship between change during the follow-up period and condition at the end of it*

Outcome at follow-up	Improvements during follow-up period				Total
	Stable	Temporary	No change	Worse	
1. Working	10	—	—	—	10
2. Satisfactory adjustment at day-centre	1	13	7	—	21
3. Unemployed: fairly satisfactory	—	2	7	—	9
4. Unsatisfactory adjustment	—	—	10	2	12
5. In-patient	—	3	7	3	13
Total	11	18	31	5	65

Note. Two interviewed patients, 2 patients who left the country before interview could be arranged, and 5 patients who refused interview and were subsequently untraced, are omitted from this table, as is 1 patient who died before being interviewed.

3.3. FACTORS PREDICTIVE OF OUTCOME

The data collected were examined in order to discover what characterized the members of these groups. Table 19.8 shows the relationship of the groups defined in Table 19.2 (groups E, C, T, and R) to condition at follow-up. It is evident that patients who refused to come to interview, those who were interviewed but

Table 19.8. *Relationship of the various treatment groups to outcome at follow-up*

Outcome at follow-up	Experimental	Control	Treated already	Refused	Total
1. Working	4	4	1	1	10
2. Satisfactory adjustment at day-centre	6	3	7	5	21
3. Unemployed: fairly satisfactory	1	2	—	6	9
4. Unsatisfactory adjustment	—	4	—	8	12
5. In-patient	3	1	1	8	13
Total	14	14	9	28	65

Note. Exclusions as for Table 19.7.

refused to be considered for rehabilitation and those who were thought unsuitable for rehabilitation had a poorer outcome than those who were treated. This result remains highly significant when those who were excluded from rehabilitation on the grounds of their unsuitability are not considered.

The relationship between Catego classification and follow-up status is shown in Table 19.9. All the patients with an affective

Table 19.9. *Initial Catego classification and outcome at follow-up*

Catego class	Outcome group at follow-up						Total
	1	2	3	4	5	NK	
Schizophrenia (S)	5	11	4	7	12	2	41
Paranoid psychosis (P)	2	2	1	2	1	3	11
Other psychosis (O)	—	3	1	1	—	2	7
Affective psychosis (M, D, R)*	3	3	—	—	—	2	8
Epilepsy	—	1	2	1	—	—	4
Not known	—	1	1	1	—	—	3
Total	10	21	9	12	13	9	74

* One patient with phobic anxiety state and past history of paranoid psychosis following barbiturate withdrawal included here.

grouping whose outcome is known are in groups 1 or 2, whereas over half of those with a schizophrenic or paranoid grouping are in classes 3, 4, or 5. Moreover, all of the 8 patients in group 2 whose adjustment is precarious are in classes S or O.

The relationship of the measure of severity of illness made at the

Table 19.10. *Severity and type of symptom rated at initial interview and outcome at follow-up*

Clinical group	Outcome at follow-up						Total
	1	2	3	4	5	NK	
Moderately impaired							
1a. No symptoms	2	4	1	2	1	1	11
1b. Moderate symptoms	5	8	3	2	2	—	20
1c. Moderate symptoms apart from severe blunting of affect	—	4	—	—	—	—	4
Severely impaired							
2. Coherent delusions predominant	1	3	2	1	5	—	12
3. Incoherence of speech predominant	—	—	—	1	—	1	2
4. Poverty of speech predominant	1	—	1	1	1	—	4
5. Mute	—	1	—	—	—	—	1
Not known	1	1	2	5	4	7	20
Total	10	21	9	12	13	9	74

time of initial interview with 54 patients was also clearly associated with outcome at follow-up as shown in Table 19.10. Those who were only moderately impaired were more likely to be in groups 1 and 2.

Those who had ever been married or cohabiting for as long as a year, those who were not self-neglectful at the time of examination, those who had never spent a year as an in-patient, and those whose parents had not suffered from overt mental disorder all had a relatively more successful outcome, according to both of the measures used. The psychologist's ratings of drive and realism were also significantly associated with success, and the association with the patient's own self-confidence approached significance. None of the other social factors, including the ratings of social performance, showed a statistically significant association.

3.4. PATIENTS' AND RELATIVES' NEEDS AT THE TIME OF FOLLOW-UP

When the research team discussed each patient in order to decide their condition at the time of final follow-up, we also tried to arrive at a formulation concerning the services which ideally should be made available in the light of the patient's handicaps and any burden felt by relatives. The problems fell naturally into three groups; those concerned with work and other day-time activities, those concerned with residential accommodation and those concerned with leisure activities and personal relationships.

1. *Work*

Among those who were unemployed and not attending a day-centre, i.e. nearly all the 21 patients in groups 3 and 4, 5 would probably have accepted rehabilitation or day-centre attendance if this had been offered sufficiently persuasively (4 of these were in the control group). Another 5 patients had already attended a day-centre or hospital but had become agitated or worried at the prospect of being expected to perform at a higher level. The relatives with whom they were living were tolerant people who decided that it was not worth pushing further. In only one of these cases was there any considerable burden; a brother who was completely tied to looking after his sister, although she did help a little with the housework. In another 4 cases, the patient was living alone in a fairly self-neglectful state but was no danger to himself or others; in view of his or her distaste for work or attending a day-centre there seemed no point in insisting. The remaining seven patients in groups 3 and 4 presented other problems to which unemployment was secondary.

2. Residential accommodation

Accommodation problems could arise in any of the six outcome groups. A rough classification of needs is shown in Table 19.11. Only 2 of the 34 patients living with relatives give rise to no problems (both are married). The biggest problem concerns patients with elderly parents (and a few who are cohabiting), some of whom could cope on their own ($N = 9$) or could live with other relatives ($N = 4$). However, in 16 cases the patients could not manage by themselves and a supervised hostel would be needed. These patients are mostly slow, inactive, and self-neglectful and would require supervision at night and at weekends.

Table 19.11. *Accommodation needs at the time of follow-up*

Accommodation needs	Family	Present accommodation				Total
		Own flat	Lodgings	Hostel	Hospital	
<i>Present accommodation satisfactory</i>						
Stable	2	6	3	2	—	13
Could cope if need for change	9	1	2	—	—	12
Precarious but other relatives available	4	—	—	—	—	4
Precarious: could not manage alone*	16	—	—	1	—	17
<i>Present accommodation unsatisfactory; better off in:</i>						
Hostel	—	—	—	1	6	7
Lodgings	—	1	—	—	1	2
Hospital	2	—	—	1	6	9
Not known	1	—	—	—	—	1
Total	34	8	5	5	13	65

* These patients would need supervised hostel or bed-sitter accommodation if their present relatives died or refused to carry on.

Note. Exclusions as for Table 19.7.

Most of those now in lodgings or their own flats are reasonably well settled or can cope, although several need supervision with personal hygiene. Those in hostels are not so well off. Six of the 13 in hospital will probably need to stay some time but the other 7 patients would probably settle in a supervised hostel or lodgings.

3. Leisure activities and personal relationships

There was very little change in the ratings of social performance during the course of the study. Much of the dissatisfaction of relatives was centred on the fact that patients were withdrawn, reticent, and unoccupied. A few patients attended social clubs

but this was the exception. Very few leisure activities were provided in which patients could take part and, in any case, most were unenthusiastic. One patient who wished to remain in hospital was mainly attracted by the opportunities for recreation there (he knew many other patients, was on good terms with the staff, and played in the cricket team during the summer). In general, a very much more active policy would be required in order to change leisure patterns, and many patients would be unco-operative.

Table 19.6 shows that many relatives are much less content than patients with this state of affairs. Most experienced financial burden, often quite considerable, and many experienced symptoms of anxiety and depression which they thought were due to the strain of living with the patient. Out of 29 single patients living with parents or siblings, the mother was over 60 in 19 cases (over 70 in 10). Concern about the patient's future was very common. As Stevens points out, there are advantages and disadvantages for both parties in the relationship between handicapped patient and relative. The patient receives support in a protected setting where not too much is expected of him and can often function to a limited extent within it (doing some housework, running errands, communicating to a limited extent) when he is incapable of performing at all outside. On the other hand, the relative may become domineering or indifferent, so that the twin risks of overstimulation and understimulation are still present. From an aged relative's point of view, the patient can provide companionship and help with household tasks, but can also be a source of worry or even distress and give rise to considerable financial problems.

3.5. PATIENTS WHO DIED

One patient died in 1968 who, had she lived, would have been included in the study. Another died in 1969, before interview had been arranged. Two patients died during the course of the study and two shortly after its completion. Of these 6 deaths, 5 were by suicide and one man suffered a heart attack. If these are regarded as being distributed over a five-year period, the death-rate from suicide among patients such as those in the study group is 132 per 100,000 per year, eleven times that in the total Camberwell population (approximately 12 per 100,000 per year).

4. Comparison of experimental and control groups

4.1. INITIAL COMPARISON

The experimental and control groups were more comprehensively examined and tested than the rest of the series, particularly by the

psychologist. The two groups were compared on all the data mentioned above and on the more detailed psychological measures but no significant difference was found between them except for the fact that the leisure activities of patients in the control group were even more sparse than those of patients in the experimental group. Four patients in the experimental group and three in the control group were in hospital at the time of initial examination. The type and severity of symptoms was similar to the rehabilitation series examined by Wing, Bennett, and Denham (1964) except that there were fewer totally symptom-free patients and more with active delusions at the time of examination (see Table 19.5).

4.2. COMPARISON OF OUTCOME

At the time of final follow-up, two years after the first contact in 1968, four patients in each group were working. The distribution of patients in the other five outcome groups is shown in Table 19.8. There is no significant difference. A slight trend towards a more satisfactory outcome in the experimental group disappears if four patients are added who were selected for the experimental group but who did not want to attend when the time actually came. There was one each in groups 3-6. The same conclusion is reached if other criteria of outcome are used, such as improvement in behaviour or attitude or decrease in burden.

The patients in the control group did not receive any very considerable alternative rehabilitation. Two patients entered a local authority day-centre; one tried a day-centre and failed. None of these three was working at the time of follow-up.

4.3. REHABILITATION OF EXPERIMENTAL GROUP

Seven of the 14 patients in the experimental group were not thought suitable for transfer to the rehabilitation workshop and 1 other only stayed in the workshop two weeks. Five of these 8 patients had adverse reactions while in the day-hospital, particularly to the increased role expectations to which they were exposed and, in two cases, also to the group sessions which appeared to provide too complicated a situation. One patient nevertheless spent nearly nine months in the day-hospital, the others remaining approximately two months each, which is not sufficient as a preparation for the rehabilitation unit. The reaction did not appear to do any harm in the long run but, in each case, it meant that the patient was reluctant to attend for follow-up.

One characteristic patient will be described by way of example. The patient lived in his own flat and was completely solitary apart

from attending a day-centre. He had a discharging right ear with tinnitus and partial deafness and had a hypochondriacal and somewhat paranoid attitude. He had never been properly assessed and it was thought that he might well be capable of a more active and responsible life. He appeared very suspicious during the first few days in the day-hospital but was persuaded to attend, though erratically, until the first case conference (three weeks). He spoke very little and worked very slowly. He did not like the system of payment by piece-work (at the day-centre money was shared out equally) and was worried about entering his output on a work sheet. The social worker thought him lost and confused and the occupational therapist remarked that he seemed out of the habit of doing anything spontaneously. The doctor explained that the object was to get him back to work but the patient argued that he would eventually get back to work anyway, without special effort in the day-hospital. He did not think he would get a job in the near future.

The patient did continue in the day-hospital but he never showed any enthusiasm or responded to any of the efforts made to help him. He finally took his own discharge, unrealistically writing to the RAF to ask for training in a trade. He returned to his previous day-centre but due to a lack of communication they knew nothing about him, and would not accept him. He never returned there. While unemployed he became more morose and paranoid in attitude and his sister wrote to the research sociologist because she was worried about him. An out-patient appointment was arranged, which he kept. He had some ideas of reference concerning the neighbours who, he thought, had been responsible for sending him to hospital. He blamed all his difficulties on his discharging ear. There was some pressure of speech and a tendency to switch from one subject to another. Asked what he thought about his experience in the day-hospital, he said he had not liked it because 'it is not good for a man to sit on his backside all day'. He had not liked the group meetings: 'Everyone disagrees with everyone else all the time. It is ridiculous.' At the time of follow-up, the patient was again attending an undemanding day-centre and appeared to be in much the same condition as when he was first seen.

The other four patients had more sharply defined adverse reactions than this but the effects were not long-lasting. One had been living at home and his main difficulty appeared to be with the group meetings. Moreover, he had not worked for twenty years and could not cope with the more normal expectations in the day-hospital workshop. His mother thought he was worse rather than

better when he took his discharge after three months in the day-hospital but he quickly returned to his ordinary condition. At follow-up he was unemployed and his 88-year-old mother was mainly worried about what could happen when she died. The other three patients were all in hospital at the time of selection. Two in Cane Hill were transferred to St Francis's in order to be near the day-hospital. The third was already in St Francis's. None of these three patients settled at all. Two just passively refused to attend, one became anxious and finally deluded.

By way of counterbalance, an example may be given of a patient who appeared to benefit considerably from the stay in the day-hospital, although she was not transferred to the rehabilitation workshop. She had had many different symptoms during the previous fifteen years; she had heard voices talking to her, had experienced double meanings being put into her mind, had had obsessional rituals, hoarding, and compulsive swearing. More recently she had found it difficult to cope with housework and her flat was full of heaps of newspaper and piles of unwashed clothes. She weighed nearly 17 stone. She quickly settled in the day-hospital and accepted its routine and ideas. She lost weight, became less solitary and co-operated in therapeutic sessions with the psychologist in which she practised various activities she was afraid of (such as travelling), became able to keep her flat spotless and gave up hoarding. She remained very slow and there was never any question of her being able to transfer to the rehabilitation unit. She continued to have obsessional symptoms, particularly checking and rumination. She was discharged after staying more than eighteen months in the day-hospital. She took up voluntary work in a general hospital, which was not too exacting but gave her much satisfaction. She remained partially disabled by obsessional symptoms but was smart in appearance, looked after her flat well and attended the out-patient department regularly. She was able to travel to visit relations, which she had not been able to do for years. She expressed herself as very pleased with her period in the day-hospital.

Six patients entered the rehabilitation unit after a period in the day hospital varying from a month to over a year. They tended to stay in the day-hospital and rehabilitation unit a long time (5, 7, 11, 15, 17, and 24 months). At the time of follow-up, 2 patients were in group 1, 3 rather precariously in group 2, of whom 2 were still in the day-hospital, and 1 was in hospital. One patient, who had the characteristic residual symptoms of chronic schizophrenia, slowness, blunting of affect, social withdrawal, and underactivity, had been living at home for several years, without being able to work.

He stayed in the day-hospital three months, becoming anxious and tense whenever too much pressure was put on him. He improved a little, becoming more talkative and sociable and rather quicker in his movements. However, at home, he still disappeared to his room whenever visitors came and he was still unwilling to venture out on his own except to the day-hospital. His elderly parents were chiefly worried about what would happen to him when they died. He was transferred to the rehabilitation unit and after two years there he was working steadily at light assembly work. He was slow but methodical and persistent and probably brought in about £12 a week to the workshop (of which he was only allowed by law to receive £5). A sheltered factory would probably be the correct placement but none exists nearby. At the time of follow-up he was still in the rehabilitation unit. The other patient who was in the unit at follow-up had very similar characteristics. It is possible that these two patients will improve further.

5. Discussion

This chapter does not consider the problems of all patients who need rehabilitation, nor is it concerned with all the patients who passed through a particular rehabilitation unit. The results are strictly limited to Camberwell patients aged 18-54 who contacted a psychiatric service some time during 1968 but had been out of work for at least a year due to a psychotic condition. This means that several important groups were deliberately excluded. It also means that we were *not* attempting to evaluate the Maudsley rehabilitation unit as such, but only one possible function of that unit.

The prevalence found, 44 patients with the specified characteristics per 100,000 population, may be compared with the 50 in-patient beds per 100,000 recommended by the DHSS for all psychiatric purposes. In addition, it may be hypothesized that the additional 40 psychotic patients per 100,000 population who were in the same age-range and had been resident in mental hospitals for more than one year at the end of 1968 presented somewhat similar problems. Some of the same-aged patients known to the Register in previous years would certainly also come into this category. From the data presented in Chapter 17, it may be estimated that at least another 8 patients per 100,000 should be added and an unknown but possibly similar number from the group aged 55-64. This would give a minimal rate of over 100 psychotic patients per 100,000 who had not reached retiring age but were in need of rehabilitation or a sheltered environment (non-psychotic patients are altogether omitted from this calculation).

The present discussion will be centred on the needs of the 75 patients with the characteristics specified. These may be compared with the long-stay patients studied by Wing and Brown (1970) who were much more severely handicapped although part of their negative symptomatology was undoubtedly due to institutionalism. On the other hand, the long-stay patients who were selected for a course of industrial rehabilitation by Wing, Bennett, and Denham (1964) were less severely impaired (only 9 per cent instead of 35 per cent of the present series being placed into the category of severe impairment). There were more actively deluded patients in the community group than in either of the hospital series but, by and large, handicaps were mainly negative.

The needs of those of our series who were traceable at the time of follow-up were for employment, particularly under sheltered conditions, for hostels and for help with leisure activities. Work is particularly important because of the observation that schizophrenic patients who are unemployed tend to become even more inactive, withdrawn, and emotionally blunted and also because it is one means of decreasing the amount of face-to-face contact with an emotionally over-involved relative. Only about 5 patients out of those whose outcome was known both needed and probably would accept a place at a day-centre, while another 9 might have accepted a place if the process of rehabilitation had begun much earlier. Another 7 might also have needed day-places if other problems could be solved, and 7 of the in-patients might also need places. The addition of these 28 places to the day facilities of the Camberwell service should not provide any special problem, except that once patients are reasonably well rehabilitated the day-centres they will need will be more like sheltered workshops, perhaps on the Remploy pattern. No local authority has yet begun to think in these terms although some, such as Croydon, are more advanced than others.

The need for places in hostels or other sheltered residential accommodation is more difficult to calculate but at least 9 places were needed at the time of follow-up (mostly for those in hospital) and another 16 places might well be called for, since the patients were only precariously settled with elderly or reluctant relatives. If the hostel or bed-sitter were acceptable to the patients, their parents might well agree to their moving in immediately, so that there would be time to settle while the mother or father was still alive. Supervision would mainly be necessary in the matter of personal hygiene, getting up in the morning, and checking on the patient's whereabouts in case of wandering. So far as leisure activities are concerned, it is much less easy to provide for patients'

leisure hours when they are in the community than when they are in hospital and most of those in the series were very inactive indeed. Social clubs were not much favoured by these patients. However, if more were attending day-centres or hostels there would be less need for concern about activities out of working hours.

Attention must be drawn to two major risks. The first is that of suicide. Out of 75 patients chosen for the series, 4 committed suicide and another would have been selected but for the fact that she committed suicide first. All these 5 were young people suffering from schizophrenia. It is worth spending a good deal of time and trouble to prevent such deaths.

The second risk is that patients in this group will wander off altogether and join the increasing number in common lodging houses and reception centres. Nine patients could not be traced at the time of follow-up. Two were known to have left the country and one other probably did so; the other six might well have joined the army of the destitute (see Chapter 21). In addition to these, one patient was known to be living in a reception centre and one in a common lodging house while several others might easily find their way there. If only five patients out of this group wandered off and became destitute it means 1,500 on a national scale, and this is from only one year's prevalence.

The biggest problem was lack of co-operation. More might have been achieved if patients had been willing to attend the day-hospital, although those who refused tended to have the worst prognosis.

The outcome was most satisfactory within the control, experimental, and treated groups ($N = 37$) but this was clearly due to the fact that those who went to the day-hospital and rehabilitation unit were selected for their co-operativeness and because they showed some drive to achieve a constructive settlement. Even so, 4 out of those allocated to the experimental group did not actually attend and had to be replaced. Moreover, 5 out of 14 patients had an adverse reaction to attending the day-hospital, although this did not appear to do any harm in the long run. Two main factors seemed to be involved; the higher standard of performance expected and the pressure the men felt to join in group meetings which they disliked.

There was no such reaction in the case of the other 9 patients in the experimental series but 3 of them did not stay long enough to allow any opportunity for rehabilitation. The other 6 did all stay for a reasonable length of time and were eventually transferred to the rehabilitation workshop. In several cases there was undoubted improvement. In view of the fact that the outcome in the control

group was just as satisfactory, it is important not to attribute too much to the effect of the course of rehabilitation. However, there were at least 4 patients in the control group who would have been suitable for admission to the day-hospital assuming, that is, that they agreed to attend when the time came. On the experience of the experimental group at least one would have refused at the last moment.

The numbers are not large enough to predict which patients would have improved anyway. The day-hospital is geared to a philosophy of rehabilitation in small stages over a long period of time, years if necessary, and periods are expected when no progress is apparently being made. Over a very long time (longer than the two to three years of this study) it might be possible to see results that were not evident to us. The two patients still in the rehabilitation unit at the time of final follow-up had improved quite a lot, considering their initial handicaps, and, if sheltered work facilities had been available locally, they could have earned a wage which would still have required subsidy but would have given them a degree of independence and therefore self-respect and a higher status in the eyes of their relatives. It is very difficult to imagine that these two patients, or the lady whose obsessional characteristics were treated while she was in the day-hospital (see p. 301), would have improved to the extent they did if they had been in the control group. Although the judgement is purely a clinical one, at least these three patients improved *because* they had had a course of social treatment and might well have deteriorated without it. (Another patient might also be placed into this category.) Similarly, there are four or five patients in the control group who made no progress or deteriorated somewhat who might well have benefited from a course of rehabilitation.

If it had been possible to implement a cross-over design (which is really out of the question with such long investigations) and a minimum of 7 patients, 3 in the experimental and 4 in the control group, had been considered to have benefited specifically from rehabilitation, the result would have been a significant one. As it is, the judgement must remain speculative.

It is useful to compare the progress of patients in the experimental and control groups with that of patients in earlier rehabilitation studies (Wing, 1960; Wing, Bennett, and Denham, 1964). Many of the patients in the present series were very similar indeed to those in the earlier groups. The higher numbers of patients who were actively deluded (and their relatively poor outcome) is not unexpected. Among the 17 moderately impaired patients, 3 were working at the end of the study, 1 was doing voluntary work, and 1

was in sheltered employment with Remploi (29 per cent). Of the 45 patients moderately impaired studied by Wing, Bennett, and Denham, 30 per cent were working and 22 per cent in sheltered employment a year after discharge.

One of the main differences between the two studies is in the degree to which the patient's active, as opposed to his passive, co-operation is required. Chronic schizophrenic patients tend to be inactive. In hospital, it is possible to exercise certain of their motor and intellectual functions for them since they will not usually refuse to attend a workshop if a whole group goes as part of the daily routine. If they have to catch a bus, or walk a mile or more, there has to be a certain initiative about attending and a certain ability to cope with unexpected events (what to do when the bus conductor has no change or a policeman thinks the patient looks odd and questions him or someone asks the way). Similarly, it is much easier to manage adverse reactions if the patient is in hospital: the level of expectation, the hours of attendance, and the alternative occupations available can be manipulated so that the patient is never out of his depth and reassurance can continue when the patient is *not* in the workshop. Preparation for industrial work for outside contacts can also be more thorough. Above all, it is possible to keep in touch with the patient so that he can be re-introduced to the workshop as soon as it is feasible. The information available to the day-unit staff is less complete since they often do not know what is going on when the patient is not in the unit and therefore cannot react immediately if something goes wrong, or if the opportunity arises to advance another step. It cannot be too much emphasized how much can be lost in two or three days during which the patient does not attend the day-unit. The day-unit staff cannot, however, always be calling at the patient's home whenever his attendance lapses. Finally, there is the fact that the hospital can offer more opportunities for activation during leisure hours, a more varied social interaction, and sometimes a higher standard of living.

These differences are partly responsible for the necessity, in the day-unit, always to be anticipating eventualities and always to be making sure that gaps and deficiencies in the service do not occur. A transfer to another unit, for example, is relatively simple if the patient is in hospital (though even here, things can readily go wrong) but it requires a good deal of planning when the patient is in the community. He must be introduced to the new unit in advance. The staff there must know his level of functioning and not expect anything much higher or much lower. The date of first attendance must be absolutely clear to the patient, he must

not be left at home doing nothing in between whiles, and if he does not turn up as instructed someone must *immediately* discover why. The staff of the new unit must know what kinds of adverse reaction could occur and be ready to deal with them. All this takes time and intelligent and co-ordinated planning on the part of two sets of staff. It is no wonder that it often goes wrong. Even a matter as apparently simple as getting treatment for a patient's varicose veins (which may be a major reason for her unemployment) can be a complicated business if the patient is also handicapped by chronic schizophrenia. Some of the problems mentioned in Chapter 23, concerning the severely mentally retarded, particularly the practical ones like getting dental caries treated, are very close to those encountered in a day-unit for the mentally ill. It may seem ludicrous that a higher than average level of administration is necessary in order to get apparently routine decisions implemented but this is indeed the case. Morbidity will not be reduced or contained unless such excellent administration is available and doctors, nurses, and occupational staff need special training in order to appreciate this.

For all these reasons, clear rules, clear social structure, and a clear allocation of responsibility for decision-making seem to be particularly necessary in a day-unit. This may appear to be advocacy of a more authoritarian regime but it would be sad if it were thought that clarity of social structure was inevitably authoritarian. Maxwell Jones (1962) considers that the leadership of a therapeutic community should be charismatic but this can be one of the most uncritical and authoritarian kinds of leadership. A democratic system can operate without charisma; it allows criticism of leadership without obscuring the fact that someone must finally make decisions and take responsibility for seeing that they are carried out.

Another question arising from this analysis is whether some of the patients in the series would not benefit from a period of rehabilitation in a residential setting. We did not think that more than three required admission to hospital for treatment, apart from those who were already in-patients. Several patients seemed to need hostel places purely as a matter of asylum. Others would probably be better off if they were in a supervised hostel near the rehabilitation unit and forming part of its service. Their relatives would probably welcome such an idea (particularly those with aged parents). The problem of co-operativeness would still arise, however, since at this late stage some patients might not be willing to accept a hostel place.

This raises the most basic problem for discussion. None of the

patients in this series had received any formal rehabilitation although they were all very chronically handicapped; half had been ill for more than ten years. How much of the success of past rehabilitation experiments has been due to putting right what had gone wrong during long years of institutionalism? Those studies came to the conclusion that most patients still remained handicapped but that attitudes could nevertheless be changed and a reasonable settlement achieved in a proportion of cases. To what extent are patients in the present series exhibiting parallel secondary handicaps? In fact, it appears that the secondary handicaps are just as great and that a form of community 'institutionalism' is inevitable: patients come to accept their lot, wherever they are. The decision whether to leave them as they are or to try to help them, in the belief that they will eventually be glad to be more independent, remains the same whether the patient is in hospital or outside. The main reason why moderately handicapped patients in the present series did not do as well as those studied by Wing (1960) or Wing, Bennett, and Denham (1964) appears to be the degree of active co-operation necessary in a non-residential setting.

The amount of burden felt by relatives was, in most cases, not intolerable (though occasionally it was too much). However, the conditions in which some patients were living and their state of personal self-neglect was such that, if it had been present in long-stay hospital patients, the hospital concerned would have been regarded as a very poor one. The alternative of supervised hostel accommodation has not been properly tested but the advantages, both from the point of view of providing an alternative to common lodging houses or reception centres and from the point of view of providing a positive means of social rehabilitation, would appear to be considerable, so long as patients would co-operate.

Clearly, these problems would be much eased if rehabilitation could begin at an early stage, so that a relationship of trust between patient and services could be built up and attendance at day-units or hostels could be taken for granted if in the patient's interest. Such facilities are available nowhere in the UK at present and it is therefore impossible to test this final conclusion. It seems, however, to make good sense.

The other conclusion is that all the rehabilitation services must be integrated. To separate day-hospital and rehabilitation workshops from day-centres, to put sheltered workshops under yet another administration, to have hostel and hospital places under different authorities is senseless. Patients need to be able to move freely throughout the services available and the staff need to be integrated within one sociomedical service.

D. H. Bennett and Lorna Wing

1. Development of social work services

(D. H. Bennett)

The preceding chapters tell a story of change in the provision of psychiatric hospital care. We have seen that with less compulsory detention, more out-patient treatment and the establishment of day-hospitals and general hospital psychiatric units, the locus of care has shifted steadily from the hospital outwards to the family and to the community. As this has been happening changes in the social order have made it increasingly difficult for families to care for their sick or disabled members. Affluence, more education, and the growth of a consumer-conscious middle class, have enlarged the expectations of all and increased the demands for more and better psychiatric provision (Goldberg, 1965). The assumption by the state of increased responsibility for the welfare of the individual citizen has led to an increasing acceptance of what is often called 'the comprehensive principle'. This principle recognizes the right of all sections of the community to health and welfare services. It has often been seen in the limited context of social class, but it also means that treatment is provided not only for the 'recognized' patient, but for the whole family. The implications of such a development for psychiatry were recognized by Adolf Meyer in 1913, when he said that social service was the 'agency which reaches into the home and makes it its duty to supervise the conditions outside of the hospital and the activity of the patient in relation to the family and the community'. So for Meyer the

psychiatric social worker was 'one of the fundamental and most important factors of progress in psychiatry'. One must imagine that he was not uninfluenced by his wife, who was among the first psychiatric social workers. It was in about 1904 that she began to visit patients in their homes and in the wards of Manhattan State Hospital (Lubove, 1965).

Matters moved more slowly in Britain. When the Maudsley opened in 1923, a half-time almoner was appointed to the hospital. Although her work was increased in 1924, her main duties seemed to be the assessment of the amount that was to be paid by patients for their treatment, dental work, massage, etc. But in the Medical Superintendent's report for 1924, Mapother said that the homes of the patients had been visited and reports submitted on home conditions and family history. By 1926 there was talk of three students completing three months' experience and more space was given in the almoner's report to family problems and their effect on children. In succeeding years this department became the Social Work Department and by 1935 the distinction between almoners and psychiatric social workers was dropped; all newly appointed workers in this department being psychiatric social workers.

In the local authorities, change proceeded even more slowly. In 1958 Harris thought that his readers might be puzzled when he spoke of community services in connection with the hospital and that they might object that such services were the responsibility of the local authorities.

Perhaps one of the most urgent administrative problems with which we will be faced in the near future is the prevention of loss of efficiency in the service given to patients by this distinction. At the present time local authorities have some sort of service for the supervision of mental defectives and services of widely varying standards of completeness for care of old people. None, as far as I know, makes any substantial provision for the psychotic discharged from hospital (Harris, 1958).

His view is, perhaps, not so surprising when we read in the report of the County Medical Officer of Health for London for 1959 that 'It was not until November that the full complement of five psychiatric social workers became available; previously not more than three could be obtained'. The official policy of the LCC towards its Mental Welfare Department was that its function was not to do social work, but to act as an emergency service for dealing with urgent psychiatric problems in the London area.

The function of the Duly Authorized Officer (DAO) was thus to visit as many people referred to the department as he could and to take such action as he thought necessary and right, with due regard to his powers under the Acts and to deal with each problem as quickly and efficiently

as possible. . . . His primary concern was with the individual referred and only secondarily ought he to consider the amount of stress in the social situation, or the nuisance and distress to families, friends, other tenants, landlords, neighbours and strangers. In fact, many DAOs did take these aspects into account, but most DAOs considered them outside their province. Their approach to the problem, however much understanding they might possess, had essentially to be legalistic and different from that of the social worker who is normally tentative, enquiring, and able to take into consideration the whole family and social situation. The social work approach was supposed to be provided by the psychiatric social workers' department for the London County Council, which was also situated at County Hall. Since contact between the two departments was minimal it was probable that each dealt with the same cases from time to time (Lawson, 1966).

At night only two duly authorized officers were on duty for the whole of London. In this situation, of course, the duly authorized officers were happy to have St Francis's observation ward as a dumping ground for awkward patients who did not seem suitable for other places. The need was determined mainly by lack of staff, by the lack of co-operation between different agencies and hospitals and even of departments within the same organization. Thus the LCC's mental welfare and psychiatric social workers' departments were not working together, nor were mental hospitals referring their discharged patients to the psychiatric social workers' department at County Hall. They preferred to rely on their own social workers. As Harris said, there must be continuity of treatment with regard to psychiatrists and social workers, and any administrative set-up which necessitates patients being transferred to different groups of personnel is a thoroughly bad one, since the distinction between treatment and after-care is highly artificial.

In 1959 the Mental Health Act was passed. This led to marked changes in social work within the Metropolitan area. This area, in many respects, was behind other parts of the country where crude ideas of community care had already been put into practice. The LCC Mental Welfare Department moved out of County Hall and was divided into nine divisional offices scattered over the London area. Other departments, health, education, and housing had already been 'divisionalized'. The psychiatric social workers' department, which had been little used, was incorporated into the new scheme. Divisions, which had a variable population, usually had eight or nine members of staff to deal with all duties. More staff were sent for training, both to university diploma courses in mental health for qualification as PSWs or to colleges of further education to take the new 'Younghusband' certificate in social work. Even so, follow-up care was woefully inadequate. Parkes,

Brown, and Monck (1962) showed that, of 100 male schizophrenic patients discharged from mental hospitals in the London area only four patients were visited by a social worker during the follow-up year. In another study, Rehin and his associates showed how professionally qualified psychiatric social workers were engaged in providing short-term services in hospital, while less-trained workers were undertaking more difficult problems of long-term care in the community (Rehin, Houghton, and Martin, 1964). They suggested that hospital and local authority social work services should be joined in a single service with a local authority base. Psychiatrists and hospital staff had a very limited view of the meaning of community care. The Royal Commission on the law relating to mental illness and mental deficiency, reporting in 1957, were in favour of 'community care' which they felt should emphasize 'the forms of treatment, training and social service which can be given without bringing patients into hospital as in-patients, and which make it possible to discharge them from hospital sooner than in the past'. Thus, prevention of hospital admission and early discharge from hospital became the first aims of psychiatric community care. This was a great step forward for the person who had been defined as mentally ill but it completely overlooked the realities of the family and the social situation when it formulated community in these geographical rather than in sociological terms. It saw the community as being somewhere which could provide a normal social environment outside the hospital in contrast to the abnormal institutional environment. Improvements in the hospital were viewed largely in terms of size and location and the Commission recommended that smaller hospitals and units be located nearer to the patient's home. Most of these recommendations were desirable as far as they went. But they represented a strictly medical approach to psychiatric care, uninformed by the facts which were to become available later from the social and behavioural sciences. These limited views of community psychiatry with their advantages and shortcomings were exemplified in a number of services established mainly in county borough areas. These boroughs re-established a pattern of co-operation between the local authority social work services and the local mental hospital which had existed before the establishment of the NHS in 1948. The aims of these services were described by May (1965), who defined community care as 'the provision of adequate care and treatment of chronic illness without admission to hospital or institution in the best interest of the patient and his associates'. Although he saw community care as directed to the needs of chronic patients, May's views differed

from those of most psychiatrists involved in such services. He did not accept that the patient should be kept 'out of hospital at all costs'. He also recognized the difficulties caused by the 'hospital's mainly clinical approach to the patient and his problems, without due reference to social factors', by the circumscribed nature of hospital admission, by the view that the patient was a person who had come to be cured, and by the unrealistically low expectation of patients held by staff. Most county borough services, although they stressed co-operation between the hospital and the local authority social work services, were mainly hospital centred and it was not until the middle or late 1960s that some services like that in Croydon found their main focus outside the hospital.

During this same period attempts were first made to evaluate these services. The most comprehensive evaluation was that of Brown, Bone, Dalison, and Wing (1966) who, taking schizophrenic patients admitted to hospital in 1956, studied both the patients' clinical condition and various social effects on their families over a period of five years in three separate areas of England. Only one service of the three provided community care on the county borough model. These authors concluded that the outcome in terms of clinical and social morbidity for patients and families was much the same in all three areas but that the relatives of patients in the community care service reported more problems. Although these community care schizophrenics were much more in contact with community services, this did not lead either to lower clinical morbidity or to greater family cohesion. Little more could be expected from a system of care with such limited aims, so that it is perhaps significant that the patients in the community service did so little worse than those in hospital. The main strain was on the family and we know from the studies of Sainsbury that this can to some extent be modified by social work (1968).

If community care is to be improved we have to change our ideas about it. Care, whether in hospital or outside, must be planned in accordance with concepts derived from social psychiatry and the other behavioural sciences. For some time to come, planning will have to rest on theory as well as on facts. But theories can be tested and revised while nothing can be learned from, and little will be achieved by, unplanned or expedient care. Decisions about patients' care must take into account long-term as well as short-term aims. Decisions which meet the patient's immediate needs, too frequently take little account of the effects on him or on his children in five or ten years' time. We pay lip service to preventive psychiatry but in our day-to-day work we tend to forget about it. The community to be served can usually be recognized only as a

population of a geographically defined area, for in large parts of urbanized western society it is difficult to delineate communities in a sociological sense. These views are condensed and summarized by Sabshin (1966) in his definition of community psychiatry, which, of course, includes hospital care. He says that community psychiatry uses the methods and theories of social psychiatry and other behavioural sciences to meet the psychiatric needs of a geographically defined population over a significant period of time. The present aims of the organization of hospitals and local authority social service departments need to be reviewed and judged in the light of this definition.

We have seen, how, in the past the community used St Francis's observation ward as a dumping ground for awkward patients with whom it could not deal, as well as for those with whom it did not wish to cope. Now the process has been reversed. Hospitals, in their turn, are saying that they cannot, or will not, cope with certain patients, who are then discharged to the community. At present much of this buck-passing results from the failure of the hospitals and the social services to define the needs of the patients and their families not in terms of illness but of 'help with problems'. The other important point to which all subscribe is the need for the continuity of this help between the health and social work services. This continuity presents more difficulties than are superficially apparent and these are rarely analysed. Harris saw the need for continuity between treatment and after-care services. He saw it in terms of personal continuity; that is, continuity between an individual patient and an individual social worker, and also in terms of administrative continuity, and suggested that the best way of achieving this was for both services to be administered by the hospital authority.

Meanwhile the social workers, who in London were transferred from the LCC to the boroughs in 1965, had other views. They believed that since community care involved families, there was a need to bring together the fragmented personal social services. The Committee on Local Authority and Allied Personal Social Services which was appointed in December 1965 and is more commonly known as the Seebohm Committee reported in 1968. It suggested that social workers should cease to concentrate on a series of isolated maladies, like mental illness, homelessness, or physical handicap. They should concentrate instead on helping families. This approach, of course, required a new attitude among social workers and a new organization for their work. There was to be a single new social service committee in each local authority, and a single director of social work. The aim was to provide a unified

coherent system of personal social service in partnership with the proposed integrated health service. Continuity of care was to be centred on a particular person or problem. The doctors protested but the social workers were not impressed. They were well aware of the failure of doctors to call on social services needed by their patients, even when they were there to be used.

The Local Authority Social Services Act was implemented in April 1970 but it has not yet been possible to develop a broad pattern of co-operation between health services and social work services. So when social workers and psychiatrists work together they will not be trying to provide personal continuity of care for the recognized patient alone. They will not be the only members of the team. Nor will there be only one community care team, but many, for it is only when teams are small and close that decisions come automatically from likemindedness. When teams are large, heterogeneous, and scattered, active decision-making is hampered. Medical social teams will have to be 'specialized'. It is senseless to bring the disablement resettlement officer or probation officer to a discussion of the problems of a demented old lady living alone, nor do working men need Meals-on-Wheels or Home Helps. There is much talk of 'generic' social work, but it is very doubtful whether at the present time there are many social workers with enough skill or training to practise such a difficult art. The administrative discontinuity between health and social services must make teamwork difficult. It is for this reason that continuity in terms of geography is important, since the only link between the two services is through clients who reside in a geographical area served both by health and social services. Much has been made of geographical continuity in the present planning of social work services but it is uncertain whether the physical accessibility of social work to the public will make much difference to care. It seems obvious that the division of service responsibility into too many small areas may make communication difficult between the large number of social workers and the small number of psychiatrists involved.

To overcome some of the difficulties in integrating psychiatry and social work in a district service we have, for some years, jointly appointed social workers between the local authority and the Maudsley. The first appointment was made in 1964 between the mental health department of the LCC Division 7, for patients residing in the then borough of Camberwell. This appointment was maintained with the mental health department of the borough of Southwark which absorbed Camberwell in 1965. In 1967 two further jointly appointed social workers were linked to St Francis's

Hospital. There were difficulties in operating such appointments both for the administrators and the workers themselves but they are well established and have already attracted able social workers. With the disappearance of the mental health department these social workers are now linked to the area social work teams and the hospital. We shall face further changes in the near future and these again will strain our adaptive powers. But although we may, at times, despair of establishing the full partnership between community-based psychiatry and social work which is essential for first-rate psychiatric or social care, we can take heart from the very considerable advances made in the past ten years.

2. Two studies of hospital and local authority social work

(Lorna Wing)

2.1. INTRODUCTION

As we have seen in the previous section, throughout much of the time-span covered by this book there were two groups of social workers dealing with the psychiatric problems of Camberwell residents, those employed by the hospital and those employed in the health department of the local authority ('mental welfare officers'). In addition, certain social workers were appointed jointly by the two kinds of authority. These groups will be designated, for convenience, hospital social workers (HSWs), local authority social workers (LASWs), and jointly appointed social workers (JSWs). The principles involved remain important now that LASWs are employed in the social services rather than the health department of the borough of Southwark. The relationship between the groups was not discussed in detail in the Seebohm Committee's report but the imminent proposals concerning area health boards, which will integrate the administration of the various parts of the health service, will emphasize even more strongly the division between medical and social services.

The Seebohm Committee was concerned to describe and underline the aspects of social work which distinguish its theory and practice from those of other professions, and the 'generic' courses for social workers have placed case-work with families as a central feature in the training programme. Problems of specialization (for example, in social work with the blind, deaf, retarded, etc.), and of training in more instrumental types of skills, have received relatively less attention. However, questions concerning social case-work versus social action and the value of the specialist skills of hospital social workers are again being asked. Now that the

problem of status and professional identity is settled it may be worthwhile considering some of the basic issues afresh.

The two studies to be described here were undertaken in order to discover whether there were major differences in the ways in which the various groups of social workers were functioning in relation to psychiatric patients in Camberwell. The inquiries were of a preliminary nature, and limited to this one aspect, but it was hoped that some progress would be made in understanding the relationship between the medical and the social services.

2.2. METHOD

In the first study, the work of the LASWs was recorded and studied during the period 1 October 1966 to 31 March 1967. In the second study, the work of HSWs and JSWs was also included, covering the four-week period 17 June to 12 July 1968. Several joint appointments had been introduced in the interim. In each case, details of the contacts made by social workers with clients were recorded on a special form and the results examined in the context of the other contacts made by these clients and reported to the Camberwell Register. The studies will be referred to as the 'six-month' and the 'four-week' studies respectively.

2.3. RESULTS

1. *The main areas of work*

The LASWs worked with adult psychiatric patients, and adults and children who were mentally retarded. They were not concerned with children with psychiatric conditions except for the very occasional child whose family was referred to the mental health department for other reasons. The HSWs were concerned either with adult psychiatric patients, or with children with psychiatric conditions, depending upon the hospital or department to which they were affiliated. The child guidance clinics also employed psychiatric social workers. The mental subnormality hospitals serving the area did not have any social workers during the periods the two studies were being carried out, so almost all the social work with retarded patients was done by LASWs. The JSWs were concerned with adult psychiatric patients, and saw only one or two retarded adults or children.

2. *Numbers in contact with social workers*

The numbers of clients in contact with LASWs and psychiatrists during the six-month period are shown in Table 20.1. About one-quarter of all adult psychiatric patients (excluding the long-stay in-patients), who were reported as in contact with services during the six-month period, saw an LASW.

Table 20.1. *Adult psychiatric patients. Numbers in contact with LASWs or psychiatrists during the six-month period 1 October 1966 to 31 March 1967*

	N	%
<i>In contact with psychiatrist only, during the six months</i>		
(a) No contact with LASW recorded on Register	1,287	77
(b) In contact with LASW before the six months	120	7
<i>In contact with both psychiatrist and LASW during the six months</i>	175*	11
(a) In contact with psychiatrist before the six months	42	3
(b) No contact with psychiatrist recorded on Register	49	3
Total	1,673†	101

* Includes 6 patients with mental retardation as well as psychiatric condition.

† Excludes 399 long-stay in-patients.

Table 20.2, which gives the equivalent figures for all groups of social workers, shows that about one-third of patients reported to the register during the four-week period were in touch with a

Table 20.2. *Numbers in contact with social workers or psychiatrists during four weeks, 17 June 1968 to 14 July 1968*

	N	%
1. All patients		
In contact with psychiatrist only, during four weeks	687	69
In contact with psychiatrist and social worker during four weeks	176	18
In contact with social worker only during four weeks	136	14
Total	999*	100
2. Patients in contact with social workers during four weeks		
In contact with LASW only	118	38
In contact with JSW only	89	29
In contact with HSW only	84	27
In contact with two or more types of social worker	21	7
Total	312	100
3. Duplicated count of patients in contact with social workers during four weeks		
In contact with LASW	128	41
In contact with JSW	102	33
In contact with HSW	104	33
Total number	312	—

* Excludes 351 long-stay patients.

social worker, roughly equal proportions seeing LASWs, JSWs, and HSWs.

It can be calculated from these figures that approximately 775 Camberwell patients will see a social worker each year, out of 2,500 reported to the Register, excluding long-stay patients. There was a considerable difference in the proportions of patients at the various hospitals who saw a social worker. At the new district treatment unit at St Francis's (see Chapter 6) 70 per cent of patients were referred to the two JSWs, who themselves decided policy in this matter, compared with only about 20 per cent of patients attending the other hospitals serving the area. A rather small proportion of the total case-load comprised patients who had not been in contact with a psychiatrist for at least three years; this proportion was seen only by LASWs (18 per cent of cases).

Table 20.3 shows the diagnoses of patients in the four-week study who were seen by social workers, compared with those of patients seen only by psychiatrists. (The proportions were much the same in the six-month study.) The HSWs saw patients with much the same diagnoses as those seen by psychiatrists, while the LASWs saw more patients with schizophrenia and fewer with depressive and other neuroses; the JSWs were intermediate.

Table 20.3. *Diagnosis of patients in touch with social workers and/or psychiatrists during the period 17 June 1968 to 14 July 1968 (percentage)*

Diagnostic group	Patients contacting SWs*			Patients contacting psychiatrists only
	LASWs	JSWs	HSWs	
Schizophrenia	26	20	12	14
Affective psychoses	15	17	17	19
Depressive neuroses	25	33	39	34
Other neuroses	2	8	6	10
Dementia	4	5	2	5
Other	20	14	16	15
Not known	9	5	8	4
Total number	118	89	84	815

* Twenty-one patients who saw more than one type of social worker omitted

Approximately 40 per cent of the LASWs' case-load consisted of mildly or severely retarded adults or children, who are not considered in the tables so far presented. The HSWs and child guidance clinic social workers who dealt with children with psychiatric disorders worked quite separately from the other groups and, again, their case-load is not considered in Tables 20.1-3.

In two-thirds of cases, the LASWs saw clients in their own homes; the equivalent proportion being 44 per cent of JSWs'

interviews and 37 per cent of HSWs' (Table 20.4). The LASWs' interviews lasted, on average, 56 minutes compared with 34 minutes for HSWs and JSWs. Whichever type of social worker was conducting the interview, those in the client's own home lasted longest.

Table 20.4. *Place of interview with social workers during four weeks 17 June 1968 to 14 July 1968.*

Place of interview	LASW		JSW		HSW		Total	
	N	%	N	%	N	%	N	%
Home	186	66	81	38	33	16	300	43
Office	40	14	24	11	40	19	104	15
Ward and day-hospital	36	13	106	50	135	65	277	39
Other	18	6	3	1	1	1	22	3
Total	280	99	214	100	209	100	703	100

There was surprisingly little variation in the number of interviews per patient by diagnosis or by type of social worker. Patients were seen approximately twice during the four-week period irrespective of the type of professional worker involved, though LASWs tended to see clients with depressive and other neuroses rather more often than they saw other clients or than other social workers saw any of their clients.

3. Reasons for undertaking social work interviews

In the four-week study, social workers were asked to select from a checklist which reasons were most important in determining whether a client was interviewed. The reasons given differed markedly between the groups. The LASWs mentioned 'case-work' for 70 per cent of the contacts with patients or relatives, the JSWs mentioned it for 44 per cent and the HSWs for 37 per cent. On the other hand 'advice and help with practical problems' was mentioned for 10 per cent of interviews by LASWs, 20 per cent by JSWs and 36 per cent by HSWs (Table 20.5). Case-work predominated as a reason for interviews with the relatives and children attending psychiatric or child guidance clinics (96 per cent).

The LASWs' emphasis on case-work was also obvious in connection with the mentally retarded patients. They gave this reason for 80 per cent of contacts, and advice and help with practical problems for 15 per cent only.

The LASWs' interest in case-work was shown in another analysis of the data from the six-month study. During this time 42 patients (16 per cent of the total seen) made 10 or more contacts with the MWOs. In the same time period, only 2.5 per cent of the

Table 20.5. *Reasons given for contacts between social workers and clients during the four weeks, 17 June 1968 to 14 July 1968*

Reasons for interview*	LASW		JSW		HSW	
	N	%	N	%	N	%
Case-work						
(a) With patient	219	78	93	44	78	37
(b) With relative	44	16	73	34	55	26
Practical help	27	10	42	20	75	36
Arranging admission	17	6	5	2	3	1
Follow-up after discharge	7	3	17	8	6	3
Other	75	27	46	22	47	23

* Several reasons were given for some interviews.

patients in contact with a psychiatrist saw their doctor in an out-patient clinic 10 or more times. Of the patients who were seen this frequently, those with neurotic depression formed the largest single diagnostic group, representing 25 per cent of the total for both MWOs and psychiatrists. Of all the patients seen by the MWOs, those with neurotic depression had the highest average number of visits. They were seen on average 6.9 times, patients with other neuroses 5.2 times, and those with schizophrenia 4.8 times, during the six-month study period. Patients with depressive and other neuroses perhaps tend to be rather more demanding than those with chronic schizophrenia, but an additional reason may have been that 'case-work' was more rewarding with the former than with the latter patients.

2.4. DISCUSSION

The separation of local authority from hospital social workers arose as an administrative accident of history rather than by deliberate choice. There were, in fact, many similarities in the work they were doing and a considerable amount of overlap in clientele. For example, two-thirds of all the patients who contacted a social worker during the four-week study had seen an LASW at some previous time, irrespective of the type of social worker they contacted during the period of the study. The joint appointment of social workers partly to hospital and partly to local authority further bridged the gap.

The two studies described in this chapter are concerned only with 'psychiatric patients'; that is to say with patients, most of whom have at some time contacted a psychiatrist. In fact, there was a small proportion (3 per cent) in the six-month study, who had not been reported to the Register and may never have seen a

psychiatrist. In general, however, all the social workers were specialized in the sense that they saw only patients who could in some sense be said to have 'psychiatric' conditions. Two-thirds of such patients, in Camberwell at any rate, were looked after by psychiatrists without any social worker being involved during the periods covered by the studies.

The system of having different groups of social workers involved with patients at different stages in their service contacts does not seem an efficient one, since it does not make for continuity of care nor for the high level of communication which is needed between professional workers. Both psychiatrist and patient probably find it convenient for a hospital social worker to be involved when the patient visits the hospital or is admitted but this seems to have two consequences; one is that most interviews take place in the office or on the ward, the other is that the interviews tend to be relatively brief and to be concerned mainly with practical matters. The LASWs are relatively more independent of hospital referrals, they traditionally carry out their interviews at home rather than in the office and they are less often concerned with practical matters. Presumably the situation in which the social work takes place does in fact affect its nature. There seems no reason, however, why social workers with joint appointments should not combine the best of both worlds.

The interest of local authority social workers in the subject of case-work seems to have increased considerably, if the results of a comparative study undertaken by Rehin and Martin (1968) can be generalized. They found in 1961 and 1962 that LASWs (mental welfare officers) mentioned case-work as a main reason for interviewing a client in only 2 per cent of contacts in Salford, 8 per cent in East Middlesex, and not at all in Oldham, West Sussex, or Devon. The difference from Camberwell must partly be due to the way the question was asked but there has also probably been a change in the way LASWs describe what they do and a change in their actual work. It is most unlikely that the difference between hospital and local authority social workers in Camberwell is purely one of terminology, though it is true enough that case-work is very difficult to define.

Evaluation of the effects of case-work raises similar problems to that of psychotherapy. It was shown in Chapter 16 that many more patients than are at present receiving supportive or specialized psychotherapy would be eligible for these treatments. If resources were available, and if it had been demonstrated that they were valuable, many more patients could benefit. The same is probably true of case-work. Indeed, the two kinds of therapy, each in a way

supposed to be specifically characteristic of a profession, may very well overlap a good deal. Perhaps social workers should be undertaking more psychotherapy; this would certainly be economically attractive. Perhaps psychotherapy and case-work are already very similar. Perhaps, however, there are specific elements, both in case-work and in psychotherapy, that require specific forms of training, not readily undertaken by members of the other profession. In either case, there is no doubt that leaving the process of referral to the therapist himself will inevitably result in a large increase in patients treated, as happened at St Francis's when the social workers changed their functions. This may well be a good thing; however, it was pointed out in Chapter 2 that 'usage' and even 'demand' are not the same as 'need'.

The alternative, or perhaps interlocking, approach is to suggest that psychiatrist and social worker each bring certain skills to the process of what might be called 'management'; particularly the management by patients and relatives of long-term disabilities. Some attention has already been given to this matter in Chapter 18 and it will be taken up again, in the context of mental retardation, in Chapter 24. More general discussion will be found in Chapter 25. Briefly, the suggestion is that many patients have very specific types of disability which may need intermittent or continuous specialized medical treatment over long periods of time, but which can nevertheless be coped with if everyone concerned is well-informed and prepared. Social action may be necessary from time to time, in which the social worker points out to client and family what their rights are and how to achieve them (Sinfield, 1969). Experienced and skilled workers, both medical and social, are needed to carry out this long-term programme of treatment and counselling, the affective aspects of which arise naturally out of the instrumental. Considerably more specialization than was envisaged in the Seeborn Report would be required to sustain the social worker's role in such a partnership. Some social workers may feel that giving practical advice on the problems encountered by the families, for example, of severely retarded children, should not be one of their functions, but it is difficult to see who else could take on such a responsibility. Perhaps community nurses will take on such a role but, if they do, social workers will find that the nurses are doing the 'case-work' as well. Hewett (1970), in her study of families containing a retarded spastic child, quotes a remark made by one mother concerning a local authority psychiatric social worker: 'He doesn't have much to say. He just wants to know if there's anything he can do in any way to help, which he can't, and that's about all that goes on.' The fact is that a social worker with

the appropriate specialized knowledge *is* in a position to help such a family.

Now that parity of esteem has been established as between social workers and psychiatrists, it is permissible to ask such questions, although it is not yet possible to answer them. Scientific evaluation is now being undertaken in the field of social work (Reid and Shyne, 1969; Goldberg, 1970) and there is no doubt that answers will eventually be forthcoming.

PART FIVE

PSYCHIATRIC ASPECTS OF DESTITUTION

Psychiatric aspects of destitution: a study of the Camberwell Reception Centre¹

D. Tidmarsh and Susanne Wood

1. Introduction

In this chapter we turn our attention to a need for health and social services which is not at present being adequately met, either in Camberwell or in any other London borough. This is the need for services for the destitute men and women at present residing in common lodging houses and reception centres. The historical development of services for these 'down and outs', particularly for the mentally ill among them, has been described in Chapter 3. Here we will consider in detail the needs of the men using Camberwell Reception Centre, concentrating on the provision of psychiatric services, but emphasizing that this is only one of several areas of need. Although Camberwell is unique in containing the largest reception centre in Britain, to which are attracted destitute men from a wide geographical area, the problem of destitution is not solely to be found in Camberwell, since other boroughs also contain high numbers of common lodging-house beds and are thus faced with similar social problems and demands for services: furthermore, it is precisely because of the lack of local authority and health service provision to meet the needs of these men that such a large number are found concentrated in Camberwell.

Camberwell Reception Centre is the modern equivalent of the old casual wards and workhouses. It is now administered directly by the Supplementary Benefits Commission for the DHSS, having been taken over from the LCC in 1965. The Reception Centre is

1. This is a preliminary and selective report of work which will be published more extensively elsewhere.

expected to discharge the responsibilities laid down in the Ministry of Social Security Act 1966 (5.34 and Schedule 4) and formerly in the National Assistance Act 1948. Schedule 4, section 2 (1) of the more recent Act describes the duty 'to make provision whereby persons without a settled way of living may be influenced to lead a more settled life' and to 'provide and maintain centres to be known as reception centres for the provision of temporary board and lodging for such persons'. 'Persons without a settled way of living' is the modern euphemism for the old terms, 'casuals', 'vagrants', and 'wayfarers'. At present the Reception Centre provides the destitute man with a bed for the night and some supper; in return he must agree to have a bath and to disinfection where necessary, and must not bring in liquor or drugs to the premises. Other rules of orderly behaviour must be observed or he will be evicted. A welfare section aims to interview and assess a proportion of the men and where possible to offer a man help which might encourage him to lead a more settled life. This may range from giving shoes and clothes to contacting social agencies, landladies, etc., in an effort to 'set him up'. An employment agency, an outpost of the Department of Employment, attempts to place some in jobs, a clinic assesses and treats physical and mental conditions, and other officials can put the man back into the normal circuit of welfare benefits, with letters to the local Social Security offices and to the Department of Employment. Hospitals, hostels, probation officers, the police, relatives, and voluntary agencies are some of the many groups contacted by reception centre staff: it is a two-way process, they refer men to the Reception Centre and the Reception Centre refers others to them.

On average, 500 men slept in Camberwell Reception Centre on any one night in 1970. This rose to as many as 900 in the winter months. Roughly half were 'residents'; this category comprises those who agree to stay for some time, the aim being to learn how to live a settled life. These men work within the Centre, cleaning, preparing food, or working in the workshops. They eat separately from the 'casuals' and may stay in the Centre during the day and have a midday meal. Various other small privileges are given them in an attempt to make the resident role more attractive. In terms of bed-nights, it is this category of residents which makes a relatively greater demand on the services of the Centre: it is also amongst this category that the most pathology is found, although large numbers of men with similar characteristics are found in the 'casual' category, who, if offered the opportunity, could be expected to make similar demands on services. Some residents finish their 'resettlement' programme by living in the Centre and working outside.

Although the research to be reported will refer to 1970, the situation has changed since then. During 1971 the average nightly number of men accommodated at the Centre was usually between 700 and 800 (the only exceptions being the months of May, June, and July). In January 1972 the average nightly occupancy was 822 and in February 833.

2. Aims and methods

The research which will now be described is part of a study conducted at Camberwell Reception Centre between April 1970 and April 1972. The aim of this study was to discover the characteristics of the men using the Reception Centre and to consider the functions of reception centres in dealing with such destitute men. We shall now outline the methods used in this research, emphasizing particularly the case-paper survey, from which most of the data to be described in this chapter were derived. Initially we concentrated on absorbing the background material on the subject which was available in books, articles, official reports, and records; other information was acquired from discussion with officials and voluntary workers, and from unofficial reports, circulars, and newspaper articles.

2.1. THE CASE-PAPER SURVEY

The second stage of the research involved a description of the Reception Centre itself and an analysis of what was happening there. It was decided to study the functions of the Reception Centre in terms of the career of the clients passing through it, and to describe the variables which appeared to influence their progress. This analysis was based on secondary data already available within the Centre in the form of official records and case-papers.

Approximately 16,000 case-papers were filed at the Centre in 1970, in alphabetical order. A new case-paper is completed each time a man books into the Centre for the first time. Thereafter whenever he returns to the Centre this fact will be recorded in the case-paper and a record made of any contact he has with agencies inside the Centre. The case-papers are similar to those used in local Social Security offices and contain a continuous record of each man's contact with the service. In theory therefore this system should provide a detailed description of a man's basic characteristics and of the form and content of his contact with Camberwell Reception Centre. Particularly helpful are the detailed interviews conducted with the new cases, and the assessments and details

of referrals kept by duty officers, welfare officers, and medical staff. In practice however interviews are not always as thorough as one would ideally require; not even all new cases are thoroughly interviewed on particularly busy nights; the welfare officers cannot see all those who wish to see them and thus not all case-papers have detailed information in them. Some claimants prefer not to give information and avoid interviews where possible or may even give false information and false names. What happens therefore is that two streams emerge; one stream is dealt with in detail and referred to the welfare officers, offered a chance of residence or referral to other agencies; and another stream passes through the Centre relatively untouched by the facilities available. Thus some case-papers are rich with data, others virtually empty. Because of this variability in the detail in which information is recorded, the survey of secondary data covered only the basic facts which were available for the majority of cases.

A case-file is kept for each man presently in contact with Camberwell Reception Centre. If a man has not attended the Centre for two years his case-paper is destroyed. Periodic reviews of the files are carried out in order to clear away such redundant cases. Case-papers have been kept in this way only since 1965 when the Centre was transferred from local authority to central government control. Thus the case-papers stored in the files represent men coming to the Centre within the preceding two years who may or may not have been attending since 1965.

In April 1970 a 5 per cent random sample of all these stored case-papers was collected by selecting every twentieth case, marking it, and recording separately the name, CRC number, and date of birth of the man. These totalled 801 cases. (The total of case-papers at this time was 16,022.) Each case-paper was then surveyed and the data recorded in a standardized fashion. Four case-papers were not available at the time of the survey, having been transferred or having disappeared since the sample was collected. Thus 797 cases were surveyed.

The data were divided into three sections; the first section covered basic social characteristics (age, marital status, place of birth, previous occupation, and religion); some information on the extent of their contact with other services (whether they had been in prison or mental hospital) and an account of their use of the Reception Centre (the years in which they attended). A classification of each case was attempted on the basis of the available information; principally this relied on the welfare officers' assessments and on comments recorded in the case-paper on the behaviour and characteristics of the man by interviewing

officers, the visiting physician and others with whom he came into contact. Any other data provided in the man's record, such as whether he was on the disabled person's register or had been in hospital, or letters from outside agencies, were utilized to form the over-all impression. In many instances, the total information was so meagre that a classification could not justifiably be attempted. Thus almost half the cases are described by the term 'inadequate data'. However this does mean that where a classification has been made, it was based on fairly reliable evidence; thus we feel confident that where the patterns of activity of the various sub-categories are described, this is with some validity.

The random sample used for the case-paper survey was stratified into those who attended in 1968 and those who did not. On the 1968 sample, the second and third sections were completed. This cohort was selected since 1968 was the first full year for which a year's records should be extant and which allowed consideration of a complete twelve-month period in a follow-up. The data covered in the second and third sections related firstly to patterns of attendance (measured by date of first attendance at Camberwell Reception Centre, number of periods of residence, total nights in residence, number of 'repeating casual' episodes,¹ total nights as 'repeating casuals' and number of nights as casual; these data were recorded for the twelve months prior to the first attendance in 1968 and for the subsequent twelve months). A second series of questions related to the route followed within the Centre (measured by contact with sub-sections of the organization, such as the welfare officers, DEP, or medical officer) and patterns of discharge (to agencies such as hospitals and after-care hostels and landlords).

The reliability of the information on 9 cases was doubtful and these were therefore discarded. Thus the total number of cases analysed in the case-paper survey was 788. Those who attended in 1968 numbered 413. The data derived from this survey allowed estimates to be made of the number of men using the Centre in a defined year, the frequency of their attendance as casuals and the length of their stay as residents, the number of claimants falling into various broad assessment and social categories and the extent of their contacts with various agencies both those within the Centre and those to which they were discharged.

2.2. THE MAIN SURVEY

The third stage of the research which formed the major part of the exercise involved conducting intensive interviews with a sample of

1. A repeating casual episode consists of at least five consecutive nights booking in as a casual.

the men coming to the Centre between October 1970 and April 1971. This study is referred to as the main survey. Our aim here was to collect reliable and consistent information on a representative sample of users. The advantage of this use of primary data was that more detailed information could be collected than was available in the existing records on a wider range of variables and in particular that an assessment of each man's mental state could be made by a qualified psychiatrist. The methods used in this section of the research will not be described in detail here since the bulk of the material described is drawn from the case-paper survey. It will suffice to state that the population of users was divided into new cases, casuals and residents: a sample of 210 new cases was collected, of whom 142 were interviewed (the remaining 68 were followed up through the case-papers); the total size of the sample of casuals numbered 211, of whom 176 were interviewed (the remainder again being followed up through the case-papers); and 64 were in the resident sample of whom 61 were interviewed.

3. Results

3.1. NUMBERS USING THE CENTRE

Fig. 21.1 shows the average nightly population in all reception centres in the UK during December of each year since 1948 (figures provided by the DHSS). There was a marked decrease in numbers from 2,400 soon after the war to 1,200 in 1964, due mainly to a decline in the use of centres outside London. Since then, the Camberwell Centre has accounted for approximately half the national figure. The 1970 data show a marked rise in the population of destitute men using centres. The mean December 1970 figure for Camberwell was 800 men. This is higher than the mean figure for the whole year, since the centres tend to fill up during the winter. The average nightly occupancy during the whole of 1970 was 540, made up of 10 new cases, 220 casuals, and 310 men in residence.

The mean annual number of new cases, derived from official Camberwell returns for the years 1967-70, is 4,056. We estimate from the case-paper survey of 1968 and 1969 an annual intake of 4,180 new cases and 3,930 casuals. We therefore propose to use round figures of 4,000 new cases and 4,000 casuals as estimates of the annual numbers attending Camberwell Reception Centre. We shall also estimate the number of men staying at the Centre on any one night at 500. It should be recalled that these figures relate to 1970; there has been a considerable increase since.

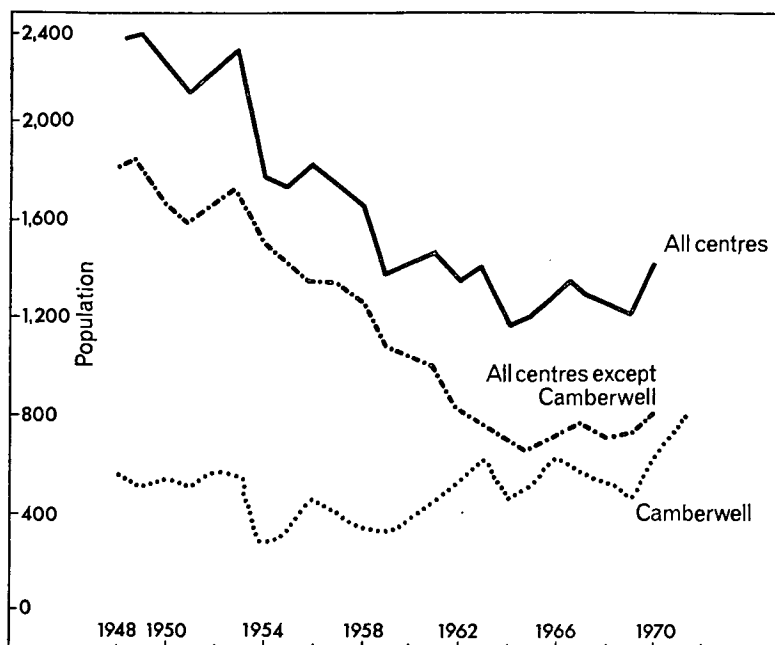


FIG. 21.1. Average December Reception Centre population. (Note: The month ends on the third Tuesday, and therefore does not include the Christmas holiday period.)

3.2. PREDOMINANT TYPE OF DISABILITY OR PROBLEM

The condition of each man interviewed in the main survey was categorized into one of ten categories according to the research team's judgement of the predominant type of disability or problem. Table 21.1 shows the ten categories used and their estimated distribution among the 8,000 men using the centre annually. Table 21.2 summarizes these data using only five categories. In addition, an estimate was made using data from the case-paper survey and the interview survey, of the categorization of men using the centre on any given night in the year, 1970, and this is shown in Table 21.2. It should be recognized that these figures are approximate but the relative proportions should not be far wrong.

The category of 'mental illness' comprises men with organic, schizophrenic, and affective psychoses, with neuroses and a few with mental retardation. 'Alcoholism' comprises alcoholic psychosis, alcohol addiction, and a few cases of other types of drug addiction.

Table 21.1. *Estimated categorization of men attending the Centre as new cases or casuals during the course of 1970*

Category: predominant impairment or problem	New cases (N = 130)		Casuals (N = 171)	
	N	%	N	%
Mental illness	892	22	540	14
Alcoholism and addiction	553	14	1,520	37
Personality disorder	680	16	800	19
Pathological gambling	90	2	140	4
Epilepsy	30	1	70	2
Physical illness	120	3	230	6
Old age	60	2	70	2
Migrant worker	60	2	120	3
Job problem	1,145	29	420	11
Situational	370	9	90	2
Total	4,000	100	4,000	100

Clearly, the assumption that these categories can be mutually exclusive is wrong. Many men could be classified into several of them. The judgement of which impairment or problem was predominant was made on the basis of information from the interviews, the case-papers, the clinic notes, and in records received from

Table 21.2. *Estimated categorization of men using the centre on an average night in 1970 or attending as new cases or casuals during the course of that year*

Category: predominant impairment or problem	Using Centre on one night		Attending during one year		
	Mean no. per night*	Mean no. of nights stay during year*	New cases	Casuals	Total
Mental illness	150	50	890	540	1,430
Physical illness, epilepsy, old age	95	45	210	370	580
Alcoholism, other addictions	165	25	550	1,520	2,070
Personality disorder, pathological gambling	55	10	770	940	1,710
Migrant worker, job problem, situational problem	35	5	1,580	630	2,210
Total	500	21.2	4,000	4,000	8,000

* Because of skewed distributions, these two figures cannot be used to derive total attendances.

hospitals and prisons. A heavy intake of alcohol was common, even in categories labelled 'personality disorder' or 'job problem', but the judgement in these cases, based on all the information available, was that heavy drinking was not the main problem. However, many of the men needed services appropriate to other categories as well as to the one to which they were allocated, and this should be born in mind during the discussion that follows.

The rest of the chapter will be mainly concerned with the men in the 'psychiatric' categories.

3.3. DEMOGRAPHIC AND SOCIAL CHARACTERISTICS

1. *Age*

Men using the Camberwell Centre are similar in age-distribution to men in the working population of the UK. This is true also of the mentally ill users, while men with alcoholism tend to be older and men with personality disorders tend to be younger.

2. *Marital status*

Few men using the Centre have ever been married; only 26 per cent of the mentally ill, 35 per cent of those with alcoholism, and 19 per cent of those with personality disorders, compared with 32 per cent of Centre users as a whole (part of these differences can be explained in terms of age). Only 5 per cent of all Centre users had a present-enduring marital tie; the rest were single, living apart, divorced, or widowed.

3. *Next of kin*

Among Centre users as a whole, 20 per cent said they had no next of kin. About 15 per cent of the mentally ill and of men with personality disorders said this, compared with 31 per cent of those with alcoholism. The relative most frequently named by all categories was a parent or sibling.

Among the mentally ill, only 25 per cent of those who had any next of kin named a relative living in Greater London or the Home Counties, the equivalent proportion of men with personality disorders or alcoholism being 15 per cent.

4. *Birthplace*

Table 21.3 shows the birthplace of men using the Centre. In general, the men were born in economically deprived areas of the British Isles, but the mentally ill are rather more likely to have been born in the Midlands or southern England.

Table 21.3. *Place of birth of men using the Camberwell Reception Centre (percentage)*

Place of birth	Category			
	<i>Mental illness</i> (N = 84)	<i>Alcoholism</i> (N = 81)	<i>Personality disorders</i> (N = 21)	<i>All users</i> (N = 717)
Greater London	13	6	19	8
Southern England	11	2	14	8
Midlands	13	1	5	5
Northern England	22	14	24	20
Wales	4	1	—	3
Scotland	8	27	19	21
Northern and Southern Ireland	19	43	14	25
Other	6	5	—	4
Not known	4	1	5	6

5. Occupation

Most Centre users are living at a very low economic level and have few resources to fall back on when things go wrong. Some 19 per cent have had no work during the year before entry to the Centre. (This includes those over retirement age.) The ordinary occupation in three-quarters of the employed men was within the Registrar-General's socio-economic class V, compared with 8 per cent of the economically active population of Great Britain. Some 19 per cent were employed in the catering trade. The proportions in unskilled manual occupations were somewhat higher among men with alcoholism (88 per cent) than among those with personality disorders (71 per cent) or with mental illness (76 per cent).

6. Accommodation on the night before booking in at the Centre

This low economic status is further illustrated by consideration of where the men spend the night before booking in at the Centre. Of all the Centre users, 42 per cent slept rough, 25 per cent were at another reception centre or a common lodging house, and 33 per cent were in other accommodation (a living-in job, lodgings, with relatives, etc.). The alcoholics were most likely to have slept rough and those with personality disorders most likely to have been in a common lodging house. The mentally ill were mostly likely to have been in relatively respectable accommodation (45 per cent); even so, 35 per cent of them slept rough.

3.4. ADMISSIONS TO MENTAL HOSPITALS, GENERAL HOSPITALS, AND PRISONS

Of the 359 men in the main survey, 98 (29 per cent) had been admitted to a mental hospital; 9 per cent within the previous year. The total length of stay in mental hospitals of these 98 men averaged 882 days (almost 2½ years).

During the year 1965, 111 men were admitted to mental hospitals from the Camberwell Reception Centre. These admissions, four of which had not been completed by 31 December 1971, lasted an average 232 days.

In general, men from the Reception Centre were likely to stay a longer time in hospital than those admitted from a settled address. Table 21.4 illustrates this in respect of patients admitted from the Camberwell Reception Centre compared with patients admitted from a home address in Camberwell.

Within the previous year, 18 per cent of men had been in prison and 12 per cent in a general hospital.

Table 21.4. *Length of stay in hospital of psychiatric patients admitted from a home address in Camberwell and of men admitted from the Reception Centre (by selected diagnoses)*

Address and diagnosis	Up to three months		Three months or more	
	N	%	N	%
<i>Admitted from a home address in Camberwell</i>				
Schizophrenia	60	77	18	23
Personality disorder or alcoholism	44	90	5	10
<i>Users of Camberwell Reception Centre admitted to psychiatric hospitals</i>				
Schizophrenia	23	54	20	47
Personality disorder or alcoholism	34	68	16	32

3.5. THE SLIDE INTO DESTITUTION

Three items of information bear upon the question as to whether men in the mental illness categories have become destitute by reason of their illness or for reasons unconnected with it. Table 21.5 shows the degree of contact with the family at the time of first admission to mental hospital. At that time most of the mentally

ill patients were living with relatives and many of those who were living alone were in a normal domestic setting for their age. This was less clearly the case for those with personality disorders and not at all the case for the alcoholics.

Table 21.5. *Contact with family before first admission to mental hospital (percentage)*

	<i>Mental illness</i> (<i>N</i> = 33)	Category	
		<i>Personality disorder</i> (<i>N</i> = 18)	<i>Alcoholism</i> (<i>N</i> = 37)
Contact with family			
With parents	52	33	8
Living alone before marriage	21	45	43
With wife	21	11	11
Living alone after separation	6	11	38

If the accommodation in which the men were living before the time of first admission is divided into 'settled' and 'no fixed abode', then 87 per cent of the mentally ill, 59 per cent of those with personality disorders, and 50 per cent of those with alcoholism could be regarded as 'settled' at that time.

Similar conclusions can be drawn from a comparison of the average age at which men first became of no fixed abode with that at their first admission to psychiatric hospital. The psychotic were first admitted at 30.4 years and were of 'no fixed abode' at 37.7 years, while those with personality disorders were admitted at 32.9 years and of 'no fixed abode' at 37.5 years but the alcoholics were first admitted at 38.3 years only after becoming unsettled at 35.9 years. As it happens the age at which they became destitute was the same for those admitted and those not admitted both for the psychotics and the alcoholics, suggesting that treatment had done nothing to arrest their downward slide.

The failure of the psychiatric hospital services to maintain contact with these men can be estimated from the relative speed at which they appear at the Camberwell Reception Centre following their last discharge from hospital. Some 33 men, 9 per cent of the sample, or 720 men annually, had been discharged from a mental hospital during the preceding twelve months; nearly one-third of these turned up at the Centre within less than a week, another quarter within three months, and another quarter within four to six months.

4. Discussion

Approximately 1,500 men whose main problems are caused by mental illness (the commonest diagnosis being schizophrenia) use the centre in the course of a year; on any given night they occupy 150 beds. These numbers may be increasing. If those with physical illness or disability and those with alcoholism are added, the total numbers of handicapped or ill men using the Centre each year is 4,000 and the number of beds used by them nightly is 410 out of 500. Thus more than 80 per cent of the beds are taken up by people for whom other and better provision is needed on a long-term basis.

An estimate of how many mental hospital beds are used each year at present by the men who pass through the Centre may be obtained from their own account of length of stay during the year preceding the research interview, checked by hospital records in most cases. The average for all entrants was 0.4 month or 266 psychiatric beds during one year; only 70 of these are used for men directly referred from the Centre.

It is more difficult to estimate how many more psychiatric beds would be required if all those who needed to be admitted to hospital actually were able to benefit. However, on the basis of the interviews with a sample of the men using the centre a judgement could be made. It was assumed that destitute men with positive symptoms might well need admission at the moment, when no hostel or day-centre accommodation is available for such people. Some 160 mentally ill men would need to be admitted from the Centre during the course of a year, apart from those who are already transferred in this way. If their average length of stay was 72 days (as was the case for all short-stay patients from the Reception Centre admitted to hospitals serving Camberwell and reported to the Camberwell Register) 30 beds a year would be needed in addition to the 266 already being used. However, this is rather a short stay, hardly compatible with a reasonable period of in-patient rehabilitation. If it were possible to offer these men a really useful period of social as well as pharmacological treatment, the period of stay would inevitably become longer and the 300 beds so far estimated might need to be multiplied by four or five, giving the equivalent of a fair-sized mental hospital. In the past, of course, many of these men would have remained in hospital throughout their lives.

This is to reckon without the admission of any extra men with alcoholism. The present trend is away from treatment in hospital, although there is no evidence that treatment elsewhere is likely to

be more successful. However, this matter will be subject to more detailed attention in reports to be published later.

It has been estimated (Homeless Single Persons 1966) that there are 10,000 homeless men in London. There is no reason to suppose that the proportions of the mentally ill found in the Reception Centre hold true for this larger population (indeed, the turnover figures suggest the opposite) but it is clear that the Centre is a means of bringing to notice a much larger problem. Most of the mentally ill men using the Centre were not destitute at the time of their first admission to hospital; on the contrary, 90 per cent were living in settled homes. It would appear that further in-patient rehabilitation facilities, the provision of more accommodation for single men, and a considerable expansion of short-term and sheltered long-term hostels and day-centres for the more chronically mentally disabled, would lead to a reduction in the numbers of such men among the destitute in our large conurbations and therefore to a reduction in their admission to reception centres.

The beginnings of the slide into destitution among the mentally ill can be seen in some of the patients described in Chapter 19. It does not require many patients per year from each area the size of Camberwell for build-up to occur of the proportions that are evident at Camberwell Reception Centre. The fact that this area has been singled out for the development of a model psychiatric service is doubly advantageous, since the opportunity to evaluate it is present but, at the same time, the Reception Centre in the middle of the area acts as a constant reminder of what happens when services are not comprehensive.

PART SIX

PLANNING SERVICES FOR THE MENTALLY ILL IN CAMBERWELL

Planning services for the mentally ill in Camberwell

J. K. Wing

1. Introduction

The data so far presented in this book will be brought together in the present chapter in order to provide a basis for a plan of the way the psychiatric services of Camberwell might develop during the next ten years. No attempt will be made to look further ahead than that. The problems discussed will therefore be parochial: however, the relevance of the plan to the problems faced in other areas will be readily apparent and the broader issues discussed in Chapter 25 will be easier to understand in the light of the proposals put forward here.

One major priority is to prevent further patients being admitted to Cane Hill Hospital; this means solving the equations of long-term accumulation and finding a local solution to the problem of dementia. The ideas suggested have been discussed in committees and working parties by all those with a responsibility for providing services in Camberwell. By no means everybody agrees with them and by no means all of them are feasible or acceptable. In general, however, they have won support, and since they would come into operation gradually over a period of years, while being subjected to monitoring and evaluation, there would be plenty of room for modification on the basis of trial and error. The plan is presented in this chapter simply as a model for discussion.

In terms of the six levels of evaluation described in Chapter 2, we have considerable information at the first or descriptive statistical level, a fair amount at the second and third levels (the assessment of need in those attending services at the moment and

the effectiveness of the services in meeting the need), and rather little at the fourth level (assessing unmet need in those not attending services). We are only just beginning to reach the fifth and sixth levels, at which we deliberately modify services or introduce new ones and then evaluate the modification. However, even here there is some information. The present chapter is a preliminary attempt to answer the question posed at the fifth stage of evaluative research; what services are required to cater for unmet need? The discussion will remain centred, however, on the existing hospital services on the assumption that piecemeal social engineering is more effective in the long run, so long as it is rationally, energetically, and continuously applied, than attempting to begin again from the beginning.

The main problems for consideration may be summed up under the headings, 'old' long-stay beds, 'new' long-stay accommodation, shorter-term accommodation, day-places, and out-patient facilities. No attempt will be made to look further ahead than ten years.

2. Those who have grown old in mental hospitals

Of the 416 Camberwell patients who had been in hospital for a year or more on 31 December 1964, exactly half were still resident seven years later, at the end of 1971. About 60 per cent of them were in Cane Hill, the rest in various other mental hospitals all round the periphery of Greater London. According to the curve shown in Fig. 9.1, 100 patients will still be left in these hospitals by the end of 1980. Some of the others will have been discharged (probably not back to Camberwell except in a few cases) but most will have died. There has been a special effort at rehabilitation in Cane Hill Hospital recently (Dawson, personal communication) but since links with Camberwell have often long since been severed not many patients return to the area as a result. Others are too severely impaired, and too institutionalized, to make the chance of discharge very likely. From the point of view of priority, most people, lay and professional alike, take the view that prevention is better than cure and that the major effort should be placed into seeing that such a long-stay population will not build up again. It is important not to lose sight of this principle, but to return and examine whether the preventive measures are in fact successful, because if they are not, the policy will have been wrong and it will be necessary to realize the fact in order to learn the appropriate lessons for the future.

The disadvantages that can accrue, whether or not the alternative policy of prevention is successful, are obvious. The Whitting-

ham hospital inquiry (1972) made it clear that large old-fashioned hospitals, if required to handle mainly long-stay patients in an atmosphere of deteriorating staff morale, can tend to lose their therapeutic or sheltering functions and take a more custodial and punishing aspect.

The underlying issues are more general and will be discussed in Chapter 25. All that need be said here is that it is not feasible for the 208 long-stay patients from the 31 December 1964 cohort who were still in various mental hospitals at the end of 1971 to be made the responsibility of the new Camberwell service.

3. The new build-up of long-stay patients with psychiatric conditions other than dementia

During the seven years from the end of 1964 to the end of 1971, 53 'new' long-stay patients accumulated who were not suffering from dementia. For the four years from the end of 1967 to the end of 1971 the equivalent accumulation was 27. Reasons were given in Chapter 9 why it might be assumed that 65 'new' long-stay places would build up over a period of ten years. The most recent statistical trends appear to suggest that this figure is on the safe side. On the other hand, it is clearly possible for such trends to change quite quickly from year to year since they depend upon the practice of a few clinicians. These clinicians are in turn influenced by the pressures from patients and relatives that they experience in their day-to-day clinical work. At the moment, there is no great pressure for long-term places but it will be necessary to operate the new policies for at least ten years (that is, 1967-77) before the full pressures of the new accumulation are experienced.

For the moment, therefore, the figure of 65 long-stay patients will be accepted as a basis for planning. The next question that arises is, where should these patients be accommodated? So far as patients who are not suffering from dementia are concerned, the study reported in Chapter 15 suggests a classification into six types of accommodation, three of which deserve special consideration.

3.1. LONG-TERM TREATMENT

The first of these was for patients whose treatment had not been completed within six months but who were expected to recover sufficiently to be discharged within a year or shortly thereafter. The numbers were not expected to be large. If more use were made of transfer to day-hospital after a period of in-patient treat-

ment, together with a greater use of other residential accommodation, it is doubtful whether many patients would need to stay in hospital for longer than one year purely to receive treatment. Those that did need to stay longer would be included within one of the other categories. An extension of long-term in-patient psychotherapy might prove an exception but would need evaluation. At the moment, the numbers of Camberwell patients involved are very small and no specific provision need be made beyond the one-year point.

3.2. LONG-TERM IN-PATIENT SUPERVISION

The second category was composed of patients who required considerable supervision over a long period of time because, by reason of mental illness, there was a high risk that they might endanger themselves or other people. The examples in the series studied were three young men suffering from schizophrenia and one middle-aged woman who was addicted to barbiturates. There were five others who might well have been included in the category and the data given in Chapter 19 show that a few other patients, not in hospital at the time of the survey of patients who stayed six months to three years, were also potential candidates for this group. None of these patients was, however, admitted on a court order (Section 60 or Section 65 of the Mental Health Act).

The problems of setting up a unit for such people hardly need emphasis. If they are resident for more than a year it would be inhuman to accommodate them in an ordinary hospital ward. The unit would be their home and it would need to be planned as such. Moreover, it should have a predominantly therapeutic orientation, the object being to terminate the period of stay as speedily as was consonant with the safety of all concerned. Morale among the staff would have to be high and this would call for exceptional dedication and special qualities of leadership among the senior members.

The South-East Metropolitan Regional Hospital Board's working party on the development of adult psychiatric services in the region (1971) suggested that a 'Security Unit' of 30-50 beds would be needed. The population covered comprises some three and a half million people so that, by these standards, an area of the size of Camberwell would hardly require a unit of its own.

The fact is that there is still little information on the numbers or types of patients who require 'secure' accommodation and it would be wise, in planning for Camberwell, to retain an open mind on the matter. Several surveys should be made over a period of years so

that more precise information could be made available on which to plan more rationally. Meanwhile no special unit would be set up.

3.3. SUPERVISED HOSTELS

The third category comprised a rather heterogeneous group of patients. One particular subgroup, however, is fairly clear-cut and has been confirmed by the findings of Chapter 19. This is composed of patients, mostly with chronic schizophrenia who need considerable supervision in order to ensure that they follow a fairly normal life routine; getting up in the morning, caring for their personal hygiene and appearance, eating adequately and spending a part of the day in a reasonably structured working environment (for example, attending a local day-centre or sheltered workshop). Mental hospitals provide villas for such patients, who work in the service departments, in the grounds or domestically on the wards. Their handicaps tend to be fairly stable in such a social environment but if subjected to the stress of everyday life or to the pressures of a more active rehabilitation unit the likelihood of relapse is increased.

A hostel for such patients would ideally be situated on the periphery of a hospital site, with the front door opening on the general community and the back door opening on the hospital grounds. An experienced nurse would be the best person to be in charge but, otherwise, fully trained nurses would not be necessary. It is a moot point whether such a hostel should be set up by the local authority or the hospital service and, ultimately, some kind of shared responsibility would probably be the best solution. For the moment, however, the pressures come from the hospital, local authority finances are strained to the uttermost, and the staff with the greatest skill and experience are in the mental hospitals. It would seem sensible, in the first instance, for the joint hospital to set up such a hostel, with the provision that eventually some share in its administration might be accepted by the local authority. In any case, the borough has no plans for this kind of hostel, closely associated with the hospital, within the next ten years and the need is urgent now.

So far as other types of patient are concerned, it is clear from the results of Chapter 15 that many do require long-term hostel accommodation of a somewhat similar type. A tentative estimate of 25 places needed altogether, 15 of them for women, would seem to cover the requirements during the next ten years. Experience of these provisions and of pressure on the available places would indicate what modifications or extensions of the plan were necessary.

Chapter 19 indicates that patients not already in hospital may also benefit from such hostel provision and that this may halt the slide towards destitution described in Chapter 21.

3.4. OTHER SPECIFIED ACCOMMODATION

Reference was made in Chapter 6, section 6.2, to the Windsor Walk Housing Association, a voluntary organization which has begun in a small way to provide bedsitters on a long-term basis for patients who might otherwise have to remain in mental hospital for a long period of time. Ten such places have already been established and, with encouragement from the hospital and local authorities, this form of service could be expanded. Early (1965) has indicated its value in Bristol. The patients involved are chronically handicapped but able to look after themselves with relatively little supervision from doctors, nurses, or social workers. They would, however, remain on the active list of those at risk of further breakdown.

Other specified accommodation needed would be in Part III hostels (for elderly people not suffering from dementia) and in facilities for the blind, deaf, chronic sick, and severely retarded. Only constant pressure from hospitals where such patients tend to find shelter and accumulate, together with co-operation with the appropriate voluntary bodies and local government authorities, is likely to ensure sufficient places. A significant proportion of the past accumulation in mental hospitals has been due to their filling in the deficiencies in other services. The shortage of Part III accommodation is particularly unfortunate, since many patients remain in hospital simply because their priority on the waiting-list is low, compared with that of patients who are not already in some kind of sheltered situation.

3.5. ACCOMMODATION OFFICER

Another valuable adjunct to the psychiatric services, not at present available in Camberwell, would be an accommodation officer, whose main function would be to find suitable housing for patients who did not need to remain in hospital but who were unable to find accommodation for themselves. Several boroughs have a roster of landladies who provide room and board for people who have been in hospital and who need a degree of protection although they can look after themselves and most have full-time occupation (in employment or at day-centres). The accommodation officer can also help with other types of housing problems and will have an expert knowledge of all the specialized residential units serving the area.

Again, it is an open question as to whether such a staff member should be employed by hospital or local authority social services department and, so long as the job is done well and the service is integrated, it does not much matter. The pressure, however, comes from the hospital though eventually a joint appointment would seem ideal.

3.6. SUMMARY OF 'NEW' LONG-STAY ACCOMMODATION

The numbers of patients requiring each of these forms of accommodation have not been specified except for the over-all estimate of 65 long-stay places. For purposes of practical planning, it may be suggested that 20 hospital beds will be needed for patients needing treatment or supervision for longer than one year, 25 hostel places still need to be supplied under hospital auspices, and 20 places will be needed in less intensively supervised accommodation such as that provided by the Windsor Walk Housing Association. These estimates are provisional and should be kept under review. Local authority accommodation, particularly Part III, also needs expansion.

4. Short-stay beds for the mentally ill

It was demonstrated in Table 4.6 that the residence rates of male Camberwell patients were similar to those of the Metropolitan regions and of England and Wales, both for short-stay and for long-stay beds. The same was true of long-stay beds for women. There was, however, a considerably higher rate for women who stayed for less than a year: 133 per 100,000 Camberwell women, compared with 81 per 100,000 in the Metropolitan regions and 74 nationally. The data presented in Chapter 13 show that a substantial proportion of admissions to hospital, particularly of women, could be prevented by setting up extra day-services and modifying their pattern of use. About one-third of the women meeting the selection criteria studied could perhaps have been treated elsewhere, accounting for about 20 beds. If the same proportion is assumed to hold for all patients under the age of 65, some 30 beds would be saved. (The results of a study of the older group are not yet available.)

The number of shorter-term beds used by the mentally ill at the moment is approximately 140 (see Table 9.5): 40 for men and 100 for women. The latter number could therefore be reduced to 70 so long as extra day-places were available to make up the difference.

5. Day-hospital services for the mentally ill

The idea of a more flexible policy of admission, so that patients could be admitted in an emergency to a ward or to a day-hospital,

or for a brief period of in-patient treatment followed by rapid transfer to the day-hospital, is attractive but it would be difficult to achieve at the moment, since many patients are admitted to St Francis's Hospital while the day-hospital is on the Maudsley site. The day-hospital would also need to be considerably enlarged since it would serve two different kinds of function, the treatment of acutely ill patients and the preparatory stages of rehabilitation. In-patient and day-patient care could be even further integrated if the two types of unit could be brought together, since the type of follow-up service described in Chapter 6, section 2.3, could well be incorporated into a combined unit.

The extra 30 day-places needed for the treatment of patients who would otherwise be admitted (see section 4 above) would be mainly for women. There are already approximately 20 Camberwell patients attending the day-hospital, roughly half men and half women. Follow-up visits might account for another 10 patients per day (allowing for an 'active supervision' list of some 100 patients, attending on average, once a fortnight). Sixty day-hospital places would therefore be needed (roughly equivalent to the 65 per 100,000 advocated by the DHSS, since about half of these are to be for patients in wards). About two-thirds of the places would be for women.

6. A district services centre

One solution to the present artificial separation between the in-patient and day-hospital services would be to set up a new combined unit on the Maudsley site, close to the workshops and to the new supervised hostels mentioned in section 3.3 above. This centre would combine the functions of the present St Francis's psychiatric wing (including its after-care service) with those of the present Maudsley day-hospital (including its preparatory rehabilitation functions). Thus 50 beds and 60 day-places would be needed for Camberwell patients; in addition, extra day-places for 15 patients living within easy reach but not in Camberwell would be required, in order to provide an alternative service. Space should also be provided for further day-places, in the event that even fewer patients need to be admitted to wards.

The basic plan of the centre would be to include two small ward units, for disturbed patients or for those needing close observation, but to provide self-contained bedrooms on an upper floor for most patients, rather on the lines of a hotel or university residence. Patients using these rooms would join the day-patients for much of the time and there would be common-rooms for evening and

weekend use. There would be adequate occupational provision and an extensive range of facilities for rehabilitation. Apart from the fifty in-patients, the day-patients might be living at night in the wards of the joint hospital, in the Maudsley or other hostels, in lodgings or in their own homes.

The main function of the in-patient unit would be to treat patients with relapsing conditions who were well known to the Camberwell services. Other patients could be treated in the wards of the joint hospital.

Table 22.1. *Suggested provision for those needing in-patient or day-hospital treatment*

	N	Rate per 100,000
<i>In-patient</i>		
'Old' long-stay (in mental hospitals)	100	—
'New' long-stay:		
Joint hospital wards	20	26.6
Supervised hostel	25	
Short-stay:		
Joint hospital wards	60	64.9
District services centre	50	
<i>Day hospital</i>		
(district services centre)	60	35.4

Table 22.1 gives a summary of the suggested in-patient and day-hospital services. Counting the supervised hostels as part of the hospital provision, 45 'new' long-stay and 110 short-stay beds are envisaged; giving a residence rate of 91.5 per 100,000 population, well above the norm of 50 per 100,000 laid down in the DHSS circular. This circular did not, however, include a figure for the 'adequate' number of places for chronically handicapped patients which was also recommended.

Further studies should then be mounted in order to discover whether the modified services were meeting the needs of patients and relatives and whether a further transfer of in-patient to day-patient places would be justifiable. Decisions have to be taken on the basis of the best information available but, once taken, they become themselves subject to evaluation.

7. Day-centres and workshops

Chapters 17 and 19 present evidence that substantial numbers of patients are completely unoccupied and too handicapped to obtain work in a competitive market but are not attending day-centres or

workshops. An intensive survey of the local day-facilities has not been undertaken, but they do not claim to achieve, for example, the standards of a Remploy factory. A further increase in the number of day-places available is inevitable if the trend described in Fig. 7.1 continues; that is, if more and more places come to be occupied by chronically handicapped patients needing permanent placement. The underlying problem will be discussed in Chapter 25 but it is already apparent at a practical level that there is likely to be a pressure on the available places. Both the quality and the quantity of the local authority day services need to be assessed. About seventy places are provided at the moment, nearly half of them long-stay.

The Maudsley rehabilitation workshop provides sixteen places for Camberwell patients and it would be possible to provide more if patients could reach its exacting standards. However, its policy should certainly be directed in the future towards preventing the severe secondary handicaps that were noted in Chapter 19. Once an attitude of mistrust has developed towards the hospital services, it is very difficult to gain the patient's co-operation long enough to help him achieve his full potential. Some, at least, of the patients described there (and also in Chapter 17), would have been more ready to accept that it was possible for them to climb the occupational ladder as far as the level represented by the rehabilitation workshop if the appropriate services, particularly the preparatory ones, had been available from the early stages of their illness. If the workshop were successful in this, however, it would mean that more places at the Remploy level of sheltered employment would need to be made available. Probably the best solution would be to upgrade one of the local authority day-centres to this level and to provide another at the intermediate grade.

The whole subject of long-term local authority day provision needs further investigation.

8. Out-patient and community services for the mentally ill

The out-patient service is already fairly extensive (all patients referred are seen within one week) and the emergency clinic provides an adequate service numerically. Domiciliary visiting by doctors also functions well but it would be useful to have an emergency domiciliary social work service. An 'active list' of patients who are at high risk of further breakdown is now being compiled and will form the nucleus of a preventive out-patient and domiciliary service. The only community service which is not

well developed is that of consulting to outside agencies but it is hoped that one of the Camberwell physicians will make this his special concern in future.

Relationships with the social service department of the local authority remain good. The field services have been reorganized into area teams, four of which cover the Camberwell area. One member of each team will be jointly appointed to hospital and local authority which means that the former close collaboration can be continued. Further study will be required of the overlapping areas between the duties of doctor, nurse, and social worker (see Chapter 25).

A Southwark-Maudsley liaison committee has been set up to keep all the problems arising in the area which affect both authorities continuously under review and all the plans mentioned in this chapter have been considered in detail by jointly appointed working parties.

9. Services for patients with dementia

In Chapter 6, section 5, and in Chapter 9, it was shown that some 15 short-term and 50 long-term beds were likely to be needed for patients suffering from dementia, though the trend has recently been towards lower numbers than this. A few short-term places are available in a hostel for the mentally infirm, Evelyn Coyle House; mainly to give a periodic respite to relatives who otherwise carry the burden of such patients. A few Camberwell patients also attend Evelyn Coyle House on a day basis but, so far, few patients with dementia have attended a day-hospital, mainly because most of the beds are in Cane Hill Hospital and day attendance is out of the question.

Ideally, all these patients should be cared for within Camberwell itself and the setting of the geriatric hospital would appear more appropriate than that of the psychiatric hospital. The geriatrician would be in general charge and the psychiatrist would be closely involved as a consultant.

If the plan to transfer the functions of the St Francis's psychiatric wing to a district services centre on the Maudsley site were adopted, the evacuated buildings at St Francis's would become available for other purposes and might well prove adaptable for use by patients with dementia. Since the rest of St Francis's is, in fact, a geriatric hospital, this would appear to constitute a practical solution. Many local problems would be raised which will not be discussed here since they are not strictly relevant to our present focus of interests, which is the Camberwell service. Moreover, St

Francis's is part of King's College group of hospitals and it would not be appropriate to do more than outline the main principles involved.

One of the chief difficulties is to know whether some of the beds at present used by patients with dementia would not be better placed in hostels which were run in close collaboration by the local authority and hospital. Local clinical opinion is in favour of such a solution (which has worked well elsewhere) and also of providing some day-hospital places.

Table 22.2 presents a possible redistribution of the 65 beds estimated to be needed over a period of ten years. Some 35 places

Table 22.2. *Estimated needs of Camberwell patients suffering from dementia who now occupy hospital beds*

Service required	Short-stay		Long-stay	
	M	F	M	F
Hospital beds	2	8	5	20
Day-hospital places	1	2	—	10
Hostels	—	5	1	14

would be in a local hospital unit, 5 would be in the short-stay hostel, 15 in a local authority long-stay hostel, and 10 patients would attend the hospital unit on a long-term day basis. A few extra short-term day-places are also included. The 55 residential places give a residence ratio of 2.8 per 1,000 Camberwell population aged 65 and over, which falls within the range recommended in the DHSS circular (2.5–3.0 per 1,000).

There is already a psycho-geriatric assessment unit which would be closely linked to any such reorganized service. The borough of Southwark has plans for a hostel which could be used in the way suggested. Since the numbers shown in the table would build up only gradually over a ten-year period there would be plenty of time for experience to accumulate and for modifications to be incorporated in the plan.

10. Other services

Many other services have not yet received detailed attention although most are now under review. The services for children with psychiatric disorders are a case in point as are services for patients who are addicted to alcohol or other drugs.

One particularly important problem for any service dealing with Camberwell is the presence of the Reception Centre in the very

heart of the area. It is quite clear from the data presented in Chapter 21 that this problem cannot be tackled locally; its scale is regional, even national. Recommendations for dealing with the numerous and varied problems presented at the Centre are being put forward in the context of the full research report and they will not be considered here. However, the joint hospital, if it takes over full responsibility for the area from the regional board, will need to be concerned in some way with the clinical problems arising at the Centre, perhaps by means of a medical link through a jointly appointed consultant and registrar.

11. Comparisons with national rates

The estimates made in this chapter depend upon many assumptions, some of which may prove to have been wrong. If the extra facilities required to replace the use of mental hospital beds, in particular the supervised hostels and the district services centre, did become available, so that admissions to Cane Hill could be stopped altogether, and if the basic assumptions were correct, the hospital services being used ten years later are estimated to be as shown in Table 22.3. The estimated number of long-term beds

Table 22.3. *Estimated hospital places required for Camberwell patients*

Type of hospital facility	Dementia		Adult mental illness		Total	
	M	F	M	F	M	F
<i>'New' long-stay</i>						
Hospital wards	5	20	12	8	17	28
Supervised hostel	1	14	15	10	16	24
<i>Short-stay</i>						
Hospital wards	2	8	40	70	42	78
Supervised hostel	—	5	—	—	—	5
Total short-stay	2	13	40	70	42	83
<i>Day-hospital</i>	1	12	20	40	21	52

Note. In addition, 100 'old' long-stay patients originally admitted from Camberwell will probably still be in various mental hospitals in 1980, about 60 of them in Cane Hill.

needed for treatment or supervision might turn out to be too low and the estimated number of short-term beds, particularly for women, might turn out to be too high. Further evaluation is needed on both these points. Certainly any rigid imposition of an ad hoc formula seems quite out of place. Flexible planning is

required, based on an on-going programme of evaluation, revision and further evaluation.

Comparisons with national rates are difficult since equivalent information to that provided in this book is not available. In 1969, the residence rates of patients staying in hospital less than one year (including those suffering from dementia) were 55 per 100,000 men and 74 per 100,000 women in England and Wales. The equivalent rates calculated from the figures given in Table 22.3 are 52 for men and 93 for women. Taking into account the fact that the hospitals concerned are teaching hospitals (the implications of which will be discussed further in Chapter 25) the differences do not seem very great.

If all the short-stay and long-stay beds are considered, including those in hostels set up at the instance of hospitals and run in close collaboration with them, the rate becomes 124 per 100,000 total population. This figure does not include the 'old' long-stay patients who will still be in various mental hospitals scattered round London during at least the next fifteen years.

The guideline laid down in circular HM (71) 94 suggests that 50 beds will be sufficient for all purposes per 100,000 population. No details are provided as to how this figure should be split to accommodate men and women, or long-stay and short-stay patients, nor how quickly it is supposed to come into operation. It is agreed that additional facilities will be required by teaching hospitals but no guidance is given as to how much. Perhaps the figure in Table 22.3 which is most comparable is the number of short-stay adult mentally ill patients (not suffering from dementia), which amounts to 65 per 100,000 population. Without very much more information about how the national estimate is derived, and how much it will be allowed to vary to fit local circumstances, there is little point in making further comparisons. The underlying question of providing for the longer-term handicapped will be more speculatively discussed in Chapter 25.

PART SEVEN

MENTAL RETARDATION

Services for mentally retarded children and adults

*Lorna Wing, J. Corbett, Dierdre Pool,
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1. Definitions of terms

(Lorna Wing)

1.1. MENTAL RETARDATION

Throughout this chapter, the term 'mental retardation' will be used instead of the now outmoded 'mental subnormality'. The former has been adopted by the World Health Organization and is used in the 8th revision of the *International Classification of Diseases* (WHO, 1967). The term 'mental handicap' is now used by the British Department of Health as a synonym for mental retardation, but this usage is to be deplored. Mental handicaps of many different kinds are found in patients suffering from schizophrenia, other functional psychoses, dementia, dysmnestic syndromes, aphasia, various neuroses, and other conditions. Mental retardation itself is not a homogeneous impairment but comprises widely different disabilities. These do, however, have in common the effect of retarding the child's intellectual, emotional, and social development so that the term 'mental retardation' is accurate as well as convenient. It carries no pejorative overtones except for those that inevitably become attached to any label denoting a socially unattractive condition. There seems no reason not to accept it.

1.2. GRADES OF SEVERITY OF MENTAL RETARDATION

The definition of different grades of mental retardation is a complicated problem. Until the 1959 Mental Health Act 'mental deficiency' was the legal term used for mental retardation in

general, and people labelled in this way were commonly divided into idiots (intelligence quotient less than 20 approximately), imbeciles (intelligence quotient 20-49 approximately), and feeble-minded (intelligence quotient 50-69 approximately). The Mental Health Act substituted the terms 'mental subnormality' and 'severe subnormality'. The former was roughly equivalent to the previously used 'feeble-minded' and the latter covered both imbecility and idiocy. In the present paper, the former will be replaced by the term 'mild mental retardation' and the latter by 'severe mental retardation'.

The definitions in the 1959 Act were descriptive, including social and educational as well as intellectual criteria, and levels of intelligence as measured by tests were not mentioned. However, research workers in the UK tend to use an IQ of below 50 as the definition of severe mental retardation, and an IQ between 50 and 69 as the definition of mild mental retardation. These have been adopted as a practical compromise to give some readily definable standard of comparison between different studies. It is fully recognized that definition by IQ alone is extremely unsatisfactory, but definitions which give a more detailed description of each patient's handicaps and skills are, as yet, not sufficiently standardized to permit comparative work. It is to be hoped that this situation will change in time.

The difference between the legal definition and that based on measured intelligence level is seen most obviously among the mildly retarded group. Many children with IQs of 50-69 receive education in special schools (or even in schools for normal children) without being legally labelled 'subnormal'. Similarly adults in this category may live independent lives, work, marry, and bring up children without coming to the notice of the services. Conversely, some children and adults with IQs of 70 or more may (for many different reasons) function at a level which necessitates contact with the mental retardation services. There is less disagreement between the legal definition and that based on IQ in the case of severe mental retardation, since almost all children and adults with IQs below 50 need care and supervision, most of them having obvious biological handicaps accompanying their intellectual backwardness.

The World Health Organization's *International Classification of Diseases* (8th revision, 1967) uses 'mild retardation' to refer to people with IQs of 52-67. Those with IQs of 51 and below are labelled moderately (IQ 36-51), severely (IQ 20-35), or profoundly (IQ under 20) retarded. These last three groups combined are therefore almost, but not quite, identical with the category 'severe mental retardation' used in this paper.

In Camberwell, the great majority of children who are under the care of the mental retardation services and who are educated in schools for severely retarded children¹ or in special care units have intelligence quotients below 50 (see Table 23.3). Only a few are above this level, and they are placed in the schools for severely retarded children because their level of achievement falls well below that expected from their performance in IQ tests. Conversely a few children with IQs below 50 are placed in schools for the educationally subnormal (ESN schools).

It should be emphasized that Camberwell contrasts with many other areas of the UK in having so few mildly retarded children in schools for severely retarded children. This is because there is generous provision of places in ESN schools. It will be interesting to see if the situation will change now that the schools for severely retarded children are under the education authorities, instead of being a separate system under the health department. Since admission to such a school no longer involves the legal label of 'unsuitable for education' with all the emotional connotations for parents, it may be that these schools will further develop their expertise with children who have complicated and severe learning problems. The actual IQ level may then lose its importance as a major factor in placement. Future staff training will be of crucial importance in determining the development of this aspect of the educational service.

With regard to adults, a higher proportion of mildly mentally retarded people are catered for by the Camberwell mental retardation services than is the case for children. Some who attended ESN and other special schools as children are unable to find work as adults, and need to attend the adult training centre for sheltered employment. Others become social problems and are admitted and readmitted to mental retardation hospitals (see section 5.4).

2. History and recent development of the local authority services

(Sybil Yeates)

The health, education, and social services departments of the local authority have duties to provide certain services and are

1. These schools were originally known as junior training centres, and in the last few years of their existence as junior training schools. They were previously run by local health authorities and were not part of the educational system. The Education (Handicapped Children) Act of 1970 placed the responsibility for the education of all children, whatever the nature and degree of their handicap on the education authorities. The former junior training schools and special care units were, from April 1971, known officially as schools for the educationally subnormal (severe) and schools for the educationally subnormal (special care).

empowered to provide others for severely mentally retarded children and adults. Aspects of these services which have undergone recent change or are of particular importance will be described below.

2.1. DETECTION AND ASSESSMENT OF HANDICAPS IN CHILDREN

Local health authorities are responsible for the ascertainment of mental retardation. In Southwark an observation register of children at risk of developing handicapping conditions (physical or mental) is kept. Children are placed on this register if there are abnormalities in family history, pregnancy, delivery, or neonatal period, or if their physical or mental development gives cause for concern when they are seen by the health visitors and welfare clinic doctors. Local hospital paediatric departments often notify handicapped children to the local authority although there is no statutory obligation to do so. Children who are known to be physically or mentally handicapped are also noted on the 'handicap' register. Regular follow-up of the children on both registers is arranged by the local authority medical officer concerned.

The medical officers are involved in examining handicapped children to decide which type of special educational treatment is appropriate. (Before 1971, when the local education authorities assumed responsibility for the education of all handicapped children, the medical officer was responsible for ascertaining whether or not a child was 'suitable for education in school'.)

The purpose of early detection of mental retardation is to provide appropriate services to help the child and his family. Many of these services are a local authority responsibility.

2.2. DAY AND RESIDENTIAL SERVICES

1. *Administration*

These services were formerly provided by the local health authority, but the responsibility is now divided between the local education and social services departments. In the case of Camberwell, the former is the Inner London Education Authority (ILEA). The services are as follows:

(a) Special schools for the educationally subnormal (severe) including special care units, which the ILEA has a mandatory duty to provide under the Education (Handicapped Children) Act 1970. They were formerly known as junior training centres. The two schools serving the whole of Southwark are Tuke (incorporating the special care unit) and Kirkwood. They are now generally referred to as 'junior training schools'.

(b) Adult training centres, provided under the Mental Health Act 1959, Part II Section 6 (2), and now run by the social services department. There is one such centre in Southwark, called Crispin House.

(c) Hostels for children and adults, similarly provided under the Mental Health Act 1959, Part II, Section 6 (2). Southwark has one hostel for young women, called Dover Lodge, and one for young men, called Gibson House, also now run by the social services department.

(d) Preschool care in day-nurseries, provided under the National Health Service Act 1946, Section 22 (i), now run by the social services department. There are at present four day-nurseries with special units in Southwark, and a fifth is soon to be opened.

2. Early development of day training schools

It is interesting to look at the history of the two schools, Tuke and Kirkwood, which became the responsibility of the ILEA on 1 April 1971, and particularly to note that 1972 appears to mark fifty years of progress in this field.

There have been schools for 'backward' or educationally sub-normal (i.e. mildly mentally retarded) children in Camberwell since the year 1900. The records of the LCC show that Gloucester Road School and Leo Street School, Asylum Road, were the earliest in the area, both having been used from 1900 onwards. Highshore School, formerly known as Victoria Road School, was also used from the year 1906. At this time there was no provision of day-care for the severely mentally retarded by the local authority.

Considerable progress was achieved by the Mental Deficiency Act of 1913 under which the LCC became responsible for the ascertainment of the mentally retarded. At least this must have given some indication of the size of the need for a service, and it seems possible that it was the onset of the First World War that hindered any further immediate progress. However, by 1922 the LCC made it known that they wished to adopt a limited scheme for providing occupation centres, 'for the training and occupation of mental defectives under supervision', but as they had no powers to enable them to provide such establishments, they made substantial grants to voluntary bodies who were already running them. The London Association for the Care of the Mentally Defective did in fact provide a service for Southwark and Camberwell children and young people. In 1923 they opened a centre at St John's Institute, Larcom Street, SE17 which functioned for five sessions a week and had an average daily attendance of eight.

In 1924 this moved to the Browning Hall, SE17, and in 1926 to St John's Parish Hall, Stead Street, SE17, which was to be a more permanent home for the centre. By 1927 the centre had doubled its activities and was open for ten sessions weekly.

The Mental Deficiency Act of 1927 provided the next impetus to the service. Under Section 7 (2) of this Act, local authorities were empowered to run occupation centres themselves. Accordingly on 1 April 1931, the LCC took over many of the centres it had been subsidizing, including St John's centre.

In 1929, two craft centres were opened for older boys, and one of these was situated in the former LCC Blind School in Albany Road, SE5.

In 1935, St John's Centre extended its activities again by providing classes for 'elder girls' and young women, so that by 1935, there was some sort of service for a fairly wide age-range.

In 1936 there was a major change of organization, with the setting up of the Hatcham Occupation Centre in Canterbury Road, near the Old Kent Road, and in 1937 there was yet another move to Ilderton Road, SE 15. But the story ceases again in 1939, with the onset of the Second World War.

After the war, by 1949, provision had again been made by the LCC for groups described as juniors, elder boys, and elder girls. 1949 seems to have been a particularly significant year. Accommodation at the Orchard Mission Hall, near Queen's Road, Peckham, was rented to provide day-care for 25 mentally defective elder boys. In the same year, a centre for 45 elder girls was opened at St Chrysostom's Hall, Peckham Hill Street, which continued to function until 1955 when better premises were obtained at the Clifton Congregational Church Hall, Studholme Street, SE15. This hall was judged suitable for 60 elder girls and it accommodated them until 1959. When Orchard Mission Hall had to close for war damage repairs later in 1949, the elder boys were transferred to All Saint's Hall, in Blenheim Grove, SE15. But Orchard Mission Hall reopened in 1950, giving 'improved' accommodation, with the rent increased by £10 per annum. The new rental was £185 per annum. It was then used for juniors and continued in use until 1959. In this year, again significant, a new purpose-built centre was opened in Lewisham. Some Camberwell children were transferred there. Others were transferred to Studholme Street, which then began to become the 'Peckham junior training school', of recent years. Yet others went to Herne Hill Centre, which transferred to Kingswood House, Dulwich, in 1966 and to Kirkwood Hall, SE 15 in October 1967. The present head teachers of Tuke and Kirkwood Schools were originally with the

Peckham and Herne Hill junior training centres respectively.

An important administrative change occurred in 1965, with the reorganization of local government in London, when the training centres were taken over by the health departments of the London boroughs. The borough of Southwark took over the responsibility for Peckham and Herne Hill training centres.

3. Peckham junior training school

The accommodation occupied by the Peckham junior training centre, subsequently renamed junior training school, in the Clifton Congregational Church Hall, Studholme Street, SE15, must have been typical of its kind and it is worth describing. The fifty children were in three classes. The infants had a small room to themselves, but the junior and senior classes shared the main hall, where there was also a stage. The children and staff worked on long tables. These, together with the chairs and all the equipment, had to be packed away each afternoon. The supervisor had a small room, where the staff also had their lunch, where medical and psychological examinations took place, where ill children were cared for, fractious children calmed, and disturbed children generally 'coped' with. The stowing system, whereby large amounts of equipment and materials were piled and stacked in this room was particularly ingenious. The rooms were badly ventilated and appallingly cold in the winter. Washing and toilet facilities were totally inadequate. There was no outdoor play space. In spite of all the difficulties this was an excellent training centre, with a delightful and dignified atmosphere. There was no shortage of equipment or apparatus, for the staff exploited every means of obtaining it or of obtaining the money to buy it. The curriculum was surprisingly wide, in spite of the cramped accommodation, and the children had regular outings. It was almost impossible for staff to cope with incontinence or behaviour disturbances, yet no child was excluded from the centre without very careful and prolonged discussion with the medical officers, social workers, and all concerned. However, occasionally parents had to be told that their child could not attend the centre and this was a most agonizing decision for everyone. (When the new special care unit finally opened in January 1970, it was implicit from the start that no child would be excluded because of any disability.)

Thus, while all the premises available for the care of severely mentally handicapped children consisted of church halls or other halls used by the general public it was not possible to give day-care to those who were also severely physically handicapped or who had severe disorders of behaviour.

4. *The first special care unit*

Another step forward in the service was achieved by the acquisition on 30 January 1968 of a 'pre-fab', i.e. a prefabricated family dwelling house in East Dulwich Grove, which was rented from the housing department of the borough of Southwark. This consisted of three rooms, a kitchen, and a bathroom with WC. There was also the blessing of a garden. This unit, which was the first special care unit in Camberwell, offered ten places, five days a week, for children in the borough of Southwark. One place was divided so that two children could attend part-time. The children were mainly accommodated in the two front rooms, which looked out on to the main road. The third room was a multiple-purpose room, being used as a staff room, for storage of big equipment, to accommodate the medical officer and so on. Children were brought to and from the unit by a health department minibus, provided with suitable harnesses, and supervised by an escort.

This unit was very suitable for severely handicapped children with additional physical disabilities but its layout of small intercommunicating rooms precluded the admission of the hyperactive child with aggressive tendencies. However, it was undoubtedly a great success. It was run by three staff, one of whom acted also as escort on the minibus. It became a close-knit community supported by the parents, social workers, and many other people associated with it, such as the minibus driver and the ladies from the Meals-on-Wheels service of the welfare department who delivered the midday meals. Some of the neighbours became interested and there were only very occasional complaints from surrounding householders.

The population of this first special care unit was almost stationary, the only changes occurring when one or two children went into long-term care. Therefore, although some relief was provided for a few families, there was still a formidable waiting-list. This could not be cleared, or even much reduced, until the opening of Tuke junior training school and special care unit, in January 1970.

5. *Tuke junior training school*

It has been well worth while to recount the travels of the occupation centres and the training schools from one church hall to another, for this part of the history of the service has a satisfying conclusion. Provision was finally made by the health committee of the borough of Southwark for a purpose-built junior training school, at a cost of more than £90,000. This was built during

1969, in Harders Road, Peckham, SE15. The borough employed interested and enlightened architects, Gordon Bowyer and Partners, who produced a most interesting and imaginative building, despite an awkwardly shaped site. The new building is designed in three sections with an octagonal central hall. The main classroom section, for 75 children, is on two floors, but the special care unit for 20 children and the nursery unit for 20 children are both built on one floor only. All three sections have separate utility provisions and separate play areas. The special care unit has its own entrance and, in fact, can function completely separately from the rest of the school, although staff and kitchen facilities are communal. The main school section contains a domestic science room and a craft room. It is worth mentioning that the only three mature trees on the site were preserved!

Children can now be educated in separate, attractive, and highly functional classrooms. These same classrooms contain the equipment that had been accumulated in the Peckham junior training school. There are spacious, step-in, storage cupboards to replace the cardboard cartons and boxes of Studholme Street. The hall houses the splendid gymnastic equipment presented by the Southwark Society for Mentally Handicapped Children. The school is named after Daniel Hack Tuke (1827-95), an early physician concerned in the field of mental health.

6. Tuke special care unit

When Tuke School opened in January 1970 it was at once apparent that the special care unit would have to extend from its purpose-built suite containing two adjoining rooms into one of the classrooms in the nursery wing. However, on 12 January, 19 Southwark children were admitted to the unit, 14 of these being from the Camberwell area. Of these 14 children one had received no previous day-care, 7 came from the original special care unit in East Dulwich Grove, and 6 had been excluded from junior training schools for severe behaviour problems or intractable incontinence. As was anticipated, the admixture of extreme physical disability and helplessness, with hyperactivity and aggressive, antisocial habits, gave rise to enormous problems. A natural division seemed to take place, dividing what was loosely called the immobile room from the hyperactive room. (The glass screen between the two rooms has been a most useful barrier which still allows communication.) Over the following months further children were admitted, including two from Camberwell, aged 11 years and 13 years respectively, who had had no previous day-care. The third special care room was geared to take children who were neither immobile, nor

very mobile, and it was hoped that a few of these might pass into the main school. At the beginning of the autumn term 1970, there were 32 children on roll at the unit, of which 19 were Camberwell children.

The sudden expansion of the service brought to light the incipient problems within a short time. The staff ratios that had previously been accepted were found to be inadequate. It was felt that all the old standards of staffing should be rewritten, for some of the children needed almost individual attention. A ratio of one staff to two children would have been more realistic for the hyperactive group. Staff shortages, of course, lead to anxieties and these increase the level of absence through sickness. Extraordinary qualities are demanded of the staff of such a unit. It is indeed little wonder that there are difficulties in recruiting sufficient staff of the right calibre.

Some of the deficiencies of the carefully planned building also began to become apparent. An ablution area was found to be slightly too small for a suitable changing table to be kept *in situ*. The position of the bath in the bathroom rendered it useless. The shape of the medical room made an adequate developmental assessment almost impossible. A great deal has been learnt from this new and highly attractive building. This knowledge can be used to the benefit of the new building for Kirkwood school, which is now in the planning stage.

The problems caused by the sudden inflation of the special care unit were remarkably eased by the timely opening of Hilda Lewis House in August 1970 (see section 3.3). Those children who had been causing most concern to the staff and to their parents were admitted immediately. This gave the staff a very valuable breathing space. It also gave them a great sense of security. For here was a unit whose staff would assess, advise, visit, discuss, and keep in touch. Never before had so many people, including consultants, psychologists, social workers, occupational therapists, and nursing staff, taken so much interest in these children. It was a novel and highly valued experience for the staff to take part in regular case conferences. It must be stressed how valuable and heartening has been this upsurge of interest in the children at Tuke and Kirkwood schools. There have been regular visits between schools and hospital and these form a vital hospital-community liaison, which must be continued and expanded further.

A special care unit caring for 30 children is probably bigger than the optimum. As regards the future, the time must be envisaged when the plans for Kirkwood school materialize. These include a special care unit with 20 places, which together with the 20 at Tuke, will give 40 for the whole borough. Unfortunately, this still will

not be adequate as the present size of the waiting-list shows. Each unit would contain children from Camberwell, although the site for the new building is in Bermondsey. It is salutary to remember that the present unit now has a waiting-list and there are children at present in the special units of the day nurseries who are approaching school age and will need special care. This has once again become a problem requiring urgent solution.

7. Preschool services

The services offered to the preschool, mentally retarded child are becoming increasingly important. In 1965, when the borough of Southwark came into being, there were special units for physically or mentally handicapped children in two day-nurseries in Wyndham Road, Camberwell, and in Bishops House, Kennington. There are now four special units in the borough and a fifth will be opening shortly. These will provide forty-four places which give five-day care all the year round, bank holidays being the only exception. It is important to note that four of these units are purpose-built. In common with the other services described, the nursery units serve the whole of the borough, transport being provided to take the children to and from their homes.

8. The adult training centre

The services are completed by the adult training centre and the hostels for young men and young women. Mention has already been made of the early efforts to provide training during the post-school years. In 1965, an adult training centre was opened in the Benhill Hall, SE5. In June 1969, this transferred to the magnificent building now known as Crispin House, which stands on the site of the Old Grange Tannery, Grange Walk, SE1. One of the original tannery buildings, known as the Troopship Block, was incorporated in the development. The spacious accommodation for 180 trainees at Crispin House includes two light industrial workshops, a domestic science 'flat', classrooms, and a pleasant dining-room and sitting-room for the trainees. Training can be provided here for those young people who can ultimately go out to work in the community. Others can find secure, sheltered, and suitable employment for many years of their life. There is also a place for those who cannot work in any way but benefit from the training and stimulation of the smaller community within the centre. The continuation of education for the school-leaver is of utmost importance and one looks forward to the time when the ILEA might be actively concerned with the education of the 16-21-year-olds within the adult training centre.

9. *The hostel service*

The hostel service at the moment remains very limited. Gibson House, which is a purpose-built hostel for young men, forms part of the Crispin House development. It has rooms for twelve residents. Dover Lodge, a big family dwelling-house in Wood Vale, SE23, accommodates twelve young women. There is enormous need for a hostel for children and the requirements for hostels for adults will increase sharply in the next decade. There is a site and there are plans for the children's hostel, the responsibility for which passed to the social services department of the borough of Southwark in April 1971.

One looks forward hopefully to a further five years of progress, similar to that which has been described between 1965 and 1970.

2.3. SOCIAL WORK SERVICES

Social work is discussed in detail in Chapter 20, and the history of the local authority social services is summarized in Chapter 3. It is worth emphasizing here that, before the 1959 Mental Health Act, the 'local assistant organizers', one of the three categories of social workers employed by the LCC, specialized in working with mentally retarded people. As a consequence of the Mental Health Act this specialization disappeared, and the mental health social workers (mental welfare officers) were employed by the health departments of the local authority to deal with both psychiatric illness and mental retardation.

The Social Services Act 1970 continued the move away from specialization. The welfare, children's, and mental health departments of the local authority have been combined into the new social services department. The social workers who previously worked in one of these fields only, now have a much wider range of problems to deal with. It remains to be seen whether this new system of generic social work will provide a good service for all types of problems and handicaps, or whether certain groups, particularly the mentally retarded, will tend to take second place. It is also difficult to predict whether the generic social workers, with their wide responsibilities, will have the time to acquire the expertise necessary for working in the field of mental retardation. This involves detailed knowledge of all the day and residential services, the special services such as free incontinence pads and laundry, the financial help available, and the possible emotional problems of the relatives produced by the presence of a retarded person in the family.

In Camberwell, social work services for mentally retarded

children and adults were, until the opening of the unit in Hilda Lewis House (see section 3.3), supplied almost entirely by the local authority. Now the children who are admitted to this unit, or are seen as out-patients, are visited by the unit's social worker who collaborates closely with the local authority social services and health departments. A few families are also seen by social workers from voluntary societies concerned with childhood handicaps. Children under 5 years of age are visited by health visitors from the local authority health department, although they may be referred to the social services department if social work help is needed before school age is reached.

As explained in section 2.2, until 1971 the training schools and special care units for severely retarded children were run by local health departments. The mental welfare officers were also employed by the same department, and were automatically notified of each retarded child as he reached school age, if he was ascertained as unsuitable for education in a school run by the local education authority. In 1971, when the education authorities became responsible for the education of all children, the *automatic* notification of mentally retarded children to the social services department ceased. However, the local authority health department still has knowledge of all retarded children because of its child welfare and school health services. In Southwark, the two departments, health and social services, are currently arranging to re-institute a system for the exchange of information concerning handicapped children, because past experience had proved how useful this was.

The ILEA education welfare service is now also involved with some families of severely retarded children and will be co-operating closely with the social services department.

3. History and recent development of the hospital services

(W. Wollen and J. Corbett)

The histories of the two hospitals and one hospital unit (all serving Camberwell) to be given in this section once again illustrate the familiar evolution, since the middle of the last century, of the residential services for patients with any kind of chronic handicap (see Chapter 3). The story began with high hopes which proved to be unrealistic. Then followed a period of pessimism and attempts to deal with handicapped people by isolating them. After this came the slow process of improving the existing hospitals which had deteriorated in the long period of neglect. The latest stage is a

return to the idea of community care and the provision of small, locally based residential units to replace the large institutions. The future success of this policy depends entirely upon the provision of adequate alternatives to the large mental hospitals. If this is not done, there may well be a return to the era of pessimism the consequences of which are still to be found in the residential services.

3.1. THE HISTORY OF DARENTH PARK HOSPITAL

1. *Administrative history*

The 'Darenth School' for 500 'imbecile' children, modelled on the French 'school for idiots' built in France since 1837 and in this country since 1846, was opened on 18 November 1878. After a year it became clear that, in order to avoid returning those over 16 to unsatisfactory family environments and breaking continuity of training, more accommodation and training facilities were needed. Accordingly, the asylum for 1,000 adult 'imbeciles' was built in 1880, followed in 1888 by the 'pavilion' section for 'improvable' young patients, bringing their number, by 1896, to 2,260.

In 1911 Darenth Park became Darenth Industrial Training Colony for 'trainable cases of mental deficiency' and the management was transferred from the Children's Committee to the Metropolitan Asylums Board. In 1919, it was renamed Darenth Training Colony and much emphasis was placed on the training of 'high-grade mental defectives'. By the end of the nineteenth and the beginning of the twentieth century, it was seen that hopes of restoring 'defective' brains to normality were not being fulfilled and at the same time the large group of people who were feeble-minded began to attract much attention. As the latter were thought to be responsible for the majority of crimes, vagrancy, drunkenness, prostitution, and sexual offences, attempts were made to introduce stringent eugenic measures of segregation, isolation, prohibition of marriage, and even sterilization. As a consequence of these beliefs and attitudes multistoried buildings forming the institutions for 'mental defectives' were erected far away from the community centres to house as many residents as cheaply as possible. Self-sufficiency of institutions became the rule and, in line with these directives, Darenth Colony grew most of its food, drew water from its own well and produced clothing, furniture, etc., as well as gas for heating and lighting, at least until 1927 when conversion to electricity took place.

In 1930 the LCC took over from the Metropolitan Asylums Board. In 1936 Darenth Training Colony was renamed Darenth Park (hospital).

From 1948, following the Health Service Act, the hospital was

administered by the South-East Metropolitan Regional Board. The Mental Health Act of 1959, by removing the designation of hospitals, made treatment and training in Darenth Park available not only for the mentally retarded but also for patients suffering from all other types of mental disorder. This increased the variety and interest of the work of the staff. For example, special attention began to be paid to the previously neglected group of psychopaths, with or without subnormality of intelligence, who, after the 1959 Act, could be admitted to the hospital.

The introduction of informal admission, which was effected by the same Act, altered the status of patients, opened the few doors that remained locked, speeded up discharges into the community and created better relationships, between the patient, his family, the hospital, and the local authority. The re-classification of patients immediately after the Act produced the figure of 70 per cent informal and 30 per cent detained under order, which gradually changed to the present 94·5 per cent informal and 5·5 per cent detained.

Involvement with the local communities served by the hospital was increased by the establishment of three out-patient clinics between 1951 and 1969. In addition, a number of wards were converted into hostels for patients who were able to go to work outside the hospital.

2. Education and training

When the Darenth School was first opened, the education and training provided was based on the theory that the dormant faculties may be awakened and brought back to normality by Seguin's intensive 'learning by doing'. The teaching staff consisted of a headmistress, five assistant mistresses, and seventeen industrial trainers, all of whom also helped in the wards, thus remaining with their charges for the whole day. The children, classified according to their abilities, were grouped in five classes: nursery, kindergarten, testing, oral-manual, and '3R'. Various forms of handicraft were also taught with the aim of preparing children for the occupations they were to follow when transferred to the adult section at the age of 16.

By 1919, when the emphasis was placed on the training of high-grade patients, the school population had grown to 582, industrial shops were expanding and socialization of patients was helped by a boy scout troop, girl guide company, and the patients' 'military' band. In 1926 the General Nursing Council approved Darenth Nursing School and participation of the final-year student nurses in the industrial training became a regular feature.

In 1933 an occupational therapy scheme was started initially for fifty blind patients, but was soon extended to those suffering from cerebral palsy, epilepsy, and parkinsonism. By 1934 expansion of workshops reached its peak and further farm and domestic training was provided for men in Chaldon Head Hostel in Surrey and for women in Leytonstone House in London, E11. Until 1937 women patients were receiving no reward whatsoever for their work, but the men were given the equivalent of 6*d.* in tobacco and cigarettes. In 1937 the scale of payments from 3*d.* to 1*s.* was approved but, because of the war, implemented only in 1947, with increases in 1950 from 1*s.* 6*d.* to 6*s.*

The outbreak of the Second World War in 1939 not only halted a much-needed modernization programme, but, owing to the acute shortage of staff and rationing, also crippled the industrial training and output. In 1947 an attempt was made to recapture pre-war efforts and, although the number of patients in workshops decreased, the men began to be employed outside the hospital removing rubble from bombed-out areas and working on the building sites. The extensive ornamental gardens, orchards, glass-houses, and farm covering 103 arable acres and 46 acres of grass-land, provided training for 80 patients, with weekly classes in farming and horticulture. However, it was clear that Darenth Park's industrial production could not compete with outside industry, in spite of new machinery such as a Heidelberg automatic printing machine, carding machine, an electric hand tin shearing machine, bookbinder's perforating machine, etc. The scheme of converting in the workshops the hair mattresses to interior sprung ones for the whole hospital brought no extra revenue but considerably contributed to hygiene and comfort of the patients.

By this time the hospital had been getting so many unstable and disturbed patients that a special scheme was devised for their treatment and training with the help of Drs Tizard and O'Connor (who were then working in the MRC Social Psychiatry Unit). Their personality test battery aimed to discover the extent to which emotional disturbance among mental defectives resulted in bad work record and behaviour disorder and indeed a number of test results did show a fairly close association between neurosis and work success on daily licence. This knowledge was used and within twelve months 50 per cent of fifty-five maladjusted patients had outside wage-earning jobs.

In the meantime, with the assistance of the Ministries of Labour and Health, several local factories agreed either to employ the patients or to subcontract the work to the recently opened Social

Adjustment Centre where payment was calculated by converting trade-union female rates into piece-work and paying the patient in accordance with the effort shown. Gradually a firm link was established with local industries and commerce and the number of male patients on daily licence grew from 70 in 1949 to 223 in 1951, when it started to decrease to the present 60. The openings for females never exceeded 12, but they were trained in the hospital in needlework, soft toy making, sock and jersey knitting, rug-making, housewifery, and plain cooking. In November 1971, arrangements were made for a group of severely retarded patients with IQs of 30-50 to work daily at the Intertruck factory in Dartford.

3. The admission of children

As mentioned above, the original Darenth School provided places for 500 children. By 1930, the number of children, after reaching 600, started to diminish as other institutions were making provisions for the children in their areas. In 1934 the number of children had fallen to 62 and, after the Education Act 1934 was passed, the children ceased to be admitted for long-term care until 1954. However, in 1952, the short-term care scheme under Circular 5/52 was implemented by the admission of 15 children with the peak of 99 in 1964 and with an average of 60 per annum until the present day.

In 1954, because of the increasing pressure from the community, where services for the mentally retarded remained inadequate, admission of children into one of the 'pavilion' wards started for the first time since 1934. In 1958 the second children's ward was opened permitting their regular intake to the peak number of 140 in 1968. The year saw the reduction of children from 140 to 122 to combat overcrowding and to improve the standard of care, with a further reduction to 70 in 1972.

3.2. GOLDIE LEIGH HOSPITAL

Goldie Leigh, built originally in 1902 as a children's home, soon became a hospital for children's skin diseases, but decline in this speciality resulted in its partial conversion in 1961 to units for mentally retarded children. On 18 May 1961, Bostall Unit with 54 beds, for cot and chair cases, was opened and almost immediately filled from the waiting-list of 69. The psychiatric cover was provided by a consultant psychiatrist from Darenth Park Hospital.

In 1962 the hospital for mentally retarded children was opened and a supervisor with seven assistants also trained severely handicapped children on the wards. The physiotherapy and speech

therapy departments were developed and facilities for hydro-therapy were provided.

In December 1963 two more units for semi-ambulant and ambulant mentally retarded children were opened and in 1971 a further unit for mentally retarded children was added allowing reduction of the numbers of children in Bostall Unit, with the ultimate aim of providing a number of small (12-bed) units.

In 1970 the link with Hilda Lewis House at Bethlem Royal was established by the introduction of reciprocal psychiatric sessions in Darenth Park/Goldie Leigh and Bethlem Royal (see section 3.3).

3.3. HILDA LEWIS HOUSE

1. *Planning and organization*

In common with many recent developments in the provision of residential care for retarded children, the design of Hilda Lewis House was profoundly influenced by the work of Tizard and his colleagues. In the Brooklands experiment (Tizard, 1960, 1964; Lyle, 1960), sixteen severely retarded children from a large sub-normality hospital for children were cared for in a small domestic unit run along the lines of a family group children's home, with a nursery regime, relatively free activity and a somewhat higher staff/child ratio than existed in the parent hospital. They were compared with a matched control group who remained in the hospital and were found over a period of two years to have improved socially and behaviourally, particularly on tests of their verbal ability. Lyle (1959) showed likewise that comparable severely mentally handicapped children living at home have a better vocabulary than those living in an institution.

Subsequent work has confirmed Tizard's view that residential accommodation for the retarded child should, as far as possible, take the form of small homes, containing groups of up to ten children of mixed ages and sexes, living a socially normal life and run on family lines by staff trained in child care. The institutionalizing effect of large hospitals, often oriented mainly towards medical and nursing supervision, has been sufficiently demonstrated (Tizard *et al.*, 1966; King and Raynes, 1968; King *et al.*, 1971).

Kushlick (1966) adopted the Brooklands model in setting up a hostel for all the severely retarded children in an area of Southampton who need residential care. Nursing skills are utilized but the setting is mainly non-medical, although selection is purely according to residential criteria and no child is excluded because of the severity of his handicaps or his behaviour disorder.

Hilda Lewis House was planned to take these ideas into account but its main function is to act as a short-term assessment unit, so

that the setting is a hospital and the staff is composed of doctors, psychologists, occupational therapists, and nurses. Twenty-four boys and girls up to 16 years old are cared for in small groups with separate recreational, teaching, sleeping, and eating facilities. An attempt was made to combine the maximum flexibility for children with various handicaps with provision for more intensive care, treatment, diagnostic, and research facilities. Provision was also made for the accommodation of two mothers at a time. The building lies on the periphery of the hospital site adjacent to a main road but accessible to the local shops and community.

After long delays building started in 1969 and the unit was opened in July 1970. The first step was to consider the integration of its functioning with the local hospital and community facilities. It was decided that approximately eighteen of the beds should be used initially for children from a limited catchment area. Although the unit was built at the Bethlem Royal hospital some three miles from the southern extremity of Camberwell, this was the catchment area chosen, for the following reasons:

(a) It was the catchment area of the remainder of the community services provided by the joint Bethlem and Maudsley hospitals.

(b) The Camberwell Register provides a frame of reference for evaluating the community service provided by the unit.

Close links were established with Darenth Park and Goldie Leigh hospitals and children from their catchment areas are admitted for assessment and treatment to Hilda Lewis House. Consultants from the three hospitals have joint appointments so that liaison is free and flexible.

Hilda Lewis House opened in July 1970. During the first year fifty-nine children have been admitted from Camberwell (see Table 23.1) and during this period no child from Camberwell has been admitted to long term hospital care elsewhere.

Prior to this time a waiting-list for long-term care had been kept by the regional hospital board and children on this were given priority for admission to the unit.

Referral to the unit has usually been through the local authority principal medical officer with special responsibility for the mentally retarded (who has an honorary attachment to the joint hospital), after consultation with the social worker concerned with the family. The child has then been seen initially at the junior training school and later at a domiciliary visit carried out by the consultant or the senior registrar from the unit together with one other member of the unit staff. This visit is co-ordinated by the unit social worker and provides an opportunity to assess the child's handicaps in the

Table 23.1. *Admissions to Hilda Lewis House, 30 July 1970 to 30 July 1971*

	<i>N</i>
First admission	50
Second admission	9
Third or subsequent admission	7
Darenth Park catchment area	4
Camberwell district	59
Other areas	3
<i>Length of stay</i>	
Less than two weeks	4
More than two weeks, less than one month	26
More than one month, less than three months	21
Three months, less than six months	9
Six months, up to one year	6

context of the family situation. It also allows the staff member who will meet the child on admission to get to know him and discuss practical problems of day-to-day care, such as feeding, special clothing, and various likes and dislikes. This is often a major concern to the parents of severely handicapped children who are very familiar with their child's limited repertoire of responses and it lessens their reasonable anxiety about the effects of separation and admission.

The member of staff is usually a nurse but may be a teacher, occupational therapist, or psychologist. He or she writes a report on the visit, so that all members can relate the children's home situation to the environment provided on the unit. The opportunity to observe the effects on the family of the treatment of specific handicaps and short-term care constitutes valuable training and it is therefore extended to as many different staff members as possible.

In cases of urgency a domiciliary visit is always made by the consultant in charge of the unit who has, in agreement with the other local consultants and local authority, taken on responsibility for this service in the case of children from the Camberwell district.

In less urgent cases where the parents are able to manage, or when children come from outside Camberwell, patients are seen in the out-patient clinic in the children's department at the Maudsley hospital. On the whole the out-patient appointments have proved difficult for parents with handicapped children and less informative. Home and school visits are therefore made, following the out-patient appointment, in all cases.

2. Medical assessment

History-taking follows lines similar to that used in the remainder of the joint Bethlem and Maudsley hospitals, with more detailed information about specific handicaps of behaviour, language development, and the acquisition of social skills. A routine physical examination, including a standardized neurological assessment, is carried out by the senior registrar. The consultant paediatrician visits the unit twice weekly and provides a link with the paediatric department of King's College Hospital, where further detailed assessment of hearing, vision, and other handicaps is carried out in appropriate instances.

A physiotherapist from a neighbouring unit for physically handicapped children visits the unit in liaison with the unit occupational therapists to advise on the management of children with cerebral palsy.

A routine pathological screening of specimens of blood and urine has been devised and a technician visits the unit regularly to separate and prepare samples of blood from a single venepuncture for chromosomal and biochemical analysis, emphasis being placed on clinical pathology and, in particular, plasma and urinary amino-acid chromatography.

So far no previously undiagnosed cases with biochemical or chromosomal abnormalities have been found, which reflects the adequacy of the previous paediatric assessments, but it is hoped by this systematic investigation to devise effective and economic methods of screening for use in the community service. Other routine investigations include chest and skull X-ray, dermatoglyphics, and dental assessment.

Electro-encephalography is carried out at the unit as part of an MRC project on the epidemiology of epilepsy in severely retarded children. So far, four cases of previously untreated epilepsy have been found.

3. Psychological assessment

In addition to psychological testing, which focuses on building up a profile of the child's major handicaps and skills and which may be of practical value in devising individual treatment programmes, a therapeutic conference is held by the psychologist during the second week of the child's stay and is attended by the teacher, occupational therapist, senior registrar, and the nurse who has had most contact with the child. At this meeting, the child's handicaps are identified and a programme aimed at managing each of them is devised, including educational and training approaches as well as more specific behaviour modification techniques.

This programme is then typed out and hung up in the duty room so that all staff may be aware of the child's individual programme and maximum consistency obtained. The programme is extended or modified at intervals during the child's stay as his behaviour and therefore his treatment needs alter. New techniques are worked out, and ultimately form the basis of that part of the discharge report which provides practical suggestions for managing the child's handicaps after discharge. This is sent to the junior training school or other agency mainly responsible for the day-to-day care of the child and also provides a basis for continuing work with the family. In drawing up individual programmes, use is made of checklists covering the major areas of the child's handicaps in day-to-day living (behaviour problems, feeding, toileting, and other social skills) as well as language development. These checklists were devised by the unit staff and, perhaps for this reason, have proved more acceptable than previously published scales.

When this preliminary assessment has been completed (three to four weeks after admission, or in some cases earlier if the child is in for short-term care) a full assessment conference is held which is also attended by the visiting consultants, local authority principal medical officer, and social worker, a teacher from the junior training school and other outside visitors by invitation. Here a full account of the assessment is presented and discussed in the light of future plans for the child. This weekly conference is the major teaching occasion on the unit. Visitors to the unit are frequently present.

4. Unit staffing

A summary of the unit staff in July 1971 is given in Table 23.2. There were 11 full-time staff and 15 part-time. Six were trained nurses, usually in more than one field of nursing; 4 were generally trained, 5 trained in work with mentally retarded patients, 3 with general psychiatric training, and 4 with experience in other hospitals. Two have also been trained in child care work.

A crucial feature of the staffing has been the attempt to build up an integrated team caring for the children to which widely differing previous experience can be contributed and shared. This has been facilitated by the architecture of the unit in which areas for teaching, occupational therapy, and nursing are poorly defined and by such simple measures as the decision not to wear uniform, as well as the holding of frequent meetings of the unit staff at all levels.

It seems likely that in the further development of the unit, staff

Table 23.2. Unit staff.

	<i>Sessions</i>
<i>Medical</i>	
Consultant child psychiatrist	4
Consultant paediatrician	2
Honorary consultant in mental subnormality	1
Part-time honorary senior registrars	2
Senior registrar	Full-time
<i>Nursing staff</i>	
Administrative nursing officer	1
Charge nurse	1
Deputy charge nurse	1
Deputy sister	1
Staff nurses	2
State-enrolled nurses	2
Nursing assistants	10½
<i>Other</i>	
Psychologists: part-time lecturer	1
full-time lecturer	2
Psychiatric social worker	1
Teachers: one full-time (establishment for 2½)	1
Occupational therapists	2

roles will come to be more sharply defined but with participation of all members in the total pattern of child care, in counselling of families, in some assessment procedures and in the use of specialized techniques such as behaviour modification which cut across disciplinary barriers and provide a common language and sound theoretical basis for devising treatment programmes.

Because of the difficulties of recruiting nurses an attempt has been made to assemble an integrated team of well-trained senior staff, the junior staff being mainly untrained but given in-service training.

5. Grouping of the children

Over the first year an attempt has been made to subdivide the children into groups along the lines of the Brooklands experiment.

This has been difficult mainly because of the short stay of many of the children and the heterogeneous nature of their handicaps. (In the Brooklands experiment the children were ambulant, non-psychotic, non-epileptic, and functioning at imbecile level.)

The first year has ended with two major groups, the 'Lambs' (cerebrally palsied and other dependent children) and the 'Lions' (ambulant, less dependent but more behaviourally disturbed

children). On the whole the older psychotic children have been catered for in the second group and have required more individual attention. The children remain in these groups for the major part of the day, coming together in periods of free play and for group activities such as gymnastics, music, and outings.

6. Psychological treatment

Considerable emphasis has been placed on the development of specific training programmes to overcome individual handicaps and operant techniques have been widely used, both with individual children and to a lesser extent in groups.

Generally speaking, the primary aim of these programmes has been to gain control over the child's behaviour and attention. Food rewards have been used initially, for example, by rewarding the successful completion of a task, but progress is rapidly made towards the use of social rewards.

A pilot token economy was set up over a three-month period with members of the 'Lions' group. It was confined to mealtime behaviours with the aim of extending it to other areas of the children's activity if it were found useful. The initial finding was that this type of management and training technique was less suitable for use in this unit than it would be in hospitals with a more permanent population since its benefits to those children in the unit for only a few weeks were negligible.

However, a further study is being considered with children staying for a longer time. The use of tokens has also proved useful in the case of individual children where a more extended reward system has been necessary.

Language handicaps are of major importance with many severely retarded children. Operant programmes directed towards enhancing language development have been used with non-communicating children with varying degrees of success. The more successful programmes have been those carried out with children who already have minimal speech. A system of mime has been found valuable both as an alternative means of communication and as a reinforcement of speech and use of it has resulted in considerable increase in the speech and decrease of disturbed behaviour in a psychotic retarded girl.

Psychiatric and paediatric treatment have involved such widely diverse aspects as the evaluation of psychotropic drugs in the modification of behaviour, psychotherapy, treatment of families in conjunction with the adult psychiatric service, the management of epilepsy, and of epidemics of minor infection which have been not infrequent in a unit providing much short-term care.

7. Home contacts

Children remain in the unit for the first two weeks after admission and after this return home each weekend. Arrangements have been made with the local education authority to transport the children to and from home, escorted by a nurse from the unit who can meet the parents. There are rarely more than six children in the unit at weekends. Parents appreciate the value of five-day care even with the most disturbed children. This gives an opportunity for intensive group care with the smaller number of children at weekends.

There are bedrooms for two mothers on the unit and these have been used by eleven mothers, who have come for two to four nights each week in order to gain experience and to help with the treatment programmes. Follow-up discussions with the psychiatric social worker or psychologist take place at home after discharge. Evening group meetings of parents have also been held.

8. Discharge, follow-up, and reassessment

Discharge reports give a summary of the medical and psychological reports containing recommendations for practical management. This summary is sent to the child's GP, the paediatrician, and local authority health and social services departments. The psychologist's report is also sent to the head teacher of the junior training school. Follow-up visits are made to the junior training school and the home, and out-patient appointments are also made. Sometimes, the child is subsequently readmitted for short-term care, if behaviour again becomes disordered or if the parents need a period away from the child.

9. Research

As part of a postgraduate teaching hospital, Hilda Lewis House has a commitment to research as well as to providing a service. Initially the major research effort is being devoted to an epidemiological evaluation of the severely mentally retarded children in Camberwell. This is described in more detail in section 5.5. An examination of the handicaps and service needs of mentally retarded adults is also planned, based on a one-day census from the Camberwell Register.

10. Future development

It is hoped that, when the projected children's hostel in Camberwell is completed and paediatric facilities for assessment and residential care of physically handicapped children in the community are developed (see Chapter 24), the unit in Hilda Lewis

House will be able to function more specifically as an assessment and treatment centre for behaviour disorders in mentally retarded children.

4. An experimental dental service for handicapped children

(Dierdre Pool)

4.1. BACKGROUND TO THE STUDY

Handicapped children need dental care just as much as normal children but, because of their other problems, their mouths are often neglected. However, good dental health is particularly important to the child who is handicapped. The unsightly appearance of carious teeth and diseased gums together with an associated halitosis may be a serious bar to the social acceptance of a mentally retarded child or adult. In addition, the common problems of speech, mastication, and feeding may be exacerbated by dental neglect.

Adelson (1965) in studying a group of mentally retarded patients found that many had dental abscesses, pulpal exposures, and rampant caries which would commonly cause pain, but they had not given any clear indication that they had suffered pain. He also found that by treating the patients and eradicating possible sources of discomfort there was a significant improvement in some aspects of behaviour such as tooth-grinding, drooling, and poor eating that were previously assumed to be due to the general mental retardation. The question is posed 'Do we know when the mentally retarded child or adult is in pain?'

Whether handicapped children have more or less dental disease than normal children is the subject of some discussion. Swallow (1965) reported that there was no greater caries prevalence though periodontal disease was found to be a greater problem, particularly for those in residential care. Magnusson and De Val (1963) found that the young cerebral palsied child had slightly more caries than the control group and periodontal disease was much more prevalent. It seems probable that handicapped children living at home have a similar caries rate to normal children but unfortunately in many cases the amount of dental care they have received is not comparable; more extractions and fewer fillings are carried out for mentally retarded children and adults even though they may be quite incapable of using dentures at 'the end of the line'.

Mentally retarded people are entitled to dental treatment under the Health Services Act 1946, Section 20, but they have to compete

for dental care with the rest of the population. It is scarcely surprising that, with the shortage of dental manpower, many dentists are unwilling to accept patients who may take up more time, be exhausting to treat, and possibly make strange noises which the dentist considers may disturb the other patients. The general dental practitioner is paid by item of service, so he receives the same fee for filling the tooth of a normal adult as he would for a noisy, difficult, handicapped child.

The local authority dental services have a duty to examine and offer treatment to schoolchildren. Since the Education of Handicapped Children Act 1970, school provision for the severely mentally retarded child is the responsibility of the Department of Education so he should now benefit from the school dental services on the same footing as children attending ordinary schools. However, the handicapped child has a special need for dental care so provisions should be made over and above those available for other children.

4.2. SETTING UP THE STUDY

Because of the difficulty many families had encountered in obtaining dental treatment for their handicapped child, some workers in Guy's Hospital children's dental department have been investigating the feasibility of taking dentistry to the children in the schools and centres.

The Handicapped Children's Aid Committee generously donated a well-equipped mobile surgery, a large converted Ford van with a lift at the back for wheelchairs, etc. Equally generous help was also received from the Spastics Society and the DHSS. When the unit was first set up it was used to relieve the problem of treating handicapped children in an over-crowded hospital department but as so many children were being referred for extractions under general anaesthesia it was decided to tackle the problem at source by going out to the schools and centres to investigate the problem of the dental care of handicapped children in the area.

For the purpose of setting up a dental service handicapped children can be divided into three groups:

Group I. Children for whom dental disease and its treatment present special hazards.

This group includes children with many physical disabilities such as congenital and acquired heart disease, bleeding diatheses, etc. These children do not necessarily present any problem in management. The most important aspect of their care is prevention and early treatment.

Group II. Children whose physical handicaps make dental treatment difficult to obtain.

Large numbers of physically handicapped children have never received regular dental care because their immobility makes it such a problem to get to the dentist. Once in the dental chair they may not be any more difficult to treat than normal children, though many are naturally anxious at first due to their past experience in hospitals. However, we have found, treating them away from a hospital environment, that they are usually cheerful, co-operative patients.

Group III. Children who are likely to have difficulty in accepting dental treatment.

Although many normal children have difficulty in accepting dental treatment at least they can understand the purpose of it and, if persuaded of its value, most will eventually co-operate. There is a large group of children with mental retardation who could be considered as potentially difficult patients. They are unable to understand the purpose of dental care so, to secure their co-operation, a different approach is required.

Also included in this group are children with multiple physical handicaps together with mental retardation and children with special handicaps such as autism and other conditions causing behaviour disturbances. These children often present a serious problem in the dental chair. Some may have to be treated under general anaesthetic though, unfortunately, they are often adversely affected by staying in hospital and may be better treated on a day-stay basis when it is considered medically advisable.

Group III provided the greatest number for our study. Because so many parents have had difficulty in finding someone to take on the dental care of their mentally handicapped children, very few of the children in the group had received adequate dental care in the past. There were certainly some problems in treatment but it is interesting to note that, once they became accustomed to the mobile unit, most severely retarded patients accepted dental treatment under local anaesthesia quite readily.

The main problem seems to be that because of their own fear of dentistry and fear for their child, many parents avoid taking their handicapped child to the dentist. They assume he will react badly, so that by the time they arrive at the dentist, dental disease is often so far advanced that mutilating extractions are the only possible treatment.

During the past three years the mobile dental unit has visited special schools and day-nurseries for the mentally and physically

handicapped children in the boroughs of Southwark, Greenwich, and Lewisham. We have also visited special care units for children with multiple handicaps and a residential hospital for severely mentally retarded, physically handicapped children.

The main aims of the project were to assess the need for dental treatment, to discover if there was a demand from the parents for the need to be met and, finally, to establish whether it was possible to carry out dental treatment in the mobile unit at the school or centre. We were most interested to find out the proportion of children requiring general anaesthesia for all or part of their dental treatment. In addition to this we hoped to gain information about the dental treatment of handicapped children and their reactions.

4.3. RESULTS

It was found possible to examine and assess nearly all the children. When it was not possible to do a full examination at the first visit, it was completed at a later date. After the initial examination, forms were sent to the parents informing them of the findings and inviting them to allow their children to be treated in the mobile unit at the school. Even if no active treatment was required, preventive treatment and regular examinations were offered. The treatment given consisted mainly of polishing and scaling the teeth and fillings and extractions under local anaesthesia. Preventive treatment in the form of prophylaxis and topical fluoride application was given as routine to all the children.

When a child was able to understand, he was given instruction in oral hygiene. In addition to this, advice on diet and oral hygiene was given to parents, nurses, and others who had the care of the children. Unfortunately, very few parents attended to make use of this important part of the programme.

It was found that 75 per cent of the children were in need of some treatment and very few had received regular dental care in the past. Approximately 78 per cent of parents gave permission for their children to be treated in the mobile unit. A small number (5 per cent) failed to return the consent form and the remainder attended general dental practitioners, hospitals, or the school dental service.

Of the children for whom consent was given, 95 per cent were treated in the mobile unit. The figure includes many children who needed regular examinations and preventive treatment only. When treatment was completed the children were seen every four months throughout the experimental period of three years. It was found necessary to admit approximately 5 per cent of the children to

hospital for treatment under general anaesthesia. This was usually because they were found to be unmanageable in the dental chair or, occasionally, because they required so many extractions it was considered advisable to carry out treatment in hospital. No child was given more than one general anaesthetic. Follow-up examinations, prophylaxis, and fluoride treatments were carried out in the mobile unit.

4.4. ADVANTAGES OF TREATING HANDICAPPED CHILDREN IN A MOBILE UNIT AT THE SCHOOL OR CENTRE

1. *Availability*

Many of our children have to make so many visits to hospital and other centres that their dental needs have been neglected. They may also be unable to use public transport and a visit to the dentist by ambulance can take a whole day. This may present a real problem to a mother with other children to care for.

2. *Prevention and early treatment*

One of the problems in treating handicapped children is that their parents assume they will behave badly and therefore put off bringing them until they are in pain or dental disease is in an advanced state. Many of the children seen in hospitals need several extractions early on in treatment: an unfortunate introduction to treatment for any child. By seeing the child at the school we hope to discover dental disease at an earlier stage and prevent new disease arising. Also, if a child is noisy in the mobile unit it causes less upset to parent and dentist than it would in a busy practice or hospital.

3. *Children in groups*

Usually several children are brought into the mobile unit at one time. This has a two-fold advantage: it cuts down time spent fetching children from ward and classroom and, by watching others during treatment, the more anxious ones are often reassured. In some of the schools we are able to make use of our patients; some may mix amalgam while others tidy up or even wash the floor and make coffee. This can become somewhat chaotic at times but the informal atmosphere helps to reduce anxiety and enables us to treat many more children than would be possible in a hospital environment.

When a child is brought to a hospital or clinic by ambulance the feeling of both parent and dentist is that as much as possible must be done in one visit. By taking the hospital to the child, this pressure is relieved and often treatment may be carried out more

successfully in repeated short visits. A child may be seen every day for a week to complete treatment. Because the child is so readily available there is nothing to be lost by trying again.

4.5. DISADVANTAGES OF THE MOBILE UNIT

1. *Lack of parental involvement*

We have been disappointed in the interest exhibited by parents; although so many agreed to their children receiving treatment, very few were willing to attend when their children were examined. Perhaps it is too easy for the parents! Many just sign the form and feel this discharges their responsibility for the dental care of their child.

2. *The problem of periodontal disease*

After the initial treatment has been carried out we take the mobile unit back to the school once a term. For normal children four-monthly visits to the dentist are considered to be adequate. Many handicapped children suffer from periodontal disease because of the stagnation due to inadequate mastication, soft diet, and poor oral hygiene. It has been disappointing to note that in many instances the state of the periodontal tissues has not improved, particularly in those children whose parents never attended while the mobile unit was at the school. The problem of dental caries seems to be more easily managed than the problem of periodontal disease.

4.6. CONCLUSIONS

There is certainly a need for a special service to be set up for the dental care of handicapped people to prevent them from becoming dentally handicapped in addition to their other problems. Perhaps the ideal service should have three parts:

- (a) Early counselling and preventive treatment.
- (b) Easily accessible routine dental care for the handicapped of all ages.
- (c) Specialized centres for more advanced treatment, treatment under general anaesthesia, and the management of particular medical or behaviour problems.

When a child is first investigated for mental and physical abnormality, dental examination should be included either as part of a combined clinic, or as an automatic referral. If this is done early it should be possible to teach parents to care for their child's teeth and gums. The earlier this advice is given, the more effective

are the results because the child's dietary habits and the attitude of parents to dental health are established at a very early age. It is sad to see so many children are only referred by our medical colleagues when dental disease is already rampant.

Readily accessible regular dental care must be available to all the handicapped. If a child cannot attend the family dentist with the rest of his family, then the use of mobile clinics or surgeries on the premises of schools and centres are probably the best way of treating the handicapped. This must be extended to include those who do not attend centres regularly, such as the elderly and disabled. For these people, transport may be needed to take them to the nearby clinic. These peripheral clinics should take care of the bulk of routine dental treatment and prevention. In addition to seeing the dentist every four months the dental health of mentally retarded children could be improved by employing auxiliaries and hygienists to visit more frequently to help with oral hygiene and advise parents on particular problems.

Specialized centres are needed for the referral from the peripheral clinics and the general dental practitioners. Most handicapped people should be treated as normally as possible and therefore a general anaesthetic should only be used as a last resort. When treatment under general anaesthesia is indicated, particular dental, anaesthetic, and nursing skills are required. Often mentally retarded people do not fit into the routine of an ordinary hospital ward, therefore specialized centres where they can be admitted for one day or more are an essential adjunct to the peripheral clinics and mobiles.

Parents of handicapped children are usually very anxious to do all that is possible for their children and, in the care of the teeth, they can feel that they are making a positive contribution to their child's health and well-being.

5. Statistics concerning the use of services: monitoring and evaluating the effects of changes

(Lorna Wing)

5.1. COLLECTION OF INFORMATION

Information concerning mentally retarded children and adults is recorded on the Camberwell Register (L. Wing, 1971a). Information is collected from:

- (a) The local authority health department handicap register.
- (b) The records of the social services department.
- (c) The special units in day-nurseries.

(d) The schools for severely retarded children and special care unit.

(e) Two nearby centres for spastic and for retarded children run by voluntary bodies.

(f) The adult training centre.

(g) The local authority hostels.

(h) Residential homes run by the local authority social services department, and those run by voluntary or private bodies.

(i) Area hospitals for the mentally retarded.

(j) Hilda Lewis House.

In addition, for children, information is routinely collected from ESN schools, and a unit for partially deaf/partially blind children, both of which have some children with IQs of less than 50. Data from other special schools are not collected routinely, but details are available when children enter these schools after having being known to the mental retardation services.

5.2. MONITORING CHANGES IN THE CHILDREN'S SERVICES

The effects of the changes in the children's services will be presented by discussing the result of two census surveys of children aged 0-14 (L. Wing, 1971a), the first on 31 December 1967 and the second three years later.

Kushlick and Cox's scale of social and physical incapacity (Kushlick, 1970) was completed for each child who appeared in the first census by the training school teacher, health visitor, nurse, child care worker, or mental welfare officer as appropriate and this material was analysed together with Register data.

1. *Prevalence on 31 December 1967*

Table 23.3a shows that the age-specific prevalence of school-age children with IQs below 50 (including those in ESN schools) was 3.89 per 1,000,¹ a figure which is of the same order as that found by Lewis (1929) in three urban areas for children aged 7-14 (3.71), and Goodman and Tizard (1962) in Middlesex for children aged 5-14 (3.34).

Table 23.3b gives the numbers and age-specific rates of children under the care of the mental retardation services on the census day. The children under 5 years old were too young for reliable testing of IQ but were included on clinical evidence of presumed severe

1. The population base used for all the subsequent tables is obtained from the 1966 sample census, corrected for under-enumeration.

Table 23.3

(a) *Ascertained prevalence of severely retarded children (IQ 49 or below) of school age on 31 December 1967 (numbers and age-specific rates per 1,000)*

<i>Age-group</i>	<i>N</i>	<i>Rate</i>
5-9	51 (5)*	4.09
10-14	40 (1)	3.66
5-14	91 (6)	3.89

* The figures in brackets represent the children with IQs of 49 or below who were in ESN schools on the census day. They are *included* in the absolute numbers and rates.

(b) *Retarded children under the care of the mental retardation services on 31 December 1967 (excluded from education in school, or thought likely to be excluded on reaching school age)*

<i>Age-group</i>	<i>N</i>	<i>Rate</i>
0-4	47	3.12
5-9	50 (4)*	4.00
10-14	40 (1)	3.66
0-14	137 (5)	3.56

* The figures in brackets represent children with IQs of 50 or above who were excluded from education in school. They are *included* in the absolute numbers and rates.

retardation recorded by the local authority medical officer or the paediatrician concerned. All children with Down's syndrome were automatically included. It should be noted that the rate for these children was not much lower than that for those of school age, which suggests that a high percentage of the severely retarded children in Camberwell are detected in the preschool years.

The age-specific rates for school-age children under the care of the mental retardation services were similar to those for children with IQs below 50. The fact that placement depended on achievement, rather than on IQ alone, in practice affected only a small percentage of the children.

Table 23.4 shows the numbers of children under the care of the mental retardation services who had additional handicaps as measured by Kushlick's and Cox's scale. Altogether 51 per cent of all children and 45 per cent of those over 3 years of age had a marked physical or social incapacity. If the children under 5 were excluded, because their small physical size made non-ambulance or incontinence less of a problem than in the older children, there were still 41 per cent with additional problems.

Table 23.4. *Retarded children aged 0-14 in the care of the mental retardation services on 31 December 1967 (numbers and age-specific rates per 1,000).*

SOCIAL AND PHYSICAL INCAPACITY	AGE-GROUP							
	0-4		5-9		10-14		0-14	
	N	Rate	N	Rate	N	Rate	N	Rate
1. Non-ambulant	21 (11)*	1.39	10	0.80	2	0.18	33	0.85
2. Ambulant and								
(a) Severely incontinent	5 (4)	0.33	7	0.56	4	0.37	16	0.42
(b) Severely disordered in behaviour	5	0.33	3	0.24	3	0.27	11	0.29
(c) Severely incontinent and disordered in behaviour	2 (1)	0.13	6	0.48	2	0.18	10	0.26
(d) Not severely incontinent or disordered in behaviour	14 (2)	0.93	24	1.92	29	2.66	67	1.74
Totals	47 (18)	3.12	50	4.00	40	3.66	137	3.56

* The figures in brackets represent the numbers of children under 3 years of age.

It can be seen that the numbers of non-ambulant children declined markedly with increasing age, but the relationship between severe incontinence or severe behaviour disorders on the one hand and age on the other was less clear-cut.

Table 23.5. *Retarded children in the care of the mental retardation services on 31 December 1967 (numbers and age-specific rates per 1,000).*

Service by age-group	0-4		5-14		0-14	
	N	Rate	N	Rate	N	Rate
Not attending day or residential centre (visited by health visitor, social worker, or occupational therapist)	22	1.46	16	0.68	38	0.98
Day-nursery unit	14	0.93	3	0.13	17	0.44
Day special care unit	1	0.07	3	0.13	4	0.10
Junior training school	—	—	47	2.00	47	1.22
Other day-care	2	0.13	1	0.04	3	0.08
Home: private or children's department (long-term care)	6	0.40	4	0.18	10	0.26
Mental retardation hospital (long-term care)	2	0.13	16	0.68	18	0.47
Total	47	3.12	90	3.85	137	3.56

The services provided for the children at the time of the census are shown in Table 23.5. The majority of children (80 per cent) were living at home. Of the 28 in long-term care, nearly two-thirds were in mental retardation hospitals, and the rest were in small residential homes.

At the 31 December 1967 census, 38 (26 per cent) were living at home and not attending day-centres, although visited by MWOs or health visitors. Twenty-two of these were under 5 years old and presumably many of these were too young to need day-care. However, there were 16 children of school age (18 per cent of those aged 5-14) who were also without any day provision apart from occasional home visits. Of these, 9 were non-ambulant and 5 were severely incontinent or disturbed in behaviour and must have presented a severe burden to their family.

2. Prevalence on 31 December 1970

The important innovations in the services which occurred between 1968 and 1970 have been described in sections 2 and 3. Table 23.6 shows that the total prevalence rate on 31 December 1970 was similar to that in the census of 31 December 1967. Measurements of the social and physical incapacities of the children are being repeated as part of a systematic study of retarded and psychotic children (see section 5.5). This started in February 1971 and will not be completed until the end of 1972. It is probable, however, that the proportion of children with additional handicaps will be similar to that in the census of 31 December 1967.

The major change that had occurred by the time of the second census was that only one child of school age was left at home without day-care, compared with sixteen on 31 December 1967. This particular child has since been admitted to Hilda Lewis House. The numbers of children in nursery units and training schools remained virtually unchanged. (The additional places made available by the opening of the new unit were mainly utilized by children from parts of the borough outside Camberwell.) On the other hand, twelve more children were placed in the new special care unit, and this has afforded considerable relief to their families. Despite the increase in day-places there were slightly more children in long-term residential care, although after the opening of Hilda Lewis House, none had been admitted to the large area mental retardation hospitals. It should be emphasized that the figures given in Table 23.6 do not include children receiving short-term care for temporary family relief, or short-term admission for diagnosis and assessment.

Table 23.6

(a) *Ascertained prevalence of severely retarded children (IQs of 49 or below) of school age on 31 December 1970 (numbers and age-specific rates per 1,000)*

Age-group	N	Rate
5-9	55 (5)*	4.41
10-14	43 (6)	3.94
5-14	98 (11)	4.19

* The figures in brackets represent the children with IQs of 49 or below who were in ESN or other special schools on the census day. They are *included* in the absolute numbers and rates.

(b) *Retarded children under the care of the mental retardation services on 31 December 1970*

Age-group	N	Rate
0-4	44	2.92
5-9	50 (2)*	4.01
10-14	37 (5)	3.39
0-14	131 (7)	3.41

* The figures in brackets represent the children with IQs of 50 or above who were excluded from education in school. They are *included* in the absolute numbers and rates.

(c) *Retarded children in the care of the mental retardation services on 31 December 1970*

Service by age-group	0-4*		5-14		0-14	
	N	Rate	N	Rate	N	Rate
Not attending day or residential centre (visited by health visitor or social worker)	23	1.53	1†	0.04	24	0.62
Day-nursery unit	13	0.86	—	—	13	0.34
Day special care unit	—	—	16	0.68	16	0.42
Training school	—	—	43	1.84	43	1.12
Other day-care	3	0.20	—	—	3	0.08
Home: private or children's department (long-term care)	5	0.33	8	0.34	13	0.34
Mental retardation hospital (long-term care)	—	—	17	0.73	17	0.44
Hilda Lewis House (long-term care)	—	—	2	0.09	2	0.05
Total	44	2.92	87	3.72	131	3.41

* The children under 5 years of age are on the Handicap Register and are thought to be severely mentally retarded on clinical grounds.

† This child is now in Hilda Lewis House (as on 6 June 1971).

5.3. SERVICES FOR PSYCHOTIC CHILDREN

Childhood psychosis produces retardation of specific aspects of cognitive development, and is often (though by no means always) associated with severe general retardation. It is, therefore, appropriate to consider the services for psychotic children in this chapter.

On the census day (31 December 1970) there were nineteen children with home addresses in Camberwell diagnosed as 'autistic' or 'psychotic', who had contacted a psychiatric or sub-normality service since the Register started on 31 December 1964. They are all included in the group selected for study in the survey of severely retarded and psychotic children (see section 5.5) but, at the time of writing, they have not yet been investigated. Therefore, no details can be given of the types of behaviour disturbance shown, nor the severity of the children's handicaps. It is not certain that the diagnosis of childhood psychosis will be confirmed in all cases.

Twelve of these children (71 per cent) were being cared for by the mental retardation services (and are included in the tables giving numbers of children who were severely retarded), 4 attended various types of special schools (other than junior training schools or special care units), and 2 were at home with no provision, but were under school age. The agencies attended by the children are shown in Table 23.7 from which it can be seen that only 3 of them attend schools or classes specializing in childhood psychosis or autism.

Lotter, from his survey in Middlesex, calculated that in every 10,000 children there were 2.1 with classic early childhood autism,

Table 23.7. *Services attended by psychotic children on 31 December 1970*

<i>Service by age-group</i>	<i>N</i>
0-4	
At home	2
Special unit in day nursery	1
5-14	
Special school unit for autistic children	3
ESN school	1
Junior training centre	4
Special care unit	3
Special hospital unit	2
Mental retardation hospital	3
Total	19

2·4 with many autistic features, and 3·4 with some 'psychotic' behaviour who could not be described as autistic (Wing, O'Connor, and Lotter, 1967). On the basis of these figures there would be about 11 Camberwell children aged 5-14 in the first two groups and another 8 in the third group, a total of 19 children altogether. This can be compared with 16 children aged 5-14 diagnosed as autistic or psychotic found from the Camberwell Register. Clearly, other children with psychotic behaviour could have been found in Camberwell, some in special schools not contributing information to the Register, and some who had not been diagnosed. At the moment, the majority of children with autistic or psychotic behaviour have to be fitted in somewhere within the services locally available for handicapped children. These services have been designed for a variety of different handicaps but not specifically for psychotic children. Problems, therefore, often arise when the staff (and the other children) have to cope with the very difficult behaviour that usually accompanies childhood psychosis.

One hospital agency which sets out to provide specialist service for children of this kind is the unit at Hilda Lewis House (see section 3.3). The staff are acquiring experience in methods of management and teaching which they hope to pass on to parents. The local authority special care unit also has a section for very disturbed and retarded children which the most severely handicapped of the psychotic children can attend.

5.4. SERVICES FOR MENTALLY RETARDED ADULTS

Table 23.8 shows the numbers of adults in different services on one census day (31 December 1968). The figures given are subject to revision when the results of a new, more detailed, census become available. However, the numbers in the later census are unlikely to be very much changed from those in 1968.

The table shows that, compared with the children, a much higher proportion of the mentally retarded adults were receiving residential care (approximately 55 per cent of adults and on 31 December 1970, rather less than 25 per cent of children). Most of the care was in hospitals rather than voluntary or private homes, unlike the children who were fairly evenly divided between homes and hospitals. Most severely retarded people have to be admitted to hospitals or homes once their parents are no longer able to care for them. Hardly any become self-supporting, and up till now other relatives have been on the whole unwilling to take on the responsibility. Those living at home and attending the adult training centre were mainly in the younger age-groups.

The other type of patient admitted to mental retardation hos-

Table 23.8. *Mildly and severely retarded adolescents and adults in Camberwell in the care of the mental retardation services on 31 December 1968 (numbers and age-specific rates per 1,000)*

SERVICE BY AGE-GROUP	ADOLESCENTS 16-24		ADULTS 25-64		ELDERLY 65+		TOTAL 16+	
	N	Rate	N	Rate	N	Rate	N	Rate
At home and not attending day or residential centre	*	*	*	*	*	*	*	*
Adult training centre								
(a) Living at home	53	2.21	24	0.28	0	—	77	0.59
(b) Living in local hostel	4	0.16	0	—	0	—	4	0.03
Long-term care homes (run by voluntary or private bodies)	8	0.33	9	0.10	3	0.15	20	0.15
Area mental retardation hospitals	28	1.17	127	1.46	26	1.31	181	1.38
Psychiatric hospitals	2	0.08	15	0.17	9	0.45	26	0.20
Total	95	3.95	175	2.01	38	1.91	308	2.35

* The figures for people at home and not attending day or residential centres are not yet complete.

Note. These figures are provisional and subject to revision when a new, more detailed, census is completed for 31 December 1971.

pitals is the adolescent or young adult who is mildly retarded but who has social problems (sometimes amounting to delinquency) and who finds it difficult to find and settle down in work. Many of these stay in hospital for a comparatively short time. Up to the present the Southwark local authority has provided only twenty-four hostel places for retarded adolescents and young adults. It remains to be seen how successful future increase in this provision will be in reducing admission to mental retardation hospitals.

5.5. EVALUATING THE SERVICES FOR CHILDREN

The philosophy of evaluation is discussed fully in Chapter 2. It is only necessary here to emphasize the fact that statistics from the Register cannot in themselves demonstrate the quality of the services nor the desirability of any changes. They cannot, to take a specific instance, explain why more children in Camberwell were in long-term residential care after the opening of new day-places in the community (see section 5.2). These questions can be investigated only by studying the problems of individual patients and their families, and their experience of the services.

A study of this kind is being carried out in Camberwell in order to examine the services for severely retarded children and for children with psychotic behaviour, whether or not they are also severely generally retarded. The method and some preliminary results will be described as an example of one approach to the problem of evaluation. All the children with these diagnoses identified in a census taken on 31 December 1970 are included.

For each child, a parent, teacher, and social worker are interviewed using structured interview schedules. Information is obtained about the child's level of functioning, handicaps, skills, and behaviour; how much of a burden he represents for the family and the areas of family activity in which the problems occur; the past experience of medical, educational, residential, and social services; the family's ability to cope with the child; basic medical and social data on the child, his parents, and his siblings. Each child is also given psychological tests appropriate for his age and degree of handicap.

A complementary study of the frequency of epilepsy and neurological handicaps in the same children and their association with behavioural handicaps is also being carried out by the medical and psychological staff of Hilda Lewis House. One of the major aims of these studies is to examine the service needs of the children and their families in relation to the child's specific mental and physical handicaps.

At the time of writing, fifty-four children and their families had been seen. No detailed results can be given, although certain points to be described below are emerging as important.

1. Children with additional handicaps

The division of the multiply handicapped children into non-ambulant, severely disturbed in behaviour, or severely incontinent, using Kushlick's and Cox's scale, is useful, especially since these authors have defined these categories precisely, thus making possible comparisons between different areas. However, detailed examination of the children's handicaps shows the necessity for a further breakdown of these groups. This is because children who vary considerably in the ease with which they can be managed and the effect they have upon parents and staff may be included under the same general heading.

To give some examples, 'non-ambulant' children may present no other problems than those caused by the necessity for total physical care. On the other hand, some children who are not mobile may scream loudly, frequently, and at length, they may repeatedly injure themselves, have severe feeding problems, or

have a succession of major fits. The 'quiet' children are easy to fit into any service with sufficient staff and appropriate physical facilities, but those with the problems listed are distressing to many people and may cause sufficient stress to lead to their exclusion from day or residential services.

Similarly, children classified as severely disordered in behaviour may have a behaviour pattern which is easily accepted by the staff of the community services providing they have experience and understanding of handicapped children. Other disturbed children can upset even the most experienced teachers and nurses because of such problems as constant spitting, smearing, apparently deliberate spitefulness or self-injury. These children often have a history of moving from one agency to another with many periods of being at home with no provision at all, until they are finally placed in a large area mental subnormality hospital, unless a unit like that in Hilda Lewis House is available. Another variable which affects the placement of disturbed children is the extent to which they endanger other children with whom they come in contact.

The results so far suggest that one of the most important variables affecting the teaching and management of the children is the level and nature of their language development. Those who are able to understand spoken instructions covering everyday situations and who can talk enough to make their wants known are on the whole responsive to the ordinary methods of child rearing appropriate for their mental age. The children who have severe problems of comprehension and use of language (including those with early childhood autism and other childhood psychoses) need a special approach which parents and professional workers have to learn and which they cannot pick up from contact with normal children or retarded children who can talk. The techniques are based on the use of non-vocal methods of communication and the principles of behaviour modification (Mittler, 1970a, b; L. Wing, 1971b). Their successful application depends upon a knowledge of child development and an understanding of the nature of each child's specific handicaps. It is already clear that lack of appropriate training to enable staff to cope with this type of child is one of the major problems to be faced in providing comprehensive community care.

2. Parents' attitudes

The study is still in progress and the 54 subjects completed so far included a disproportionately high number of the most handicapped, because children admitted to the Hilda Lewis Unit were seen first, in preference to others. Out of the 54 families, 8 had

children in long-term care. The parents of all of these still kept in contact as often as they could and would much prefer to have their children in small units near home, rather than in hospital twenty or more miles away.

Four families with children at home expressed, at the time of interview, the strong desire to have them placed in long-term residential care, although they would all like well-run units within the area so that they could visit frequently and have the children home for weekends or holidays. Seven families expressed ambivalent attitudes for a variety of different reasons, partly related to the children's handicaps and partly to their social situations. The rest (35) wanted to keep their children with them at home as long as they were able. While there was, of course, some relationship between the extent of the child's handicaps, especially the severity of behaviour disturbance, and the desire of the family to have him at home, the correlation was by no means absolute. Some of the most physically handicapped and some of the most disturbed children in the area have parents who refuse to consider residential care. It is hard to predict which parents will have this attitude. It is interesting to speculate how much the current emphasis on community care, for a long time particularly strong in Camberwell, had influenced the attitudes of families and increased the number who actively want their handicapped children at home. Comparisons with the results of a parallel study being carried out in Aarhus, Denmark, may help to answer this question.

3. Gaps in the services

Parents with handicapped children at home were, on the whole, appreciative of the day-services. The general medical care was also felt to be adequate. The special dental service (see section 4) was especially praised. However, there are still large gaps in the services. These were complained of both by the parents who placed their children in long-term care and those who kept their children at home.

One of the most important deficiencies is the lack of skilled advice for parents on how to teach their children practical and social skills and how to manage behaviour problems. Health visitors are not specifically trained in dealing with severely retarded children and most social workers do not consider this to be one of their functions. Some of the parents found things out for themselves, often by joining voluntary societies and talking to other parents, but many were less able to learn in this way. A further problem was the difficulty the less well educated parents had in obtaining full information about the services and special help

available to them, including financial assistance and the laundry service. The parents' organization was helpful but reached only those who became members.

The schools and the special care units are open in school term time but are closed for the school holidays, for thirteen weeks per year. Many parents with children who have additional handicaps found the holidays a considerable strain. They often contrasted this with the year-round care provided in the preschool special units in day-nurseries. This factor sometimes caused much bitterness when a child moved from nursery to school.

Unless the parents have helpful relatives or close friends in the vicinity, the social life of those with handicapped children at home tends to be very restricted. There are no formal arrangements made by any of the services to overcome this very real problem, except that, if the retarded child cannot be taken on holiday, it is usually possible to arrange short-term care in a residential hospital or home. Most parents were satisfied with the short-term care their children had received, but some had had unfortunate experiences. A few families had refused short-term care altogether, despite much hardship. Unfortunately, but inevitably, short-term care is hardest to find at the time when most families want to take their holidays.

Housing and domestic help were special problems to some families, especially those with a multiply handicapped child. Departments of the local authority deal with these matters but both are in very short supply.

Finally, all parents without exception were worried about the future when they would no longer be able to care for their child. They did not like the idea of admission to a large understaffed institution and they wanted to see adequate provision for adults within the area, so that siblings and other relatives could maintain contact. The emphasis on community care has forcefully underlined this problem, especially with regard to multiply handicapped or disturbed people who would probably not be suitable for a local authority hostel. Having encouraged parents to keep their children at home, those running the services should not be surprised to find that old-fashioned institutional care is highly unwelcome when those children have become adults.

4. Families in need of special help

Parents of severely retarded children who were themselves socially incompetent, of low intellectual achievement, and overburdened with housing, financial problems, and difficulties in managing relationships within the family, presented a special problem. Of the

small number seen so far the majority seemed to be devoted to the handicapped child, even if they found their other children a constant source of irritation. One family whose retarded child had been placed in care for some years went to incredible lengths to bring him back when they at last had a home of their own. The parents in this group, despite their deep feeling for their child, tended not to provide appropriate food, clothing, and general physical care. They also did not know the kinds of toys such a child needs, nor did they provide intellectual stimulation at the appropriate level. These are the families which really test the philosophy of community care. The present study so far indicates that the problems which directly affect the handicapped child in this situation remain unsolved.

A plan for a comprehensive service for the mentally retarded

J. Corbett and Lorna Wing

The description of the new and expanded services given in Chapter 23 shows that progress has been made in improving services for severely retarded children and adults in Camberwell. However, many gaps still remain and this chapter will be devoted to discussing a plan for a comprehensive service, parts of which are being put into effect while others are still hypothetical.

In order to prepare a plan for a comprehensive service that is geared to the needs of the mentally retarded children and adults in an area, the results of a series of studies covering all age-groups and types of handicaps are needed. Without this information plans have to be based on guesswork. However, the preliminary findings from the Camberwell study and work in other areas such as that of Kushlick and Cox (1970) provide enough data for the outline of a plan to be made, although details cannot yet be filled in.

The scheme, as presented here, deals separately with different groups, divided according to age and type of handicap. This method was adopted in order to cover every possible need, but it is not meant to imply that some groups cannot be combined and catered for by the same service. To take one example, it might be possible to follow the example of some hospitals and local authorities by opening a family group hostel in which children and adults of all ages live together. The advantages and disadvantages of various ways of catering for mentally retarded people have still to be discovered by experiment and evaluation.

The plan to be outlined is based on experience gained in the newly expanded hospital and local authority services and on

preliminary results from the survey of retarded children in Camberwell described in Chapter 23, section 5.5. It can only be put forward tentatively at the moment. It will be modified in the light of the final results of the children's study and the study planned to investigate the needs of the adults.

1. Diagnosis and assessment

The services for diagnosis and assessment of both physical and mental handicap in young children in Camberwell need to be expanded. The local health authority already run a general screening and follow-up service. The local district general hospital is planning a paediatric diagnostic and assessment unit with both out-patient and in-patient facilities. Camberwell would be included in the catchment area, but the centre's total responsibility would cover a wider geographical area. Follow-up of the children, with periodic reassessments throughout childhood would be an important feature of the service.

2. Parent counselling

Parent counselling on practical problems and methods of child-rearing should be available as early as possible after birth. At present it is generally given by health visitors for preschool children, and by local authority social workers for those of school age and above. Unfortunately, these professional workers have little or no special training in this field. Parents of children with psychotic syndromes, for example, find it especially difficult to cope with disturbed behaviour which is particularly severe in the children under school age (L. Wing, 1971*b*). In addition they do not have the knowledge and experience necessary to teach their children elementary social and self-care skills. They could be helped by detailed advice on management (Schopler, 1971).

The staff of Hilda Lewis House are in the process of developing methods of parent counselling for children who are admitted. However, not all children from Camberwell come into the unit, and, in any case, the policy of the unit is against long periods of stay in most cases. There is a need for advice and help to be given to parents of children living at home and to staff in day and residential units over a long enough period of time to be effective. One way of providing this service would be to employ a psychologist with appropriate experience specifically to help parents and the staff in the various community agencies dealing with these children. This psychologist could be called in to help in specific

cases by the medical consultant concerned and should work closely with that consultant. He or she could perhaps be employed jointly by the Maudsley Hospital, the district hospital paediatric assessment centre and the local education authority, and should be in contact with research work in teaching methods being carried out in the Institute of Psychiatry. A worker in this field would need to develop expertise in the management of children with severe language problems, including those with early childhood psychoses. He or she could deal not only with children who were severely generally retarded but also those with similar learning problems but who were less generally retarded.

3. Preschool children

The planned increase in places in the special units in day-nurseries and the opening of a nursery class in one of the junior training schools has been mentioned in Chapter 23, section 2.2. A further 20 nursery class places will be provided in the new building planned for Kirkwood School. The numbers of places available will eventually be adequate for the need.

4. Retarded children without additional severe handicaps

When Kirkwood School is rehoused in a new purpose-built building, there will be 115 places in the schools for severely retarded children for the whole borough, which appears to be adequate for children who do not have additional very severe physical or behavioural handicaps.

If children of this kind need residential care, the appropriate placement is in a hostel within their own community. The social service department's plan for a children's hostel (see Chapter 23, section 2.2) will provide 20 places for the whole of Southwark. However, the census figures suggest that approximately 25 places are needed for Camberwell alone, 16 for long-term and the rest for short-term care.

5. Retarded children with additional severe physical or behavioural handicaps

A second special care unit for Southwark is being attached to the new building for Kirkwood School. When this is open there will be altogether 40 places for the whole borough, but the high

demand for places in the present unit at Tuke School suggests that the full need will not be met even when the second unit is open. As described in Chapter 23, section 2.2 the staff of these units are under heavy pressure as they have to deal with children with severe multiple handicaps needing much time and physical effort for their care as well as children with gross behaviour disorders.

One way of solving the shortage of places and providing relief for the special care unit staff when special medical or psychiatric crises arise would be to provide appropriate local hospital units. A combined day and residential hospital unit with 15-20 places, for severely physically handicapped and mentally retarded children, could perhaps be attached to the district general hospital paediatric assessment centre. The residential care could be short or long term as appropriate. Another day-hospital for retarded children with severe behaviour disturbances (10 places) could be attached to the Maudsley Hospital and be closely associated with the residential unit for the same kind of children in Hilda Lewis House. The hospital units could work together with the special care units so that children could move easily from one service to another as appropriate.

6. Severely retarded adolescents and adults

Severe mental retardation in childhood almost always means continued handicaps and dependency throughout life. There must be a smooth transition from the services provided for children to those provided for adolescents and adults.

The same categories of handicaps can be found among the adults as among the children, although there is a tendency to excess mortality in those with multiple handicaps. Some estimate of the future need for day and residential places can be calculated by applying to the Camberwell figures Kushlick's and Cox's findings concerning the proportions of non-ambulant, severely incontinent, and severely behaviour disordered people among all the severely and mildly retarded adults in the Wessex survey (Kushlick and Cox, 1970). These estimates are likely to be lower than the real need, because no complete survey of retarded adults has been done in Camberwell. More accurate figures should be available when the census for 31 December 1971 is completed (see Chapter 23, section 5.4).

Sheltered work is provided in the adult training centre which has 180 places for the whole of Southwark. This is at present more than adequate but, in the future, if community services are

developed as planned, at least 258 will be needed for Camberwell alone. One section of the adult training centre could be developed to cater for more severely handicapped people, who, with special supervision and training, might learn to do some regular work.

Residential care for adults within the community is necessary if the large area mental retardation hospitals are to be run down. Many of those at present in hospital could be in local hostels. The social services department is planning to open 3 hostels which will give 75 places for the whole of Southwark. However, Kushlick's and Cox's figures would suggest that approximately 150 hostel places might be needed eventually for Camberwell.

As with the children, provision is needed for retarded adults with severe physical handicaps. A local authority adult special care unit could provide perhaps 20 places, but a small day and residential hospital unit in the community with approximately 30 places is also needed. This might be attached to the district general hospital. Adults with severe behaviour problems might also be catered for in the adult special care unit, but others will need a special day and residential hospital unit. This could be run by the Maudsley Hospital in association with the unit at Hilda Lewis House (not more than 20 places).

7. Mildly retarded adolescents and young adults with social problems

As mentioned in Chapter 23, section 5.4, young mildly retarded adults who are delinquent or who present other social problems are frequently admitted to mental retardation hospitals but do not usually become long stay. They need psychiatric supervision both as in-patients and as out-patients. A study of this group, based on the Camberwell Register, is projected, but until data are available, no concrete plans for their future care in the community can be put forward.

8. Elderly mentally retarded people

As yet, it is difficult to estimate how many elderly mentally retarded people there will eventually be in the community if community care is provided for most children and adults, nor how many will have psychogeriatric problems. Mentally retarded adults who need medical care because of senile changes can be catered for by the ordinary geriatric services. It may be found that a hostel for short- and long-term care for frail elderly mentally retarded people would serve a useful function. This could be provided by the social services department.

9. Children with early childhood autism and other psychoses

9.1. EDUCATION

Some autistic and other psychotic children make most progress if they are placed in schools which specialize in these problems. The severity of handicaps and the educational needs of the autistic and psychotic children in Camberwell are likely to be too diverse to justify a school unit for Camberwell alone. The ILEA are gradually expanding their provision for autistic and psychotic children and it is to be hoped that eventually enough special places will be available for those who can benefit from them. It should be borne in mind that such units tend to cater for children with a variety of language problems in addition to classic autism and care has to be taken not to exclude the latter because they are more difficult to manage and their progress tends to be slow.

Not all autistic or psychotic children are best placed in a specialized school. Some of the less handicapped are accepted in other kinds of special schools and even in schools for normal children. At the other end of the scale, the most severely retarded may be most appropriately placed with other kinds of severely retarded children. The most important point to emphasise is that if these placements are to succeed, there must be enough staff who are trained to deal with the children's specific impairments and with their difficult behaviour. The basic handicap in early childhood autism, as in most other types of childhood psychosis, is a profound impairment in the development of any kind of language, verbal or gestural. Comprehension as well as use of verbal and non-verbal language is affected and the children are as handicapped as if they were born partially deaf and blind. Children with these problems can be helped only by people with a high degree of specialized skill and experience. If sufficient staff with this kind of skill can be provided then the children can be placed in mixed units as successfully as in specialized ones. However, it may be easier to organize special units rather than to try to have specialist staff in all kinds of schools. This problem, and the problem of devising adequate staff training, both still have to be solved.

9.2. RESIDENTIAL CARE

On the whole, psychotic children do best if cared for by their own families. Sometimes, however, residential care is necessary because of special family circumstances. If the child is very disturbed, or is multiply handicapped, it is difficult to arrange for care outside an

area mental subnormality hospital. Hilda Lewis House provides long-term care for a very small number of such children and further residential provision for disturbed retarded children has been discussed previously. It would, however, be desirable for the future local authority hostels to be adequately staffed so that they can accept some of these children. A counselling service, as suggested above, would be able to help child care in the hostels, as well as parents.

Some autistic or psychotic children are best placed in residential schools, but the small numbers mean that these have to be provided for much larger areas than that covered by a single borough.

9.3. ADOLESCENTS AND ADULTS

The majority of children with autism and related childhood psychoses will be handicapped throughout their lives and will eventually need sheltered accommodation and sheltered work. It can be predicted that, in Camberwell, the number of autistic adolescents and adults who are in the mildly retarded or normal range of intelligence will be far too small to organize appropriate services locally. Of this group, some may be able to obtain suitable employment on the open market. Others may eventually find places in special hostels and sheltered communities which are projected in the long-term plans of the National Society for Autistic Children. Various other voluntary bodies (such as the Steiner organization) already have sheltered communities which accept autistic adults who are not too disturbed in behaviour.

These plans, however, do not cater for the adults who have had childhood autism or a similar type of psychosis and who are also severely retarded in intelligence. If there are 12 such children in the 5-14 age-group, it can be calculated that there are 65 people in Camberwell aged 15 and over who are handicapped in the same way (38 per 100,000 total population). This calculation makes the assumption that there is no excess mortality and that the handicaps do not improve in adult life. Both these assumptions need to be investigated in a proper epidemiological study, but the figure gives some basis for discussion.

A number of these people will need long-term care from childhood or adolescence and all are likely to need sheltered accommodation from the time their parents or other relatives die. Some of the psychotic group may be able to manage in local residential hostels for retarded people, but others will need to be in units providing more intensive supervision and care, such as the day and residential hospital unit for retarded disturbed adults mentioned above (see section 6).

Appropriate employment is important for this kind of patient, since their behavioural disturbances (self-mutilation, destructiveness, aggressiveness, stereotypes) are much less in evidence when they are occupied. The local adult training centre should be able to provide this employment. However, it is essential that a number of extra staff who have had special training in these problems should be appointed to the centres to enable the disturbed group to fit in successfully. These staff should understand the handicaps of early childhood psychoses and the principles of behaviour management, so that they can cope with disturbed behaviour and teach the appropriate skills. Until such time as training courses are available at national level, the Camberwell service will need to organize its own 'in-service' training scheme in co-operation with existing hospital and local authority facilities, such as the psychologist for staff and parent counselling suggested above.

It is worth emphasizing that close liaison between different disciplines and different agencies is needed if children and adults handicapped because of childhood psychoses are to receive the best services available throughout their lives.

10. Special services

In order for the day and residential services described above to function efficiently a variety of special services are needed.

Social workers from the social service departments can be of most help to the family with a handicapped child if they have an encyclopaedic knowledge of all the services and the special financial and other assistance available. They also need some knowledge of child development and methods of management of retarded children of all kinds, since without this they cannot effectively deal with any emotional problems the families might have. As emphasized previously, Chapter 23, section 2.3, the problem for the future is to organize social work so that mentally retarded people are not neglected. Possibly some members of the social work departments will have to specialize in this field after they have had their 'generic' training.

Further education for severely retarded adolescents and young adults should be provided. They often reach the stage at which they can begin to learn just as they have to leave school. Part-time education and vocational training could be provided by the education authorities in collaboration with the adult training centre.

Social clubs and activities for children and adults are very necessary including such sports as swimming and horse-riding. The local branches of the NSMHC organize social activities, but

the more severely handicapped are not yet catered for. The local authority and hospital units for physically handicapped and disturbed children and adults could perhaps be involved in providing social activities.

A special dental service for retarded children has already been described (see Chapter 23, section 4). This needs to be extended to cover preschool children and adults. Medical treatment is also sometimes difficult to obtain for retarded people. The district general hospital should be able to provide a service which can cope with difficult children and adults, especially if experience is gained in a day and residential hospital unit.

Speech therapy and physiotherapy are important in the field of mental retardation. The shortage of trained people in both these fields makes it necessary for the professional workers to train parents, nurses, and teachers to carry out the treatments under supervision. This system seems to work well and could with benefit be extended in Camberwell. Workers from both professions need to gain experience in the problems presented by retarded children and adults. The skills of the occupational therapist who is experienced in the field of mental retardation are most valuable in helping the more severely handicapped children and adults. If the community services are made completely comprehensive, more occupational therapists will be needed.

Parents with young retarded children or multiply handicapped children of any age living at home are usually overworked and in need of domestic help. The Home Help service could be utilized by many of these parents, if the service could be adequately staffed. The laundry service is also likely to have more demands made on it as complete community care for retarded people becomes a reality.

The social life of families with handicapped relatives tends to be very limited. A baby-sitting service could perhaps be organized and staffed by volunteers. It would be necessary for them to acquire some experience in the day or residential units for a number of sessions before sitting in for parents in a private home.

Housing is a major problem for a substantial minority of Camberwell families with retarded children. There may be overcrowding, no bath or hot water, an outside lavatory, or stairs up and down which it is impossible to carry a wheelchair or a heavy immobile older child or adult. Lack of indoor and outdoor space can be a nightmare for a family with a hyperkinetic child. Housing is, of course, a major problem in cities and having a handicapped child is only one among a multitude of reasons why any family may need rehousing. Nevertheless, it is unrealistic to expect a family to

accept community care if it means keeping a handicapped child or adult at home in grossly unsuitable housing. If the housing situation allows it, one suggestion is worth considering; that is, to build some local authority housing specially adapted to handicapped people. Such houses and flats could be fairly close together and reasonably near the local day-schools and units, but interspersed with ordinary houses and flats. This would allow for co-operative baby-sitting, transport, and social gatherings, but would not produce a little enclave of families marked out as being different from everyone else. The schools, units, parent's society, and the social workers concerned could make sure that the families knew of each other's existence and could mix or not as they preferred.

II. Staff training

One of the major problems of improving the services for mentally retarded people is that of finding staff for residential hostels and hospitals. Good staff must be attracted to the work and given appropriate training. The former is partly a question of adequate pay and conditions (including accommodation for staff and their families), but is also affected by the satisfaction of the work, which in turn is enhanced by interesting training and a chance to use the skills acquired. None of the standard training courses at present available (for example, nursing, child care work, etc.) are wholly relevant to the care of mentally retarded people. One solution would be to devise a new training for a new profession of mental retardation care staff, as has been done in Denmark. This, however, is a national rather than a local problem.

In Camberwell, the staff for the new services such as the hostel could be employed before the opening of the units in order to give an opportunity for preliminary training (see Department of Health and Social Security, 1971). The present services, such as the day-nursery units, the training schools, the special care unit, and the Hilda Lewis Unit could help by providing practical experience and some specialized theoretical training.

Problems of training are not confined to the residential care staff. They affect all workers in the field, including teachers, social workers, occupational therapists, physiotherapists, speech therapists, psychologists, and doctors. In addition to the general background of expertise in their chosen professions, each of these workers needs training and experience in the specific problems of mentally retarded people, in order to make the most efficient use of their services. Again, this is a national problem, but the future plans for Camberwell should include short training courses and

practical experience for all grades of staff, making full use of the opportunities offered by the established Camberwell services.

12. Co-ordination of services

The plan presented above recognizes that the main requirement in planning services for the mentally retarded is that they should, as far as possible, be community based. The division of responsibility between hospitals and local health, social service, and education departments, with no provision for machinery for over-all planning, has in the past made this very difficult to achieve. Without such provision, the new legislation on the social services and the transfer of responsibility for education is likely to make planning more difficult in the future. In particular, the various authorities may be allowed to sidestep the issues of providing adequate residential care and the children will suffer. In spite of the good will of individual workers, official policy will thus perpetuate an unbalanced service. For example, the setting up of a hospital unit without providing residential accommodation for children not requiring hospital care might well lead to an uneconomic and detrimental use of hospital facilities, which could only be offset by a determined effort by the hospital to keep patients in the community. This, in turn, however, could increase the stress placed on some families and children. The lack of integration in the services for mentally retarded children leads to such pressing and complex problems that a partial return to the older system of one authority with over-all responsibility for planning and administration is perhaps called for.

In Camberwell, staff from all the agencies involved have, in the past few years, begun to develop both formal and informal contacts with each other. The old barriers are disappearing, to the benefit of the children and the relief of their parents. It is to be hoped that this process will continue and that new developments will be integrated with the existing services without administrative difficulties in spite of the fact that three different local authority departments are involved, as well as the hospital service. The voluntary bodies concerned, such as the parents' society, should be seen as an essential part of the services, and their ideas and experience utilized as readily as those of professional workers.

If children are to move easily between residential and day facilities and if the training schools are to call upon the specialist medical and psychological services for help with specific problems of physical handicap or behaviour disturbance, then close contacts must be made between staff at all levels. Personnel from different

agencies who are likely to be concerned with the same child should feel free to visit and to discuss problems with each other.

Case conferences should be open to the people closely concerned with the child who is being discussed (as at Hilda Lewis House) whichever agency employs them. Good co-ordination and co-operation is hard to achieve, but a first-class service cannot exist without it.

PART EIGHT

GENERAL DISCUSSION

Further problems of evaluation and planning

J. K. Wing

Although this book has chiefly been concerned with the evaluation of local services, several wider issues were raised which deserve more general comment, even though this must be to some extent speculative. One of the most obvious issues is that of the development of services which would possibly be more viable if serving a region rather than a small locality. Special provision is already made at the joint Maudsley and Bethlem Royal Hospital for children and adolescents, for those dependent on alcohol and drugs and for in-patient psychotherapy, and there are metabolic and forensic units. These and other services require investigation on a regional as well as a local basis.

Another important issue is the provision of alternative and back-up services in a comprehensive system. There will always be individuals who do not wish to be referred to the local service or whose doctors prefer occasionally to use facilities elsewhere. A tightly organized district system allows little choice and is not geared to look after those who become 'extra-territorial'. Every area should therefore provide more flexibility. An emergency clinic is one way of doing this and there must be some non-area beds. Mental hospitals have traditionally filled in the gaps left by other agencies and it is essential that this function should be undertaken by any services that replace them. The danger is that new services will be restricted to more specific functions and that the needs of patients who fall out of care, or who do not seem to fit into any of the prescribed categories, or whose links with the local area are somewhat precarious, may not be catered for. If so, the only back-up services left will be the common lodging house, reception

centre, and bomb-site. Voluntary services have traditionally been set up to fill in gaps and their enthusiasm and innovating potential deserve encouragement from more established organizations but they should not be expected to provide routine services.

This discussion raises the question of the place of the teaching hospital in a local service. Teaching hospitals have traditionally provided an alternative for patients and GPs and some have a long history of regional or even national service. They should be encouraged to retain this role. There are several other reasons why teaching hospitals need extra resources. Chapter 8 indicated that there is a new clientele derived from the general wards and clinics, and that regional units dealing with accidents and attempts at suicide, to say nothing of the problems of heart surgery and renal dialysis, all lead to mounting pressures on the psychiatric department. It is clear that the out-patient load in teaching hospitals is much greater than elsewhere partly perhaps because of the decreased stigma and increased prestige which leads to a higher referral rate from GPs. Patients are usually investigated and treated more thoroughly so that the turnover is slower. In addition, the teaching and scientific programme requires relatively uncommon conditions to be represented in larger numbers than in the general population of the area. Finally, the teaching hospital is often the best site for many of the regional specialist psychiatric units which are likely to be needed in future. Insufficient attention has been given to the way the teaching hospitals can play an integrated part in regional services and to the way in which they can co-operate with local government departments not only in service activities but in teaching and research.

A further problem deserving investigation arises from several chapters in this book and raises fundamental issues for psychiatry and allied subjects. This is the matter of staff functions and training. As Chapters 16 and 20 indicate in a preliminary way, psychotherapy and case-work are each, in a sense, characteristic of the treatment methods of a profession. In what way are they different and how much do they overlap? How effective is either compared with management and advice based on an understanding of handicaps, practical assistance with social problems, and the long-term affective support which arises naturally out of such instrumental help? Much of the evaluative work on individual psychotherapy is not relevant to conditions of practice in the NHS but some of the studies of case-work (for example, that by Reid and Shyne, 1969) indicate that there is likely to be a substantial overlap with psychotherapy, both in terms of the problems tackled and probably of the techniques used.

Many further examples of an overlap in the functions of different professional groups could be given. The skills needed for long-term management, whether in hospital, hostel, day-centre, or workshop, are not neatly divided between those of nurse, social worker, vocational expert, and housekeeper. King, Raynes, and Tizard (1971) have shown this very clearly for mentally retarded children. Mountney (1965) suggested that supervisors of hostels for adult psychiatric patients need to combine the skills of housekeeper and social worker. Marks has shown that nurses can be technically trained as behavioural therapists. There is room for much rational experiment in staff training. Maxwell Jones (1962) thought that staff should themselves be prepared to discover how they function best 'and not be too identified with any stereotyped concept of their role'. This virtually means making it up as they go along and rather exaggerates the extent of our ignorance about management. Nevertheless, the whole field of staff functions and training should be considered more flexibly and evaluated so that the effects on the quality of services can be judged.

Another role that needs more detailed and specific investigation than has been given so far is that of relative. The success of a community care system depends upon relatives, who provide most of the domestic supervision that would otherwise be given by trained staff in hospitals or hostels. If the social morality of leaving this responsibility to relatives is accepted (and it can be questioned; see Slater, 1971), far more sympathetic attention needs to be given to the problems which must arise. The tensions inherent in the role are obvious enough, since a marital partner or parent will naturally continue an emotional relationship while at the same time having to act in a more neutral manner as supervisor. This combination is easy to accept when the handicapped person is a child but it can go wrong when the element of dependence ought to be minimized. Perhaps the most significant work in this field is that of Schopler and Reichler (1971) who have shown how the parents of autistic children can be brought into partnership in the process of therapy and management from the very beginning. The observations of Brown, Birley, and Wing (1972) on the relatives of schizophrenic patients, and on the differences between the role of parent and of spouse, and those of Goldberg (1967) who attempted to define a number of family constellations, may provide a basis for a more rational system of long-term management, in which the relative is seen as an ally. It will, however, be impossible to gain the relative's cooperation if adequate services are not provided.

All these questions concerning staff roles and staff training raise

the deeper questions about the nature of psychiatric handicap which were mentioned in Chapter 2. The present book is focused on empirical studies of services, which go some way to provide answers even when the underlying theoretical issues are not settled. Advances in theory, however, if solidly grounded in empirical fact, would provide a firmer basis for planning. In particular, a clearer statement of the many medical and social models of providing care, as opposed to a stereotyped rejection of 'the medical model' and substitution of a vaguely expressed and untestable alternative, might provide common ground on which all the helping professions could meet to agree a plan of action.

A further problem which has barely been touched upon in this book but which requires investigation concerns the path of referral to specialist services and the extent of the unmet need in the general population. There is some evidence that severity of clinical condition is one of the main reasons for specialist referral, at least when specific diagnostic entities are considered. Marks and Herst (1970), in a nation-wide survey of 1,200 members of an 'agoraphobic' club, 959 of whom had attended their family doctor, found severity of clinical condition was the important factor determining referral to a psychiatric clinic and subsequently determining admission to hospital. Most people with conditions such as severe retardation, severe dementia, schizophrenia, and mania are probably referred and, in such cases, the problem of unmet need is more that of people falling out of care than of failing to be referred at all. Chapter 21 shows how serious this problem already is and other chapters (for example, 17 and 19) show it in the course of development.

So far as less-specific conditions are concerned, and to some extent even with those that have been mentioned, many other factors must be involved in the process of selection from the 15 per cent psychiatric morbidity found in general practice studies to the 2 per cent dealt with by the specialist services. The most important question, which also involves the difficult problems raised earlier about professional roles, is whether there are techniques such as behaviour therapy or psychotherapy, which can only be used at the moment by specialists, which might benefit many people not now receiving them.

A similar practical question might be asked about methods of preventing psychiatric disorders altogether. To take the housing environment alone, what are the psychiatric effects of living on an urban motorway or in the flight path of London airport, or of being compulsorily 'relocated' because of housing redevelopment, or of being allocated an apartment at the top of a tower block? There are

many hypotheses but rather little hard fact which would help a planner.

These issues have been raised because they indicate obvious gaps in knowledge and areas where further evaluative research is required. One particular problem deserves more extended discussion since much of the work reported in this book is relevant to it, although on a local rather than a national scale. This is the government's plan to transfer the functions of mental hospitals to psychiatric units in general hospitals and to local authority social service departments. Since the plan is so far not very specific about the problem of dementia, less attention will be given to this important subject, except to point to the local solution suggested in Chapter 22. Government policy with regard to the mentally retarded is, in many ways, quite close to that suggested in Chapter 24. In both these cases, further 'action research' is required on a fairly large scale; to set up various kinds of demonstration model and to invite high-quality independent evaluation. Many of the same issues arise as in a consideration of the plan for the adult mentally ill and in the interests of brevity the following discussion will be concentrated chiefly on this problem. The underlying problem, however, for all these categories, is the allocation of scarce resources between those whose handicaps are likely to be prolonged, so that they accumulate on the books of the helping agencies, and those whose social and psychiatric difficulties are likely to be resolved fairly quickly. The natural tendency is to hope that most problems will be of the latter kind and that early help will prevent the former kind from occurring. Sound public health principle, natural optimism, and an appreciation of the economics of providing comprehensive social and medical services, all incline the planner to allocate highest priority to the shorter-term problems.

The DHSS's plan to meet the needs of the adult mentally ill is strikingly imaginative and enterprising. It seems to be based on three premises; that the present long-stay population in mental hospitals will gradually disappear, that any new long-stay population can be coped with by local authority social service departments and that the shorter-term needs of in-patients can be accommodated in 50 beds per 100,000 population sited in psychiatric units in district general hospitals. The detailed reasoning behind the plan has not been published but it is clear that the early reliance on statistical projections, discussed in Chapters 4 and 9, has been replaced by an acceptance of the claims made by a number of clinicians concerning services run on the model favoured by the DHSS.

The three papers cited by the Chief Medical Officer in his annual report for 1970 (Downham, 1967; Baker, 1969; Oldham, 1969) are descriptive and brief. The only evaluation involved is the judgement of each clinician concerning his own service that it is comprehensive and causes no undue burden on relatives or the community, in spite of the fact that local authority services are not outstanding. No independent assessment of any of the services, either statistical, clinical, or social, is provided.

Everything therefore depends upon certain key assumptions which have not yet been tested: that very few patients will in future become severely handicapped psychiatrically, that those who do will either not require residential care or can be looked after adequately by the social services, and that the disadvantages apparently inherent in the mental hospital system will not be inherent in any system which replaces it. These assumptions are all the more important for being unspoken. Each deserves separate consideration.

The patients most concerned are those who would, in the past, have been at high risk of a prolonged stay in a mental hospital, particularly those suffering from schizophrenia. Do they still become severely handicapped? Evaluative studies which concentrate on first referred patients only, such as the comparison of two Manchester Region services by Hoenig and Hamilton (1969), are only partially relevant to this crucial question. The outcome of the small group of first referred schizophrenic patients studied by Hoenig and Hamilton, not all of whom were admitted to hospital at all, would be expected to be quite good, and it was in fact very similar to that of the first admissions studied by Brown *et al.* (1966). 'Over half of first admitted schizophrenic patients require little attention from psychiatric after-care services. They constitute no intolerable burden on their families nor serious problems to the community. On the contrary, they contribute a full share, by working or running a household, to the social good' (Wing, 1966).

However, the MRC study also included the high-risk group of readmitted schizophrenic patients and here the prognosis was more serious. Twenty-seven per cent were in-patients during the final six months and 24 per cent were severely disturbed in behaviour during this time. A further 16 per cent were unemployed for the whole of the final six months although not severely disturbed in behaviour. The problems of relatives were far from negligible in spite of the fact that many did not complain. The best organized of the three community services (with a reputation, if that is anything to go by, far beyond that of any of the other

services mentioned so far) did not appear to prevent considerable disability from occurring (Brown *et al.*, 1966).

Since these studies were made, it has been demonstrated that regular phenothiazine medication, by injection if necessary, is of value in many cases and it can be expected that the prognosis will have improved further (Leff and Wing, 1971; Hirsch *et al.*, unpublished). An understanding of the patients' vulnerability to social stresses and family tensions (Brown and Birley, 1970; Brown, Birley and Wing, 1972) and to an impoverished social environment (Wing and Brown, 1970) may also lead to better management and decreased likelihood of relapse. Certainly, an application of the principles of rehabilitation which have been worked out in the best mental hospitals might be expected to do so (Wing and Freudenberg, 1961; Wing, Bennett, and Denham, 1964; Early, 1965; Wing, Leff, and Hirsch, unpublished).

These suppositions are hypothetical however. The work described in Chapters 17 and 19 indicates the kind of problems still posed by many unemployed schizophrenic patients, in an area where community resources are particularly rich. What happens when the resources fail might perhaps be reflected in the movement out of the area described in Chapter 17 and is illustrated by the plight of two of the patients mentioned in Chapter 19, one of whom actually went to a reception centre while the other appeared to be at risk of doing so. Chapter 21 indicates that the number of destitute people is rising again and that reception centres, valuable though their functions are as a stop-gap for other services, were never intended to provide long-term care for the chronically handicapped. Chapter 15 shows that 'new' long-stay patients who need residential care are still accumulating in hospital. Some patients, particularly among those who are at home with elderly parents, might well be better off in nearby hostel or other residential settings with the full agreement of their relatives, as is suggested in Chapter 19 and by Stevens (1972).

The two kinds of primary handicap shown by schizophrenic patients have been described many times. The commonest is negative; slowness, lack of initiative, poverty of thought and speech, social withdrawal. The other is a tendency to respond to stress (which may be mild compared to the vicissitudes which ordinary people can take in their stride) with a relapse of more florid symptoms; including delusions and hallucinations and the expression of these in odd and embarrassing behaviour. The long-acting phenothiazines are more likely to act on the second than the first of these impairments.

Thus it is clear that some patients (number at present unknown)

still become chronically handicapped and need sheltered residential and occupational accommodation. It would be expected that, by now, a substantial literature on the subject would have been built up, demonstrating the advantages which accrue when local authorities take over the educational, occupational, domestic, and protective functions of mental hospitals. In fact, the literature is rather scanty and not very reassuring. In the first place, almost nothing has been written about hostels deliberately planned as places where handicapped people can make their homes. Nearly every hostel described was intended to have a 'transitional' function, in spite of the warning by Clark and Cooper (1960) that such hostels, although useful, are of limited value. The Ministry of Health's survey (1966) included the 31 local authority hostels open in 1966. All had originally been designated for rehabilitation purposes but the average daily occupancy was only 60 per cent. In the 39 hostels studied by Apte (1968), out of a total of 725 places 41 per cent were occupied by people who had been resident for more than a year although only 6 of the hostels were intended to be long-stay. The 3 hostels described by Fletcher (1970) also contained mainly long-stay patients although 2 of them were called 'short-stay'.

The message conveyed by these studies is one of regret that the intended short-stay hostels were not fulfilling their functions of rehabilitation and resettlement. Mountney (1965) warned that 'transitional' hostels could become 'almost a replica of the worst aspects of old Institution life but at almost twice the cost'. Apte found that communications between hospital and local authority had often broken down. The routine of the hostels was frequently based upon administrative rather than therapeutic criteria. Occupational and industrial therapy was the exception rather than the rule, there were few organized recreational activities and many of the wardens had 'stereotyped and institutional attitudes'. Some of the details of hostel life are strongly reminiscent of those described by Goffman (1961) as typical of 'total' institutions. Apte even mentions that 'a large number of the hostel-employed residents have been in the home for several years and have become part of the establishment' and comments on their similarity to 'worker-patients'. Many other residents, who were working out, stayed in the hostels long after they could have been discharged. Forty per cent of the hostels were classified as restrictive in regime and characterized by a low expectation of responsibility in the resident (based on scales similar to those used in Wing and Brown's study). Nearly one-half of the residents were totally unemployed during their stay in the hostels although employment opportunities at that time were plentiful.

Thus in terms of social milieu and function, the hostels did not appear to be as much superior to hospital wards as might have been expected. They were, however, considerably smaller (on average containing eighteen residents, though they were under-occupied) and they were all within the area they served. They were pleasant and home-like in appearance but Apte points out that this made discharge more difficult. His most serious warning deserves quotation: 'Without a clarification of purpose, the half-way house could turn into a diffuse and aimless institution, similar to the *workhouse* of former years' (author's italics). This echoes precisely the reverse warning of Early and Magnus (1966) who pointed out that if all its therapeutic functions were removed, 'the mental hospital will have become what the workhouse was a century ago'. Fletcher (1970) puts it like this: 'Some way must be found to avoid the development of new chronic wards; isolated and forgotten in the middle of the community as surely as they were at the back of the asylum.'

The curious thing is that a way *has* been found to prevent the development of new chronic wards, and that this discovery has been made within the mental hospitals themselves. None of the authors writing about hostels shows much familiarity with the literature on rehabilitation, nor do they appear to realize that, in some mental hospitals, the low standards they describe as characteristic of many hostels would not be tolerated. It may therefore be worth examining the strong reaction against the mental hospital which is so marked a feature of current psychiatric and social thought.

Mental hospitals have a multiplicity of functions. Clark (1956) described four: observation ward, geriatric hospital, unit for psychopaths, and neurosis centre. A more social classification of functions would specify those of the hospital, the training centre, the place of work, the hotel, the hostel, the detention centre, and the asylum. The most medically oriented units, the hospitals proper, are usually separated from the rest and constitute only a relatively small part of the whole institution. Quite often the buildings are relatively new or have been recently refurbished, the staff ratio is higher than elsewhere and morale is good. The 'admission wards' are the most attractive parts of the mental hospital so far as staff are concerned and there is little criticism of the way they function.

Geriatric units raise different problems, particularly of staffing, and though allegations of serious clinical neglect have not been substantiated, the problems are similar to those of the long-stay parts of the hospital (Robb, 1967; Report of Committees of In-

quiry, 1968). For most long-stay patients the mental hospital consists of a collection of hostels and sheltered work places under various degrees of supervision, set in grounds which provide a degree of seclusion from the outside community (Catterson Bennett, and Freudenberg, 1963). One of the main criticisms has been levelled at the persistence of Poor Law attitudes; what might be called pauperism (Belknap, 1956; Barton, 1959; Dunham and Weinburg, 1960). This poverty of the social environment reflects back to the patient a low estimate of what he can achieve and thus is an important source of secondary handicaps (Wing and Brown, 1970). The operation of the system of privileges so graphically described by Goffman (1961) depends upon the fact that a cigarette can be a potent reward.

Two other criticisms are that the mental hospital promotes institutionalism and that it allows cruelty and neglect. There are two factors in institutionalism; firstly an isolated community with its own distinctive way of life which in some respects is incompatible with that of the outside world, secondly a reaction on the part of a member of the community of indifference about leaving or an active wish to stay. Such attitudes are often present in embryo before entry. Indeed, in the case of religious orders, for example, the whole process is voluntary. Schizophrenic patients (like many other handicapped people) are vulnerable because they may never have developed strong social ties to a group outside hospital. Institutionalism may be compatible with high staff and inmate morale and a reasonable standard of living. In the comparative study of three mental hospitals, the one with the most superior social environment contained almost as many institutionalized patients as the others (Wing and Brown, 1970). What is less acceptable is the fact that, at the time of admission, many patients presumably wanted to leave. Nowadays, those who stay a long time tend to be those who have adopted institutional attitudes and habits very early on, as was shown in Chapter 15. It is highly probable that surveys of the long-stay population of local authority hostels would find the same thing.

However, the most emotive charge against mental hospitals is no longer pauperism or institutionalism but cruelty and neglect, though all four do tend to go together. The reports of the committees of inquiry into complaints made about conditions at Ely, Farleigh, and Whittingham hospitals (1969, 1971, 1972) made it clear that cruelty was rare but neglect not uncommon. Low standards of training and skill among nursing staff, poor morale, lack of leadership, and absence of clearly defined lines of responsibility from the management committee (whose function it is to

represent patients), and from administration, senior doctors and nurses, were the factors held responsible. In these circumstances it was possible for pockets of authoritarianism, bullying, neglect, and delinquency to develop or persist from the old days, with the passive acquiescence or ignorance, in the name of loyalty or a quiet life, of the decent majority. At Whittingham, however, there was a healthy reaction from the student nurses and a young psychiatrist and psychologist, who brought the whole story to light in spite of active opposition from some senior staff.

One comment of the committee which inquired into the Whittingham incidents will be quoted since it reflects upon the policy of moving the admission units into general hospitals before the longer-term units have been catered for. The report states:

In all this the Regional Hospital Board must bear a share of blame. They have pioneered a plan of opening psychiatric units in general hospitals which has been generally accepted as desirable for the whole country. But their plan is no more than half a policy when the problem which it entails of running down and closing existing out of date hospitals has not been fully thought out. Without adequate recognition of the continuing need for alternative accommodation for elderly long-stay patients, an old hospital can never close. Appreciation of this fact has led to a frank disbelief and dichotomy of aim between the Board and the Whittingham Hospital management. Worse, there is a danger that it could lead to a two-tier system of psychiatry—well staffed ‘acute’ units and ‘long-stay dumps’ which are professionally unattractive and hence understaffed, yet indispensable.

The committee did not have to consider the wider social aspects of the phenomena they were investigating but it is clear that all the disadvantages so far considered (pauperism, institutionalism, cruelty, and neglect) are those of closed institutions in general. They can occur in army units, prisons, refugee camps, orphanages, and other closed environments. We may surmise that they can occur in local authority hostels as well.

One further element in the reaction against mental hospitals needs to be discussed before we try to balance the pros and cons. This element is provided by the writings of sociologists such as Goffman (1959, 1961) and Scheff (1963, 1964, 1966). Goffman's descriptions of ‘total’ institutions are well known and constitute a powerful indictment of the conditions in American state mental hospitals at the time he was writing. In effect, he states that their main functions were custodial rather than educational, therapeutic, resocializing, or protective, so much so that Etzioni (1961) was able to include them without question into the same category of institutions as prisons. Goffman took the argument further by

proposing that much of the career of a mental hospital patient was determined, not by his illness or handicaps, but by the way of life imposed upon him. Scheff, after studying the process of admission to mid-western state hospitals, which was via a court procedure in which the psychiatrist sometimes appeared to play a similar role to that of the police, took this line of argument to its logical conclusion and subsumed mental illness under social deviance. He put forward the general hypothesis that 'labelling is the single most important cause of a deviant career'. If the sick role is forced upon an individual he may have to embark upon a deviant career even though he was never ill. Both Mechanic (1969) and Wing (Wing and Brown, 1970, chapter 9) have made observations indicating that such a process can occur but that in other cases, the existence of prior illness or handicap must be assumed. Certainly the evidence of Chapter 14 does not suggest that many people are compulsorily admitted in this country without prior manifestation of illness. To argue that the imposition of a social label, with its consequent effects, means that a diagnostic label has no independent significance, is to risk throwing out the baby with the bath water.

The views of Goffman and Scheff must be taken seriously as a contribution to scientific knowledge but they are seen in more messianic form in the writings of the 'anti-psychiatrist', the purport of which varies from the naïvely optimistic to the nihilistic. At the most optimistic, any patient in a mental hospital (even any patient who sees a psychiatrist) is regarded as being there only because of some form of coercion and freedom will restore health. At the most pessimistic, society has created mental illness and nothing short of a complete social revolution will make any difference.

These opinions may not have consciously influenced the policies of practical administrators in this country, but they are in the air and are accepted as gospel by many people who are quite unaware that there is a case for any other point of view. Thus the rational argument against those services which provide for chronically handicapped people becomes subtly reinforced by irrational elements.

The conclusion of this brief survey must be that the potential advantages and disadvantages of hospitals and hostels are much alike. Understanding the way that pauperism, institutionalism, and neglect may develop should help to prevent them in either setting. Understanding the principles of rehabilitation, and re-settlement at a level appropriate to the individual's residual handicaps, will lead to those handicaps being minimized in either setting. Other considerations may therefore be taken into account: size,

geography, ease of obtaining staff, past traditions, the presence or absence of sheltered grounds, the nearness of other services, the adequacy and appearance of buildings, and so on. The factor of size is important psychologically but it makes no independent contribution to outcome (Ullman, 1967). Where the mental hospital is in the centre of its area and its tradition is a good one, the existence of a sheltered space could be exploited by utilizing houses on the periphery, with their front doors opening on to the general community. The presence of a fast-moving as well as a slow-moving stream within the same complex of units may contribute to maintaining staff morale. On the other hand, there seems no reason to suppose that local authority services could not also make such provisions so long as they were willing to learn, not only from their own excellent models (Mountney, 1968), but from mental hospital experience as well. Otherwise they would make all the old mistakes before a body of knowledge was again built up. The only reason for dealing with the functions of hostels for the severely handicapped separately from those of mental hospitals is that they operate under different administrative hierarchies. It requires far-seeing professional people on both sides to understand how closely linked the functions in fact are. In practice, the people with most energy and enthusiasm for building up a new service might be doctors, nurses, or social workers and it would be a pity if a rigid administrative division had to be made.

If the new plan were put into operation without providing the alternative long-term services, it seems inevitable that the standards even of the best mental hospitals must fall (the incidents at Whittingham could be symptomatic), and also that 'small back wards' would begin to build up outside. Priorities must therefore be considered. It would be rational to develop demonstration services in different parts of the country according to different models, depending on local circumstances, which would be independently evaluated. In some areas, the alternative longer-term services might already be fairly good, in which case priority might be given to building a new district general hospital unit. In many other areas, the benefit to be derived from the cost of a new hospital might not match that which would accrue from setting up high-quality services in the community for the chronically handicapped. In that case the priority would go the other way. In other words, the plan would become part of an ongoing cycle of planning and evaluation. The opportunity might well be taken to incorporate parts of the plans of the regional hospital boards, for example those of the South-East Metropolitan (1971) and East Anglian (1970) regions. It would, however, be essential to the

success of any such scheme that the plans of local authorities, such as those of the City of Leicester (1972) should also be taken fully into account.

There seems no reason why evaluation and planning should not be as successfully integrated on a regional and national as on a local scale.

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