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CONFIDENTIAL

SERVICES FOR THE MENTALLY ILL

Paper by the Department of Health

1. This paper provides an overview of the Government's present strategy for the provision of hospital and community health services in England for those people who are disabled by mental illness, and proposes new initiatives.

Background

2. Until the 1960s there was little alternative for those suffering from long term, disabling mental illnesses such as schizophrenia to prolonged in-patient care in one of the large and often remote mental hospitals.

3. Scientific advances in the 1960s, particularly the discovery that the psychotic symptoms of schizophrenia could often be controlled by drugs, together with the development of community psychiatric services, opened up the possibility that many sufferers could be treated on a largely out-patient basis. The vision of a new pattern of services on this basis, anticipating the dramatic fall in hospital beds over the last thirty years (from 150,000 in 1960 to about 70,000 in 1986), was outlined by Mr Enoch Powell in 1961 in the context of his Hospital Plan. It was turned into detailed policy under Sir Keith Joseph in the early 1970s, though the product - in the the form of the White Paper "Better Service for the Mentally Ill" - was actually published in 1975 by Mrs Barbara Castle. The policy as stated in that White Paper has remained essentially unchanged since - supported by both major parties.

4. There is no doubt that over the last thirty years improved therapeutic methods and professional standards, and the new pattern of services resulting from them, have meant that sufferers who would have faced the prospect of spending many years in hospital are now satisfactorily treated on a largely out-patient basis. There have also been great improvements in the conditions in the mental hospitals for those who do need in-patient treatment. These changes have clearly been beneficial; what is less clear is whether as patients have transferred to out-patient care resources from the hospital have been reallocated to support them in the community.

5. Despite the general satisfaction that many people can now be treated, effectively, on an out-patient basis, however, there is increasing public concern, expressed by such bodies as the National Schizophrenia Fellowship (NSF), that there are growing numbers of obviously disturbed people on the streets, and that it seems to be difficult to get appropriate treatment for them as hospitals run down and close.

6. The concern seems largely to be about the implementation of policy: whether adequate alternative services are being provided for those who, in principle, everyone agrees could be sustained on a largely out-patient basis, and whether the policy is being pushed too far in trying to treat, on such a basis, those who are too seriously ill for it to be realistic.

The Present Situation

7. There has been a substantial shift of resources from hospital in-patient provision to community-based services provided by health and local authorities. Over the last ten years for which information is available (1977 - 1987), the number of places for people with a mental illness in local authority, voluntary and private residential homes almost doubled (to 9,000) and there was a 50% increase in day centre places (to 6,000). On the health service side there has been a 44% growth in day hospital places (to 19,000) over the same period; the number of community psychiatric nurses has more than doubled since 1981, and it is estimated that the number of districts with a community mental health centre has doubled every two years throughout the 1980s.

8. These increases are impressive, and welcome. But across the country the situation is patchy, with great differences between the better and the poorer provided districts. For example, it is estimated that less than a third of district health authorities have multi-disciplinary teams of staff concerned with the continuing long-term care of patients in the community.

9. Resources may well turn out to be the central issue. A good locally-based service is much better for very many patients than long term treatment in hospital. It could, however, be more expensive if it is to function well, actively keeping in touch with patients.

Action

10. Ministers' aim is that subject to the resources that are available the standards of all parts of the country should be brought up to the achievements of the best, as is the aim of the proposals in "Working for Patients". Ministers have set in hand a programme of work that will give them a much better assessment of the quality of services across the country. They are keeping in close touch with progress, and undertaking a number of visits and meetings to get a first hand sense of the situation. In the meantime, a linked set of initiatives is being developed to assist health authorities in their task of providing effective locally-based services; to support the parents and friends of the mentally ill living in the community, and to monitor more effectively the implementation of policy and the quality of services. Most could be announced as part of the response to the Griffiths Report without any risk of pre-judging the fuller assessment:

a. Assessment and continuing care. The 1988 NHS planning guide lines require health authorities to initiate care plans for all patients discharged from hospital, by 1991. There is no single "right" way of establishing plans: Departmental guidance, which is almost ready for issue, will emphasise the need for locally developed approaches. Much more importantly, at officials' initiative, the Royal College of Psychiatrists has agreed to draw up what would in effect be

minimum acceptable professional standards for assessing patients prior to discharge, and for follow up after discharge. A preliminary statement of good practice is expected from the College soon, to be followed by a more substantive one in the Autumn. Subject to the agreement of the College, this initiative could, quite properly, be linked to those for which the Government is directly responsible;

b. Social work. Since 1974 health authorities have been required to look to local authorities to provide them with social work support. In spite of the successful introduction of approved social workers, however, local authorities have not in general met health authorities' expectations of a social work service for mentally ill people. The Department is looking at ways to enable health authorities to secure the social work input they need. This may require an amendment to the law (now the NHS Act 1977) to clarify functions and to enable health authorities either to employ social workers or to buy social worker time from local authorities, or both. A change on these lines would help establish the principle that those seeking to use resources should meet the cost;

c. Code of Practice for admitting and treating patients compulsorily. A small high-powered working group external to the Department is being constituted to complete the task of drawing up the Code of practice required under the 1983 Mental Health Act, with a view to it being laid before the House this Autumn. This will at least provide a common basis for handling compulsory admissions, an area where there seems wide agreement that the law is adequate but its interpretation by practitioners often not. It is expected that the composition of the group will be finalised shortly;

d. Finance from mental hospital sites. The new forms of service for the mentally ill - both in terms of staffing and facilities - could be established faster and more effectively if the money tied up in the sites of hospitals that will close when the new services are available could be unlocked in advance. Mr Idris Pearce, Property Adviser to the NHS Management Board, is developing proposals to release in this way substantial sums over each of the next five years, for discussion with the Treasury shortly. These proposals are, in Treasury terms, "unconventional financing". If, exceptionally, they could be agreed, it would make a great difference to the rate at which the necessary local facilities such as hospital hostels could be provided;

e. Supporting parents and friends of the mentally ill. A lot can be done, through better use of Departmental grants to voluntary organisations, to increase the information and mutual help available to the parents and friends of patients. Officials are reviewing current grants, looking particularly critically at the larger, longstanding grants to

bodies like MIND, whose vitality and value to the mentally ill may be diminishing. There are known to be potentially valuable initiatives coming up from other bodies, and the aim will be to switch grant aid to support these. One or two are sufficiently developed to be announced shortly;

f. Monitoring the implementation of new services. Policy statements have long emphasised that mental hospitals should not be closed before adequate alternative facilities have been developed. This will be re-emphasised to Regional Health Authority Chairmen by Ministers. New arrangements will be introduced under which RHAs will monitor and report the process of providing the alternative facilities needed to replace the forty or so major mental hospitals scheduled for closure over the next few years, and thus ensure that these arrangements are satisfactory;

g. Monitoring the quality of services. In the wake of scandals about the conditions in some mental hospitals in the 1960s and early 1970s, the Health Advisory Service was established, to keep a watch on standards and encourage better services. The HAS still functions largely as originally envisaged, (the main change being that reports are now published), and there is some concern that it is now not as effective. Ministers are exploring ways in which the work of the HAS and the parallel body for services for people with a mental handicap (the National Development Team) might be done more effectively, and in a way more relevant to the NHS as it will develop following "Working for Patients".

11. Thus even at this preliminary stage there is a number of initiatives which, if agreement could be reached by the Departments concerned, could be announced as part of the response to Griffiths and would go a long way to meet concerns about the implementation of longstanding policy. The next stage would therefore be for the implications of the proposals, including their potential costs, to be discussed by officials from the Departments concerned to see what form any such announcement could take at this stage.

12. As part of any package announced it would be made clear that other initiatives will follow, if the fuller assessment referred to in paragraph 10 indicates the need, and that if necessary the Government will not hesitate to seek further statutory powers to ensure that proper community care facilities are provided for the mentally ill.