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PRIME MINISTER

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COMMUNITY CARE: MENTAL ILLNESS

I was invited, at our meeting on 18 May, to bring forward for discussion at our next meeting details of the approach we have adopted in Wales for the development of services for those suffering from mental illnesses.

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Despite substantial investment in mental illness services in the Principality over the past decade, we are still far too reliant on an inheritance of large Victorian and Edwardian hospitals. These are often remote and in poor physical condition. Even if there were no change in current patterns of use, they would require considerable investment to maintain. The key issue is to make possible the humane transition to a much more decentralised pattern of services.

The choice for most people with mental illnesses should not be a stark one between hospital care on the one hand and community care on the other. Most have a range of clinical and social needs which vary in their nature and intensity over time, as their symptoms and circumstances change. We estimate that perhaps up to 200,000 people in Wales will at some time in their lives suffer from a significant mental illness, yet under 4,000 are hospital in-patients at any one time. Of these nearly a third are in hospital for less than 3 months; and over 42% for less than a year. The need is therefore for a continuum of care to be available, ranging from the maximum security provided by the special hospitals, to regional medium secure units, to local hospitals, hostels and domiciliary support. Without this many people who do not need hospital care - and who may actually deteriorate if they are cared for in a hospital - will either be denied care altogether or be cared for inappropriately.

From our experience in Wales, 3 things are essential to ensure the successful development of more local and appropriate services for those with mental illnesses.

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The first is to ensure that the most vulnerable and the most disabled - those with major acute and chronic conditions - get the priority they deserve. During consultation on our proposed all-Wales strategy I came under strong pressure from some quarters to extend its scope and promote the comprehensive provision of services for all problems of mental health, as well as for those posed by clinical mental illness. I resisted this pressure, since it was clear that the mental health services involved included just about every conceivable social malaise and maladjustment, from juvenile delinquency to mild neurosis, and that, within any conceivable level of public resources which could be made available, such wider patterns of service provision could be secured only at the expense of those with major problems, on whom the traditional hospitals have rightly concentrated. There is no doubt, in my view, that unless we insist on this clear pursuit of priorities and ensure that it sticks at local level, there is a continuing danger that services for the most vulnerable will be undermined and we will have the worst of all worlds: accelerating expenditure which is not targeting those most in need, and which leads to the kind of exposures of inadequate services which have been prominent in the media over the last year or two.

The second essential ingredient is the effective ring-fencing of existing investment in health and social services for the mentally ill to ensure that they continue to be used in support of those with mental illnesses. Without this there is the strong likelihood that the acute sector (apart from mental illness) will secure much of the resources which are shaken out by the process of reducing reliance on old mental illness hospitals.

The third key factor is that there should be sufficient bridging finance so that fully acceptable alternative services are in place before existing services are run down or closed. I welcome Kenneth Clarke's proposals to develop more flexible arrangements which will produce such finance through partnership deals involving the private sector in funding the bridging element, but we do need to bear in mind that site values differ substantially across the country and that up-front investment from public resources is still likely to be needed in many areas. In Wales, some of our authorities have already had detailed feasibility studies of the development potential of traditional mental illness hospitals carried out and the results have been generally disappointing.

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We are securing these 3 key ingredients for managing the process of change under our all-Wales mental illness strategy which I launched recently following highly successful public consultation. Both this and the initiative we have been running since 1983 to provide better, more appropriate services for people with mental handicaps (which I described in detail in my minute to you of 7 April) take advantage of the absence of a regional tier of health authority and the Welsh Office's direct relationship with 9 health and 8 social services authorities (co-terminous in all but one case) and the other key agencies to secure joint plans for development and investment, including the contributions of the private and voluntary sectors.

Both the mental handicap and mental illness strategies for Wales are consistent with the agreement we reached on 18 May that the bulk of expenditure should be through main programmes (in the case of local authorities, via the revenue support grant) but that targeted specific grants could be used to secure central Government objectives. The targeted grants will come to an end when I am satisfied that the new patterns of services are substantially in place and it is therefore prudent and sensible to transfer the relevant sums to the local authorities through the revenue support grant and to health authorities' main allocations. The use of limited targeted grants in this way is enabling me to obtain significant leverage over total health and local authority expenditures on these services so as to secure strategic objectives, but without enabling the authorities to duck their responsibility for the level and quality of local service provision. Indeed, I have made it clear that I reserve judgement on what, if any, additional investment I am prepared to make in mental illness services until I am satisfied with the quality of service proposals and with the case for additional investment in particular circumstances.

Local authority expenditure in support of mental illness services is, at some £11 million a year, about 10% of the total estimated expenditure on these services in Wales. I expect, through the leverage achieved by limited targeted grants, that the contribution of the social services authorities will increase in absolute terms under the Welsh strategy. I have been eager, therefore, to avoid any suggestion that securing care for those with mental illnesses should be seen as solely the responsibility of health authorities and thereby giving the local authorities any excuse for failing to make that contribution. Moreover, I am reluctant to see Welsh health authorities providing social support rather than clinical care, and I think it is important that this distinction should be observed so as to achieve clarity in the relevant areas of expertise and responsibility as between social services and the health authorities.

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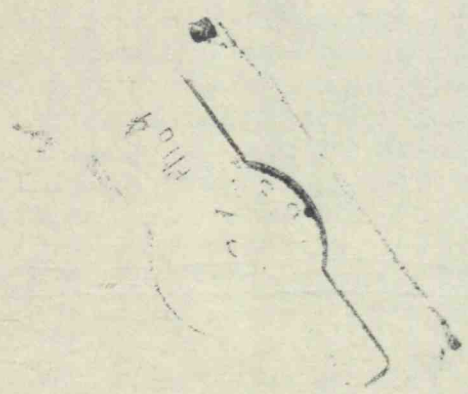
It would be consistent with our earlier conclusions in respect of other client groups for people with mental illnesses (including elderly people suffering from dementia), who are not being treated as hospital in-patients, to be eligible for income support and housing benefit and in a way which does not distinguish between receiving domiciliary support and those in residential or nursing homes. I would prefer in Wales to have the responsibility for providing any topping-up payments to individuals in receipt of care to rest, as we have agreed should be the case of other client groups (including elderly people), with the social services authority. The health authority and general practitioners would be responsible, as now, for providing any clinical input to care which is needed.

Giving the responsibility for any topping-up payments to the health authority would be likely, in my view, to lead to health and social services authorities arguing about whether or not a particular person should be their responsibility in this respect. This could be expected to be an especially significant problem in respect of elderly people with senile dementia, where there is no precise and unchanging line which can be drawn between clinical and non-clinical needs and where the condition normally involves progressive deterioration, starting with relatively minor social difficulties, but shading over time into a range of major social and clinical problems.

/ I am copying this to Nicholas Ridley, Malcolm Rifkind, Kenneth Clarke, John Moore, John Major, David Mellor, Sir Robin Butler, Sir Roy Griffiths, Mr Wilson and Mr Monger (Cabinet Office), and Mr Whitehead (Policy Unit).

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