LOST IN THE HAAR: A CRITIQUE OF MENTAL HEALTH IN FOCUS

NANCY DRUCKER

The Scotland and Wales Bill was in trouble in Parliament. The Lib-Lab Pact had just been formed. It was in the same year, 1977, that a Committee was set up to review the mental health services for adults in Scotland. Eight year later it has published its report, *Mental Health in Focus.*[1] That this should be "the first comprehensive report on these services ever to have been produced" is, as the authors comment, an indication of their low priority. So too is the fact, on which the authors do not comment, that such a lengthy gestation has been allowed. No subject about which the government or opposition parties or the public felt strongly would have been left so long. In this chapter, I shall examine the origins and status of the document, outline its major proposals and then, by concentrating on one issue central to any debate about Scottish mental health policy – the future of its psychiatric hospitals – seek to show that far from bringing issues into sharp relief it more often shrouds them as if in Scotland's soft grey mist, the haar.

Origins and Status of Mental Health in Focus

The Scottish Health Services Planning Council, comprising representatives of the Scottish Home and Health Department, the Health Boards and Medical Schools was created in 1974 to advise the Secretary of State for Scotland. The Council in conjunction with The Advisory Council on Social Work set up a number of Programme Planning Groups of which the Mental Disorder Programme Planning Group was one. This body in turn created sub-committees which have reported on services for mentally handicapped people (1979), the elderly suffering from dementia (1979) children and young people (1983) and now the mentally ill.

The members of the mental illness sub-committee comprised doctors, social workers, psychologists, nurses, occupational therapists and a health service administrator together with the director of the Scottish Association for Mental Health and a councillor from Strathclyde. The last two were the only members not employed by the health and social work services. Senior professional and administrative staff from the Scottish Home and Health and Scottish Education Departments acted as assessors. There were no consumer representatives.

The Committee operated in the face of great difficulties. Only 11 of the 18 people listed as members served throughout. The turnover of assessors

was even higher.[2] The Committee worked by discussion among its members. It commissioned an analysis of past and projected changes in the numbers of hospital patients. Otherwise it had only the most limited research and statistical assistance. It never called for evidence. It never made visits either in Scotland or elsewhere. One measure of its insularity is that half the references it cites are Scottish Office reports. Yet this insularity was not the result of a cosy consensus. Far from it. Although its recommendations are unanimous, close reading of the report suggests that on some critical questions the authors could not agree and on others the hidden hand of civil servants and the Minister constrained forthright discussion in print.

For not only were committee members denied the assistance they would have needed to do a proper job, their relationship (like the relationship of the other sub-committees) with the Scottish Office was unsatisfactory. The Secretary to the Planning Council was a civil servant: civil service assessors participated in all the sub-committees and were responsible for submitting the final reports to the Secretary of State for comment and permission to publish. Despite this not one received his wholehearted endorsement. Indeed, after the election of a Conservative Government in 1979, some feared that the reports then ready for publication would be suppressed. Instead, a formula was devised which has been used with variants. The preface to *Mental Health in Focus* reads:

> *Note by Scottish Home and Health Department*
> 'This Report...is being published for the information of interested bodies and those concerned with the future planning of relevant services. The Secretary of State has indicated in his foreward to the Report by the Scottish Health Service Planning Council on *Scottish Health Authorities Priorities for the Eighties* (1980) that he agrees with the Council's assessment of priorities which places services for the mentally ill in the highest category.'

Those with a relish for bureaucratic prose may savour the reference to a foreword to a report published five years previously which by all the available evidence has had a negligible impact on services for the mentally ill. Others may find it leaves a bitter taste.

Thus *Mental Health in Focus* is neither the report of an independently constituted group of experts arguing for what they believe to be right nor a political document like a White Paper put forward by a government as a statement of its policy. Instead, it falls awkwardly between the two. This is all the more unfortunate because it is the *only* substantial document on Scottish mental health policy. In England by contrast there has been much activity since 1975, the year in which the DHSS promulgated its White Paper *Better Services for the Mentally Ill.*[3] The DHSS has published a number of documents both on policies for the mentally ill and more

generally on community care.[4] In 1983, Mind, The Richmond Fellowship, and the union COHSE all produced major reports.[5] And in 1985, the Social Services Select Committee reported in 2 volumes and 900 pages, (including evidence submitted) on *'Care in the Community for Mentally Handicapped and Mentally Ill People*.[6]

The Report

Let us now see how *Mental Health in Focus* discharges its responsibilities. It runs to 150 pages. Its first nine chapters are concerned with the future development of services including, for example, accommodation, employment, day, hospital and preventive services. Chapters 10 and 11 cover alcohol-related problems and mental health services for offenders. Chapter 12 deals with patients' rights and Chapter 13 with organisational issues. Chapters 14 and 15 review the number of staff and facilities now available and set future targets while Chapter 16 suggests subjects for further study.

The theme of the report is that although there have been significant advances in the treatment of people suffering from mental illness and the general quality of their lives, the mental health services are still "a deprived area of care". Thus, for example,

> "Staffing levels are uneven and, in general inadequate; while some psychiatric hospitals are still too large and institutional, with much of the accommodation currently in use, dating back to the middle of the 19th, or the beginning of the 20th century".[7]

But the Committee's most serious concerns relate to the shortage of community alternatives to hospital in-patient care:

> "The fundamental shift of emphasis to community care envisaged for Scotland in the 1958 and 1959 Dunlop Committee Reports has not been achieved".[8]

The evidence they marshall supports this. In March 1983, they could uncover only 3 day centres with 160 places for mentally ill people run by local authorities and voluntary organisations. This, they laconically observe, "falls seriously short of the DHSS guidelines....which are 0.6 per 1000 population or 3000 for Scotland."[9] The number of places in hostels and supported accommodation, was they estimated, only a third of requirements. In fact, the position is worse than they indicate. They include a table which states that in March 1983 there were 41 local authority staffed homes.[10] This is wrong. Other published information suggests the figure should be 7 at most, the remainder being unstaffed group homes.[11] And the picture for employment was no brighter.[12]

Given this dismal litany, what does the Committee recommend? A clear need, they say, has emerged "for a comprehensive and co-ordinated range of locally-based mental health services".[13] Greater priority must be afforded them and the number of professionals involved substantially increased. In each area the needs of mentally ill people for accommodation, employment and daytime activites should be assessed and targets for new services set. Joint Liaison Committees involving health boards, local authorities and voluntary organisations "should be mandatory and should have a substructure of multi-disciplinary working groups for the mental health services....The JLCs should urgently initiate joint reviews...so that co-ordinated strategies for the mental health services can be devised, put into operation and subjected to periodic evaluation....Consent to major developments in provision for the mentally ill should be conditional on full use having been made of the proposed joint planning arrangements."[14]

These are fair recommendations with which most professionals would doubtless concur. But they might also expect an informed review of present policies and a cogent analysis of how these objectives might be realised. What they would find is a document which while it brings together much data which was previously scattered or unavailable and states the case for better services with conviction, proves on examination to be deficient. Relevant information is presented either unsystematically or not at all; factual errors have slipped in and difficult issues and conflicts of interest are repeatedly evaded by resort to euphemisms and vague bureaucratic nostrums. Perhaps the most serious defect is the failure ever to attempt to see the world from the users' point of view. This is epitomised in Chapter 12 "Patients Rights" which consists mainly of a recitation of recent legislative changes and the praise of public bodies such as The Mental Welfare Commission and The Scottish Hospital Advisory Service.

These are harsh allegations, but the report after eight years should have been a beacon on the road to better services. It would be possible to exemplify these shortcomings chapter by chapter. Instead I shall concentrate on one issue – the future of Scotland's psychiatric hospitals – and seek to show that the report neither adequately analyses their present role nor demonstrates how they would fit into the community-based pattern of services it proposes.

The Future of Scotland's Psychiatric Hospitals

The future of its hospitals must be at the heart of any debate about the pattern of Scottish psychiatric services. In most other Western countries such hospitals are sharply reducing their numbers or even closing. But in Scotland, as the report explains "forecasts of a dramatic reduction in the need for inpatient provision have not been fulfilled."[15] Hospital places,it is true, drifted steadily downwards from 20,200 in 1965 to 16600 in 1982,but admissions to hospital increased equally steadily. The reduction in beds was

possible because in Scotland as elsewhere hospital stays were becoming shorter. Half of the 23,700 patients admitted in 1982 were discharged within a month. On the other hand there were also in 1982 1900 patients who had been in hospital between 5 and 10 years and another 4800 who had been in hospital more than 10 years.[16] For many people in Scotland a hospital is still the only home they know or will ever know.

Psychiatric hospitals are significant for another reason – one which the report does not mention. At present, care of hospital inpatients takes most of the mental health budget. In the year ended March 1984 the running costs of Scotland's 27 psychiatric hospitals amounted to £153 million of which approximately £147 million was spent on in-patients and only £6 million on out-patients and day patients.[17] Furthermore, a generous estimate of local authority expenditure on specialist non hospital services would be £1 million a year.[18]

Given the predominance of the hospital sector how does the report deal with it? The authors mirror the change in the pattern of services they would like to see by discussing community services before reaching "hospital care" in Chapter 9. Unfortunately, this attempt not to over-emphasize hospitals gives the report an imbalance of another kind. Though it is true that much of the report concerns hospital services in one way or another (e.g. the chapter on staffing is much concerned with hospital shortages) Chapter 9 is but 4 pages long and the section entitled "The Future Role of the Psychiatric Hospital" runs to just 13 lines. A separate 3 page section in Chapter 15 estimates future requirements for hospital beds.

Size, location and role of hospitals

The first point to note is that the reader is given surprisingly little information. We are told "there are considerable variations not only in the size of such hospitals, but also in the bed: population ratios in different parts of the country".[19] We are not told how many hospitals there are, where they are, nor what precisely there variations are. Nor are we told that there are substantial variations in the money spent on patients in different hospitals. Yet, all this information is published annually by SHHD .[20]

The report goes on: "while there are fewer excessively large psychiatric hospitals in Scotland than elsewhere in the UK many Scottish hospitals are still too institutional".[21] If one takes excessively large as over 1000 beds then the first part of this statement is certainly true. There were in 1984 but two hospitals with more than 1000 beds – Hartwood in Shotts with 1600 and Leverndale in Glasgow with 1005. Another 14 had between 500 and 1000 and the other 11 fewer than 500.[22] On the other hand, for a local service, even a hospital of 500 beds may be 'too large'.

Nor is the geographical distribution of services satisfactory. The report

does not discuss the location of existing hospitals though it does propose that "when new hospital provision is being made its proximity to the catchment population should be foremost in the minds of the planners."[23] Considering that the locations of the present hospitals were almost all chosen in the 19th century some, such as the Royal Edinburgh, are surprisingly well situated being either from the first, or as a result of the expansion of the towns they serve, embedded in them. Others, however,even in central Scotland have large catchment areas (an example would be Bellsdyke in Larbert) or are right out in the country (an example would be Roslynlee in Midlothian). Others again serve populations scattered over a wide area. Examples would be Craig Dunain, Inverness which serves the whole of the Highlands and the Western Isles and the Argyll and Bute Hospital Lochgilphead which takes patients not only from Argyll but also from Dumbarton 80 miles away.

Staff often express concern about about the difficult journeys on foot and by public transport made by patients and visitors who are increasingly elderly. And they recognise that their hospitals can be psychologically as well as physically inaccessible. Many have attempted to get over these problems – for example by running-out patient clinics in health centres but often in Scotland all the functions have been carried out on one site – even to the extent of day hospitals and hospital hostels being created within the hospital curtilage. And there were only 341 beds in 9 inpatient units in general hospitals in March 1984.[24]

In their review of the changing role of the psychiatric hospital the authors state "the development of closer links with health and other services in the community has enabled the psychiatric hospital to specialise in the tasks which it is best fitted to perform".[25] They do not adumbrate these tasks but instead make a series of recommendations to "give further encouragement to these developments." Here is their own summary:

a) Out-patient clinics should be held in varied community locations.
b) Short stay units should emphasize immediate assessment, intensive treatment and earliest possible return to the community.
c) Staff input into the rehabilitation area in the hospital should be such that daily programmes are tailored to individual needs.
d) Specific provision, based on a joint planning approach, should be made for the elderly in the psychiatric hospital and for new long stay patients.
e) An adequately staffed intensive psychiatric care ward of not more than 20 beds should be provided in every psychiatric hospital for patients requiring a high degree of supervision.
f) Specialised services e.g. for those with alcohol problems, undergoing behavioural modification or suffering from head injury should be kept under review.
g) Hospital day serices should be closely articulated with day provision

in the community.[26].

A little later the authors mildly observe,

> "whilst it should be the general policy to care for patients as far as possible within the community, psychiatric hospitals, in association with psychiatric units in general hospitals... will continue to play a major role in the future, complementing and supporting a community based pattern of care".[27]

No indication is given of how hospitals can play both major and supporting roles simultaneously. The list suggests the former rather than the latter. The next sentence is even more baffling:

> "This gradual change in the role of the psychiatric hospital should bring about an acceleration of existing trends toward a milieu which, particularly for elderly and new long stay patients, is based on an appropriate range of accommodation including facilities for 'small unit living'."[28]

This seems to imply that "the elderly and the new long stay" will still find themselves in psychiatric hospitals, but it is impossible to be sure. Nor do other chapters resolve this ambiguity.

The place of hospitals in the care of the elderly

The care of the elderly is a major task of all psychiatric hospitals People over 65 constituted 28% of those admitted to psychiatric hospitals in 1982 and 59% of those who were resident on the census day December 31st 1982. Indeed over a third of residents on that day – 6000 people – were over 75. And a quarter – 4022 – had a diagnosis of dementia.[29] Futhermore the demand for places is increasing rapidly. Despite this *Mental Health in Focus* does not explore the needs of older people in general and makes minimal reference to the Timbury Report *(Services for the Elderly with Mental Disability 1979)* which was concerned with dementia sufferers.[30]

The Timbury Report had been forthright in its conclusions:

> "...those with severe dementia have tended to be cared for in unsatisfactory accommodation...the facilities, services and location of many mental illness hospitals still leave much to be desired. In any case it is our view that wards in large mental hospitals of whatever standard are inappropriate for the continuing care of most elderly people with dementia."[31]

They advised that existing mental hospitals should not be enlarged or adapted for the mounting numbers of elderly people with dementia.

Instead an urgent start should be made on increasing community and day services and on building continuing care units. These units, run by the NHS, would have 40 to 60 beds and be closely associated with other facilities for the elderly such as geriatric units. The report urged that half (1500) the beds in psychiatric hospitals being used for dementia sufferers be replaced by beds elsewhere and that an extra 4000 beds be supplied for people wrongly placed in general hospitals and old people's homes or left in danger at home for want of an alternative.[32]

One might have expected *Mental Health in Focus* to comment on these proposals and the progress towards their fulfillment. Instead in one of the deadpan statements for which it is so notable it observes:

> "The location of beds for the mentally disordered elderly is discussed in the Timbury Report; it is by no means certain that these will continue to be located in mental illness hospitals".[33]

Whether they think this desirable they do not indicate. Yet the question is critical not just for the dementia sufferers themselves but for all other adults who may experience mental illness. If services for this group were provided elsewhere it would call into question the desirability, indeed the feasibility, of continuing to locate other services at the psychiatric hospital. For as the report itself shows the number of beds required for other patients is falling and is likely to continue to fall.[34] But as patient numbers fall, the expense of maintaining buildings and staffing does not fall proportionately and the cost per patient rises. It is this equation which has caused planners and politicians elsewhere in Britain to consider hospital closures.[35]

Health Boards are now faced with a challenging question. How should they meet the clamant demand for dementia places? It is usually simplest and quickest for them to build or adapt on their present hospital sites. They own the land and the buildings and if all their staff are on one site they can cover for each other. Furthermore, wards are falling vacant as the number of younger patients diminishes. On the other hand, those who believe in decentralising services see continuing care units as an ideal case. Why not allow people to spend their final years in their own localities? Why not conceive of continuing care units as the hub of local services for the majority of sufferers who will be struggling at home? And if continuing care units were scattered, why not mental health centres for younger adults too?[36]

If *Mental Health in Focus* had commented on Timbury it would have been obliged to admit that little progress had been made in the creation of

continuing care units. Responses to Parliamentary questions in May 1985 revealed that since 1980 "two such units have been opened both in the Grampian Health Board area" and that information about the number opening in the next five years "is not available centrally. Health Boards are currently reviewing their plans."[37] These answers are discouraging since a study completed in 1984 found that not one Health Board had taken decisive action on Timbury. Lack of money was a factor, but so too was uncertainty about the right course. For example, some health board staff were concerned that continuing care units might become not centres of excellence but isolated outposts with low standards and lower staff morale.[38] Equally there is a danger that existing hospitals might themselves so deteriorate if all new building were elsewhere.[39] These are legitimate concerns about which a policy-aker might expect to find guidance in *Mental Health in Focus*. But the report is silent.

Future size of the hospital sector.

Nor would a policy-maker find consistent guidance about the likely future size of the hospital sector. He could, it is true, consult the meticulous analysis by Carstairs and Redpath of data about admissions, residents and discharges between 1965 and 1982. He could also consult their projections of future bed requirements. Both are included in an appendix. But he would be rubbing his eyes in disbelief if he tried to follow the use made of these statistics in the final section of the appendix and in Chapter 15.[40] For to Carstairs and Redpath's projected hospital residents in 1991 are added the number of beds for dementia sufferers recommended by the Timbury Report. There is a treble confusion here. Firstly patient numbers and bed numbers are distinct:occupancy is never 100%.[41] Secondly Carstairs and Redpath's projections are based on the assumption that existing trends which are the sum of decisions of thousands of professionals and patients will continue. Whether these trends, for example to shorter hospital stays are advantageous is never debated. Conversely, Timbury's recommendations are based on a set of judgements of value. Thirdly Timbury explicitly disavowed psychiatric hospitals as the place for the majority of their recommended beds. Ironically the upshot of these calculations is the conclusion (which is buried in the appendix) that by 1991 elderly patients will account for almost 75% of resident patients compared with 43% in 1979.[42] Yet the report still doesn't comment on the implications for hospitals.

As the chapter continues confusion is only confounded. It ends by considering "how far the present stock would go to meeting likely bed requirements." But information about the physical condition of the stock is

combined in a single calculation with speculation about who is now and will in the future be using it. The complete paragraph is as follows:

> "Of the current stock of 17,400 beds 3,600 are in new or relatively new accommodation (commissioned since 1955) and 4,500 in wards substantially upgraded since 1970. Of the remaining 9,300 around 2,800 are likely to become redundant for their present use. While these 2,800 could provide some of the beds required for the care of the elderly with senile dementia, a substantial proportion are unlikely to be suitable for this purpose. This suggests that there may be a need for around 3,500 additional beds for this group which would be new provision and upgrading or replacement of the remaining 3,500 beds."[43]

No amount of juggling with projections from *Mental Health in Focus* or the Timbury Report can made sense of this paragraph or even I think get it to add up. Since even the lower figure for new beds is the equivalent of all the beds commissioned over the last 30 years, the reader can only be startled that the chapter ends there without any attempt at costing or further comment.

Yet it should now be clear that the question of how many beds are required and where is a matter of judgement not simply of technical calculations. Many professionals would argue that the whole terminology of "beds" whether in hospital or out is misleading. Rather we should be thinking more precisely about people's varied needs and wishes. The report to be fair does concentrate much more on services than bed numbers, but the numbers in such documents tend to be accorded an authority by virtue of their provenance.

For the authors to have satisfactorily considered the future of hospitals and their place in the "locally based community orientated services" they advocate they would have had to tackle at least four subjects more thoroughly: patterns of need and of services; the physical condition of hospitals; finance and staffing.

Patterns of Need and of Services

Mental Health in Focus lacks firm foundations. For example, the reader will search in vain for a definition of mental illness or a discussion of the nature and prevalence of specific conditions. All we are told is that

> "Some 20% of the population will have to cope with some form of mental illness at least once in their lifetimes".[44]

The epidemic of depression and anxiety represented by the 4½ million prescriptions written for sedatives and anti-depressants by Scottish GPs each year receives scant attention.[45] And schizophrenia is barely mentioned. Yet it has been described as one of the most severe and widespread disabling illnesses affecting young adults.

Secondly, although the report acknowledges that "the great bulk of emotional disturbance is located in the community",[46] it does not adequately explore the repercussions. Goldberg has suggested that each year out of 1000 people about 250 will suffer distressing nervous symptoms. About 125 will be treated by their family doctor, 11 will be seen as outpatients by a psychiatrist and only six will be admitted to hospital.[47] Other studies have shown that among sufferers even from severe disorders by far the majority at any time are outside hospital not in it.[48] These studies immediately raise the question of whether a major realignment of finance and staff is required.

Nor does the report set out the principles on which its new pattern of services might be founded. Many practitioners and researchers have argued that programmes of community care have failed because the diverse needs of different groups (and individuals) have not been recognised. In particular they have not been designed to safeguard the most disabled who frequently are those with schizophrenia. Such sufferers may not need prolonged hospital stays. They do need long term medical treatment and social support.[49] The report might have discussed the approaches which have been tried in Scotland and elsewhere. At Fulbourn Hospital Cambridge, for example, a group of specialist workers have responsibility for 350 long-term patients wherever they are living. Accommodation from highly staffed wards to ordinary houses is available and varied day time activity too. Drama, art and music therapists are employed as well as conventional staff.[50]

Furthermore, if consumers, carers and professionals throughout Scotland had been consulted conflicting views about patterns of care would have been expressed. This would have been illuminating, especially if the evidence had been published. Such conflicts are manifest in the 51 memoranda from professional, statutory and voluntary bodies to the Social Services Select Committee on Community Care. This covered England, Wales and Northern Ireland. On the future of hospitals, for example, the reader can study both the DHSS' statement of its policies and the blistering attack on them and their statistical forecasts by the National Schizophrenia Fellowship. Case histories are given which are almost unbearable to read.[51]

If evidence had been collected in this way, the authors of *Mental Health in Focus* would have been forced to explain the disagreement which often surfaces among Scottish professionals and which seems to have

bedevilled their own work. To oversimplify, there are those who believe that Scotland's relatively large hospital sector has ensured good quality care for the most part and reasonably humane admission and discharge policies: its maintenance offers the best protection against exploitation and neglect for vulnerable people. Community facilities are necessary, but not at the expense of hospital provision. Their opponents believe that many hospital facilities could be replaced by small scale local services tailored to the specific needs of individuals whether for accommodation, employment, nursing care, companionship, counselling or medical treatment. Such services could assist thousands who now receive little help. And even severely disabled people could enjoy a better life so long as the new arrangements were properly financed and organised. In between are many who hold parts of both views. It would have been enormously helpful if the authors had set out the arguments and the evidence relating to Scotland and had quarried research and experience elsewhere.

The Physical Condition of Hospitals.

The authors give only passing attention to the physical condition of hospitals. They do state that "substantial upgrading or replacement is required. It is totally unacceptable that some mental patients are still accommodated in temporary huts erected in the 1930s."[52] They also, as we have seen, propose that either 3500 or 7000 new beds will be needed. Yet between 1980 and 1984 another group was at work under the auspices of the Scottish Home and Health Department, a group which in its final report argued "the urgent need for improvement in the long stay sector." *Mental Health in Focus* cites this report but does not comment on its findings or its arguments.[53]

The task of the Capital Steering Group was to produce a report to "guide consideration of the health capital building programme in Scotland". One cannot help comparing this document to which SHHD and the Health Boards must have devoted countless hours of professional, technical and statistical staff time with *Mental Health in Focus*. One example will suffice. The Capital Steering Group commissioned two 100% surveys of hospital buildings in Scotland and followed these up with sample checks to validate the results. The *only* research completed for *Mental Health in Focus* was the analysis by Carstairs and Redpath based on existing routinely collected statistics.

The investigations by CSG revealed the need for £26m to be spent on the backlog maintenance of psychiatric hospitals. The figure for major acute hospitals was £78m and for mental handicap and large geriatric hospitals £15m. They advocated an urgent repair programme (so large that it would require to be funded from capital rather than revenue allocations) over 10 years.[54] Their figures indicate extreme discomfort for patients and staff. Buildings which are too cold in winter or poorly ventilated or which

have inadequate kitchens and bathrooms are all too familiar. Patients and staff are familiar with another problem too: buildings which "do not fit their current use".

The CSG asked Health Boards to assess the suitability for its current use of each department in each hospital. They calculated that in 1981 only about 14,000 of Scotland's approximately 17,000 psychiatric beds ("taking the term bed to represent a unit of investment including plant, buildings and support services") were in "suitable accommodation". By 1991 taking into account planned new buildings and closures that figure would have advanced to 14,500.[55]

Their overall argument was for a substantial investment in hospital buildings and within that for priority to be given to the long stay sector because of its past neglect. They suggested that £300m. might be invested over 10 years in developments for groups given priority by the Shape Report (1980).[56] Given their own estimates of the suitability of beds for the mentally ill as compared with the elderly and the mentally handicapped it would be reasonable to assume that half of that – £150m – should be allocated to mental illness.

Where does that leave the future of Scottish psychiatric hospitals? Some of the buildings are dilapidated and require heavy investment. Further, on a conservative estimate 20% of the accommodation was "unsuitable" in 1981. Conservative because firstly the questions asked about current use and as the hospital population ages what was suitable becomes unsuitable. And conservative secondly because suitability was judged (reasonably given the survey's purposes) on the assumption that the patients using the accommodation were correctly placed there. But this is a matter of judgement. How suitable is the treatment offered by an admission ward in however new a building which can offer but brief respite before discharging patients with little after care? And a Scottish survey has shown that some longer term hospital residents could live in supported domestic accommodation if only it were available. For them accommodation on a hospital ward may be 'suitable' in one sense but not in another.[57]

The CSG Report is a powerful document and its recognition of the decay and unsuitability of some hospital buildings in Scotland is welcome. But there is a danger that its advocacy of new hospital building will be taken at face value. For capital planning is more sophisticated and more powerful in Scotland than service planning as the two reports bear witness. Moreover, there is often little interconnection between the two. That the two committees could be working simultaneously on their reports without discussing them with each other symbolises the problem. Yet when spending on such a scale is proposed, it must be right to ask whether this is the best use of the money. The CSG Report advocates the appraisal of

options before any major investment, as does *Mental Health in Focus.* Neither gives guidance on relevant criteria.

Finance

If the authors of *Mental Health in Focus* had had the resources to collect their own data and to make use of others', they would surely have examined the question of finance. There are calls for more money, but the section devoted to finance runs to just 1½ pages.[58] They do not explain how the money now spent on mental health is divided either between services or geographical areas nor what redistributon might be required.They do not seem to realise, for example, that 4000 hospital beds have vanished over the last 20 years, but have not been replaced by community services of equal value.

The authors have costed none of their proposals. If they had done so they would have uncovered one of the conflicts at the heart of thei document. For if as they advise psychiatric hospitals continue to play a major role, it will be necessary to spend money on their maintenence and development. But if money is spent on rehabilitating existing buildings or building new on the same sites, this will preempt the possibility of creating from within the health service budget the more community based services for which they argue. Yet the sums suggested by The Capital Steering Group for hospital development – £150m over 10 years – might be used to begin to create different patterns of services if that is what the public and policy-makers thought was desirable.

Equally serious is their failure to tackle three other problems. The first is the imbalance within the health service between expenditure on the acutely physically ill and other groups such as the mentally ill and mentally handicapped. To give a single illustration. At any one time almost a third of patients in Scottish hospitals are in psychiatric hospitals, but only a seventh of the hospital budget is spent on them.[59] This is a longstanding problem which The Shape Report addressed in 1980. Their recommendation that priority be accorded to patients in the 'long term' groups was endorsed by the Secretary of State.[60] But there is little evidence that this has been translated into action. SHHD undertook to monitor the implementation of Shape priorities,but the results have never been published.It would have been invaluable if *Mental Health in Focus* had set out the evidence relating to the mentally ill and suggested how to achieve even marginal change.

Another imbalance is geographical. Almost all of the figures given in the report are for Scotland as a whole. Although it refers to geographical disparities, the evidence is not set out. Yet in 1984 for every 100 patients The Royal Edinburgh Hospital employed 6 doctors while Bellsdyke in Forth Valley only 1.7 and The Royal Liff Dundee employed 91.5 nurses while Ailsa in Ayr only 61.3.[61] Further, in 1983 60% of those who attended

a day hospital lived in either Lothian or Fife.[62] This raises questions both about equity and about the viability of proposals for local services. Would not their creation require staff and therefore spending to be spread more evenly across Scotland? And is it not likely that this would be resisted ? It is highly likely, but the fact of such resistance let alone ways of overcoming it are never broached.

Thirdly, the report fails to come to grips with the local authorities' exiguous expenditure on mental health. "Bloody child care is the bane of social work" was the exasperated comment of one champion of the mentally ill within a Scottish Social Work Department. She was referring to the importance traditionally ascribed to children and families. Extensive legislation reflecting society's concerns is one reason for this. By comparison,legislative requirements relating to the mentally ill even after the Mental Health (Scotland) Act of 1984 are small. The report notes that the Act imposes a duty on local authorities to provide after care services and comments "it will be for each local authority to determine the extent of the requirement for such services".[63] But it is this "determination" which has in the past resulted in a bare handful of services.

This is a delicate subject given that since 1979 the main policy goal of The Scottish Office seems to have been to hold down local authority spending and in the mental health field at least local authorities have complied. Nonetheless it is a pity that neither the problems of transferring money from health to social work services nor of transferring money within social work from, say, children and families to the mentally ill are analysed. The authors' themselves recognise that their sole recommendation though vital is unlikely to be accepted:

> "We do not think community care will become a reality until there is a central allocation of resources specifically directed to that purpose, although we recognise the force of conventional objections to earmarking. We recommend that Ministers consider ... restricting the use of part of the rate support grant to the development of community care."[64]

Staffing

Staffing is much more thoroughly reviewed and is the subject of some of the report's most robust statements:

> "While there has been a general improvement in staffing levels in recent years, the general position is still a matter of concern. Particularly in psychiatric hospitals, there are gross shortages of certain categories of staff, uneven distribution of staff and an imbalance between trained and untrained staff....We do not underestimate the cost of achieving (our suggested) targets...but we do not accept that present staffing levels should be allowed to continue."[65]

Far more information is given about staffing than any other topic and the data presented about doctors, nurses, occupational therapists, social workers and psychologists substantiates their concern. What is unfortunate is that the document does not focus equally on the question of who is to work in their proposed community facilities. For if the hospitals, already stretched, are to maintain their major role where are the specialist staff to come from?

The authors do not explore a dilemma which already confronts staff. How do they reconcile a responsibility for patients in hospital (whose needs are immediate and visible) with a responsibility for numberless sufferers outside (whose needs are equally immediate but are not so visible)? When staffing complements are so low that even those in hospital cannot be given sufficient care, how can time be made for those outside? And conversely if time is made are hospital patients put at risk? This is a concern which The Scottish Hospital Advisory Service has expressed on several occasions. For example, in 1982:

> "We are pleased to note the development of community psychiatric nursing services, day hospitals and rehabilitation programmes, but, to some extent this has been at the expense of adequate numbers of trained staff in the long stay and geriatric psychiatry units".[66]

This is linked to another point. Donald Dick, formerly Director of the (English) Health Advisory Service has estimated that 95% of all psychiatrically trained staff are to be found inside hospitals while the opposite holds for people identified as mentally ill: 95% are in their own homes or other domestic accommodation.[67] The distribution in Scotland is likely to be similar.If the pattern of services is more closely to match the distribution of people suffering mental illness then it is certain both that some existing staff will need to be redeployed and that more and probably different staff must be recruited.

Yet the report gives no inkling of the size of this task and how it might be tackled. Community psychiatric nurses are mentioned only briefly. The role of community psychiatrists is not discussed at all. Nor does the report analyse the contribution of other staff who would be needed such as residential and day care workers , support workers for people living in dispersed accommodation, homemakers and administrators. Instead it asserts,

> "It is difficult to estimate future staffing requirements of particular programmes such as day and residential services, crisis intervention and the community work aspect of mental health services.

> Experimentation, evaluation and special studies will be necessary."[68]

It would not be advisable to hold one's breath since only two paragraphs earlier the report has informed us, presumably tongue in cheek,

> "The staffing requirements of social work departments have been under discussion since they were set up in 1970 and we look forward to an early decision."[69]

In truth this is a serious matter since "care in the community" cannot materialise unless the number of staff and the costs involved are computed and then accepted by government. It has been suggested, for example, that local authorities be allowed to recruit workers to implement the policy without incurring the wrath of the Secretary of State for "profligate staffing". But no commitment has been given.

Conclusion

In England one response to the reduction in hospital residents, to the recognition of the expense of maintaining hospital plant and to the fact that hospitals require large numbers of staff to care for a small proportion of all sufferers, has been to consider closure. In Exeter, for example, it was estimated that at Exminster Hospital only half the budget was spent on medical and nursing care, the rest being taken by such items as catering, cleaning and caring for the Victorian fabric. Calculations also indicated that if the hospital was closed and replaced by new and converted decentralised facilities the proportion of the budget spent on direct care could be significantly increased.[70]

The closure of Exminster Hospital has taken a decade to plan. Elsewhere in England, health authorities under heavy ministerial pressure are acting more precipitately. In 1981 *Care in Action* outlined the Government's English priorities. For the mentally ill health authorities should

> "create ... a local service in those districts that still have little local provision ...; provide in every district enough suitable accommodation for the care of the elderly severely mentally infirm ...; and make arrangements satisfactory to patients and staff locally for the closure over the next ten years or so of those mental illness hospitals which are not well placed to provide a service reaching out into the community and are already near the end of their useful life."

The document suggested that such closures should

> "provide a source of staff, capital and revenue to support the

> development of the new pattern of health services ... and perhaps local authority services."[71]

A year earlier a consultation paper from the DHSS had predicted that while about 70 of the existing hospitals would continue "to be the focus for services in their own district," the other 30 would no longer be needed.[72] Despite widespread concern that the pace is too quick, some health authorities are well into the planning process and several large hospitals are expected to close in the next five years.[73]

In Scotland The Minister has issued no policy document. But permission has been granted to The Greater Glasgow Health Board to start work on 240 replacement beds for elderly patients at Leverndale Hospital. In addition there is to be a new kitchen and a unit offering physiotherapy, occupational therapy, dental and other services both to inpatients and day patients. The cost is estimated at £7.7 million. The Board has also submitted plans to the Scottish Office for a development at Gartnavel Royal at a cost of £10 million.[74] Elsewhere proposals are being prepared for major rebuilding at The Royal Cornhill Hospital Aberdeen and at The Royal Edinburgh Hospital. In the latter case The Health Board are anxious to move quickly to close and sell off the rambling expensive and unsuitable Thomas Clouston Clinic which stands apart from the main hospital on a valuable site. In its stead they wish to build new 30 bed units for elderly patients on the former kitchen gardens and orchards of the main hospital. These are all, it is true, city hospitals, but there is little sign of decentralisation elsewhere either.

It could be argued that Scottish policy is well founded and that the maintenance of a major role for its hospitals will best protect the interests of people suffering from mental illness. The problem is that this argument is implicit rather than explicit in *Mental Illness in Focus* and is not supported by evidence. It does not compare the benefits and disbenefits of alternative ways of spending money or deploying staff. Certainly there is reason to fear that the headlong rush to reduce hospital places in England before alternatives exist will result in large numbers of severely ill people failing to receive any service at all. But there is no need for Scotland to follow that path. It should have possible for *Mental Health in Focus* to analyse in some detail alternative ways of moving from where we are now to a variety of futures. It should have been possible for it to describe the strengths and limitations of specific community initiatives in Scotland and England (and indeed elsewhere) in order to indicate the most promising and practical approaches. It should have been ...

It could also be argued that a long delayed and inadequate document is of little consequence, but this would be fallacious. The authors repeatedly point to deficiencies and call for change. Yet change is unlikely unless the principles on which it is to be founded and the mechanisms by which it

might be achieved are widely discussed and the obstacles confronted. In Chapter 13 the authors comment in relation to inter-agency planning:

> "The maintenance of an unsatisfactory status quo is unacceptable and the response to exhortatory strategies such as have chararacterised the last two decades ... has not been encouraging."(75)

They could have been talking not just about inter-agency planning, but about mental health services in general. It is unfortunate that so much of their own report is exhortatory rather than informative or analytic. For this reason it is unlikely that the response from those who peer through the haar will be any more encouraging.

Nancy Drucker. Department of Social Administration, University of Edinburgh

References

1. Scottish Home and Health Department and Scottish Education Department, *Mental Health in Focus*. Report on the Mental Health Services for Adults in Scotland. HMSO 1985

2. The names of some members of the Mental Illness Sub Committee and of assessors to it were omitted or incorrectly listed in the published report. A week after publication, The Planning Council sent out an amended list on which these calculations are based.

3. DHSS, *Better Services for the Mentally Ill*. Cmnd 6233, HMSO 1975

4. For example DHSS, *Mental Illness: Policies for Prevention, Treatment, Rehabilitation and Care*. 1983 and DHSS, *Care in the Community. A Consultative Document*. 1981

5. Mind, *Common Concern*. London 1983. Richmond Fellowship, *Mental Health and the Community*. London 1983. COHSE, *The Future of Psychiatric Services*. London 1983

6. *Second Report from the Social Services Select Committee. Session 1984-5. Community Care*. House of Commons Paper 13 I-III. This covers England, Wales and Northern Ireland.

7. *op.cit.*, Para 2.3

8. *op.cit.*, Para 2.7

9. *op.cit.*, Para 15.5. Even 160 places may be an overestimate as Para 7.6

states that "there were, in 1983, only two centres..."

10. *op.cit.*, Para 15.11. Table 2.

11. This estimate is derived from Scottish Education Department Statistical Bulletin *Residential Accommodation 1983*. Tables 23, 27 and 28 and previous bulletins.

12. *op.cit.*, Paras 4.20-40

13. *op.cit.*, Para 2.11

14. *op.cit.*, Chapter 17 Paras 124, 129 and 131.

15. *op.cit.*, Para 2.4

16. Sources:
SHHD, *Mental Health in Focus* Appendix 1 Paras 1 & 2
SHHD, *Scottish Health Statistics 1982* HMSO 1984 Table 6.3
SHHD, *Scottish Health Statistics 1983* HMSO 1984 Table 4.14

17. SHHD, *Scottish Health Service Costs* 1984 p24 & 25

18. This is estimated because The Scottish Office could not provide figures in response to parliamentary questions (Written Answer Jan. 28th Hansard 1984/5 Number 1334 col.17). By contrast English figures are included in *Second Report from the Social Services Select Committee Session 1984-5*, Vol II, P.27, Table III

19. *Op.cit.*, Para 9.2

20. See SHHD *Scottish Health Service Costs* and *Scottish Health Statistics*.

21. *Op.cit.*, Para 9.2

22. SHHD, *Scottish Health Service Costs*, 1984, p.24

23. *Op.cit.*, Para 9.2

24. SHHD, *Scottish Health Service Costs*, 1984, p.74

25. *Op.cit.*, Para 9.4

26. *Op.cit.*, Chapter 17, Para 80

27. *Op.cit.*, Para 9.13

28. *Op.cit.*, Para 9.13. The Scottish Hospital Advisory Service is far from satisfied with "existing trends". The following paragraph appears almost unchanged in each of their reports:

> "Unfortunately large nursing charges, sanitary facilities with very limited privacy and an inappropriate case mix of patients in some of the hospitals have hindered the introduction of individual patient care programmes and, in some cases, ward programmes".

This version was published in *Health in Scotland* 1983, SHHD, HMSO, 1984, Para 12.15

29. *Op.cit.*, Appendix 1, Tables 2 & 7

30. SHHD & SED, Report by a Programme Planning Group of the Scottish Health Service Planning Council and the Advisory Council on Social Work. HMSO, 1979.

31. *Ibid.* Para 2.35

32. *Ibid* Paras. 3.51-4

33. *Op.cit.*, Para 15.22

34. *Op.cit.* Appendix 1

35. See COHSE, *The Future of Psychiatric Services*, 1983, Paras.2.16-2.21

36. For models see C. Gilleard, *Living with Dementia*, Croom Helm, London, 1984, p.115-121 and Torbay Health Authority and Devon Social Services, *Community Mental Health Centres: The Way Forward.* Exeter, 1982

37. Written Answer, May 10th Hansard 1984/5. Number 1347 Col.516-7

38. D. Hunter et al. *Psycho-geriatric Provision in Scotland. A Review of Research Needs.* Department of Community Medicine, University of Aberdeen, Unpublished Paper, 1984.

39. DHSS, *Organisation and Management Problems of Mental Illness Hospitals.* 1980, Para.2.6

40. *Op.cit.*, Appendix 1, paras.13-22 and Chapter 15, paras 15.14-15.24

41. Although Chapter 15 Para 15.21 refers to occupancy rates, it muddies the waters further. It i) implausibly states that since continuing care beds will form an increasing proportion of all beds, occupancy rates of all beds will rise to 95%; ii) applies 'occupancy rates' to a figure which because it includes Timbury's recommended bed numbers partially allows for the fact

that beds will be empty some of the time; iii) mistakenly suggests that a table in another report has been calculated on the same basis.

42. *Op.cit.*, Appendix 1, Para 22

43. *Op.cit.*, Para 15.24

44. *Op.cit.*, Para 1.2

45. SHHD, *Scottish Health Statistics*,1982, HMSO, 1984, Table 7.6

46. *Op.cit.*, Para 8.1

47. D Goldberg & P Huxley, *Mental Illness in the Community*, Tavistock, London 1980, Chapter 1

48. For a simplified summary of such studies D Dick "Services in the net" in J Reed and G Lomas, *Psychiatric Services in the Community.* Croom Helm, London 1984, p.141-2

49. J. O'Brien, "Community support systems for people with severe mental disabilities" and D Bennett, "The practical problems of establishing a district service" in Kings Fund, *Creating Local Psychiatric Services*, 1983

50. D Clark, "The long term psychiatric patient and the future" in *The Future of Mental Hospitals*, Mind 1981

51. *Second Report from Social Services Committee Session 1984-5*, Vols.I-III

52. *Op.cit.*, Para 2.3

53. SHHD, *Scottish Health Building Programme. Report of The Capital Steering Group*, 1984

54. *Ibid*, Chapter 4 and Appendix 5/Annex V(ii)

55. *Ibid*, Chapter 3. It should be noted that Chapter 3 suggests that 18,424 beds will be needed in the psychiatric sector by 1991 – compared with the figure of 17,273 in *Mental Health in Focus.* The CSG estimate is based on a crude extrapolation of residence rates in 1979. However, in Appendix 4, Annex 4, Table 2 they rework the projections from the Programme Planning Group to reach a similar total (17,381) though by a different route

56. *Ibid*, Para 5.45

57. R. McCreadie et al, "The Scottish survey of 'new chronic' inpatients",

British Journal of Psychiatry, December 1983

58. *Op.cit.*, Paras 13.12-17

59. SHHD, *Scottish Health Statistics 1983*, HMSO 1984, Tables 6.2(a) and 10.2(a) and SHHD, *Scottish Health Service Costs 1984*, p.25

60. SHHD, *Scottish Health Authorities Priorities for the Eighties*. HMSO 1980

61. SHHD, *Scottish Health Service Costs 1984*, p.55

62. Letter to Mrs Anna McCurley, MP, from John MacKay, MP, Minister for Health and Social Work, Scottish Office dated 4 March, 1985

63. *Op.cit.*, Para 12.2

64. *Op.cit.*, Para 13.16

65. *Op.cit.*, Paras 14.1 and 14.2

66. SHHD, *Health in Scotland 1982*, Para.11.10

67. D Dick, "Services in the net" in J Reed and G Lomas, *Psychiatric Services in the Community*, Croom Helm, 1984, p.143

68. *Op.cit.*, Para 14.29

69. *Op.cit.*, Para 14.27

70. Internal documents. Exeter Health Authority 1984 *Scottish Health Service Costs 1984* (p.54) suggests that the patterns of expenditure within Scottish hospitals are similar.

71. DHHS, *Care in Action. A Handbook of Policies and Priorities for the Health and Personal Social Services in England*. HMSO 1981

72. DHHS, *The Future Pattern of Hospital Provision in England*, 1980

73. *Second Report from the Social Services Committee Session 1984-5*, Vol.I, Chapters I-III

74. Information kindly supplied by Capital Services Division, Greater Glasgow Health Board

75. *Op.cit.*, Para 13.5