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DEPARTMENT OF HEALTH AND SOCIAL SECURITY
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From the Secretary of State for ~~XXXXXXXXXX~~ Health

CONFIDENTIAL

Paul Gray Esq
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14 April 1989

Dear Paul

COMMUNITY CARE: MENTAL ILLNESS

I attach a paper on mental illness from my Secretary of State for next Wednesday's meeting on community care. A paper on options for the care of elderly people will follow on Monday.

Copies of this letter and enclosures go to Roger Bright (Environment), Steve Williams (Welsh Office), David Crawley (Scottish Office), Stuart Lord (Social Security), Carys Evans (Treasury), Alan Davey (Minister for Health), Trevor Woolley and Richard Wilson (Cabinet Office) and Professor Griffiths and Ian Whitehead (No 10).

Yours sincerely

Andy

A J McKEON
Private Secretary

CONFIDENTIAL

SERVICES FOR THE MENTALLY ILL

Paper from the Secretary of State for Health

1. This paper reports progress in England in implementing the Government's policy on services for adults suffering from a mental illness; re-examines the policy in the light of the points made at the Ministerial meeting on 21 March, and sets out the action I propose to take, subject to colleagues' views. I propose that we should deal separately with services for the mentally ill, as the primary responsibility of the NHS.

The Government's current policy

2. The core of current policy is the establishment of locally-based hospital and community services adequate to meet the needs of adults with a mental illness. The development of such services is necessarily a collaborative process between the 190 district health authorities, social services authorities, the voluntary sector and, perhaps increasingly, the private sector. As these locally-based services develop, many of the larger, and often remote mental hospitals are running down and will close. As the annex to this paper makes clear, (paragraphs 1 - 2), this is a long-standing policy, supported by both major parties.

Progress

3. We can say three things with certainty:

(a) there has been an impressive and welcome increase in community-based services;

(b) the number of beds in mental hospitals has fallen dramatically;

(c) there is considerable satisfaction with many of the new services, while considerable concern is expressed about the situation in other areas, especially about arrangements for those disabled by the major mental illnesses such as schizophrenia. There are particular problems with the homeless mentally ill in London.

More details on these points is set out in the annex (paragraphs 3 - 5).

4. I believe that the policy is a sound one but that success so far is very patchy. There are model local services which have demonstrated clearly that even those disabled by chronic illnesses such as schizophrenia can be sustained effectively largely on an out-patient basis. Moreover, the number of patients from mental hospitals discharged into the community after a long period (five years or more) in hospital is small - an average of about five per district per year.

5. I do, however, believe there are legitimate concerns about how well policy has been implemented in some areas. There are particular concerns about arrangements for the continuing care of sufferers being treated on an out-patient basis (summarised in paragraphs 6 - 7 of the annex). For example, recent research suggests that less than a third of the 190 health districts have multi-disciplinary teams of staff concerned with the continuing long-term care of patients in the community. I am also concerned about whether district plans make enough provision for locally-based "asylum" arrangements, such as hospital hostels.

Action required

6. I propose to separate out action in relation to services for the mentally ill from the general consideration of community care and "Griffiths". We know enough about what steps to take to deal effectively with problems on this front without any changes to the existing responsibilities of the statutory bodies concerned.

7. First, I propose to restate, in more forceful terms, what has been part of Government policy throughout - namely that the closure of hospitals is not the primary aim of the policy, but a consequence of the development of better alternative services. We will introduce more effective arrangements for keeping in touch with how the regional health authorities monitor progress at district level, and I will make it clear that mental hospitals will only be allowed to close when Ministers are satisfied that adequate alternative services have been put in place. I believe this will go a long way to meet current concerns.

8. Second, I have identified several other initiatives which could be announced soon. Only one of them - (d) - has significant resource implications which clearly go beyond existing provision to the Department and the NHS. These initiatives are:

(a) **Assessment and continuing care**. Last year's NHS planning guide lines required health authorities to initiate care plans for all patients discharged from hospital, by 1991. My Department is preparing guidance which will emphasise the need for locally developed approaches, including registers of vulnerable discharged patients. Much more importantly, 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 in late Summer, to be followed by a more substantive one developed in concert with the other professions concerned. 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. Local authorities have, however, not in general met health authorities' expectations of a social work service for mentally ill people. My Department is looking at ways to enable health authorities to secure the social work input they need. This will 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**. The aim is for the Code of Practice required under the 1983 Mental Health Act to be laid before Parliament this Autumn. The preparation of this Code has been lengthy, because of the professional issues involved. But when published it will 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 sometimes not;

(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. 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. My 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;

(f) **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), but there is some concern that it is now not as effective. Roger Freeman is of the view that this activity may be more effective at regional level, and is overseeing an analysis of options as to how 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";

Timing

9. In my judgement, we can draw a clear distinction between our review of strategy in the long term and immediate measures to respond to present public concern, and detach services for the mentally ill from the issues raised by Roy Griffiths' report. There would be considerable political advantage in pressing on with the immediate measures and, subject to colleagues' agreement, I plan to announce the overall package of initiatives soon.

ANNEX

History of the present policy

1. 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.

2 Scientific advances in the 1950s, 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 a substantial fall in the number of hospital beds, 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.

Progress

3. Development of locally-based services. 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.

4. Reduction in mental hospital beds. The number of beds has fallen from around 150,000 in 1960 to 91,000 in 1978, and to 70,000 by 1986.

5. Response to changing patterns. Research studies have shown that few patients transferred from hospital to a community setting regret the change, and many see benefits. On the other hand, there is undoubtedly 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.

Keeping in touch with patients in the community - a key element of the new form of service

6. A key problem to be addressed by those developing new forms of locally-based services in which sufferers are increasingly treated on an out-patient basis is arranging effective continuing treatment. The situation where effective arrangements are not made can be summarised as follows:

> A patient would be discharged from hospital, with arrangements made for him to return regularly as an out-patient for medication. He would miss an out-patient appointment. The consultant would ask a community psychiatric nurse to call to see what was wrong. The patient would either be out, or fail to answer the door, and after perhaps two fruitless visits there would be no further positive action on the part of the health services to make contact. Without medication, the patient would manage for a period, then relapse, but would not seek treatment until, perhaps, he was so ill that he could be hospitalised compulsorily. Meanwhile he would have been a heavy burden to his parents and a nuisance to society.

7. It does not have to be like that: there are examples of local services where things are better managed. Crucial features are individual care plans for patients, registers of vulnerable patients, determined efforts on the part of the services to keep in contact with patients once discharged from hospital, good links with family practitioners and arrangements to minimise the likelihood of relapses. But a service with these features takes much more organising, and perhaps more resources, than some had anticipated.