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Prime Minister

COMMUNITY CARE: SERVICES FOR THE MENTALLY ILL IN ENGLAND

I was invited to circulate further paper on services for the mentally ill in the light of our discussions so far.

Main aims

2. In preparing my proposals I have had two main aims:-

First, to respond effectively to public concerns that whatever the correctness in principle of our present policies of locally based hospital and community services, their implementation has not been working as well as was expected.

Second, to implement the proposals in the Griffiths report in a way that clearly recognises the responsibilities of the NHS in ensuring that severely mentally ill patients are properly cared for when they leave hospital.

Presentation of present policies

3. The key to this is to convince the public both that any necessary hospital treatment continues to be available and that severely mentally ill patients will not be discharged from hospital until it is clear that there will be proper medical and social care for them in the community.

4. I see our approach to this as being in two parts:-

The first part will be an assurance (in practice a reassurance, since it is existing policy) to the public that discharges of severely mentally ill people from hospital will take place only when medical and social care is available for them outside hospital. Such an assurance could be part of my statement on community care.

The second part will be the package of measures we have previously discussed. Such a package will both reinforce the effectiveness of present policies and underpin the credibility of my assurance on discharges. The details of this are in Annex 1. I have agreed with the Chief Secretary how we might deal with the disposal of mental hospitals in announcing the package. This is set out in Annex 2.

Community services for the mentally ill

5. The major groups covered by the Griffiths proposals are the elderly, the physically and mentally handicapped and the mentally ill. Of these groups, only the mentally ill are generally accepted as primarily a medical concern. And although local authorities have responsibility now for the social care of the mentally ill, it is generally recognised that the services provided have been inadequate.

6. Having looked at the options carefully in the light of our earlier discussion, particularly on discharges from mental hospitals, I have reached a somewhat different conclusion from Peter Walker so far as services in England are concerned. It is that we should make special provision for the most severely mentally ill patients discharged from hospital, defined by reference to the length of stay in hospital.

7. What I propose is that mentally ill patients who have been in hospital for 3 months or more should after discharge continue to be the responsibility of the health authority for social care as well as medical care for as long as is medically necessary. In practice, this would mean the hospital remaining responsible while the patient was under the continuing care of a consultant psychiatrist.

8. The effect of these arrangements will be that for this defined category of mentally ill people the health authority would themselves provide or purchase from other providers, including local authorities, a range of social support services a well as providing any nursing and medical care. This new responsibility, for which health authorities would have to be funded, would be set out in legislation. I have it in mind at the same time to repeal s.7 of the Disabled Persons (Services, Consultation and Representation) Act 1986 [the Tom Clarke Act]. This section, which has not yet been implemented, places a statutory duty on local authorities to assess and meet the needs of mentally ill patients discharged after 6 months or more in hospital.

9. The social needs of other mentally ill people would be the responsibility of the local authority, in line with the Griffiths Report. It will be important to complement the work of health authoritiesfor the long stay patient discharged from hospital by ensuring that equivalent help is given to similar mentally ill people who have not been in hospital or only been there for short periods. My proposals on planning and monitoring social services activities and on specific grants are aimed at securing this by making such help a priority area for local authorities.

10. More generally, I will be paying particular attention to the need to ensure effective links between health and local authorities. We need to be sure that when responsibility passes from one to another action is taken and that there is no unnecessary duplication of provision. I shall be asking both the NHS Management Executive and the Social Services Inspectorate to watch these aspects carefully.

Financial Implications

11. The financial implications of the package of measures in the annex have been discussed with Treasury. It is accepted that there are no new resource implications on four of the proposed initiatives ((a), (b), (d), (e)) and that an announcement can be made subject to the terms of the announcement being cleared with Treasury beforehand. Annex 2 deals with (c) - finance from hospital sites.

12. My proposal to make health authorities responsible for the social as well as health care needs for a defined group of severely mentally ill patients is new and will need to be costed. I will bid for it in the 1991 Survey in the usual way.

Conclusions

13. I commend these proposals, with which Sir Roy Griffiths is in general agreement, to colleagues.

14. I am copying this to the Secretaries of State for the Environment, Social Security, Scotland, Wales and Northern Ireland, the Chief Secretary, the Minister for Health, Sir Roy Griffiths, Mr Wilson and Mr Monger (Cabinet Office) and Mr Whitehead (Policy Unit).

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16 June 1989

K. C.

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DISPOSAL OF MENTAL ILLNESS HOSPITALS

These proposals will require a substantial increase in the rate at which replacement community facilities are provided for inappropriate hospital accommodation.

2. One way in which authorities can find the necessary resources is to unlock the land value of mental illness hospitals. We shall therefore invite them to identify sites which can be disposed of once replacement facilities are available.

3. At present timing can be a problem. Selling hospital sites provides valuable capital for replacement facilities, but these facilities are needed before hospitals can be vacated. They in turn have to compete for resources with other priorities within capital programmes, and this may hold up the whole process.

4. One possib le solution would be for health authorities to enter into agreements with developers to build community facilities for the mentally ill, in return for which they would receive all or part of the vacated site. In each case, the objective would be to bring about the degree of private sector involvement that maximised value for money. In this way, health authorities may find cost effective ways of developing community services while overcoming the problems of unlocking land values of hospital sites at the right time for investment in replacement facilities.

MENTAL HEALTH INITIATIVES

(a) Assessment and continuing care. There has been concern about the adequacy of continuing health service care for psychiatric patients discharged from hospital. Last year a requirement was placed on health authorities to initiate, by 1991, explicit individually tailored programmes for continuing health service care for all such patients. The Department of Health will shortly issue guidance to authorities on developing these care programmes, which will emphasise the need for locally developed approaches, including registers of vulnerable discharged patients. In addition, the Royal College of Psychiatrists has agreed to draw up 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;

(b) Code of Practice for admitting and treating patients compulsorily. Work is well advanced in preparing the Code required under the 1983 Mental Health Act. It will be laid before the House this Autumn, and provide a common basis for handling compulsory admissions to hospital for psychiatric treatment, an area where there seems wide agreement that the law is adequate but its interpretation by practitioners sometimes not;

(c) Finance from mental hospital sites. Selling hospital sites provides valuable capital for replacement facilities, but these facilities are needed before hospitals can be vacated. They in turn have to compete for resources with other priorities within capital programmes, and this may hold up the whole process. One possible solution is for authorities to enter into agreements with developers to build community facilities for the mentally ill, in return for which they would receive all or part of the vacated site. Authorities will be invited to identify sites where this approach would be suitable: the aim will be to bring about the degree of private sector involvement that maximises value for money;

(d) 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, services and mutual help available to the parents and friends of patients. Current grants to voluntary organisations in the mental health field are being reviewed, looking particularly critically at the larger, longstanding grants to bodies 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;

(e) 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. The work of the HAS is being examined with a view to identifying how it might be done more effectively, and in a way more relevant to the NHS as it will develop following "Working for Patients".