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Beyond mental hospital sites

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Professor R. G. Priest and Dr K. A. Day have prepared a discussion document on the future of mental hospital sites on behalf of the Public Policy Committee (*Psychiatric Bulletin*, April 1990, **14**, 245–248), and may be complimented for stating their views in such detail.

They advocate three main categories of use that *should* be considered for existing sites: a variety of specialist regional units; certain units maintaining continuing expertise; and, asylum. The main concession is that where mental hospital sites are remote from their catchment areas, acute psychiatric admissions should be to district general hospital units.

Their aim is to put forward the view of the majority of UK psychiatrists. But if the discussion document is accurate, that majority appears to be out of step not only with the principal thrust of current thinking, research and policy on the provision of treatment for people with mental illness, but also with the wishes of the majority of patients and their carers.

Our intention is to look beyond mental hospital sites. In doing so, we recognise that for the foreseeable future there will remain a requirement for the NHS to provide staffed accommodation for relatively small groups of people for whom alternative responses are not presently available, i.e. people with

(a) certain acute mental disorders
(b) special needs for continuing care
(c) particular challenging behaviours.

But provision for these groups could well be provided away from mental hospital sites.

The future: comprehensive community orientated mental health services

WHO, for example, has consistently promoted comprehensive community orientated mental health services staffed by multidisciplinary teams (WHO, 1985). This strategy has been endorsed in the UK by successive Governments and all main political parties. For its part, The Royal College of Psychiatrists acknowledges: "that treatment should be based, as far as possible, within people's ordinary life and domestic surroundings, unless there are compelling reasons for it to be elsewhere" (Royal College of Psychiatrists, 1988). Leading clinical psychiatrists also agree: Donald Dick observes that: "the majority of psychiatrically troubled people are best sleeping in their own surroundings and family structure and not in exile" (Dick, 1982).

In fact, scientific confirmation of the superiority of mental hospital sites over alternative methods of providing psychiatric treatment is conspicuously lacking.

Treatment for people with mental disorders can be better provided outside mental hospitals

By contrast, there is now evidence worldwide that treatment for people with mental disorders can be better provided outside traditional mental hospitals. In a review of international research on the economics of mental health services, one of us concluded that: "care provided round the clock, seven days a week in the community has clinical, social and economic advantages over hospital care" (Wilkinson & Pelosi, 1987).

Thus extramural psychiatric care has been shown to be superior to mental hospital based approaches across the spectrum of psychiatry, for acute and long-term care; psychoses and neuroses; substance misuse and mental handicap (see appendix for selected annotated references).

Moreover, extramural care for people with mental disorders can be provided in a comprehensive strategy that integrates locally-based specialist services with primary care, statutory and voluntary social services, private sector provision, and self-help groups.

Barriers to implementation

In the light of current policy, research and clinical opinion, we therefore find it hard to believe that most psychiatrists would wish to promote the continued existence of specialist mental hospital sites. However we recognise that psychiatrists may have a number of justifiable concerns about prospects for the successful implementation of alternative forms of psychiatric service delivery. Chief among these are professional anxieties and fears about the political commitment to fund adequate forms of community care.

Professional anxieties

Research showing that traditional methods of providing psychiatric care are no longer best and that some of what a psychiatrist does can be done equally well by others may be perceived as threatening by a number of psychiatrists. Indeed Shepherd (1987) suggests that psychiatric protectionism may be a major obstruction to the evolution of psychiatric services.

Greenblatt (1984), analysing resistance to community-based treatments, comments that the necessary changes are anxiety provoking for many psychiatrists and mental health workers who have previously based their activities in hospitals:

> "They may fear losing their professional identity; may be concerned about the blurring of roles when working with other professionals and non-professionals, may feel concern about lack of professional backup and even security backup.... The hierarchy of professional rights and privileges simply does not work as well in the community as it does in clinic.... Skills to meet the (new) demands are foreign to many psychiatrists. Some professionals are so wedded to institutional life they fear that with the movement of patients, staff and funding into the community, the hospital will wither away and they with it."

He concludes that a great deal of education and reorientation of psychiatrists and other mental health professionals will be necessary to shape the new attitudes and beliefs required.

Fears about political commitment on funding

Most psychiatrists are fearful that the political rhetoric about establishing comprehensive alternatives to existing mental illness service provision may not be translated into action through lack of adequate funding, in particular for the social care of people with long-term psychiatric disorders.

One example is the concern about the numbers of ex-psychiatric patients 'on the streets' and in prisons. Birley points out, however, that the real problem is homelessness (*The Guardian [Society]* 14 March 1990, p. 21):

> "Increased homelessness across the board is the central problem, and it's a bit tough on mental hospitals to be set up as the places which can solve that problem, which is essentially political. With the right sort of accommodation there could be better services for such people than mental hospitals could provide."

Although the Government has not as yet grasped the nettle of homelessness, this is surely not a sufficient reason to support the continued existence of old mental hospitals: the problem of homelessness for ex-psychiatric patients is often not one of availability of housing stock but more of aftercare planning, liaison with public and private sector housing agencies, and social support.

There are some signs that Government is beginning to acknowledge such concerns and the White Paper *Caring for People: Community Care in the Next Decade and Beyond* (DoH, 1989) represents a significant shift in thinking about the medical and social care of people with disabilities.

Recently Government has instructed Health Authorities that they *must* ensure that a range of services in settings best suited to the needs of patients, and which reflect their wishes, are available for people with mental disorders and mental handicaps before they are discharged from hospital (HC(89)24, 1989). These, it makes clear, should normally be in the community rather than in large institutions.

In the White Paper (DoH, 1989) the Government reiterates this commitment:

> "since 1975 it has been the policy of successive governments to encourage the development of locally-based health and social services working with the voluntary and private sectors to meet the needs of people of all ages suffering from mental illness including those with dementia".

The Government has also stated clearly that existing institutional provision must not be run down and closed until adequately resourced alternatives are in place to support each individual.

Conclusions

Rather than "clamouring" (*Psychiatric Bulletin*, April 1990, **14**, 245–248) for the retention of existing mental hospital sites, psychiatrists, as medical scientists, would do better to support their case on the effective and efficient care of people with mental disorders using reliable and valid clinical and economic research evidence.

At present the weight of evidence favours the superiority of extramural psychiatric care over that provided on mental hospital sites. The challenge for psychiatrists is to translate these research findings sensitively into clinical practice taking account of local circumstances and needs in a "cycle of planning and evaluation" (Wing, 1972).

The crucial point is that psychiatrists, by virtue of their current training, are poorly equipped with the knowledge, attitudes and skills that are necessary to enable them to take the leading role in developing the new pattern of services. It is this training issue which the Royal College must address urgently.

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