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EDITORIAL

'De-institutionalization' and the community: fact and theory[1]

Few would doubt that the Mental Health Act, 1959, was potentially the most compassionate instrument of legislation of its kind yet devised in England or, indeed, elsewhere. The intent of the Act is precisely stated in the preamble which reads: 'An Act to repeal the Lunacy and Mental Treatment Acts, 1890 to 1930, and the Mental Deficiency Acts, 1913 to 1938 and to make fresh provision with respect to the treatment and care of mentally disordered persons and with respect to their property and affairs.'

The Act was the outcome of lengthy and searching deliberations by the Royal Commission on Mental Health Law (1957) and adopted as official policy by the Government of the day. In acknowledging the need for reform the Commission recognized that: 'advances in medical knowledge, new methods of treatment and the development of new organs of government and new social services have naturally demanded changes in the medical and administrative methods by which these objects are pursued'.

In furthering these objectives the recommendations of the Royal Commission were written into the Act and defined the obligations and functions of the hospital and local authorities. In effect they reversed the long-accepted practice of isolating mental patients in large institutions, themselves often isolated, in remote parts of the country. It was hoped to prevent admission to a hospital of any sort by comprehensive out-patient services, but if admission proved inevitable, then this was to be in the first instance to psychiatric departments of general hospitals. The desirability of keeping in-patient treatment to a minimum, and as a corollary, to return the patient as soon as possible to the care of the community, or to 'community care' as it has come to be known, was the principal article of faith. Furthermore, it was emphasized that, 'the division of functions between the hospitals, local authorities and other official bodies should be broadly the same in relation to mentally disordered patients as in relation to others'.

Implicit in these recommendations is the obligation by the community, that is the local authority, to set up prophylactic services and all types of community care for those who do not need or who no longer need in-patient care. They would include day or residential training centres, residential accommodation in private homes or hostels, especially for the old, and general social help or advice.

Diagnostic clinics were to be established on the lines of child-guidance clinics, but dealing with adults. At these centres clinical conferences between hospital and local authority staffs on the disposal of individual cases could be held. They would in effect become the local Mental Health headquarters.

Unfortunately – and here's the rub – no date was given as to when the local authorities should meet their obligations as laid down in the Act, and what in effect is to be discussed here is the extent to which the realization of dreams of a psychiatric Utopia remain latent and to what extent they have been fulfilled in the 17 years since the 1959 Act came into operation.

Basically the two essential planks on which the new Act was originally built were (1) the new and allegedly potent methods of psychiatric treatment and (2) the mandatory transfer of emphasis for the care of mental patients from the mental hospitals to the community, or to 'community care'. A wave of sublime optimism had swept the country at that time, based to no small extent on very favourable statistical forecasts provided by workers of no mean repute. Both the optimism and the

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forecasts were seized upon by the then Minister of Health, Mr Enoch Powell, and woven into his Hospital Plan of 1962 in which it was predicted that by 1975 there would be a reduction by nearly half in the number of local mental hospital beds and that their function would be split between community agencies and general hospitals.

How sound have these two planks proved to be? To take the new methods of treatment first. Undoubtedly, the so-called 'tranquillizers' in particular have produced a revolution in treatment if the sheer tonnage alone of these drugs dispensed through the UK and the rest of the world is taken as an index of their popularity. Certainly, in the treatment of schizophrenia, which still remains the overriding problem of mental hospital practice, they do appear to effect a remission earlier than might otherwise be expected. But what they seem incapable of doing with any degree of certainty is to prevent relapses. How else may one explain the alarming number of re-admissions to mental hospitals of patients who all too often have been only recently discharged? The 'open-door' policy of yesterday, it might be said, has in effect been transmuted into the 'revolving-door' policy of today.

The second plank, which calls for the most careful inspection relates to 'community care'. No one would deny the advisability in principle of such a switch of emphasis, but the sad fact remains that before attempting to put this major operation into effect, little was done to determine if indeed the community cared.

In all fairness, however, it must be stated that in certain localities a real attempt has been made to translate the concept of 'community care' into a working reality. Psychiatric units in general hospitals have been established, day hospitals and hostels, either purpose-built or conversions from existing buildings have been constructed, and a substantial increase in medical and ancillary workers, i.e. psychiatric social workers, trained and untrained social workers and mental welfare officers, has been realized. But for the country as a whole the field of community care is less green and less lush. Some of it is paved with good intentions, but unfortunately a large part is an arid waste which for lack of money and personnel has failed to be cultivated. For instance, as recently as March 1974 it is officially stated that: '31 local authorities, as then constituted, had no residential accommodation for the mentally ill and 63 no day facilities' (DHSS, 1975).

That there has been a substantial reduction in the number of occupied beds in British mental hospitals cannot be gainsaid. Thus, in the decade 1960–70, the number of beds declined by 24000, and the decline continues. But if our modern methods of treatment are less effective than we had hoped, then the prognosis for the chronic psychotics, particularly the schizophrenics, remains more or less the same. Furthermore, if the concept of community care is for the most part only an inspired slogan, then the socially non-viable, ex-hospital patients must continue to erupt in other ways. Many, as already mentioned, will find their way back to hospital, as is evident in the ever-increasing number of re-admissions which now account for two-thirds of all admission (DHSS, 1976). Some, less fortunate perhaps, will swell the ranks of the unemployed and unemployable. Others will join the army of vagrants and elbow each other off the park benches, or lengthen the queues outside the doss-houses. It is relevant to mention in the context the paper by Berry & Orwin (1966), who report on the steep rise in the number of patients of No Fixed Abode (NFA) admitted to their mental hospital in Birmingham since the 1959 Act came into operation. In their conclusions the authors state *inter alia*: 'Their [the NFA's] plight is evidence that the initial enthusiasm evoked by the new Act for the discharge of chronic psychotics into community care was premature in view of the resources available, and has resulted in the overwhelming of existing community services.' Similarly, Edwards *et al.* (1968) in their study of inmates of Camberwell Reception Centre, London, showed that of a population of 279, 24% had previously been in a mental hospital for reasons other than drinking, and of these 7% had been out of hospital for six months or less. Other studies of 'dossers', e.g. Lodge-Patch (1970) and Scott *et al.* (1966), paint equally gloomy pictures.

There are still further tragic illustrations of the inadequacies of community care. In one report, 'Mental Health of East London in 1966', it was found that of 174 schizophrenics discharged to known addresses from one mental hospital in Epsom, Surrey, only 94 could be traced within 12 months, of whom only 29 were in satisfactory accommodation, 33 were without employment or

occupation, and 28 were neglecting themselves. The fate of the 80 (nearly 50%) who have disappeared is unknown, but of those who have physically survived there is a strong probability that they will turn up in one of the loci of re-distribution already mentioned.

In all the circumstances, it might be assumed that those ex-patients who have a home to go to are of necessity better off. That this is not so is made quite clear in the reports of the National Schizophrenia Fellowship, a ginger group, which in recent years has taken up the cudgels on behalf of patients and their families in the community.

In his foreword to the first report (1974) John Pringle, the honorary director of the fellowship, does not pull his punches. He castigates those whose duty it was: 'to provide the community support, in replacement for custodial care, which many chronic sufferers (from schizophrenia), unable to fend for themselves, cannot do without'. He goes on: 'The closure of mental hospital wards, which at least provide the basic minimum shelter and life support, goes ruthlessly on, leaving nothing in their place.'

But there is still another locus of redistribution of ex-mental hospital patients not yet mentioned which is considered to be more retrogressive then any other – namely the prisons. There they may land following the commission of offences, usually petty, but not necessarily so by any means. A not inconsiderable proportion of those who, in effect, have exchanged a hospital bed for a prison cell are so severely crippled by their mental illness that they are not socially viable without substantial support which, alas, has not been forthcoming. In the absence of this support the crimes of which they are often found guilty, e.g. thefts of food, are committed in order for them to survive.

The situation which has developed, and continues to develop, has prompted the Principal Medical Officer of Brixton Prison, London (Report on the Work of the Prison Department, 1963), to write: 'I have been impressed over the last few years by the number of people received into prison for mental observation and reports to court who have been in psychiatric hospitals within twelve months of reception. The figures amount to an alarming total of 384 for 1963.' It is noteworthy that the number so remanded in England and Wales has doubled from 6366 in 1961 to 12530 in 1974 (Report of the Work of the Prison Department, 1961, 1974) and the number of Hospital Orders (Section 60) has increased from 838 to 1034, an increase of 23%. But these figures are taken from official criminal statistics which do not include mentally abnormal offenders who, for one reason or another, were not prosecuted, but were admitted directly to a mental hospital under emergency procedures. Of special importance in this respect is the increase in the use of Section 136 (Part IV of the Act) which permits the police to deal expeditiously with social crises involving the mentally disordered in public places by removing them to a 'place of safety', in practice, almost invariably a mental hospital. For example, in the 12 mental hospitals administered until very recently by the South-West Metropolitan Regional Hospital Board the number rose from 308 (1·9%) of all admissions in 1965 to 709 (4%) of all admissions in 1972, a rise of well over 100% (*British Medical Journal*, 1973).

It was, indeed, the dramatic rise in the admission of mentally abnormal offenders to Horton Hospital, Epsom, both prosecuted and unprosecuted, since the implementation of the 1959 Act which stimulated the author's interest in the problem of the mentally abnormal offender. One paper (Rollin, 1963) analyses all male offenders admitted to Horton in 1961, the first complete year after the 1959 Act became fully operational. A total of 98 were so admitted, a fivefold increase compared with the 19 admitted under existing legislation in 1959, the last year before the new Act was implemented. Seventy-nine (81%) of those admitted were suffering from schizophrenia. In 63 (66%) offenders there was documentary evidence of previous mental illness, in that 41 had had multiple admissions to mental hospitals and 47 had spent an aggregate of more than six months in them. It is a fair assumption, therefore, that a high proportion of the offenders were not only mentally ill at the time of their offence, but had been chronically so for some considerable time before the particular offence was committed. Fifty-three of those admitted had committed their offences within two years

of the last recorded discharge from a mental hospital. Four had failed to survive even for a day. Twelve had collided with the law in under a month, and within a year 43 had done so.

A second paper (Rollin, 1965) analyses 75 male unprosecuted offenders, the majority of whom were under Section 136, admitted to Horton in the years 1961 and 1962. They revealed psychiatric histories very similar to those obtained in the first enquiry. Thus, of 53 who had a recorded history of previous mental illness, 43 had had multiple admissions to mental hospitals and 27 had spent an aggregate of six months in them. Schizophrenia was again overwhelmingly the commonest single diagnosis and was made in 59 (78%) cases. The incapacity of these chronic psychotics to survive in society as measured by the length of the interval from their discharge from mental hospitals (in less than half was Horton the hospital involved) and their collision with the law was, if anything, more marked. Five cases were arrested on the very day of their discharge, 18 in less than a month and 40 within a year of leaving hospital.

To have criticized 'de-institutionalization', or more precisely, the provisions made thus far to convert the myth of community care into a reality would have been considered a very few years ago not only reactionary, but sacrilegious. It comes, therefore, as a surprise, agreeable as it might be to those who did not side with the big battalions, that the Department of Health and Social Security has performed a nimble somersault. This is evidenced in the recent white paper, Better Services for the Mentally Ill (DHSS, 1975), which contains expressions of indignation which might well have come from the pen of those who for years have criticized official practice if not policy. One or two examples suffice: 'The term "open-door hospital" has like "community care" become with time something of a catchphrase.' Or, even more pertinent, or poignant: 'Those who work in the health and social services fields have to recognize that families and relatives, and indeed the public at large cannot be expected to tolerate under the name of community care the discharge of chronic patients without adequate arrangements being made for after-care and who perhaps spend their days wandering the streets or become an unbearable burden on the lives of their relatives, etc.' But the most important statement of all is that of the then Minister of Health and Social Security, Mrs Barbara Castle, herself. In the foreword she writes: 'What we have to do is to get to grips with shifting the emphasis to community care' – as good an example as one could wish for of the futility of closing the stable door 17 years after the horses have left, or perhaps more accurately, were driven out.

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