

*Closure of Large Mental Hospitals— Practicable or Desirable?**

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The move towards community care essentially aims at the provision of a comprehensive psychiatric service in each District with facilities for the chronically disabled based outside the hospital for the greater part. Parallel with this move runs the aim to close all large mental hospitals. The present debate centres around the extent to which we can move towards a system of comprehensive District psychiatric services alone at this stage in time and the question of whether it is desirable to abandon totally the large psychiatric hospital style of care. The brief of this paper is to summarize the reasons for concern about a wholesale move towards District-based services from the large mental hospital from the psychiatrists' view-point. Unfortunately, much of the debate is based on speculation because of the experimental nature of this move and the fact that objective research is lacking on any changes already made in this country.

International context

Changes from a large psychiatric hospital system to local services have been made only in parts of the USA and Italy. Well documented problems with radical changes have now become evident.¹

Great Britain

Initiative for change in this country originally came from the staff of large mental hospitals, these being the only location of service. In more recent discussions on closure of large mental hospitals and the move to community care the voice of the professional familiar with patients and the actual operation of the services has tended to be heavily outweighed by that, on the one hand, of the mental health enthusiast fired with visions of reorientating services in their entirety, and on the other, by health service management motivated towards administrative rationalization while tied to demands for financial savings. Unrealistic expectations of the number of dischargeable patients and the cost of community provision are now prevalent for the following reasons:

(a) *Disability level of remaining long-stay patients:* DHSS policy has echoed the recognized need for more local facilities, but inevitably there is a lag-time for incorporating professional views into Departmental policy. Current assumptions on the proportion of remaining psychiatric long-stay patients capable of 'ordinary lives in the community' are often falsely high because of direct extrapolation from the proportion of large mental hospital patients with potential to lead independent lives a decade ago. For example, there were at one time 3,000 patients at Friern Hospital; there had been a reduction of half this number by 1972 (i.e. 1,400 discharged), a further

reduction of 600 by 1976, and a further 150 discharged by 1980, but since then only 60. The trend in discharge pattern is exponential rather than linear and the proportion of new patients requiring long-term care is now constant, if not slightly increasing (*Friern Hospital Inpatient Survey*, January 1983).

(b) *Geographical generalizations:* Further unrealistic assumptions arise from the generalization of adopting the same policy for rural areas as for major conurbations. The geographical drift of those with severe mental disorder to the major cities has resulted in a disproportionately high number of those long-stay patients with greatest needs in these locations.^{2,3} Predictions have been based on experience in Worcester and other rural areas. The replacement of major urban mental hospitals requires more staff-intensive services affecting cost assumptions and running contra to RAWP adjustments (i.e. contra to the policy of revenue, readjusting to reduce the extent to which urban areas are favoured).

Furthermore, many of the patients in large urban mental hospitals were already dislocated from their original communities and have more significant links with the locality of the large mental hospital than with their District of origin.

Community care—an improved lifestyle?

A number of underlying assumptions are made in the proposals to move the location of care for the chronically disabled from large mental hospitals to non-hospital District bases. These assumptions ignore some important factors.

The community role of large mental hospitals

Large mental hospitals provide in effect a caring community, both internally in relation to social networks within the hospital and externally in relation, not only to the build-up of long-standing tolerance of psychiatric patients in the surrounding community, but also the positive fostering of community involvement with 'Friends' schemes, etc. While grouping of long-stay patients has been criticized on the basis of the 'ghetto effect', in reality dispersion within a District community is more likely to lead to small backwaters in which social isolation from the surrounding population is more pointedly in evidence and experiences of rejection by neighbours are not uncommon.

Special needs of patients suffering from schizophrenia

Half the patients requiring long-stay care in hospital at present are suffering from schizophrenia. There are two key features of this disorder which are often overlooked in the community debate:

(a) *Adverse effect of interpersonal stress:* Much work has been done in recent years on the adverse effect of demanding

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interpersonal relationships on people with chronic schizophrenia.⁴ The principles of community care involve encouraging people to stay in close contact with relatives, which frequently can perpetuate psychotic relapse and increase the level of medication required. Alternatively, patients are resettled in small tight-knit groups where the likelihood of interpersonal friction is considerably greater than in the looser structure of a large mental hospital unit where space, both interpersonal and geographical, is available. It is of relevance that in the Maudsley Hospital/Hostel, a model for future District developments, patients reported having less privacy than when cared for in a ward setting (Wykes, personal communication).

(b) *Symptom of apathy*: It is now well recognized that many of the problems attributed to institutional life result from the effect of chronic schizophrenia as an illness rather than the type of care provided.⁵ Scattered housing within the community makes for difficulties in maintaining a satisfactory lifestyle. If occupational and recreational needs are to be met, encouragement on a daily basis to attend facilities elsewhere and the provision of transport are both essential.

Special needs of other chronically disturbed patients

Many of those at present requiring long-term care who are not suffering from schizophrenia have already failed in community settings because of their associated personality difficulties. Such people are very difficult to place in small community settings where close individual contact with other psychiatrically disturbed individuals is inevitable.

Limitations of community care in practice

Those who do not readily fit into the available district community developments or hospital facilities in practice experience a series of rejections from the available organizations and frequently slip through the net of the caring professions into the penal system or the vacuum of a vagrant lifestyle.⁶ (Reasons for this are given below.) The large mental hospitals have provided an important 'long stop' which is still much in evidence in the Friern catchment area, even in relation to model community developments. Not only do large mental hospitals still have the capacity to contain a level of disturbance and 'difficulty' greater than that of local units, but provide an invaluable background security for the patients themselves.

District Health Services—Can they fulfill DHSS policy?

While some Districts have catchment populations of half a million people, many are considerably smaller and closure of large mental hospitals in these cases involves fragmentation of service (e.g. Friern Hospital—440,000 catchment population to be sub-divided into four Health Districts). This fragmentation affects the following areas.

Education and training requirements

Many large hospitals provide the central hub of extensive multi-centre training schemes. The difficulty of relocating these in individual Districts is particularly evident for

postgraduate medical facilities and post-basic nurse training, which depend on opportunities for experience in subspecialty work as well as more general training.

Specialized provision of social and occupational facilities for chronic psychiatrically disabled people

The clustering of patients on a campus, such as exists in a large mental hospital, enables a range of social and recreational and occupational options to be made easily available, e.g. industrial therapy, adapted sports facilities, regular film shows and other social amenities. Such options within the community, i.e. in non-sheltered settings, are used to only a limited degree by those with the chronic apathy of schizophrenia because of the initiative required at the outset and the motivation required for regular attendance without which social links are not developed. Those with long-standing personality disorders or related disability are often not readily accepted by the general public, or welcomed in community facilities.

Attempts to provide a full range of accessible sheltered rehabilitation facilities within small districts are hampered by lack of suitable sites (particularly in comparison with the spacious parkland available to large psychiatric hospitals) as well as the effects of fragmentation. In particular, it is impossible to provide as full a range of options both of work and social settings for the comparatively smaller numbers of chronic psychiatrically disabled people in a small district as was available at the large mental hospital.

Specialized provision for other minority needs

Specialized services are needed for patients with chronic severe disorders, for disturbed adolescents, drug addicts, brain damaged patients, forensic patients and other minority groups. These services are practicable only with concentrations of patients and staff expertise and, therefore, are difficult to provide in a framework of individual District units for the following reasons:

(a) *District autonomy*: The present degree of district autonomy does not aid the development of supra-District/sub-Regional specialized units. There is no framework for effective inter-district strategic planning, but there is also an administrative reluctance to be dependent on other Districts with poor funding arrangements for cross-boundary flow. (In practice, planning for the Friern catchment area has been restricted to the provision of basic service requirements only, despite the differentiated range of specialist services at present available here.)

(b) *Specialist staffing*: The aim to provide certain subspecialties within each District is unrealistic because of the difficulty of recruiting psychiatrists with a special interest in the least popular areas, e.g. alcoholism. The same applies to other staff groups in which there are shortages of those with relevant interest or skills in psychology. Problems have already emerged in the nursing management of acute and chronic severely disturbed patients in District units where there is less scope for nurses to achieve expertise in these areas.

(c) *Financial considerations:* Attempts to provide a full range of rehabilitation and other specialist facilities for small numbers of patients on a District basis are inevitably more costly because of the loss of the large mental hospital economies of scale.

Practical limitations of district general hospital psychiatric units

The siting of psychiatric units within district general hospitals poses further problems:

(a) *Management of acutely disturbed patients:* In order to contain the acutely disturbed within DGH units which are inevitably in close proximity to general hospital wards, there is often a need to resort to higher levels of sedation than when similar patients are managed in self-contained psychiatric hospitals.

(b) *Management of chronically disturbed patients:* Lack of suitable facilities available for reasons given above can often give rise to reluctance to provide an ongoing service for the more disruptive chronic patient whose needs for intensive nursing care can only be provided within a DGH setting on an acute admission ward—an unsatisfactory environment.

District community services: some points of concern

Even if the move towards totally district-based services could provide an improvement in lifestyle for all patients, it is questionable whether such a policy can be effectively put into operation at present for the following reasons.

Local authority structure unsuitability

The move towards District-based services in the Friern catchment area also involves some transfer of responsibility for the chronically psychiatrically disabled patient to local authority social service departments. These are not structured very suitably for this role:

(a) *Lack of co-ordination of mental health service:* No local authority has a co-ordinated mental health service. The division into residential and day care, domiciliary services and community social work result in a lack of overall integration between the parts of the service upon which the individual ex-patient depends. Furthermore, there are problems with decision making in a management structure which is generic and prevents decisions on resource allocation being made at mental health planning meetings. Such decisions have to be made through the Social Services Committee, a lengthy and unpredictable process, because most departments do not have a defined mental health policy or a budget for this client group.

(b) *Generic social workers:* Since Seebohm's the social service departments have been unable to give priority to those with psychiatric disorder because of the increased recent demands for child care and related legislation. Social workers with the scope for developing expertise in mental health care are scarce.

(c) *Lack of established monitoring procedure:* There is a statutory independent process for monitoring of care standards in health service facilities through District Health Auth-

ority members. This structure for independent monitoring does not have an equivalent within the social services organization and is particularly necessary for long-stay facilities, especially those employing untrained care assistant staff.

District Health Service/local authority: ineffective administrative integration

The large mental hospitals have traditionally provided a long-stop resource for those patients for whom suitable facilities were not available at a local level. For the current policy of change to a community service to work, there must be a degree of shared responsibility between Health, Social Services and other community organizations.

(a) *Lack of co-terminosity:* Local authorities are often not co-terminous with District Health Authorities. This complicates joint planning and impedes comprehensive provision.

(b) *Lack of joint management structure:* Despite the long-standing existence of close working relationships between medical, nursing and social work professionals at an individual case work level, there is no established joint management structure which could enable shared responsibility for the provision of a full range of facilities. This is particularly crucial to the accommodation of those disruptive patients who require some degree of support but do not fit into a group setting. The problem occurs for two reasons: (1) DGH psychiatric units have a limited capacity in practice—not only do such units have problems in providing a service for chronically disturbed patients, but there is a well recognized tendency to move progressively 'up market', rejecting those patients who are seen as too unmotivated or disturbed to benefit from the therapies offered. This rejection is justified on the basis of chronically disturbed patients having an adverse effect on other in-patients and is further rationalized by imputing responsibility to the social services network to provide suitable sheltered accommodation from which such patients could receive community nursing care and out-patient follow-up. (2) Social services sheltered provision has limited availability. Similar rationalizations for rejecting the 'difficult' chronic psychiatrically ill occur within the Social Services framework, i.e. that the chronically disturbed have an adverse effect on other clients in sheltered accommodation and no suitable facility can be found for them. This tendency is compounded by the fact that many of these patients drift socially and have no established residential rights in any District. Without the claim of prior residence, they are not eligible for financial help from any local authority for sheltered or other housing.

Non-NHS/local authority residential provision: lack of any monitoring procedure or long-term reliability

With the move to community care, many individuals are taking advantage of the DHSS weekly allowance to open their homes to small groups of ex-patients. While this has obvious value in general principle of providing domestic style care for those able to benefit from it, there is no mechanism for ongoing monitoring of the quality of care provided. Furthermore, there is no way of ensuring continuity in that individuals

setting up establishments are not expected to make a long-term commitment so that those patients settled in this way have no security of home and lose out on the possibility of resettlement grants.

Community psychiatric nursing: limited availability and embryonic stage of training and career-structure development

The effective move of long-stay patients into the community depends for many on the availability of nursing care for much of the waking day. The decline of large mental hospital populations dates from the advent of effective anti-psychotic medication and those remaining in hospital today do so frequently because of their need for oral medication to be regularly administered with scope for adjustment as necessary. The capacity to provide effective care outside hospital for these patients is, therefore, dependent on a considerable extension of the community psychiatric nursing role and further developments in nursing career structure need to be developed urgently for a move to District-based services to work.

THE FINANCIAL ISSUES

Specific concerns about financing large mental hospital closure

The financial aspects of service re-provision have been a major source of concern in the Friern/Claybury closure debate. The North East Thames RHA has stipulated that the changes should take place using no more revenue than is currently available to run the two large mental hospitals. The Districts involved submitted reports at the end of a year's feasibility study in which they considered that approximately twice the revenue at present available would be needed to re-provide services in the new community-orientated pattern of care. This major disagreement in funding predictions has yet to be resolved.

Can we afford closure?

There are claims that community care is cheaper than large mental hospital provision. It is essential to examine very carefully if there will be an overall financial saving in the long as well as short term by closure of large mental hospitals. It will have financial repercussions on the following:

(a) *Cost to DHSS:* Patients placed in local authority community settings who are on supplementary benefit can claim rent and various other allowances from central government funding. This only amounts to about £20–£30 per week. However, non-health service/local authority settings can claim a DHSS grant per person being discharged from an NHS provision of between £95–£120 per week. This is of infinite duration at present and the grant is made for accommodation and support if the local authority is unable or refuses to fund a placement. It does not provide for the cost of professional input, be it medical care, day care, or other professional services. In particular, day care in the form of occupational and recreational provision is an expensive and crucial part of the overall service which health and local authorities will have to continue providing.

(b) *Cost to voluntary organizations:* Some financial input from other sources, e.g. GLC grants, are available for community care through voluntary organizations. These revenue sources are fluctuating. Furthermore, voluntary organizations vary considerably in capacity from one area to another, depending on the availability of motivated volunteers, etc.

(c) *Cost of the private sector:* There are reasons for seriously doubting the capacity of the private sector to provide facilities for chronic severely psychiatrically disabled patients as cheaply as is being done at present by the large NHS mental hospitals. In that DHSS grants are available, the overall cost to the health service of placing people in private accommodation may be cheaper, but the overall cost to the government is likely to be higher as in the case of using the private facilities of St. Andrews' Hospital for acute forensic patients who are cared for more cheaply in NHS Medium Secure Units.

(d) *Cost to the local authority:* Our present experience is that rehabilitation provided by the local authority for long-stay patients is considerably more expensive than in our large mental hospital (Friern), e.g. approximately £400 per week for a hostel and day care local authority provision compared with less than £270 per week at Friern. (The present in-patient cost at Friern is £276 per week, but this is an average of the cost of acute, psychogeriatric and long-stay patients, the long-stay group being the least costly.) In practice only a small amount of this additional cost is being borne by DHSS payments. Although this expensive provision is justified on the expectation that patients will attain a level of functioning where less costly care will be adequate, this is as yet unproven and those who are familiar with the patients concerned have realistic doubts about this being achieved.

Can we rely on the financing of community alternatives?

Large mental hospitals provide a fairly consistently funded care structure for those with chronic severe psychiatric illness. Although the health service is not immune from financial cuts in revenue, priority can be defined and is being given to the needs of special groups such as the psychiatrically ill. As outlined above the move to District-based community services involves dependence on other organizations for providing services, many of which rely on a range of revenue sources. These are not identified for mental health needs only and, therefore, not afforded the same protection. This is well-illustrated by the present uncertainty of long-term funding created by the fate of the GLC and the squeeze on local authority revenue through 'rate capping' which affects all of the Friern catchment Districts.

Large mental hospital closure—Difficulties experienced

Morale can too easily plummet in a hospital doomed for closure or major reduction in size unless early precautions are taken. Serious problems have been encountered in our own situation at Friern Hospital. Some of the reasons for this are as follows:

'Poor care'—a self-fulfilling prophecy?: The denigration of service provided in a large hospital by major political efforts to close it have inevitable repercussions on the staff who assume

that their work is considered to be inferior and unsatisfactory. When such staff are already working under pressure in adverse conditions, this can have a profound effect.

'Closure' before feasibility studies and strategic planning?: Much can be done by way of constructive planning prior to closure announcements. This could enable movement to District-based services to involve the large hospital staff at a preliminary stage and give a positive focus to the change process. Many of the concerns outlined already could be tackled in advance of a closure date announcement to reduce the planning 'vacuum' and its adverse consequences.

Personnel policy issues: When major changes involve more than one District, advance planning in this area is essential. The lack of clearly integrated mechanisms for transfer of personnel has created a situation of uncertainty in which many experienced staff, whose services will be needed in the new developments, are looking elsewhere for employment. This gives rise to considerable fears that large mental hospitals could close themselves in advance of adequate replacement facilities.

Prevention of 'blight': Planning blight has been affecting not only the maintenance of fabric in our existing mental hospitals, but also potential new service developments which are being held back in the hopes of being financed from the large mental hospital budget instead of from existing resources and because of lack of agreement on long-term service plans.

CONCLUSION AND RECOMMENDATIONS

The majority of those working in large psychiatric hospitals are keen to facilitate community developments wherever practicable and viable, but have strong reservations about moving solely to this pattern of care. Furthermore, the problems of morale in large hospitals designated for closure are considerable but not inevitably destructive if appropriate measures are taken to safeguard the future of patient services and clarify staff prospects.

The following proposals would alleviate, if not prevent, the potential difficulties outlined in this paper:

- (1) Retain some large psychiatric hospital facilities per half million catchment population to keep as a resource centre, linked wherever possible with teaching hospital specialist facilities and training provision. This would enable provision of the specialist facilities required for the

most disabled group of patients in an appropriate geographical setting (see section on 'Community Care') without becoming a backwater.

- (2) For such facilities, space could be used to build domestic style accommodation to replace Victorian ward settings. These would provide a sheltered campus of flexible future use should the most dependent long-stay psychiatric population diminish in size. Where sites have no potential future use for psychiatric purposes, the buildings which will be retained for short-term use should be upgraded to reduce the adverse affect on morale of deterioration.
- (3) Give priority to: (a) developing community psychiatric nurse training and career-structure; (b) developing joint local authority/NHS management structure models; (c) developing a monitoring structure for community developments.
- (4) Develop the training resources and personnel policies required to facilitate movement of experienced staff from large mental hospitals to local district services where practicable.
- (5) Set up independent evaluation of existing community developments with particular attention to: (a) daily life-style; (b) stability of accommodation and rate of relapse of those patients who have been highly dependent on large mental hospitals; (c) the degree to which local District developments have provided a reliable and cost effective alternative to large mental hospital care.

REFERENCES

- ¹JONES, K. & POLETTI, A. (1984) The mirage of a reform. *New Society*, 4 October, 10-12.
- ²FARIS, R. & DUNHAM, H. (1939) *Mental Disorders in Urban Areas*. Chicago: University of Chicago Press.
- ³HOLLINGSHEAD, A. & REDLICH, F. (1958) *Social Class and Mental Illness*. New York: Wiley.
- ⁴BERKOWITZ, R., KUIPERS, L. & LEFF, J. (1981) Keeping the patient well: Drug and social treatments of schizophrenic patients. *Psychopharmacology Bulletin*, 17, 89-90.
- ⁵JOHNSTONE, E. C., OWENS, D. G. C., GOLD, A., CROW, T. J. & MACMILLAN, F. (1981) Institutionalization and the defects of schizophrenia. *British Journal of Psychiatry*, 139, 195-203.
- ⁶CHADLE, J. & DITCHFIELD, J. (1982) *Sentencing Mentally Ill Offenders*. London: Home Office Research and Planning Unit.
- ⁷SEBOHM, F. (1968) *Report of the Committee on Local Authority and Allied Personal Social Services*. Cmd 3703. London: HMSO.

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(ii) lectures and discussion.

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