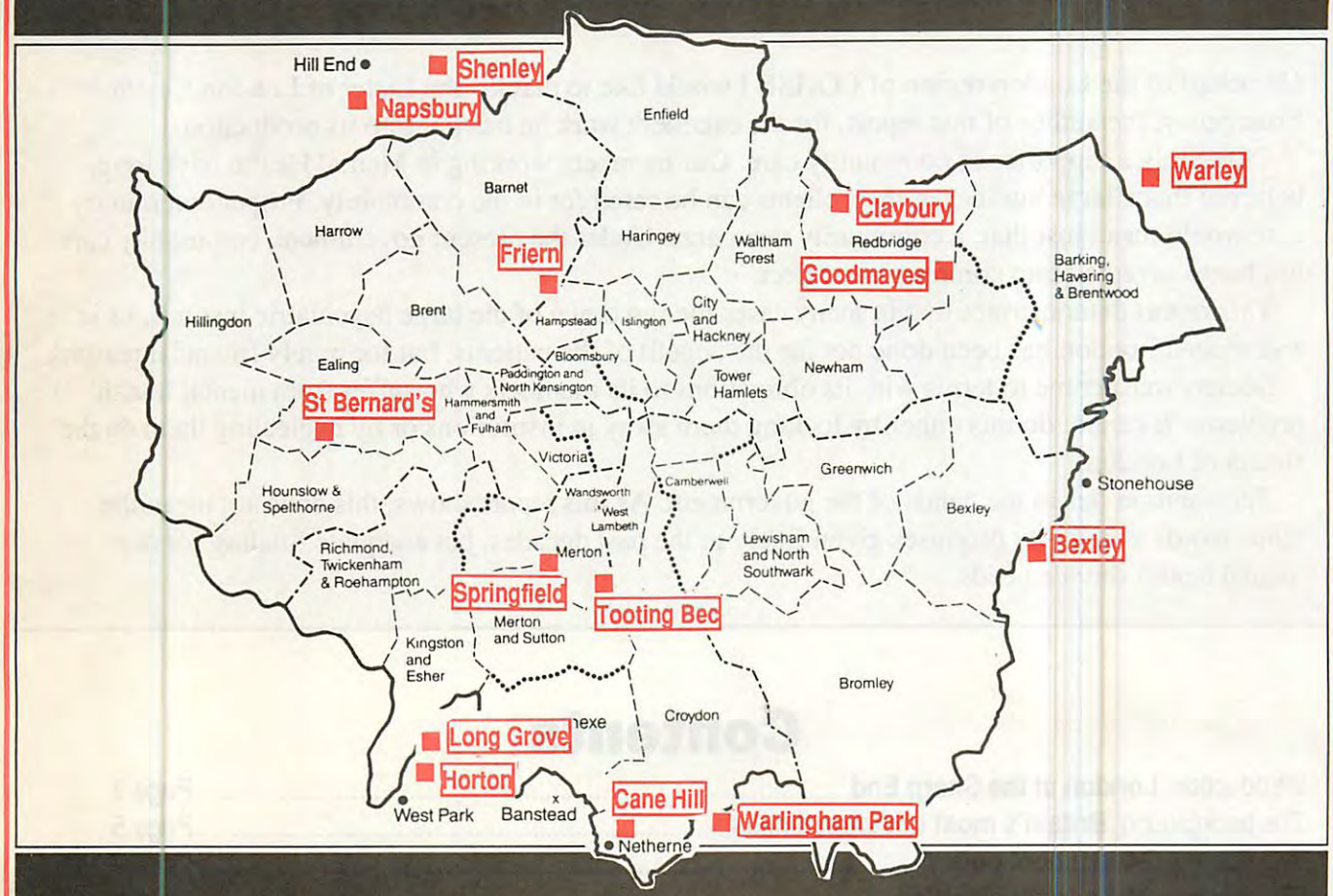
As they close the big psychiatric hospitals



WHERE'S the CARE?

An investigation into London's mental health services

Researched for COHSE London Region by JOHN LISTER of London Health Emergency

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Foreword

By Pete Marshall, COHSE London Regional Secretary

On behalf of the London region of COHSE I would like to thank John Lister of London Health Emergency, the author of this report, for the excellent work he has put into its production.

COHSE is a supporter of community care. Our members working in Mental Health have long believed that a large number of their clients can be cared for in the community. Proper community care would mean just that: a community that *cares*. Under the present government, community care has been corrupted into community neglect.

This report demonstrates that in many cases the run down of the large psychiatric institutions in and around London has been done not for the benefit of the patients, but for purely financial reasons.

Society must come to terms with its obligations to its members who suffer from mental health problems. It cannot do this either by locking them away in institutions or by neglecting them on the streets of London.

The solution lies in the hands of the government. As this report shows, this does not mean the pious words and empty promises given freely in the past decades, but adequate funding for our mental health service needs.

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Introduction

London at the sharp end

LONDON'S mental health services were always going to face the toughest challenge in the transition from institutional to community-based forms of care.

London District Health Authorities have historically based their services in the country's largest concentration of big psychiatric hospitals: in 1976, 90% of London's mental illness beds were sited in 16 vast mental hospitals averaging 1,000 beds apiece, all situated on the edge of the capital, with nine of them outside the boundaries of Greater London. As late as 1981, London's DHAs ran 15 of only 25 psychiatric hospitals in the whole of England with over 800 beds.

The process of switching resources from these huge, impersonal and crumbling Victorian-style asylums to more approachable and locally-based acute units and community mental health services always required more than just a top-level policy decision. It needed substantial additional *resources* – revenue and capital – to set up what must inevitably be a *more expensive* system of care and support; and the new system needed to be up and running *alongside* the existing mental hospitals to facilitate the process of discharging patients, and the run-down and closure of the hospitals. If this did not occur, the danger would be that ex-patients could be discharged not to properly-resourced local care, but to a limbo of pending plans, good intentions and actual neglect.

Almost everyone who has looked at the issues has acknowledged that the process of transition from hospital to community care involves a period of double running-costs and an injection of extra capital to finance the new network of community services *before* the land and property assets of the closed hospitals can be realised.

However there has been *no* such dramatic injection of cash into mental illness services. Despite ritual nods in the direction of mental health as a 'priority' service, it has not managed – any more than has care of the elderly – to elevate itself into the hierarchy of influence in health service policy- making, which remains dominated by the more 'glamourous' acute services.

Though the cash has not been forthcoming, the closures of beds in the big hospitals have continued at a rapid pace. According to the *Hospital and Health Services Yearbook*, bed totals at 15 of London's larger psychiatric hospitals added up to 14,236 in 1984, reducing to 10,311 in 14 in 1989 (Banstead Hospital had closed); by 1990 there were just 9,344 – a reduction of 34%. This is far faster than the national decline in numbers of mental illness beds, which dropped by about a third over the ten year period, from 89,000 in 1979 to 50,000 in 1989.

Bed closures in London's big psychiatric hospitals 1984-91

Hospital	1984	1989	1990	Actual	Beds lost	% lost
St Bernards	1120	764	651	526	594	53%
Shenley	1239	769	769	620	619	50%
Napsbury	1005	933	933	524	481	48%
Horton	(1873)	937	937	692	1181	64%
Claybury	1205	848	730	500	705	58%
Friern	962	830	680	598	364	38%
Goodmayes	780	780	780	527	253	32%
Warley	929	800	711	630	299	32%
Cane Hill	953	564	477	257	696	73%
Bexley	994	737	504	449	545	55%
Tooting Bec	906	600	615	323	583	64%
Long Grove	813	550	550	434	379	46%
Springfield	(982)	(808)	(616)	563	419	43%
Warlingham Park	475	391	391	240	235	49%
Totals	**14236**	**10311**	**9344**	**6963**	**7273**	**51%**

Sources: 1984, 1989, 1990: *Hospitals and Health Services Yearbook*. Horton figure for 1984 includes Banstead, now closed: Springfield 1984-90 includes Morris Markowe Unit, now closed.'Actual' figures are latest available totals of beds open, compiled from DHAs, RHA papers or from unit management.

In practice the cutback in the big London hospitals has been much greater: over 2,000 of the beds listed in the *Yearbook* are already closed: Goodmayes Hospital, for example, listed as still having 780 beds, had just 527 open last April. Some are down to around half the beds suggested in the latest *Yearbook*. (See Table)

Resources

These bed closures have come at a time of growing financial pressure on the capital's health services – and on local government, which has increasingly been seen by ministers as a handy scapegoat to carry the can for inadequate NHS provision. Most drastic has been the impact of the South East property slump on the capital programmes of the four Thames regions.

The lion's share of the increase in NHS capital since 1979 has come not from the government – whose contribution has remained almost constant – but from *land sales*, totalling over £1.1 billion since 1979. So when sales in 1989 slumped from a projected £280m to just £160m, it created an immediate crisis, which is still restricting any capital development in the South East, and having an especially severe impact on mental health services.

The major asset of most big psychiatric hospitals (other than those caught in 'green belt' planning problems) has been the vast tracts of land surrounding the crumbling buildings: now the inability to sell this land leaves health authorities in limbo, unable to finance new community-based services or to carry out essential maintenance on the existing mental hospitals which had been expected to have closed already.

The capital squeeze has had a devastating impact on mental health community care provision, which is relatively expensive to establish. However the squeeze on revenue spending has also hit mental health budgets, forcing panic cutbacks often extremely detrimental to the strategy of moving to more community-based care.

It is a boring cliche, commonly trotted out by ministers defending real reductions or already inadequate levels of resources, to argue that problems of health care cannot be solved "simply by throwing money at them". Of course there are many unresolved debates concerning the theory and practice of mental health policy: **but it is equally true that *no* policy can deliver a satisfactory level or standard of mental health care on the existing level of capital and revenue resources.**

Even the most conservative "do nothing" option of retaining treatment in the old Victorian asylums involves considerable cost in backlog maintenance of buildings that have been deliberately run down; in upgrading and development work to equip these hospitals to cater for a changed in-patient population; and in increasing staffing levels and improving training to ensure a proper level of care.

Early in 1985 the Commons Social Services Committee, in a major report, criticised the government's two-faced policy of advocating 'community care' without providing the necessary cash:

"A decent community-based service for mentally ill [...] people cannot be provided at the same overall cost as present services. The proposition that community care could be cost neutral is untenable. Even if the present policies of reducing hospital care and building up alternative services were amended, there would in any event be considerable additional costs for mental disability services.

"There are growing numbers of mentally disabled people living in the community with older parents; some provision will have to be made for them. The Victorian hospitals in which thousands of mentally ill [...] people still live, in visibly inadequate conditions, will either have to continue to be shored up, at growing capital and revenue expense, or demolished and replaced by more appropriate housing, at even greater expense.

"If the hospitals were to be maintained, it is also inevitable that in most hospitals staffing ratios and the proportion of trained staff would have to be improved. [...]

"Proceeding with a policy of community care on a cost-neutral assumption is not simply naive, it is positively inhuman. Community care on the cheap would prove worse in many respects than the pattern of services to date.

"...There is ample evidence of the decanting of patients from mental illness hospitals in years past without sufficient development of services for them. This has produced a population of chronically mentally ill people with nowhere to go."

Despite these problems, there have been some important advances in the quality of care, and movement in some districts towards a radically different, community-based system of mental health care. Many health workers have become enthusiastic supporters of these policies, even though it may involve them in a leap into the unknown, and a substantial change in the circumstances in which they work.

It seems that many of the scandals that hit the headlines arise not from recent premature discharges of 'long-stay' patients into the community, but from earlier phases of the policy, and from the inadequate resourcing of some acute psychiatric units, which are not able to follow up patients who may be homeless after they are deemed fit for discharge. Others have fallen victim to the way in which mental health services as a whole, and community care policies too, have been shaped around the hospital model, or focussed on the discharge and care

of the relatively small proportion of mentally ill people who are or have been in- patients, while the large majority of sufferers receive little or no specialised help.

This present report, which has been drafted by London Health Emergency for the health union COHSE, will look at the extent to which the 1985 warnings of the Social Services Committee have been heeded, and how far the plans for community-based services have successfully replaced the mental illness beds closed in the big hospitals. Our purpose is not to denounce or decry the efforts of management, but to appraise the emerging pattern of services and assess their ability to cope with demand.

Our critique is based on a *defence* of the concept of community care – in the sense of genuine care and support for people living as individuals. It is designed to reinforce the arguments of those pressing the case for more money now in order to implement this philosophy in practice.

The background: Britain's most common illness

MENTAL ILLNESS equals heart and circulatory disorders as one of the two most prevalent health problems in Britain: there are six million sufferers each year, that is one in ten of the population – three times the number affected by cancer. It is also a major killer, accounting for some 20,000 deaths each year, more than four times the toll from road accidents.

There is little evidence to show that demand or need for mental health services have decreased in recent years. Despite the growing focus on alternative forms of care, there has been a significant rise in numbers of short-term admissions to psychiatric hospitals since the mid 1960s, from around 160,000 a year nationally (half of which were 'first time' admissions) to 200,000 a year since the mid 1980s (just 25% of whom were first time admissions, indicating a changing pattern of care but broadly similar numbers). Meanwhile, with far fewer available beds, the pressures on services (and staff) have increased – driving hospital staff to seek more rapid discharge of patients.

While numbers of psychiatric beds have been cut, there is little sign that a new form of 'community care' based on out-patient treatment is emerging: indeed out-patient attendances in England have remained almost constant over a 10-year period 1979-89, rising from 1.6 million in 1979 to a peak of 1.8 million in 1985 and 1986, before falling back again to 1.6 million a year since 1987. Even new out-patient attendances, which should reflect the new policies of treating mental illness outside of hospital admissions have risen only by an average of 0.7% a year since 1979, from 180,000 in 1979 to around 200,000 since 1985.

What has been cut substantially is the number in long-stay psychiatric beds – down from around 50,000 in hospital for 5 years or more (out of 100,000 in-patients) in the early 1970s to around 17,000 (out of a total of 50,000 in-patients) by the mid 1980s. (OHE figures).

There is no doubt that the new policies on admissions have to some extent avoided the creation of a new group of long-stay patients, as many of the older long-stay patients have died or been discharged to other forms of care. It is more questionable, however, whether sufficient resources are now available to deal with the growing numbers of elderly people suffering from forms of mental illness, notably dementia and Alzheimer's disease.

Surveys show that about a quarter of people aged over 65 suffer from some form of mental illness, much of which is easily treated. However dementia affects about 10% of people over 65, and 20% of those over 80. The latest estimates suggest that nationally 750,000 elderly people are suffering from dementia, and an additional 500,000 from Alzheimer's disease. **During the 1980s it was estimated that as a result of the growing elderly population, up to 20,000 more Londoners would be suffering from dementia in 1991 than in 1981 – an increase of 30%. There has been no attempt to expand NHS or other services on anything like this scale to deal with the problem.**

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In the mid 1980s it was calculated that *half* of all mental illness in-patients were elderly, and that 25% of all referrals to psychiatric departments were aged over 65. In many cases these people are unsuitable for treatment in short-stay acute beds, while the NHS capacity to give long-term care has been drastically reduced, with no sign that local authorities, the voluntary sector, or private enterprise are in any position to take on the responsibility.

WHERE'S THE CARE?

Nationally 55% of mental illness sufferers are women, and nearly all are adults, with 4.5 million aged 15-64, and a further 1.2 million over 65. 71 million working days were lost through mental illness in 1989 – 17% of the total days lost through sickness.

60% of mental illness patients suffer from neurotic conditions – depression and anxiety states – while 35% had behavioural and acute stress disorders, and just 7% had some form of psychotic illness. The National Schizophrenia Fellowship estimates there to be 250,000 sufferers from this condition, 20,000 of whom are hospital in-patients.

Other figures suggest that at least 3.7 million people each year suffer from *severe* mental illness. Yet only a small proportion of these sufferers receive any specialist medical attention. 99% of mentally ill people live in the community, with just 60,000 receiving treatment as hospital in-patients. Only one in ten of severe sufferers – 350,000 – attended psychiatric outpatient departments. A maximum of 28,000 NHS psychiatric day care places are available throughout the country, though it is not clear how many people actually use them. Of the 25% of over 65s who suffer from mental illness, only one in fifteen was in any form of institutional care in the mid 1980s, with many of these in local authority homes or geriatric hospitals rather than a psychiatric unit.

According to the South West Thames RHA, no serious research has yet been done on the numbers of residential places required to run a community-based mental health service. But it is immediately clear that the present provision falls far short of replacing the lost beds or meeting the level of demand. England has only 25,000 local authority-funded residential and day-care places in the community (just 4,000 of them in London), most of these allocated to discharged former in-patients.

The numbers of local authority *residential* places for the mentally ill in the capital have actually *fallen* by 4% between 1981 and 1989, with most of this reduction (14%) concentrated in inner London, where eight out of twelve authorities now offer less places than in 1981. Department of Health figures also show a dramatic *fall* in numbers of local authority supported residents in homes and hostels for the mentally ill in England: in the seven years since 1982, the numbers have dropped 25%, from 4,880 to just 3,600 in 1989.

Nationally, spending on mental illness treatment and care, at over £2 billion a year, is the biggest single item on the NHS budget – double the amount spent on cancer treatment, and 30% higher than spending on heart and stroke disorders. Yet 71% of this allocation – £1.5 billion – is spent on the hospital care of just 60,000 in-patients, while spending on community-based services provided by local authorities to 25,000 people comes to just £200m. Mental health spending accounts for just 3% of social security budgets.

However a major problem in the planning of replacement services is that the costs of in-patient treatment tend to *increase* as the number of in-patients goes down. The Commons Social Services Committee discovered in 1990 that while mental illness in-patient numbers fell 27% in 10 years – from 77,000 in 1979 to 56,000 in 1989 – the overall cost of mental illness in-patient services *rose* by 7% (from £1,179m to £1,262m) [in 1989 prices], with the cost per case rocketing by 47%.

This increase in costs is the result of a number of factors – the inefficient use of large, maintenance intensive hospital buildings; a greater throughput of patients in each bed, meaning that each requires more treatment; the ageing population of those people now resident in long-stay hospitals; and the fact that as those most able to fend for themselves have been discharged, the remainder tend to be the most dependent patients, requiring higher staff members per occupied bed. But what it means is that there is no automatic release of resources for community care as hospital beds are closed and patients discharged.

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The all-party Social Services Committee argues that to provide a satisfactory level of social care in the community costs £2,752 per person per year. By this reckoning, to provide social care for the 3.7 million sufferers from severe mental illness would cost £8,256 *million* (£8.256 *billion*) a year – around a third of the whole NHS annual budget, and more than *four times* the present NHS spending on mental health! London's share alone would be at least £1 billion!

The same committee estimates that it costs about eight times as much – £21,366 a year – to provide a satisfactory level of residential and day care services to people discharged from psychiatric hospitals. This helps explain the lack of government commitment to plug the obvious gaps in the service. To put right what is wrong in mental health care would cost far more than this government is prepared to spend.

Indeed the government has looked increasingly to rope in voluntary sector organisations to help make good the shortfall in NHS and local authority services for people with mental illness. In this context it is useful to recall how small these voluntary organisations really are. The leading mental health charities between them raised less than £10 million in 1989. Though they often play an active role in helping shape alternative policies, and increasingly act as local service providers, they simply do not have the resources to fill in for the government's refusal to pay up.

The theory:

Government policy

There have been two consistent elements in government policy since Enoch Powell as Health Minister made his historic 1961 'Watertower Speech' to the MIND annual conference, in which he projected the phasing out of the existing large psychiatric hospitals, and their replacement with local, community-based services.

Consistent rhetoric; consistent underfunding

One consistent element has been the verbal, rhetorical commitment to community care, as reaffirmed in the 1975 Labour government White Paper *Better Services for the Mentally Ill*; in 1981 a government consultative paper was issued, entitled *Care in the Community*, and this was followed up by a DHSS circular of the same title in 1983 – the year of the 'Lawson cuts' that hit health services throughout the country and in London in particular. In 1988 came the report on community care from Sir Roy Griffiths, and in 1989-90 the government's *Caring for People* White Paper, closely followed by the NHS & Community Care Act.

On each of these occasions and throughout most intervening years public government pronouncements have declared support for the philosophy of community care, and implied that the transition from institutional to community care of the frail elderly, people with learning difficulties, and people with mental illness is taking place smoothly.

However the other, even more consistent and relentless element of government policy has been the *refusal* to allocate sufficient additional resources to the NHS or local government to allow them to set up the new services that are vital if community care is to *work* – rather than simply serve as a euphemism for the rundown and closure of existing services for so-called priority groups of users.

Despite the reductions in in-patient beds from the early 1970s, local services failed to develop to take their place. A 1971 memorandum urging the establishment of psychiatric units in District General Hospitals was not linked to any provision of capital or revenue to finance this change. By 1981, eleven of Greater London's 31 districts still had no psychiatric in-patient facilities; indeed even now, 20 years later, several districts still have not complied. The units which do function on DGH sites tend to cater almost exclusively for short stay, acute admissions, with long-stay patients largely remaining in the old asylums.

The 1975 White Paper made it quite obvious that there would be no big injection of cash to fund community care. By 1983 the introduction of the new Mental Health Act came alongside a steady rise in the numbers of readmissions to psychiatric hospitals which served to underline the inadequacy of community support for discharged patients.

Not until 1986, 25 years after Powell's speech, did the first London psychiatric hospital close. Banstead Hospital closed its doors amid complaints that it had been replaced not by community care but by new forms of institutional care – with some smaller institutions set up, and 400 patients simply transferred from Banstead to Horton Hospital.

Social Services Committee

Early in 1985 the Commons Social Services Committee published its damning critique of the progress so far on community care, insisting that:

"The stage has now been reached where the rhetoric of community care has to be matched by action, and where the public are understandably anxious about the consequences.

"...The pace of removal of hospital facilities for mental illness has far outrun the provision of services in the community to replace them. It is only now that people are waking up to the legacy of a policy of hospital rundown which began over 20 years ago. Many of the horror stories of mentally ill people living on the streets or miserably in board and lodging are the results of an earlier era.

"...We do not wish to slow down the exodus from mental illness ... hospitals for its own sake. But we do look to see the same degree of Ministerial pressure, and the provision of necessary resources, devoted to the creation of alternative services. **Any fool can close a long-stay hospital: it takes more time and trouble to do it properly and compassionately".**

The Committee stressed the lop-sided focus of government and NHS policy – on the apparently 'cost-

saving' policy of closing (and asset-stripping) the big long-stay hospitals, while the much bigger task lay elsewhere:

"The vast majority of mentally ill people are not and may never be in hospital. The almost obsessive concentration in public policy on the mechanisms for 'getting people out of hospital' has sometimes obscured the fact that **most mentally ill people already live in the community**, whether with their families, in lodgings, group homes, hostels or private accomodation."

The Committee also pointed out the pitifully small resources available to implement the various plans for community care:

"Around a third of Joint Finance has been spent on mental handicap services, but only around five percent on mental illness. The total funds available have ben steadily increased since 1976 to an estimated £104.6 million in 1985-6. It has now been made clear that there will be no further real increase. It should also be understood that the total even now represents only around three percent of total Personal Social Services expenditure, or less than one percent of NHS expenditure. A typical RHA receives around £6 or £7 million a year; divided up locally and among a number of different services this cannot be more than seed money. It has not achieved, and with the benefit of hindsight could and should not have been expected to achieve, a major permanent transfer of resources from the centrally-funded NHS to locally financed and controlled social services."

Going further, the Committee pointed out that:

"Health authorities at present spend scarcely enough per capita on mentally ill patients to enable a decent community service to be provided at the same price, even if immediate and full transfer of patients or cash or both were possible. Such a transfer is in any event not possible for good practical reasons. **Only central funding over a period of several years can help the development of genuine community care over the hump.**"

Audit Commission

Following on the heels of the Social Services Committee came an equally withering and embarrassing report from the Audit Commission, which exposed the shambles of community care services, creating a well of confusion and the potential of a limbo of neglect between the contending responsibilities and cash constraints of the DHSS, health authorities and local council social services.

The Audit Commission drew attention to the fact that while 25,000 psychiatric beds had closed between 1974 and 1984, only 9,000 new day centre and day hospital places had been added: numbers of community psychiatric nurses had risen from just 1,300 in 1980 to a mere 2,200 in 1984. It commented:

"It must be a matter for grave concern that although there are 37,000 fewer mentally ill and mentally handicapped patients today than there were 10 years ago, no-one knows what has happened to many of those who have been discharged. Some, of course, have died; others are likely to be in some form of residential care; the rest should be receiving support in the community.... If recent US experience is any guide, it is likely that a significant proportion of those discharged from NHS hospitals will have been before a court and will now be imprisoned; others will have become wanderers, left to their own devices with no support from community-based services."

Griffiths

The embarrassment created for the government by the Audit Commission report, with its far-reaching recommendations, goaded Ministers into setting up their own 'inquiry' into community care, which it hoped would produce rather less brutally frank conclusions. In December 1986 Health Secretary Norman Fowler persuaded Margaret Thatcher's leading advisor on health matters, Sainsbury's boss Sir Roy Griffiths, to embark on a study of community care. But his *Agenda for Action*, published in February 1988, was to prove another source of government blushes.

Largely ignoring the mentally ill and people with learning difficulties, many of whom live in poverty, with few job prospects and low earning potential, Griffiths homed in on those potential users of community care who are most likely to have disposible assets – savings and houses – the elderly.

His report centred on two issues: assigning overall *responsibility* for community care to local government (in the clear recognition that council social services are subject to means-tested charges, while NHS services are funded from taxation and provided free at point of use); and insisting that in a restructured system, much of the *resourcing* of community care for the elderly should come from central government, in the form of a ring-fenced community care grant.

Sir Roy argued that means-tested charges for residential and other community care should take the place of individuals' present entitlements to DHSS benefits. Overall this would *limit* government spending and maximise the individual contribution paid by the elderly for their own care. The whole set-up should, argued Griffiths, be supervised by a new Minister for Community Care.

The whole Griffiths package was decorated with a non- controversial proposal that local authorities, in liaison with health authorities, should assess the care needs of each potential recipient of community care, with a specific 'case manager' placed in charge of their care. Unfortunately this was not linked to any recommendation for increased resources to make it possible: instead local authorities and DHAs were urged to make a 'realistic' assessment of the level of services they could afford to provide *within* existing cash and capping limits.

Nor did Sir Roy propose that any individual should have the *right* to an assessment, or any appeal against the results of such an assessment, or any right to a review of the level of care they receive should they find it unsatisfactory.

However the Griffiths report was followed by a prolonged and constipated 21-month silence from the Thatcher government. Though Thatcher still clung on to her gut hatred for local authorities exercising real power outside of Whitehall control, she clearly appreciated Griffiths' general idea of landing the responsibility (and blame!) for under-resourced community care onto local government while keeping tight hold of the purse strings, and of tapping in to the personal property and savings assets of the elderly to finance their community care.

Also popular with Thatcher were Sir Roy's plans for boosting the private sector by forcing local authorities to put all community care services out to tender, and to create a 'market' in community care by separating out councils' role as 'purchasers' of services from that as providers.

But she strongly opposed Griffiths' proposal for government funding to be ring-fenced, and any idea of a Minister for Community Care, both of which would lay the responsibility for future shortcomings at the door of Downing Street rather than the local town hall.

NHS & Community Care Act

Eventually in November 1989 came the government's bowdlerised version of Griffiths, the White Paper *Caring for People*, followed almost at once by the NHS & Community Care Bill.

As far as mental health is concerned, local authorities were to retain formal responsibility for the 'social care' of sufferers, but this was to be exercised under the supervision of health authorities, which would administer the eye-dropper amounts of cash arising from the new mental health specific grant, and continue to take main responsibility for the treatment in the community of people suffering with mental illness.

By April 1991, all DHAs were to have adopted the 'care programme' approach to ensure effective arrangements were in place for people discharged to the community; this was to be carried out in collaboration with social services.

This and other requirements for closer liaison between DHAs and local authorities ran strangely counter to the NHS Bill's other proposals, which included the *removal* of the previous local authority representatives from local health authorities, which were to be made smaller and less representative; and the provision for large NHS hospitals to 'opt out' of local health authority control, gaining complete autonomy as self-contained businesses within the NHS to decide which services they would – and would not – provide.

The proposals for an expanded local government role in mental health and other community care services also ran against the historically poor record of most councils on this question, allocating on average only a minute share (3%) of social service spending to mental illness. But most significantly, it landed hefty new responsibilities onto councils at the very point when the government was using the Poll Tax – followed quickly by Poll Tax capping – to *hold down* the spending of local authorities regardless of local opinion and local levels of need and deprivation. There can be few more blatant demonstrations than this of government hypocrisy on community care.

The new Act also carries another threat to mental health care, in the form of its new – untested – 'internal market' formula for the funding of services. Once the Act comes fully into force, health authorities will be funded only for the per capita population in their own catchment area, and called upon to buy an appropriate range of services from 'provider units'.

Hospitals (and community units) which provide treatment for patients outside of regular contracts with health authorities will be obliged to draw up and submit *bills* covering the cost of treatment/care to the health authorities where each patient lives. **This is a particular problem for large psychiatric hospitals and inner-city acute units, many of whose in-patients are either long-stay patients with no clear district of origin, or homeless. Where are these hospitals to send the bills? Who will pay for the treatment of these patients? Will they become part of the overhead running costs of these hospitals, increasing their prices compared to those further from town centres? Will community-based units be expected to refuse to care for patients unless they can first decide where to send the bill?**

The same problems arise even more sharply for those mental illness hospitals and units that 'opt out' under the new Act to become self-contained businesses within the NHS, some in April 1991.

It is easy to understand frustrated managers, after years of seeing mental health budgets raided to prop up acute hospital services, seeing the new opt out proposals as a way to 'ringfence' their budgets. But the requirement on each Trust to run its services at a 6% per year surplus (even while many mental health units sit on extremely large, interest-bearing land and property assets) must raise severe doubts on their viability. They will be forced rigorously to police their admissions and billing procedures, with the danger that some vulnerable patients will be deemed uneconomic, and turned away.

Despite a few temporary setbacks in the House of Lords, on issues including the ring-fencing of community care funding, the NHS & Community Care Act was passed almost unchanged, and received the Royal Assent in June 1990.

Clarke's retreat

Less than a month after his Act reached the Statute Book, clearly concerned that his confused and confusing package of policies had the potential to push up Poll Tax bills for 1991 and at the same time to create an embarrassing debacle for the government in the run-up to the next election, Health Secretary Kenneth Clarke announced a major *retreat* from his initial timetable for implementation of the community care reforms.

Now the largely irrelevant inspection and complaints procedures covering local authority services would come first, in April 1991; then would come the requirement to draw up plans for community care (beginning in April 1992); and finally the financial changes – two years late – would not come in until in April 1993. All this was further proof of the government's cynical determination to adopt a policy without allocating the resources to carry it out.

For thirty years, 1960-1990, the pattern of government policy has been consistent: community care on paper, coupled with profound neglect of the so-called 'priority' services in practice. It is a pattern that is leading into huge problems for front line health workers delivering care, and for those stuck at the sharp end as sufferers, forced to use our under-resourced mental health services.

The practice:

The current situation

EVEN BEFORE Kenneth Clarke's ungainly retreat from implementation of the new Act's Community Care proposals, a discernible if careful shift in government pronouncements had begun. Ministers were moving away from the (not entirely unreasonable) denunciation of the old psychiatric hospitals as latter-day Gothic horrors, towards proclaiming them 'well-loved' hospitals, wisely built to last by the Victorians.

Alongside this shift (coloured as it was by the cold draft of financial crisis holding back the development programmes to replace the old 'bins') came a new government call on health authorities *not* to discharge patients from psychiatric hospitals unless there were services ready and available to receive them. There was a sudden new focus on the need for especially vulnerable patients to be able to find 'asylum', and it was said that existing hospitals should not be closed if it were more cost effective to refurbish them rather than build new, smaller units elsewhere.

Bridging loans

In fact the grim reality of the promised government 'bridging loans' (to enable health authorities to build new community services before closing mental hospitals) began to emerge in January 1990. Health Minister Roger Freeman announced that the *total* sum involved *nationally* was just £50m over three years, with a mere £30m available in the first year, and this to be split between mental health and mental handicap services. All of this money was repayable in full, with interest!

Even so, the Department of Health was deluged with 140 applications from DHAs desperate for bridging loans. Just ten DHAs – in nine regions – received pitifully small sums of money, while the others were left empty-handed. SE Thames region alone successfully bid for some £17m for two schemes – leaving just £13m for the rest. SW Thames, on the other hand, submitted claims totalling £33m, and received only £184,000 for a single scheme in Croydon!

Mental illness specific grant

In May 1990 the government unveiled its plans for the new mental illness specific grant. It was to contribute to the *revenue* costs only of services for 'people whose mental illness (including dementia) is so severe that they are being treated by the specialist psychiatric services or would clearly benefit from those services' (DoH Draft Circular, May 1990).

Yet the grant proved to involve a *total* of just £21m of government money (this to be made up to the publicly quoted figure of £30m by compelling local authority social service departments to make up the difference). Though it is to cover *revenue* costs of *new* services, the grant runs only for three years, with no guarantee of renewal. The total for Greater London is just £4.2m – just over a quarter of the amount of money set aside for Joint Finance of community care projects with local

authorities back in 1983-4. In practice, it is such a tiny amount for most London boroughs (averaging £130,000, and with seven outer London boroughs receiving less than £100,000) that its effect will be extremely small.

To make matters worse, almost £1 million of the government's contribution has already been taken back to help pay for the highly-publicised scheme to take a few of London's homeless mentally ill people off the streets of a few selected inner- London districts. This scheme is to receive a total of £2.5 million a year for just two years. It is to fund 60 short term hostel places, 450 places in permanent accomodation from April 1991, and three psychiatric teams.

Homelessness

While this might scratch the surface of what has become a politically embarrassing problem for the government in the inner areas of the capital city, it is not seriously intended to offer more than tokenistic relief to London, while similar problems in other parts of the country are ignored.

In fact there are no reliable figures for the numbers of homeless people who suffer from mental illness. A 1989 article in *The Lancet* suggested that 40% of people in homeless hostels were past or present psychiatric patients. It also points out that for every four beds lost in psychiatric hospitals, the prison population has increased by one.

Other estimates suggest that 30-50% of single homeless people sleeping rough or living in hostels may be mentally ill. According to Shelter this could mean 15,000 people in England. Government figures conservatively estimate 3,000 people in this category are in London. The latest scheme, if fully implemented, would accomodate just over 500 of these people.

Housing is a huge problem for people with mental illness. Though local authorities have a legal duty to provide housing to homeless people deemed vulnerable because of mental illness, less than 3% of those accepted as homeless by local authorities are mentally ill. Shelter points out that despite this, the number of households accepted as homeless through mental illness increased by a massive 70% in the twelve months to September 1990.

There is no easy way out of homelessness for people whose mental illness also makes it extremely hard for them to find paid employment, and who therefore live in poverty. Out of 3,100 special needs housing schemes in England offering 45,000 bed spaces in shared accomodation, the National Federation of Housing Associations estimates that just 9% – a total of 4,050 places – are allocated to schemes for people with mental illness. And less than half of special needs housing is permanent accomodation.

Resourcing local government community care for mental illness

An average of just 4% of local authorities' social services budgets is currently allocated to mental health. The government's new 'Mental Health Specific Grant' will total just £4.2m in London for just 3 years – not enough to make any real difference to a declining provision of day centre places.

Local authority	MI specific grant allocation	Places in Day centres 1981	1989	Places per 1,000 population	Places in homes (MI) LA, volunt & private
Camden	£160,000	82	80	0.6	37
Greenwich	£120,000	0	0	0.0	63
Hackney	£170,000	80	80	0.7	48
Hammersmith	£150,000	59	49	0.5	45
Islington	£150,000	100	100	0.9	88
Kensington	£110,000	79	62	0.7	94
Lambeth	£210,000	162	90	0.6	148
Lewisham	£160,000	145	195	1.3	144
Southwark	£160,000	85	65	0.5	12
Tower Hamlets	£120,000	145	75	0.7	18
Wandsworth	£210,000	85	55	0.3	78
Westminster	£160,000	95	80	0.7	116
Inner London	**£1.86m**	**1085**	**931**		**891**
Barking	£ 70,000	50	50	0.5	25
Barnet	£150,000	81	80	0.4	89
Bexley	£ 80,000	40	27	0.2	40
Brent	£190,000	80	120	0.7	74
Bromley	£130,000	0	0	0.0	61
Croydon	£150,000	100	100	0.5	121
Ealing	£190,000	50	65	0.3	93
Enfield	£140,000	0	0	0.0	100
Haringey	£150,000	55	55	0.4	170
Harrow	£ 90,000	45	90	0.7	25
Havering	£ 90,000	0	0	0.0	75
Hillingdon	£100,000	30	30	0.2	71
Hounslow	£100,000	45	0	0.0	46
Kingston	£ 70,000	30	30	0.3	8
Merton	£ 90,000	68	51	0.5	37
Newham	£150,000	150	165	1.2	68
Redbridge	£110,000	0	0	0.0	38
Richmond	£ 90,000	30	75	0.7	44
Sutton	£ 70,000	0	0	0.0	72
Waltham Forest	£150,000	50	50	0.4	32
London Total	**£4,190,000**	**1,989**	**1,919**		**2,180**

Sources: SW Thames Regional paper (October 1990); DoH PSS statistics, 1981, 1989.

While psychiatric hospital beds have been slashed by 24,000, only 11,000 extra hostel places have been created for mentally ill people in the community. To make matters even worse, it was announced in November 1990 that housing projects funded by health authorities and social services are no longer eligible for subsidies from the Housing Corporation.

Local government under the knife

While more and more health authorities have recognised they lack the resources they need to implement a fully comprehensive package of community care policies for mental illness, there have also been huge financial pressures on local government.

It is important to remember that the cash obstacles placed in the way of expanding councils' social care for people with mental illness comes on top of their historical failure to devote serious resources to the mentally ill: at most only 4% of social service spending has been on mental health provision, with some councils spending only an average of a few pence – the price of a cup of tea – per head of population.

Recent figures published by shadow community care spokesperson Jeff Rooker MP show widely varying levels of council spending on these services. Among the London districts the top spenders per head of population were Kensington and Chelsea (£15.85) and Lambeth (£10.57): lowest were Bromley (£0.31), Havering (£1.81) and Redbridge (£2.90).

This situation has been worsened by the succession of government measures during the 1980s which have set out to curb local government spending; each time such cuts are imposed they take their toll of the most neglected services.

In the past 10 years we have seen reductions in central government's Rate Support Grant, followed by rate-capping – both of which specifically targetted a number of London boroughs. More recently there has been the Poll Tax, the purpose of which was argued to be forcing cuts in council spending, all of which now seems to be regarded as 'waste' by the present government: we are now in the second year of Poll Tax-inspired cuts and "charge-capping", leaving councils little or no leeway to plug gaps in community care services.

It is little surprise therefore that all six of the London boroughs which failed in 1981 to provide any day centres for the mentally ill also failed to do so eight years later, in 1989. In fact numbers of day centre places have *declined* in London, despite growing demand, with this decline concentrated on the inner-city boroughs.

The picture is no brighter on residential care: four of the six boroughs which provided no residential homes for the mentally ill in 1981 still provided none in 1989, while one cash-starved borough closed down its places. Greater London has seen new residential places emerge at an average rate of just 21 a year since 1981: but within this figure twelve of the 32 boroughs have *cut* their

Housing people with mental illness

New housing regulations, coupled with the Poll Tax and capping make it even less likely that local authorities can increase their residential places for the mentally ill from the present 1,138 across London. Meanwhile in London the private sector contribution to accomodation for people with mental illness was insignificant in scale in 1989.

Authority	LA home places 1981	LA home places 1989	Voluntary homes	Places	Priv homes	Private places	Places /100,000
Camden	7	0	2	37	0	0	24.2
Greenwich	36	49	1	14	0	0	37.3
Hackney	20	20	2	28	0	0	32.8
Hammersmith	22	20	3	25	0	0	36.4
Islington	30	25	3	42	1	21	64.1
Kensington	0	25	5	69	0	0	88.2
Lambeth	0	54	3	54	3	40	76.7
Lewisham	50	100	4	35	1	9	78.6
Southwark	24	12	0	0	0	0	6.9
Tower Hamlets	0	0	1	18	0	0	14.3
Wandsworth	81	78	0	0	0	0	37.0
Westminster	53	45	4	71	0	0	79.9
Barking	25	25	0	0	0	0	21.3
Barnet	37	18	1	48	2	23	36.8
Bexley	22	40	0	0	0	0	22.6
Brent	46	52	1	22	0	0	36.1
Bromley	0	0	6	53	1	8	25.0
Croydon	63	60	1	26	2	35	47.8
Ealing	70	74	1	19	0	0	39.1
Enfield	23	53	0	0	4	47	47.8
Haringey	37	44	10	85	6	41	110.5
Harrow	45	25	0	0	0	0	15.9
Havering	52	32	2	43	0	0	39.4
Hillingdon	69	71	0	0	0	0	38.1
Hounslow	37	32	1	14	0	0	30.5
Kingston	0	0	1	8	0	0	7.2
Merton	12	15	1	22	0	0	28.0
Newham	49	68	0	0	0	0	42.7
Redbridge	11	38	0	0	0	0	20.3
Richmond	28	24	2	20	0	0	33.0
Sutton	19	37	1	24	1	11	52.8
Waltham Forest	0	0	1	20	1	12	18.9
Total places	**1981:**	**968**					
	1989	**1136**		**789**		**247**	

provision, and six are unchanged in eight years of supposed transition to community care. This has been worsened by the government's imposition of ringfencing on housing revenue accounts, which prohibits councils from subsidising housing services from their general fund.

Also battered by ten years of local authority cuts have been the voluntary organisations, even while the government has increasingly seen them as a cheap means of securing 'community care' services. The latest round of cuts seems certain to reduce or remove funding from local voluntary organisations which have until now struggled to provide limited services and support to mental illness sufferers.

The Griffiths proposals, now echoed in the NHS & Community Care Act, do nothing to address the fundamental problems of under- resourcing. With overall spending so tightly constricted by legislation, social services for the mentally ill can only be expanded at the expense of other council services.

Councillors and council officers, already under fire from vocal lobbyists battling to defend education and other existing services, know that there are no new votes to be won by making unpopular, high-profile cuts in order to channel resources into new services for a group of sufferers who may be numerous, but receive almost no positive media publicity, and enjoy little public sympathy or support.

Race and mental health

Studies have shown that a quarter of all inner-city mental patients are black, compared to less than 20% of the population of Inner London. Afro-Caribbeans are more frequently diagnosed as schizophrenic than other patients. But black patients are also twice as likely as white British patients to have their diagnosis changed during treatment.

There is evidence that while schizophrenia may be over-diagnosed, depression is often missed in black patients.

The pressure of racism in society clearly contributes in many cases to the stress on black patients, while discrimination in housing as well as employment can make it especially difficult to resettle black clients from pyschiatric hospitals into supportive community care.

Within the psychiatric hospitals themselves, issues such as special diet, interpreting and other facilities for ethinic minorities often remain unresolved.

However it is beyond the scope of this general report – which looks simply at the overall level of mental health services provided – to examine all the special problems faced by black people and those from ethnic minorities, which have been the subject of earlier, detailed studies.

Little progress – 30 years on

Towards the end of 1990, MIND published a detailed document *Waiting for Community Care* which weighed up the extent of progress on mental health services, and declared the results less than impressive:

"One view on the way forward is that the process of hospital rundown should be halted or slowed, to prevent the possibility of community neglect. In MIND's view this argument is fundamentally ill-conceived. The problem with the pace of change from hospital to community care is not that it has been too fast, but that it has been painfully slow.

"In 1979 for every £1 spent by the health and social services on mental health, 12p went on community services and nearly 90p on hospital care. The policy of community care demands that this ratio be reversed. Yet in 1988 community spending had increased by 3p – to 15p – and nearly 90p was still pouring into the hospitals. **The reason for service gaps in the community is at root that no adequate mechanism has been found to transfer resources from hospital to community. Slowing or halting hospital rundown can only exacerbate that deficiency".**

Meanwhile, even as the overall strategy finds itself bogged down for lack of resources, the pressures of short-term financial constraints have brought wholesale chaos to the capital programmes of all four Thames regions covering London, and compelled several London DHAs into new rounds of cuts in existing levels of services during 1990, with no sign of relief at hand.

Cuts that hurt the sufferers

IN JANUARY 1990, Concern, a new charity, unusually supported by a combination of psychiatrists, church groups and voluntary organisations including MIND, appealed for a new policy of reopening one ward in each region to cut the numbers of mentally ill people discharged into homelessness and destitution. London consultants warned that patients were being discharged too quickly to make room for emergency psychiatric admissions, and that homeless hostels were becoming asylums in the community.

A look at some of the other key events of 1990 helps underline the double crisis faced by mental health services in London. Starved of capital to remodel the service on community lines, mental health units have been

simultaneously hit by cuts in revenue that compel cuts in the acute services.

Early in the year, Bloomsbury health authority, facing a £7m shortfall, imposed a 25% reduction in acute psychiatric beds – down from 96 to 72. Managers argued for the cut to take this form in order to protect plans for improved community services, while still generating a net reduction of £250,000.

In March, consultants from the Bethlem and Maudsley hospitals protested publicly at the likely impact of cuts totalling £600,000 to take effect from April. Among the services under threat were the Maudsley's unique child psychiatry service, its 24-hour emergency clinic, and its community services for adults with long-standing mental illness.

In April, NW Thames region produced a round-up of the cutbacks arising from financial constraints and reported that:

"The biggest difficulty facing mental health services comes from the virtual cessation of the Region's Capital Programme. A substantial proportion of those capital schemes were for mental health services, nearly all of which (apart from those in progress) have been delayed for two or three years, and with some uncertainty even about those revised dates".

Meanwhile in Wandsworth, another package of cuts designed to eliminate a £9m deficit over 15 months, forced the closure of 20% of acute psychiatric beds – a move publicly denounced by two top local consultants. In a statement issued in February 1990, Barry Matthews and Jeremy Bolton paid tribute to the way in which until then the unit's affairs had been run to avoid having its funds 'raided' to support other services, and avoided having to cut front line psychiatric services. Now, however, ward closures were the only way to save the amounts demanded:

"The closure of a long-stay ward for elderly mentally ill people would result in a catastrophic reduction of an already under-resourced service. ... The loss of one fifth of our acute beds would mean we could no longer guarantee the immediate admission of severely ill patients, some of whom will be suicidal or dangerous to others. We could no longer guarantee to accept patients from prison or the Courts, thus ensuring they stay longer in what are agreed to be totally unsatisfactory and non-therapeutic conditions."

Only months later, health minister Stephen Dorrell proudly announced (November 1990) a 'review' of services for mentally disordered offenders. Addressing a conference on crime and mental illness, he declared – somehow keeping a straight face – that:

"You will be well aware of the basic principle of government policy today. It is that *where possible*, [emphasis added, JL] mentally disordered offenders should receive care and treatment in hospital from health and social services rather than in the criminal justice system. This means ensuring that people defined by the Mental Health Act as liable to be detained, who are brought before the courts, are directed from the penal system to hospital. It means the government and health authorities continuing to work to ensure that the NHS is able to accomodate such patients and that a comprehensive service and an adequate range of secure facilities is available." (November 30, 1990).

Yet in 1989 about a third of the 47,774 inmates in English prisons were referred to a psychiatrist, and in 1990 five major voluntary organisations concerned with mental illness and prison conditions (MIND, NACRO, the Howard League for Penal Reform, the National Schizophrenia Fellowship and the Prison Reform Trust) wrote to draw the Home Secretary's attention to the numbers of mentally ill people who end up in prison as a result of committing minor offences to obtain food or shelter. Nobody knows for certain the number of minor offenders in prison or police cells at any one time: almost all research on the mental health of the prison population has focussed on those sentenced to six months or more – generally for more serious offences.

MIND points out that psychiatric services in prisons are run under the Home Office, and three quarters of the officers providing the care have no nursing qualification. While new government guidelines urge the diversion of mentally ordered offenders from custody, "The problem arises if there are no resources for diversion schemes or no available housing and support".

Among other painful cutbacks imposed by Wandsworth on mental health services was the closure of the patients' cafeteria at Springfield Hospital, one of the few social facilities available to in-patients on the site. In August 1990, it was revealed that a 1988 plan to replace Springfields's notorious Phoenix Ward – where conditions have been described as 'sub-human' by Wandsworth CHC – had been scrapped for lack of cash. The 14 seriously ill patients live in 'prison cell' rooms with soiled furniture and fittings and 'appalling' washing facilities.

An interesting sidelight on the reams of pious documents proclaiming management's quest for 'quality' care came in the hot summer of 1990, when members and officers of Parkside CHC visited the psychiatric wards at the Patterson Wing of St Mary's Hospital. They voiced patients' consistent complaints that while their medication made them particularly thirsty, there were insufficient supplies of orange squash available to drink. Management responded that budgets were so tight that to supply more bottles of squash could mean 'losing two

members of staff'! Six months later patients were still thirsty, management suggesting they should be happy to drink tap water – of which supplies were (generously!) still not rationed.

In September 1990, management at Friern Hospital agreed to investigate complaints by COHSE that unqualified nursing assistants – some of them agency staff – had been left without supervision for hours on end in charge of wards at night.

In crisis-hit Riverside health authority, facing cuts of £9 million, management threatened early in the year to close the Cassel psychotherapy hospital; and the autumn saw them admit that they have once more deferred the building of an acute psychiatric unit at Charing Cross Hospital which was promised as part of the reprovision for the closure of Banstead hospital in 1986. It is now highly unlikely that the promised project will ever see the light of day, despite endless promises and assurances from District General Manager David Knowles.

Another autumn casualty were the dreams of building the long- postponed Phase 2 of City & Hackney's Homerton Hospital, intended to replace the psychiatric beds and facilities provided in the ghastly Hackney Hospital. In the ruins of the District's failed opt-out bid, General Manager Ken Grant announced plans to close Hackney Hospital within 18 months even without the new building, simply dumping existing in-patients into some of the districts hundreds of vacant beds.

The Hackney crisis flowed from the freeze on all capital projects imposed by NE Thames region; this also coincided with strong criticism of conditions for patients at Claybury psychiatric hospital by the Hospital Advisory Service.

Also in the autumn of 1990, an article in the *British Medical Journal* argued that bed reductions have left acute psychiatric services in London under huge pressure. Surveying 48 acute units in Greater London over peak Bank Holiday periods when community services are largely unavailable, they found more than 95% of beds were occupied, with beds in a third of districts completely full. 23 units were running above the accepted efficiency level of 85% occupancy. Their report argued that:

"Widespread pressure on beds and overcrowding allows less scope for admissions of other than the most severely disturbed patients ...

"We think ...that there has been an acceleration in the rate of closure of beds without adequate increase in the provision of services and especially of day care."

With day-to-day services under such pressure and long-term plans thrown into chaos and confusion by the lack of cash; and with local authorities confronted with Poll Tax capping and a barrage of restrictions and impediments on their ability to provide social care for people with mental illness, most of the problems of today's mental health care programme could be resolved by a change of government policy and the allocation of sufficient resources to make community care a reality. The record of the last ten years suggests that no such change of heart can be expected from the present government.

Where's the information?

Compiling a report such as this helps reveal the extent to which mental health care remains a 'Cinderella' service, very much on the fringes of the concerns of district, regional and national NHS managers.

In the absence of capital to fund new projects, regional health authorities no longer bother to compile strategic plans; most do not even keep overall figures for mental health services in their districts. They no longer publish 'norms'for bed provision or per capita targets for services. The Thames regions do not even have up to date figures on the numbers of mental health beds in the hospitals they cover.

Their ignorance in this regard will be compounded from April 1 by the 'opting out' of 13 self-governing Trusts in London, to be followed by a second wave next year – each of which will operate under a secretive cloak of 'commercial confidence'. We can safely predict that as these Trusts run into financial problems, they too will squeeze resources for mental health services: but it may take months for the real facts to emerge. In Lewisham & N. Southwark, for example, the local CHC has been refused financial information on the mental health services to be provided by the Guy's-Lewisham Trust, on the grounds that this is now part of the confidential 'business plan' of what from April 1 will be a self-contained business.

Just as the government ducked away from Sir Roy Griffiths' suggestion that they establish a ministry to take responsibility for community care (thus leaving local councils and DHAs to carry the can for failures), so the regional health authorities are tending to adopt a similar 'arm's length' approach, urging most districts to do their own thing, at their own pace, with only the most cursory interest taken in the progress they make – except insofar as they are able to free up land and property assets for quicker sale. There are exceptions to this rule, notably the priority and resources given by SE Thames to the Cane Hill closure and by NE Thames to the

closure of Friern: but in each case the extra resources devoted to these closure programmes come at the expense of reduced funding and concern for other mental health projects.

The result has been a very patchy development of community care, and varying types of reprovision, some of which is light years removed from community care. The less regional coordination takes place, the less likely it is that lessons – positive in some cases, more negative in the instance of the Banstead Hospital closure in 1986 – are not generally learned from collective experience.

It is clear that some managers will talk openly of achievements and problems, while others appear to regard any enquiry as a threat. **Yet some degree of public scrutiny is important if the service is to pursue and win its struggle for adequate resourcing.**

Mental health has little or no public profile. Other than occasional 'scandal' stories in the gutter press about 'violent' or 'anti-social' people with mental illness being seen 'on the streets', there is almost no general public discussion on the level or quality of mental health services. This silence is compounded by the fact that DHAs and RHAs have traditionally been dominated by the powerful consultants' lobbies of the acute sector, while for most of local government mental health is at best a side issue they are happy to leave to others. Many CHCs, too, have tended to devote relatively limited energy to mental health issues.

There is unfortunately no reason to believe that these histroric 'priorities' will be changed by the NHS Act's organisational division of the NHS into purchasers and providers. Those with control of the purse strings will still tend to spend money on those services they have traditionally favoured, and ignore other vital services – especially when the new Act increases the administrative costs of the NHS without increasing the overall size of the resource 'cake' to be shared between the different units.

The low level of public discussion on mental health helps explain the poor quality of information on the service, and why sources are obscure and out of date. Indeed it appears that the greater the proliferation of computers and administrative staff in today's NHS the harder it is to obtain information. It turns out that the *Mental Health Enquiry*, the Department of Health's once-regular compilation of statistics on mental health services, has not been published since 1986. Yet it is precisely the last five years that have seen the most rapid run-down of mental illness beds and supposed emergence of community care.

Some sets of government figures seem to be mutually contradictory. For instance one set of DoH Personal Social Services statistics shows a 25% *decline* (from 4,880 to 3,600) since 1981 in numbers of residents supported by local authorities in homes and hostels for mentally ill people, while a completely different set of statistics from the same Department apparently shows a small but steady *increase* in local authority home and hostel places, and far larger numbers of places in the voluntary and private sectors. Are these extra places standing empty? If not, which set of figures is wrong?

Other statistics – such as the estimated number of sufferers – rest on various 'guesstimates' and projections which nobody has bothered to test out.

Another problem is that some figures, such as those for day centre and day hospital places, give only a broad brush notion of the *quantity* of places available: they give no idea of the *quality* of the service they provide. Do the centres succeed in their aims, and offer satisfactory therapy and stimulation for their clients? Or do they fail? Does anyone really care? How much choice to elderly clients have on whether or not to attend a day centre?

There is considerable confusion about the numbers of clients who on average and in practice actually *use* each day centre and day hospital place. Some come one day a week or less, others may come every day: is this at the choice of the client, or the result of limited places? Nobody appears to have actually worked out how many *more* clients might want to use such places if more were available, if transport to and from them was improved, or if the quality of activity and therapy in the day centres and day hospitals were improved.

There appear to be no figures for the numbers of acute psychiatric patients discharged from hospital beds with appointments for outpatients or day hospitals, but who then fail to turn up, and disappear from any system of community care. A question along these lines raised by Parkside CHC threw management into a prolonged and constipated silence.

Least of all are there figures, or any effort to obtain them, showing the numbers of sufferers who are not and have not been in hospital but who *ought* to receive some form of community- based care and currently receive none. A recent Wandsworth Mental Health Unit document suggested as many as 420 people per 100,000 people in the community suffer from long-term and severe mental illness: this would suggest a London-wide figure of 250,000. Needless to say nobody has attempted to show how the NHS hopes to match its services to this level of need.

A survey of London's big psychiatric hospitals

St Bernard's (Ealing DHA)

Hospital services

The hospital has run down to 526 beds from a 1984 complement of 1120, and is trying to sell off some of its land assets, but is not scheduled to close.

Instead a brand new 75-bed acute unit, reputedly the first in the country to be based on single room accomodation for clients, is about to open next to Ealing General Hospital, and management are working on proposals to "opt out" and seek Trust status as a self-contained business.

St Bernards still provides long-stay beds to three neighbouring health authorities – Hillingdon (63 beds); Riverside (15 beds for North Hammersmith residents) and Hounslow and Spelthorne (22 beds for the Ashford catchment area). In addition it houses the a 40-bed Regional Secure Unit and a 30-bed Regional Drug and Alcohol dependency unit, though funding constraints are likely to reduce this to 15 beds.

Local beds

Of the local beds, 16 have until April been allocated to Connolly Ward, a therapeutic community mainly for younger people, combining residential and day users, and relying on psychotherapy rather than drugs. However the staffing of this unit has been run down, and the ward itself left to fall into appalling disrepair – despite offers by both staff and patients to redecorate.

With the crumbling state of the ward it has become less attractive to potential clients – especially on a residential basis, and so numbers have declined. These two factors have been used as arguments to move the unit from Connolly to Conway Ward, and to threaten its closure from April 1. The matter is still unresolved.

Rehabilitation

Another 165 local beds are classified as 'rehabilitation' beds, and though the Hospital still contains numbers of patients who cannot be discharged only for lack of adequate accomodation outside, some of the clients are very long-stay patients.

Management are still picking up the pieces after the abrupt and ignominious departure of the previous unit general manager Tom McClusky, under whose stewardship large numbers (over 120) of St Bernards clients were discharged in the course of just 11 months to homes and hostels in 28 different places scattered far and wide throughout the Home Counties – and as far afield as Lytham St Anne's on the North West coast.

Following on complaints from North West Regional Health Authority that 22 people from St Bernard's had been "resettled" in Lytham, without any support provided or organised from Ealing, in a nursing home not registered for psychiatric patients and without informing either the local health authority or social services, NW Thames RHA was forced to hold a major inquiry into the resettlement programme. This concluded that while some good work had been done and some clients had been successfully discharged to improved conditions, "because of the methods used some of the resettlements are unstable and could rebound on St Bernard's in the way that the Blackpool resettlement has. A few have been very unsatisfactory."

The policy of accelerating the discharge of patients without establishing the proper infrastructure of support to assist them to find their feet in the community – and in some cases clearly 'dumping' them at long distance from any capacity of Ealing DHA or social services to assist them – was strongly criticised in the resultant RHA report. But the blind eye turned to these activities by Ealing DHA and its officers was ignored, and the report set out to restrict its criticism to managers and staff of the mental health unit.

While still under suspension as a result of these events and revelations, Tom McClusky resigned as unit general manager. The new management team is still "mopping up", and has set up a working party to review all policies and procedures on the discharge of patients. A resettlement team is tracing and visiting all those who have been resettled under the old system. Meanwhile the emphasis is on consolidating a "steady state" and slowing the resettlement except where there is strong medical pressure for the discharge of a patient.

Beds for elderly

St Bernards has a further 97 beds for the Elderly Mentally Ill (EMI), and 26 day assessment places for the elderly, though management want to expand to at least 120 beds. A further 60 EMI beds are provided by the private company Takare, on the basis that the DHA has 100% nomination of clients, and 'tops up' their Social Security income support payments to cover Takare's weekly fees.

However according to the *Health Service Journal* there are signs that the government may be about to crack down on this method of DHAs cashing in on Social Security money (which will in any event be substantially changed in 1993 by the NHS & Community Care Act). Managers argue that if Ealing were to meet bed norms for its elderly catchment population, St Bernards should have 160 EMI beds and a further 120 day places.

Such proposals and plans are all restricted by the financial crisis gripping the unit and Ealing DHA, which affects revenue as well as capital spending. It is not clear how many of the beds for the elderly in the new acute unit management can afford to open: and 50 places in two day centres at Acton and Southall Norwood have been completed and are ready for use – but there is no revenue to open them.

Community services

The unit boasts that one of the achievements under Mr McClusky was that the rundown of beds at St Bernards was accompanied by the development of substantial community services – 'the best in the country', according to one unit manager. Funds freed up by the closure of beds and wards were immediately reinvested in community services, which include no less than 4 community mental health resource centres, each with a team of around 15 qualified staff: there are still hopes of a fifth centre – held back by lack of capital and revenue. A Resource Centre costs at least £400,000 a year to run. Ealing MHU employs over 50 Community Psychiatric Nurses.

The Community Health Council and health workers expressed concern that the Resource Centres tended to deal with the 'worried well' rather than sufferers from chronic mental illness who live in the community; but management figures show that in fact the majority of each centre's work is with the chronic sick – sufferers from schizophrenia and psychotic conditions, and elderly people, who might otherwise have become 'new long-stay' in-patients. They maintain a very high open caseload numbering some 3,000 clients, with each walk-in clinic receiving an average of 50 new clients a month, whether from GP referral, self-referral, or referral by relatives.

Housing

Management insist that – especially in the aftermath of the resettlement scandal – they will not discharge any patient without accomodation. Long-stay patients in particular are very carefully discharged. This has been facilitated by a good working relationship with Ealing council's Housing Department, making available more suitable housing:

"But there are not enough hostel places: we could do with *hundreds* more. The few local authority places are quickly filled up with people who stay there. The fact that we have people on the wards at St Bernards who shouldn't be there, and should be living independently in the community is terribly unfair to them: but if there are no places, we are duty bound to keep them. On one ward four out of 15 patients are ready for discharge but have no home to go to," said assistant unit manager Kathy Hogan.

However Ealing NALGO has warned that plans to integrate the council's mental health team with housing advice and sheltered housing workers in a single Special Needs Unit could undo much of the progress that has been made on the resettlement of mental illness sufferers. It points out that the resources of the Mental Health Team are already limited 'and it is unable to cope with the growing number of ex-psychiatric patients being housed within the community'.

Staffing

However one other aspect of the Resource Centre system is that those people who are admitted to hospital tend to be only the most severely ill and disturbed. There is less of a 'mix' on each ward than before, and this can make things much more stressful for staff.

Management are campaigning for extra money to improve inadequate staffing levels at St Bernards, arguing that the existing establishment figure is too low to provide quality care. They also hope that the improved physical environment of the new wards on the acute unit will make life more pleasant for patients and lift the morale of staff.

Cash crisis

However as the battle for resources hots up, so does the financial crisis facing the unit. While the first parcel of St Bernard's land was sold before the end of the property boom there has still be no move to develop it: and there is no sign of a buyer for the second phase. The unit also faces a revenue overspend, and all of the uncertainty faced by other parts of the service as the new NHS Act begins to take effect from April.

Shenley (Parkside DHA)

Hospital services

The (relatively new – 1930s) Hospital has run down to 620 beds from a 1984 total of 1239 – but during this period a new 90-bed acute unit serving Parkside has opened at Central Middlesex Hospital. Harrow DHA, which also uses beds at Shenley, has provided its own acute services from Northwick Park Hospital for 10 years.

Much of Shenley's substantial land assets have been earmarked for sale in four phases (moving concentrically towards the middle core of buildings), but the Hospital has no closure date, and some services seem set to remain there for the foreseeable future.

Though the hospital still provides some limited acute services (a secure Intensive Care Unit and a regional 9-bed Mother and Baby Unit) these are due to transfer to Central Middlesex as soon as funding allows, and most of Shenley's current in-patients are long-stay elderly people. Parkside has another 95 beds for the Elderly Mentally Ill within its district boundaries.

Rehabilitation and resettlement

The services at Shenley continue to be shared between 'Brent' (the current Parkside catchment area) and Harrow patients, and each health authority has set its own pattern of rehebilitation work. The Brent programme has been especially careful, taking an average 16 months per patient in preparatory work for resettlement to accomodation in

the community. This effort has been backed up by a new Mental Health Resource Centre in Willesden, though a second Resource Centre planned for Wembley has been held up for lack of cash. Of 58 long-stay patients discharged, 8 have had to be readmitted. Staff regard this as quite successful, and are confident these patients are not simply being 'dumped'.

However cash pressures mean that as these patients are discharged, the beds are taken down. If they then have to be readmitted to hospital for acute care, there is nowhere to accomodate them in Shenley, and they will wind up in the unfamiliar surroundings of the acute unit at Central Middlesex Hospital. About 130 'Brent' patients are left in Shenley waiting for rehabilitation, almost all of them elderly. Staff and managers agree that it becomes more difficult to rehabilitate patients once the first wave of mainly younger, less disturbed patients have been discharged.

Harrow DHA has resettled 20 patients, with another 9 discharged to a hostel in Harrow View and 12 to Besborough Road (both run by consortia). This leaves around 30 long stay patients in the Harrow beds.

Beds for the elderly

Shenley staff complain that Harrow DHA has deliberately left many of its allocated beds empty, even while it faces a waiting list for EMI patients in Harrow. This in turn pressurises Shenley management to seek additional ward closures.

The remaining Shenley patients, mostly elderly, are being individually assessed as part of a major reorganisation to regroup those with similar problems (functional groups) on the same wards over a 2-year period. This would then 'shadow' the provision of care in the community, as the MHU seeks to reprovide as many as possible of its services – where possible jointly with social services and the voluntary sector – in smaller, community-based units. There appears to be a consensus between staff and management at Shenley that some present in-patients cannot be rehabilitated. As the draft Parkside Mental Health Strategy document puts it:

"It is felt that a proportion of the longer stay patients at Shenley from Brent, Harrow and no borough of origin (stateless) should stay at Shenley for the rest of their natural lives."

Community services

Establishing community care to replace Shenley's services runs into the problem of restrictions on both DHA and local authority funding. Parkside's Community Unit has just 100 day hospital places for the mentally ill, more than half of which are allocated to the elderly.

There are a further 260 Day Hospital places at the big Parkside hospitals – Central Middlesex, St Mary's and St Charles, but the use of these places has been hit by staff shortages. Parkside CHC expresses growing concern that patients are being discharged too quickly and without proper follow-up from acute beds to Day Hospital care – and then fail to arrive.

The planned Wembley Resource Centre was to have been financed through sales of Shenley land. But despite heavy investment in services (new roads, lighting, etc) no buyer has yet been found, and the whole NW Thames capital programme remains bogged down in the property slump. The same goes for all of the more ambitious plans in the latest Parkside MHU strategy document.

Acute services

There are 196 mental illness beds designated as 'acute' serving Parkside – 90 at Central Middlesex; 60 at St Mary's Patterson Wing; 36 at St Charles; and 10 at Willesden. The vast majority (86%) of their 1,964 cases a year are emergencies.

Concern is voiced both by Parkside CHC and by health unions that the acute beds are developing a group of patients who face the 'revolving door syndrome', going through repeated admissions followed by premature, ill-managed discharge. COHSE members argued that this could only be tackled by the injection of additional 'pump-priming' resources to establish more thorough rehabilitation procedures in the acute units.

The CHC is also concerned that one in eight of the district's acute psychiatric patients has no known or an overseas address: at St Mary's, closest to the inner-London area, the percentage is almost one in four, with an average of eight patients a month admitted without an address, many of them homeless people. Yet management still has not replied to CHC questions on how many are *discharged* from the Patterson Wing and Central Middlesex to bed and breakfast accomodation or no fixed address (or how many are given out-patient appointments which they then do not attend).

Staffing

Staff at Shenley freely admit that the attitude tends to be 'conservative', with few really believing that the Hospital will ever close. Most live locally and see little attraction in the long, awkward journeys that would be involved in taking up posts with the community-based units. 'To go from here to the Willesden Resource Centre is a major outing'.

Management have made few serious moves to push staff to retrain for work in the community, and indeed in-service training has been one victim of cash cutbacks. They had considerable problems staffing the acute unit 16 miles away at Central Middlesex: some staff were only persuaded after management promised a free minibus service.

The long-running, unresolved saga of clinical grading, with its pool of grievances, has not helped build morale or fill vacancies; nor have the inadequate numbers of qualified staff on the wards.

Cash crisis

Staff morale however has not been improved by the impact of revenue cash constraints, and the replacement of paid overtime by the use of agency working, through which largely the same staff are paid less than their proper grade entitlements for working extra hours.

Patient services have also been hit: at Shenley, the patients Alpha Club has been threatened with cuts and closure to 'save' the cost of the qualified staff in attendance: COHSE has been fighting to keep the Club open.

Repairs to the fabric of Shenley have been held up as a result of the cash crisis. Management have also attempted to close the (3 days a week) X-ray facility – encountering strong staff opposition.

Meanwhile at St Mary's Patterson Wing, management warn that even a few extra bottles of orange squash a month for in-patients to drink would run well beyond the limited budget – to the extent that it could be a choice between orange squash or a couple of members of staff!

Napsbury (Barnet DHA)

Hospital services

Despite reporting a mere 7% reduction in beds between 1984 and 1990, Napsbury had run down from 1005 beds to just 704 (on DHA figures) a 30% reduction. Of these, 307 were assigned to elderly long-stay, 348 to other long-stay, 29 to short-stay, and 20 to the secure unit. However unit management figures show an even bigger decline in actual numbers of patients, from 744 in 1986 to 557 in March 1990 and 524 in October 1990 – a drop of 30% in four years.

The latest plans expect Napsbury to continue to decline in size to around 210 patients by 1996, with 236 existing patients resettled in the community in Barnet and SW Herts and a predicted 'natural decline' of 140 old long-stay patients. Still at Napsbury would be 90 long stay beds; 20 old long stay; 60 EMI; 20 beds for psychiatric intensive care; and 20 beds for the Brain Injury Rehabilitation Unit.

At present acute services are provided from the 72-bed unit at Barnet General Hospital (12 elderly short stay; 30 elderly long stay; 30 other short stay).

The 20-bed Northgate Clinic provides a Regional adolescent psychiatric service for residential and day patients.

In October 1989 40 EMI beds opened at Colindale, enabling the closure of a ward at Napsbury, though the full opening of the EMI Day Hospital was delayed by staffing and financial problems.

By the year 2000 management hope to have a 200-bed hospital on a 44-acre site, with the remainder redeveloped into a business park, hotel and leisure facilities.

Yet the capital requirement for replacement services to enable the closure of Napsbury's West Hospital is £23m; and the extra revenue costs of a community-based service are estimated at £5.7m.

Community care

Management explain that the rapid reduction of Napsbury beds arises both from the 'inevitable decline' of the hospital's old long-stay population and from the development of community- based services.

The District was one of the first to set up a 24-hour multidisciplinary team (in 1970) to respond to psychiatric emergencies. This approach has helped hold down the numbers of hospital admissions. In 1985 the admission rate for Barnet DHA was 281 per 100,000 population compared to a regional (NW Thames) average of 420. In 1989 the DHA had a team of 37 CPNs.

In November 1989 the 12-place Leecroft hostel opened, run by the Richmond Fellowship, and monitored by Barnet DHA and the local authority.

Four EMI patients have been moved into places 'bought in' from the Meadowside Home for Elderly People. And by November 1990 some 60 over-65s had been resettled in private and voluntary residential care homes, with 'about half being supported by 'top-up' payments by BHA/CHSU'. 20 more EMI in-patients have been resettled in Abbots Langley Hospital (14) and a local authority home in Watford (6).

A new rehabilitation unit has been established at Church House, including five houses, and two adjacent houses in Barnet have been purchased as a community resettlement base.

The DHA has appointed a Job Search Manager, who has helped find work experience places for 42 out of 89 referrals. A £1.4m community workshop facility is due to open in High Barnet in autumn 1991.

Horton (Riverside DHA)

Hospital services

If the controversial 1986 closure of Banstead Hospital is taken into account, Horton has undergone a massive 64% reduction in beds since 1984. It is scheduled to close in 1996 – a rapid rundown from its present 692 beds. Unfortunately it appears that few lessons have been learned from the experience of closing Banstead, and little in the way of community care exists or is planned.

The Banstead closure was accomplished in such an unsatisfactory and uncaring way that it drew from MIND, one of the leading lobby organisations campaigning for the closure of large psychiatric hospitals, an angry pamphlet which strongly argued that:

"While we continue to wholeheartedly believe that large psychiatric hospitals are inappropriate settings for mental health care and are not places in which anyone should be required to live, *it remains clear that they are better than nothing. ... At least hospitals offer people food, shelter, a degree of safety and friendship.*

"Regarding Banstead's closure, we believe this bears no resmblance to community care as we understand it."

(*When the Talking Has to Stop*, MIND 1986)

Carried out in the context of a massive 45% cut in Riverside DHA's mental health budget, the closure of Banstead was achieved to a large extent by the dumping of patients into other, smaller hospitals, as well as the nearby Horton (which MIND described as 'a monolithic superbin'). MIND asked:

"Why is it necessary to move or 'decant' patients from one large institution to another? This is not care in the community. The 'new facilities in the community' are, in lieu of adequate community facilities, nothing more than smaller hospitals which may well be doomed to becoming mini-Bansteads."

Managers also ran down Banstead by taking minibus and coach loads of elderly patients to placements in cheap lodging houses in less fashionable resorts on the South Coast.

Early in 1987 the *Sutton Guardian* under the headline 'Friendless, Forlorn ... Forgotten' exposed the plight of some of the elderly ex-Banstead patients consigned to some 84 Hastings boarding houses, without Riverside DHA even informing the local social services or health authority.

Community care

Unfortunately, some five years after the Banstead closure, Riverside mental health management still appear to have no clear idea of how to provide a community-based service.

The most recent planning document (September 1990) shows that while many other health authorities are seeking to expand their networks of community-based teams and resources, Riverside bosses still have not yet even decided whether or not they want to set up Community Mental Health Teams ("Discussion is still in progress around the Mental Health Unit over whether to move ahead with this as the agreed method"); nor have they decided yet on the elementary question of whether they want to increase the number of Community Psychiatric Nurses from the present 41 after Horton's 692 beds are 'reprovided into the community'. After the closure of some 1,100 beds, we are told that Riverside currently provides just 135 day places in three centres, and still has no acute intervention service. From this it is easy to see why the document makes no assessment of the experience so far of providing community care: there isn't any!

The document gets worse: vague hopes of a new 120-place 'Horton Haven' to offer continuing care are not backed by any committed funding. It was "assumed" that a grand total of 14 patients would move into community-based housing in 1990. The report discusses the theoretical "overall aim" of providing a range of new accomodation from intensively staffed hostels to supported lodgings and group homes – but does not admit that plans for the first intensively staffed home have for years (since before the closure of Banstead!) been drawn up – sometimes to the level of commissioning architects' drawings – and then shelved for lack of funding. It argues limply that:

"It is an inescapable fact that the speed with which these developments will take place will be largely dictated by the availability of resources".

While Riverside's plans are vague to the point of total abstraction, there seem to be no more concrete proposals for the reprovision of beds for Horton patients from Richmond, Twickenham and Roehampton DHA:

"RTR will need to replace this (28-bed EMI) facility locally but as yet do not have a definite timescale for achieving this".

Riverside's main hope for 'reprovision' of services for Horton residents is that almost half of the 380 long-stay patients will die by 1996, and the remaining 200 can be dumped into *another* nearby local 'bin' – Mid Surrey DHA's West Park Hospital. With astounding cheek, showing that they are looking for ways to offload the bills as well as the patients, Riverside managers declare that:

"Consideration will have to be given prior to this move as to which Authority will meet the cost of the care following the transfer to West Park Hospital".

There is little hope of any cash bonus to flow to Riverside's mental health services from the assets of Horton Hospital, if the Banstead experience is anything to go by. Far from freeing resources to develop community care for mental illness sufferers in Riverside, the cash from the sale of the Banstead site served only to finance an *underground car-park* at Charing Cross hospital!

The car-park was supposed to be the first phase of a new 78-bed mental health unit; but the funds to complete the unit itself have now (predictably) run out, with every available pound being funnelled into the huge Riverside overspend and the new £210m Westminster and Chelsea Hospital. There is no prospect of the Charing Cross mental health unit being built in the foreseeable future.

Seldom does a health authority document read as such an open admission of failure either to learn lessons from past mistakes or to map out a serious blueprint for future development.

Nor can the DHA depend upon the local authorities to step in and cover the huge gaps they are leaving in mental illness services. With Westminster cutting its social services spending, Hammersmith and Fulham faced with poll tax capping and cuts in services, and Kensington & Chelsea not completing its community care plans until summer 1991 it is unlikely that vast resources will be unleashed.

Hammersmith & Fulham social services express their concern that it the aftermath of Banstead's closure they saw no serious expansion of local services, and warn that if Horton is run down and closed in the way Banstead went, there could be no facilities at all for the care of a large number of local people (estimated as at least 500-600 long-term sufferers) with long-running mental health problems.

Housing

In this corner of inner London, providing decent housing is a vital factor in supporting people with mental illness – yet local authority housing budgets have been put in a financial straitjacket by a decade of government restric-

tions, while health authorities lack the capital to launch proper schemes to rehouse patients in the community. Even previous avenues for progress have been blocked by cuts in grant funding to voluntary organisations such as MIND, and restrictions on the Housing Corporation.

"It is counter-productive to try to rehabilitate people if there are no resources to support them in the community," argues Frankie Pidd of Hammersmith's social services. "And if Horton closes and the Charing Cross unit still has not been built, what hope will there be of a proper service for people in Riverside?"

Friern (Hampstead DHA)

Hospital services

The hospital has always been scheduled for relatively early (1993) closure, and under the Dispersal Programme begun in 1983 had been run down from 885 beds to 598 by July 1990. However the growing capital crisis in NE Thames region brought pressure on management to attempt an even more rapid closure – by September 1991.

This has been spurred on not so much by any clinical judgement on the Friern patients as by the complications in selling the Claybury Hospital site, and the easier prospect of selling Friern's land assets. To break even on its capital programme the Region needs t. raise some £100 million in land sales, much of this from the sale of Friern.

The RHA admitted that 'existing plans ... for Friern and Claybury could not be advanced', and that 'The future of the Claybury reprovision programme was effectively put in abeyance, whilst this work on Friern progressed'.

By October 1990, regional chiefs concurred that it was not practical to aim at a 1991 closure, but also agreed on a drastic reduction in the capital spending available for the reprovision of services, to ensure a cheaper scheme still allowed closure by March 1993.

Plans until July 1990 had involved providing a total of 426 beds (90 of them specifically for the elderly) and a range of day hospital and other services, in Bloomsbury, Islington, Haringey and Hampstead – at a total cost of £46m.

The two biggest schemes in this reprovision were the refurbishment of Friern's (1960s vintage) Halliwick building to give Haringey DHA 128 mixed beds at a cost of £8.3m, and the development of a 79 bed unit at Highgate Parkside for Islington DHA, at a cost of £8.8m.

As the cash squeeze was applied, the Halliwick scheme was first cut in half – to 60 beds at a cost of £4.2m – and then scrapped altogether, along with plans to build a new regional medium secure unit in the same grounds. Instead, Haringey DHA decided to move its Friern beds to empty wards at St Ann's Hospital vacated by previous spending cuts (the hospital also has modern, mothballed operating theatres, axed to save cash). The medium secure unit is now to be built at Chase Farm in Enfield.

Islington DHA (now merged with Bloomsbury) followed suit with its cancellation of the Highgate Parkside development, which had in any case been criticised by the CHC as falling well short of community care.

With these and other reductions in the previous plans, the NE Thames region was able in October to cut the capital provision for the Friern closure to £25m – just over half the original requirement. However many of the 'interim' arrangements made by the user DHAs are miles removed from any concept of community care. Bloomsbury/Islington is to spend £12m dumping some 183 patients (95 Bloomsbury, 78 Islington) into a series of more or less makeshift wards at the Royal Ear Hospital, St Pancras Hospital, St Luke's and the Whittington..

Haringey is to focus much of its mental illness service and move most of its 172 Friern patients to wards at the run-down St Ann's (completely reversing their previous plans). And Hampstead is to shift most of its Friern patients to the Royal Free.

Community services

None of these hospital environments could remotely be described as community care: and though most of these moves are seen as simply a temporary measure to facilitate early closure and sale of the Friern site, in the absence of large scale new capital resources to the NE Thames region, it seems likely that they will become more or less permanent. NE Thames Director of Service Development assured the RHA's October meeting that 'the term "temporary" referred to *a stay of several years* rather than constantly moving the patients'.

Of course it would be wrong to ignore the units that had been established or begun before the cash crunch wrecked the Friern reprovision: by July 1990 a total of 31 homes and hostels were operational or had dates for completion before the end of September 1991. Four centres of nursing accomodation for the elderly had been established, along with four day hospitals and three mental health resource centres. All of these offer improved and much more localised, accessible care than the crumbling wards in the forbidding Friern Hospital.

Staffing

However these services themselves have come under pressure from revenue costs. The Friern branch of COHSE, which opposed the plans to rush through the Hospital closure by September 1991, while supporting the move towards more community-based services, complains that in at least one hostel run by Hampstead DHA staffing levels have been cut back – and rotas changed – to save money.

There are also concerns that the job protection policy agreed with management did not specify where the new jobs would be; and some 20 or more nurses who are likely to want to remain have not yet been given a firm promise of a job. COHSE points to a retreat by management from the concept of community care: 'We were told it was going to be a more intensive form of care and support:

now we can see it swinging back towards care in under-staffed hospital wards'.

COHSE's Friern secretary Allan Warby commented:

"Putting people into smaller units does not necessarily amount to community care, unless they are properly backed up by services. Homes and hostels can wind up just giving patients a bed, food and television all day long. Proper funding is also essential. Last year's holidays for patients went over budget, so that won't be repeated. Many long-stay patients in Friern had not been on holiday for years, and really enjoyed it.

"We place some of the blame on managers for not speaking out on under-funding: they tend to just go along with orders from above unless the staff kick up. We can talk to our managers at Friern, but some of the hostel managers try to bypass the unions and Whitley agreements.

"We are monitoring to ensure that all the promised facilities are provided and up to scratch."

Claybury (Waltham Forest DHA)

Hospital services

Claybury was originally targetted for an early (1993) closure date, and has run down rapidly from 1205 beds in 1984 to just under 500 in early 1991. However the capital shortfall in NE Thames – and the diversion of all available resources to speed the closure of Friern Hospital – has now forced Claybury's plans for service reprovision to a grinding halt. Regional chiefs admit there is unlikely to be any additional cash available to resume the reprovision programme until after 1993.

Claybury serves five DHAs as well as Waltham Forest. Only one of these – City & Hackney – is anywhere near completing its own reprovision of services to transfer its patients from the Hospital. Haringey DHA still has to provide for a further 72 patients, West Essex 97, Enfield 67, and Redbridge 65. Waltham Forest DHA itself, having transferred 104 patients so far, needs a further 149 places to enable the closure of the Hospital.

However Waltham Forest has also seen six major schemes, to provide a total 217 beds plus day hospital services, caught up in the NE Thames capital freeze. These are:

- An 80-bed acute psychiatric 'base unit' and 40-place day hospital at Whipps Cross Hospital;
- A 30-bed admission and assessment unit for the elderly at Whipps Cross, with 30 day places.
- A 12-bed respite care unit for the elderly;
- Two nursing homes for the elderly (totalling 48 beds) to be built in Chingford;
- Two more community units, one of 24 places plus 30 day places, for people with difficult and challenging behaviour; the other 23 places plus day care, for continuing care of the very frail elderly.
- In addition, mental health unit managers insist on the need for two more Community Mental Health Centres as well as the one already in operation; and their plans for a base for psychotherapy, psychology and mental health management have also been caught in the capital freeze.

Community care

The cash crunch has brought a halt to a promising range of alternative provision in Waltham Forest that had accomodated over 100 clients in four major projects embracing a variety of staffed homes and smaller units of housing (none larger than 25 places and some as small as 3 person houses); some are run in conjunction with the local authority and some with the voluntary sector.

Management now argue that the top priority must be the establishment of Community Mental Health Centres, but "At present, no firm proposals are available".

Staffing

Management say they are actively encouraging staff to undertake additional training for the new shape of services to come after the closure of Claybury.

Goodmayes (Redbridge DHA)

Management at Goodmayes have been among the least cooperative in assisting this survey, and appear to be profoundly reluctant to divulge information on the services they provide or their plans for the future. The most recent bed total available (obtained only after repeated inquiries) shows 527 at March 1990: this is now almost certainly an over-estimate in view of the opening last summer of East Ham Memorial Hospital in Newham.

Hospital services

Goodmayes serves Newham DHA as well as much of Redbridge (which also makes use of beds in the nearby Claybury Hospital). Though it has been substantially run down, it is not due to close, and its main land assets are not for sale: indeed with the building of a new District General Hospital on the one end of the site, the psychiatric hospital is likely to remain for a long time to come.

The standard of some of the wards is far from ideal. Late in 1989, management in Barking Havering and Brentwood decided against seeking to transfer 90 patients from the crumbling old ruin of Warley Hospital to Goodmayes on the basis that the accomodation in Goodmayes was actually *worse* than Warley!

Goodmayes has relied upon cash savings from 'retrenchment' and ward closures to finance those services it has reprovided in the community. This is more complicated when most of those patients resettled from the Hospital appear to have come from (and returned to) Newham.

Almost 50 Newham patients have been discharged to staffed accomodation (some run by voluntary organisa-

tions, some by the DHA, but much of it, to the annoyance of the CHC, outside the borough boundaries of Newham).

Another 87 Newham patients have been transferred to the new unit at East Ham Memorial Hospital, which combines acute and continuing care. Two wards of 25 contain under-65s, while there are 37 elderly patients, 29 of them acute.

This leaves 241 Newham patients (25 adult, 108 elderly, 108 continuing care) still in Goodmayes, and using one rehabilitation ward.

Around 20 of the Newham patients are judged to be too frail to move, and then only to nursing home accomodation: yet plans to expand nursing home accomodation have been held up for lack of capital. Newham DHA is now looking at the possibility of using vacant wards at Plaistow Hospital with some refurbishment.

Newham management want to move more of the long-stay patients out of Goodmayes, but are restricted by lack of resources. Two more schemes to accommodate 28 patients are funded – but not scheduled to open for 18 months.

Cash crisis

Goodmayes management however are reliant upon extensive bridging loans from NE Thames region (seeking £1.1m in 1990-91). This has come under severe pressure in the capital squeeze. A summer 1990 DHA assessment of the financial position warns that in the mental health unit cash savings and possible cash receipts "have been accounted for at maximum levels with no leeway, and the Unit will be in serious financial difficulty if the planned levels of income and cost saving are not achieved".

The DHA also laments the lack of resources to "facilitate more progress in implementation of the NHS Review 'Caring for People' ...."

In fact progress on provision of community care in Redbridge has been very slow, with little or no support on offer from Redbridge council, notorious for its lack of services. It is one of five outer London boroughs that provide no day centre places at all for the mentally ill.

Community care?

Goodmayes has a rehabiliation ward (largely used by Newham patients) and 21 rehabilitation places in houses on the hospital site. But without adequate housing units to transfer these patients into, this can only achieve limited progress.

In a summer 1990 visit to one of the houses, Newham CHC concluded that the frame of reference of rehabilitation work had changed from being 'client-led' – awaiting sufficient development in the client before seeking suitable accomodation – to being 'resource-led', working in the shadow of ward closures and the lack of availability of community housing.

Staff comment that clients living in the rehabilitation ouses can frequently be seen back on the main hospital site for lack of any other activity during the day.

A 1988 study of the attitudes of Goodmayes long-stay patients to possible discharge showed 90 out of 270 were too incoherent or unable to speak. Of 152 replies, 32% did not want to leave, while 56% said they would like to leave if they had somewhere to go. 24% said they had nowhere else to live, while 40% said they felt unable to cope outside.

Answers in the same survey showed that 20% of the 152 wanted to live in a sheltered flat complex, and 13% in their own home. Only 4 people (3%) wanted to live in a group home, and just 9 individuals (6%) favoured hostel accomodation.

(DPH report *Health and Health Services in Newham*, 1990).

Three homes run by Redbridge Community Housing Ltd, and sited in the Wanstead and Barkingside areas have taken a number of discharged patients from Goodmayes and some from Claybury.

A 30-place EMI day hospital in Chadwell Heath, due to open last year, is now announced to open in March 1991. Redbridge DHA has a department of 26 CPNs.

Newham has developed two day hospitals with a total of 80 places for adult and elderly patients, and a CPN service with 17 staff, 9 of whom cover geographical sectors, while the remainder specialise in rehabiliation or work with the elderly.

Yet the 1989 report of Newham's Director of Public Health highlighted the pressure on mental health resources, pointing out that the psychology service had had to close its waiting list, while the jointly-funded Newham Counselling Service had been forced to close for a period. Of £3.4 million capital projects in Newham DHA in 1988-89, over half – £2m – had been allocated to mental illness projects.

Staffing

The summer 1990 DHA document admitted to a major problem in staffing the wards and services at Goodmayes:

"Most seriously, these budgets make no provision for improving the acknowledged staffing deficiencies at goodmayes ... this is particularly concerning because to date there has been no movement to redress the serious staffing situation which was the subject of protracted discussions with the RHA in the latter part of 1989".

As this report goes to press, some nine months after the DHA issued these warnings, the COHSE branch tells us that Goodmayes is still some 80 qualified staff short of the numbers required to staff the wards properly.

Morale and recruitment are not assisted by the management refusal to pay overtime, and insistence upon running a 'bank' system which employs staff for additional hours but on a flat rate irrespective of their grading.

Warley (Barking, Havering & Brentwood DHA)

Hospital services

Late in 1989 management admitted that among the weakness of local psychiatric services was the fact that it is "largely institutional, on one site (Warley), without District General Hospital provision". Its biggest threat was seen as "the short supply of revenue and capital".

Warley is one of the oldest 'Gothic horror' psychiatric hospitals, built in 1853, and set in remote (greenbelt) countryside with extremely poor public transport access. It has also reduced in beds more slowly than many other hospitals, with an apparent loss of 32% of its beds since 1984.

An early (January 1988) 'strategy' document had envisaged a reduction of in-patient beds from 799 to 423-463 (a 42-47% cutback) by the year 2000, along with new places in the community. However while the bed closures have begun, the reprovision is almost non-existent. Barking Havering and Brentwood (BHB) management continue to declare 710 that beds remain open; but DHA members were told in January 1990 that only 630 patients were in the hospital.

It is a sorry comment on the general standard of psychiatric hospitals that plans to transfer 90 Warley in-patients to Goodmayes Hospital were dropped at the end of 1989 because the Goodmayes accomodation was actually *worse* than Warley.

Plans for alternative provision have been in constant confusion for years, and this has been worsened by three new factors:

- The formulation of yet another new 'strategy' document for the District (*A Blueprint for Better Health Care*), which proposes to close Oldchurch and Rush Green Hospitals to focus all main services on a single-site DGH at Harold Wood.
- The subsequent 'expressions of interest' by both Harold Wood and Oldchurch/Rush Green managements in opting out of DHA control as (competing) Self Governing Trusts: if either or both bids were to succeed, the entire strategy would be called into question.
- The chronic capital crisis facing NE Thames region, which has forestalled any prospect of new building in BHB for the foreseeable future.

In particular the various early proposals that had been floated for a new 114-bed acute psychiatric unit, taking the form of or two 57-bed units at Oldchurch and Harold Wood have become a dead letter, while hopes are fading for the planned 80-120 new places in the community. At the end of 1989, a management seminar heard that plans had been scaled down to just 36 community places: and while 150 patients were planned to move out of Warley, they were simply to be 'decanted' to other hospitals (50 each to BHB's St George's and High Wood, and 50 to Redbridge's Barking Hospital).

A rump of some 300-350 patients seemed likely to be left over at Warley:

"Their future will depend on funds from outside the District, whether this be from Region or private accomodation. Our capital position is dire: the Region's is direr."

Community care

Management strategy to reduce in-patient beds at Warley has been driven more by cash constraints than by any vision or commitment to community care. It has relied upon a change of admissions policy to keep out any further intake of elderly patients above an arbitrary limit of 120, and as existing patients die, the beds vacated "should be taken down and not used for further admissions from the community". (Warley rationalisation plan, November 1988)

We should note that this policy has been introduced in the absence of adequate locally-based acute or community facilities; BHB has among the worst staffing levels in the country for Community Psychiatric Nurses. In late 1989 the management seminar heard that:

"On the care in the community programme there was concern that local authorities had not been able to provide enough day support facilities to support the level of discharges from psychiatric hospitals, and there was a shortage of skilled paramedical staff to carry out assessments and provide care".

At the January 1990 DHA meeting, a member complained that "We have been talking about community care for six years and yet the changes are normally only about 20-30 per year".

Management replied that:

"The problem is that community care schemes are extremely expensive."

The first of *eleven* planned Mental Health Resource Centres only opened late in 1990, and there are now three DHA-run day hospitals, along with two "travelling" day hospitals. A new 25-place day hospital is planned, as are 24 places in community homes, but these will not be available for 6 months to one year. There are 20 places for industrial therapy.

Local authority provision is complicated by the fact that the 470,000-strong BHB catchment area spans four councils (the London boroughs of Barking & Dagenham, Redbridge and Havering, plus Brentwood). Havering has historically provided no day centre places at all for the mentally ill, and just 75 places in local authority and voluntary homes.

Barking & Dagenham provides a 50-place Day Centre (to be developed as a resource centre) and 28 residential places in 8 group homes. Local voluntary organisations in Barking & Dagenham run a Drop In Centre. Plans for the borough include two 12-bedded homes for the resettlement of long-stay patients, to be run by Barking and Dagenham Housing Consortium Ltd; industrial therapy and sheltered

workshops; an enlarged specialist Mental Health Social Work Team.

Staffing

BHB has a chronic short-staffing in its community services, with just half the NE Thames region average quota of speech therapists; the sixth worst provision in the country of occupational therapists, and one of the lowest levels of CPN cover.

Early in 1990, Warley was running some 30% below its establishment for qualified staff, relying on student nurses to cover the shortfall. As the COHSE secretary Peter Cunningham pointed out, it is hard to attract staff to such a crumbling, cash-starved hospital whose closure programme has ground to a halt for cash reasons, but whose long-term future is in serious doubt.

While staff are committed to defend the services, there is no real affection for the Warley building itself: "It has been left to go to wrack and ruin," commented Peter Cunningham, "but even when it was new it must have been one of the most unconfortable places imaginable, especially before central heating and when it was really full."

Bexley (Bexley DHA)

Management at this Hospital are among the least willing to impart information on their services or plans: this may well be linked to the fact that their latest strategic plans, adopted in June 1989, have not yet begun to be implemented, leaving severe gaps to be bridged before anything approaching a community-based serive can be established.

Hospital services

Bexley Hospital has been run down from a peak of 2,000 in- patients, and 994 beds in 1984, to just 439 available beds, of which 379 were occupied at the latest count. Built in 1893, it has a backlog of maintenance estimated at £7.5 million in 1988, but still has no target date for closure. A SE Thames regional working party has been set up to assess the Hospital and its possible future use.

Meanwhile ambitious plans spelled out in the 1989 Strategy, for a new 44-bed acute psychiatric unit and for a 20-bed assessment, rehabilitation and respite ward and 15-place day hospital for the elderly mentally ill at Queen Mary's Hospital, Sidcup, and another 20 beds for difficult to manage patients Erith and District Hospital, have come to nothing. These plans must be thrown even further into question with the plans of both Bexley Acute and Bexley mental health and mental handicap services to 'opt out' as self-contained businesses from April 1992.

Greenwich DHA has removed its 31 continuing care patients from Bexley to the Memorial Hospital, in developments to local mental illness services costing almost £2m. Lewisham & North Southwark DHA, too is working to reduce the numbers of its patients using beds at Bexley, though this, too, will be complicated by the uncertainties of the opting-out of Guy's- Lewisham Hospitals as a Self Governing Trust.

In April 1989 a major Health Advisory Service report on Bexley argued that:

"The rundown of Bexley Hospital ... has taken place at a faster rate than was envisaged. This uncontrolled contraction is resulting in an overspending of the Bexley Hospital revenue budget despite efforts to rationalise the services and reduce costs to match the lower patient numbers. (...)

"The environment in which care is given is generally of a very poor order and, even when in a fair state of decoration, is cavernous, impersonal, and unacceptable for anything but the shortest of short terms. ... The overall picture reflects inadequate past investment ..." (pages 15-16)

Community care

Bexley DHA has just 12 CPNs, offering no out of hours service; they aim simply to respond to referrals 'within 48 hours'. The 1989 Strategy included wildly ambitious plans to set up four Community Mental Health Teams, four 20-place centres to serve also as day hospitals, and two Community Psychogeriatric Teams. None of these have happened. In place of the planned 140 day hospital places the District still has only two day hospitals with a total of 49 places, not all of which are fully utilised: one centre, Castlewood, is still shared with Greenwich DHA.

Bexley council is no more generous in its provision for mental illness: it offers just 27 places at one day centre in Crayford. The HAS report comments:

"It is self evident that a 27-place day centre cannot meet the needs of a population in excess of 200,000. At the present time ex-hospital patients living in the community, some in the Social Services Department hostel, have to return to Bexley Hospital daily for support and occupation." (p11)

The hostel, at Chapel Hill, Crayford, has 25 assessment and rehabilitation places, and a waiting list. The HAS also reports on a 9-place medium/long stay hostel at Oakwood Drive, and seven unstaffed group homes offering a total of 22 places, some run jointly with the voluntary sector. It notes that the standard of the group home it visited was not as high as the hostel, and remarks:

"These are the only mental health residential resources in the London Borough of Bexley, there being no specialist, private or voluntary homes registered with the Social Services department."

It also reports that some 59 ex-patients have been deposited in private accomodation in Margate, some 70 miles away; they are given some support and follow-up from Bexley.

Nine local government residential homes provide 407 long-stay and 32 short stay places for the elderly: the HAS estimates that 65- 70% of these are EMI. There is also one specialist home for EMI patients with 32 places, though its staffing levels are described as 'inadequate'. The HAS also criticises as plans for a 49- place EMI home as being too big to offer a homely environment to residents.

Cash crisis

The schemes spelled out in the Strategy document have remained a dead letter for lack of capital or revenue to im-

plement the shift towards more community-based care. The capital cost alone of the various developments outlined amounted to £14.5 million at 1988 prices, with revenue costs adding up to £7.6m. These sums may not appear large in themselves, but are clearly beyond the means of a cash-starved DHA and Region.

With its land and property assets trapped in the planning restrictions of green belt countryside, Bexley is unable to generate quick cash to fund these overdue developments. Meanwhile its plans – when compared to the actual care available – read like a rather sick joke.

Cane Hill (Bromley DHA)

Management at Cane Hill have proved strangely reluctant to impart information on the level of hospital services and detailed plans for reprovision of these services when Cane Hill closes (target date June 1992). The following information has been gleaned from the December 1990 report of the Health Advisory Service and from informal discussions with organisations and health staff in Bromley and Cane Hill.

Hospital services

Though registered with SE Thames Region as having 343 beds open, by September 1990 Cane Hill had run down to just 257 in-patients, just over a quarter of its 1984 beds total. Among these are still some patients from Camberwell DHA, though much of the former caseload of Lewisham & North Southwark patients has now been resettled in their own district.

The closure of Cane Hill has been prioritised by SE Thames region in similar fashion to that of Friern in NE Thames, with allocations of bridging capital made available to user districts to facilitate reprovision. As the report on Camberwell DHA shows, this has not always been spent in a way which CHCs and others consider a prudent investment in long-term facilities.

The HAS report complains that large parts of Cane Hill had been sealed off and "appear to be deteriorating rapidly. Despite the strenuous efforts of staff, the general impression is of a rundown institution close to closure".

In addition to Cane Hill, the Portnalls Unit at Farnborough Hospital (part of the District General Hospital) provides 175 beds in nine wards in mid-Victorian ward blocks. It also houses day hospitals for mental illness and EMI as well as a day centre for mentally ill people under 65 living in the community.

The HAS report is critical of the lack of accessible space and resources for occupational- therapy and physiotherapy at Cane Hill and Portnalls.

Acute care is still provided from both sites, with one ward at Cane Hill serving the north of Bromley DHA, and acute wards at Portnalls, which the HAS describes as:

"characterised by an almost continuous bed crisis, with patients frequently being admitted to the beds of patients absent on leave. ... *The problem is partly due to the absence of places for patients who do not get better, either in hospital or in hostels.* Though small in number, such patients can occupy beds for long periods, and the resulting mixture of acute and long-term patients can cause problems. ... The length of stay is twice the Regional average."

Cane Hill's rehabilitation programme, of which staff appear proud, is clearly geared to facilitating the discharge of as many as possible of the remaining in-patients – though the rehabilition team will remain in existence to support clients after their move into the community. The HAS is critical that "People with long-term mental illness who are not residents of Cane Hill Hospital tend not to have access to the rehabilitation opportunities that they require."

The CHC complains of insufficient numbers of nursing and occupational therapy staff at Cane Hill, too little respite care provision, and inadequate provision for long-term mentally ill patients with behavioural problems. Relatives and carers, too, told the HAS of their concern at the current shortage and planned further reduction in numbers of long-stay beds for EMI patients, coupled with a serious lack of council provison for the elderly mentally ill.

Current health authority plans for the care of 'new long-stay' patients after the closure of Cane Hill involve the establishment of a new 32-bed 'Haven' complex on the Orpington Hospital site, with a 12-bed hostel, an 8-bed behaviour modification unit, and a 12-bed facility for intensive care. It is not clear whether this will prove adequate to the level of need for continuing care services: but in any event the Haven has not yet been built, and in the meantime some long-stay patients are occupying 'acute' beds at the Portnalls unit for lack of any other accomodation.

The HAS comments that:

"the provision of NHS beds for elderly people with long-term problems appeared to us to be sparse. Only 24 such beds are planned, the remainder being transferred to nursing homes. Serious problems can be anticipated with such an arrangement. The numbers of demented elderly people with major behaviour problems requiring the skills of a psychiatric team under the clinical supervision of a psychiatrist are likely to be more than this. There is a desperate need for health-related respite care, which cannot readily be secured in nursing homes ..."

Community care

The Cane Hill rehabilitation programme is in full flow as this report is compiled, with a target of providing residential facilities for 68-70 mainly long-stay patients aged between 20 and 80. The first high-support hostel, housing 10 people has now opened; a 7-8 place medium support hostel and a 6-7 place short- term rehabilitation hostel are to open at the end of March 1991. The first two of nine planned 5-bed staffed houses are also already open.

In a few cases, where patients had strong links or wishes to resettle outside of the district placements have been arranged in liaison with local services.

Also planned is a 12-14 bed hospital-based residential facility for medium to long-term patients, and in the fur-

ther future a 12- bed rehabilitation unit to be built on an appropriate Bromley general hospital site. (This must be in considerable doubt, since because of planning and funding complications, nobody yet knows where the future Bromley DGH will be.)

Other long-stay patients who have not been placed in alternative accomodation before the Cane Hill closure will be transferred to the Portnalls unit – which is far removed from any concept of community care, and can only be regarded as a 'mini-bin'.

The DHA has now opened its first mental health centre, in Orpington; two more are planned, along with a 'clubhouse'- style day centre in Bromley and a day care project in Orpington. There is a staff of 25 CPNs to cover the catchment area of almost 300,000 people.

Bromley council has consistently failed to provide any residential places or day centre places for people with mental illness, and local voluntary organisations complained to the HAS of the lack of council day care facilities.

Day hospitals include the 20-place EMI Keston Day Hospital at Portnalls, to be extended to 35 places; and DHA-run day units for EMI patients at The Willows, The Meadows and the Ravensbourne Centre, where the HAS reports on the 'impressive' dedication and energy of the staff in 'makeshift' accomodation. Other day centre facilities are provided by the voluntary sector in Beckenham, Orpington and Bromley

The CHC complains that patients with behaviour problems had been discharged to live in flats without being able to cope alone or proper support; and that when this was brought to the attention of Bromley's Director of Social Services, the council's response had been to refuse any further allocation of housing to such people in the absence of community care!

The CHC and voluntary organisations also complain of the lack of any after-hours cover from CPNs and duty social workers. Voluntary organisations stress the lack of support for carers once patients have been discharged into the community from Cane Hill, and are incensed at the attitude of the Director of Social Services and Housing who has publicly criticised the voluntary sector for not doing enough work!

Despite criticisms and recommendations from the HAS in 1987, there is still no provision by DHA or council of community work facilities for people with mental illness.

Staffing

The HAS report shows time and again that management has a poor attitude and relationship with staff at Cane Hill and generally in the DHA:

"There appears to us to be insufficient consultation with therapy and other professional groups of staff. We sensed a generalised air of distrust and suspicion throughout all levels of the Health Authority's organisation and, indeed, many members of staff perceived the need for more open management. ... many staff declared to us that they have no confidence in consultation procedures in general and those relating to applications for self governing status in particular."

This theme recurs throughout the HAS report:

- "All grades of staff conveyed to us their feelings of being undervalued by the Health Authority and management."
- "Therapy staff, including helpers, continue to be uncertain about their future following the closure of Cane Hill hospital. There appears to be no understanding by managers about the future employment needs of therapy staff. Skilled helpers have been encouraged to apply for posts that will not utilise their skills..."
- "[nursing] Establishments at Cane Hill Hospital are often on the low side, giving cause for concern. ... The occupational therapy establishments are unacceptably low and probably adversely affect recruitment."
- "Many nursing staff consider that they are not consulted sufficiently in upgrading schemes that take place on their wards, and that their ideas and skills are not sought appropriately."

Tooting Bec (West Lambeth DHA)

Closure plans and the cash crisis

The Hospital, which has already been reduced to around 33% of its 1984 complement of 923 beds, was scheduled to close by 1995 under an ambitious 'Speeding and Self-Funding' strategy designed to use capital from the site to fund the establishment of community-based services.

However the cash crisis has intervened to render this plan inoperable in its original form: and now a new proposal has been adopted despite strong opposition: this represents a major retreat from community provision, and in effect amounts to building a new 'mini-bin' on the site of the South Western Hospital.

The document outlining this new strategy makes no bones about the fact that 'The biggest single factor that led to the review of the planned reprovision was the availability of money'. It goes on to explain that this refers not only to the capital investment involved, but also to the revenue funding of services, especially after the changes in the way DHAs are funded take effect from 1991-92. Another limitation has been the 'bridging' or 'double-running' costs incurred for the transitional period in which services are being provided at less than full capacity from two hospitals.

Community care

For these reasons the plans to transfer more Tooting Bec patients to supported houses have ground to a halt. 80 have been moved to private nursing homes in Epsom, which staff concede offer excellent accomodation and pleasant gardens, even while they are critical of handing care over

to profit-making organisations. The residents are being monitored by NHS staff and are well looked after.

30 more are to go to a private home in Stockwell, which is also described as well appointed with a nice garden.

However another group has been moved to a home in South Kensington, which has two disadvantages: it is out of reach of Lambeth's Unity Workshops where many have earned small amounts of spending money as well as passing their daytime hours; and it has no garden. Residents on the top floor have the choice between sitting indoors all day, or wandering the streets. "Tooting Bec clients have been used to walking round these huge grounds as they wanted. They could do what they liked. It is not right to take someone from that situation and confine them on the top floor of a building with no garden," argues COHSE Secretary Bernard Morgan.

Tooting Bec staff are much more enthusiastic about the local supported houses set up by the DHA; a Clapham cluster of three houses close to each other is already in operation, and a Streatham cluster is soon to open.

Each house is planned to accomodate 6-10 clients, and to be staffed, not necessarily by nurses. The Streatham cluster will have 28 staff to care for 25 residents, and there is pressure to ensure that all staff are experienced nurses. Some posts are still being advertised, and the job descriptions are very wide- ranging: staff will be expected to help residents with every aspect of living independently.

These houses should take most of the Tooting Bec clients who are thought capable of living reasonably independently; but clients will take a long time to settle into unfamiliar surroundings.

"Lots more clients *could* transfer out of Tooting Bec from the nursing point of view, but they don't want to leave the Hospital," said Bernard Morgan.

COHSE believes that about 90 elderly Tooting Bec clients are too severely ill ever to be resettled into community care.

Staff would have liked to see longer preparation for discharges, but this has been complicated by delays in opening the clusters.

As the team leader for the Streatham cluster commented:

"Will it work? We don't really know. We want to make it work, but it's something we've never done before. Ask us in six months".

Bernard Morgan added: "We want to see more staff get out from here, too, to work in the clusters and in the community. But it is difficult work, seen as a step into the unknown. Some staff still don't really believe Tooting Bec will ever closed: they can become institutionalised as well as the clients."

Hospital services

Services have already been 'decanted' off the South Western Hospital site to Tooting Bec while building work takes place to establish a range of new services: 60 EMI nursing home places in two units; 60 EMI day hospital places; and a 40-bed 'Haven' for younger people. If this did not already have many of the hallmarks of an old-fashioned 'bin', management also propose to add an acute psychiatric unit and to offer space to a regional Psychiatric Forensic Unit, to be transferred with the closure of Cane Hill Hospital.

These plans have been strongly criticised by health chiefs in neighbouring Lewisham & North Southwark DHA. Their General Manager of mental health services, Peter Reading, denounced the proposals as "conservative, institutional and segregated," insisting that: "It is quite misleading to entitle the Consultation Document *Developing Community Services*, for by proposing to group together on a hospital site so many 'replacement' facilities, West lambeth will not be achieving any form of community provision. This is a not-so- mini, mini-hospital development, whose culture would militate against aspirations to offer people with severe mental illness life in a more personalised, domestic, community-based setting. West Lambeth disregard the experiences of other successful psychiatric hospital replacement programmes in this Region and elsewhere, and openly opt for the cheapest solution."

On the same site, argues Mr Reading, would be people

"from among the most disabled and stigmatised client groups, whom it is particularly disadvantageous to group together. Of particular concern is the proposal to locate a forensic unit in the same complex as so-called "community" residential units."

He is especially critical of the proposed 'Haven' facility:

"While acknowledging the likely levels of disturbance associated with inner-city areas like Lambeth, it would be surprising if at least a proportion of the 40 beds proposed for the 'Haven' could not be more suitably located in high support community settings. This proposal effectively condemns young people with severe psychiatric problems to spend most of their life in hospital-based institutional care."

Similar criticisms have also made by Lewisham's Director of Service Development in Public Health; however implementation of the plan has already begun, with the decanting of patitns to Tooting Bec, even while bulldozers begin demolition of part of that site for later development by Tescos.

Meanwhile 1990 saw serious problems as spending cuts took their toll of services and staffing levels at Tooting Bec. In March, West Lambeth CHC raised a series of complaints including:

- Staffing on the Intensive Therapy Unit cut from 5 to 3;
- Ward staffing cut to dangerous levels, with two nurses for 34 elderly confused residents on one ward, and three to cover 30 highly dependent confused elderly on another.
- The scrapping of agency Occupational Therapists, hitting day hospitals, and reductions in physiotherapy.
- Repeated closures of the Tooting Bec patients' canteen through lack of cover for absent staff.

● Works not being carried out, leaving one ward without curtains until the new financial year.

● Reductions in supplies of bread and milk and breakfast food to wards, leading one resident to comment that 'It's like living on war rations'.

● Staff cuts forcing cuts in caseload at Lambeth Community Care Centre.

Long Grove (Kingston & Esher DHA)

Hospital services

Long Grove was originally planned to close in 1990, but the date was put back to late 1992 as a result of inadequate capital and revenue for replacement services, and is now uncertain (possibly 1993). In the mean time it has run down from 813 beds to 451, 96% of which were occupied in January 1991.

The closure programme has been additionally complicated by the fact that Long Grove caters not only for Kingston & Esher DHA, but also takes patients from different catchment areas of Richmond Twickenham and Roehampton DHA (RTR), and a sizable number of continuing care patiets from a wide variety of historic districts of origin, including City & Hackney and Tower Hamlets in the East End.

Many (266) of its existing long-stay beds are planned to be replaced by alternative hospital-baseo provision. As far as Kingston is concerned, 90 EMI beds, and 15 continuing care beds are to be moved to a long stay unit at Tolworth Hospital, for which capital funding has just been agreed by SW Thames Region. Enabling work is now beginning on the site, but the new facilities (originally planned in 1985) are unlikely to be available for use before February 1993.

Tolworth already houses a 30-place EMI day hospital, which is described as 'over-full'.

From the RTR catchment, 23 EMI and 17 continuing care patients will be moved to the nearby Horton Hospital run by Riverside DHA.

And among the 'non-catchment' patients, 25 EMI and 96 continuing care patients will be moved to the neighbouring West Park Hospital (Mid Surrey DHA).

Among the proposals to resettle patients in community-based accomodation, ten people are in a rehabilitation ward at long Grove awaiting the opening of a new 16-bed purpose-built hostel, Rose Lodge. A further 13 Kingston and four non-catchment patients are also receiving rehabilitation.

Acute services are still provided at Long Grove, with 13 intensive care unit beds, a 19-bed admissions ward for Kingston patients, and a 16-bed ward for RTR.

Other acute services are based at the Kenley unit at Kingston Hospital, which currently has 44 in-patients, 38 of them from Kingston, 6 from RTR, and 20 day hospital places. Plans drawn up in 1985 for the expansion of this unit have still not been funded, and the lack of alternative acute provision is a major obstacle to closing Long Grove. A relatively new 25-place day hospital for younger mentally ill patients has been opened at Surbiton.

The bed closures that have already occurred create substantial pressures on the service, since they leave little flexibility for admissions.

Community care

Kingston DHA has a staff of 22 CPNs, which should be increased to 25 in 1991-2; though no community mental health teams are yet in place, a pilot project is under way at Elmbridge.

Other than the Rose Lodge unit, and a new 4-place unstaffed DHA group home at Chestnut Grove, local community-based accomodation is provided largely through Kingston social services – which provide a number of 3-bedroomed 'cluster flats' and an adult placement scheme – and by the voluntary sector (under contract to the DHA). The Mental After Care Association runs two 16-bed long-stay hostels.

Day care services consist of the council's Sherwood day centre, which is used occasionally by some 60 clients, and is beginning to offer home care support, and by the voluntary sector's Fircroft day centre, where 30 places are used by some 60 clients. 'Very few' day hospital places are offered by Surrey County Council, while Kingston DHA runs the Springboard Industrial Therapy unit in Surbiton, with a potential 60 places, though only around 40 attend.

In 1986 it was estimated that 58% of places in the council's 'old people's homes' were mentally ill. The DHA also referred to '50 group homes' provided for the mentally ill by Kingston council: however there is no record of this provision or of the 'cluster flats' in the Department of Health's statistics on Personal Social Services, and the DHA provides no community facilities geared to supporting such accomodation.

Cash crisis

In 1986 management pointed out that the District was being called upon to develop a new model of mental illness service 'utilising a significantly reduced revenue allocation': in fact the projected reduction in budget was £3m – almost a third of the mental health budget at that time. The additional capital cost was estimated then at £3.5 million. The strategy document was adopted in the hopes that SW Thames region could somehow find the extra money from its Capital Programme, which was expected to total £300m over ten years.

In fact both region and districts have found themselves heavily squeezed by the property slump, which has stemmed the availablity of capital. Most recently, Kingston has had the Rose Lodge unit ready for use for some time, but no revenue to fund its opening until the 1991-2 financial year.

Once built, the new provision at Tolworth, together with the 'decanting' of patients to Horton and West Park is likely to enable the closure of Long Grove. Management are wisely pressing for this move to take place in one go rather than move patients twice.

However there remain gaps in the service – both in terms of the day-to-day support for ex-patients discharged to the relatively few supported units of accomodation in the community, and in terms of non-hospital services for sufferers in the community who have not been in-patients. With the existing beds so heavily used, and day hospital places at a premium, it seems there is an obvious need for greater resources to be injected into day care, supported accomodation in the community, and community mental health teams.

Springfield (Wandsworth DHA)

Hospital services

Springfield Hospital was purpose built as an asylum in the mid nineteenth century. It takes patients from the borough of Wandsworth and from the Merton end of Merton & Sutton DHA.

The DHA points out that Wandsworth has a high level of social and material deprivation which is reflected in a high incidence of mental health problems. The Mental Health Unit in 1988 recorded 15,500 outpatient and 21,500 day hospital attendances a year, and 2,000 admissions (1,850 to Springfield, 150 to Atkinson Morley's Hospital): "Admission rates from Battersea, the locality with the highest indices of social/material deprivation, are higher than from all other localities in a statistically significant way."

Springfield is due to be substantially redeveloped but not closed under long-term plans to reshape services. Taking account of the related closure of the Morris Markowe Unit, beds have been dramatically from 982 in 1984 to 563 in 1991.

However the original plans for new adult acute beds and day hospital places, together with 40 short stay elderly beds and 50 elderly day places to be built on the site of St George's Hospital in Tooting have ground to a halt for lack of regional capital. The sales of St John's and St James's Hospital sites have taken longer and generated much less money than at first expected because of the slump in the property market.

Also 'frozen' as part of the same capital squeeze is the provision of 50 adult acute psychiatric beds in Merton.

Community care

There have been some important advances towards community care; four multidisciplinary teams, two with community-based premises, and two working from Springfield, are functioning to give a more flexible and accessible service. Other teams are beginning to develop in a more community style, though the acquisition of suitable premises has been severely hampered by the lack of capital.

A range of supported community housing has been developed, providing 65 places in 13 houses for Wandsworth and 10 places in three houses in Merton.

However ambitious plans for extended day hospital provision have run into capital problems, with 113 of 218 planned places frozen, including all of the planned day hospital places in Merton. A further 100 work opportunity places are funded by the DHA.

One of four planned intensively-staffed community hostels – intended to provide a total of 62 places for Wandsworth – is now operational at Thrale Rd; but there has been no progress in provision of 33 places in two or three hostels for Merton, for lack of cash to purchase or develop sites.

A new scheme providing 30 long-stay beds and 20 day places will open in Battersea later in 1991, but plans for 120 beds and 50 day places in five community-based nursing homes have as yet got nowhere for lack of money.

It is planned that provision for an estimated 50-80 other old long-stay patients, judged unable to benefit from resettlement, will continue at Springfield Hospital.

However the reduced facilities at Springfield will still be a far cry from a community unit. Eight Regional Specialty psychiatric services will continue to focus on the site, with the planned addition of a 24-bed child and adolsecent unit and a 15-bed forensic treatment clinic.

Staffing

In August 1989 the DHA admitted that:

"The funded establishment of nurses remains well below that deemed necessary to provide a high quality of individualised care in the community and the hospital, and to mee SW Thames Regional Health Authority guidance on nursing ratios a further 40.0 WTE community psychiatric nursing posts are required (double the existing) and 80.0 WTE other nursing posts."

Other staffing grades that will be needed in larger numbers include nurses, occupational therapists and psychologists as well as specialist mental health social workers.

Cash crisis

The August 1989 document points out that to achieve the strategy for district services it would have been necessary for SW Thames Region to provide substantial bridging funds.

Unfortunately this has not occurred; instead Wandsworth DHA's own financial crisis has forced a range of cutbacks including cuts and closures in the Mental Health Unit, which was not in deficit. Among the less conspicuous cutbacks was the proposed closure of the patients' canteen at Springfield, one of the few social facilities available to those living there.

More dramatically, top consultants warned of the dire consequences if, as predicted, one or more ward was forced to close. Closure of a long-stay ward for the elderly "would result in a catastrophic reduction of an already under-resourced service. Waiting lists for the admission of severely mentally ill and demented people would lengthen ...".

On the other hand closure of an acute psychiatric ward would have "equally unacceptable consequences". Some 20% of acute admissions are under one or other Section of the Mental Health Act; and closure of a fifth of acute beds "would mean we could no longer guarantee the immediate admission of severely ill patients, some of whom will be suicidal or dangerous to others. We could no longer guarantee to accept patients from prison or the Courts ..."

This widely circulated letter of protest from consultants made the point that the cuts hit Wandsworth's mental health services in the run-up to (indeed as part of) the preparation of the new NHS Act. Yet:

"Far from starting on a 'level playing field', to quote the Secretary of State, ours will be a barren wasteland with little prospect of improvement."

Since that letter was written in February 1990, the constraints on capital and revenue have if anything tightened. The implementation of the Strategy has ground almost to a standstill for lack of capital. "It's been downhill all the way," one top manager concluded.

Warlingham Park (Croydon DHA)

Hospital services

The hospital has no date for closure, but has run down rapidly from 475 beds in 1984 to 243 in early 1991, mainly through non- replacement of beds for elderly long-stay patients.

30 beds (two 15-bed wards) are for intensive care; there are 80 acute beds; 90 are for EMI continuing care; 27 are allocated to the alcohol dependency centre which has been a Regional specialty but will now be charging user DHAs; and 16 are psychogeriatric assessment and treatment.

Plans include a reduction of the (proportionally quite large) acute bed complement from 80 to 70, and a 44% reduction in EMI continuing care beds – cutting back from 90 to just 50, with the intention of providing the same level of nursing care at home through an outreach team of community staff.

Eventually when resources permit, the plan is to move the reduced Warlingham Park facilities into Croydon, possibly the Queen's Hospital site. However this will be phased, with the acute unit being the very last services to be moved, for fear that once they move off site, the remaining hospital will become a psychogeriatric ghetto, jeopardising recruitment and staffing.

Community care

47 Warlingham Park patients were moved to a group home in 1989- 90, but no more could be resettled in 1990-91, for lack of resources. The whole strategy is now delayed by the SW Thames capital crisis.

Croydon DHA is relatively well resourced for CPNs, with its staffing more than doubled from 20 to 43 to cover a population of 317,000. These work in twelve teams, with seven assigned to consultants.

Five day hospitals give 145 places, some used by local authority clients, while there is a 35-bed in-patient rehabilitation unit at the old maternity hospital site at Westways.

Croydon council offers 29 places for varying degrees of dependency in three staffed hostels, three four-person group homes, and operates a 'Supportive lodgings scheme' which offers a total of 65 places in 25 establishments which 'vary from straightforward bed and breakfast to full integration into family life'.

The council also has a budget 'to allow people to be placed in specialist registered homes which are run by private and voluntary agencies', by topping up payments when fees exceed the DSS benefits available to the client. "The number of placements in private and voluntary homes that can be provided at any one time is limited to the amount of money available within the budget".

It also runs two 50-place day centres, and supports two part- voluntary informal day care projects offering 35 places.

The Council has since 1982 funded a 6-person Community Mental Health Team, and also maintains two domiciliary day service officers for clients who do not wish to or cannot attend day centres.

A brief district-by-district survey of London's mental health services

North West Thames Region

"The biggest difficulty facing mental health services comes from the virtual cessation of the Region's Capital Programme. A substantial proportion of those capital schemes were for mental health services, nearly all of which (apart from those in progress) have been delayed for two or three years and with some uncertainty about even these revised dates."

(Service profile, April 1990)

Barnet

see Shenley

Ealing

see St Bernard's

Harrow

see Shenley

Hillingdon

In 1989 Hillingdon's Director of Public Health reported approximately 600 admissions a year to mental illness beds and 76 mentally ill people receiving community care.

Since 1971 Hillingdon DGH established a 54-bed acute unit to cater for the population south of the A40, with those living to the north still being sent to St Bernard's in Southall. In the summer of 1990 a new £3.6m 48-bed extension at Hillingdon allowed the transfer of EMI/Alzheimers patients from St Bernards, giving a local provision of 102 beds, 36 of which are acute, 18 long-stay adult mentally ill. Part of the 1990 development was a 30-place day hospital.

All other mental illness projects for the district, including £2.1m for the rebuilding of the original two acute wards at Hillingdon DGH have been delayed or deferred as a result of the NW Thames capital crisis. Hillingdon DGH becomes a self-governing Trust on April 1. Also held up is a new 48-bed unit (33 adult mental illness plus 15-bed rehabilitation and a 30-place day hospital) at Mount Vernon Hospital, on which £1m had already been spent. Another £4.2m is required to complete the building, and no date is yet fixed. Mount Vernon also becomes a Trust on April 1.

A new 30-place continuing care unit for elderly mentally ill patients to be built at Harefield Hospital (where a first-round Trust application was rejected) has been delayed indefinitely.

A joint local authority/DHA/RHA £1.2m day centre resource centre at Ruislip has been postponed from summer 1990 by at least two years.

The local authority runs two mental health teams, one for the north and one for the south of the A40. It currently runs one day centre with 30 places, which is due to be sold in 1991; a replacement is promised. The latest Hillingdon council spending cuts in social service spending on mental illness amount to more than the government's specific grant allocation of just £100,000.

The borough provides 42 places in two staffed homes for people with mental illness and 27 places in five unstaffed homes, as well as an unknown number of bed-sitters and flats. There are 29 places in five voluntary sector homes, and 12 places for adult mentally ill in 4-5 private homes within the borough. These places are becoming increasingly blocked for lack of suitable alternative accomodation for clients, resulting in pressure on local acute mental illness beds.

Hounslow & Spelthorne

The District has 70 acute beds (35 at Ashford and 35 at West Middlesex Hospital), each of which has a 35-place day hospital. 90 EMI continuing care beds have been provided at South Middlesex Hospital (46) and Ashford (44), with another 22 long-stay patients using beds at St Bernard's Hospital. For the elderly there are 16 acute assessment beds and a 5-bed respite care facility at West Middlesex Hospital.

There are no community mental health resource centres, and management would like resources to develop centres that would cope with the chronically mentally ill rather than the 'worried well'.

Hounslow council has submitted proposals for a Community Mental Health Support Scheme, aimed at the long-term social care needs of people with mental health problems, for funding under the government's mental health specific grant.

Parkside

See Shenley

Riverside

See Horton

NE Thames Region

Barking, Havering & Brentwood

See Warley

Bloomsbury (now merged with Islington)

See also Friern

Plans have been scaled down to fit the reduced Regional Capital Programme and facilitate the closure of Friern by 1993.

In particular a £5.4 million plan to provide purpose-built, permanent accomodation in Bloomsbury for 24 elderly people from Friern have been scrapped for lack of cash. Instead management are making use of beds at St Pancras Hospital to decant Friern patients, despite the fact that they are widely regarded as unsuitable for long-stay patients, and the danger is that St Pancras could itself become a smaller version of Friern.

The Bloomsbury plans have been hacked back since the autumn of 1989 when a planning group on the development of services wanted a shift from in-patient to community-

based care. By November 1989 the DHA had imposed cuts in its Short Term Programme.

Under pressure, the mental health unit agreed to cut 25% (24) of its acute beds in order to keep some development of community services. Yet in the end these new services – a day hospital, a crisis intervention team and community mental health teams – were all lost anyway for lack of cash.

A promised self-contained building to integrate mental health services on one site – the old ENT unit at UCH – has not materialised. Only after a Friern ward had closed were MHU management told that they could not have the whole building, but only three wards, not including the ground floor or basement.

As a result of the loss of 25 Friern acute beds all the remaining acute wards are under much greater pressure, running at an average 93-95% occupancy in the months following the bed closures, with an actual occupancy ranging from 86 to 100%. This in turn has forced a dramatic reduction in the average length of stay since August 1990, though this is not backed up by the necessary support services in the community.

Pressure on staff in the acute wards has also increased as a result of a reduction in agency hours worked since the Friern beds closed in August 1990.

The acute services also include 26 rehabilitation beds and 11 behavioural therapy, while Bloomsbury runs one acute and one long-term day hospital.

Discharge of patients has been further complicated by the financial problems of local government, with social work posts frozen in Camden.

To make matters worse, the unit faces a new 3% cutback in DHA funding from April 1. Management believe it impossible to cut this much without closing a ward or cutting services.

City & Hackney

The long-running saga of plans to replace the crumbling wards at Hackney Hospital with new psychiatric beds in Phase 2 of the Homerton Hospital is still unresolved: however it is clear that the NE Thames capital crisis rules out any such new building for the next few years at least.

Also abandoned has been the radical plan of DGM Ken Grant to close Hackney Hospital within 18 months by simply 'dumping' the existing wards into various empty and disused spaces in other hospitals in the District. Instead the latest document proposes a 3-4 year plan to move wards, using some accomodation (notably the St John's wing of the Homerton site) which is almost as bad as Hackney Hospital itself, wards of which were described as 'arguably the worst in the country' by the Mental Health Act Commission as long ago as 1974.

In February 1990 management reported that it would cost £10 million to bring Hackney Hospital, St John's wing and the Regional Neurological sites up to acceptable modern standards. Even annual patch and mend maintenance was estimated at £750,000 a year.

Within the Hospital, rehabilitation programmes have run down for lack of alternative accomodation for patients discharged. Management have claimed that as many as 40% of patients on some acute wards should be discharged, if there were somewhere for them to go.

Day facilities include the council-funded Shoreditch Centre; but a day centre run by the Psychiatric Rehabilitation Association is threatened with loss of funding; a volunteer-run drop-in centre at Hackney Hospital is closed, and a new day hospital for EMI patients at the Mothers Hospital cannot recruit enough staff.

The CHC is concerned that the new contract specifications for community services do not even mention mental health.

Enfield

The DHA has run its own 100-bed acute unit, with its attached 50- place day hospital at Chase Farm Hospital since the 1970s. However the danger signs are that this substantial unit could begin to become a new 'mini-bin' as Friern and Claybury Hospitals run down.

The reprovision from the two hospitals has so far brought a 28- bed EMI unit to Chase Farm, while another villa unit is to house 16 EMI patients; and the latest plans for the closure of Friern involve switching the Regional Secure Unit to the Chase Farm site.

The last 22 Enfield patients in Friern are being transferred to an adapted ward on the Highlands Hospital site, with a 15-place day hospital.

However, with some 60 Enfield patients still in Claybury Hospital, the CHC argues on a basis of surveying local GPs that this leaves the district at least 120 EMI beds and 70 EMI day places short of the number needed. This is partly concealed by the fact that the DHA has 'closed' the list for EMI admissions.

Hopes of establishing new mental health centres have been largely abandoned for lack of resources. Two community mental health teams are based at clinics, one in Cheshunt, and others are hospital-based. The DHA employs just 16 CPNs.

Hampstead

See Friern

Haringey

See Friern

Islington (now merged with Bloomsbury)

The DHA has its own acute beds and day hospital at the Whittington Hospital, and there has been an overall loss of beds as a result of the Friern closure programme. Users of the service, however have been lobbying for alternatives to acute admissions, which have not yet been developed.

Local short-stay patients appear to be the main losers in the revamped service, which has been geared to reproviding places for the existing in-patients at Friern.

The axing of the 80-place Highgate Parkside home for ex-Friern

patients for cash reasons has not been by any means universally mourned. Islington CHC had condemned the proposal as creating a mini-institution, and now welcomes the fact that much smaller schemes have come forward instead.

However 25 of these places are in non-NHS homes, and the CHC is concerned that these places may not remain available for others once the existing elderly clients die. A 25-place nursing home is being built on the Hornsey Hospital site.

Newham

See Goodmayes

Redbridge

See Goodmayes and Claybury

Tower Hamlets

A draft report from a Joint Development Group on mental health services has shown no shortage of ideas – but no sources of funds to carry them out.

Among the positive proposals are three community mental health resource centres, expanded day care and day hospitals, and a range of supported housing schemes in addition to the building of a new psychiatric unit (with fewer acute beds) on the Mile End Hospital site to replace the present 98-bed mental illness unit at St Clements.

It is doubtful if the district could manage to provide services with fewer beds: figures show that no less than 60 of the 98 available acute beds are occupied by patients on section. In December 1990 NE Thames Region heard that because "St Clements was unable to cope with the balance of acute admissions", 19 psychiatric beds at the Royal London's Whietchapel site would have to remain open "in the short term".

However the DHA has been reneging even on the limited amount of capital required for small-scale housing schemes, and there is little chance of the new Mile End unit being built: it is more likely that the St Clements beds would be transferred into vacated wards in the existing Mile End Hospital. This situation and any attempt at planning hospital and community services has become even more confused with the launching of the London Hospital group as a self-governing Trust from April 1 – with an immediate £7m cash crisis.

Waltham Forest

See Claybury

South West Thames Region

Croydon

See Warlingham Park

Kingston & Esher

See Long Grove

Merton & Sutton

(See also Springfield)

While Merton patients are referred to Springfield Hospital, the Sutton part of the DHA is serviced separately, from 142 beds at Sutton Hospital (60 acute; 10 rehabilitation; 5 locked; 67 EMI). The DHA is no longer referring Sutton patients to Netherne Hospital, but continues to use some beds there (23 in February 1990).

Community services for Sutton focus on a council-managed, DHA-staffed resource centre in Wallington which has 30 day places and caters for up to 76 adults with mental illness each week: it is over-subscribed, and was forced to refuse new referrals for the first three months of 1990.

Meanwhile Sutton council has for cash-saving reasons transferred its only hostel for people with mental illness to independent management.

Richmond, Twickenham & Roehampton

(See also Springfield and Long Grove)

With only 38 acute beds provided locally in P1 Ward at Queen Mary's Hospital, Roehampton (described by management as an 'unsatisfactory, interim building'), RTR is dependent upon no less than *three* large psychiatric hospitals for services (Springfield, Long Grove and Tooting Bec) each of which is running down towards closure.

An elaborate Joint Strategy document drawn up by RTR along with Richmond and Wandsworth councils and the voluntary sector in March 1990 became an immediate dead duck with the imposition of a capital freeze by SW Thames Region.

A particular concern is the future of acute services, which presently depend heavily on Long Grove and Horton Hospitals. The Strategy calls for a unit of 60 beds, presupposing "a *complete* network of supporting facilities including hostels, residential care, day care and Community Mental Health Teams". This optimistic pattern of care is unlikely to occur.

The Strategy involves capital of £19m for hospital, day hospital and supported housing projects, as well as the establishment of four community mental health teams. This would require a near-doubling of (DHA and council) revenue spending over six years – from £4.115m in 1989-90 to £7.412m in 1996.

Meanwhile a social services report estimates that some 2,800 elderly people in the borough may suffer from dementia, and that a massive 48% of elderly people living in Richmond's residential homes suffer from mental illness. Day services for EMI patients have 90 places and a waiting list of 22.

Wandsworth

(See Springfield)

South East Thames Region

Bexley

See Bexley Hospital

Bromley

See Cane Hill

Camberwell

(see also Cane Hill)

From April 1, Camberwell's local psychiatric services will be managed under contract by the Bethlem and Maudsley Special Health Authority (SHA). This will mean that services

will transfer from unsuitable accomodation at Dulwich hospital to superior wards on the Maudsley site on Denmark Hill, or at the Bethlem Royal Hospital in Beckenham, where new facilities are opening.

Reprovision for Camberwell's long-stay residents at Cane Hill hospital has been funded with capital from SE Thames region, and many have been moved into five staffed houses and a new 30-place purpose-built home for elderly mentally ill on Camberwell Green, run (controversially) by Age Concern.

More Cane Hill residents have been settled in accomodation as far afield as Yorkshire, while others are in private nursing homes. Noting the costs and complexity of monitoring 20-30 nursing homes around the country, the CHC also asks whether this is a prudent use of capital money, which was supposed to be used to guarantee a level of services in perpetuity. It is not clear what will happen to some of these places once the present elderly incumbents die.

Greenwich

The existing service is largely hospital-based. Some £2m of capital has been spent to reprovide within Greenwich district the in-patient services previously provided at Bexley Hospital.

There are now 44 acute and 29 rehabilitation beds for adult mentally ill, with just 25 day hospital places three days a week.

There are 64 residential places plus a number of group homes for people with mental illness provided by the council or by the voluntary sector, but the Health Advisory Service in November 1990 reported that there is "a shortage of accomodation in the District for mentally ill people who need longer-term support, resulting in many patients staying longer in hospital than is necessary".

For the elderly, there are 86 EMI beds (24 acute, 62 continuing care) and a further 44-place EMI nursing home. It is estimated that a third to a half of the places in nine local authority homes for the elderly are people with mental health problems. Day hospital provision for EMI is just over half the Region's recommended level.

The HAS points out that the service for EMI is under-resourced: "Ward 2G in the Greenwich District Hospital is usually full, and at times there is a waiting list which has included suicidal patients".

The HAS also commented that the return of Greenwich patients from Bexley Hospital to the Memorial Hospital "was achieved very quickly but entailed additional demands on already stretched resources". The admission wards for mental illness "are unsuitable in layout and depressing in aspect". The wards are "unusually full, and often less ill patients may be discharged earlier than expected because of emergency admissions" – hardly a promising basis for community care follow-up.

Lewisham & North Southwark

In mid 1980s, LNS had 100 patients at Cane Hill and 300 at Bexley Hospital, in addition to its own acute beds at Guy's and Hither Green. The priority has been placed on the reprovision of services to facilitate the closure of Cane Hill, and capital for this has been protected against cutbacks that have hit other projects.

15 LNS acute beds from Cane Hill have been switched as a ward to Hither Green, where there are now 75 acute beds. 53 Cane Hill residents have already been resettled in new or purpose-renovated accomodation in the community, and another 17 are about to transfer to similar facilities.

The new accomodation is of varying sizes, from 4-5 place houses to a maximum of 12-places – an intensively-staffed nursing home for the elderly. Some are managed by the DHA, others by housing associations. In addition there are two 8-bed 'high support houses', whose residents include people with challenging needs: they are staffed by seconded DHA staff.

Management boast of the quality of the buildings, which have been expensively renovated and adapted, at a cost of around £150,000 for each house and £750,000 for the nursing home: they are also proud of the fact that much of the accomodation is managed by housing associations, giving residents tenancy rights.

Another £2m of regional funds are now available for community day/resource centres. Two new day teams have already been recruited, with an overall increase of 20 staff, and LNS employs 36 CPNs.

However the other side of the development of community-based services is that services have been very much geared to replacing beds at Cane Hill. There is little spare capacity in the community to discharge patients from acute beds, while long-stay beds are now almost unavailable. There are no further admissions to Cane Hill, and great pressure on the remaining 200 LNS beds in Bexley Hospital (60 Bexley beds were transferred to Hither Green and 40 to community-based services between 1985-9).

As a result some patients remain in acute beds at Guy's and Hither Green who should be discharged or cared for in long-stay beds.

Meanwhile the new Guy's-Lewisham Trust has been established, dropping its original reference to mental illness. In an alarming portent of things to come, the Lewisham & North Southwark CHC has been refused financial information on mental health services on the grounds that this is confidential to the business plans of the Trust.

West Lambeth

See Tooting Bec

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