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Mental health services: results of a survey of English district plans

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In November 1987, I wrote to the 'Planning Officer (Mental Health)' of the 192 English Health Authorities requesting a copy of the section of their 1984 Strategic Plan dealing with mental health and any recent update. A checklist of information to be analysed was drawn up on the basis of an initial reading of the plans. This contained a substantial proportion of the elements for a comprehensive service listed by Hirsch (1988) and by MIND (1983). Replies were received from 137 (71%) of the health authorities. Of these, 127 (67%) sent planning documents, ten wrote saying that their plans were under review and therefore unavailable, or "meaningless". Strategies were sent dated 1983 (2), 1984/5 (63), 1986 (11) and 1987/8 (45). Planning reports and Short Term Programmes were also sent which meant that four (3%) provided information updated to 1988, 74 (58%) to 1987, 16 (13%) to 1986, 17 (13%) to 1985, 15 (12%) to 1984, with one giving details relating to 1983 only.

Almost a half (49%) did not mention the existence of any joint planning group; 16 (13%) specifically mentioned the contribution of a group comprising Local and Health Authority representatives only, 49 (38%) mentioned planning groups which also contained representatives of voluntary groups. General objectives of the service were given by 77 (61%). MIND's (1983) eight principles were noted by five (4%). Most, however, had their own variation of similar themes. Data collection facilities designed to collect detailed information about community prevalence of mental disorders (including four epidemiological surveys), or specific details of patients presenting to a service (five case registers with two planned, and five planning 'at risk' registers) were mentioned by 30 (24%). Information about the specific community for whom the service was being planned varied from those in which the mental health section of the strategic plan sent did not contain a total population figure (47; 37%) or figure for the over 65s (62; 49%) to those which gave an outline of the specific demographic and geographic character of their district (19; 15%). The Jarman index which provides a measure for each Health Authority (Hirsch, 1988) of Social Deprivation was noted in three plans.

Of districts replying, 67 (53%) contained a mental hospital, 35 (28%) were planning the closure of such a hospital and 64 (50%) appeared already to have a District General Hospital unit with 66 (52%) planning such units. Specific figures were given for acute bed numbers in 80%; in others, where figures were given, they were combined with those for long-stay or psychogeriatrics. 'Crisis' beds to provide alternatives to hospital admission for those in need of refuge rather than nursing care were noted in 18 (14%) plans. Therapeutic communities rarely received comment (7; 6%); mother and baby facilities more often (27; 21%); child and adolescent (64; 50%) relatively frequently. Psychogeriatric assessment bed numbers were mentioned by 85 (67%) but some plans included those over 65 who had mental disorders clearly distinguishable from dementia in these figures, with others including this group in acute bed numbers. Twenty-two (17%) planned or had in existence joint assessment beds shared between geriatricians and psychogeriatricians.

Provision for "new long-stay" was frequently not specified or included under figures for "rehabilitation" beds. Nine (7%) planned all new long-stay provision in community facilities. Thirteen (10%) mentioned the availability of a rehabilitation flat for assessment or treatment purposes although few were outside hospital grounds. Some districts did not plan to provide for the return of long-stay patients to their district of origin when closures occurred, while others had made active plans for this where patients wished this to happen. Of these latter, one planned all new and old long-stay provision to be community based and one had such provision. Two districts intend to provide all NHS continuing care for those with dementia in nursing home provision. Most others planned to care for this group by increasing or redesignating existing hospital beds. "Intensive care" and forensic provision within districts was a common (57%) source of concern. The size of units planned varied from four to 65 beds to provide for any one district and 11 are planning shared provision. Regional Secure Units received mention in 30%, but few mentioned care for those leaving special hospitals or inappropriately placed in prison.

About half planned or had existing community residential provision for mentally ill adults staffed by the Health Service. Hospital hostels were specified by 11 districts. One-fifth planned NHS nursing homes for psychogeriatric patients. Few plans anticipated significant growth in Social Services hostel provision from present levels. One health district, however, intended to hand over responsibility and appropriate finance to the local Social Services department to provide continuing care for all psychogeriatric patients requiring it. Hostels run by voluntary organisations were noted relatively infrequently. Specialised hostels for those with drug problems were mentioned by nine (7%), and alcohol problems by 15 (12%). Collaborative enterprises with established housing associations were a common (43; 34%) way described to develop both staffed and supervised accommodation in the community. "Sheltered accommodation" detailed included group homes (61%), warden aided (20%), adult placement (14%), and "boarding-out" (10%) schemes. Where the private sector was mentioned, it was almost always to provide care for the elderly in non-specialised nursing homes.

The distinction between different forms of day provision was mentioned in some plans which pointed to duplication between different agencies in some areas. Very significant increases are planned in day hospital places for general adult and psychogeriatric patients with only seven not planning increases. Five adult and eight psychogeriatric day hospitals mentioned an intention to open during evenings and weekends. Day hospitals for children and adolescents received mention in 32 (25%). Day centres were run by a variety of agencies. Where there was a mental hospital the day centres were frequently based at it and run by the NHS. In other districts Social Services tended to provide this care. Where provision had been poor, at least until recent times, the voluntary agencies, in particular MIND, were often playing a major role. Existing day centres (16–65 year olds) were mentioned by 54 (46%), with 70 (55%) planning, or perhaps hoping, for such facilities. Sheltered work provision was commented on by 56 (44%).

Day care for the elderly was infrequently mentioned (27; 21%). Travelling day care was a feature of 17 (13%) plans, with virtually all in rural districts. Social support groups, luncheon and contact clubs were mentioned in 36 (28%) plans. "Drop-in facilities" were relatively popular (58; 46%).

Community Mental Health Centres, alternatively known as Resource or Mental Health Advice Centres, were described as in existence in 23 (18%) of the plans but a three-fold increase to 76 (60%) is anticipated. Catchment areas of 40–60,000 population were most popular, although some planned such areas to serve populations of over 100,000 population. Community teams for those with drug (30; 24%), alcohol (24; 19%) and "substance abuse" problems (10; 8%) are increasingly being established.

Rehabilitation/Resettlement teams received mention in 42 (33%) particularly where closure of hospitals was envisaged. Community psychiatric nurses received attention in 112 (87%) of plans. Specialist areas being developed included psychogeriatrics (37; 29%), drug and alcohol problems (27; 21%), behaviour (10; 8%), family (3) and psychotherapy (2), rehabilitation (10), for child adolescents (6), and ethnic minority groups (2). Liaison psychiatry received attention in 16 (13%). Psychotherapy as a term is only mentioned in 36 (28%).

The voluntary sector was not mentioned by 23 (18%) at any stage in their planning; 28 (22%) specified the role of this sector in the planned service. Mention was made of MIND/Associations of Mental Health (51; 40%), National Schizophrenia Fellowship (10; 8%) and other specific groups (37; 29%), particularly Councils on Alcoholism.

Comment

These plans confirm that the pace of the changes now occurring is rapid and it is therefore not surprising that some failure in planning and co-ordination is occurring. In these circumstances more detailed guidance from above through the regional review system for the next planning cycle commencing in 1989 could improve the comprehensiveness and joint nature of such planning. Demoralisation because of the present "financial crisis" in the health service appeared to be responsible for some feeling that there was little point in planning when finance would not be available in the foreseeable future. However, clearly if plans are not comprehensive, and concise cases of need for developments made, these will most certainly not occur and indeed resources removed from areas which appear from outside to be unnecessary. Medical involvement in this process, by both general practitioners and psychiatrists, is fundamentally important and specifically commented upon by Peter Horrocks (1988) in his final report as Director of the Health Advisory Service. The development and implementation of these plans will continue to require professional and financial commitment. The general direction of "where we are going" seems in these plans to be no longer in doubt, although the exact routes being taken may vary according to circumstances.

References

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