THE EVALUATION OF THE PLYMOUTH NUFFIELD CLINIC

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If our therapeutic armamentarium were restricted to measures of proved worth, it has been said, we would have practically no weapons left. Perhaps this remark is the corollary to Osler's snide advice to use new remedies quickly, while they are still efficacious. Such aphorisms direct attention to two unwelcome truths: that we are content to practice therapies without requiring first a demonstration that they work, and that they are likely to prove useful only so long as the physician believes that they will. It was not psychiatry that called forth either of these rebukes, yet in that field they apply with especial force.

For, although psychiatrists have become sensitive to the need for elaborate and contrived clinical trials of somatic treatments, the sweeping changes in psychiatric administration initiated in the last 20 years, the extensive reforming procedures within the mental hospital, and the measures adopted to extend extramural and community care, all remain untested. They have taken root and spread more because of the crusading enthusiasm of their protagonists than because anyone has shown that they work. Why should the innovator[1] who has lighted on and developed a new idea—the open door, group therapy, early discharge, home visiting, whatever it might be—desist from expounding its principles? He is convinced that it is effective. It *is* effective, very often, when pursued with his zeal. To test it would be a work of supererogation. Moreover, it would scarcely be practicable; it would involve setting up criteria by which its success could be assessed; it would in-

volve the manipulation of intangibles; it would involve reducing to the meager and arid confines of measurement much of his grand design. Besides, he could not do it himself. People would have to come in from outside, people with schedules and statistics, people who would not share his approach to psychiatric care, who could not appreciate what he was doing, who might fail to measure the crucial indices (in his fearful imagining he even adopts their jargon), and in the end might very well deduce, with the aid of mathematical jiggery-pokery which he could not follow, that the whole scheme was useless. He falls back on the argument, difficult to controvert but defeatist in the extreme, that the improvements he is trying to bring about involve so many imponderables that their assessment is impossible and should not be attempted.

This is part of the explanation why almost no exercise to improve patient care has ever been evaluated. The rest lies in the reluctance of men with the necessary knowledge and techniques to embroil themselves in conducting these researches. There are several reasons why they feel like this. The orientation of the evaluator is generally opposed to that of the innovator. The evaluator[2] is by nature a doubter, an unbeliever. Otherwise he would not want to evaluate. He is likely, therefore, to start with the mental set that the innovation is not useful unless proved otherwise. (This notion, of course, is as erroneous as its converse.) He will be null hypothesis-minded. Then, he knows that he will have to undertake the Sisyphean task of translating the often poorly conceptualized and loosely worded aims of the innovator into precise formulations from which hypotheses can be framed, operational definitions fashioned, and reliable measurements made. At the back of his mind will remain the suspicion, too, that if the findings from his study run counter to the aspirations of the innovator, the latter will find some cause, some inevitable imperfection in the research design, to serve as an excuse for rejecting them. Another reason why evaluators are unhappy about measuring the effects of new procedures is that they are generally approached too late. It is no good trying to measure the effect of a change if observations can be made only after the change is supposed to have occurred.

The evaluation project of the work of the Plymouth Nuffield Clinic, however, was planned from the outset; financial support was provided by the clinic's philanthropist, the Nuffield Provincial Hospitals Trust, and co-operation with the evaluator began long before ever a brick was laid, long enough to enable detailed measurements to be made

while the old order was in sway. There was agreement, too, that what would be evaluated was the effect of the clinic on the disposition of patients within the different facilities for psychiatric care—inpatient, outpatient, day hospital, psychiatric social work, etc.—which the area services provided. We were concerned, that is, with only the first of the varieties of questions which Gruenberg[3] has pointed out that evaluation procedures might study, namely, "whether the organization of services did what it set out to do." Gruenberg justly claims that "it is not enough merely to demonstrate that the service gets more patients out of the hospital more quickly or results in other alterations in their treatment plan." He believes that one should show that the patients' well-being, wherever and however they may be cared for, has improved. We have not attempted to do this. We have not tried to assess changes in symptoms or behavior. Nor have we tackled Gruenberg's third type of question—whether the new services have given greater satisfaction to patients or to staff. We have explored no attitudes. Evaluation, even more than politics, is the art of the practicable. Within the scope of our available resources we were able only to carry out a logistical study, to count heads. Whose heads should be counted, when and where, and how they should be grouped and classified, were questions left to be resolved by discussion and by the exigencies of the research situation. However, numbers of patients were certainly to form the basis of all our measurements.

Although a child psychiatric service formed part of the clinic's activities, funds did not permit this part of the service to be included in the evaluation study.

The evaluation which we have been carrying out is a comparison of the state of affairs before the clinic opened with that obtaining a year after it had begun to operate. Research plans were laid in the latter half of 1960 and data collection, prospective and retrospective, began in 1961. The clinic was scheduled to open in 1962, but did not do so until early in 1963. Enumeration of patients continued through 1964 and follow-up information must continue to be gathered until the end of 1965.

Dr. Francis Pilkington has chronicled the historical background of the Plymouth Nuffield Clinic and outlined its aims. The clinic was designed to create in the heart of the city a nonresidential center for psychiatric treatment. The broad object was to reduce the extent of inpatient psychiatric care by providing a preferable alternative. Out-of-hospital management is not always the treatment of choice, but

where such facilities exist and can be applied aptly in the case of an individual patient then we believe it to be better for him not to have to go into a hospital. Thus the clinic was planned to provide a treatment setting which would make admission to hospital necessary less often and for shorter periods. In the context of our evaluative study, therefore, where the dispositions of numbers of patients were to be pooled together, being out of the hospital was operationally considered to be better than being in the hospital.

A subsidiary aim of the Nuffield Clinic was to bring about in Plymouth a greater awareness and understanding of, and sympathy for, psychiatric illness. The clinic had an educative role toward general practitioners and other doctors, toward clergymen, toward probation officers, toward nurses, especially health visitors (public health nurses), and toward those voluntary bodies whose functions brought them into contact with the psychiatrically ill. Once again, an attempt might have been made to measure the effect of the clinic in terms of changes in public attitudes. However, the same practical considerations prevailed even more forcefully, and we have been content to argue that the result of such educational arguments would be to increase, at any rate in the short term, the number of patients referred for psychiatric care from all sources. Further, as it was believed that psychotic patients were nearly always already being referred, we expected that the diagnostic distribution of patients would shift toward an increasing proportion of patients with less severe illnesses, neuroses, and personality disorders.

Reduction in the extent of inpatient treatment could come about in four ways:

1. by reduction in the percentage of outpatients for whom admission was recommended;

2. by reduction in the length of stay of new inpatients;

3. by an increase in discharges of long-stay inpatients;

4. by reduction in the rate of relapse requiring readmission after discharge. Changes in this item might clearly be contingent on changes in the preceding three; this would have to be explored.

The detection of changes in the number and diagnostic distribution of patients referred required an examination of both inpatient and outpatient accessions to treatment. The latter were of particular importance both because of their greater numbers and because the majority of the less severely ill patients were dealt with on an outpatient basis.

PREDICTIONS

If the clinic were fulfilling its objectives, it was predicted that:

1. the number of long-stay inpatients would fall once the clinic opened or, alternatively, that the secular decrease in their number would be accelerated;

2. the number of accessions to long-stay inpatient status would similarly be reduced, making due allowance for age, sex, and diagnostic variation;

3. patients admitted in 1963, compared with those admitted in 1961 and 1959, would, during the two years following their admission, spend less time in the hospital either in their first admission or, more important, over their total admission stays;

4. discharged inpatients in 1963, compared with those in 1961 and 1959, would show an increase in the amount of psychiatric outpatient care but a reduction in the amount of subsequent inpatient care;

5. the number of patients seen as psychiatric outpatients in 1964, compared with 1961, would show an increase, and this increase would comprise referrals from all sources and diagnostically there would be a shift towards referral of less severely ill patients;

6. the treatments recommended for these outpatients would show a shift from physical to psychological therapies because of the availability of group treatment and day-hospital facilities at the clinic;

7. the number of outpatients for whom inpatient treatment would be considered necessary would fall. Any change will, of course, have to be interpreted in the light of changes in the total number of outpatient referrals and in their diagnostic composition.

All these predictions were made and recorded before any details of "after" measurements were known.

MEASUREMENTS

Separate but dovetailing surveys were made of inpatients and outpatients in order to test these predictions. The crucial comparisons were between 1961—before the clinic opened—and 1963 or 1964,

when it was in operation. Measurements of some previous years were also made, however, to detect the possible influence of secular trends.

Inpatients

1. Patients in the hospital at the turn of the year, 1956–1957 through 1964–1965 (nine years) were enumerated, and age, sex, and length of stay were recorded. This will enable us to see what is happening to the long-stay hospital population and whether the opening of the clinic has affected the size of this group and the numbers who become long-stay patients (though for a definite answer to the latter we will have to wait until the beginning of 1966).

2. All patients admitted during 1961 and all patients admitted during 1963 had recorded about them age, sex, civil state, address, previous admissions, diagnosis, and length of stay on this first admission. Then, for each of the 24 months following their admission every psychiatric contact was noted, whether it was inpatient, outpatient treatment or a domiciliary visit by a psychiatrist, day-hospital treatment at the clinic, psychiatric social work, care from the local authority mental welfare officer, or home attendance by the hospital nursing aftercare service.

3. A similar record was prepared for each patient admitted in 1959.

4. & 5. Similar records to those in 2. and 3. were kept for all patients discharged during those years; follow-up information in these cases was obtained for two years *after discharge.*

Of course the populations in 4 and 5 overlap considerably with those in 2 and 3, respectively. The advantages of following up for fixed periods both from the time of admission and from the time of discharge, separately, are that one can examine the influence of the clinic on length of stay (for which data on admissions are necessary) and that one may follow up the progress of long-stay patients leaving the hospital (which requires data on discharged patients). Little extra work was involved in preparing the two sets of information since the record sheets of over 70 per cent of the patients did duty in both series.

The purpose of these measures was to discover—by comparing the 1963 data with those from 1961—whether in the later year the amount of out-of-hospital contact with the psychiatric services had increased

and if there had been a consequent decline in the length of stay in the hospital and in subsequent readmission spells. The 1959 data were obtained in order to determine whether any changes in this desired direction could also be found in the 1959–1961 comparison; if that were so, it would be less clear that the clinic was responsible for 1961-1963 differences.

Outpatients

Information was obtained about all outpatients on their first attendance during 1961 and this was repeated during 1964. It included age, sex, civil state, address, source of referral (e.g., family doctor, probation officer, or following discharge from inpatient care), whether this was a new patient or one continuing treatment from the preceding year, whether the patient had been an inpatient or an outpatient previously, the diagnosis made and the treatment and the disposal recommended.[4] In order to obtain complete coverage of all psychiatric referrals during the year a similar schedule was completed with respect to patients directly admitted to hospital without attending the outpatient department or being seen by a psychiatrist in their homes. This was to see if, subsequent to the clinic opening, there would be any shift in the direct admission: outpatient ratio.

The purpose of this comparison between 1961 and 1964 was to determine whether there had been any increase in outpatient referrals, whether any particular agencies had differentially increased their referring rate, and whether the diagnoses of patients revealed a shift toward less severe illnesses.

Statistics

Where tests of significance are indicated, the chi-square test will be appropriate.

Swings....

Certain hitches were encountered which should not pass unrecorded. They are the sorts of things which can so easily happen and which no research design can entirely circumvent.

There was an adjustment in 1961 to the area from which the hospital draws its patients. Although the modifications were small and affected only outlying districts, they have meant limiting the before-after comparisons to the 70 per cent of patients who live in the city of Plymouth.

The opening of the clinic was delayed, necessitating a long break between the periods of intensive data collection. This was a considerable setback to the research assistant principally involved, who had to take another job for 18 months in the middle of her three-year project. The long gap also meant a large change-over in the secretarial and nursing staff that helped in distributing the schedules and in recording some of the data, so that new people, unfamiliar with the survey, had to be instructed in what to do. There was also turnover in the junior medical staff, but this did not pose much of a problem.

Perhaps the most serious hazard to the evaluation lies in the fact that during 1964, the clinic was not functioning entirely as planned beforehand. This was because the full quota of medical staff increases that had been anticipated was not forthcoming. Consequently the clinic was not providing the extent of service that had been hoped for, particularly in respect to regular medical participation in the day-hospital treatment. The result may be that the impact of the clinic during the survey period will have been less than it will be in subsequent years. This is a problem that must always beset evaluation studies. Research grants have a limited span. It is not possible to extend the period of observation indefinitely so as to seize the optimum moment, even when that can be recognized. Unless these risks were accepted, no study could ever be undertaken. Nevertheless they are not negligible risks.

. . . . *And Roundabouts*

On the credit side we have had the unfailing help of the clinicians concerned. That discussions took place with them as early as 1960, and that the schedules used were the product of joint effort was no doubt partly responsible. The evaluation has always been done *with* them, not *of* them. It is easy to read a collated figure in a table and not to realize how arduous it is to continue through a whole year filling in a tiresome form about every patient you see, especially when someone else, not yourself, is subsequently going to process it. And then, three years later, you are called on to go through it all again when initial enthusiasm must have waned. The support and assistance of the clinical staff has been a mainstay of the research.

RESULTS

Analysis of the data is incomplete since collection ceased at the end of 1964 and follow-up information will be needed for another two

years. Yet we have certain information about outpatient attendances, comparing 1961 and 1964, and about the fate of inpatients, comparing 1961 and 1963.

Tables 1–3 give the numbers of outpatients, their sources of referral, and their status during the respective years. No important differences between the years are demonstrated except for the increase (Table 3) in the number of people referred for psychiatric consultation by the local authority service. This has undoubtedly come about because the

TABLE I. OUTPATIENT ATTENDANCES

	1961		*1964*		*1964 as Percentage of 1961*
	No.	*%*	*No.*	*%*	
New outpatients	1,258	77	1,333	74	106
Continued from previous year	201	12	293	16	
Discharged inpatients admitted during the year	99	4	86	4	
Discharged inpatients in hospital at the beginning of the year	71	6	79	5	
Totals	1,629	100	1,791	100	110
Residents within the city	1,172	72	1,301	73	111
Where these Plymouth residents were first seen:					
Outpatient clinic	80%		77%		
At home	15%		16%		
In hospital bed	5%		7%		

TABLE 2. DISTRIBUTION OF ALL NEW PATIENTS ATTENDING THE PLYMOUTH SERVICE (INPATIENTS AND OUTPATIENTS)

	1961	*1964*
n =	1,596	1,712
	(%)	(%)
Outpatient only during the year	57	56
Outpatient first—later inpatient	22	22
Inpatient first—later outpatient	6	5
Inpatient only during the year	15	17
First contact as outpatient	79	78
First contact as inpatient	21	22
Ever an outpatient during the year	85	83
Ever an inpatient during the year	43	44

TABLE 3. OUTPATIENTS: SOURCES OF REFERRAL

	1961		1964		1964 as Percentage of 1961
Total outpatients	1,629		1,791		110
Referred within the psychiatric services					
inpatients on discharge	264		359		136
by social worker or nurses	30		22		73
		%		%	
Remainder	1,335	100	1,410	100	106
general practitioner	1,040	78	1,056	75	101
other hospital doctor	193	15	208	15	108
local authority service	31	2	76	5	246
court or probation officer	16	1	22	2	138
Ministry of Pensions	18	1	13	1	72
self-referral	19	1	18	1	95
other miscellaneous services	18	1	17	1	95

TABLE 4. OUTPATIENTS: DIAGNOSIS—PERCENTAGES

	Males		Females	
	1961	1964	1961	1964
n =	658	692	971	1,099
Organic mental illness	6	8	6	5
Schizophrenia	9	12	10	9
Subnormality	1	2	1	2
Mania, hypomania	1	1	2	1
Depressive psychosis—severe	7	4	11	8
Depressive psychosis—mild	10	8	14	11
Neurotic depressive reaction	16	18	26	32
Anxiety state	23	18	13	14
Other neuroses	9	5	11	9
Personality disorder	10	14	3	5
Other, including epilepsy	3	7	2	3
Nil	5	3	2	1
All psychoses	33	33	42	34
All neuroses	48	41	50	55
All depressions	33	30	51	51

mental welfare officers (the agents of the local authority service) are now working in the same building with their psychiatric social worker colleagues and also with the psychiatrists themselves. There is consequently much more exchange of information between all concerned. This is very satisfactory.

Table 4 reveals that there was no change in the diagnostic composi-

tion of outpatients. The treatments recommended (Table 5) and the disposals arranged (Table 6) also did not alter.

Turning to the one-year outcome of all admitted patients (i.e., those who were hospital inpatients for at least some time during the year), we see that there was, for men, a decrease in the numbers remaining in

TABLE 5. OUTPATIENTS: RECOMMENDED TREATMENT

	1961		*1964*		*1964 as Percentage of 1961*
Number of patients	1,629		1,791		110
Number of recommended treatments	1,997		2,377		119
Treatments per patient	1.22		1.32		108
Psychotherapy*					
intensive	10%		10%		
supportive	14%	35%	16%	33%	94
group	1%		0%		
brief	10%		7%		
Physical					
drugs	39%		44%		
E.S.T.	8%	48%	6%	50%	104
other	1%		1%		
Psychiatric social work	6%		8%		(133)
Nonpsychiatric treatment	11%		9%		(82)

* Definitions for the research: Intensive—at least 3 sessions of at least 40 minutes each. Supportive—long-term treatment with short interviews only, not designed to effect profound changes in the patient's condition but more to keep him going and deal with his situational problems as they arise. Brief—discussions with the patient on one or two occasions only.

TABLE 6. OUTPATIENTS: RECOMMENDED DISPOSALS

	1961		*1964*	
Number of patients	1,629		1,791	
Number of recommended disposals	1,761		1,960	
Psychiatric admission	20%		18%	
Day-hospital treatment	—		4%	
Further OP attendance for treatment	39%	48%	34%	49%
Further OP attendance for follow-up	9%		15%	
To psychiatric social worker	7%		7%	
To psychiatric social club	1%	10%	0%	10%
To another social agency	2%		3%	
To nonpsychiatric hospital care	1%		1%	
To general practitioner	17%		14%	
Other miscellaneous disposals	4%		4%	

TABLE 7. ONE-YEAR OUTCOME OF ALL ADMITTED PATIENTS

	Schizophrenia Aged <65		*Depression Aged <65*		*All Other Diagnoses Aged <65*		*All Patients Aged 65+*		*All Patients*	
	1961	1963	1961	1963	1961	1963	1961	1963	1961	1963
	Males									
In hospital throughout	8	4	3	1	12	8	4	4	27	17
Died in hospital	—	—	1	—	4	1	24	15	29	16
Discharged within 1 year	28	35	51	44	65	73	29	30	173	182
Totals	36	39	55	45	81	82	57	49	229	215
	Females									
In hospital throughout	7	5	4	5	4	4	11	13	26	27
Died in hospital	—	3	2	—	5	2	25	24	32	29
Discharged within 1 year	42	55	151	148	53	64	57	40	303	307
Totals	49	63	157	153	62	70	93	77	361	363

hospital for 12 months continuously (Table 7). There were also fewer deaths. These findings did not obtain for women.

Table 8 shows the amount of time spent as inpatients during the 12 months following admission and also the number of outpatient consultations and contacts with social workers and nurses outside the hospital. Both men and women had slightly shorter initial admissions during the later year, though in men this was more than balanced by a rather longer mean stay in readmissions. Women, however, spent less total time in hospital in the later period. For both sexes there was an increased number of outpatient psychiatric consultations. The number of social work and nursing contacts, however, did not materially alter.

DISCUSSION

Now we must relate these results to the predictions made earlier in this paper. We do not yet have data relevant to predictions 1 and 2. Prediction 3 covered a two-year period and our data are for only one year following admission. There has been some reduction in length of stay on first admission but not in total time in the hospital during that period. There has been an increased mean duration of readmission stay so that prediction 4 is not borne out, despite the rather greater number of outpatient consultations for discharged patients.

Predictions 5, 6, and 7, relating to outpatients, have also not come to pass.

These findings are disappointing. Dr. Pilkington has said that nothing dramatic was expected. Certainly, nothing dramatic has emerged from the results so far. There is still some time to go before any final verdict based on the existing study can be made.

Unfortunately we have no plans to go on obtaining data about patients coming subsequently to the service.

With the aid of hindsight, I think we were too hasty in thinking that a change in habit among referring agencies could have come about so early. Equally, there seems to have been no rapid change in the psychiatrists' habits of managing patients. They now have at their disposal a new facility but it will take some time, evidently, for them to realize all of its potentialities and, therefore, to adopt new patterns of dealing wtih patients.

The finding of relatively little change, if it is borne out by our further analyses, raises important issues both for the innovator and for the evaluator. The arguments against modifying the existing state of affairs could be, first, that the study was irrelevant, inasmuch as by insisting

TABLE 8. ADMITTED PATIENTS SURVIVING FOR ONE YEAR. INVOLVEMENT PSYCHIATRIC SERVICES DURING THAT YEAR

	Males									
	Schizophrenia Aged <65		*Depression Aged <65*		*All Other Diagnoses Aged <65*		*All Patients Aged 65+*		*All Patients*	
	1961	1963	1961	1963	1961	1963	1961	1963	1961	1963
n =	36	39	54	45	77	81	33	34	200	199
Mean months in hospital at 1st admission	*5.3*	*4.2*	*2.5*	*2.2*	*3.6*	*3.1*	*3.3*	*3.5*	*3.6*	*3.2*
Patients readmitted	9	14	11	10	22	25	9	16	51	65
—Mean months in hospital on readmission	*0.8*	*1.4*	*0.5*	*0.8*	*0.5*	*1.2*	*0.7*	*1.4*	*0.6*	*1.2*
Mean months total hospitalization	*6.1*	*5.6*	*3.0*	*3.0*	*4.1*	*4.3*	*4.0*	*4.9*	*4.2*	*4.4*
Patients treated in day hospital	—	5	—	4	—	9	—	9	—	27
—Mean months in day hospital	—	*0.4*	—	*0.2*	—	*0.4*	—	*1.8*	—	*0.6*
Patients seen subsequently at psychiatric outpatient clinics	9	15	28	20	25	29	6	4	52	68
—Mean no. of outpatient consultations	*0.7*	*1.3*	*1.5*	*1.0*	*0.7*	*1.2*	*0.4*	*0.7*	*0.8*	*1.1*
Patients having outpatient contacts with social workers and nurses	3	8	6	7	4	10	6	6	19	31
—Mean no. of outpatient contacts with social workers and nurses	*0.7*	*0.9*	*0.2*	*0.4*	*0.3*	*0.3*	*0.8*	*1.1*	*0.4*	*0.6*

TABLE 8. (CONTINUED)

	Females									
	Schizophrenia Aged <65		*Depression Aged <65*		*All Other Diagnoses Aged <65*		*All Patients Aged 65+*		*All Patients*	
	1961	1963	1961	1963	1961	1963	1961	1963	1961	1963
n =	49	60	155	153	57	68	68	53	329	334
Mean months in hospital at 1st admission	*3.5*	*3.3*	*2.3*	*1.9*	*3.3*	*2.5*	*3.8*	*4.8*	*3.2*	*2.7*
Patients readmitted	12	19	36	38	22	25	16	10	86	92
—Mean months in hospital on readmission	*0.7*	*1.2*	*0.5*	*0.6*	*1.5*	*0.7*	*0.8*	*0.3*	*0.8*	*0.7*
Mean months total hospitalization	*4.2*	*4.5*	*2.7*	*2.5*	*4.8*	*3.2*	*4.6*	*5.1*	*4.0*	*3.4*
Patients treated in day hospital	—	11	—	17	—	8	—	8	—	44
—Mean months in day hospital	—	*0.6*	—	*0.5*	—	*0.6*	—	*3.6*	—	*0.6*
Patients seen subsequently at psychiatric outpatient clinics	10	23	80	73	21	23	6	12	117	131
—Mean no. of outpatient consultations	*0.6*	*1.5*	*1.6*	*2.6*	*1.2*	*1.0*	*0.3*	*0.7*	*1.2*	*1.8*
Patients having outpatient contacts with social workers and nurses	14	12	6	22	9	9	22	7	51	50
—Mean no. of outpatient contacts with social workers and nurses	*2.1*	*0.1*	*0.5*	*0.7*	*0.5*	*0.5*	*1.3*	*0.5*	*1.0*	*0.6*

on treating patients as ciphers it ignored the richer benefits conferred by the center in providing better patient care. This argument is not paltry. It contains a just criticism of the sort of evaluation we have undertaken. The second contention would be that, since the clinic was not functioning optimally at the time of the evaluation, we ought to wait and see how things turn out. This argument is more specious. *Wait,* by all means, but *see*—how? The evidence will not simply present itself later. A wait-and-see policy either means that another study must be carried out in the future (though we all know that in practice this is not likely), or that, with the passage of time, the findings will lose their immediacy and no longer call for action.

I do not think that this will happen in Plymouth but, as a matter of general concern, it is crucial to know whether action is taken following research, the results of which do not fulfill the inovator's expectations. When we assess evaluation studies, then the consequences which flow from them also merit our attention.

REFERENCES

[1] Who is the innovator? Generally he is a psychiatrist, the medical director of a mental hospital. Coming to his position after the war and inspired by the new liberality and social conscience which fired all the younger professionals in Britain, he has striven to break down the administrative system which so restricted staff and patients a few years earlier. Almost any change he wrought inside the hospital seemed to be an improvement, and an era of full employment fostered his laudable concern to discharge patients from their overcrowded and stultifying surroundings. The growth in the number of psychotic patients outside the hospital led him to develop new concepts of community care. These, however, not only required vision but involved continuing administrative burdens and drew him in to association with the public health authorities.

[2] Who is the evaluator? Because of the skills he must command the evaluator is generally an epidemiologist—usually a physician with a public health background, occasionally a psychiatrist with research training, and sometimes, especially in the United States, a biostatistician with a mathematical background, a statistical training, and an education in medical principles and nomenclature and in the ways that doctors think and work. Whatever his training, he is a scarce animal who is able to pick and choose among numerous claims on his time, and, of course, he will select the most rewarding.

[3] Reports on the Evaluation Studies Being Conducted by the Milbank Memorial Fund on the Effect of These Services, in MENTAL HOSPITALS JOIN THE COMMUNITY, *The Milbank Memorial Fund Quarterly,* Vol. XLII, No. 3, July 1964, Part 2, pp. 64–107.

[4] Although children were not specifically studied in the evaluation project, it not uncommonly happened that the neurotic or even psychotic parents of sick children were taken on for treatment while the child remained the only registered patient. Therefore, the number of new child patients in 1961 and 1964 have been ascertained.