The General Hospital and Mental Health Care: A British Perspective

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Treatment of psychiatric patients in British general hospitals, which began in the eighteenth century, came to a premature end in the mid-nineteenth century. The mental hospital was then left largely unchallenged for more than a century; when general hospitals started to make a significant contribution once again, they did so within the unified orbit of the National Health Service (NHS). In the 1960s, British hospital planning was founded on the district general hospital (DGH), incorporating psychiatry as a major specialty. These units were to form the hub of a district mental health service, where most chronic disorders would be assigned to "community care," which was primarily the responsibility of local social services. The mental hospital, therefore, appeared to be obsolete, but the questions of whether its range of functions could be entirely reproduced in small units and of how many of these functions could be assumed by the general hospital still remain unanswered, particularly in the uncertain climate of a much diminished welfare state.

The Early Period

Guy's Hospital, London, opened an adjacent "lunatic house" for 20 patients in 1728, representing the first formal provision for the mentally ill

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in a British general hospital. In most provincial cities, voluntary general hospitals were being established at that time, and several included a section for the mentally ill. A parallel development was the growth of private madhouses, comprising anything from a few cases taken into the home of a doctor or clergyman to a substantial institution that might accept pauper cases as well (Parry-Jones 1972). By the second half of the eighteenth century, there were several specialist hospitals for the mentally ill in England, and one was established in Dublin. The private madhouses, however, often ill-treated and wrongfully confined those in their charge, and general hospitals eventually found it convenient to unburden themselves of a problem that was not consistent with the acute medicosurgical model that characterized their main activities. For reasons that are far from clear, the psychiatric annexes of general hospitals had ceased to exist by the mid-nineteenth century (Mayou 1989). Had this not happened, the subsequent history of managing psychiatric disorder in Britain would have been entirely different.

The specialized mental hospital, then, became by far the most important location for full-time institutional care of the mentally ill, as it did in the United States and Western Europe. Around the time that a national system of mental hospitals was being established, therefore, in the 1840s, the contribution of general hospitals came to an end—and did not resume for a century. The only other institution to contain many cases of mental disorder was the Poor Law workhouse, whose mentally disordered were supposed to be transferred to asylums. Because this would have been more expensive, such a move was often resisted by the Poor Law Guardians. Nevertheless the asylum population grew remorselessly, and, in the words used by Rumbaut (1994) to describe Dorothea Dix's crusade for humane care of the mentally ill in the United States: "[It] was too effective, [ending] in the long run by flooding the mental hospitals."

The relentless accumulation of morbidity in workhouses, however, led to the development in them of "infirmary annexes," and, in a largely unplanned way, their rudimentary medical and nursing care increasingly came to resemble that practiced in general hospitals. In the early part of this century, "mental observation wards" were developed in many of these annexes, where cases were admitted initially and then transferred to an asylum if they did not recover quickly. In 1948, the workhouse infirmaries were to provide, first, many of the hospital resources for the

new National Health Service (NHS) and, somewhat later, the sites for most general hospital psychiatry.

During the late nineteenth and early twentieth centuries, voluntary general hospitals, like their counterparts in the United States, dealt with some less severe psychiatric disorders, but these cases were treated by general physicians or neurologists; their psychological aspects were not always recognized (Bynum 1985). A very small number of psychiatric outpatient clinics were established at general hospitals, but even by the late 1930s, only one teaching hospital had a psychiatric ward. Although disorders like "shell shock" (Merskey 1991) and "soldier's heart" were very common in World War I, only one of the facilities set up to deal with such cases outside of mental hospitals survived long after 1918. During the 1930s, the workhouse infirmaries became "municipal hospitals," often with a great improvement in standards, while some observation wards began to treat acute patients. Outpatient clinics also increased in number and were mostly staffed by doctors from mental hospitals, although some independent psychiatrists also saw outpatients at voluntary hospitals. That general hospitals could play a bigger role became clear when they temporarily accepted mental hospital patients for the treatment of tertiary syphilis with malarial mosquitoes and encountered virtually no major problems of management (Freeman and Bennett 1991).

By 1939, however, scarcely any modern development had occurred in the mental health care system; indeed, most hospitals had hardly changed since the late nineteenth century. Those in Britain who were dissatisfied with the contribution of general hospitals pointed to the example of the United States, where several large teaching departments had been endowed by the Rockefeller Foundation and 40 general hospital psychiatric units were operating in 1940 (Greenhill 1979). Nevertheless, a process of medicalization had begun in Britain, whereby mental illness would no longer be treated primarily under the auspices of the Poor Law, which had applied to all except a small minority who were wealthy enough to make private arrangements. In the planning for an NHS during World War II, mental illness services were excluded on the grounds that their administrative and legal arrangements were so different from those of general hospitals that they could not be combined in a single structure. This proposed separation, however, was eventually dropped, and British mental health care would from then on primarily reflect the structure of a comprehensive NHS.

This service, which began in mid-1948, was a mixture of radical and conservative aspects. It was radical in nationalizing all hospitals—mental and general, municipal and voluntary—and giving them all the same administrative pattern; only some small private hospitals (a few of them psychiatric) were left out. At the same time, national salary scales were established for all hospital staff—medical, nursing, and ancillary. Its conservative aspect lay in the preservation of the primacy of general practice (GP), which meant that specialists would normally only see patients on referral from GPs, who would thus remain as independent practitioners under contract with the NHS to care for the people registered on their lists—totaling well over 90 percent of the population. The new service also left city and county local authorities responsible for community health, including the mental welfare officers who undertook compulsory psychiatric admissions. Administratively, therefore, the NHS was split into three compartments, integrated only at the national level and cooperating locally to widely varying degrees. This division created significant problems in the evolution of psychiatric services, which care for many long-term disorders. In other areas of the welfare state, social services and social security diffused into the general community—away from the previous institutional basis of the Poor Law. In child care, for instance, orphanages and other institutions were replaced by small homes or foster care, and the same process emerged in the care of the elderly; this noninstitutional ideology may well have influenced views about the management of psychiatric disorder.

General Hospital Psychiatry in the NHS

At the inception of the NHS, 44 percent of all hospital beds nationally were in mental or mental deficiency (retardation) hospitals, whereas general hospitals contained only a miniscule number of psychiatric beds. The new doctors recruited in large numbers into psychiatry to fulfill the needs of the armed forces would have been unlikely, in any case, to accept the authoritarian, hierarchical culture of prewar mental hospitals; the general hospital offered them a more congenial working situation. Under the comprehensive structure of the NHS, a new psychiatric service could now be developed anywhere, if the resources could be found, and the administrative autonomy of consultants was particularly useful in this connection. Because the NHS staffing system was unified, psychi-

atrists (and later nurses) could divide their work between mental and general hospitals or transfer from one to the other. Also, because all hospital services were centrally financed, the monetary aspects of any changes were very simple. The biggest obstacles to improvement were the lack of trained specialists and the almost total absence of capital for new building. Because of the NHS, however, British psychiatry remained unified, and almost all specialists devoted the greatest part of their time to hospital-based clinical work, rather than to private practice.

Like the older, established specialties, psychiatry participated in the diffusion of services from the largest centers. However, the fact that many mental hospitals were in rural areas, a situation that succeeded in the United States, made it difficult for them to provide a readily accessible service; the problem was worst in London, where nearly all these hospitals were on the distant periphery of the metropolitan area. This geographic factor was a significant spur to the development of psychiatry in general hospitals.

An event of great importance for general hospital psychiatry in Britain was the passage in 1959 of the Mental Health Act—a comprehensive reorganization of all law relating to mental illness and mental retardation. As far as possible, it removed legal formalities from the hospital care of psychiatric disorders, and it abolished the special designation of mental hospitals. A psychiatric patient could now be admitted to any hospital, either informally (on the same basis as medical or surgical patients) or under legal compulsion. In practice, the proportion of patients admitted compulsorily dropped to a new low, and, even in these cases, the required stay was usually brief. The legal and administrative flexibility achieved by this reform was undoubtedly a very favorable factor in the development of British mental health services. It was both an embodiment of ideological changes in society since World War II and a stimulus to further developments in the services themselves. The act embodied the recommendations of a Royal Commission that, in many ways, resembled the Joint Commission in the United States, although Britain did not adopt the American model of community mental health centers, which became entirely independent of mental hospitals.

In 1961, the minister of health announced that he expected to see a 50 percent reduction in mental hospital beds in England and Wales over the next 15 years (Powell 1961). This prediction was based on a study showing a steady fall in occupied beds between 1954 and 1959, after a previous constant rise, despite the fact that admissions were still increas-

ing (Tooth and Brooke 1961). The following year, a national hospital plan embodied the concept of the district general hospital (DGH), containing about 700 beds, which would provide all major specialist services — including acute psychiatry — for populations averaging 200,000. If alternative care had to be provided for chronic patients, "the community" now emerged as the solution to this problem, and it followed that there would eventually be no further role for the great majority of existing mental hospitals. This was a bold objective, however, considering that, in 1960, there were then only about 4,000 psychiatric beds in DGHs, compared with the almost 150,000 located in mental hospitals (Rehin and Martin 1963). Nevertheless, the detailed planning proposals were in fact generally modest, and, particularly in Scotland, a generally conservative policy was maintained, even though the level of bed provision there was much higher than that in England and Wales.

While the activities of outpatient clinics and day hospitals were growing steadily — the number of new outpatients per annum increased by 50 percent between 1949 and 1959 (Ministry of Health 1959) — local authorities were mostly very slow to increase their community services. Titmuss (1961) warned against the assumption that "community care" could provide an alternative to long-stay hospitals, when it was little more than an aspiration in many places. Also, studies of outpatient psychiatry during the 1960s (Martin 1984) showed that there was "no serious question . . . of [it] replacing the hospital wards"; mostly, it "complemented the inpatient service by providing pre-admission screening and post-discharge follow-up." Day hospitals, which began in the same year as the NHS, were important because they introduced a new element of flexibility (Farndale 1961); they were to have an increasingly important role in the evolution of mental health services, and some day units were established in or near general hospitals.

The reasons for this major switch of inpatient care (at least for acute cases) primarily to general hospitals are far from clear, particularly in light of the fact that the influential expert committee of the World Health Organization (1953), although advocating a more community-orientated mental health system, saw its hospital base remaining as a specialized institution. Indeed, the committee stated that "the more the psychiatric hospital imitates the general hospital . . . the less successful it will be in creating the atmosphere it needs." Rehin and Martin (1963) could find "no solid foundation" of evaluation on which the new policy had been founded. It has often been said (see, for example, Jones 1993)

that the main motivation was a wish to avoid the enormous cost of bringing the run-down mental hospitals up to an acceptable standard. However, my own examination of government records from the period has failed to reveal any evidence for this view, and it is arguable that the creation of an almost entirely new system of hospital units would be at least as expensive as renovation, particularly because most mental hospitals would have to continue operating for many years, if at a reduced level.

Electroconvulsive therapy had come into general use in Britain around the end of World War II, chlorpromazine became available in 1954, and antidepressants began to be used in 1959; these innovations made it possible for effective treatment to be given to large numbers of patients outside of mental hospitals—as outpatients, day patients, or inpatients in general hospitals. Psychotherapy, however, had little place in mainstream British psychiatry—partly for ideological reasons related to the structure of the NHS and partly because of the extreme shortage of professional staff.

Echoing the American view voiced by Hamburg (1957) that, in a general hospital unit, "there is a strong tendency to adopt methods of policy-making which are very similar to those used previously in the hospital," critics like Barton (1963) claimed that the general hospital was an unsuitable setting for most psychiatric patients. Similarly, Jones (1963) said that, of the four functions of the mental hospital (custody, protection, clinical treatment, and socialization), only the third could be adequately performed in a general hospital. In her view, the new policy implied that the NHS would confine itself to the care of acute patients, leaving everything else to community services, which seemed poorly equipped to accept such a responsibility. It would in fact have required an enormous increase in local authority finances for them to have done this, but successive governments refused to make a specific grant for community mental health services. The only other possible ways of ensuring effective community services—creating a new, nationally funded agency for them, or amalgamating them with the NHS—have always been regarded as politically impossible, although the latter was accomplished in Northern Ireland in 1974 (Prior 1993).

A forerunner of later national developments occurred in the Northwest of England beginning in the early 1950s. The region's mental hospitals, which were of a poor standard, were each responsible for nearly a million people, living mainly in old industrial areas. Effectively, the hos-

pital board decided to bypass them by appointing new consultants to the former municipal hospitals in its larger towns; each of these had a mental observation ward, together with some long-stay wards occupied by patients with chronic mental disorders (Pickstone 1989). They did, however, all have some nurses with psychiatric training—specialized nursing had become one of the greatest assets of British mental hospitals. Fifteen general hospital units were eventually developed; the larger ones, with up to 220 beds, provided a comprehensive psychiatric service for anywhere from 200,000 to 250,000 people, while the smaller ones accommodated their medium- and long-stay patients in the nearest mental hospital. In every case, however, collaboration was emphasized, both with GPs in the districts served and with the local authority, which (to varying degrees) provided community services. Because the psychiatric unit was in the center of its population, patients could be treated flexibly as inpatients, outpatients, or day patients, according to their needs; they could also be visited by doctors, nurses, or social workers (Freeman 1960). The other services of the general hospital, including geriatric medicine, were readily accessible. The underlying principles were service to a geographically defined population, continuous and final responsibility for psychiatric disorders in that population, and the integration of all local resources, with the dissolution of administrative barriers (Freeman 1963). Thus, it was the hub of a district (or community-based) psychiatric service.

For some years, similar developments elsewhere in Britain occurred in isolated pockets and on a much more limited scale (see, e.g., Dunckley and Lewis 1963). Jones (1993) argued that this model was not generalizable because the circumstances were unusual, and, from the viewpoint of the 1990s, they appear to have been relatively easy: the units were mostly in medium-sized towns that constituted coherent communities. But the only alternative available at the time was the old-style mental hospital. These institutions usually had some advantages, like spacious grounds, but in all other respects—particularly lack of stigma—doctors and patients increasingly felt that the comprehensive district service based in the general hospital was to be preferred (Kessel 1973). At the national level, this development was noticed by the Ministry of Health, which had decided, in the mid-1950s, that no further mental hospitals should be built. Tuberculosis (TB), a disease for which a shortage of hospital beds had been chronic, quickly resolved this difficulty after effec-

tive drugs became available; the ministry considered the experience with TB a relevant example (Godber 1988).

Ironically, the 20 years after their demise was proclaimed in 1961 turned into probably the most active period ever for British mental hospitals. Very large sums were in fact spent on modernizing them, and patients' living conditions were improved out of all recognition, in conjunction with the development of treatment and occupational facilities. The large buildings and grounds also provided space for new, specialized units—forensic, addiction, child and adolescent, psychogeriatric—which would have been very difficult to accommodate elsewhere. Both the psychiatry of old age and the rehabilitation of chronically handicapped patients evolved as separate medical subspecialties, in ways that were unique internationally; these developments began in the mental hospitals, and spread later to general hospitals and other sites. During this time, the psychiatric profession was evolving into a fairly large and well-trained specialty, symbolized by the establishment in 1971 of the Royal College of Psychiatrists, which aspired to equality with the older specialties.

At one time, it seemed that mental and general hospitals might evolve jointly, through nonpsychiatric specialties moving into mental hospital accommodation. However, apart from Lancaster, where the mental hospital was on the edge of a small city (Smith 1963), this imaginative proposal—which would have embodied McKeown's (1958) idea of the "balanced hospital community"—never gained much acceptance. In fact, changes in British mental health services during the 1960s were very slow; a "demonstration project" in Worcester to show how a traditional county mental hospital could be replaced by a network of smaller facilities took 20 years to complete (Hall and Brockington 1990). A very optimistic report, however, from the first district psychiatric unit to be established in central London (Baker 1969) seems to have influenced government thinking, because it was quoted in *Hospital Services for the Mentally Ill* published by the Ministry of Health (1971) as the first official statement of that policy. The Ministry recommended that, in each district, a comprehensive, integrated mental health service should be based on a psychiatric department in a DGH, supported by a geriatric department and by local-authority community services. This constituted what was often described as a "dispersed institution." Referral of chronically ill patients to mental hospitals was discouraged, and the mental

hospitals were expected to run down toward closure, although no time-scale was given. Yet by 1970, DGH units in England still accounted for only 15.5 percent of all psychiatric admissions. In 1971, all social workers were brought into comprehensive "generic" departments of the local authorities, so that hospital psychiatric units then had to negotiate with them for their social work service.

The official view of the hospital's function (Brothwood 1973) was one of providing medical and nursing care for those people with psychiatric disorders for whom such care was the primary need, and it was increasingly to be found at DGHs. On the other hand, the chronically handicapped should not become long-term hospital residents. The basic provision of psychiatric beds (0.5 per thousand population) was to be supplemented by beds and day places for the elderly with severe dementia, as well as by some medium-security beds for seriously disturbed cases (on a regional basis). The definitive national policy emerged two years later (Department of Health and Social Services 1975), stating that the DGH psychiatric unit was to be seen, "not simply as an inpatient department but as a centre providing facilities for treatment on both a day and inpatient basis and as the base from which the Specialist Therapeutic Team provides advice and consultation." Although one of the main objectives of the program was to be the relocation of specialist services from mental hospitals into DGH units, the government's aim was "not to close or run down the mental illness hospitals but to replace them with a local and better range of facilities." By this time, however, government expenditure had been jeopardized by the oil crisis, rendering the timetable of development for mental health services much more uncertain.

The 1975 document has been much criticized as viewing mental health care primarily in terms of service structures and types of staff, rather than in the context of individual needs that are provided for in more normal settings. It had a well-formulated, coherent, and in some respects sophisticated approach, but carried neither a credible time-scale for making capital available to build the new DGH units and other facilities, nor any reasonable possibility that the necessary community services would actually be provided. Yet, if any part of the network was missing, the service could not function effectively. This was a time when managerialism was thought to provide the answer to most contemporary problems in Britain, but the generic "integration" of social work had resulted in the disintegration of the better and more coordinated mental health services (Jones 1979). Ideally, each district was to have one DGH,

but circumstances rarely provided such a neat solution; hospitals were often in the wrong place for the present-day population, while the perennial shortage of capital prevented small or obsolete facilities from being combined and rationalized. However, with the NHS reorganization of 1974, planning of "health" services began for the first time; up to then, regional and local NHS authorities had only been responsible for hospitals.

The Present Era

For 30 years, general hospital psychiatry in Britain proceeded on a slow but steady course of development, hardly affected by political upheavals. Except in marginal respects, the NHS—and to some extent the welfare state—had risen above politics. Below the national level, it was a professionally administered service, in which medical opinion was highly influential. If there was still a major unresolved problem in mental health care—other than overall lack of resources—it was the split in responsibility between the NHS and local authority community services. The concept of the DGH psychiatric unit became largely absorbed into that of the comprehensive district mental health service. Following the usual course of events in British social history, this policy had evolved inductively from a combination of trends and initiatives, rather than being deduced from any general political or economic principle. One of these trends was the continuous drop, between 1955 and 1975, in occupied mental hospital beds—a loss over those 20 years that totaled 60,000. Compared with the United States, deinstitutionalization proceeded slowly and was less influenced by financial considerations; reprovision of the mental hospital's facilities was more strongly emphasized in Britain. The comprehensive structure of the NHS allowed this process to take place on a planned basis, although the establishment of community services had to be negotiated with the local authorities. However, the argument that psychiatric hospitals were absorbing a disproportionate amount of the total mental health budget was increasingly heard.

No reductionistic explanation of this process is credible, however; a series of largely unconnected innovations gradually changed the way in which mental health care was delivered. The most important of these developments were DGH psychiatric units, therapeutic communities, day hospitals, sheltered workshops, social clubs, hostels, home visits, hospi-

tal open doors, and physical treatments. Almost all were pragmatic, not dependent on any particular theoretical basis, and not part (until much later) of any comprehensive policy. They were reinforced both by a more egalitarian culture following World War II, which was less accepting of hierarchical institutions, and by the philosophy of the emergent welfare state (Bennett 1978).

Unlike American policy at that time, particularly the community mental health center program, British developments were not greatly concerned with "preventive" activities, with "consultation" theory, or with the active participation of communities (except through voluntary organizations). British psychiatry had a firm biological basis, much influenced by European phenomenology, but it drew little from psychoanalysis, which was then all-powerful in American teaching and practice. Mental health policy remained firmly rooted in the conventional models of medicine, nursing, social work, clinical psychology, and occupational therapy. It was an atheoretical, pragmatic amalgam, which could incorporate elements of psychodynamic theory, learning theory, social theory, and the concept of a "therapeutic community," to the extent that these had proved their clinical usefulness. The activities of the DGH unit were governed by this nonideological culture.

In the 1970s and 1980s, however, cultural and ideological shifts that affected the care of the mentally ill were of two opposed tendencies. The first was "antipsychiatry"—one of the offshoots of the European and American "cultural revolution" that began with the students' revolt of 1968 and that was heavily colored by Marxism (Sedgwick 1982). In practical terms, the teaching of psychology, social work, and nursing in Europe became strongly influenced by such concepts, with the result that many of the practitioners of these disciplines saw it as a primary task to undermine "psychiatric hegemony," not only by agitating for change within existing institutions, but also by developing alternatives. As a consequence, the DGH unit, which had first appeared to be in the vanguard, became somehow transmuted into a "reactionary" organization, with the same unfavorable characteristics that had been attributed to the mental hospital in the 1950s. The alternatives to it that began to be proposed were mental health centers, crisis intervention in the home, and noninstitutional care of various forms like "respite houses," with varying degrees of professional involvement, but no psychiatric direction. Thus, the pragmatic question of *where* mentally ill patients could best be treated was converted into an ideological issue.

The second tendency was radical, right-wing monetarism. Capturing both the British Conservative Party and the Republican Party in the United States, it was profoundly opposed to the "liberal consensus" that had created the welfare state in Britain. For some years after the Conservative victory of 1979, the Thatcher administration made only limited changes to the NHS, but, after 1988, it instituted major "reforms," which have had a profound influence on mental health care, including the services provided in DGHs.

Shortly before this, an officially sponsored symposium in 1985 on mental health services (Wilkinson and Freeman 1986) included current government guidance on DGH units. Experience was said to have shown—although no data were given—that adult psychiatric beds should be at a level of 0.3–0.5 per thousand population; more would be needed, however, if there was no access to staffed hostels in the community. A separate ward for the assessment and short-term treatment of elderly psychiatric patients was advised, but these beds would be deducted from the basic provision. It was admitted that "new long-stay" patients—as opposed to those remaining from before about 1970—might begin to accumulate, thereby threatening the viability of the DGH unit, but the only solution offered was the well-staffed "hospital hostel," as developed in only three places in Britain (see, e.g., Goldberg et al. 1985). Where a DGH was not centrally located for the community it served, some of the day hospital places were to be removed from it, and relocated in a more convenient situation.

At that time, there were still 56,000 patients in the old mental hospitals in England; the total was dwindling by about 2,000 per annum. DGH units accounted for 13,000 beds; nationally, 38 percent of psychiatric admissions were going to DGH units, but in the Manchester region—where the policy had begun—the figure was 82 percent (Goldberg 1986). The usage of mental hospital beds in that region was then less than half the national average, but Goldberg felt that a service centered in the DGH, rather than in a mental hospital, was more vulnerable to budgetary reductions, which were then beginning to affect both the NHS and social services. On the other hand, it was being suggested (Simpson, Hyde, and Faragher 1989) that many DGH units were, in fact, unsuitable for patients with long-term problems because they might suffer from the proximity of acutely disturbed cases, absence of privacy, deflection of staff attention to short-stay cases, and lack of appropriate facilities for rehabilitation.

Although government policy on mental hospitals remained overtly unchanged—that is, they were not to close until an adequate alternative service for the local population was in place—it became clear that there were few financial savings from having a reduced, as opposed to a closed, institution. It was argued that the fixed assets of mental hospitals were underexploited, even though the real needs of patients were often not being met there. Therefore, both financial constraints and ideological pressure hastened the rate of closure. This process was further accelerated by an administrative reorganization of the NHS in 1984, in which consensus management (where health professionals were influential) was replaced by executive general managers. To some extent, there was a parallel with the two distinct phases described in the U.S. deinstitutionalization process: a "benign" phase (lasting from 1956 to 1965), in which new admissions were discharged earlier and better-functioning, long-stay patients were resettled; and a "radical" phase, when occupancy was drastically reduced in response to financial pressures (Morrissey 1982). In Britain, as a result of the major changes in 1989, the resources of DGH units began to be steadily reduced, a trend that gathered momentum during the early 1990s.

By the end of 1993, 89 out of the 130 mental hospitals that existed in England in 1953 had already been closed and the total number of psychiatric beds was a little over 50,000 (Kingdon and Freeman 1995). However, because one of the changes of recent years has been the dismantling of many information systems relating to mental health services, data describing the current situation are difficult to obtain. Davidge et al. (1993) claim that "the actual number of places available for the mentally ill has remained little changed" over the past decade, with "some 80,000 beds of one type or another" in England. This is because "the 'loss' of beds in large hospitals has been matched by the provision of alternative places in smaller NHS hospitals, local authority accommodation and private hospitals and homes [plus] an unquantified level of provision in various housing schemes which do not appear in official statistics." However, a place in a "bed and breakfast" hostel, operated for profit by an unqualified person, can in no way be equivalent to a bed in a fully staffed hospital with a wide range of facilities. Yet, to a significant extent, the first had replaced the second. The closure of Friern—a large mental hospital in North London—has been intensively studied (Leff et al. 1994): over 80 percent of the inpatients were resettled in the community; the remainder were transferred to another hospital. So far, this

community reprovision has been generally successful, but its cost has been very high, and the extent to which these conclusions from a demonstration project could apply elsewhere remains uncertain. In fact, no general statement can be made about the condition of mentally ill patients placed in noninstitutional settings because the relevant information is unobtainable. A survey in one coastal town, however, produced disquieting results (Barnes and Thornicroft 1993).

The NHS and Community Care Act of 1990 requires local social service and health authorities jointly to agree on needs-based individual care plans for long-term and severely ill psychiatric patients. For each person, a case manager (later renamed "care manager") is to be nominated in order to ensure that patients' needs are met as fully as possible. This change had been largely provoked by the unplanned rise in social security payments for care of the elderly (often with dementia) in private nursing homes. From 1993, the responsibility for payment was transferred from the national social security budget to local social services; the local authorities were given some money to provide for the elderly, but then had to balance this task against all their other responsibilities, including care of the nonelderly mentally ill. Whereas social services had previously owned and operated their own residential facilities (including those for the mentally ill), they were now expected to change their function steadily to that of a purchasing agent. The consequences of this change will not be fully known for some time; it seems to be—like many policies—one that would work reasonably well if adequately funded, but that will likely fail because it is being introduced without these resources (Thornicroft 1994). In one mixed industrial-rural area in the Midlands, however, the combination of DGH and community services was said to be coping well and was not under serious strain (Groves 1994).

The rate of change in British health services during the past ten years has been dizzying, as it has been in social services, education, and many other aspects of national life. Yet, as seen in the United States rather earlier, organizational changes appear to have been "hurriedly put into place . . . poorly conceived, improperly implemented, and ineffectively administered, without any systematic attempt to assess their impact" (Rossi and Freeman 1993). NHS services are now mostly provided by self-governing "trusts," with fixed budgets, in which provision is altered for financial reasons, irrespective of patients' needs. District health authorities have become the purchasers, but no longer the providers, of services for their populations—the same purchaser-provider split that

has been imposed on social services. Similarly, groups of GPs ("fundholders") are now purchasing all specialist care for the patients on their lists; they can make a choice in the kinds they buy, which will not necessarily be to the benefit of patients with more serious psychiatric disorders. The long-term effects of this "internal market" are almost impossible to predict, but its commercial ideology seems inappropriate to either health or social care. The results of 40 years of progress toward developing an integrated mental health service for each population have been jeopardized by a fragmentation into independent units, each of which is negotiating and bargaining with all the others, theoretically on a basis of "competition." Sir Douglas Black (1994) describes the intrusion of an internal market and the split between purchasers and providers as "unnecessary threats to the cooperation towards a worthwhile common purpose which was a hallmark of the NHS."

Mental health services have been affected both by the overall changes in the NHS and social services and by specific measures affecting psychiatry; these two pressures have not always been consistent (Davies and Peck 1994). In the first place, while district health authorities have to purchase services for population-based needs, fundholding GPs (who are to become the majority) have a strong incentive to obtain the cheapest care for individual patients. One way of doing this is to employ psychiatric nurses or counselors themselves, rather than refer patients to the district mental health service. This runs directly counter to the government's declared policy for mental health services: to concentrate on the severely mentally ill and work through multidisciplinary teams. A similar discrepancy occurs between health authorities (with their community responsibilities) and social services, which are obliged to purchase residential or day care on an individual basis. Furthermore, the whole philosophy of this contracting process was predicated on the model of single episodes of inpatient care, like elective surgery, whereas in psychiatry, the episodes are often impossible to define, the outcome is complex, and treatment methods are controversial. The "reforms" have been responsible for a massive inflation of management costs (which in the unreformed NHS were the lowest in the world) without real evidence up to now of clinical benefits or increased productivity (Light 1994). When all purchasing authorities in one health region were asked about the plans for child and adolescent mental health, they were found to have very limited knowledge of those services and to have made little or no attempt to

set standards of quality or to monitor what was provided (Vanstraelen and Cottrell 1994).

Can all the functions that were served by the mental hospital be reproduced outside of it? The House of Commons Health Committee (1994) identified 15 functions of old psychiatric institutions; some of these (food, clothing, basic income) have become the responsibility of social security, while others (assessment and treatment, outpatient care) have mostly been transferred to the DGH. Long-term care for the mentally retarded and the management of forensic cases have been absorbed by specialized services, although the latter are very inadequate. However, functions such as respite care, asylum, shelter, recreation, "a social world," and occupational rehabilitation, while notionally the responsibility of local social services, have ceased to exist in many places. In the committee's view, the mental hospital achieved real economies of scale, "offset by the lack of independence, choice, privacy, and individualised care for patients." The committee could have added that the stigma of an identifiably psychiatric institution was a strongly negative feature for many patients and their relatives. They concluded that an acceptable mental health service should provide functions similar to those of the old institutions—with some new ones added—but it should do so in a different location and style.

Bachrach (1984) warned Britain against underestimating the diversity of services needed to replace psychiatric institutions because "the problems of using the same community facilities for new and old long-term patients came as a disruptive and expensive surprise in the U.S." The fall in mental hospital beds in the United States was matched by a considerable growth in psychiatric care in general hospitals, although some of this increase may have been only apparent, a result of changing diagnostic practices. More recently, associated with the rise in managed care arrangements, the use of inpatient beds has been much reduced, "but this shift of patients has occurred because of cost-containment objectives, and outcome or effectiveness [has] been poorly considered" (Sharfstein 1994).

Conclusion

This account leads to the conclusion that general hospital psychiatry has only a limited meaning in isolation, not least because psychiatric disor-

ders have a strong tendency to chronicity. It is increasingly recognized that the treatment of major depression, for instance, may not be a matter of weeks or months, but, rather, possibly of several years (Kupfer 1993). Within this period, only a fairly short time may be spent as a hospital inpatient, but if the management is to be effective, the episode of full-time care must be integrated with outpatient care, possibly with day-hospital attendance and/or home supervision, and certainly with long-term oversight by the GP. Furthermore, unless the DGH unit has alternative placements (hospital–hostels, staffed hostels, medium-secure units) for those patients whose chronic disabilities or disturbance prevent them from going out without risk, it will often be impossible to admit people with acute illnesses because beds will be permanently blocked. In those circumstances, no one will gain admission unless he or she is in such a state of disturbance as to constitute an immediate danger to themselves or others, and, afterwards, the person may well be discharged before it is clinically advisable. A survey by the Royal College of Psychiatrists (1994) of inner-London psychiatric units revealed this to be the situation now; they were running at an average capacity of 111 percent. Even if the nondisturbed, such as patients with severe depression, should actually gain admission, the ward environment is likely to be very unsuitable for them. One of the main underlying problems has been the national failure to provide beds in medium-secure units on the scale advocated by expert reports over many years; patients with "challenging behavior" therefore occupy acute beds inappropriately for very long periods.

Just as the growth of private madhouses was beyond the monitoring capacity of eighteenth-century governments, so the recent housing of mentally ill people in thousands of settings throughout the country presents an impossible problem of supervising standards. In the 1960s and 1970s, "scandals in mental hospitals" were influential in discrediting large institutions in Britain, notwithstanding that almost all of these cases involved mentally retarded or psychogeriatric, rather than psychiatric, patients. What was generally overlooked in this connection, however, was that such situations were discovered and remedied because there was a manageable number of hospitals and a functioning system of inspection. Yet the more the system fragments, the more difficult this task becomes, and it is now clear that health and social service authorities mostly lack the resources to do it (Royal College of Nursing 1994). As Turner-Crowson

(1993) points out, "Noninstitutional systems tend to be poorly defined, fragmented, and vulnerable to adverse change."

Perhaps general hospital psychiatry has always contained an inherent flaw, in that it was designed essentially for the management of acute illnesses. If it includes the resources to cope also with the most severe chronic disorders from a sizable population, its capacity might approach that of a small mental hospital—as some of the Manchester region units did in the 1960s, and as many now do in Germany (Bauer 1994). But is this simply a reinvention of the mental hospital, sharing a common site with the rest of medical care—as proposed in McKeown's "balanced hospital community"? Thornicroft and Strathdee (1994) propose that "the debate on numbers of hospital beds should now be widened to include the contributions of agencies other than health providers, such as social services, housing, and voluntary agencies, which substantially reduce the need for inpatient care." How far that need can safely be reduced, however, remains undetermined. The latest government document on mental health policy (Department of Health 1993) recommends adding "user-friendly" alternative sites to the DGH (mental health centers, hostels, ordinary housing) for much of acute psychiatric care and long-term residential care arrangements. This represents a fundamental change from the predominant national assumption of the last 30 years that the DGH unit would serve as the base from which other mental health provision would take place, yet the evaluation of nonhospital acute care has so far reached only a preliminary stage. Analysis of the work of psychiatric services is hampered by the fact that most data "are based largely on paradigms derived from analysis of medical and surgical services that do not reflect the nature of mental health care" (Flannigan et al. 1994).

Two further problems in this reorientation away from hospitals do not seem to have received adequate attention. When an institution-based service is changed to a locally based one, it has been recognized that resources seem to drift away from the care of people with the most severe and chronic disorders and toward services for those who are neurotic and plagued by personality and relationship problems. Avoiding such a tendency requires the "clear setting of goals and monitoring of the extent to which they are reached" (Turner-Crowson 1993), and it is not clear that this is being done in Britain. Secondly, this policy also seems to overlook the enormous progress made recently in biological psychiatry; investigation or treatment along these lines can only take place in

a setting closely allied to general medicine, that is, the DGH. Because the DGH, with its high levels of technology, almost always has the first claim to resources, moving psychiatry to "community settings" would seem very likely to give the mentally ill a worse deal. At the very least, they deserve as much access to the facilities of the general hospital as other patients.

It seems unlikely that many mental hospitals will still exist in England by the end of this decade, except in vestigial form. Therefore, anyone needing acute treatment and care for psychiatric disorder of at least moderate severity should have immediate access to a general hospital unit that is equipped with appropriate facilities. The extent to which cases previously thought to need admission (Leff 1985) can be satisfactorily managed in other settings should be fully investigated before beds are further reduced. Relatively small numbers of people with severe, chronic psychoses will need to be under the full-time care of professional staff, but in units that do not need to be on a hospital site; an American estimate of these numbers was 15 per 100,000 population (Gudeman and Shore 1984). Those with less severe chronic disorders can be accommodated in settings with varying degrees of support, from staffed hostels to their own homes. For every district population, there needs to be an integrated management and information system to ensure that patients are not neglected, their families do not have to carry unreasonable burdens, and the community is not exposed to unnecessary risks. The extent to which this scenario can be achieved in Britain remains very uncertain at present.

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