

Findings show that 14% of patients leaving both hospitals since 1985 were readmitted in their first year of follow-up, 80% of the costs of community care go on accommodation and the social contacts of long-stay patients remain non-verbal. After discharge there were no significant changes in social behaviour, clinical symptoms, social networks or domestic skills. Figures for deaths, imprisonment, violent incidents and vagrancy are recorded. Younger chronic (new long-stay) patients are accumulating in hospital at a rate of about six per hundred thousand of the population per year. Many patients over 70 at Claybury Hospital who were functionally ill also have severe cognitive disability. The research confirms that treatment in psychogeriatric wards is determined by severe behaviour problems.

In the second year after discharge patients showed some improvement in symptoms, fewer readmissions, a slight improvement in social behaviour but a decrease in activity. Two-thirds want to stay in their new accommodation.

A small group of patients (6%) cannot be accommodated in locally based facilities.

The financial conclusions are prefaced by the statement that it is not known whether cost differences between hospital and dispersed settings are explicable in terms of *efficiency* or *neglect*.

The social network schedule is an intriguing attempt to quantify patients' social contacts systematically but the schedule could only be completed on 489 out of 775 patients.

Whether patients with long-term mental illness can become *socially* integrated into a community remains problematic.

The TAPS reports, conferences and investigations are vital. The data clarify some of the problems associated with mental hospital closure and alternative provision for psychiatric morbidity. The research process is both a safeguard and in some cases therapeutic. The possibility remains that figures about satisfactory outcome may depend on researchers' attentions.

The importance of different social interactions, the hint at increased inactivity, and the clarification of the accumulation of new long-stay patients each indicate that alternative provision remains an extremely complex undertaking.

The principles underpinning the NHS and Community Care Act are consistent with the least restrictive alternative for individuals disabled by mental illness. In practice the funding, and responsibility for services may still militate against psychiatric expertise keeping in touch with psychiatric morbidity. The TAPS study helps greatly to inform the debate.

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#### **Whose Service is it Anyway? Users' views on co-ordinating community care.**

Edited by M. Beeforth, E. Conlan, V. Field, B. Hoser and L. Sayce. 1990. Pp. 40. £4.50 plus 50p postage & packing. Obtainable from RDP, 134-138 Borough High Street, London SE1 1LB

Over the past few years a reasonably sized and significant literature has built up on users' views and users' involvement in planning, developing and running psychiatric services. This booklet specifically addressed community care.

*Whose Service is it Anyway* is the product of listening to users describing what they want and expect. For example, the Brighton Users' Charter is described and this was purely the product of users of a local psychiatric service in Brighton. Topics covered include quality of life, users' involvement and empowerment, organisation and management, information, education and training, joint planning, and a final section entitled 'Conclusion' with a sub-heading of 'towards a redesigned mental health service'. A reasonable bibliography is provided and there is also an appendix on users' organisation.

I doubt if many people would disagree with most of the things that are said, though many would disagree with some. Unfortunately, the type face used is such that it is extremely difficult to read the document. I found it unpleasant, as did two of my colleagues, though we all managed to read it from cover to cover. The general layout is excellent and it is sad that nobody thought that the type-face used was not the best for communication and certainly not the best for communication with us older citizens!

Many professionals have expressed similar views to the consumer contributors to this publication and it is reassuring to find that what some of us thought was right is also what the customers want. The sad irony of it all is that in the present Health Service, with its emphasis on the magic of management and the need for managers to manage, there seems little place for the views of anyone, be they professionals, other employees or customers. For example, professionals have been repeatedly told by senior management, when there has been criticism of the reorganisation of the Health Service, that it is too complex for us to understand and hence our criticism cannot be taken seriously. They are doing to us what they accuse us of doing to patients!

Health Service newspeak consists of talking of choice and meaning 'no choice', emphasising user involvement and meaning 'no involvement'.

In summary, *Whose Service is it Anyway* spells out beautifully the why and how of user involvement in providing a proper, effective service but, to me, has

come not at the most auspicious moment in the long continuum of Health Service change.

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**The Development of Mental Health Care in Primary Health Care Settings in the European Region. Report of a WHO Working Group – Lisbon 1989**  
Copenhagen Regional Office for Europe, 1990,  
Pp. 26

It is very difficult to produce a report on an international discussion which drives home one or two important themes in a memorable way. One successful example is in the 1973 report *Psychiatry and Primary Medical Care* (WHO Regional Office for Europe), characterised by these sentences:

“The crucial question is not how the general practitioner can fit into the mental health services, but rather how the psychiatrist can collaborate most effectively with primary medical services . . .” and “The primary medical care team is the keystone of community psychiatry.” (page 27).

The present report, from the same office, covers the same ground. The emphasis is a little different, being especially upon the relation between mental health services and primary services. This working group aimed “to review the extent to which mental health care in primary health care settings, at district and local level, has been fostered throughout the region”; “to make recommendations for further strengthening”; and “to draft indicators for monitoring and evaluating these developments”.

The report scarcely touches on the first aim because the text repeatedly veers off into discussion about how things *should* be done rather than reviewing what developments have actually occurred. It concludes that there has been a significant change, but the few allusions to local examples are expressed hesitantly and without references (one statement about the United Kingdom is misleading).

On the third aim, “the group did not feel prepared to suggest a list of indicators . . .”.

Most of the report therefore relates to the second aim. The most coherent and interesting section is about the primary care team. The two recommendations for member states (page 20) urge action by both government and workers at all levels to promote closer collaboration and more effective integration between the systems of primary health care and mental health care. But among the conclusions (pages 14 and 15) are two which imply that this working group did not wholly subscribe to the sentences quoted above from the 1973 Copenhagen report.

This is not surprising since the group included no member actively engaged in any primary care team.

The report is not a notable landmark.

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**A County Lunatic Asylum: The History of St Matthew's Hospital.**

By David Budden. 1989. Pp. 123. £4.95 (including postage). Available from: D. W. Budden, Staff Pharmacist, Pharmacy Department, St Matthew's Hospital, Burntwood, Walsall, West Midlands WS7 9ES

This account of a Midlands Asylum opened in December 1864 is of more than local interest. The author has carefully studied the archives and has brought alive, at least for this reader, the sight, sounds and smells of asylum life in the 19th century. We are reminded that in those pre-pension days Medical Superintendents had lengthy reigns. This history of St Matthew's Hospital is dominated by the Superintendency of Dr James Beveridge Spence, who finally retired in 1924 at the age of 75 having served for 53 years.

The class-ridden attitudes of Dr Spence and his managers reflected those of their peers. He wrote in his annual report for 1883: “The association of paying patients, who while in good health occupy a respectable though comparatively humble position in life, with those of the fellow townfolk of a lower class, has often proved detrimental to the former. . . . Relatives are put off sending the patient to the Asylum owing to the dread of social contamination”. The repressive Victorian attitude to sex can likewise be traced in these pages. The Commissioners in Lunacy noted in 1892: “We were glad to learn that no male artisan, or indeed anyone except the Medical Officer, have keys admitting them to the female side”. The Superintendent's control over staff's sexual mores lasted well into this century. In 1917 Dr Spence reported, “I have had an application from the Head Attendant to marry the Head Nurse. Personally I see no objection to the arrangement if the Committee approves”. It was not until three years later that the Conditions of Service for Assistant Medical Officers came under review: “there should be no question of the man having to ask permission to marry”. Dr Spence's successor in 1944 reported to his Committee that a woman employee “was pregnant and had refused to tender her resignation. It was resolved that one month's notice be given”.

Budden colourfully records the ‘entertainments’ that formed such a key part of the moral, as opposed to medical, treatment. In 1886 Dr Spence noted “the formation of a band among the attendants upon