group of the College. Forensic psychiatry, the application of psychiatry to the purposes of the law and the administration of justice, is a different and separate entity. In recent years voluntary agencies for mental health, for instance, MIND, in its publications, and the new Mental Health Act Commission, have emerged as taking a lead in seemingly paying more attention to the legal aspects of psychiatry than the College.

There would appear to be an opportunity for the College to fill the gap and to take the initiative with the establishment within the College of a special branch to develop studying experience, expertise, information and advice in the legal aspects of psychiatry, perhaps drawing in the collaboration of the Medical Defence bodies, the Mental Health Act Commission and voluntary health organisations.

DOUGLAS A. SPENCER

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Leeds

National Demonstration Services

DEAR SIRS

Members of the College may know that the DHSS has designated eight psychiatric rehabilitation services as National Demonstration Services (Hollymoor, Prestwich, Nottingham, Northampton, St George's (Morpeth), the Maudsley, Netherne and Southampton).

The co-ordinators of these National Demonstration Services met last summer and produced a joint statement expressing deep concern about the impact of management changes and financial stringency on services for the chronic mentally ill, despite Government commitment to giving priority to these services.

The co-ordinators see the problem as arising at Regional level where, despite all protestations to the contrary, the run-down of mental hospitals has become a primary objective dictating the extent and pace of resettlement in the community.

This detailed statement was forwarded to the National Health Service Management Board on 26 August 1986 and we are concerned that to date, it has not even been acknowledged. We feel that the issues are of concern throughout the psychiatric services and we ask you to publish the statement to bring it to the attention of members of the College.

BRENDA MORRIS

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STATEMENT ON PSYCHIATRIC REHABILITATION AND CARE IN THE COMMUNITY

To The NHS Management Board

From The Co-ordinators of the National Demonstration Services for Psychiatric Rehabilitation

Psychiatric services are facing considerable problems during this period of change in the National Health Service linked with financial stringency. Services for the chronic mentally ill are affected in various ways and even some of the National Demonstration Services for Psychiatric Rehabilitation report problems in maintaining their services in spite of their reputation for excellence.

1. *Nature of specialist rehabilitation teams and National Demonstration Services*

National Demonstration Services for Psychiatric Rehabilitation were introduced by the DHSS in 1981. It was a condition of desigation that they should be nominated and supported by their local District and Region. As models of good practice, part of their function is to provide an advisory, planning and education service to their Region. Their designation was based on evidence of a commitment by a skilled multi-disciplinary team to looking after the interests of people with chronic psychiatric disabilities.

Effective, economical and efficient services are hallmarks of the National Demonstration Services and are consistent with the aims of General Management. The National Demonstration Services are an invaluable resource to Management (particularly at Regional level) in the planning and delivery of services and should lead the way in showing how rehabilitation can be provided effectively to the benefit of patients and thus to the Health Service. The NHS Management Board will want to encourage full use of these valuable resources.

The educational value of these services to managers and clinical teams deserves recognition. For example, there is a myth that rehabilitation is a 'once and for all' phenomenon, i.e. that once patients are 'rehabilitated' they will stay well and function independently for many years. It is quite clear that this is not the case without considerable care over a long period and in many cases for life.

There is another myth that rehabilitation is only related to the closure of mental hospitals and has no place in a community-based mental health service. It is worth stating that psychiatric rehabilitation services have a vital role in reducing the disablement of people with chronic mental illness and thus their dependency on the NHS and other welfare services. Nevertheless, people with chronic disabilities will continue to need substantial support. The most disabled will still require prolonged hospital treatment and care. Regional objectives for mental health services will only be met if rehabilitation services are strengthened and given proper resources so that they can proceed with their task expeditiously.

An effective rehabilitation service depends on a trained specialist multi-disciplinary team whose members undertake a long-term, full-time commitment to a population of chronic patients who present recurring or continuous clinical and social problems. Such services also rely on the development of chains of linked occupational, residential and leisure-time provisions, which are properly co-ordinated and which include a comprehensive view of the patients' disabilities and assets at different times and which permit easy movement of patients through different levels while maintaining continuity of care.

It follows that adequate liaison between the team and the statutory (e.g. Health, Local Authority and Employment Services) and voluntary bodies has to be actively main-

tained since it has been shown that poor liaison leads to high levels of relapse and hospital readmission.

The development and survival of voluntary provisions depends on strong back-up support from the rehabilitation team. Assurances that rapid and effective assistance are available as required should be given to patients and their families and carers. Without them maintaining people in the community will be jeopardised.

2. *Problems related to closure*

Our considered view is that despite all declarations to the contrary the run down of the large mental hospitals has become a primary objective, dictating the extent and pace of resettlement in the community.

It is assumed by Regional and District Officers that many patients still in the large hospitals are merely institutionalised and homeless, needing only 'normalisation', when it is known to professional staff involved that those remaining in hospital after years of rehabilitation endeavour are severely ill and/or highly dependent. Thus the amount of care needed has been considerably underestimated.

The policy of funding community care from savings made by closing wards and ultimately hospitals means delay in community care developments. Failure to maintain and improve the fabric and staffing of wards will condemn remaining patients (and staff) to a deteriorating environment. This is unacceptable. Restricting staffing and other resources in rehabilitation services is counter-productive. Authorities should realise the need to run dual services during a period of transition.

Pressure from Regional Authorities to run down mental hospitals quickly will lead to patients who could have been rehabilitated to a higher standard of self sufficiency being discharged to more sheltered (and more costly) accommodation than is necessary. They will have less freedom of choice and independence than they are potentially capable of achieving and at worst may simply go from one institution to another.

Similar pressure for haste will lead to patients and their relatives having little say in plans for their future both in terms of the type of life style on offer and in the choice of companions to share it with.

In many regions there has been inadequate consultation between the Regional Health Authority and Directors of Social Services. The Health Authorities accept that many discharged patients will require multi-disciplinary support and residential nursing care, whilst the Directors of Social Services are assuming that all patients living in the community will be their responsibility and adequately cared for by residential officers in charge and care assistants. Proper negotiations and jointly agreed plans based on an adequate assessment of individual and groups of patients should take place before there is any large scale transfer to the community.

The use of the private sector is widely advocated by the government and currently partly funded by DHSS benefits. Such arrangements are vulnerable to changes in funding policy and to the instability of market forces. The interests of clients involved must be protected.

3. *Problems of manpower, organisation and management of rehabilitation and community care services*

As already stated, an effective rehabilitation service depends upon a trained multi-disciplinary team. It is important that each health district should have such a team including a consultant psychiatrist with special responsibility for rehabilitation. The size and nature of this team should be related to the needs of the district served *and not to hospital beds*. This team should be able to advise on the development of services locally for the long term-mentally ill. Without such advice services may well develop on an ad hoc basis and may be out of touch with the real needs of the client group served.

Whilst recognising that in those districts that have sectorised mental health teams the needs of many 'long-term' patients will be met by them it is clear that given the competing nature of the more acute clientele the needs of the longer-term patients may be forgotten.

If such a very vulnerable group of patients are discharged into the community, they are more likely to relapse than the general public. They may require admission, not to long stay wards in the parent hospital as they may have dispersed, but into beds which have been identified for this purpose. Other back-up facilities in the community are needed to provide support and advice to families and other carers who nowadays bear the burden of Care in the Community.

Staff training which may foster a future commitment to rehabilitation work is dependent on the integrity of a central rehabilitation service, as outlined above. This important time in the development of community care requires at least the continuation if not even the increase in training but the reality is that, in the experience of the National Demonstration Services, training budgets are being reduced or being suspended. This seems shortsighted.

Problems with manpower targets often mean that there are not sufficient staff to carry out rehabilitation tasks. Further, there are insufficient training places for consultants with specialist responsibility in rehabilitation, for occupational therapists and also for clinical psychologists. This seriously affects the effectiveness of the teams.

4. *Problems of long-term needs of patients in the community*

As mentioned previously, even when patients are successfully resettled in the community they may have long term needs which are legitimately the concern of Health Authorities. People may well develop further psychiatric or other health problems which accentuate their need for psychiatric support. There must be a mechanism for long-term support and review of needs for as long as necessary—in some cases into advanced age. Some may require an increased level of care with implications for both the variety and number of Social Services residential and day facilities. Further resources which may be required include meals on wheels, home helps, home carers and incontinence aids. These

requirements will further strain already tight Social Services budgets with the inevitable consequence for the Health Service.

Consideration must also be given to the needs of people who will develop severe disabling psychiatric conditions in the future. New patterns of services must be able to cater for their needs within the rehabilitation concept. There will be a continuing need for the expertise of rehabilitation teams.

Research evidence suggests that chronically ill people can lose touch with services; this is a particular danger in the private sector providing residential accommodation. There is consequently a responsibility on Health Authorities to devise systems that ensure that people are kept in touch with services so that their needs are being reviewed from time to time and that these needs are met.

5. *Cost of community care*

Ministers' policy statements have consistently made clear that Care in the Community should not be construed as a money saving exercise. They are on record as saying that a good quality community based service will cost more than the traditional institutional service.

Unfortunately this is not a message that reaches service providers locally nor for that matter the public at large for whom Care in the Community has come to be associated with cuts. Our experience as National Demonstration Services sadly bears this out.

In spite of the priority status given to Mental Health by Ministers efficiency savings generated in many district mental health services have been diverted by management to the general medical sector, for example, to cover their overspending on drugs.

Another area of lack of clarity between local practice and national policies is the necessity to maintain adequate hospital facilities until suitable community facilities are in place. This clearly entails dual provision for a period of time which means extra money. Whilst some regions have created adequate mechanisms to bridge, amazingly others haven't! The reality at district level in some places is that the provision of new services has to await the closure of existing ones. This provides ammunition to the critics of Care in the Community and delays the achieving of regional objectives.

Conclusion

As people professionally committed to the success of Community Care we are concerned about these problems. Our statement arises out of our lack of confidence in regional plans for developing Community Care and we are afraid that this policy might founder during this period of financial stringency. We would earnestly request the NHS Management Board to devise means of resolving these difficulties.

Co-ordinators

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Dr Arthur Robinson, Consultant Psychiatrist, St George's Hospital, Morpeth, Northumberland

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August 1986

'Human Psychopharmacology'

Human Psychopharmacology: Clinical and Experimental, a new international journal, was launched by John Wiley & Sons last autumn. It aims to communicate the results of clinical experimental studies relevant to the understanding of new and established psychotropic drugs. Papers will be published on experimental human psychopharmacology, volunteer studies, the results of efficacy studies, especially large-scale and placebo-controlled trials, and research findings of the effects of psychotropic drugs on various physiological systems, including unwanted effects. Animal studies, if they are relevant to human psychopharmacology and the theoretical background to the work is given in such a way as to give clinicians more insight into work in the laboratory, will also be published. Other subjects will include substance abuse and dependence as well as historical, ethical, psychological and social aspects of psychotropic drug use, misuse and abuse. It is aimed to publish papers within three to six months of final acceptance. Further information can be obtained from: Dr J. Guy Edwards, Editor-in-Chief, 'Human Psychopharmacology', Department of Psychiatry, Royal South Hants Hospital, Southampton SO9 4PE.

The Radical Jewish Health Group, a forum for Jews in the caring professions looking at mental health issues from a Jewish perspective, will be holding meetings on 18 June 1987 at 8.15 p.m. (Marlene Cohen, Senior Practitioner and Co-ordinator of the Jewish Mediation Service at West Central, on 'The Jewish Family Mediation Service—Meeting Community Needs') and on 16 July at 8.15 p.m. (Norma Brier, Ravenswood Foundation, on 'Mental Handicap—the Need for a Jewish Service'). Further details and venue: 01 341 1536 or 01 328 9440.