needs to be provided for doctors and other workers likely to encounter these patients. Self-help organisations, such as the Amity groups, should be encouraged. Suicide is an eminently preventable cause of death, and we believe that prompt intervention and accurate assessment of the situation may save lives.

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Requests for reprints to: Dr M W P Carney.

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Contemporary Themes

Long-stay care for elderly people: its continuing evolution

J S RODGERS, J A MUIR GRAY

The recognition that the changing age structure of society, with an increasing number of old and dependent people, will pose one of the major problems confronting social policy for the next 20 years has come lately to the public conscience. Even now it is an issue acknowledged more in the proclamation than in action at a national level, whether by government or by professional bodies. And yet services are inadequate, and the problems that ensue are on us.

The inadequacies are most apparent in institutional care, the two major issues being those of misplacement of people and the gaps between the types of provision. Both relate to former philosophies that underpin the provision of hospitals and of old people's homes. There is an adherence to roles that grew up many years ago, and which have never been revised.

In institutional care people are either residents or patients. In each case there are expectations about how they will behave, what they will demand, and, especially, how they reinforce the part staff expect them to play. If the old people do not conform to the correct image they are judged misplaced. In geriatric hospitals there are many patients who should be residents, or at least who should be elsewhere; in old people's homes there are residents who should be patients in hospital, while in both there are those who should be in psychiatric hospitals, inevitably the resources in shortest supply. The spheres of each type of institutional care overlap considerably, while each institution describes for itself a well-defined boundary that is not contiguous with any other.

This demarcation also creates gaps, into which fall the "too fit but too frail," too fit to be in hospital but too frail for an old people's home. An individual so identified is not thought to require the resources and skills of a hospital, but because of physical or mental disability is beyond the responsibility of the old persons' home.

Why should this have come about? Services for old people have been provided by the State for many years. Is it not reasonable to suppose that the roles of institutions should have

been redefined with some common purpose? This certainly has not happened, while the current emphasis in national policy, towards community care, has paradoxically highlighted the need for such a step. Domiciliary services have expanded, and steadily improved both in quality and quantity in order to keep people at home. When this is no longer possible, the old people concerned have reached such a level of dependency that they do not fit into either of the two main types of institutions. Add to this the equally praiseworthy move of hospital care towards rehabilitation, away from asylum and long-stay care, and the central issue is magnified, and continues to grow.

All this is the end result of many years of pragmatic policy-making, during which the least desirable have been excluded from the system. At first, the "incurable" were excluded from the voluntary hospitals¹ and had to be looked after in workhouses. Then the disabled, or the difficult and thus less deserving, were segregated into workhouse infirmaries,² where they languished. Neither the disappearance of the boards of guardians in 1930,³ nor the involvement of the wartime emergency medical services, changed this. In 1947 people were still sent to the workhouse infirmary if they failed to conform.⁴

Pushed always to the end of the line, out of sight, the disabled elderly might have expected a change in fortune in 1948 with the advent of the National Health Service. Even then they were forgotten. The rapid dismantling of the old system demanded easy dividing lines; those in wards looked after by "nurses" became the responsibility of the hospital service, while the rest of the workhouse residents were to be looked after by the new old people's homes, provided by local authorities and envisaged by Aneurin Bevan as providing the working-class equivalent of the residential hotels much beloved by the middle classes in the '20s and '30s.⁵ Appropriate levels of care or types of resident to be admitted were not defined. Nursing care, whatever that might mean, became the criteria for allocation to the Health Service. Personal care in the local authority home was to be provided only to the level that a relative would provide in one's own home.

This definition remains to the present day. It was last emphasised by DHSS in 1977 in the Purple Book on residential care.⁶ Despite almost 30 years, the respective roles of hospitals and old people's homes had not been reexamined, while the problems multiplied. The attitudes of the nineteenth century seem to have been implanted in the policy makers of today.

Oxfordshire Area Health Authority (Teaching), Headington, Oxford OX3 9DZ

J S RODGERS, MB, FFCM, community physician
J A MUIR GRAY, MD, MFCM, community physician

New institution or a new pattern?

The Government is now trying to introduce new ideas to solve some of the problems—for example, the NHS nursing home and very sheltered housing—but in our opinion any attempt to fill gaps or to reduce overlaps needs a new pattern of services, not another institution. *Care in the Community* perhaps marks the opening of a new era, suggesting as it does that such a new pattern would be politically acceptable to the DHSS.

To obtain an impression of the ways in which different health and local authorities were trying to tackle the problems we sent a questionnaire to every social services department in England and Wales asking for details about their residential services for elderly people, particularly for those who caused the types of problem described above—"the too fit but too frail," or "the hard to place."

Method

The questionnaire asked directors to say if they made special residential accommodation for physically disabled or confused old people, to supply information about this, and to give views as to the priorities for future developments. The definition of special provision was left to each department. Directors have no difficulty in recognising whether they separate or mix together the very dependent with other residents. Information was also sought about special sheltered housing schemes and opinion on the adequacy of the local health service for geriatric or psychogeriatric care.

Results

Replies were received from 103 of the 116 social services departments in England and Wales. Seven of these declined to complete the questionnaire while the City of London makes no provision of its own. This leaves 57 authorities who do provide some special accommodation and 38 who do not. The range of provision is shown in table I. There is little overall difference between the two groups.

Most authorities pay for residents in voluntary or private nursing homes. Nearly all do this for people with certain special requirements, as discussed below. If these places are taken into account the level of provision is increased, but there is still no major difference between the two groups of authorities.

TYPE OF PROVISION

Table II shows the type of accommodation provided by the "specialist" authorities. Fifty-three provide for the elderly mentally infirm and 18 for the physically handicapped, although a further authority maintains all its homes as category A homes and thus accepts more dependent people. Only 14 authorities provide for both groups. In no authority is the level of provision for special groups high; in only seven authorities does it exceed 10% of the total number of beds, and of these, in only Stockport and Sutton, at 18% and 32% respectively, does it exceed 15%. The commonest type of provision is in specialist homes.

Although 38 authorities decided that they did not provide special accommodation, in three local authority areas all the homes are of category A, and at least one such home has been deliberately designed to accept confused old people; one authority has a home specifically for the moderately confused, and another groups confused people together wherever "family grouping" is practised within a mixed home. Thus only 33 authorities had no special provision of any sort.

TABLE II—Authorities making special provision: type of accommodation

	Separate home	Separate living in ordinary home (wings)	Both separate homes and separate wings	Not stated	Total
Physically handicapped	7	4	5	2	18
Elderly mentally infirm	31	11	10	1	53

SPECIAL RESOURCES PROVIDED: ELDERLY MENTALLY INFIRM

All those authorities providing special units for the confused have higher staff ratios per patient than do the ordinary homes. Ten have psychiatric nurses on the staff as deliberate policy and in one, West Glamorgan, these nurses are employed by the area health authority. Eighteen other authorities have regular visits from psychiatric nurses. Visits by psychiatrists, either as a regular routine or on demand, occur in 29 areas, while in others such a scheme has been tried and failed, or been planned but never materialised. Since only five authorities have contact with psychiatric nurses, but not with psychiatrists, it can be seen that in two-fifths of the authorities no specialist psychiatric help is available to assist in caring for what can be very difficult clients. All but five authorities do, however, have regular visits from a general practitioner.

In five authorities a clinical psychologist visits, either regularly or when required, to proffer help in the caring programme. In one authority this post is paid for by joint financing money, in another, Newham, the psychologist is employed by the social services department.

Apart from architectural design features that help with the care of the confused, in 36 authorities there is little additional specialist help. Two authorities describe visits by occupational therapists, in one of which the therapist works with the psychologist to design individual management programmes, while in another area a social worker for the elderly mentally infirm visits the special units.

PHYSICAL DISABILITY

The homes for people with physical disability have a similar level of specialist help. Five of the 18 authorities deliberately employ nurses on the staff, while many others have members of staff who are incidentally nurses, but who were not recruited specifically for this reason. In Stockport there is a home jointly run with the area health authority, which thus provides nursing staff. Three authorities have either a physiotherapist or occupational therapist on the staff, while a further six have regular visits from such remedial therapists. In six areas a geriatrician visits the special units regularly, while in most (15 of the 18 authorities) district nurses make regular visits.

AGENCY ARRANGEMENTS

A few authorities purchase private care to help in coping with difficult residents, but the general view is that the private sector is more choosy about whom they accept and are unwilling to tolerate disability, either medical or physical. Eleven authorities from among the special providers and the others deliberately use the private sector to supplement their own provision, especially for the confused client, while 10 as a matter of principle reject any use of private care.

VALUE OF SPECIAL PROVISION

Each director was asked about the value of special provision. Segregation was seen to be of greatest benefit to other residents, while

TABLE I—Range of provision of special care by 95 social service departments

	Places per 1000 population aged over 65							Places per 1000 population aged over 75							
	No	10-11	12-14	15-17	18-19	20-24	≥25	25-29	30-34	35-39	40-44	45-49	50-54	≥55	NS
Special provision	57	6	12	20	8	10	1	4	8	7	10	9	9	9	1
No special provision	38	2	7	13	7	7	—	2	2	2	8	8	6	5	4
<div> <div>Places per 1000 aged over 65</div> <div>Places per 1000 aged over 75</div> </div>															
Range: Special provision:	10.6-25.1							26.3-72							
No special provision:	10.7-23.4							27.4-62.2							

NS = Not shown.

the adverse effects of segregation was the principle reason other authorities gave for not making special provision. These opposites epitomise the dilemma that social services departments experience in trying to cope with increasing levels of dependency. The move seems to be towards segregation, however; one-third of the non-specialist providers are planning separate provision.

VIEWS ON THE HEALTH SERVICE

Among the possible reasons for not making special provision was that the Health Service should provide for very dependent old people. This was mentioned by half of the 38 authorities. In very few of all the areas, however, was the NHS making the sort of contribution that the social services department considered to be appropriate. Five local authorities (Bradford, Suffolk, Manchester, Salford, and Harrow) said that the local health service for old people, whether geriatric or psychogeriatric, was satisfactory. In four other areas community services were satisfactory but hospital services lacking, while in Newcastle upon Tyne the psychogeriatric service was said to be good, an accolade that was not awarded anywhere else in the country. Ninety-three of the 103 respondents thus thought the NHS to be wanting. Generally, the health service for the confused elderly was worse than that for the physically ill. One authority said that the local general practitioners did not know how to use even those sparse facilities that did exist.

SHELTERED HOUSING

The two groups of authorities differed little in the provision of special sheltered housing—that is, schemes where care assistant type help is given to residents rather than just warden supervision. Fifteen of the 57 (26%) authorities in the special provision group had such schemes, although the total number of “units” was only small, while eight of the 38 (21%) in the non-special providers had similar schemes. At least a further 15 of the remainder (21%) are planning special sheltered housing schemes, some of them via joint financing arrangements.

DEVELOPMENT

The final question attempted to disclose priorities for development, assuming that sufficient resources would be available. Included in the choice of facilities from which the directors were asked to pick three, in rank order, was an “NHS nursing home.” The covering letter explained this concept, which the DHSS is now sponsoring in a few selected health districts.

The four most favoured services were:

<i>Special providers</i>	<i>No special provision</i>
1 Domiciliary services in social services department	Domiciliary services in social services department
2 Special sheltered housing	Special sheltered housing
3 Psychogeriatric hospital beds	Psychogeriatric hospital beds
4 Day care (social services)	NHS nursing home

Discussion

Although the useful response rate was a disappointing 77%, the replies do show that almost half of all social services departments are taking deliberate steps to cope with the severely dependent old person for whom residential accommodation is now being sought. This appears to be a direct response to the pressures experienced, often apparently undertaken without any corresponding change in the local health service, as the low level of special help from psychogeriatric services shows. Social services departments are obviously interested in schemes that will diminish these pressures on residential care, as the development of special sheltered housing and the need for more domiciliary care within the social services field shows, but they are also trying to cope with the residents already in “care.” Many local authorities seem to be resigned to the Health Service’s

inability to cope and are solving the problems in the only ways possible to them.

In this respect the advent of the NHS nursing home does not offer much hope. The DHSS operational policy for such a home identifies it as a replacement for geriatric beds, rather than as a new element in care covering the no-man’s-land between health and social services. This will have no effect on old people’s homes, nor indeed on the total number of hospital beds; it is a different way of managing rather than a new resource. Even had it been otherwise, however, such a solution found little favour with social services directors. Improved domiciliary services form the highest priority, with improvements to the quantity of NHS provision coming next. The NHS nursing home is low in the priority lists, coming an individual first in only 10% of the returns, equally distributed between the special providers and the others.

What should we be doing? Are there any known routes that we can travel, or are the map makers also as lost as the rest? Do any old people need to live in hospital; could we not provide suitable alternatives, for once following Hegel and learning something from history and deducing principles from it?

There are maps, although for a different country. The care of mentally handicapped people is undergoing a quiet change, slowly dismantling both hospitals and hostels in a bid to help individual development, fostering and maintaining independence, within an overall set of principles. Similar principles can be produced for dependent old people, with similar goals. The following should form the basis of such guidance.

(1) No old person should have to live in an institution until it has been shown that he/she cannot manage with the full range of social services/NHS and voluntary domiciliary services.

(2) No old person should have to live in an institution until a comprehensive social and medical assessment has shown that nothing further can be done to reduce the level of disability.

(3) Care in an institution should be provided as close as possible to the neighbourhood where the old person has friends.

(4) Old people with specific problems, such as mental impairment, should not be segregated in separate institutions or buildings.

These are realistic objectives. Like tender plants, however, they need the right soil, which can be provided only by close co-operation and single-minded purpose between the Health Service and local authorities. This is suggested in *Care in the Community*,⁷ and, in the field of mental handicap again, is beginning to be acted on. Both Newcastle and Kent have devised joint approaches, merging separate responsibilities and control into a combined service for their intended clients. A similar step will be needed to care for the old. The survey shows just a glimmer of this, three or four directors enclosed joint planning reviews and statements with their returned questionnaire. Stockport is the authority most widely known to have taken this particular step, but others are following. Joint financing was mentioned by several as a means to oil the wheels, but the commitment must eventually be more than this, using both local and central revenue. The means and the examples are there; what is now necessary is the will.

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