BMJ

SATURDAY 18 NOVEMBER 1989

The future of Britain's mental hospitals

Some patients will still need long term care

Mental hospitals have been under threat throughout the world for the past 40 years. The possibility of closing these rambling, neglected institutions, deliberately built far from the cities they served, was created by the introduction of neuroleptic drugs. Chlorpromazine came into use in 1953, and within two years mental hospital populations began to fall after rising steadily in most industrial countries for 150 years. Initially the enthusiasm for early discharge and rehabilitation came from psychiatrists themselves, but in the 1960s other forces began to take over. A generation of sociologists convinced themselves that mental illness was a myth and the disabilities of those so labelled were largely a consequence of their incarceration and mistreatment. Civil liberties lawyers sought to restrict or abolish compulsory detention and treatment. Health ministers, dismayed by a series of embarrassing hospital scandals, began to see abolition as the only solution; and health services managers, desperate for economies, began to calculate how much they would save by discharging psychiatric patients to "community care," closing their hospitals, and selling the sites to developers.

In England and Wales it was Enoch Powell who took the decisive step.[1] With commendable if over optimistic humanitarian zeal he adopted an explicit policy of wholesale mental hospital closure and replacement by a combination of "community care" and small psychiatric units in district general hospitals. In its essentials this has remained Department of Health policy ever since. Similar policies were adopted in other countries. In the United States psychiatric bed occupancy fell from 450 per 100 000 population in 1955 to 110 per 100 000 in 1981, and in Italy the controversial law 180 of 1978, which forbade the admission of any new patients to mental hospitals, produced an even sharper reduction, from 210 per 100 000 in 1970 to 75 per 100 000 in 1985.[2]

Slowly, however, it became apparent that all was not well. The disabilities of chronic schizophrenics did not melt away when the hospital gates closed behind them. In many parts of Britain community care has remained an empty slogan; the homeless populations of big cities have risen at the same rate as hospital closures, and "bag ladies" have become a prominent feature of many seaside towns. Increasingly, too, patients' organisations like the National Schizophrenia Fellowship and journalists like Marjorie Wallace have successfully focused public attention on the plight of former psychiatric patients adrift in an uncaring, uncomprehending society—and on the appalling burdens imposed on their families.[3]

The first sign of a change in official policy was the admission in 1980 by the then Minister for Health, Sir Gerard Vaughan, that in at least 70 English health districts the mental hospital could not close.[4] Since then ministers and health authorities have repeatedly tried to reassure an increasingly concerned public that psychiatric patients will not be discharged until adequate alternative arrangements have been made. In 1987 a multidisciplinary panel convened by the King's Fund and chaired by Lord Colville declared unhesitatingly that "asylum" would continue to be needed by several identifiable groups of psychiatric patients.[5] The rehabilitation of the mental hospital has now been taken an important step further in Scotland—where Enoch Powell's policy of replacing mental hospitals with psychiatric units in district general hospitals was never formally adopted. A national medical consultative committee working party chaired by a rural general practitioner, E M Armstrong, has concluded that despite changes in public attitudes, therapeutic advances, and improved community services "there remain groups of patients whose mental illness renders them either recurrently or permanently so disturbed as to make inpatient care the preferred method of treatment on humanitarian and social as much as on medical grounds."[6] The working party therefore foresees "the need for major reconstruction of present mental illness hospital provision and the construction of new types of inpatient facility."

For almost the first time in two generations, therefore, serious thought is being given to the kinds of patients who require long term hospital care and the kind of mental hospital they will need in the future. If the run down of the old asylums had been properly evaluated we would now know the answer to at least the first of these questions. Sadly and inexcusably, this was not done, for the politicians and administrators responsible for deinstitutionalisation policies generally regarded psychiatrists' pleas for controlled trials either as expensive irrelevancies or as covert attempts at sabotage. As a result almost no prospectively planned research has been done in the United States or Italy, and in Britain only the North West Thames Regional Health Authority has had the foresight to build a planned evaluation into its closure policies—and even this will not be completed before 1994.[7,8]

Faced with this lack of evidence both about the clinical characteristics of patients requiring long term or oft recurring hospital care and about the comparative costs of treating severely disabled patients in hospital and in the community,[9] the Scottish working party avoided suggesting how many long

term beds might be needed per head of population. It merely observed that the most important groups would be elderly people with chronic organic brain syndromes, elderly patients with chronic schizophrenia who had already spent most of their lives in hospital, new schizophrenics who failed to respond to energetic treatment, some people with chronic affective disorders, and a few brain damaged alcoholics.

The working party's most interesting suggestions, however, concerned the type of hospital such patients are likely to need. It was emphatic that neither existing mental illness hospitals nor units in district general hospitals alone would provide an adequate basis for inpatient care. Instead, it suggested creating a "mental health campus," which might, if situated sufficiently centrally, develop on the site of an existing mental hospital. The campus would contain a range of distinct facilities, including separate assessment and short term care units for geriatric and younger patients, separate medium term to long term units for the elderly developing dementia and for young patients, a special unit for brain damaged patients with intractable behavioural problems, and day hospitals. The main campus would be surrounded by smaller satellite units on other sites and would act as "a nucleus around which community care in its various guises can be planned and deployed." The frequent and regular movement of staff of all disciplines between the campus and its satellites would be "an essential element."

The most important issue remains unresolved, however: how many beds will be needed in the future and for whom? No one doubts that the improved community facilities the government's long delayed acceptance of the Griffiths recommendations should eventually create should give scope for further reductions in hospital populations, particularly in Scotland, which still had 319 inpatients per 100 000 population in 1985.[6] At the same time it seems likely that the cost of treating the most severely disabled patients in the community will exceed that of traditional residential care if unacceptable burdens are not to be placed on families and friends.[10] If the health departments are seriously interested in health services research here is a problem crying out for attention.

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Experiments on animals

Scientists should be looking for alternatives

The recently released *Statistics of Scientific Procedures on Living Animals* for Great Britain 1988 makes uncomfortable reading for those who take seriously the interests of non-human sentient creatures.[1] It shows that about 3·5 million scientific procedures on animals were started in Britain during 1988. Though that total continues a downward trend over the years, the reduction since 1987 has been a mere 4%.

The more detailed breakdowns give particular grounds for concern. Despite strong—and surely well justified—opposition to the use of animals for testing products such as cosmetics and toiletries, the number of these procedures jumped more than 15% to 17 000. The numbers of other toxicology and safety tests also increased to the point at which 588 000 animals were used. At least 232 000 of these tests appear to have been carried on to the point of death for some or all of the animals. Given that most of the other animals will at least have been made extremely ill, the quantity of suffering here is vast. It seems highly doubtful that all of this testing was for essential new substances of great benefit to humans: much product development is commercially directed and designed to produce "me too" products that will make inroads into the sales of competitors.

Procedures entailing the application of substances to the eye numbered 78 000, and all but 3000 were without the use of anaesthesia (though we do not know how many of the remainder caused pain). In 24 000 procedures psychological stress was induced.

These statistics have appeared as the result of the second year of operation of the Animals (Scientific Procedures) Act 1986. This was intended to ensure that animal experimentation would go ahead only when it was considered clear that the work was important enough to outweigh the cost to the animals. Yet, as the animal welfare movement predicted, the statistics show that the act has allowed animal experimentation to continue largely as before without any drastic rethinking.

The ethical case for a more far reaching change has been presented often enough, but it is as often distorted by its opponents. It does not depend on any kind of sentimental love for animals, nor on any fanatical or "absolutist" morality which holds that it is never justifiable to take the life of an animal for any purpose. The real basis of the case against animal experimentation is that animal pain and suffering should not be given less weight than similar amounts of pain and suffering occurring in humans. Such comparisons will necessarily be rough, but that is not to deny that there are clear cases in which we know how the balance goes and can say with confidence that we would not allow similar experiments on humans incapable of consenting. In these circumstances it is pure speciesism—an unjustifiable bias towards our own species—to allow the experiments on animals. Discrimination on the basis of species alone is no more justifiable than discrimination on the basis of race alone. In both cases we favour members of our own group, not because of any relevant characteristic that makes them suffer less, but simply because they belong to our group.

The application of truly non-discriminatory standards to animal experimentation would mean the end of the institutional practice of animal experimentation as we know it. If this is considered too radical a change to introduce all at once, we should still not find it beyond our ingenuity to cut the amount of animal experimentation by 40%, rather than 4%,