Mental Health in the 1990s

From custody to care?

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Office of Health Economics
12 Whitehall London SW1A 2DY

This paper was researched and written by Jean Taylor and David Taylor. Jean Taylor is development manager of the charity One-to-One. David Taylor contributed as a Visiting Senior Research Fellow at the Centre for Health Economics, University of York. The authors particularly thank Christine Rivett-Carnac for typing and correcting the text, and Robert Chew for his work on the statistics of mental health.

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Vagrants on the Thames Embankment 1898.
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Introduction

Mental distress or dysfunction serious enough to be regarded as illness is a common experience. In the United Kingdom four to five million people a year consult their family doctors because of conditions such as depression and anxiety. Perhaps as many again suffer similar symptoms but either do not seek medical help, or are not identified as being psychiatrically disturbed.

Amongst the more severely affected population, there are still some 60,000 people in UK mental illness hospitals. There are approaching two million psychiatric hospital and unit out-patient attendances each year, representing a workload which, although limited as compared to the nine million UK general practitioner consultations classified as being directly related to mental disturbance, demands considerable resources. Table 1 shows that approaching £1 in every £10 spent by the NHS – some £2 billion – is devoted to mental health care. In addition, there is also relevant spending by Local Authorities, the Department of Social Security and agencies like the police and the prison service.

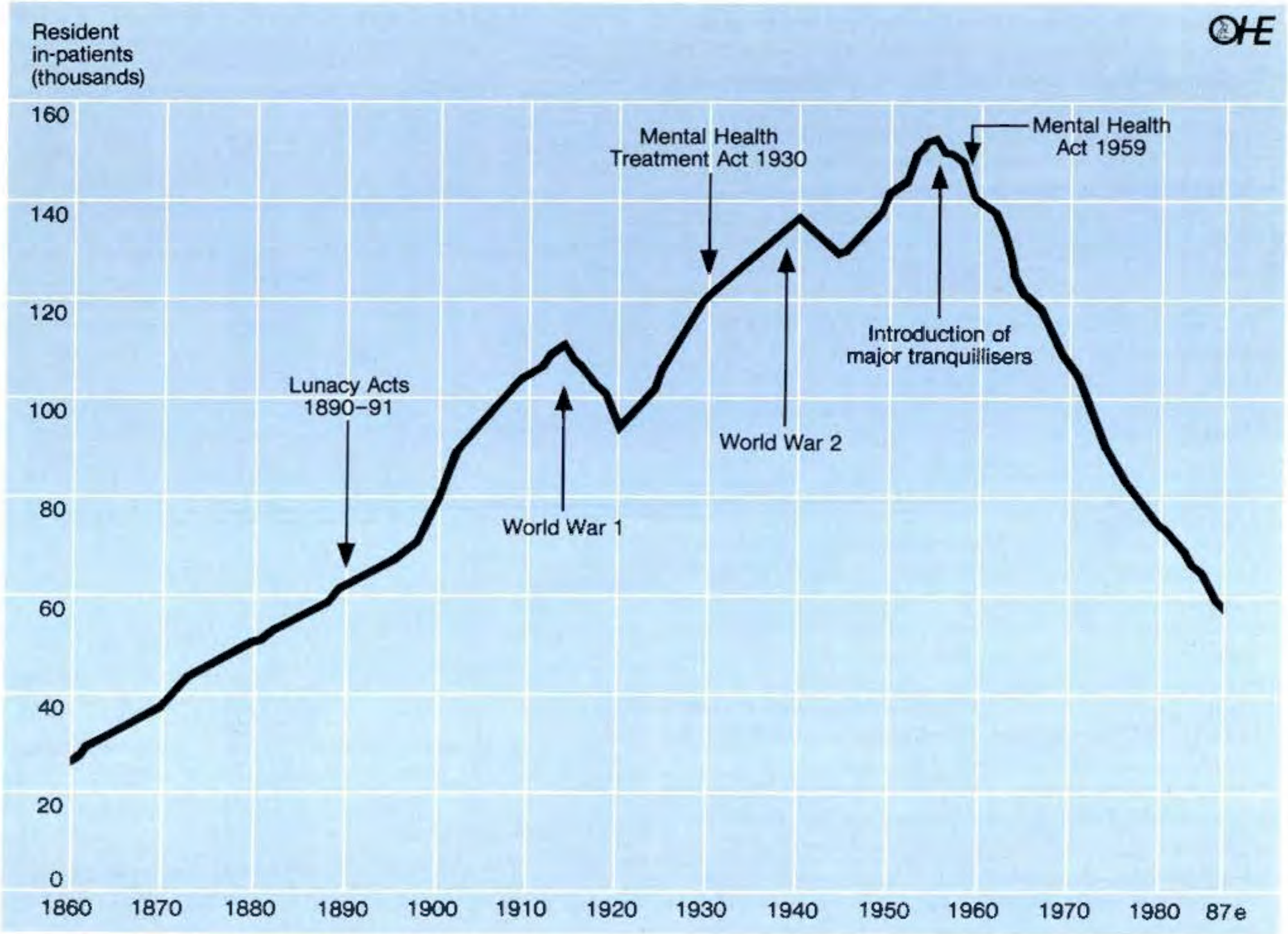
In younger people schizophrenia is the most frequently diagnosed cause of long-term, potentially handicapping, psychiatric morbidity. There are over 250,000 people in Britain who have been diagnosed as having schizophrenic illness at some point in their lives, of whom around 150,000 are significantly affected and still in need of treatment or some form of supportive care. And in the older population senile dementia now severely disables another

Table 1 **Estimated UK NHS expenditure on mental health services in 1989**

Mental illness hospital inpatient care (current cost)	c£1,250 million
Other Hospital and Community Health Service current mental health costs (Out-patients, day patients, community psychiatric nurses)	c£200 million
HCHS capital spending on mental health facilities	c£75 million
General practitioner services	c£160 million
FPS psychotropic medicine costs	c£75 million
TOTAL identifiable NHS mental health service costs	c£1,760 million

Note: In addition to this UK social service agencies spent about £50 million on residential and day care provisions for people with mental health problems in 1987, and a proportion (*circa* 10 per cent) of NHS general management and related costs might also be reasonably attributed to mental health associated activities. On top of this considerable additional sums are incurred by the NHS, PSS and Department of Social Security in relation to the support of elderly demented patients. These probably total in excess of £500 million.

Figure 1 **In-patients resident in mental illness hospitals, England and Wales, 1860–1986**



Notes: From 1970 onwards, figures relate to England only.
e = Estimated figure.

quarter of a million individuals. This total may well rise considerably further as the number of people aged 80 and over increases.

The sheer scale of such figures, coupled with the severity of individual and family suffering that psychiatric morbidity can impose, underlines the importance and urgency to be attached to the efficient delivery of mental health care in the community. Nevertheless, it is worth emphasising that the overall level of distress caused by mental illness has almost certainly fallen in recent decades. The development of a range of effective medicines from the early 1950s onwards, coupled with health and social care innovation, has helped many people to avoid the prolonged mental pain and social stigma which they would once have had to suffer. The fall in the mental illness hospital population depicted in Figure 1 is by and large an indicator of desirable progress.

Such a conclusion would not, however, be apparent from a survey of the last few years' media coverage of public, professional and political debate about the state of mental health care in Britain (Wallace 1985). As a review published by the National Schizophrenia Fellowship (NSF 1989) has shown, there are relatively frequent, tragic, stories of individual neglect and family suffering. Examples include sons killing their mothers in periods of psychotic breakdown, and severely disabled individuals apparently being left to wander the streets or live in unsuitable boarding house accommodation.

Against such a background it is perhaps not surprising that a deep divide has grown up between those who believe that it is right to proceed with, or accelerate, the closure of Britain's legacy of Asylums left from Victorian times, and those who oppose existing policies. The 1989 British Medical Association Annual Conference, for instance, voted for a halt to the closure programme.

The recently announced Government response to the 1988 Griffiths report on community care (itself a reaction to the 1986 Audit Commission analysis of the same topic) has gone some way towards relieving such concerns. But there are still uncertainties as to whether or not a satisfactory pattern of care for people with long-term, severe mental illness will, in practice, be achieved. There are also grounds for concern (often expressed as reports about overprescribing of medicines like benzodiazepine tranquillisers) about the quality of care available to the large population of distressed people with 'neurotic' depression, anxiety, and allied states.

A central objective of this OHE publication is to assess what essential service elements the nation's mental health care system should be able to offer, and to evaluate the barriers to, and opportunities for, their achievement. It outlines, first, the nature and scale of four of the main groups of mental health problems affecting the UK population. (Topics such as the harm caused by illegal drug use and alcohol related conditions are not touched on in detail, although OHE has considered them elsewhere – see, for instance, Taylor 1981.)

Second, the paper traces the development of the mental health and social care provisions available in Britain. Third, it discusses the place that medicines, alongside psychological and social approaches, have to play in this context. And, fourth, it examines the prospects for future improvements in care.

Throughout the paper emphasis is given to the need to combine social, psychological and biomedical knowledge to help generate unified and realistic understandings of mental health problems and the ways available to ease them. This is because one of the central lessons this study has to offer is that a lack of appropriate communication between professionals who should be sharing their complementary knowledge and skills, coupled with failures to listen to the experiences and ideas of mentally distressed people and their informal carers, lies at the heart of many service provision problems. Fragmentation, conflict and disillusion at the 'grass roots' promotes general public and political distrust, which all too often feeds back via inadequate resource availability for research and for care. Breaking such cycles of self-sustaining distress and defeat is a central task for everyone involved in mental health care today, at both individual and societal levels.

The nature of mental illness

Some commentators regard the term mental illness as being so wide ranging that it is at best virtually meaningless and at worst misleading. Unqualified, vague, references to 'the mentally ill' may obscure the degree to which there are many different groups of people suffering quite distinct forms of mental distress, and needing quite different forms of support or treatment. The experiences and service requirements of, say, children living in disturbing circumstances, are far removed from those of older people suffering from cognitive impairments or those of younger individuals with schizophrenic illness or depressive reactions.

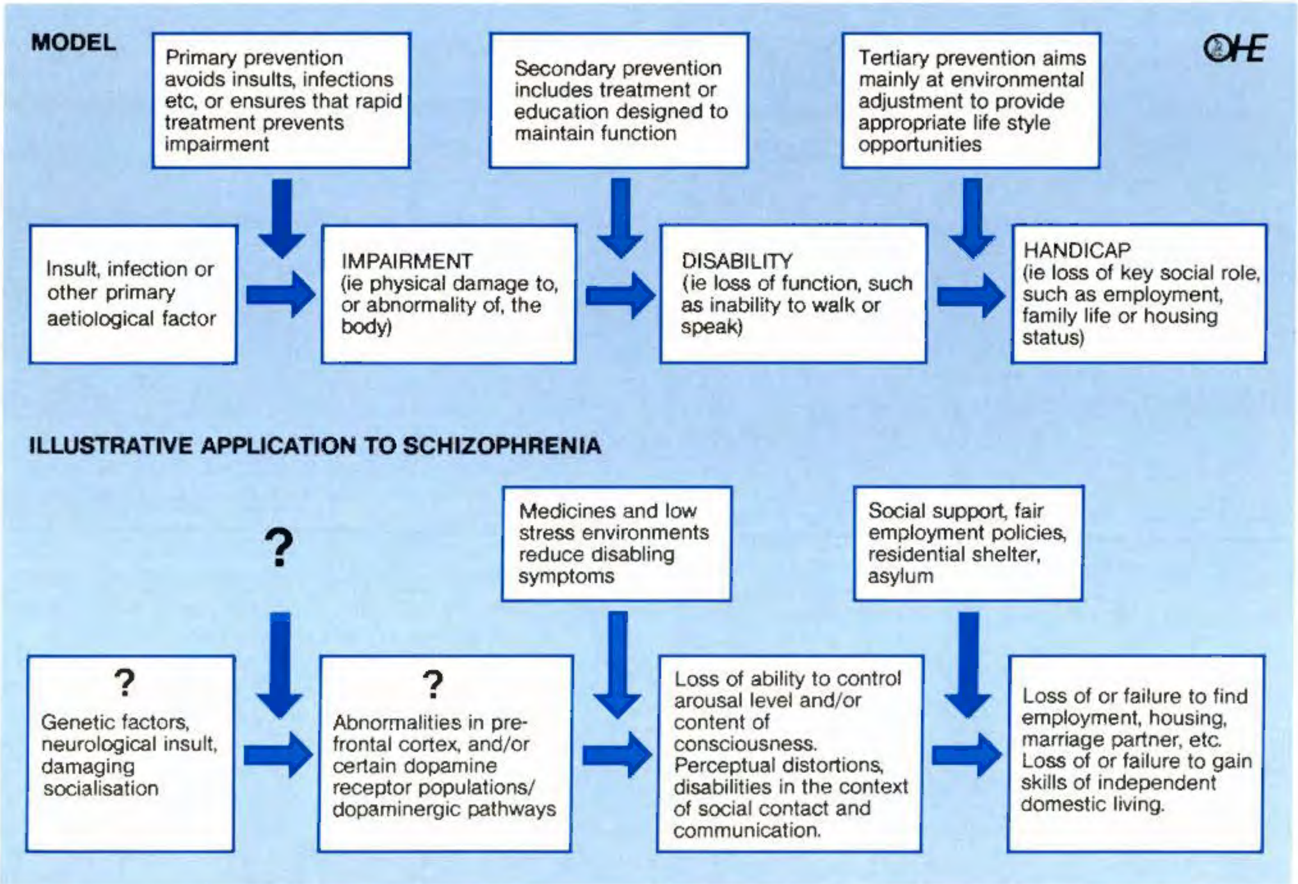
Further, insensitive use of the term mental illness may be objected to on the ground that so 'labelling' people can lead them, and others around them, to have inappropriately negative or limited expectations as to their abilities and weaknesses. In the 1960s and 1970s the writings of psychiatrists such as Laing (1959, 1967) stimulated considerable debate on topics like whether or not even severe forms of disturbance, like schizophrenia, can be seen as meaningful responses to difficult, 'sickening' social circumstances. In the United States Szasz (1961, 1971) argued that the concept of mental illness is a myth, and called for a more normal market relationship between those with 'problems in daily living' and those offering them professional help.

There is, of course, no doubt that simplistic applications of the concept of illness to problems with a strong psychosocial component can be destructive. The potential result is an unduly mechanistic 'biological' approach to therapy which might, for instance, emphasise medicine usage at the expense of attempts to understand and help with the problems which cause people to become distressed. Nor should the label 'mental illness' be used to justify removing from people rights, freedoms or obligations enjoyed by 'normal' members of the population.

However, there is also a danger that too much emphasis on this point could in itself prove confusing or mystifying, and may serve further to undermine the already limited public (and even professional) comprehension of mental health issues. Complex, essentially academic, debate on the concept of psychiatric illness should not be permitted to draw attention away from the usually quite easily understandable everyday needs of most mentally distressed people and those caring for them. For this reason the remainder of this section now turns to providing a basic description of the problems encountered in four major areas of mental health care – depressive illness, anxiety states, schizophrenia and dementia. But before this three sets of introductory points are worthy of special emphasis.

First, for the purposes of this paper 'mental illness' is used generally to refer to a wide range of states of mind involving psychiatric distress and/or observed behavioural abnormalities and physical symptoms. As Figure 2 indicates, such conditions will involve combinations of biological impairment, individual functional disabilities and a range of social determinants and sequelae, as do potentially

Figure 2 **Impairment, Disability and Handicap**



Note: In reality feedbacks and allied phenomena complicate events. For example, a person with marked abnormalities of appearance may in an unsympathetic environment become handicapped, despite having little or no disability. Similarly loss of a satisfactory social role (handicap) may undermine self-esteem and promote further disabilities in some people.

handicapping 'physical' conditions. Although the relative importance of such factors will vary between cases and conditions, it is taken here as axiomatic that no individual's situation can satisfactorily be understood without comprehensive reference to their learnt personal characteristics and expectations, their social situation and what is known of their biological strengths and frailties. And it is also taken as a matter of definition that mental handicap, otherwise referred to as intellectual disability or learning difficulty (Taylor and Taylor 1986), is a quite distinct topic from that of mental illness, although there may be some areas of overlap.

A sufficiently unfavourable environment can, for instance, stimulate anxiety or depression in anyone. Hence individuals with learning difficulties (who often have to cope with limitations in areas like speech and communication) may need psychiatric treatment from time to time. Yet even this requirement should not be exaggerated. A recent study of a community mental handicap service in South London showed that some 60 per cent of intellectually disabled individuals referred to psychiatrists did not receive a clinical diagnosis (Bouras *et al* 1988). (It may be added that a relatively small number of people with learning difficulties display 'challenging' behaviours which may stem directly from neurological impairments. The intensity of care needed by this group is considerable. It is at present uncertain whether or not, given sufficient resources, the provision of more intensive support in small 'community based' units will serve substantially to improve the personal and social skills of new generations.)

BOX 1

The value of psychiatric and social diagnoses

As described in the text, neurotic mental health problems are conventionally taken to be those involving states of mind which are quantitively rather than qualitatively different from those of everyday life. That is, it is not so much what neurotically disabled people experience but the degree to which they experience it that differentiates their condition from normality. By contrast psychotic distress usually involves a much greater divorce from generally agreed 'reality', and more severe problems in daily living.

To a degree it is useful to think of mental health problems as being divided into two main groups, the commonly occurring illnesses affecting people who are normally treated by the primary care services and the rarer, more disabling conditions, sufferers of which require more comprehensive support. However, it would be dangerous to make too much of the psychotic/neurotic distinction. For example, some of the symptoms suffered by 'neurotically' ill people can be highly unpleasant, quite unlike normal experience and disabling in the long-term, while many people with 'psychotic' conditions make complete recoveries. The most desirable approach, therefore, is to avoid the use of simplistic or potentially rigid diagnostic categories, and to try to understand each person's needs on a case by case basis. Similar caution should be exercised in the use of terms like exogenous (externally caused) or endogenous (internally originated) illness.

Broadly speaking, psychiatric diagnosis allows informed professionals to order their approach to mental illness, and to apply general knowledge to specific cases. This is vital. But the special dangers of labelling in this field, coupled with currently incomplete knowledge of the conditions subsumed by terms like 'schizophrenia' or 'depression', means that sometimes the uncaring use of psychiatric diagnoses serves to conceal individual strengths and weaknesses and likes and dislikes for little practical gain. To go with medical classifications of patients' conditions it may often be of value to add discrete 'social diagnoses', which involve assessments of each mental health service user's external problems (in employment, housing, relationships, racial status etc) and the specific help they want or need to achieve a better quality of life.

Table 2 **Filtering mental health patients: characteristics determining who is and is not treated**

	pass less easily	*pass more easily*
Filter one:		
Patients' decisions to consult	trivial disorders	severe disorders, many symptoms
	married women with children	stressful life events
	married men, old and poor (USA)	lonely people
		divorced and separated women
		unmarried people
		unemployed
Filter two:		
Recognition by the doctor	physical presenting symptoms	severe disorders
	men	
	below 25; over 65	women
	unmarried people	middle-aged people
		separated, divorced, widowed, people
	better educated, students (UK)	seen frequently before
Filter three:		
Referral to the psychiatrist	mild illness	severe disorders: psychoses
	new, acute and transient, women (UK)	more chronic illnesses
		young people
		separated, divorced, widowed women
		unmarried people
		men (UK)
		better educated

Source: Goldberg and Huxley 1980.

Second, another area of terminology which may generate some uncertainty in the minds of observers of the mental health scene is that of the distinction between 'neurotic' and 'psychotic' illness. The former, including 'milder' conditions like hysteria, phobias, obsessional states and depressive reactions (experienced by some 10–15 per cent of the population in any one year) were traditionally said to involve emotional and allied experiences which are quantitively rather than qualitatively different from those of everyday life. Psychoses, affecting in the order of one per cent of the population at any one time, are regarded as more serious: they involve symptoms and experiences well outside those of daily life. (See Box 1.)

The third and final introductory point to be made is that the recognition of mental illness by both sufferers and professionals is known to be influenced by many factors, including those linked to the way individuals behave and express themselves and the expectations of those observing them. In the 1960s Shepherd *et al* (1966) found a ninefold variation in the rates of psychiatric disorder reported by general practitioners. The available data indicate there are still substantial variations today. Goldberg and Huxley

(1980) reviewed material relating to why some people receive more adequate attention and care than others (Table 2). They noted, for example, that family doctors appear less likely to recognise mental illness in men than in women, but that once they are considered for treatment men are more likely to be referred to specialists than women.

Hence even though the use of detailed, standardised interview techniques and rating scales (the Hamilton Rating Scale, the Present State Examination and the General Health Questionnaire are all examples of relevant investigative tools) has during the 1970s and 1980s allowed psychiatric researchers to observe mental illness in populations in a much more consistent way than was previously possible, subjective bias and allied phenomena still complicate the processes of care delivery. Such problems may to a degree be inevitable. Nevertheless, it is a key task for all mental health service managers and professionals to work to improve the consistency and availability of care between, and within, localities.

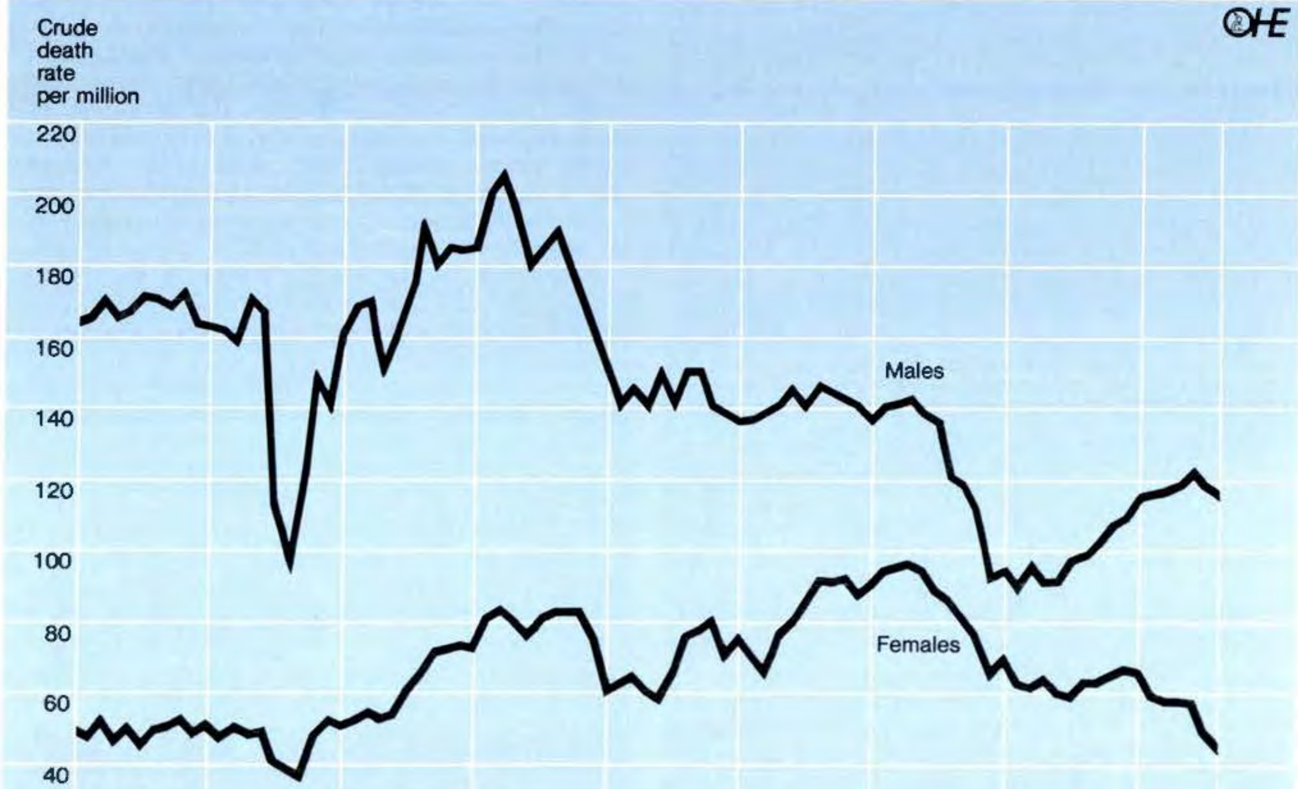
Understanding depression

Depression has been described as the common cold of psychiatry. The term encompasses a range of states, from near-normal moods of sadness, to clinical conditions of life threatening seriousness. Morbid depression is associated not only with suicide (Figure 3) but also with problems such as child neglect and abuse. It is a state of mind characterised by loss of an individual's sense of self-worth and his or her ability to enjoy life, a complication of despair which in psychosocial terms is related to loss, disappointment and rejection from which there is no obvious way forward (Brown 1989).

Psychological symptoms of depression may, in addition to feelings of sadness and worthlessness, include guilt, paranoia, and a disturbed sense of time. Physical disturbances typically include changes in sleep patterns (of which early waking is the best known), loss of weight (although a minority of subjects may gain weight), loss of libido, a lowering of pain thresholds and agitation and/or retardation. The latter means a general slowing of bodily functions; for example, walking may be slow or slouching and the voice dull and lifeless. Speech is not usually slowed, but responses are delayed. In extreme cases patients may need feeding and dressing (Lader 1981).

In manic depression sufferers experience swings from extreme overactivity, which often involves disorganisation of thought and undesirable, harmful behaviour of some form, through to deep depressive interludes. Such bipolar depression has a strong genetic base, and is relatively rare. The lifetime risk is in the order of 0.5 per 100 individuals for both men and women. There is no identified social class related influence on its occurrence, although some sufferers may enjoy unusually creative periods and thus be

Figure 3 **Death rates per million from suicide, males and females, England and Wales**



Source: OPCS

relatively high achievers despite their illness. Virginia Woolf's career is often said to provide a celebrated example of this, although her state of mind may well have been influenced by the early loss of her mother and sexual abuse during her childhood.

Early post-partum puerperal depression is another example of a form of morbid mental distress which appears to be mainly biological in origin (Martin *et al* 1989). But in the great majority of unipolar depressive episodes negative life events and adverse social circumstances appear to be of greater importance. (It is of note that, symptomatically, depressions which occur in the first week or so after childbirth are indistinguishable from post-natal depressions which appear to have more predominantly psycho-social causes.)

The available survey data indicate that, across the population as a whole, in the order of five per cent of men and 10 per cent of women suffer a depressive episode in any one year. Many do not seek or obtain medical help, but even so approaching two million individuals a year are diagnosed by UK family doctors as suffering from depression (RCGP/OPCS/DHSS 1986). Women are twice as likely as men to be so diagnosed.

In some communities prevalence rates are significantly higher. Amongst urban working-class British women with children at home, detailed research surveys have identified a 200–300 per cent excess in the occurrence of depressive episodes, with observed annual prevalence rates of up to 25 per cent in some groups. (Brown and Harris 1978; Surtees *et al* 1983; Bebbington *et al* 1984; Brown, Craig and Harris 1985.)

Newton (1988), in her study 'Preventing Mental Illness', reviewed a wide range of theories about the causation of depression, under the headings psychoanalytic, psychological, psychosocial and biological. With regard to the last of these categories there is general agreement that depressive states involve a depletion of bioamine neurotransmitters within the brain, most notably noradrenaline and serotonin. Anti-depressant medicines work by increasing the availability of such substances, although the fact that they typically take several weeks to achieve their therapeutic effect indicates that the restoration of affective balance is a complex process. As yet there is no detailed neurobiological model available as to the precise mechanisms of depressive illness.

Important themes in the psychoanalytic approaches to the aetiology of depression include the experience of inner loss (in a sense, grieving about events which undermined one's own self-esteem) and the problems encountered by some individuals in forming stable and secure childhood relationships with their parents (Bowlby 1980). Psychologists have emphasised the part played by negative styles of thinking. For example, Seligman's (1975) theory of 'learnt helplessness' emphasises the extent to which the habitual assumption of personal powerlessness may predispose people to depression. Cognitive and behavioural therapies are designed to help people learn to cope with feared situations and to avoid ways of thinking which promote needlessly despairing attitudes.

The insights generated by such concepts and associated techniques have helped many individuals. However, in terms of explaining phenomena such as the observed social class variations in the incidence of depressive episodes amongst women described above, the work of Brown and Harris and their colleagues at Bedford college is of greater importance. Since the early 1970s they have set out, in a scientifically disciplined, rigorous manner, to observe the types of experience and event associated with depressive episodes. They have also constructed models which indicate how people become vulnerable to depression, and what factors provoke or precipitate illness and influence its course (Brown and Harris 1978.)

The findings and theoretical constructs which have emerged from the research of Brown and his colleagues are complex, and still in some respects controversial. But the basic picture to emerge from this work is not. Vulnerability to depression is clearly related to inadequate or impaired early caring experiences (including for some women loss of their mother in childhood) coupled with the subsequent experience of a negative personal environment (such as having no close, supportive relationship which permits the confiding of hopes and fears). Vulnerability factors like these combine to promote a psychological state of low self-esteem, such that when individuals are faced with a crisis in their lives they are particularly likely to enter a despairing mood.

The death of a valued relative, problems with employment or financial matters or a difficulty in caring for a sick child are examples of the type of acute life event likely to precipitate depressive illness. This is particularly so if the challenge resulting somehow reinforces a subject's low self-esteem and worst fears about themselves, or promotes another loss, such as a partner failing to give expected help. The most effective way forward out of states of this type are events or opportunities which give new hope, the chance of a 'fresh start' in life (Brown 1989).

It must be emphasised that between different cultures and groups the exact nature of the psycho-social factors involved in depressive episodes, and their relative importance, will vary. For example, males in Britain may not require close confiding relationships in the way that women do. And in other European countries having young children in the home may not expose women to the risk of depressive illness observed in the UK.

Nevertheless, the challenge for health and social service providers implicit in the work on understanding depression outlined here is clear. Enough is known about the environmental causes of this common form of mental ill-health, particularly as it occurs amongst women with young families, for new forms of preventive and supportive care to be envisaged. If concerns expressed by politicians and other public commentators about the 'excessive' use of psychotropic medicines in the community have any real substance, then the provision of effective alternative approaches should be an urgent priority. This is a topic returned to later in this report.

Anxiety

Like depressions, anxiety states are common. Pathological anxiety is characterised by a sense of dread, foreboding and above all fear differing from normal experience in that it is not normally associated with any rationally defined immediate threat to the individual concerned. Physical symptoms include raised heart beat, sweating, flushing, nausea and increased micturation frequency.

The available epidemiological data indicate that in a typical developed country at least five per cent of the population will be suffering significant symptoms of anxiety at any one time. Some sources give much higher figures, which may raise questions as to the distinction between 'normal' and 'pathological' anxiety. In Britain, and elsewhere, more women than men consult their family doctors about such experiences (as with depression, the ratio is about 2:1) but this observation should be tempered by the consideration that males may relieve their anxiety in other ways. Higher alcohol consumption is an obvious difference; another is self-expression in the form of violent or aggressive behaviour.

Anxiety often accompanies other forms of psychiatric illness, including depression and schizophrenia. Indeed, depression and anxiety may on occasions be confused in the public mind so that, for example, minor tranquillisers are frequently described as being 'anti-depressant' medicines. It is worth stressing that whereas depression can be seen as a form of slowing of mental/affective function associated with despair, anxiety is by contrast a state of increased arousal associated with threat or danger. Although such states can occur simultaneously, and in the short-term sedative medicines which relieve acute anxiety may help some depressed patients, tranquillisers are in the long-term likely, as with alcohol, to deepen depressive states.

In phobic states individuals experience extreme anxiety in response to specific situations or things, like being in a confined space or seeing a spider. Older people appear to be particularly subject to phobic states – being afraid to go out is a typical problem. In free floating anxiety there is no such specific cue, although in part to explain or justify their mental state to themselves many anxious people become obsessively concerned about particular subjects. An irrational fear of death is common, as is that of 'going mad' or the belief that one is suffering a unique and untreatable disorder.

Such concerns can be fuelled by panic and, less commonly, by 'depersonalisation' or 'derealisation'. Panic involves a unique sensation of self-feeding terror (Pan was not only the ancient Greek God of shepherds – he was also the author of sudden, inexplicable fear – Lader and Marks 1971) coupled with very strong adrenaline related physical symptoms. Although seen as simply the extreme end of the anxiety spectrum by some authorities, panic disorders may be functions of neurobiological events additional to those involved in less intense anxiety experiences – see Box 2. Similarly the sense of unfamiliarity and/or removal involved in depersonalisation (which frightened people may not unnaturally feel marks the onset of long-term 'insanity') might well involve the release of neurotransmitters not normally involved in anxiety.

Figure 4 **The Anxiety Spiral**

Note: Some people who suffer marked anxiety may misinterpret normal anxiety and the attendant physiological responses as indicative of the onset of acute anxiety. This misinterpretation reinforces the original perceived threat, and 'locks' them into the anxiety cycle. See Sakol 1988.

BOX 2

Panic and its treatment

Recent research using positron emission tomography (PET) has indicated that people who suffer from panic disorders have abnormal (right) brain blood flows even before the onset of attacks. As with generalised anxiety, activity in the temporal lobes is raised during panic.

Antidepressant medicines may be capable of preventing panic in some, if not all, subjects (Tyrer 1989). Benzodiazepine tranquillisers are also used in this area, although their value can be questioned. At present psychological therapies (intended to reduce patients' fear of their panic and to enable them to feel that they have at least some ability to control their symptoms) backed by sparingly used pharmaceutical treatments appear to offer the most effective therapeutic options.

In future more specific anti-panic medicines may be developed – see text pages 24–25. In the case of generalised anxiety a new type of treatment has already become available. Its action involves enhancing the effects of the neurotransmitter serotonin in certain relatively specific parts of the brain, and has the advantage of a low dependency risk (Rickels *et al* 1988). Benzodiazepines, however, provide swift and more effective symptomatic relief for some patients, and in the specific context of panic there is no evidence that the new alternative has any role.

In considering the treatment of anxiety states it is valuable to communicate to sufferers that a degree of anxious arousal is normal and necessary for people to function in life and to respond efficiently to any dangers facing themselves and their families. (Depressive reactions may also be functional in as much as they may, for instance, serve to limit conflicts within groups.) But anxiety becomes a weakness rather than a strength when it becomes associated with a 'false target' or when sufferers become locked in to a disabling, vicious circle in which emotions of fear, perceived threat or danger, coupled with physical symptoms like dry mouth and beating heart, stimulate further rounds of anxiety and distress (Figure 4).

The immediate goals of therapy are to relieve symptoms so as to break into such cycles, and then to help individuals to learn not to respond to inappropriate cues. In many cases the psycho-social origins of anxiety run parallel with those of depression; but the types of event which promote long-term recovery involve not so much 'fresh starts' in life but 're-anchoring' (Brown 1989). Through them individuals can regain strength and purpose to face the inevitable hazards and uncertainties of existence.

Schizophrenia

Schizophrenic illness usually becomes apparent early in adult life, with the highest incidence rates being recorded amongst men in their twenties. In women occurrence is a little lower, and the median age of diagnosed onset somewhat later. Overall the lifetime prevalence rate is in the order of 0.8–0.9 per cent, which implies that there are currently some 250–300 thousand people in the UK who have had a diagnosis of schizophrenia at some point in their lives (Taylor 1979). Not all of these – perhaps only a half to two thirds – will still be significantly affected. But unfortunately there is no adequate information base available as to the overall extent of the problems suffered and living conditions experienced by people currently regarded as having schizophrenia in the UK. It is disturbing that a new Government (Office of Population Censuses and Surveys) survey of the prevalence of disability among adults (Martin *et al* 1988) failed to record any disability amongst adults living in private households as being due to schizophrenia per se. (However, schizophrenic illness was identified as being primarily responsible for the condition of seven per cent of disabled people living in communal institutions – that is, about 30,000 individuals.)

Historically, the definition of schizophrenia stems from the pioneering nineteenth and early twentieth century work on psychiatric classification by the German Emil Kraeplin, together with the contributions of the Swiss psychiatrist Eugen Bleuler. It was the latter who in 1911 first used the term schizophrenia (split mind) to describe what he saw as a process of personality disintegration stemming from distortions in thinking, perception and feeling, broadly characterised by looseness of association and flatness of affect.

During the 1960s and 1970s considerable effort was made by psychiatrists in centres in Britain, and abroad, to give greater precision and consistency to the diagnosis of schizophrenia. Increased emphasis was given to the existence or not of 'first rank' symptoms, such as hearing apparently alien voices discussing oneself in the third person, or a sensation that one's thoughts are being listened to by other people or have been placed in one's head by others. Phenomena of this type cannot be seen to relate to any behavioural advantage, either for the individuals who experience them or for those around them.

Recently, Liddle (1987) has argued that symptoms of schizophrenia can be sub-divided into three main groups – psychomotor poverty (poverty of speech, decreased spontaneous movement, lack of vocal expression), disorganisation (distractability, abnormalities of content of speech, inappropriate emotional responses) and reality distortion (hallucinations and delusions). Hirsch (1988) has suggested that through focusing on these relatively specific syndromes researchers may now be in a position to begin more clearly to identify the brain dysfunctions underlying them. For example, he drew particular attention to evidence linking abnormalities in the dorsolateral prefrontal cortex to psychomotor poverty (Weinberger *et al* 1986).

But exciting and productive as the future possibility of improved neurobiological models of schizophrenia may eventually prove to be, it has to be said that at present there is, despite many years of research effort, no clear understanding of the physical causes of schizophrenia. Even the observation that the neuroleptic medicines used to control the florid (delusional and hallucinatory) symptoms of the disease all work by blocking receptors for the neurotransmitter dopamine is of limited significance, partly because the involvement of such neural systems may only be a secondary effect of schizophrenic disorders. The negative symptoms of the latter are not relieved by currently available 'major tranquillisers', which implies the existence of other types of lesion/abnormality.

Similarly, although studies on twin and other populations have indicated that genetic factors are certainly involved in the aetiology of schizophrenia (Rosenthal and Kety 1968, Gottesman and Shields 1972, Wing 1978) their precise nature and mechanism is as yet unknown. Although important new developments in understanding this area can be expected with some confidence during the 1990s (Byerley 1989) it has to be remembered that the concordance rate for identical twins developing schizophrenia is under 50 per cent. Combinations of inherited and as yet unidentified environmental factors (such as – perhaps – birth trauma, infection or even psychologically stressful family experiences) seem to be required for the disease to appear in an overt form. (One precipitating factor related to paranoid schizophrenic symptoms appears to be deafness and the sensory/social deprivation which goes with it – Kay and Roth 1961.)

But despite the paucity of data relating to both the overall experience of schizophrenia in the community and the underlying cause(s) of the condition(s) involved, there is at least relatively hard information as to the psycho-social pressures responsible for triggering symptomatic relapses in people with a diagnosis of schizophrenia. In domestic environments where there is a high degree of expressed (critical) emotion there is a very much greater risk of the return of florid symptoms than is so in low expressed emotion homes (Brown *et al* 1972, Vaughan and Leff 1976). This can be reduced by the administration of major tranquillisers to patients in high expressed emotion environments, particularly if the duration of exposure to such stimulation is relatively high; but medicines are of much less value to those with low expressed emotion family lives.

These important findings should not be taken to mean that some parents 'cause' schizophrenia in their children, even though certain largely discredited psychological theories have suggested this. (See Hirsch and Leff 1975 for an explanatory review.) Rather, they suggest that in schizophrenia tolerable levels of social stimulation are reduced to a narrow spectrum as compared to that acceptable to 'normal' subjects. In this 'tightrope' situation too little stimulation may lead those disabled by schizophrenia to sink into a negative, withdrawn state: too much will generate florid symptoms.

The implication of this for service provision is that family members, carers and people with schizophrenic illness should be given the knowledge and support necessary to help them avoid creating or having to remain in environments with undue levels of expressed emotion. To a degree neuroleptic medicines can protect those at risk of relapse, although their benefits have, of course, always to be balanced against the risk of side effects. Concerned prescribers therefore aim at achieving the lowest possible dosage regimes (including intermittent usage) compatible with symptomatic freedom.

Dementia in old age

Dementia typically involves the irreversible degeneration of brain tissue and a consequent loss of intellectual function. At first sufferers appear to be confused or perplexed from time to time, and to have lapses in their memory of the immediate past. In more advanced cases there is a total loss of recently experienced events, and even long past recollections become restricted and confused. Cognitive impairment is progressively more severe. Individuals with dementia lose their ability to grasp or generate ideas, and their behaviour is often increasingly bizarre.

Wandering at night, irritability, anxiety, depression, loss of inhibitions, incontinence and, ultimately, the need for constant day and night personal care are all examples of the types of factor which make dementia an extremely distressing condition for both its sufferers and their carers, formal and informal alike. The mean duration of the disease from the time of diagnosis to death is currently in the order of three to five years. This span has increased in recent decades (see Wells 1979) because of more effective medical care and, perhaps, earlier diagnosis. Some individuals, of course, survive much longer in states of moderate and severe disability and mental distress.

The causes of the majority of dementias are not as yet understood, despite speculative debate as to the possible role of traumatic insults, environmentally related factors like aluminium intake and exposure to infectious agents, and the apparent involvement of genetic variables. Broadly, the dementias are of two main types – cerebrovascular and neurodegenerative. The former – comprising around 20 per cent of dementia cases – may vary in nature but can be thought of as a process of progressive brain damage resulting from a series of events such as 'mini-strokes'. The latter, the best known example of which is Alzhiemer's disease, involves a loss of specific types of brain cell and associated structural changes such as the development of large numbers of minute 'plaques' throughout the brain tissue.

The prevalence of dementia increases exponentially with age in later life, which is in part why it has emerged as a major problem in developed countries with growing 'old elderly' populations. Commonly quoted figures suggest that overall some 10 per cent of the over 65s suffer from dementia, and that in people of 80 the prevalence is over 20 per cent (Kay *et al* 1964). However, recent work suggests that the scale of the problem presented by dementia is, although large, rather more limited (Ineichen 1987, Lindesay *et al* 1989). For example, a recent community survey conducted by researchers at Guy's Hospital, working in collaboration with Age Concern, suggested a prevalence of moderate and severe cognitive impairment of four to five per cent in the population aged over 65. (The rate recorded in 65–74 year olds was 1.6 per cent, and that in those aged 75 and above was a little over nine per cent.) Severe impairment was found in about one per cent of the 65+ population, with the prevalence rate for those aged 65–74 alone being around 0.4 per cent.

Even allowing for younger victims and the 100,000 or so people in institutional care who are suffering from dementia (Martin *et al* 1988), such figures imply that the true total of people suffering from dementia in the United Kingdom is likely to be less than 500,000, with the number severely disabled as a result being more like 200–250,000. Increases in the population aged over eighty could raise this last figure by some 20 per cent by the early years of the twenty-first century, although it is impossible to be precise as to the projected number of sufferers. This is not least because future cohorts of elderly people may prove rather less vulnerable to dementia than their predecessors, a possibility indicated not only by the discrepancies between past and current studies of overall prevalence but also by the apparent existence of social class variations in the occurrence of dementia. If valid these imply that lifestyle or health care factors (such as, perhaps, the control of cardiovascular conditions like dangerously raised blood pressure) influence the onset of dementia.

The conclusion to draw from the above observations is that dementia presents a major, if as yet uncertain, challenge to the existing and future capacity of the health and social services to meet the care requirements of the UK community. But the scale of the population most in need is not such that politicians, policy makers or care providers should turn away in despair. If community and institutional support is humanely and efficiently organised it is within the resources of this country to help everyone with dementia, and their families, to make the best of what is inevitably a difficult situation.

The strategies necessary for achieving this goal are touched on later in this paper. However, in conclusion here it is appropriate to note that although at present the efficacy of the treatments available to relieve the central symptoms of dementia is at best very limited, there is some hope that in future medicines or surgical interventions involving neural transplants could be developed which will serve to reduce the disabilities suffered by people with conditions like Alzhiemer's disease. Even though it seems unlikely as yet that these will extend the overall life-span of those affected, such agents or interventions may significantly improve the quality of life for patients and carers alike.

The development of care

Throughout history the plight of markedly mentally disturbed and/or deluded people has been an unhappy one, not just because of their underlying condition but also because of the reactions of those around them. Although on occasions it may be somewhat romantically suggested that such individuals were in pre-industrial cultures accepted by their communities – for example, that there were respected roles for 'good hallucinators' as prophets or seers – the available evidence does little to support such views. Ostracism, derision, family shame and concealment, superstitious fear, punishment and early death through intervening disease or persecution often typified the fate suffered by those who today would generally be seen to be ill and in need of help.

Whatever the deficiencies in services available, the significance of the achievement of more tolerant and understanding attitudes in countries like late twentieth century Britain should not, therefore, be underestimated. Questions as to how this progress has come about, and why despite it there is still so much concern about the availability of appropriate caring services for the mentally ill, can best be approached through an overview of the historical processes and events which led up to today's situation.

In his influential book *Folie et Deraison* Michael Foucault (1961) described the period between the mid seventeenth century and the start of the nineteenth as that of the 'great confinement' in Europe. The advent of 'the age of reason', his work suggests, encouraged and legitimated on secular grounds the rejection of those whose experience or behaviour challenged the consensus views of reality or threatened order (particularly in the growing cities of France). The result was increasing state reliance on the compulsory confinement of 'lunatics and imbeciles', as illustrated by the records of the Hôpital General in Paris. Founded in the 1650s, this gained over 6,000 inmates within a decade.

However, this analysis can be challenged, certainly as far as British experience is concerned. This is not least because French demographic history is unique, that country being the only one to have gone through demographic transition (to low fertility balanced by low mortality) before industrialisation. It is true that in England the 1714 Vagrancy Act associated lunacy with criminal deviance and facilitated the imprisonment of mentally disturbed individuals considered dangerous. And conditions in many Georgian madhouses could be said to comprise a world of 'shit, straw and stench' (Scull 1983) characterised by a culture of brutality, 'mechanical restraint' and neglect. But it can also be argued that during the eighteenth century many pioneering carers devoted their lives to the support of mentally distressed individuals, and to the encouragement of the provision of humane treatments and protective asylum.

Porter (1987) has detailed the work of practitioners such as William Battie, Thomas Arnold and Thomas Bakewell in support of this case. To add to it there were towards the end of the eighteenth century better known advocates of 'moral' therapy, including the Tukes of York, Philippe Pinel in France and John Conolly, physician at the Hanwell Asylum. The efforts of such reformers led to the enactment by Parliament of new regulations for regulating madhouses in the 1770s, though even at the end of the eighteenth century there were still no more than 5,000 'lunatics' in British institutions such as licensed madhouses and houses of correction for paupers.

By the beginning of the twentieth century the number of mentally ill people in 'warehouses for the insane' was approaching one hundred thousand. As Box 3 stresses, 80–90 per cent of these men and women were paupers (Hodgkinson 1966). Even allowing for the fourfold overall UK population growth in this period it was thus the Victorian epoch of urbanisation, industrialisation and first stage demographic transition, rather than any changes in eighteenth century society or thought, which promoted the build-up of a large, segregated, institutional population of mentally disturbed and/or socially deviant people in Britain.

BOX 3

Poverty, class, race and mental health

In the Victorian Asylums and (by definition) the Poor Law hospitals the patient population was largely comprised of people who, outside their walls, would be living in abject poverty. Some would have had genuinely disabling psychiatric states, or conditions like late-stage syphilis – 'general paralysis of the insane' was a fairly common diagnosis in the nineteenth century. But many others may only have been temporarily ill and have had nowhere to go, and no source of community based relief. Once in an Asylum, both opportunities and motives to leave were for them limited.

Better off people with mental health problems were usually cared for in their homes, or in some cases in private residential establishments. However, the standard of treatment other than that offered by genuinely loving relatives was even for them unlikely to be good.

Against this back-cloth the standards of mental health care universally available in Britain in the late twentieth century represent a very significant achievement. Nevertheless, issues related to poverty, and class and race linked disadvantage, still distort patterns of mental illness occurrence and treatment. Challenging environments can make 'organic' states worse and precipitate reactive ones. And cultural and allied differences in communication style and expectation can lead to already disadvantaged individuals receiving relatively unsympathetic and/or inappropriate treatment. Quality assurance in modern mental health service delivery demands the recognition of such, albeit inevitable, dangers and the introduction of systematic checks and balances to counter them.

The legislative origins of this dramatic expansion of Asylum provision lay in the County Asylums Act of 1808, which permitted the establishment of rate funded asylums on a voluntary basis. Later in the century (after the focus of Poor Law provision had shifted from community to workhouse based support) the 1845 Lunatic Asylums Act obliged all county and borough authorities to establish asylums (Hoggett 1984).

As the nineteenth century progressed, public thinking about mental health issues appeared to become increasingly ambivalent. On the one hand there was a desire to see 'madmen' locked up for as little cost to the ratepayer as possible (although Asylums were more expensive than workhouses). On the other there was a widely discussed fear that 'sane' people might be wrongly committed. Similarly, there was in the decades leading up to the 'Kaiser's War' a growing tension between eugenic concerns (based on poorly understood Darwinian thinking) that the free movement and breeding of 'poor stock' would undermine the quality of the British population, and libertarian philosophies and concerns for individual wellbeing.

The result of this was, first, a heavy emphasis on legal aspects of, and control over, events such as admission to an Asylum. Second, despite the fact that public Asylums were first provided in response to pressure from reformers wishing to improve conditions for mentally distressed people, by the end of the Victorian era their image was an already strongly negative one. The uncertainties and contradictions relating to their dual functions of social control and individual care even then paved the way for the time when the Asylums themselves ('majestic, imperious, brooding ... rising unmistakable and daunting out of the countryside' – Powell 1961) would suffer ostracism and rejection.

Towards a medical model: The reforms of the 1950s and 1960s

The emergence of a more strongly medical approach to mental disturbance can be traced back to World War I, and observations that the terrible experiences of that conflict were sufficient to precipitate severe symptoms of mental disturbance in many previously healthy male subjects from middle and upper class backgrounds. This awareness, together with influences such as the work of Freud and the activities of the 'mental hygiene' lobby in both America and Britain (see Newton 1988), opened the way to new thinking about the origins and appropriate treatment of psychiatric conditions. For example, in the 1920s the Royal Commission on Lunacy and Mental Disorder argued that mental illness was essentially a public health problem. Its authors encouraged the renaming of the Asylums as mental hospitals; 'lunatics' were referred to as 'persons of unsound mind'.

The resulting (1930) legislation facilitated voluntary admissions and the development of some out-patient mental health services. Although the treatments which emerged during the interwar period (insulin shock therapy, electro-convulsive therapy, leucotomy etc) were often of doubtful value, and little was in fact done to improve the situation of long-stay residents in the Asylums, the passing of the Mental Health Treatment Act signalled the start of change.

Following the war of 1939–45, which added considerably more to professional understanding of the impact of environmental stresses on individuals' mental states (Ahrenfeldt 1958), there were two major events relevant to mental health care: the formation of the NHS in 1948 and the discovery and development in 1952–4 of the first of the major tranquillisers. Although the former was of great national importance, the advance in medicine availability, which was a result of French pharmaceutical research, was of global significance.

Coming as it did at around the time when antibiotics were dramatically cutting death rates from infections, the discovery of the therapeutic effect of chlorpromazine afforded the promise that conditions like schizophrenia could not only be alleviated, but might soon be cured. This was reinforced by the development of both the tricyclic and the monoamine oxidase inhibitor antidepressants in the mid-1950s. The first of the benzodiazepine anxiolytics was marketed at the end of that decade. Despite the fact that in the event the pharmaceutical treatment of mental distress proved more difficult and less beneficial than some naive commentators may have suggested (see later text), the hopes and expectations generated by the medicines of the 1950s were a powerful promoter of political and therapeutic change.

In Britain this optimism boosting effect manifested itself most obviously at the end of the 1950s through the passing of the 1959 Mental Health Act, and then shortly afterwards by the publication of the 1962 Hospital Plan. The effect of the former was to enable more people to enter or stay in mental hospitals on a voluntary basis, like patients in other NHS provisions. (By the mid-1950s only a quarter of mental hospital admissions were compulsory, but seven out of 10 residents were 'certified'.) It also allowed the doctors treating them greater freedom from legal restraint, extending their authority more to match that already enjoyed by other branches of medicine.

The 1962 Hospital Plan was based on statistical projections (extrapolated from the 1955–60 trend) that indicated a sharply falling need for mental hospital beds (Tooth and Brook 1961), coupled with a political conviction that the old Asylums no longer provided acceptable care (Powell 1961). There may also have been a desire not to have to invest large amounts of money in improving the country's

BOX 4

American mental health initiatives

The start of the 1960s saw in America the publication of both Erving Goffman's seminal book *Asylums* (Goffman 1961) and *Action for Mental Health*, a major report on mental health policy options (HEW 1961). The first opened the intellectual floodgates for a tide of works condemning oppressive conditions in institutions like the (very large) US mental hospitals. The second paved the way for President John Kennedy's high profile political initiative on mental illness and intellectual disability.

This last led to legislation in 1965 which facilitated the establishment of Community Mental Health Centres right across America, supported by federal funding (Jones 1988). The ambitious programme then laid down demanded from the CMHCs the provision of comprehensive in-patient, out-patient, emergency and other services. The original plans suggested a nationwide total of around 2,000 such facilities.

Less than half that number exist today. Problems encountered by the CMHCs during their development included 'swamping' by the psychiatrically 'walking wounded'; poor management and breakdown of satisfactory staff roles; and political and medical opposition.

The extent to which US experience can meaningfully be translated to the very different United Kingdom situation is necessarily limited. However, there are a number of lessons usefully to be drawn from it. One may be that sufficiently charismatic political leaders can venture into 'unpopular' fields like mental illness with positive new approaches and, at least for a time, draw electoral strength from urging reform.

The dangers lying behind this observation are, however, considerable. On the one hand efforts to present the need for change in a popular manner can lead to an inadequate recognition of some mentally disturbed peoples' true problems. And on the other too little effort made to maintain political interest in supporting an expensive, ongoing programme of reform (particularly after changes in Government) can lead to a loss of vital resources.

A second important insight to be gained from the US CMHCs experiment is that there is a special need to protect the interests of the most severely distressed and/or chronically disabled psychiatric service users, who are often the least socially skilled in terms of exercising consumer power or practising self-advocacy. Efforts to avoid stigmatising and isolating such people must not undermine awareness of the requirement for clear resource allocation procedures and appropriate staff dedication. Otherwise there is likely to be a drift of service focus towards acute and less severe cases.

Victorian mental hospital legacy, and an intention ultimately to cut public spending by containing the mental illness problem 'in the community' with the help of relatively low cost medicines (Jones 1988).

It was announced that the number of psychiatric beds in England and Wales would be cut by about 50 per cent by the mid-1970s (from 150,000 to 75,000). A significant proportion of the latter were to be provided in the new all-speciality District General Hospitals which the Plan envisaged. Instead of long-term incarceration, psychiatric medicine would in future be concerned more and more to provide short-term treatment followed by rehabilitation in normal community settings.

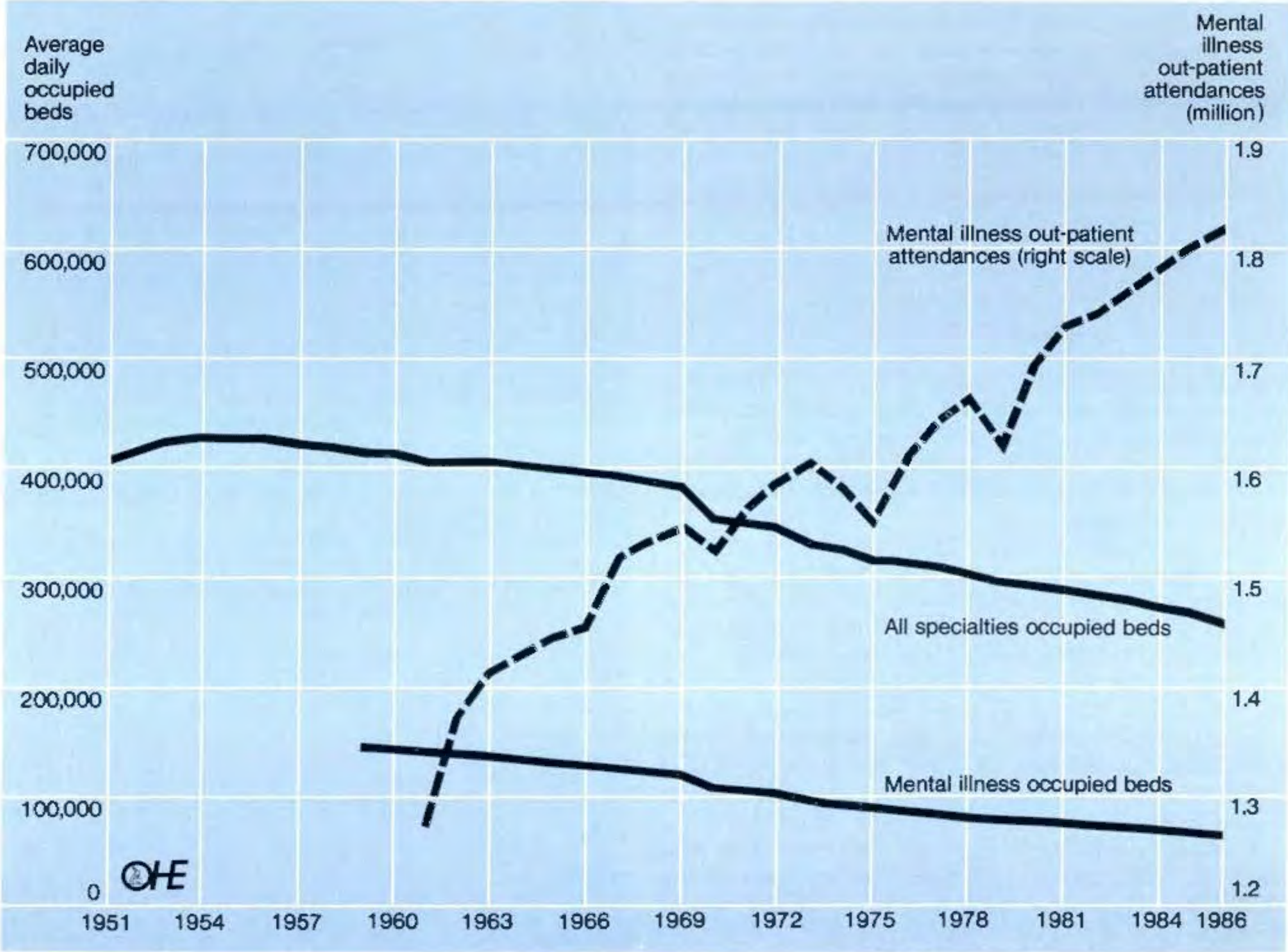
Seen together the reforms of the late 1950s and early 1960s comprised an innovation of startling magnitude. They opened the way for psychiatry to be brought 'in from the cold', to 'join the rest of medicine' (Joseph 1971). Events such as the formation of the Royal College of Psychiatrists in the early 1970s can be linked directly to the strengthening of psychiatric medicine consequent to the 1959 Act and the 1962 Plan, which in a way marked a revolution in care more enduring and profound than even that stimulated by President Kennedy's dramatic early 1960s initiatives on mental health – see Box 4.

However, few revolutions prove as successful as their supporters hope. Most merely serve to re-present underlying problems in new guises, which for a time prove more acceptable than those which preceded them. Even while Enoch Powell was Minister of Health some commentators feared that adequate community services for mentally disturbed people would not evolve (see Titmus 1968). The concluding part of this section will examine in more detail the underlying problems and disputes which have emerged in the British mental health arena during the past two decades. But before this a brief review of empirical data relating to changes in hospital activity and the build-up of alternative services is offered.

A changing pattern of care

The projections made at the beginning of the 1960s regarding the decline of mental illness hospital beds proved wrong in as much as they implied a mass closure of the Asylums during the 1970s and 1980s. Nevertheless, despite a long, complex and sometimes heated debate on bed requirements (see, for example, Royal College of Psychiatrists 1988) the national picture presented in Figure 5 – and Figure 1 on page 3 – is one of steady reduction, with a rate of a fall of around 3,000 beds per annum. Currently, there are a little over 50,000 occupied mental illness beds in England at any one time, representing some 20 per cent of all NHS occupied beds. At the end of the 1950s the equiva-

Figure 5 **Hospital occupied bed and mental illness out-patient attendances, England and Wales**



Note: From 1970 onwards, figures relate to England only

Source: Health and Personal Social Service Statistics lent total was close to 150,000, or just under 40 per cent of all NHS occupied beds.

The Scottish record is roughly comparable, although there the number of mental illness beds stayed relatively constant at around 19,000 throughout the 1960s. The rate of decline was subsequently fairly even, so that there are now about 8,000 psychiatric illness beds in Scotland. Per head, this is some 50 per cent above the level of provision available in England.

Figure 5 also shows that the mental illness out-patient attendances in England have risen by 50 per cent or more in the last three decades. Despite concerns over the alleged failure of the alternative health and social services to replace the decline in inpatient provision, significant progress is suggested by a wide range of data.

For instance, there are now over 3,000 trained Community Psychiatric Nurses working in the NHS in England, compared with just over 1,000 at the start of the 1980s. The rapid (100 per cent per annum) growth in British Community Mental Health Centre numbers is described in detail later in this paper. And another indicator of the expansion of service provision is the growth of general practice across the UK. There are now some 30,000 NHS family doctors, compared with 20,000 at the start of the 1960s. Their contribution to the care of mentally distressed people is considerable, probably accounting for between 10 and 20 per cent of their time.

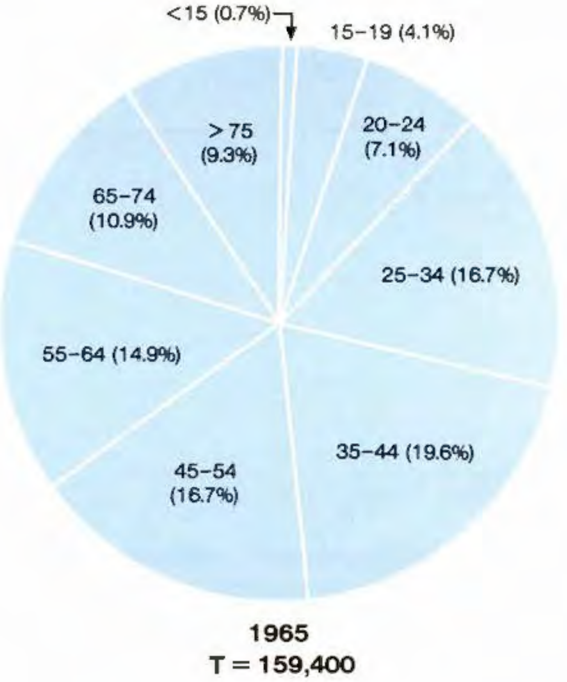
In England alone NHS mental hospitals and units now provide 19,000 day care places (excluding those for inpatients). The number of nurses employed in psychiatric hospitals and units stands at over 80,000 while the total of psychiatric consultants relative to the population rose by almost 40 per cent in the decade 1976–86. At the start of that period there were 2.2 such consultants for every 100,000 people in this country. By 1986 there were 3.1.

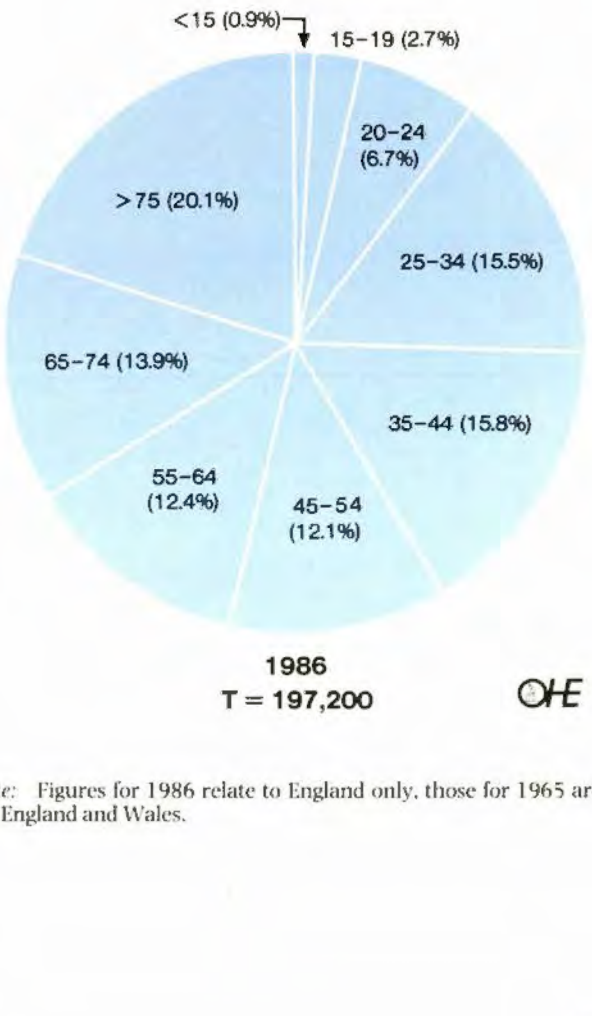
On the social service side commentators such as the Audit Commission (1986) have noted that the number of places in Local Authority and private/voluntary homes for mentally ill individuals doubled between 1974 and 1984. The current population living in such facilities stands at around 10,000. There are also around 10,000 English Local Authority and voluntarily provided day centre places for this client group, though the latter total falls well short of the target set in the 1975 White Paper 'Better Services for the Mentally Ill' (HMSO 1975). The Audit Commission's influential report *'Making a Reality of Community Care'* (the publication of which in late 1986 led immediately to the establishment by the Government of the Griffiths enquiry on community care) concluded that the provision of services relevant to the needs of mentally ill people living outside hospitals is still uneven, fragmented, and in a number of respects fundamentally inadequate.

Returning to hospital and mental illness unit data, there has been a significant rise in short stay admissions since the early 1960s. This has coincided, as Figures 6a and 6b indicate, with an increased proportion of people aged over 65 entering NHS mental illness facilities. In England, the annual total of admissions (first and subsequent) climbed from about 160,000 in the mid 1960s to some 200,000 in the mid 1980s. About a half of these were first admissions in the 1960s; only 25 per cent are first admissions today. It is this shift which has been referred to as the introduction of 'revolving door' hospital care.

As far as the length of the stays of hospital inpatients are concerned, the available information indicates that today

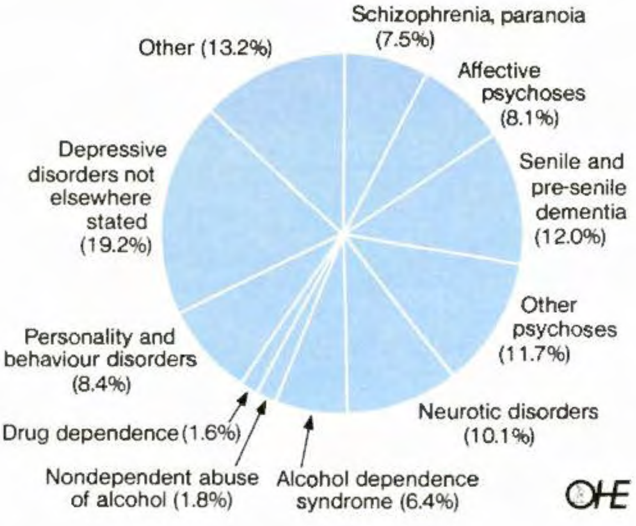
Figures 6a and 6b **All admissions by age – mental hospital and units**





Note: Figures for 1986 relate to England only, those for 1965 are for England and Wales.

Figure 7a **Distribution by diagnosis of first admissions to mental illness hospitals, England 1986**



Source: Health and Personal Social Service Statistics

Figure 7b **Distribution by diagnosis of all admissions to mental illness hospitals, England 1986**

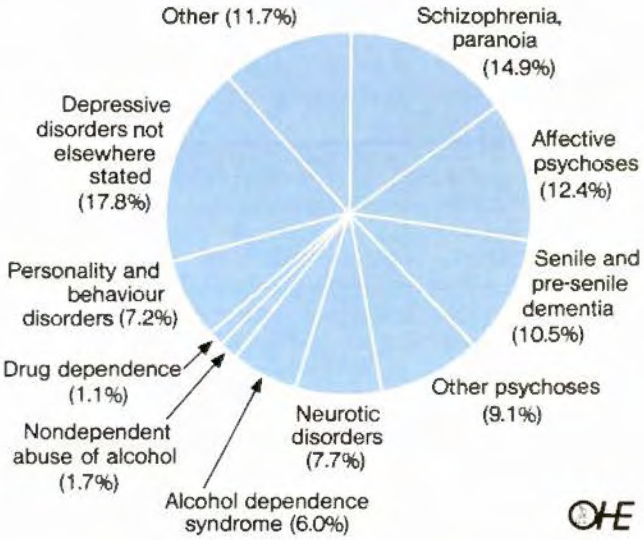
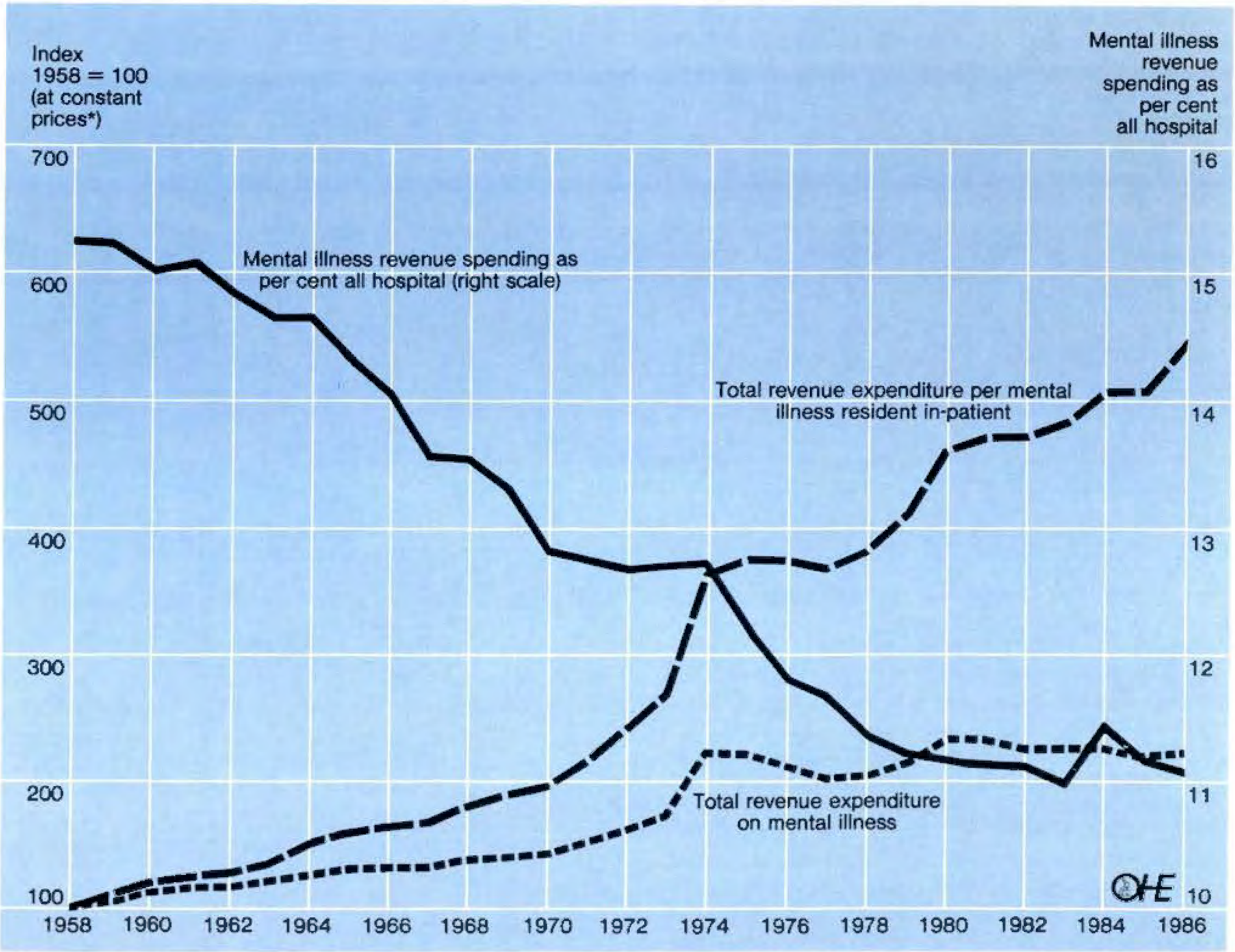


Figure 8 **Hospital revenue expenditure on mental illness resident in-patients, England and Wales (Index 1958 = 100)**



Notes: From 1970 onwards, figures relate to England only
*As adjusted by the Retail Price Index.

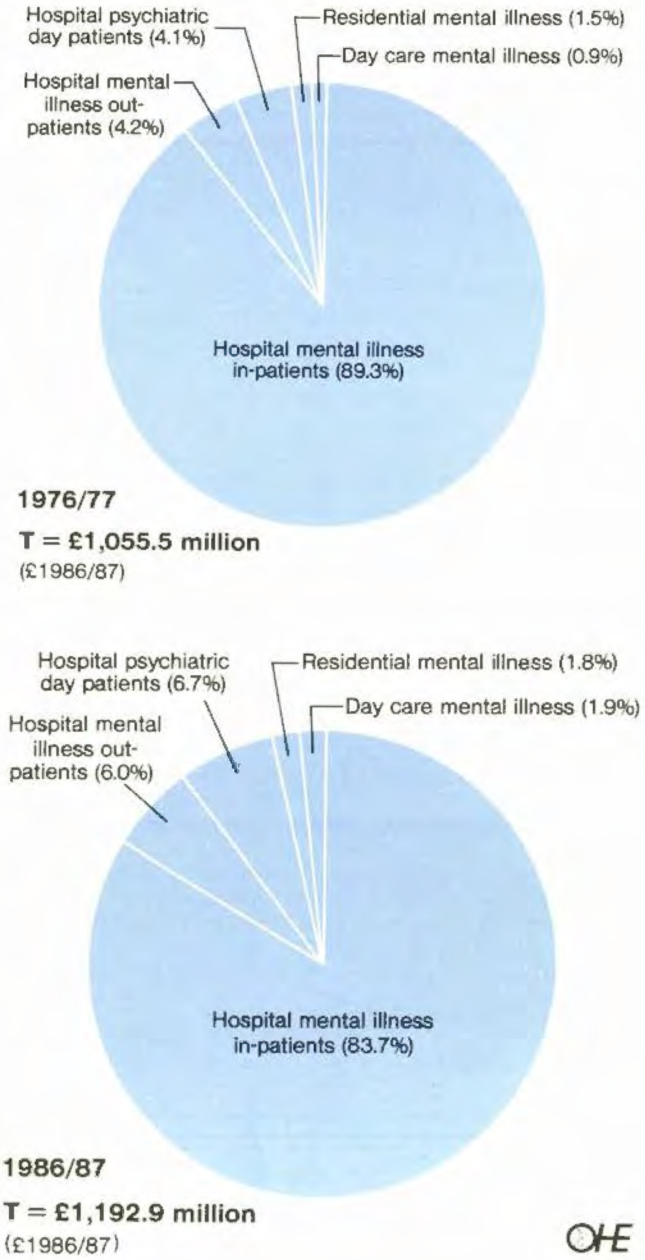
Source: Health and Personal Social Service Statistics just over a half of the 50,000 or so English mental illness hospital inpatients have been there for a year or more: about 30 per cent have been in hospital for five years or more. (Some 70 per cent of non-psychogeriatric long stay patients have a diagnosis of schizophrenia – Clifford 1989.) For comparison, the number of people in English mental illness hospitals and units at the start of the 1970s was near to 100,000. About 75 per cent had been there for a year or more, and 50 per cent for more than five years. Such data clearly support the view that hospital care has become a much more flexible resource, with most people entering and leaving it for short periods of asylum and/or treatment rather than long-term residence.

With regard to shifts in diagnostic patterns, classification changes and practice adjustments make meaningful comparisons over time difficult. Figures 7a and 7b present 1986 data, contrasting first admission figures with the averages for all admissions. Key points include the high rates of repeat admission for patients diagnosed as having schizophrenia or an affective psychosis and, since the 1960s, a rise in the number of people admitted to mental hospitals or units with senile dementia and alcohol related problems. The workload imposed by the latter appreciably outweighs that related to all other recorded drug dependence.

Finally, turning to expenditure, Figure 8 shows that as the number of people resident in mental illness hospitals and units has fallen, so per capita expenditure has risen. In inflation adjusted terms five times more is now spent per inpatient place than was so at the start of the 1960s. To a degree this reflects greater throughput, but it is also a function of the high fixed costs of institutions and the fact that few of the old Asylums were completely closed by the end of the 1980s. This meant that (even though NHS mental hospital and unit spending in England had dropped by a quarter as compared to all hospital costs) without bridging arrangements to cover periods of 'double expenditure' on old and new services together, only limited funds have been available to set up new forms of care 'in the community'.

This dilemma is in part reflected in the trends indicated in Figures 9a and 9b, which compare NHS and Personal Social Service expenditures on mental illness for the years 1976/77 and 1986/87. They confirm that hospital inpatient expenditures dominated the cost structure, accounting for 89 per cent of all sector relevant spending in the late 1970s and 83 per cent a decade later. Despite the introduction of joint financing arrangements between the NHS authorities and the social services, identifiable LA spending on services for the mentally ill still accounted for less than 4 per cent of the total in 1986/87, compared with about 2.5 per cent in 1976/77. (Such figures exclude, however, significant outlays on elderly demented individuals. For the UK NHS and state supported residential and social services together, these are estimated to cost in the order of £500 million in excess of the moneys directly identifiable as being spent on mental health care.)

Figures 9a and 9b **Hospital and Community Health Services and Personal Social Services gross revenue expenditure, England (Mental Health)**



Source: Social Services Committee, Session 1987/88

Reasons for limited success

Towards the end of the 1960s the major public concerns about the care available for mentally ill people centred on the quality of care available in the large institutions. The then Secretary of State for Health Richard Crossman made vigorous efforts to address the causes of the scandals which arose at that time regarding conditions in hospitals for elderly, mentally handicapped and mentally ill people alike. Today's Health Advisory Service owes its origins to actions taken at that time.

Twenty years later there are still some voices expressing concern about the environment offered by hospitals, and fears that the closure programme for the Victorian Asylums is proceeding too slowly. (See, for example, Heginbotham 1989). Yet there can be little doubt that much more public attention is now paid to various groups, some representing relatives, which articulate fears that closures are taking place over-rapidly, before alternative provisions have been made. Some people even appear to doubt the viability of the entire community care programme, and believe that many psychiatrically disturbed people would be better off living in adequately financed, humanely run hospitals than they would making do with widely disseminated, small scale and hence relatively expensive community based support.

It would be wrong either to 'talk down' the achievements of the last three decades, or to deny that much more can and should be done to improve mental health services. The real significance of the Audit Commission findings summarised in Box 5 is that they are pointers as to how desired reforms can be realised faster in the 1990s, not explanations of why change should be thought undesirable. Similarly, the objective of the commentary below about why progress in mental health care in the community has been, in some respects, disappointing in recent years, is to provide a basis for discussion about how future performance can be enhanced. The main points, which are not presented below in priority order, include:

Inadequate outcome evaluation

Measuring the product and value of health care interventions is a problematic process, even in the context of relatively clear cut areas like, say, orthopaedic surgery. In mental health care, which involves many complex social and subjective factors, adequate evaluation is particularly difficult. For example, few credible attempts have been made to establish the overall costs and benefits of alternative institutional and community care policies in this country, which means that resource allocation decisions have in the main been based on guesswork, rhetoric and ideological conviction rather than scientific knowledge (O'Donnell *et al* 1988a, 1988b).

BOX 5

The Audit Commission's findings on mental health care in the community

In 1986 the Audit Commission, a body independent of Government, pointed out that progress towards the provision of community services for mentally ill people has been particularly disappointing. Not only, said its report *Making a Reality of Community Care*, had there been slow movement towards the targets set by the 1975 White Paper *Better Services for the Mentally Ill*; what changes there had been had occurred in a biased manner, with the reduction of NHS hospital provision running ahead of the build-up of community services. Moreover, clinical advances had in any case outdated the 1975 plans.

The Commission highlighted gross geographical variations in care standards; perverse economic incentives for both Health and Local Authorities; the need for bridging finance during transition periods between one pattern of service provision and another; organisational confusion; complex structures and multiple agency providers; and inadequate service staffing.

The recommendations of the 1986 report were in many respects a prelude to those contained in the 1988 Griffiths report. However, in detail they differed significantly. In the context of the Audit Commission's proposals on mental illness the two strategic options put forward were: a) the formation of a single budget agency with resources contributed by both local LAs and DHAs or b) full NHS responsibility, with LA services provided on a contract basis.

The Commission was able to identify a wide range of instances in which particular Authorities had been able to achieve desirable progress. Key features of successful projects include:

1) Strong and committed local champions of change.
2) A focus on action, not bureaucratic machinery.
3) Local service integration, cutting across agency boundaries.
4) Focus on the local neighbourhood.
5) A multi-disciplinary team approach.
6) A partnership between statutory and voluntary organisations.

Despite the efforts of some psychiatrists and social scientists to improve and apply evaluation techniques (see, for instance, Marks *et al* 1987, Marks 1988) this situation still applies. Indeed, information is often so limited that it is not possible for care providers to know overall what services and treatments any one individual is receiving, much less to gain a realistic idea of the results of intervention. Weak evaluation gives rise to a risk both of continuing sub-optimal resource allocations and unresolved conflicts within and between the various mental health care professions.

Lack of clear objectives and philosophy

The basic values and objectives of people working in the mental health sphere are often poorly explained and/or loosely defined. This may be illustrated by the confusion often surrounding the definition of the term 'normalisation'. For some commentators this appears to refer to the goal of providing support outside large institutions to as many people as possible, so enabling virtually everyone with mental health problems to live 'in the community' in ordinary houses and – if achievable – with ordinary ways of spending their time. To others it may mean 'normalising' institutional cultures, so that the values of carers and the rights and freedoms enjoyed by residents correspond to those of the majority of the people. And to yet others it may mean introducing a greater sense of positive value into the care and lives of mentally distressed people so that, whatever their specific activities or living conditions, both carers and those receiving support can share a sense of purpose and meaning. Such a lack of consistency and rigorously defined objectives has helped further to fragment and internally to divide the mental health services.

Lack of political will

'The mentally ill' are not perceived by politicians as being a popular client group amongst the electorate. Providing services are 'good enough' – that is, that politically damaging scandals related to inadequacies can be avoided – few career politicians are likely to place this particular constituency at the top of their list of concerns. A lack of drive from Parliament, coupled with the other factors noted here, has at best meant that service development has been slow. The inertia and complacency implied by statements in the 1975 White Paper *Better Services for the Mentally Ill* to the effect that there was little hope of the 'kind of service we would ideally like even within a 25-year planning horizon' would not have been tolerated in more sensitive areas, like heart surgery for children.

Jones (1988) has also pointed out that the 1975 White Paper begged many questions. For example, it argued that the basis of the mental health care system in or around the year 2000 would be 'the primary care team', consisting of family doctors, health visitors, home nurses and social workers. But it never addressed how such teams were in practice to be formed, appropriately skilled and encouraged to work together. Such an intellectual lack of care is again indicative of inadequate political, and hence civil service, concern.

Structural inefficiencies and managerial limitations

The problems of divided responsibility and 'passing the buck' between various budget holders, coupled with a lacking of transitional financial bridging arrangements, have been referred to above. Economic barriers to change may be particularly great in Regions which have traditionally low unit hospital mental health costs, and hence have little opportunity to shift 'marginal' resources between institutional and community settings.

Both the NHS and Local Authority social services have long suffered from poor management arrangements and limited planning capabilities. Although steps such as the 1983 Griffiths enquiry and the subsequent introduction of general, rather than functional, management in the NHS have gone some way to improving the situation, many problems remain. Later sections of this paper discuss the Government's 1989 proposals to improve community mental health services. These follow (and indeed go some way beyond) the 1988 report from Sir Roy Griffiths on this topic, and may also be linked to public and political concerns about the publication of the White Paper 'Working for Patients' (HMSO 1989).

The limits of medical authority

The 1959 Mental Health Act was liberating in the sense that it encouraged the voluntary treatment of severe mental disturbance, and promoted the perception of the latter as treatable. But to the extent that it replaced legal control with medico-psychiatric control of those labelled mentally ill, consumer groups like MIND soon became concerned about the possibilities for abuse and the need for more clearly defined legal rights (Gostin 1975). The eventual result of the consequent build up of pressure for further reform was the 1983 Mental Health Act, the main provisions of which are outlined in Box 6.

BOX 6

The 1983 Mental Health Act

A major objective of the 1983 Act was to prevent 'human rights' abuses in mental health care. It did so through measures such as those which limit the administration, without consent, of treatments such as ECT and medicines to 'sectioned' patients to just three months. After this time independent approval is required, should the patient not wish to continue with the treatment.

This legislation also established the 90 member strong Mental Health Act Commission, with extensive responsibilities in relation to monitoring care standards, protecting patients' interests, and defining acceptable practice. Other instances of changes in the law brought about in 1983 included a halving of the period required before a compulsory care order should be reconsidered or terminated and improved patient access to Mental Health Review Tribunals.

However, only a small minority of mentally ill people ever become subject to compulsory treatment of any kind. Some commentators have therefore argued that the 1983 Act was largely irrelevant to the needs of most acutely or chronically ill mental health service consumers. To the extent that it and those who campaigned for it drew attention away from other important issues in psychiatric care such concerns are, in part at least, justified. But for the thousands of individuals each year who do undergo mandatory treatments its significance should not be under-rated.

Recently a new code of practice relating to compulsory therapy (as required by the Mental Health Act) has been drafted; this should prove to be an important influence on care standards in the 1990s. It is also possible that changes in the role of the Mental Health Commission and its staffing could enable it to play a more positive part in the overall service development process during the decade ahead.

It may be noted that although measures such as the establishment of the Mental Health Act Commission were constructive and welcome innovations, some commentators believe that the 'civil rights' debate in mental illness has drawn attention away from the vital needs of a variety of groups. This view is hotly challenged by others. But the key point is that there is continuing uncertainty over the standing and authority of psychiatrists and other doctors relative to both other professional groups active in the mental health care arena, and their patients. In part, the long standing ambiguity between Asylums as places of imprisonment and social control, as opposed to places of protection and individually oriented support and treatment, lives on in the public debate over psychiatry. It affects the authority of doctors and issues like the need for informed patient consent to treatment. To the extent that the atmosphere so generated needlessly undermines professional morale and patient confidence it continues to act as a barrier to progress.

The 'Seebohm' reorganisation of social work, and the loss of specialist skills

Together with the 1974 NHS restructuring, the reorganisation of social work at the start of the 1970s established it as a profession independent of medicine, with its own career structure and power base. In many respects this was a desirable and rational step forward, designed like the preceding Salmon reforms of nursing to equip social workers better to address the complex challenges of the 1970s and 1980s. The 1968 report of the Seebohm Committee was strongly critical of service fragmentation and inadequate health and social care linkage. However, as events developed after 1970 the emphasis on generic social work arguably served to de-skill the profession. In the light of the new challenges social service departments now face such observations raise important questions as to the adequacy of the resources available for social worker education in areas like management and mental health.

Sectional professional disputes and rivalry

Martin (1984) has shown that a major cause of inertia and sub-optimal performance in the mental health care arena is related to self-interested and destructive professional rivalries. Rather than genuinely addressing the problems of how best to serve those service consumers most in need, some members of the care providing groups appear to have been more concerned to pursue or modify in their own interests existing employment patterns and power relationships.

Poorly expressed consumer demand

Because of factors such as those which make evaluation exercises difficult, the communication of consumer needs and preferences in the mental health 'care market' is often problematic. Indeed, to the extent that the term 'madness' is traditionally used to imply a loss of grasp of one's own best interests, direct consumer sovereignty may not be viewed as always desirable in this area. However, there are in reality many points within the care process in which providers should obviously heed expressed consumer views. There are also important advocacy roles for families, friends and organised consumer representative bodies although some may argue that the groups that come under the latter category have not always been clear about their objectives, or able to demonstrate convincingly the legitimacy of their authority to speak on behalf of mentally ill people as a whole.

Concerns over medicine usage

During the 1970s and 1980s a number of commentators have expressed concerns relating to the possible side effects of medicines like the major and minor tranquillisers. Some may have hoped to encourage improvements in community mental health provision by stimulating a sense of political scandal about overprescribing, in a manner similar to that in which mental hospital scandals (Goffman 1961, Robb 1967) could be thought to have driven institutional reform two decades or so ago (Lacey 1983, MIND 1984, Lacey and Woodward 1985).

There are reasonable grounds for raising doubts as to the positive value of psychotropic medicine consumption in a variety of instances. But there are also grounds for fearing that alarmist stories could also have diverted attention away from underlying problems like those of financing alternative forms of treatment, and encouraged some patients to reject, or worry needlessly about using, beneficial medicines. At worst, organised scare campaigns have polarised biological and psycho-social approaches to mental illness, so blocking the emergence of realistic and comprehensive bio-social understandings of psychiatric complaints. Given the importance of medicines availability in catalysing changes in overall mental health service values and structures, the following section of this paper investigates further questions about the role of medicines, before investigating the various ways in which the quality, effectiveness and efficacy of existing mental health provisions may in future be enhanced.

People have used mind affecting substances throughout, and well before, recorded history. Alcohol, tobacco, caffeine, opium, cocaine and cannabis are all examples of drugs, or drug containing materials, which have been widely taken in various cultures at various times. They have also all been banned or strongly disapproved of at various points in history, a clear indicator of the controversy and social tension which surrounds mind affecting chemicals. This exists not just because of the physical dangers they can present to individuals, but also because of their potential impact on users' behaviour relating to the community around them, and the implications psychotropics have for our perception of 'reality'. The use of illegal ('alien') mind affecting drugs may (apart from by definition encouraging criminality) threaten a group's shared sense of being, while approved intoxicants or stimulants can reinforce ontological security (Taylor 1975).

The use of psychotropic drugs as medicines to treat states diagnosed as illnesses is similarly ancient. For example, in traditional Ayurvedic medicine in India rauwolfia, containing reserpine, has long been used to treat people with florid symptoms associated with schizophrenia. (In modern medicine rauwolfia alkaloids are not now normally used. There is a risk of severe depression caused by generalised bioamine depletion.)

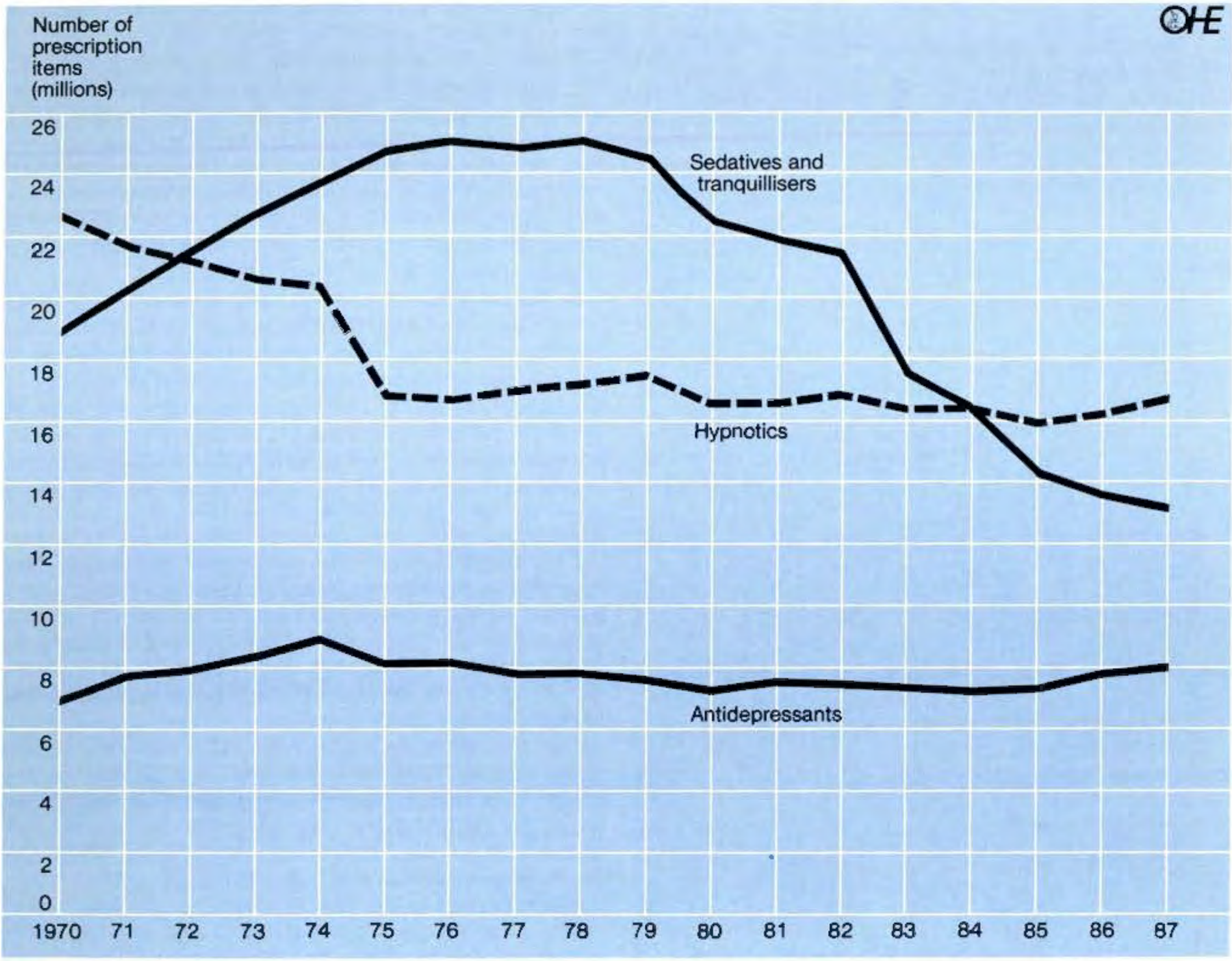
However, until the modern era the dividing line between medical and social or hedonistic drug use was often blurred, a fact illustrated by Victorian writers from De Quincey to Conan Doyle. Alcohol and opium were the main 'tranquillisers' available in Britain in the nineteenth century (Berridge and Edwards 1985), despite the fact that chloral hydrate (a compound first synthesised in the 1830s) became widely used as a sedative in the second half of the Victorian era. The barbiturates and bromide based medicines superseded 'chloral' in the early years of the twentieth century. And the amphetamines were introduced shortly after the First World War.

From today's relatively strict standpoint regarding the sale of medicines it is surprising to note that until the 1920s preparations like tincture of opium or cocaine were available 'over the counter' from pharmacists. The latter could supply barbiturates without prescription well into the 1930s. Amphetamines were on unrestricted sale until the 1950s – the original 'mothers' little helper' was not a sedative but a stimulant.

Seen from this perspective, the growth in the prescribing of psychotropic medicines by NHS general practitioners during the 1960s and the 1970s was not such a startling or unexpected a development as is sometimes suggested. Nor should the increased medical recognition and treatment of less severe forms of mental distress which took place in those decades blindly be assumed to have been undesirable. It encouraged a more open recognition of conditions like depression and anxiety and may also have discouraged inappropriate attempts at self-treatment. The latter may include excessive drinking, and smoking.

In this last context it is relevant to note that the consumption of these two 'cultural super-drugs' causes approaching 150,000 premature deaths in Britain each year, and involves consumer outlays of over £20,000 million a year. This is little short of all health service costs. United Kingdom NHS spending on all forms of psychotropic medicines (hospital and community) is currently some £100 million a year, or about 0.4 per cent of the total NHS budget. For comparison, psychotropics cost the UK NHS

Figure 10 **Number of prescription items dispensed by chemists, Great Britain (DoH categories)**



Note: Both the 'sedative and tranquillisers' and 'hypnotics' categories will include a proportion of benzodoazepine medicines – the total of the latter in 1987 was about 25 million prescriptions.

Source: Health and Personal Social Service Statistics, PPA

about £10 million per annum in the early 1960s (one per cent of all NHS costs) and some £30 million per annum at the start of the 1970s (1.2 per cent of the then total UK NHS budget).

Turning to the volume of medicine usage, the annual number of (UK FPS) antidepressant prescriptions rose slowly at first, to two million in the early 1960s. It stood at about eight million by the start of the 1970s. (During the same time psychotropic prescriptions classified as stimulants and appetite suppressants fell from over six million to about three million, and has since declined further.) As Figure 10 shows, there has been little change in antidepressant usage since.

In the case of the benzodiazepines – which today comprise most of the so-called 'minor tranquillisers' used as anxiolytics and sedatives – prescription numbers rose rapidly during the 1960s. Their total reached about 20 million at the start of the 1970s (hypnotics and tranquillisers). Benzodiazepine prescribing in Britain attained a peak of around 31 million scripts in 1979, since then it has fallen back by over 15 per cent to around 25 million (see Taylor 1987). These trends can in part be explained by the replacement of the barbiturates with the safer benzodiazepines during the first two decades of their market life, followed by a decline in usage related to fears about dependence and their limited therapeutic value in many chronic cases of anxiety and related distress.

A failure of medicines?

The use of sedatives by people who are disturbed but not seriously disabled by psychiatric symptoms is always likely to be a controversial topic, lying as it does on the borderline of what is considered to be legitimate medical activity. Barbiturate and benzodiazepine prescribing (not to mention the marketing of thalidomide as a 'safe' hypnotic at the start of the 1960s) has long been at the centre of a rolling media 'human interest' story. In the 1970s, for example, concerns were (from a sociological viewpoint perhaps naïvely) expressed that minor tranquillisers issued in response to social problems would slow social change and so perpetuate undesirable living conditions (Lader 1975). Subsequently there were anxiety generating reports of benzodiazepines causing 'brain shrinkage'. And more recently there has been a focus of attention on the issue of long-term tranquilliser 'addiction'. This is sometimes said to affect more than three million people in the UK, although the available data suggests that the true figure is very much lower – see Box 7.

There can be no question that some people experience very unpleasant symptoms associated with benzodiazepine withdrawal. However, there can also be little doubt that the 'social problem' of minor tranquillisers is often exaggerated, and may to a degree have been constructed by interested parties such as politicians seeking to divert attention away from the need for costly service improvements and media researchers and writers seeking 'scare' stories which appeal to popular tastes (Gabe and Bury 1988).

Box 7 and Tables 3 and 4 provide some key facts about benzodiazepines, and their employment both in this country and abroad. British consumption of medicines of this type appears to be characterised by relatively low rates of overall use (in males comparable to those recorded in Sweden). But it is disturbing to note also that the British figures indicate low rates of short-term use and high rates of long-term consumption. The latter approach those seen in France and Spain (Balter *et al* 1984). Although there have been shifts in prescribing patterns since 1981, when the last major international survey took place, such data suggest that in this area British general practitioner care has in the past at least tended to combine restricted availability of sedative medicines for those in need of acute help with surprisingly long-term prescribing for those with chronic problems, who might well have required alternative support.

However, there are as far as the main objectives of this paper are concerned two rather broader points to be given special emphasis here. The first is that to a substantial degree the current debate over the prescribing, value, and side effects of all psychotropic medicines reflects the dilemma which has existed in mental health care throughout this century. Is 'the system' truly aimed at helping the individual receiving care, or is it more about control regardless of personal welfare and the possible suffering and secondary disabilities caused by, say, institutionalisation in

BOX 7

Minor tranquillisers – some key facts

1) Benzodiazepines have been available for about 30 years, during which period they replaced the use of the more dangerous barbiturates in the treatment of conditions like anxiety and sleeplessness. Benzodiazepine prescribing reached a peak in Britain in 1979, when 31 million NHS scripts were dispensed. This figure had fallen to about 25 million by 1987.
2) National and international data shows that women use benzodiazepine tranquillisers about twice as frequently as men. Persons over retirement age account for about a half of UK consumption; the age skew is particularly marked with those medicines described as 'hypnotics' (sleeping pills).
3) Figures from the early 1980s indicate that at that time there were a little over a million British people who had been taking benzodiazepines on a regular basis for a year or more, and half a million who had been using them for about six months. The number of individuals who currently have taken them for such periods is likely to be significantly lower. Dependency on any drug is arguably undesirable, although there is little evidence of physical harm emanating from sustained benzodiazepine usage. Problems normally occur when dependent individuals cease taking them too rapidly.
4) The available sociological evidence is that most tranquilliser users consider them to be a 'necessary evil' rather than a positive blessing (see, for instance, Gabe and Lipschitz – Phillips 1982).
5) The decline in benzodiazepine usage in Britain (reported above) in the 1970s and 1980s appears to have taken place mainly with regard to medicines described as tranquillisers. Those classified as hypnotics continued to increase in prescribed volume until the mid-1980s. One factor involved in the complex events underlying such changes may have been the imposition of raised prescription charges since 1979. This pushed down consumption amongst people of working age. Another has been the introduction of the 'limited list' in 1985, under which the Government limited NHS benzodiazepine supply to a relatively few authorised molecules/products.

Table 3 **Past-year anti-anxiety/sedative medicine use: percentage of each sex-age group using medication (1981)**

Age (years)	*Belgium*	*Denmark**	*France*	*Germany*	*Great Britain*	*Italy*	*Netherlands*	*Spain*	*Sweden*	*Switzerland*	*USA*
Males											
18 to 34	7.3	—	8.0	4.0	5.3	6.7	1.7	10.9	2.5	7.3	9.1
35 to 44	17.0	—	13.0	7.5	7.9	10.0	12.5	8.0	5.3	8.9	3.7
45 to 54	8.7	—	11.3	17.4	8.9	14.9	7.0	14.1	12.3	12.4	9.1
55 to 64	10.4	—	13.4	14.0	8.3	11.2	8.7	13.2	9.0	14.9	12.9
65 +	24.1	—	17.3	9.8	5.1	7.1	5.8	15.2	7.9	13.4	7.4
All	12.9	9.5	11.7	8.6	6.7	9.4	5.7	11.7	6.5	10.2	8.5
Unweighted no.	(836)	(895)	(874)	(769)	(965)	(897)	(460)	(821)	(744)	(747)	(771)
Females											
18 to 34	10.8	—	14.9	6.1	10.3	9.0	5.5	9.4	5.8	17.1	12.8
35 to 44	19.3	—	19.6	17.0	11.8	18.8	6.6	14.5	12.7	17.1	18.1
45 to 54	28.9	—	24.3	11.7	23.7	18.9	12.5	26.4	6.6	19.2	21.5
55 to 64	26.3	—	29.6	18.5	22.0	15.1	13.0	20.0	15.0	20.9	20.8
65 +	28.9	—	17.8	18.9	14.9	9.7	14.8	19.0	24.1	23.3	17.9
All	21.4	14.0	19.3	13.0	15.3	13.5	9.1	16.4	10.8	18.7	16.9
Unweighted no.	(1015)	(1036)	(1097)	(961)	(1053)	(994)	(1026)	(1055)	(759)	(795)	(758)
All persons	17.6	11.9	15.9	12.0	11.2	11.5	7.4	14.2	8.6	14.6	12.9
Unweighted no.	(1851)	(1931)	(1971)	(1730)	(2018)	(1891)	(1486)	(1876)	(1503)	(1542)	(1529)

Note: Percentages based on weighted numbers. *Age data for Denmark not compatible with designated intervals

Table 4 **Duration of regular daily use: percentage distribution for all persons**

Duration	*Belgium*	*Denmark**	*France*	*Germany*	*Great Britain*	*Italy*	*Netherlands*	*Spain*	*Sweden*	*Switzerland*	*USA*
No use	82.4	87.4	84.1	88.8	88.4	88.5	92.3	84.9	90.8	84.5	86.5
Less than 1 month	3.8	5.9	6.5	5.8	4.2	6.5	3.8	6.3	6.7	9.2	9.3
1 to 3 months	4.4	1.3	2.7	2.5	2.7	2.6	1.3	2.6	1.3	2.6	0.9
4 to 11 months	1.4	1.8	1.1	0.8	0.9	0.5	0.2	0.2	0.2	0.5	0.5
12 months or more	5.8	1.3	5.0	1.6	3.1	1.6	1.7	3.8	0.5	1.2	1.8
No answer	2.1	2.4	0.6	0.3	0.3	0.2	0.5	1.3	—	1.0	0.5
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Unweighted no.	(1851)	(1931)	(1971)	(1730)	(2018)	(1891)	(1486)	(1876)	(1503)	(1542)	(1529)

Note: Percentages based on weighted numbers *Source:* Balter *et al* 1984

Asylums or the side effects of major tranquillisers? (Tardive dyskinesia(s), which involve symptoms such as involuntary facial and other physical movements due to acquired dopamine receptor hypersensitivity, can be caused by neuroleptic medicines. The latter can also promote a subjective feeling of 'being drugged' and a range of other unwanted phenomena, like bloating. Careful prescribing and patient monitoring can of course minimise risks.)

The second point is that while the pharmaceutical developments of the 1950s caused optimism and raised expectations in the mental health sphere, the subsequent failure of pharmaceutical researchers to provide major new innovations for the treatment of psychiatric illness during the following three decades might be blamed for subsequent disillusion. Most of the medicines available at present are not fundamentally different from those available at the time of the 1962 Hospital Plan. Safety, convenience, compliance potential and in some cases specificity of action may all have improved, but the basic range of therapeutic options has not been radically extended. Even the observations which led to the use of lithium to treat manic-depressive illness can be dated back to animal experiments conducted in the late 1940s, although it was later that such therapy was developed in the clinical context. (Its mode of action is still not clear.)

There is an element of truth in the charge that since the 1950s progress in psychotropic medicine research and development has proved disappointing. And simplistic models of mental illness which imply that it can be cured like an infection are in any case highly questionable. It is unfortunate that some decision takers and care planners probably have been encouraged to ignore the social determinants of mental distress because of over-enthusiastic or premature claims made by the proponents of pharmaceutical and other biological interventions. Such errors must be avoided in the future, if the welfare of mental health service users is to be maximised.

However, having recognised this fact, it is also important not irrationally to deny the benefits that modern psychotropic medicines have already brought to many millions of people in Britain alone, or to ignore the opportunities now emerging for further fundamental therapeutic gains. The remainder of this section therefore comprises a brief summary of relevant medicines research now in progress in British and other laboratories. It is followed by an examination of overall service development options, intended to highlight those ways forward most likely to promote a balanced use of all the social, psychological and pharmaceutical forms of support which should comprehensively be available in the community.

Understanding brain chemistry

The delicacy of the brain and the fact that it is protected in life by the skull has made experimental investigations using traditional techniques extremely difficult. In recent years, however, powerful new techniques of analysis, in areas ranging from molecular biology and molecular genetics to imaging of brain activity using positron emission tomography (PET), have become available. The information being generated via the application of these methods should, when coupled with advances in neuropharmacology and related disciplines, enable researchers to understand the physical origins of mental illness more clearly, and eventually to develop new, more specific, therapies.

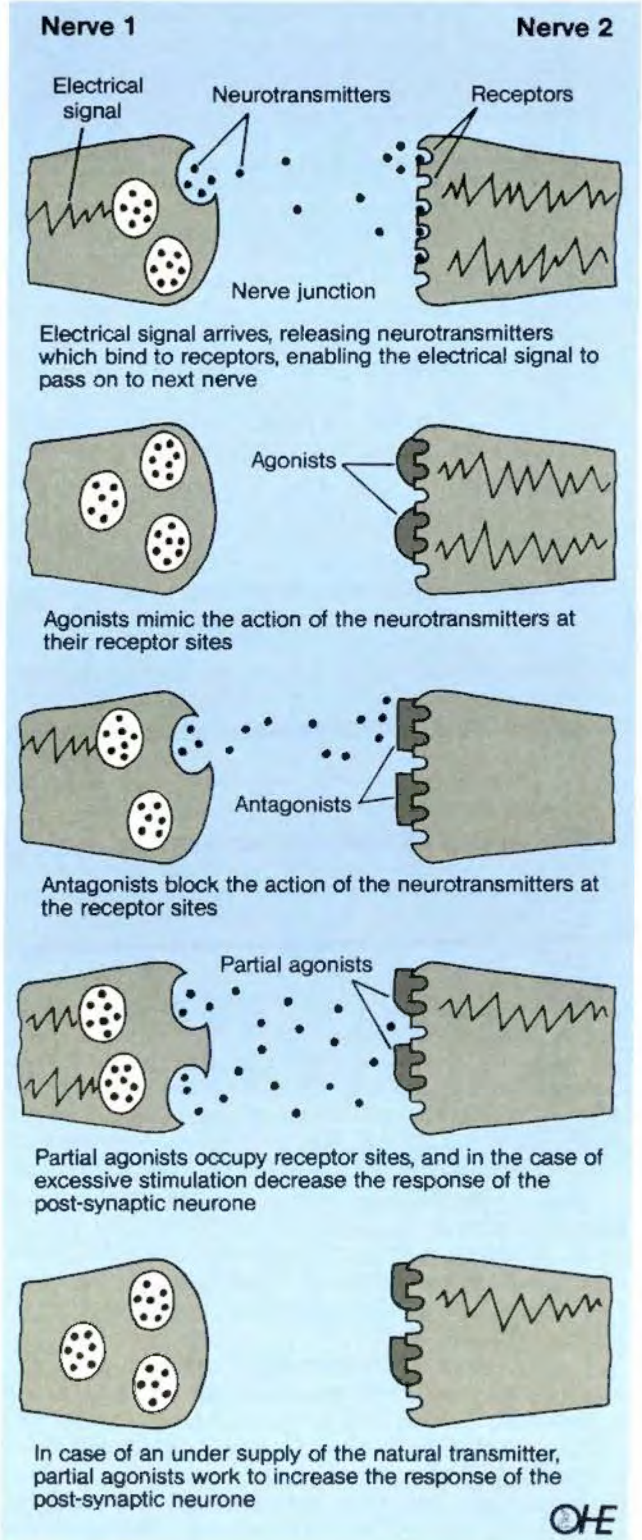
At present all psychotropic medicines work by modulating the effects or availability within the brain of naturally occurring, and widely distributed, bioamine neurotransmitters. These are chemicals which facilitate the passage of impulses from one nerve cell to another. They are stored in reservoirs near the nerve endings and released into the synaptic gap – the space between nerve cells – in order to 'carry over' an electrical discharge coming down one cell to the next. They are then very swiftly broken down or reabsorbed. Well-known examples of such substances include dopamine, noradrenaline and serotonin.

Psychotropic medicines modify the action of neurotransmitters in a number of ways. Some (agonists) amplify them by mimicking the action of the natural substances, and binding to the receptor structure on the receiving cell (Figure 11). Others (antagonists) block access of the neurotransmitter to its target, as in the case of the major tranquillisers with dopamine. And yet others alter bioamine synthesis, re-uptake or break down rates, as in the case of monoamine oxidase inhibitors. These last stop the destruction of serotonin and noradrenaline, and in time relieve depression.

The challenge now facing pharmaceutical industry scientists and their partners in academia and the health service is three-fold. First, to increase the selectivity/ specificity of existing approaches. Second, to develop additional palliative treatments based on new therapeutic concepts. Third, to discover the underlying lesions involved in conditions like dementia and schizophrenia and if possible to develop definitive preventive or curative interventions.

The most important way in which researchers are attempting to increase medicine selectivity is through experimenting with structural alterations to molecules which are therapeutically useful, but which have a 'blunderbuss' action. That is, they influence, sometimes detrimentally, a wide range of 'brain circuits' using a given

Figure 11 **Neurotransmitter agonists, antagonists and partial agonists**



Electrical signal arrives, releasing neurotransmitters which bind to receptors, enabling the electrical signal to pass on to next nerve

Agonists mimic the action of the neurotransmitters at their receptor sites

Antagonists block the action of the neurotransmitters at the receptor sites

Partial agonists occupy receptor sites, and in the case of excessive stimulation decrease the response of the post-synaptic neurone

In case of an under supply of the natural transmitter, partial agonists work to increase the response of the post-synaptic neurone

Source: Taylor and Laing 1988

neurotransmitter. In nature such small amounts of transmitter are released that the various neural structures are in effect insulated one from another. The way to achieve this with medicines is to find ways of making them bind to receptor associated structures unique to the physiology of given types of cell, so that even though the neurotransmitter they amplify or moderate is widely distributed their action is targetted.

An example of the potential importance of seemingly trivial changes in molecular structure is provided by research into the biology of obsessions and compulsions (Rapoport 1989). These were until recently thought to be rare, but are now believed to affect two per cent or more of the population in the US and, presumably, Western Europe. Illustrations of obsessions include an unusual, constant, concern about dirt or germs, a fear that something terrible might happen to oneself or a loved one and a consuming interest in symmetry, order or exactness. Compulsions include excessive or ritualised handwashing and other repeated rituals. (Doctor Samuel Johnson, the eighteenth-century critic, author and lexicographer, could not pass through a door without executing a strange series of gesticulations and bodily movements.)

Obsessions and compulsions affect people of all ages, and in their most extreme form can severely disable victims. Treatment by behavioural therapy can relieve some subjects, particularly by exposing them to feared situations and helping them to overcome irrational feelings. But much suffering remains unrelieved.

Because of this, clinical researchers have investigated the use of medicines in this area. It has now been demonstrated by Rapoport (at the US National Institute of Mental Health) and other scientists responsible for conducting some 14 double-blind trials that one anti-depressant, which differs only minutely in structure from the standard drug imipramine, relieves obsessional and compulsive symptoms in a uniquely effective way.

A possible explanation is that its structure may allow it to bind to cells in parts of the brain responsible for controlling certain specific, 'hard wired' behaviours. This theory has important evolutionary and neurobiological implications. But whether or not it is proven, the observations it relates to appear to provide a clear example of the innovative value of medicine targetting achieved by small modifications in the structure of therapeutic molecules.

Turning to other aspects of medicines research relevant to mental health, currently promising areas of investigation include:

1) Selective Serotonin (5HT) agonists and antagonists

Serotonin availability is known to be associated with both depression and anxiety, together with a range of other brain and bodily states/functions. Recently scientists in the British pharmaceutical industry have been able to identify a series of 5HT receptor subgroups which differ physiologically. There are already available new anxiolytic/sedative medicines which appear to act specifically on one of these sets (and in some circumstances provide an alternative to benzodiazepine therapy) and it is hoped that novel anti-depressants may also emerge from this research. Innovations based on selective 5HT agonism or antagonism might eventually prove relevant to the treatment of schizophrenia as well as to quite unrelated conditions like migraine and sickness associated with anti-cancer therapies.

2) Mechanisms related to benzodiazepine action

It was once thought that benzodiazepines bind directly to receptors for the inhibitory neurotransmitter GABA (gamma-aminobutyric acid), amplifying that substance's action in activating systems which 'brake' the nervous system, preventing runaway neural firing and 'tuning' the responsiveness of excitatory networks (Gottlieb 1988). It is now known, however, that benzodiazepines act on structures associated with, but distinct from, the GABA binding sites known as type A receptors. These influence the permeability of neural cell membranes to chloride ions. Medicine researchers have been working to develop partial agonists to the benzodiazepine receptors, which could provide improved therapies for conditions like anxiety. A naturally occurring (anxiogenic) peptide which binds to the benzodiazepine receptors now appears to have been identified, and this could also open up new opportunities for intervention.

Recently scientists working in the MRC and British universities have argued that the benzodiazepine receptor is unusual in that it has three sorts of ligand – sedative agonists, neutral (blocking) antagonists, and arousing inverse or contra agonists. They have suggested that it may prove possible to 're-set' the sensitivity of GABAergic neural systems with the use of antagonists. (File 1988, 1989, Nutt 1988.) If so, the implications for both the treatment of dependency states and of people who have chronic anxiety states, and even for preventing subsequent mental ill-health in those who are undergoing acute, stressful episodes, may prove profoundly significant.

3) Psychotropic medicines affecting the action of recently identified peptide neurotransmitters

In the last decade or so over 40 'new' peptide neurotransmitters have been identified. Some are believed to be associated with very specific brain functions or states. For example, cholecystokinin (CCK – which is also found in the digestive tract) is said to be involved in the neural systems responsible for the feeling of satiety. Recent Canadian investigations have also linked CCK release to panic attacks. It is thus possible that CCK antagonists could provide a valuable, specific, new treatment (Iverson 1989). Similarly it is also possible that medicines which selectively moderate or enhance the brain's 'natural opiates', peptides known as the enkephalins and endorphins, could prove helpful in some forms of psychiatric illness.

4) Agents for treating schizophrenia

Greater selectivity in agents active on brain dopaminergic receptors promises more effective relief for people with symptoms of schizophrenia, and (perhaps) less risk of side effects. Some researchers hope that work related to the functioning of what are known as phencyclidine receptors will also be of value in relation to schizophrenia(s).

5) Medicines for alleviating senile dementia

Alzhiemer's disease has been linked to declining availability of the transmitter acetylcholine, associated with the destruction of cholinergic neurones which connect the cerebral cortex with activating structures deep within the brain. In the same way that L-dopa can reduce the symptoms of Parkinson's disease by increasing dopamine availability, so it is hoped that agents which inhibit the enzyme acetylcholinesterase (which breaks down acetylcholine) or which act agonistically on brain acetylcholine receptors will help, temporarily at least, to improve the condition of some people with dementia. Trials of a substance known as THA (tetrahydroaminoacridine) have been conducted – amongst some controversy – in the United States, and the results should be available shortly (Byrne and Arie 1989). Other related research initiatives are taking place in Britain and elsewhere.

Interest has also been expressed in a variety of other ways to approach pharmaceutically the problem of dementia. Perhaps the most interesting of these relate to the role of nerve growth factors in preserving or regenerating nerve tissues (Hanley 1989). However, for the moment the acetylcholine route is the most promising (Iverson 1989). If it does prove possible significantly to reduce the disability suffered by dementia victims, even while their underlying impairment progresses, the future benefits for both individuals, their families and health and social care system as a whole would be of great importance. This underlines the point that the role of medicines in mental health care should never be ignored or denied, any more than it should be exaggerated or seen out of context of other necessary elements of service provision.

Planning for the 1990s

The Government's response to *Community Care: Agenda for Action* (Griffiths 1988) was first announced in July 1989, prior to the publication of the White Paper *Caring for People* in November 1989. The Secretary of State for Health, Kenneth Clarke, accepted the central recommendation that Local Authority Social Service Departments should become the 'lead agencies' in community care provision, and the budget holders for all forms of state supported residential care, including support offered to people in their own homes. This is intended to permit a more cost effective and efficient use of resources, essentially because the temptation to 'buck-pass' between care providers will have been removed, or at least reduced.

BOX 8

The 'post-Griffiths' approach to mental health care provision

Immediately after Kenneth Clarke, the Secretary of State for Health, outlined the Government's overall response to the 1988 Griffiths report on community care, Roger Freeman detailed its implications for mental illness services. The key points of the approach described then, and subsequently developed in *Caring for People* are:

a) **HOSPITAL CLOSURES.** Commitment given to the maintenance of a locally based hospital and community approach, with closures not taking place until alternative provision is established. The importance of providing asylum acknowledged.

b) **CARE PROGRAMMES AND FINANCING.** New grants for Local Authorities, payable via Health Authorities, to pay for DHA/SSD planned 'individual care programmes' for those leaving hospital. Arrangements to be operative from 1991. Such payments should be made available in future to permit the appropriate care of individuals who would otherwise have to enter hospital for significant periods.

c) **BRIDGING.** Site sale and lease-back options being offered to Health Authorities to enable them to fund alternative service developments during periods before hospital closure.

d) **CODE OF PRACTICE.** A new code of practice (as required under the 1983 Act) relating to the compulsory assessment and treatment of people suffering psychiatric illness in hospital to be laid before parliament in the Autumn of 1989. New legislation regarding compulsory treatment in other settings to be explored.

e) **QUALITY ASSURANCE.** Activities of the Health Advisory Service to be reviewed. (The role and functioning of other bodies, including perhaps the Mental Health Act Commission and the Social Services Inspectorate, may also be adjusted.)

f) **VOLUNTARY SECTOR.** Financial support for voluntary bodies to be reviewed, in order 'to ensure that public funds are used in the most effective way to encourage the development and provision of services for patients and their relatives'.

g) **PRIMARY CARE AND ALLIED SERVICES.** Areas under investigation include general practitioner education; emergency service provision; and services for homeless people.

h) **SECURE AND SPECIAL HOSPITAL CARE.** The Special Hospitals Service Authority has from October 1989 assumed responsibility for managing Broadmoor, Rampton, Moss Side and Park Lane where about 1,700 patients live in conditions of maximum security. The authority is the first to reflect the 'Working for Patients' proposals for health authority membership, and includes both executive and non-executive members. Its duties will involve the forging of closer links between the special hospitals and other NHS (and private sector) hospital and community services and the Prison Medical Service.

Overall, the new Government proposals have been welcomed, despite fears amongst some commentators that the end result could simply be enhanced cost control rather than better service delivery. Factors such as the limited expertise of Social Service Departments, the lack of a Minister for Community Care (as proposed by Griffiths) and the absence of specific quantifications or 'ear-marking' of the resources intended for community care have contributed to such doubts. Obviously the worst outcome would be a diversion of moneys away from those most in need of support, with care responsibilities being passed on more and more to families and other informal helpers.

In the mental health sphere, however, where the question of discharging severely disabled patients from hospital to situations of little support 'in the community' has gained considerable political significance, the new arrangements should bring significant benefits. Roger Freeman, the Parliamentary Secretary for Health, first outlined in July 1989 the new grant (available from 1991) for Local Authority social care for mentally ill people, payable through the Health Authorities (DoH 1989). He emphasised (and has since re-emphasised) the Government's continuing commitment to the programme of Victorian Asylum closure started in the early 1960s, but also stressed that proper alternative provision must exist. For those who require it, this will include asylum.

The measures summarised in Box 8 should serve to protect the interests of mental health care recipients and their families during the 1990s. They may also reduce public worries about so-called 'psychopaths' being at large and give good reason for hope that during the 1990s the 'Asylum question' will cease to dominate public and professional debate about mental health care provision. Rather, the implications of developing a pluralistic provision of services across the private, voluntary, NHS and local authority sectors is likely to become the major topic of discussion (Murphy 1989).

Having said this, however, it has to be accepted that the challenges involved in creating a comprehensive, integrated pattern of residential and day care and other mental health services supportive to ordinary living remain very considerable. For instance, the solid identity of the Asylum, with its clear boundaries, has to date contrasted starkly with the uncertain definition, fragmentation and vulnerability of community care provisions. This factor alone may have made some groups of care providers – notably psychiatrists and nurses – fearful that changes in the pattern of provision will deprive them of a 'defensible' base and put in jeopardy their own professional existence, as well as that of the people they support.

The creation of a satisfactory professional environment and a trusted and valued network of consumer services for the 1990s will require great commitment from all the groups involved, coupled with sensitive planning and managerial strength and expertise at both local and national levels. It will also require more basic thinking about issues like how, where it is vital, social support and psychiatric care can effectively be linked, and how genuinely two-way consumer/provider-purchaser communication can, in such complex circumstances, be achieved. The more effective involvement of mental health service users in defining 'good practice' should be considered a vital priority for the 1990s.

It may be added that the 'Working for Patients' proposals, which have encouraged discussion in some localities about establishing NHS Trust mental health care providers, add a further dimension of uncertainty. On the one hand greater separation between 'care purchase' and 'care provision' within the NHS could sharpen management and introduce greater pressures to raise service quality. But on the other some fear that 'opting out' could delay change and inhibit appropriate service development, and that competition in mental health service provision could prove a destructive chimera. Questions remain, too, as to how better to reduce the acute and/or chronic suffering of the millions of Britons who experience conditions like depression or anxiety every year but who never require, or ask for, hospital inpatient care or longer-term residential support. The large scale problems of primary mental health care provision are all too often ignored by politicians and professionals alike.

Against this background this paper identifies some of the possible ways in which British mental health care provision could be desirably developed in the period leading up to the twenty-first century. No attempt is made to define or legitimate the normative values/principles which should underly future services. This is an area which has already been extensively discussed by, amongst other organisations, MIND (MIND 1983 – see Table 5). Nor does this analysis try to detail an ideal service structure, although again several agencies have produced valuable studies of, and suggestions about, this. (See, for instance the Richmond Fellowship 1983. This report first suggested the idea of a Community Care Minister. And Figure 12 illustrates a concept developed in the UK by King's Fund Centre researchers concerned with the necessary functions of mental health – and other – services.)

Rather, the comments below relate first to the opportunities open for preventing psychiatric impairment, disability and handicap. Their purpose is to highlight those areas and types of service development most likely to lead, in the foreseeable future, to significant improvements in the welfare of care recipients. Attention is then given to the 'case management' approach now favoured by many authorities, and to the potential role of family doctors and other primary health care professionals in promoting mental health progress in the 1990s.

Primary prevention

At the organic level there are no major opportunities currently open for the primary prevention of mental illness. The nature of the genetic and/or neural lesions involved in most psychiatric conditions is still unknown, and there is no technical equivalent to, say, vaccination even for those known to be at a raised statistical risk of experiencing conditions like schizophrenia, manic depressive illness or senile dementia. Despite hopeful signs that the age specific incidence of the latter may be declining (which imply that environmental improvements or life-style differences between generations could be protective, at least in relation to the timing of symptomatic onset) the only option available in this context is further investment in fundamental biomedical, and particularly neurobiological, research. This will almost certainly eventually lead to techniques of value in screening people for particular vulnerabilities, and protecting them from their expression: but this promise is unlikely to materialise before the start of the twenty-first century.

Table 5 Principles of good practice for a comprehensive local mental health service. (As promulgated by MIND 1983)

The Service

1 Values the client as a full citizen with rights and responsibilities, entitled to be consulted and to have an active opportunity to shape and influence relevant services, no matter how severe his or her disability.

2 Aims to promote the greatest self-determination of the individual on the basis of informed and realistic choice.

3 Aims to provide and evaluate a programme of treatment, care and support based on the unique needs of the individual, regardless of age or severity of disability.

4 Aims to minimise the dependence of the client on professional resources, but which does not allow this as an excuse to withdraw appropriate services.

5 Aims to meet the special needs arising from disability through a locally accessible, fully co-ordinated multi-disciplinary service offered by appropriately trained staff.

6 Is easily accessible locally, and delivered, wherever possible, to the client's usual environment.

7 Plans actively for those in institutions to reintegrate into society if they so wish.

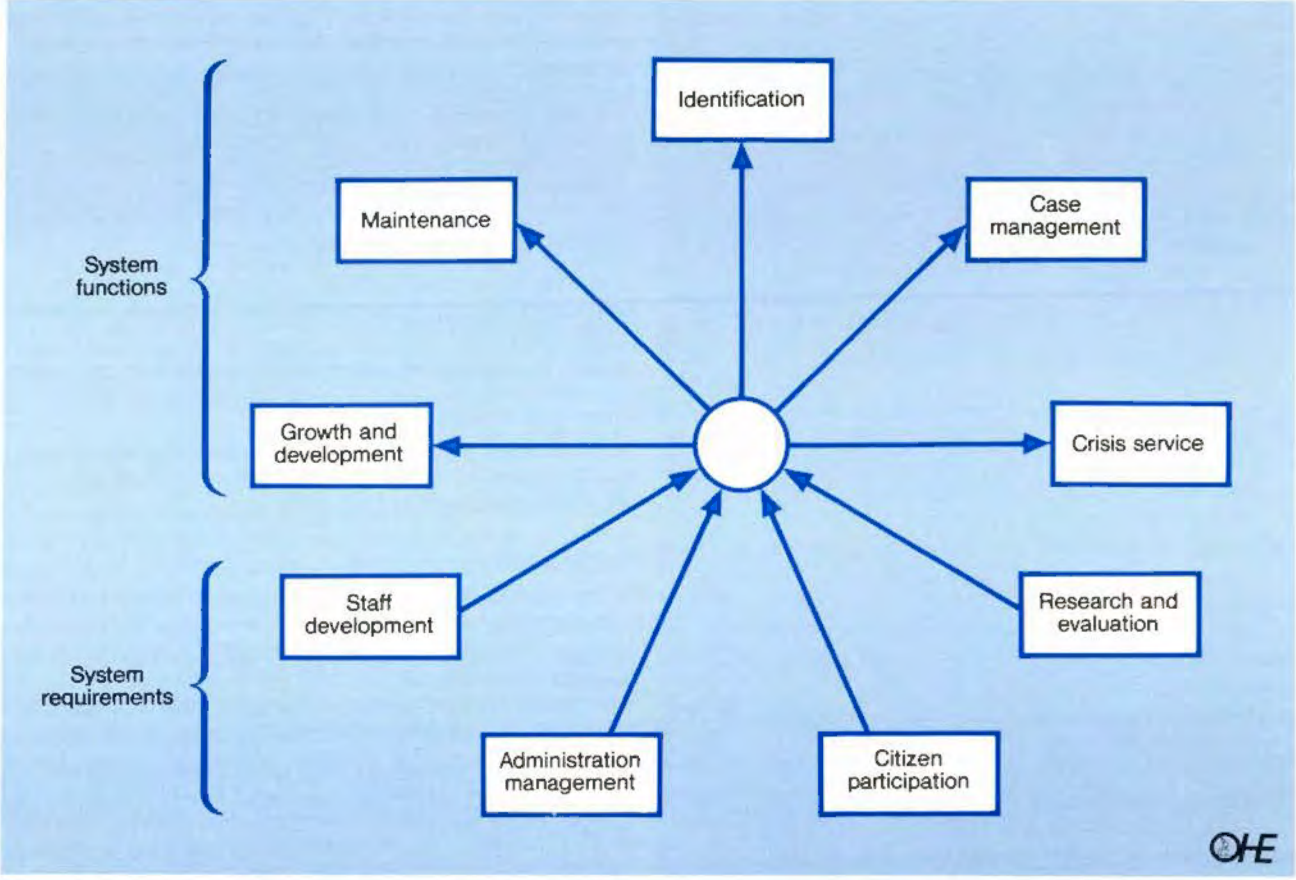
8 Aims to enhance the individual or collective capacity to cope with or alleviate distress.

At the social level, however, the prospects for service innovations designed to help people avoid reactive mental illness are much more hopeful. The Royal College of General Practitioners argued in as early as 1981 that a framework of prevention aimed at assisting people to cope with psycho-social transitions (such as bereavements, job losses, loss of physical abilities in old age) could help cut the incidence of depression (RCGP 1981). Since then advances in knowledge like those described by Newton (1988) have led to the identification of specific areas for action.

For example, there is now hope amongst informed professionals that women at raised risk of post-natal depression related to environmental factors can be identified by fairly simple screening tools, and given social support which protects them from affective illness. Although there may be dangers associated with 'false labelling' and the unsophisticated use of screening instruments, academic units and independent research agencies such as the RDP (Research and Development for Psychiatry – formally the National Unit for Psychiatric Research and Development) are actively investigating this field.

Closer to the borderline between primary and secondary prevention (that is, the corrective treatment of a condition which has already developed) the work of organisations like NEWPIN (a charity based in South London) has demonstrated how befriending projects and allied social support schemes for depressed women, and men, with young children can relieve their distress. Indeed, the NEWPIN initiative demonstrates how self-esteem can be restored though enabling women who were once depression sufferers to become supporters of others, so spreading a network of simple, effective, non-professional care throughout local communities (Jenkins 1989). There is also

Figure 12 **Developing Individual Services in the Community (DISC) Key service functions and needs**



Notes: Regarding 'system functions' maintenance refers to the need to support individuals in a manner which maintains their current level of function, whilst growth and development involves the presentation of appropriate challenges and the development of new skills. Identification involves finding all those in need of support/treatment. On the 'system needs' side, some particularly pressing problems relate to staff development. Maintaining morale and a sense of career advance in circumstances where clients either do not progress or gradually regress (as in dementia) can be very challenging.

Source: King's Fund Centre Community Living Development Team, 1989

research being conducted into the ability of professionals such as health visitors to help reduce such problems through their contacts with clients (Elliot *et al* 1988, Holden *et al* 1989).

Similarly, in the context of preventing relapses amongst people with schizophrenia, research quoted earlier in this paper emphasises the deleterious effects of family environments characterised by high levels of expressed (critical) emotion, and the protective role played by relatives with low emotion generating behaviours. Educational efforts designed to help the families of people with schizophrenia to understand how best to help them stay in good mental health is another specific area for preventive investment. Despite the fact that the need for appropriate family support and training was appreciated by some British observers almost two decades ago (see Creer and Wing 1974, Wing 1978) there has been relatively little activity in this area.

Finally, it should also be noted that support for children in distressing circumstances and distressed states may also have a valuable preventive function, as well as offering more tangible short-term gains. There are considerable methodological difficulties in demonstrating the long-term benefits of interventions provided by child psychiatrists and their colleagues, but this does not mean they should be ignored. Nor should the relevance of relatively low-cost programmes like NEWPIN (and that of the pioneering Homestart scheme, first established in Leicester – Eyken 1982) to the parenting styles and skills of mothers and fathers, and so the mental health of following generations, be neglected. If 'cycles of psychological deprivation' can be interrupted, particularly in key groups such as people brought up 'in care', then society as a whole should have much to gain from adequate investment.

School based psychotherapeutic programmes involving, for instance, discussion groups are also of demonstrated value (Kolvin 1981, Newton 1988), as too may be more general programmes designed to explain the nature of mental health and ill-health. (See, for example, Stewart and Brownlow 1985.) The costs and benefits of very broad educational efforts are difficult precisely to quantify. Yet the advantages that a more understanding social environment could bring to those with mental health problems could be profound. The value of simple, basic knowledge to individuals who come, say at the time of examinations in their later school or – for some – university lives, to experience the challenge of conditions like anxiety and panic might also prove considerable. Hence what is in part needed is more disciplined, effective research aimed at identifying 'best-buys' in mental health promotion, and their cost-effective provision throughout the community.

Case management and care co-ordination

During the 1970s the idea of the 'key worker', a single person who, for a specific client, serves as a contact point and guide through complex mazes of health and social care provision, became increasingly popular. In the 1980s thinking about how best to help individuals in need of a variety of complementary forms of support was taken further, and is now embodied in the concept of 'case management'. This approach, reflected in *Caring for People*, demands that each care recipient should have planned for them a personalised 'package' of services, which should be delivered in a coherent, and monitored, fashion. As a form of financial control case management may also serve to create informed demand within the mental health marketplace.

The challenge this basically straightforward and sensible goal represents in a complex, multi-agency field like community mental health care should not be underestimated (O'Donnell 1989). Nevertheless, progress has been already achieved in a number of contexts. The support offered to elderly people via initiatives such as the Kent Community Care Scheme is an illustration (Challis and Davies 1986, Challis *et al* 1988) although the range of services being purchased is in this example limited to social care. (Box 9 examines some key issues relating to mental health in later life).

During the 1990s advances in areas ranging from the introduction of computerised information systems to the establishment of more sensitive and appropriate managerial arrangements in facilities like, say, sheltered housing schemes and agencies like DHAs (King's Fund Institute 1987, NUPRD 1988) should help further to enhance case management. And in the mental health context continuing growth in the number of Community Mental Health Centres (CMHCs) may also improve care coordination. The potential value of the latter in providing convenient, community based access to mental health services, and locations in which multi-professional contributions to care can be achieved, has long been emphasised by organisations such as MIND (MIND 1983). The 1986 Audit Commission report *Making a Reality of Community Care* highlighted service developments in Torbay, where the closure of local mental hospitals has been associated with the build up of comprehensive community provisions, including several Community Mental Health Centres. (One of the managers responsible for this programme became an advisor at the Department of Health at the time its response to the Griffiths report was announced.)

It is thus encouraging to note that a survey conducted by the National Unit for Psychiatric Research and Development (now the RDP) showed that at the end of 1987 there were 81 CMHCs open in the UK, with a further 230 in various stages of planning. Starting from a base of only five or so such Centres at the start of the 1980s, their numbers have more or less doubled each year since the middle of the decade. There will be about 200 open by the beginning of the 1990s (NUPRD 1988).

However, welcome though such progress must be, the American experience with CMHCs described in Box 4 (page 13) offers a warning that they are not an automatic 'cure-all'. For example, there is a danger that they may become swamped by, and/or preoccupied with, requests for advice and psychotherapeutic support from relatively articulate, non-disabled individuals. This is often to the detriment of efforts better to co-ordinate the care of the relatively small population of significantly impaired, and potentially handi-

BOX 9

Mental health and the elderly

It is often wrongly assumed that mental health problems grow worse as people grow older. Although in terms of prevalence dementia is of course primarily a condition of later life, there is little evidence to show that elderly people are *per se* more vulnerable to conditions like depression than younger adults. Indeed, as people gain experience in life most appear to become increasingly able to cope with mental health problems.

It is, however, the case that in later life many individuals have to face loneliness (or life in an institution) and decreased opportunities for pleasure. And they may accept needless restrictions, in a sense 'giving way' to fears about activities like 'going out' which they would once have made every effort to overcome. In a relatively undemanding population it can be difficult to identify those in need of psychiatric help, as opposed to those needing social support to help them maintain a satisfactory way of life.

The Royal College of Physicians and the Royal College of Psychiatrists (1989) have produced a report calling for a doubling of the number of consultants specialising in the psychiatry of old age in the next 10 years. It also warned about the danger of 'over-loading' informal carers (and their families) who look after relatives with conditions such as dementia, and pointed to the need for appropriate training for support groups ranging from staff in residential homes, day centres and sheltered housing developments to home helps, community nurses and general medical practitioners.

Clearly, considerable financial investment will be needed to enable the community to cope with the challenge which dementia in old age will present during the 1990s and beyond. But as argued in the main text, the scale of resources required to support genuinely adequate levels of care would not be beyond the nation's purse, given sufficient political will.

In the future local schemes designed to help elderly individuals with early stage dementia to stay in their own homes may increasingly be needed. Provided there is properly co-ordinated 'case management', people who have lost their short-term memories can often enjoy life to the best of their ability in long familiar environments. Advances in high dependency sheltered housing provision, with comprehensive service availability 'planned in', are also likely to prove valuable, and might serve as a base resource for those living in their own housing elsewhere in the community. The pioneering work of Anchor in Newcastle illustrates this point (Business Sciences 1989).

In the context of primary medical care the new family doctors contract, which demands regular contact with and review of the needs of all patients aged over 75, could also lead to desirable service improvements. Family doctors have a natural role as the gateway to other forms of provision, as well as being well placed to treat many health problems in the elderly. Provided good general practice and specialist medical links are built up, and contacts with bodies like social service departments positively developed, family doctors should be able to contribute even more than they have in the past to the wellbeing of the 'post Griffiths' generation of elderly mentally distressed or disabled patients.

capped, people with mental health problems (Craig 1989). Given that there may be a natural tendency amongst care providers to sympathise most with those they identify closely with, this risk should not be underestimated.

Such observations could well be taken to mean that every effort must be made to ensure that CMHCs direct those in need of uncomplicated primary mental health care to their family doctors, leaving their resources free to be concentrated on those who need them most. But the problem in this (apart from a lack of discipline within CMHCs) is that at present not all general practitioners can provide a service which genuinely meets the requirements of 'neurotically' disturbed individuals. Indeed, the possibility that CMHCs could be overwhelmed with requests for help from less disabled service users in part stems from this situation. As the data collected by Balter and his colleagues (see Tables 3 and 4 on pages 22–23) suggests, the fact that British family doctors have controlled the gateway to specialised psychiatric support effectively in terms of not letting 'too many' people through does not necessarily mean that they have been in a position efficiently to identify those most requiring treatment, or to ensure its appropriate delivery.

The implications of this understanding are not trivial. Even for individuals suffering 'minor' states such as intermittent anxiety, the effect of mental illness on their lives, and those of close relatives, can be seriously disruptive and long-lasting.

However, in a complex and fast developing field this should not be taken to suggest that family doctors, individually or collectively, are to blame for inadequate care. Scapegoating will not solve any problems. Rather, it needs generally to be accepted that the mental health system as a whole is in need of continuous efforts to improve it. In the specific context of primary provision there are at least three broad areas where immediate action could be taken to allow general practitioners to offer enhanced care to mentally distressed patients. They are:

1) **The provision of special education and advice for established family doctors, designed to enable them to identify mental illness in a more accurate and consistent manner than is, on average, achieved at present.** The information available to primary care teams should include material relating to issues like the particular needs of local immigrant groups. In this context many studies have shown that the stresses of arrival in a new culture, coupled with conflicts relating to the values of the old, can lead to high levels of psychiatric distress (Clare 1976). Although particular attention has recently been paid to issues like the prevalence of schizophrenic forms of behaviour in (particularly first generation, British born) West Indian populations, communities like, say, the Irish and Greeks in Britain also have particular needs (see Bouras and Littlewood 1988).

2) **The provision of better information and communication systems between general practitioners and specialised psychiatric care providers.** Restructured Family Practitioner Committees (FPSAs) could, during the 1990s, play a key role in achieving such service improvements (Good Practices in Mental Health 1989) as well as in gathering the type of local needs data touched on above.

3) **The provision of enhanced information about the therapeutic options available to family doctors treating patients with conditions like reactive anxiety and depression, and action to ensure that as wide a range of treatments as possible is available to each family doctor and his or her patients.** In addition to a full range of pharmaceutical products (including innovative products as they become licensed for sale) general practitioners' prescribing choices might in future be reasonably expected to include referral to local befriending and voluntary support schemes and/or cognitive and behavioural therapies given by psychologists. These last have, in a variety of studies, been shown to be comparable in efficacy (but not necessarily cost effectiveness) to established medicines in treating, at least in community circumstances, conditions like depression. (See, for instance, Scott and Ross 1986). The possibility that in future more practices will be able to employ psychologists or appropriately trained counsellors or nurse therapists (Marks 1985) is one that could lead to considerable long-term improvements in the mental health of the general population.

Conclusions

Fear of mental illness, and of those affected by it, is not simply related to the (usually unwarranted) suspicion that psychiatrically disturbed people may behave in a manner hazardous to those around them. Its roots lie also in the challenge that mental illness may present to established interpretations of reality, and the underlying threat that contact with such distress may somehow unmask previously repressed conflicts in the minds of 'normal' people. In addition to the stigma that all groups of disabled people have in the past had to suffer, individuals with psychiatric conditions have encountered rejection stemming from, in a sense, the desire of those around them to avoid contagion.

This is still reflected in some of today's debates about issues like Asylum closure and psychotropic medicine usage. An amalgam of overt concern for, and covert hostility towards, 'the mentally ill' continues to characterise many people's attitudes.

Nevertheless, the material presented in this report indicates that the opportunities open for the provision of genuinely humane and effective mental health care and preventive support are now greater than at any other time in British history. Already, much has been done, amongst professionals at least, to de-mystify the concept of mental illness. For example, the critically important work of Professor George Brown and his colleagues (financed in large part by the Medical Research Council) offers a clearer picture of the psycho-social origins of depression and anxiety than ever before available. Projects like NEWPIN indicate the practical potential of such insights, and also the positive role that service users can and should play in determining the nature and process of mental health care. (A major evaluation of befriending schemes designed to relieve mental health problems is now being conducted by Brown, Harris and others).

There is also good reason to hope that advances in neurobiology will, in not too great a time, reveal the precise nature of the neurological lesions and/or transient functional imbalances involved in conditions like schizophrenia and, say, panic. Ultimately this should provide doctors working in psychiatry with a range of more precise therapeutic instruments, comparable in efficacy to those used by specialists in other areas of medicine. When this occurs it should further boost the confidence of psychiatry as a profession, and ease the way to more productive collaboration between all mental health care providers. The formation of comprehensive biological and social models of mental illness is also likely to prove a vital step towards this long-term end, not least because it should help to establish a consensus about the boundaries of medical authority.

In the immediate future the Government's post Griffiths plans for mental health care in the community provide additional grounds for optimism. Compared with the, in certain respects, disappointing standard of policy analysis and political decision embodied in documents like the 1975 White Paper *Better Services for the Mentally Ill*, the plans announced in *Caring for People* appear incisive and viable. But they will not be translated into practice without continued and considerable investments of public money and individual time and effort. There is no 'instant remedy' to the problems of achieving effectively integrated health and social care, and of creating 'informed market demand' for relevant services.

If scarce resources are to be used to best effect there must also be adequate investment in research. The need for more rigorous economic evaluations of 'best buy' approaches to mental health promotion is one clear cut example of this. It is also apparent that the organisational and allied issues related to how to achieve effective and efficient multidisciplinary mental health care delivery require further attention.

For acutely distressed, severely ill and/or chronically disabled clients development of Community Mental Health Centres could prove to be the best way of establishing a system in which all mental health service staff 'have no need to stand on professional dignity, (but) get on with the job' (Jones 1979). In the context of primary care for the greater numbers of people suffering psychiatric 'common colds', however, the value of this type of initiative may be limited. Here it could be more realistic to look towards the improvement and extension of NHS Family Practitioner Services. Desirable measures include enhancing the psychiatric care support available to general practitioners (Shepherd 1989) and involving more frequently carers other than traditional community practitioners. A key option to explore in the 1990s is whether or not moves to make more widely available the skills of psychologists, nurse therapists and trained counsellors would, perhaps if combined with arrangements for new types of multiprofessional partnership formation, open the way to desirable progress.

Yet in the light of such service possibilities and evaluation challenges it is disturbing to note that, as the Mental Health Foundation has recently pointed out, only six per cent of the UK's total available (public and private) medical research funds are channelled into mental health topics. This includes spending on projects relevant to intellectual disability.

Fear of mental illness appears still to lead people to put it 'out of mind', just as psychiatrically distressed people were themselves 'put away'.

The irony of this is that if research in areas like service evaluation is not undertaken then value for money in care delivery will not be demonstrated, psychiatric service developments will further be inhibited, and many people's worst fears will consequently be reinforced. This in turn will promote further neglect of the area. Breaking such self-feeding cycles of despair and defeat is, as the introduction to this OHE report stressed, an essential task.

To achieve it at the societal level effective mass communication of the gathering 'good news' about mental illness currently appears to be one of the most important priorities for action. Scandals about service failures and 'bad apples' involved in psychiatric services may on occasions have served a function. But in the final decade of the twentieth century there are, regardless of previous events, many new and positive opportunities for improving mental health in Britain, and the quality of life of individuals with conditions such as schizophrenia, chronic depression and even dementia. What is important is not to dwell on the errors or tragedies of the past. Rather, it is to build continuously on what has already been achieved, so to create a brighter future.

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