The future of mental hospital sites

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(A) Synopsis

There are three main categories of use that should seriously and urgently be considered for existing mental hospital sites.

Firstly, they may be used as locations for *specialist regional units* including, for example, centres for forensic psychiatry, the young brain damaged, mental handicap, substance misuse, alcoholism units, mother and baby units, and 'modest security' facilities.

Secondly, *continuing expertise* could be maintained in hospital rehabilitation units and industrial therapy units.

Finally, a site for *asylum* will be needed for some chronic psychotic patients and vulnerable personalities. Sheltered residential care and semi-independent houses will be required.

It is unlikely that a standard DGH unit will meet all of the nosocomial needs of the psychiatric patient. There is a danger that by the time deficiencies are identified, suitable sites for buildings will have been lost.

(B) Introduction

Wide differences of opinion are expressed by British psychiatrists on the ideal role of large psychiatric institutions. Our aim in writing this position paper (at the request of the Public Policy Committee of the Royal College of Psychiatrists) is to try to put forward what we think is the view of the majority of psychiatrists in between these extremes acknowledging that there are balancing views on either side.

It is based on the discussion paper 'The Future Role of Mental Hospitals' which was prepared in March 1988. This was widely circulated, in particular within the Royal College of Psychiatrists, and was debated at the Quarterly Meeting of the College in April 1989, in the session on 'The Future of Mental Hospitals'. We have therefore been able to incorporate that document into the present paper and take into account the comments that have been received.

Meanwhile, the DHSS has issued a circular [HC(88)43 Resource Assumptions and Planning Guidelines] stating that the future of the mental health services is not predicted necessarily on the abolition of mental hospitals, so this position statement is timely.

(C) Background

Hospital beds for acute in-patients should not be placed at a long distance from the patient's home.

It is generally agreed that where a traditional psychiatric hospital is conveniently placed in its catchment area it may be adapted and existing buildings used for the purpose of acute psychiatric admissions.

When the existing mental hospital is remote from the catchment area, as is often the case, it should be replaced *for this purpose* by a local DGH unit. The question that remains is whether there is still a role for the remote existing mental hospitals or, perhaps more particularly, a role for their sites. Similar considerations apply to mental handicap hospitals [see D1(c) below].

This subject (or a closely related one) has been addressed before by individuals (Furlong, 1985; Jones, 1987) and groups (King's Fund, 1987). It has received mention in official documents (NHS Health Advisory Service Report, 1987; Interdepartmental Working Group of Home Office and DHSS Officials on Mentally Disturbed Offenders in the Prison System in England and Wales, 1987). The most recent substantial contribution relates particularly to Scotland (Scottish Home & Health Department, 1989) but much of that report will be of relevance to the remainder of the UK. However, until now there has not been a statement on the subject which attempts to reflect the views of the Royal College of Psychiatrists.

(D) Possible uses for the hospitals or their sites

There are three main classes of potential use:

(1) A site for regional units

The District Health Authority, catering for a population of, say 250,000 persons, will normally be expected to provide general psychiatric services within the geographical boundaries of the district.

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For some specialised services it would not be a viable option to provide local facilities in every district, and it would make more sense to provide them in the form of regional or sub-regional units.

The following services may be considered for such units.

(a) *Forensic psychiatry service*

Already Regional Secure Units are being planned on a regional (or sub-regional) basis, and this is often appropriately at a mental hospital site.

(b) *Service for the 'young' brain damaged*

At present there is no accepted pattern of care for patients who develop organic brain disease or suffer brain trauma between the ages of 16 and 65 years. This topic is currently under active discussion by both the Royal College of Psychiatrists and the Department of Health, and various recommendations are being considered.

Meanwhile it seems probable that, while some provision should be made in each District, there should also be a regional unit for patients with behavioural or severe psychiatric problems arising out of their brain damage.

Such a unit should be placed alongside other facilities for rehabilitation in a multidisciplinary setting.

(c) *Mental handicap*

Beds in mental handicap hospitals are decreasing in the same way as those in mental illness hospitals. Patients with simple mild mental handicap are best cared for in the community rather than in in-patient units of any sort.

For those patients who require in-patient admission for treatment or investigation of multiple handicap or coincident mental illness, behaviour disorder and anti-social behaviour, specialised units are required (Royal College of Psychiatrists, 1986).

Because of the small numbers, such units would probably serve several districts and would need to provide a sufficient treatment setting to cater for the spectrum of problems presented and the range of intellectual levels. They could, with advantage, be provided on a campus site along with other psychiatric units enabling the sharing of certain facilities.

(d) *Substance misuse and alcoholism units*

It is the view of the Substance Misuse Section of the College that regional and sub-regional centres should be provided for both alcohol and drug dependent patients, and that psychiatric hospital sites would be particularly suitable for these centres. This would be consistent with Departmental advice in HC(86)3 *Services for Drug Misusers.*

(e) *Mother and baby units*

The mother with puerperal psychosis who needs admission to a psychiatric bed can be cared for in one of two ways, both useful under different circumstances.

Modern psychiatric units are being built with some single rooms purpose-built for a mother and her baby (e.g. where the washbasin can also be designed to be used as a baby's bath).

Alternatively the mother can be treated in a 'mother and baby unit'. Although this is more likely to be far from her home, more expertise can be built up there, especially useful for the more complex cases.

It would seem that both types of facility should be available, in each region, and the choice made on the particular clinical features of each case. The mother and baby units could be sited adjacent to a DGH unit, to take advantage of the availability of obstetric and paediatric services. However, these units have also been sited very successfully on the campus of mental hospitals.

(f) *'Modest' security facilities*

In large psychiatric hospitals, part of the hospital is often devoted to a specialised unit to treat patients who are too violent to be dealt with on the average ward. DGH units normally admit the vast majority of violent patients from their own catchment area, and their success rate in treating them on site is very high indeed. However, it has become apparent that there is a group of patients for whom a 30 or 60 bedded DGH unit is not suitable, and yet who do not meet the criteria for admission to the Regional Secure Unit. This applies not only to general psychiatric patients, but also to special subgroups such as the mentally handicapped and the elderly.

Sub-regional units for these high risk patients should be developed to serve several districts each. The flare-up of violence is often in the context of an acute-on-chronic illness. While some such patients can be promptly referred back to their districts of origin after a short period, others require more specialised care for a year or more. Thus it may be necessary to provide two types of 'modest' security facilities, one giving prompt admission to the small minority of patients requiring urgent transfer, and the other taking on the longer-term care of violent patients. The latter may also have a role in rehabilitating patients discharged from regional Secure Units.

(2) A site for continuing expertise

Within any psychiatric service there is competition between the merits of specialised care and the merits of continuous care. The model of continuous care may be illustrated by that of a patient who is seen by a

particular consultant and his team as an out-patient. If that patient subsequently requires admission, the same team cares for the patient in the high dependency ward, then in the normal open ward, later in the rehabilitation ward, in the day hospital, and finally once again as an out-patient. Most psychiatrists would prefer this method to a situation (seen in some other countries) where a different team looks after the patient at each step of his journey. To some extent this principle is observed in most psychiatric units. However, exceptions are made and in most large mental hospitals specialised wards develop, whether for intercurrent physical illness, rehabilitation, token economy programmes, violent patients, or for other purposes.

Over the years a good deal of specialised expertise has been built up in this way, and it would be a shame to destroy it. Moreover, it is unlikely that such centres of expertise could be reduplicated in each district. As the large psychiatric hospitals run down there may have to be a positive effort to preserve such centres, of which the following are examples:

(a) *Hospital rehabilitation units*

Rehabilitation takes many forms and can be carried out both with in-patients and with patients outside the hospital and all Districts should have a range of such facilities. However, skills in helping very disabled and chronic patients have been developed in most mental hospital rehabilitation units and there will remain a need for these, particularly for those who require 'slow-loop' rehabilitation and who may become demoralised in acute units.

(b) *Industrial therapy units*

These have proved valuable at a certain stage in the rehabilitation of psychiatric patients. They prove to be valuable centres, maintaining contacts with non-hospital based facilities for sheltered employment or other forms of industrial therapy. They should not disappear, yet it would not be justifiable to have one in each district.

3. A site for 'asylum'

Many psychiatric patients relapse, or become distressed or worse, when confronted with the demands of society and of interpersonal relationships, particularly in urban areas.

(a) *The chronic mentally ill*

The majority of these can be treated in DGH units or in non-hospital settings in their own districts. However some do better in less demanding surroundings.

(b) *Vulnerable personalities*

There are patients who, while not suffering from overt psychosis, have long-term difficulties with interpersonal relationships or who disturb communities by their strange behaviour (or are teased and persecuted by society). Sometimes categorised as 'inadequate psychopaths' they vibrate uneasily between hospitals, prisons or other social agencies, often encountering hostility and frequently consuming an expensive total sum of professional attention. Mental hospitals have traditionally served as a site of respite for these patients who form only a tiny proportion of the treated population in any district. A small number of mentally handicapped people with personality and behavioural problems also come into this category.

Care of vulnerable personalities and related patients need not be purely custodial, and could employ treatment methods based on principles of a therapeutic community.

(c) *Sheltered residential care*

Villas, hospital hostels and group homes are found on mental hospital sites. Increasingly in the future they will be provided in a district location, but there will probably remain a demand for land on which to build such facilities. The regional sites will remain a valuable resource, where the difficulties of land purchase and obtaining permission from neighbours will be less of a problem in the medium term.

(d) *Housing on hospital sites*

A case has been made for providing, even when the patient no longer needs close supervision, housing in the vicinity of psychiatric expertise.

Creative schemes have been developed for using the mental hospital sites as new housing areas, recreational parks and so forth, integrating the community with the mentally ill.

Conclusion

There are a variety of possible facilities which could be situated on the sites at present occupied by mental hospitals. The speed at which large psychiatric hospitals are run down should be governed by the rate at which improved provision is made closer to the patient's home.

We should be clamouring for the continued availability of the site for the delivery of mental health services unless we have better alternatives for regional and sub-regional units, for continuing expertise in rehabilitation, and for places of asylum. Otherwise there is a danger that when we find out what is *not* provided in a standard DGH psychiatric unit, it will

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be a very hard struggle to have these deficiencies rectified. This will be all the more galling if those facilities *had* existed in the previous, mental hospital based, model of psychiatric care.

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