

Matching service development to mental health needs: a case study of a rural county

Chris Ring

Housing and Social Services Department, London Borough of Haringey

Paul Cambridge

Tizard Centre, University of Kent

John Carpenter

Centre for Applied Social Studies, University of Durham

Abstract: The development of Somerset's mental health services from 1991 to 1996 involved the closure of the county's last long-stay hospital, and its replacement by more local in-patient provision and an expansion of community services. The process and outcome of this change is examined, drawing upon (a) an externally-commissioned evaluation in 1994-6 and (b) a comprehensive mental health needs assessment in 1996. The findings from these studies indicate that the development of accommodation for people with severe and long-term mental health problems has been dominated by the needs of long-stay residents in the old institutions. This led initially to geographical inequities and a shortage of supported accommodation for others with severe and enduring mental health problems. However, developments during this period also suggest a local capacity to detect and respond to unmet needs in this group.

Introduction

The replacement of the Victorian asylums with alternative models of care for people with severe mental health problems has now been national policy in Britain for 35 years and the underlying influences governing this shift have been well explored (Renshaw *et al.*, 1988; Tomlinson, 1991; Knapp *et al.*, 1992; Ramon, 1992; Goodwin, 1993). The recent development of community alternatives has also been influenced by changing conceptions of mental health, increasing acknowledgement of the rights and social status of people with mental health problems, recognition of the risk of trans-institutionalisation and the development of new treatments and care.

The introduction of the NHS internal market outlined in *Working for Patients* (Department of Health, 1989), with its separation of service commissioning and delivery, has been accompanied by major organisational changes in the NHS, and an increasing emphasis on service quality and value for money. Analogous changes in the delivery of social services for adults, envisaged in *Caring for People* (Department of Health, 1989b), sought a much closer matching of service provision to client need, both by separating responsibility for assessment of individual need from the management of service delivery, and by the introduction of a 'mixed economy of care'. These changes in policy and practice have been a major feature of the recent development of mental health services, both nationally and in local areas such as Somerset.

Much research has been conducted on the organisational, client and cost outcomes of replacing institutional with community-based care for people with mental health problems (see Knapp *et al.*, 1992 for an example). The Team for the Assessment of Psychiatric Services found that patients resettled from two large psychiatric hospitals on the north-eastern fringes of London experienced improvements in social networks and a much freer environment outside hospital (Leff *et al.*, 1994). Similar benefits associated with resettlement from other long-stay hospitals have been reported from south London (Pickard *et al.*, 1992) and North Wales (Crossby and Barry, 1995). These successes suggest that, where psychiatric hospital reprovision programmes are well-planned and adequately resourced, the outcomes for patients immediately involved are mostly - although not invariably - positive.

However, the 1990s have also seen a series of reports which describe serious weaknesses in mental health care systems in the UK. Resources are inequitably distributed in relation to population need and remain predominantly committed to hospital care (Audit Commission, 1994). Nevertheless, in some areas, in-patient services remain under extreme pressure (Mental Health Act Commission, 1994; MILMIS Project Group, 1995).

So while long-stay patients resettled from old institutions appear consistently to have benefited from their closure, the substitution of new systems of mental health care appears to be failing others with mental health

problems, particularly in inner city areas. The recent establishment by the responsible Minister of a high-level review group to vet all future hospital closures (Valios, 1997), indicates the level of central government concern. It can certainly be argued persuasively that removal of the option of asylum for a relatively small number of highly disturbed people has contributed to this situation, as well as to the high proportion of the prison and the homeless population which is mentally-ill (Gasson, 1995). It was against this policy and practice backdrop that Somerset Health Authority and Avalon NHS Trust worked to develop new community mental health services.

The local context for mental health care

The weaknesses in community mental health care alluded to above have been most evident in large urban areas. Somerset differs greatly from these in its social and economic geography. It is an affluent, mainly rural county with a population of 487,000 (1.4 persons/hectare). There are significant concentrations in the county town of Taunton (population 60,000) and Yeovil (39,000). Until 1991, apart from one acute psychiatric ward in Yeovil District Hospital, in-patient services were provided solely from two large institutions: Mendip Hospital in the north-east of the county, which closed in that year, and Tone Vale Hospital, just outside the county town of Taunton. Until this closed in 1995, it provided in-patient psychiatric services for the entire south and west of the county, with the exception of people admitted to Yeovil District Hospital.

The successful resettlement of over 400 people with learning disabilities from three long stay hospitals (see account in Cambridge *et al.*, 1994) helped pave the way for the development of Somerset's community mental health services. This involved the closure of Tone Vale Hospital, completing the replacement of the two old institutions with a comprehensive, locally-based service. We have alluded above to the nationally-determined changes in health and social service organisation which took place concurrently. In Somerset these included establishment of the Avalon NHS Trust, the sole mental health provider for 90% of the county, and the 'floating off' of the Social Services Department's domiciliary and residential care for older people to Somerset Care Limited, a not-for-profit trust.

Aims

This paper is based upon the findings of two separate studies: an evaluation in 1994-6 by Kent University of the process and outcome of closing Tone Vale Hospital and a mental health needs assessment carried out in 1996 by Somerset Health Authority and Somerset SSD. Our central aims here are firstly to examine how far the closure of

Somerset's last psychiatric institution, and associated service developments, has provided a range and volume of services which correspond to the needs of adults with severe and long-term mental health problems. Secondly we seek to account for some apparent discrepancies between need and provision, and to comment on these.

People with severe mental health problems are a priority group for specialist mental health services. However, a straightforward definition of this group is elusive. While the *Building Bridges* document (Department of Health, 1995), offers the criteria (for severe mental illness) of diagnosis, disability, duration, the need for formal and informal care and (threats to) safety, an operational definition is not offered.

For our goal of assessing the adequacy of current services, the definition of people with 'severe (and enduring) mental health problems' needs to capture those requiring most intensive and prolonged care and treatment. Wing (in Stevens and Raftery, 1997), points out that the need for this is principally determined by social disablement. This he describes as: '...a pattern, level, and persistence of malfunctioning which is not diagnosis-specific' (2:212).

Operationally, in an era of freely available institutional care, this group might be defined - albeit crudely - as the long-stay hospital population. However, in community-based services, the criteria offered by Wing (in Stevens and Raftery, 1997:2:257), for defining those who (while living outside hospital) are at particular risk of relapse, readmission, and deterioration in health, are more appropriate:

- in residential or day care for more than 3 months;
- judged to require care or observation for 6 months or more after discharge from acute short-term treatment;
- any other referral with disablement persisting for 6 months or more.

For our purposes, to include those requiring continuing in-patient care (or its equivalent) the definition also needs to include:

- anyone requiring 24-hour nursed care for 3 months or more.

This definition captures a cohort with a very similar range of disabilities to those of the long-stay hospital population, but receiving different services as a result of hospital closure. We have tried here to assess the effects of this process on both cohorts. We have excluded services primarily for people aged over 65: their care raises rather different issues which were outside the scope of the present research. We have also largely excluded day services and other community support

which contribute substantially to an optimum quality of life and to other policy objectives for mental health care. This choice derives from an assumption that the provision of suitable accommodation and associated care has a major influence on the achievement of these objectives.

Knapp (1984), describes 'need' in the context of providing social care, as: '... a normative, social cost-benefit judgment about priorities in the allocation of resources'. He distinguishes four stages of reaching this judgment: a statement of objectives; a statement of welfare shortfalls; a statement of the (alternative) means to remove these shortfalls (interventions); and a statement of the most efficient means of removal. Stevens and Raftery (1997) define need in the context of health needs assessment as: 'The population's ability to benefit from health care'. The determinants of this are identified as:

- the incidence or prevalence of a health problem;
- the effectiveness of interventions available to deal with it.

These principles form only part of the context for specifying the range and volume of mental health services required in a particular district. The process also relies (to varying degrees) on epidemiological evidence, subjective value judgments and consultation with stakeholders. Johnson *et al.* (in Thornicroft and Strathdee, 1996) describe four main approaches to mental health needs assessment:

- local need estimated on the basis of national epidemiological figures for prevalence of psychiatric disorder;
- levels of service provision which would be expected locally may be calculated from national and international patterns of service provision;
- current local services may be compared with expert views on desirable levels of service provision;
- the validity of estimates derived using the preceding method may be increased using a deprivation-weighted approach.

To assess the extent to which available services correspond to required levels of provision we have relied largely on the last two approaches - described in more detail below. We have applied the levels of provision for various facilities recommended by Wing (1997) for an 'average' district, to the Somerset population. We have also adjusted these estimates using the *Mental Illness Needs Index* developed by Glover *et al.*, (1995) to take account of the effect of socio-economic variables on the need for mental health services.

To illustrate the directions in which mental health services evolved and their relation to client need, we use the findings of the Kent University study to describe their

configuration at the beginning and end of the strategic planning period. To account for observed developments, we relate these both to the strategic objectives identified by Somerset's Mental Illness Strategic Planning Team in 1991-2, and to their evolving understanding of the needs of this group. We assess the end-stage provision of accommodation for people with severe and long-term mental health problems in qualitative terms using the findings from our quality of life survey, and quantitatively drawing upon the 1996 needs assessment. This compares actual provision of different types of accommodation with estimated requirements, derived as described above. Such an approach is consistent with vertical targeting (Audit Commission, 1984). We also examine the geographical distribution of these services to explore the effectiveness of horizontal targeting (Davies and Challis, 1986). Finally, we seek to account further for our findings and discuss their implications.

Methods

Data about the processes of hospital closure and service development, the underlying policy objectives, and the final outcome, were derived from two main sources:

1. A 21-month evaluation, commissioned by Somerset Health Authority in 1994, of the outcome of closing Tone Vale Hospital. This employed a utilisation-focused approach (Patton, 1987), involving the formation of a project advisory group including the research commissioners and stakeholders in mental health services, followed by a structured process to identify the research questions of particular concern to them. The evaluation included:
 - a postal survey of all in-patient and other specialist accommodation and non-residential services, provided largely or exclusively for people with mental health problems. The questionnaire covered basic details about the nature, location and client group of each facility, staffing, interventions offered, and extent of user involvement. Responses were received from 100 of the 129 facilities contacted (a response rate of 85% - with the lowest response rate from small private sector homes);
 - a series of structured interviews with managers and professionals from the health authority, the social services department, the NHS trust and a representative of service users. These explored the diversity of views and experiences associated with the development of community mental health services in Somerset;
 - a survey of the destinations and quality of life of long-stay patients relocated from the hospital.
2. A comprehensive mental health needs assessment was carried out as part of a multi-agency review of mental health services in summer 1996. This involved:

- collection of local epidemiological data from primary and secondary care and its comparison with national figures;
- assembling a detailed 'profile' of service provision, including supported housing schemes which had been omitted from the earlier evaluation;
- soliciting the views of key informants on the adequacy of current provision and desirable service developments;
- a comparison of the level of different available services with estimated requirements based upon two published methods - Wing (1997) and Glover *et al.*, (1995).

This allowed a 'triangulation' of different approaches to increase the reliability of the needs assessment. It also permitted an extension of this to the individual commissioning localities used by Somerset Health Authority (coterminous with Somerset Social Services Department's operational divisions). The description and analysis provided here excludes an area in the extreme east of the county which was located outside the health authority's purchasing boundary until April 1996.

The strategy for reprovision

The changes we have examined are set out in Somerset Mental Illness Strategic Planning Team's *Revised Strategy for Services for Adults with Mental Illness* (1991). Mendip Hospital, serving the east of the county, was then about to close, so the changes identified related to the south and west of the county and the closure of Tone Vale Hospital, located just west of Taunton, by 1995. Figure 1 overleaf illustrates the pattern of services in 1991, when in-patient and residential care was heavily concentrated in Taunton (including Tone Vale), Yeovil and units in the Wells area which replaced Mendip Hospital. Day care for people with long-term mental health problems was unevenly spread and not necessarily targeted on those with priority need (Somerset Mental Illness Strategic Planning Team, 1991).

An amended version of the strategy (Somerset Mental Illness Strategic Planning Team, 1992) identified the components of a rehabilitation and day service specifically for people with more disabling and chronic conditions:

- multidisciplinary mental health teams serving a locality and providing treatment, support and care to patients, support to carers, advice to primary care teams, a range of day services and access to advice and practical help at home;
- a range of residential facilities: in-patient assessment, treatment, rehabilitation and long-term care, community-based hostels and satellite housing, access to ordinary housing, and respite accommodation;

- a monitoring and review process for people using mental health services on a long-term basis, building on the care programme approach.

Existing and projected numbers of acute and rehabilitation beds and for day places are cited in the Strategy, based upon:

- i) an assumption that 50% of long-stay patients at Tone Vale Hospital would be amenable to rehabilitation and might thereafter live in less supported setting (implying that the remaining 50% would require continuing NHS care). On this basis the required number of rehabilitation beds was anticipated to be 147. The strategy makes very limited reference to the development of complementary provision for the less disabled 50% or to the potential contribution of the independent sector to this;
- ii) an estimate of the number of people with chronic mental illness in Somerset Health District - at least 530. An earlier study (O'Brien, 1990) had identified an inadequate level of day care for this group. Starting from a (1991) baseline of 53 NHS day places, the planning total of 133 places aimed to provide at least one session per person per week for this group.

Although details of these are not cited in the strategy, other evidence (Somerset Joint Strategic Planning Team - Mental Health, 1992) shows that regular assessments of the rehabilitation patients in Tone Vale took place and influenced the reprovision process, certainly in its later stages. However, the strategic planning team was candid about the degree of uncertainty attached to its estimates, and the likely need to revise these, as indeed occurred:

... it is nevertheless quite apparent that the ability of the Health and Social Services to fully understand the needs of clients is presently unsophisticated... As we get better at measuring and responding to individual clients' needs it is possible that plans made in this document will require revision (Somerset Mental Illness Strategic Planning Team, 1992:11).

While estimates were made at this point of the required volume of NHS accommodation and day provision, there is no evident consideration of the geographical distribution of need nor of possible changes to this over time. Neither was there any reference to catchment areas for the new services.

Implementation of the strategy

Figure 2 overleaf shows the actual distribution of NHS i n - strategic planning period in March 1995. Comparison of this with the strategy highlights some key features:

Figure 1: NHS Mental Health Services for Adults Under 65 in January 1991 (Nos indicate beds or day places)

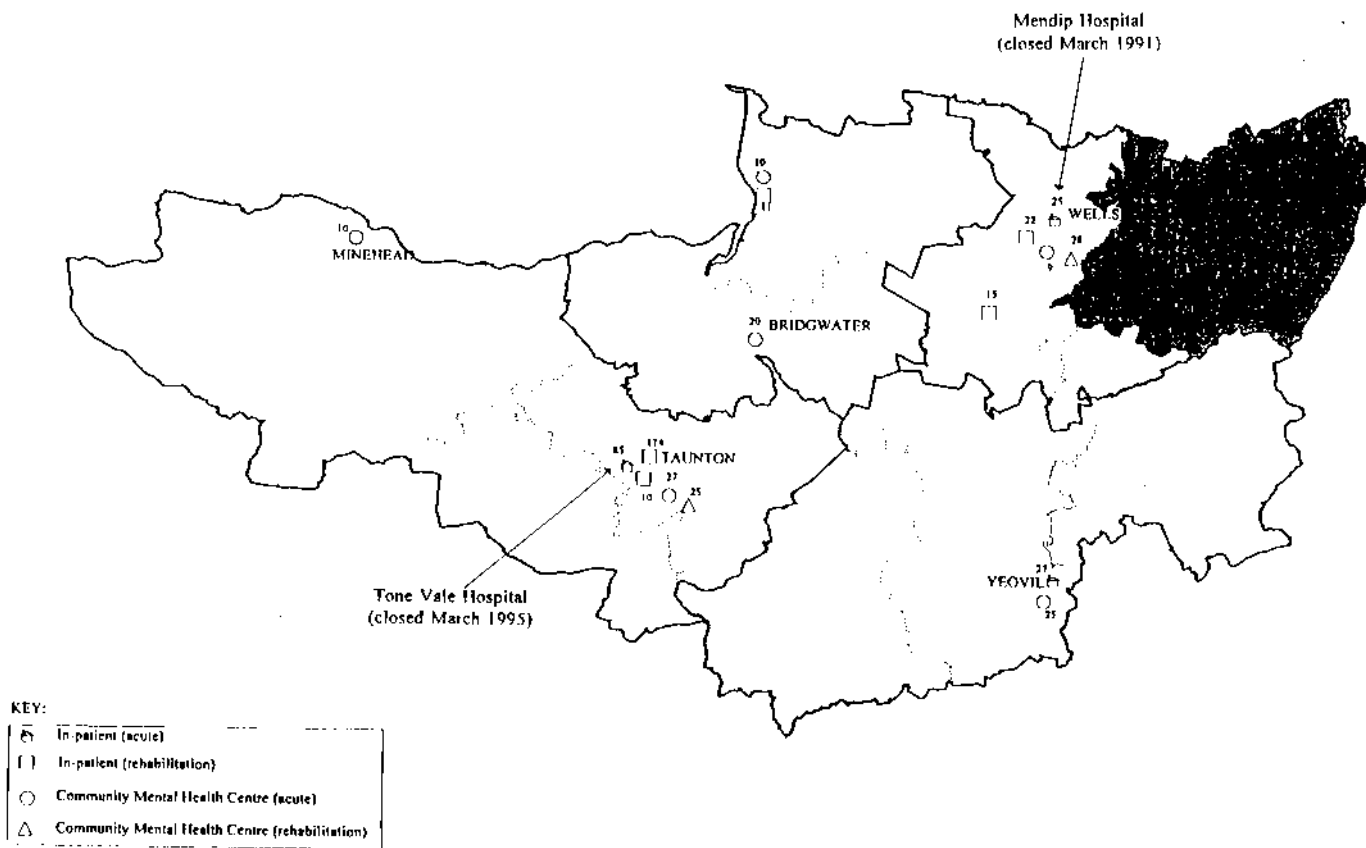
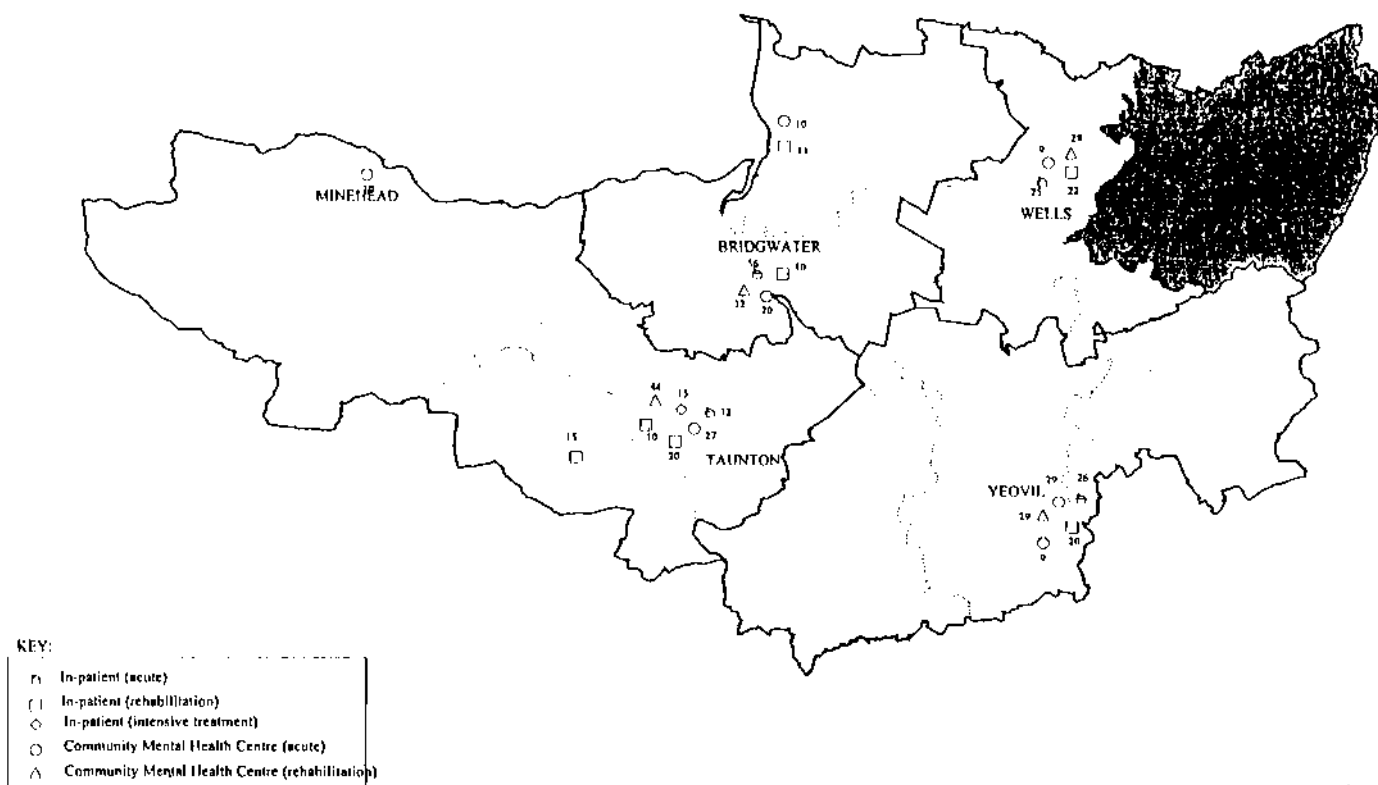


Figure 2: NHS Mental Health Facilities for Adults Under 65 in March 1995 (Nos indicate beds or day places)



- in-patient provision for people with long-term mental health problems was considerably less than originally planned (108 beds compared with 147). This was achieved by placement of a higher proportion of patients outside the long-stay NHS beds than the 50% originally envisaged;
- the volume of NHS day facilities for this group exactly matches that envisaged;
- the new facilities remain largely concentrated in the major towns - particularly Taunton.

A review by Somerset's Mental Illness Strategic Planning Team (1994) indicates that the reduction in the number of long-stay beds from 147 to 108 was based upon periodic reviews of the care needs of the dwindling Tone Vale population. At that point, uncertainties were also noted about the demand for prolonged NHS care for people then living in the community and about the growth of provision by the independent sector. In 1994 this was unevenly distributed across the County, and not growing at all. The relocation of patients from long-stay hospital therefore took place in the context of considerable uncertainty about the relative roles of NHS continuing care, nursing home and residential care.

There is a lack of clarity locally and nationally on the boundaries of care between those who should have their care provided by the Health Authorities, those who should have their care provided in registered nursing homes, and those who should have their care provided in registered care homes. (Somerset Mental Illness Strategic Planning Team, 1994)

However, Table 1 demonstrates that a mixed economy of care was well established by 1996. It is based upon our (1995) survey of facilities for people with mental health problems, updated using the (1996) mental health needs assessment. Below we seek to compare this 'profile' with published estimates of the need for accommodation providing differing levels of care and support.

Outcomes for people with severe and long-term problems

The replacement of long-stay hospital beds with more modern facilities will directly affect patients relocated to these, and (less immediately) others with severe mental illness living in the community. The evaluation and the needs assessment provides evidence on how far the spectrum of available provision matches the needs and wishes of people with severe and long-term mental illness. Among a number of features, four are examined in detail here: substitution of independent sector for NHS care; evidence of trans-institutionalisation; an undue emphasis on 24-hour nursed care; and the inequitable distribution of accommodation.

Table 1: Specialist accommodation primarily or solely for non-elderly people with mental health problems by sector of provision

SECTOR AND DETAILS OF PROVISION	Places /beds
NHS TRUST	
5 acute in-patient units	106
6 continuing care units	108
1 psychiatric intensive care unit	15
SOCIAL SERVICES	
1 rehabilitation hostel	11
11 supported housing schemes	30
PRIVATE SECTOR*	
14 registered nursing homes	392
3 residential homes	29
39 small homes (registered for 3 or fewer people)	113
NOT-FOR-PROFIT (including Housing Associations)	
1 residential home	10
13 supported housing schemes	73

* This includes some provision for people over 65, including those with dementia

Substitution of independent sector for NHS care

In 1994 the Mental Illness Strategic Planning Team observed that some of the people expected to need long-term NHS care had already been placed in the independent sector. As part of the service evaluation, in January 1996 we examined the place of residence of all long-stay patients, excluding those with dementia, discharged from Tone Vale between January 1991 and March 1995 (when the hospital closed). This exercise found that approximately 40% - less than the 50% originally envisaged - moved to long-stay NHS accommodation, confirming the Strategic Planning Team's observation. This shift is consistent with central government policy to develop a mixed economy of mental health care. However, the substitution of independent sector care for NHS provision may not allow for future changes in the pattern of demand for accommodation for people severely disabled by mental illness.

Evidence of trans-institutionalisation

While evidence from elsewhere (Pickard *et al.*, 1992; Leff *et al.*, 1994) suggests that similar re-provision programmes deliver an improved quality of life for long-stay patients, our survey of a 25% sample (n=25) of the surviving long-stay patients from Tone Vale suggests that this may not be true in Somerset. Using the Lancashire Quality of Life Scale (Oliver *et al.*, 1996) we found that

many were relatively dissatisfied with aspects of their new accommodation, such as their current living arrangements, the lack of independence, limited influence and the other residents. This has been reported in greater detail elsewhere (Carpenter *et al.*, 1996). Most of those interviewed lived in new NHS residential units or nursing homes.

An undue emphasis on 24-hour nursed care

The (1991) mental health strategy specified a range of accommodation to be provided for people with long-term mental health problems. While projected numbers of acute and continuing care NHS beds were specified, this was not the case for non-NHS accommodation, such as staffed hostels or supported housing schemes; the need for the latter was recognised, but without being quantified.

Table 1 summarises the range of accommodation actually provided as at mid-1996. We have used the categories provided by Wing (1997) to reclassify this according to the level and type of support provided. This allows comparison with required levels of provision estimated using two methods (Table 2). The first is based on Wing's estimates of the volume of different types of accommodation needed in an 'average' district of 250,000. It is important to note that these are for mentally-ill adults of all ages, except those with dementia. The second method adjusts these estimates using the *Mental Illness Needs Index* (MINI) developed by Glover *et al.*, (1995), to allow for the well-documented effect of social geography on the relative demand for mental health services. It estimates requirements only for the 15-64 age group and therefore provides a more valid standard than the first method for comparison in this context with actual provision.

MINI is based on a statistical model which identifies the main variables affecting the demand for mental health services. Using census data, it derives an index for the locality concerned. Index numbers for the four Somerset commissioning localities lie between 90 and 95 (related to a base of 100 for the North-East Thames Region), implying a lower level of need for mental health services in Somerset.

The following features are apparent in Table 2:

- the number of acute beds provided is less than the required level estimated using the Wing (1997) methodology, but is considerably greater than that estimated using MINI;
- the number of NHS continuing care beds ('hostel wards') exceeds estimated requirements using both approaches: the existence of substantial numbers of beds in the independent sector supplements this provision further;

Table 2. Actual and required provision (beds/places) for a range of mental health care facilities

TYPE OF PROVISION	ACTUAL	REQ. (Wing)	REQ. (MINI)
Acute/crisis care	106	171	59
Psychiatric intensive care	15	17	10
Regional secure/special hospital beds	16	7	3
Hostel wards	108	85	49
Nursing homes*	392		
Residential homes*	39 (+113 small homes)		
High-staffed hostels	19	128	77
Day-staffed hostels	60 (+26 planned)	85	49
Visited homes	27	77	38

* Neither Wing nor MINI explicitly provide figures for registered homes

NB: The ratio of requirements estimated using the two methods differs between accommodation types due to differing levels of use by people over 65.

- as high-staffed hostels are roughly equivalent to registered residential homes, there appears to be sufficient accommodation in total providing overnight cover (although this is lacking in some areas);
- there is evidence of a serious shortage of low-support, specialist housing.

These comparisons need to be qualified for three reasons. Firstly, we were unable confidently to assign registered nursing and residential homes to the categories used by Wing (1997) or Glover *et al.* (1995), and have assumed (based on local knowledge) an approximate correspondence of nursing homes to 'hostel wards', and of residential homes to 'high-staffed hostels'. Secondly, the Wing model will predict higher numbers than those required for the 16-64 population which concerns us here, since it includes services for older people with functional (non-dementing) illness. Thirdly, while MINI covers the same population age range as our study, it predicts considerably lower numbers of acute and continuing care beds than Somerset provides. While there may indeed be over provision, it is likely that the index underestimates the demand for beds in relatively affluent, but rural, areas such as Somerset. It is based on a model which relates in-patient admission rates to demographic factors. The

admission rate predicted by MINI for Somerset is 16% less than that actually observed, which supports the above interpretation.

Such observations suggest that where such methods suggest over- or under-provision, other evidence should be sought to validate them. Where possible therefore, commissioners should undertake their own needs assessment work rather than rely solely on statistical assumptions.

Inequitable distribution of accommodation

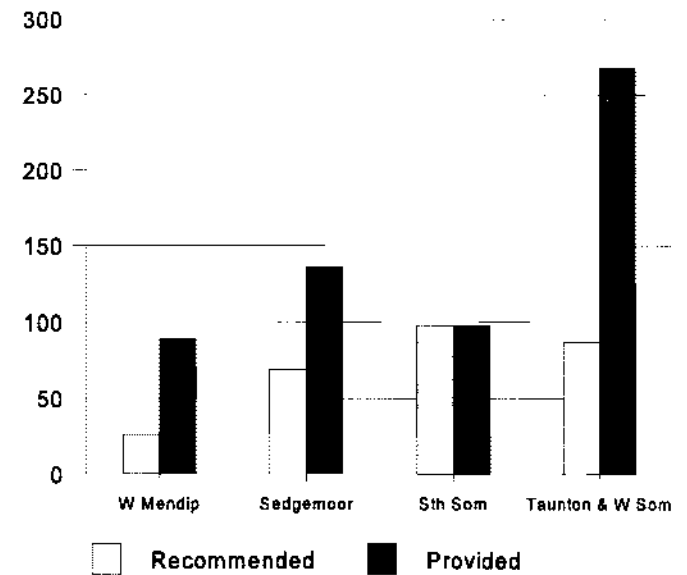
Table 3 shows the distribution of specialist accommodation in each commissioning locality. Figures 3 (a) and (b) present this data in graphical form. In order to compare localities, we have divided facilities into (a) those with 24-hour nursing cover and (b) all other staffed/supported accommodation. We have applied Wing's (1997) recommended levels to the population of each locality to estimate the requirements for each set of facilities.

Since there is evidence (see above) that MINI underestimates actual need for services in Somerset, we did not use this to adjust Wing's recommended levels. In comparing actual provision to these, however, it should be noted that a proportion of independent sector beds is used by people with dementia, whose needs are excluded from Wing's estimates.

Figure 3a demonstrates that combined NHS and nursing home provision exceeds recommended levels in all localities except South Somerset. The excess is particularly apparent in the Taunton and Mendip areas,

which previously accommodated the large psychiatric hospitals of Mendip and Tone Vale. Figure 3b also suggests a mismatch between the requirements for residential home and supported accommodation, and the distribution of provision.

Figure 3(a): NHS and nursing home beds: recommended (Wing) and actual provision by commissioning locality



While this seems to correspond with estimated needs in Sedgemoor and West Mendip, in Taunton and West Somerset there is a substantial excess. This is consistent with the connection of Tone Vale Hospital with this locality. South Somerset, by contrast, appears particularly

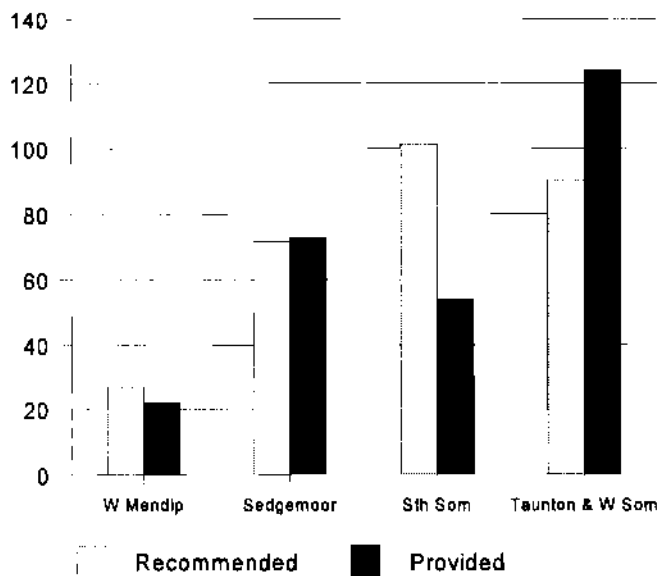
Table 3: Number of places (rate per 10,000 population) for different types of specialist accommodation, by commissioning locality (populations in italics)

Type of facility	West Mendip	Sedgemoor	South Somerset	Taunton & West Somerset	District-wide	County except E.Mendip
	<i>39 751</i>	<i>105 704</i>	<i>148 937</i>	<i>132 881</i>		<i>427 273</i>
In-patient beds	47 (11.8)	44 (4.2)	46 (3.1)	62 (4.7)	30* (0.7)	229 (5.4)
Nursing home beds	42 (10.6)	92 (8.7)	52 (3.5)	206 (15.5)		392 (9.2)
Residential home places	0	20 (1.9)	10 (0.7)	9 (0.7)		39 (0.9)
Small home places	6 (1.5)	25 (2.4)	25 (1.7)	57 (4.3)		113 (2.6)
Hostels staffed by night	0	0	8 (0.5)	0	11 (0.3)	19 (0.4)
Hostels staffed by day only %	10 (2.5)	25 (2.4)	10 (0.7)	41 (3.1)		86 (2.0)
Visited homes	6 (1.5)	3 (0.3)	1 (0.1)	17 (1.3)		27 (0.6)

* 15 "slow-stream" rehabilitation beds, 15 intensive treatment beds

includes 26 places planned to open during 1996.

Figure 3(b): Residential home beds and supported accommodation: recommended (Wing) and actual provision by commissioning locality



under-provided, with only half the recommended level of accommodation. This shortfall risks diverting local residents, requiring only supported accommodation, into local NHS or nursing home care. Alternatively, they may be placed in more suitable, less intensively supported accommodation, but in other areas. This is likely to disrupt their natural support systems and local connections and maintain the existing uneven provision.

This analysis suggests that the presence of a large number of long-stay hospital patients at Tone Vale and Mendip has dominated the development of provision for people with severe and long-term problems. Their relocation into NHS and nursing home facilities developed locally effectively maintained the geographical distribution of mental illness in the population. However, the passage of time, and the availability of local in-patient care, will result in the emergence of a new cohort of people with severe and enduring mental illness in other areas. As a result, local demand will develop there for a range of specialist long-term accommodation, including supported housing. Since 34 places in such schemes opened in 1996-7 (included in the Figures cited above), there is evidence that agencies are to some degree recognising and responding to this emerging need.

Discussion and conclusions

National policy, public demand for more individual and local care, and changing population needs have combined to maintain the progressive elimination of the old psychiatric institutions throughout the UK. In Somerset this has involved their replacement by dispersed, more

community-based services. We have traced above some major local influences on this process. Evidence from planning documents, the apparent over-provision of NHS continuing care and nursing home beds and their concentration near the old hospitals, all suggest that the needs of their long-stay patients have dominated the development of alternative accommodation.

This process has been facilitated by the targeted availability of public funds for independent sector provision of residential and nursing home care. In spite of the transfer of these (now cash-limited) funds to local authority control, they still favour the development of highly-staffed accommodation at the expense of supported housing.

The Audit Commission (1994) also cite evidence concerning the historical effects of the large psychiatric hospitals located in other parts of the country. Districts which used to run such hospitals still spend more on mental health care than those which did not. Their location in suburban (and in some rural) areas means that these are now better endowed than inner cities, which used to 'export' their populations to hospitals now closed. Geographical inequities have not been abolished by the policy of deinstitutionalisation. The Audit Commission urged the government to reconsider its resource allocation policy to take account of these imbalances.

Until recently evaluation of psychiatric hospital closures focused principally on the outcomes for long-stay residents leaving them. Increasingly, however, concerns have been expressed on behalf of other people with serious mental health problems, but without experience of long-stay institutional care. Many of these also require permanent accommodation with varying amounts of care and support. Some of them, the 'new long-stay', continue to be accommodated in NHS facilities where skilled nursing care is available for lack of suitable alternatives. They tend either to have a history of violence or a severe risk of self-harm or self-neglect (Lelliott *et al.*, 1994). But not all of this high-risk group live in hospital. Recent press coverage (Thompson and Sylvester, 1998) suggests that Ministers are now determined that they will be accommodated at least in 24-hour residential care, rather than in less supported settings.

While we lack estimates derived locally for the numbers of people falling into this category in Somerset, evidence cited above suggests that the county is adequately supplied with NHS continuing care and nursing home beds to accommodate them. This conclusion contrasts with the situation in many urban areas. In view of recent concerns, it may be that the level of secure provision in the county needs to be reviewed, which was not addressed in detail in our work.

Other people with long-term mental health problems, who are rather less disabled, require accommodation providing more modest levels of staff support, linked to individual treatment programmes, social and occupational opportunities and income maintenance. Such accommodation remains concentrated in the areas of Somerset close to Tone Vale Hospital in the south-west of the County: it appears particularly lacking in the extreme west and south-east of the County. However, the development during 1996 of new supported housing schemes in these areas is evidence that service development is responding to these inequities. Similarly, the recognition of a shortfall in NHS day places for people with long-term problems at the beginning of the strategic planning period led to a nearly three-fold increase in these. This suggests that the planning system has the capacity to detect and respond to unmet need - at least in some respects.

Accumulating evidence demonstrates that the long-standing policy of replacing large institutions with local mental health services has generally enhanced the quality of life of long-stay patients relocated from them - although this is less apparent in Somerset. However, the policy must be also judged with reference to a younger cohort of people with severe and enduring mental health problems: they may be far less well-served by it, at least in urban areas. Action in Somerset, however, suggests their needs can be recognised. The capacity of evolving services to meet these is not yet clear, but there are concrete reasons for a modest degree of optimism.

Acknowledgements

Thanks to Azra Sadiq-Sangster for her work on the quality of life interviews; Dr Tony Morkane for comments on the paper in draft and to Nigel Holland for preparation of maps.

References

Audit Commission (1993) *Taking Care: Progress with Care in the Community*. London: HMSO.
Audit Commission (1994) *Finding a Place*. London: HMSO.
Cambridge, P., Hayes, L., and Knapp, M (1994) *Care in the Community: Five Years On*. Aldershot: Arena.
Carpenter, J., Sangster, A., Ring, C. and Cambridge, P. (1996) *Evaluating Mental Health Services in Somerset: IV. The Quality of Life of Former Tone Vale Residents*. Canterbury: Tizard Centre, University of Kent.
Crossby, C. and Barry, M. (1995) *Community Care: Evaluation of the Provision of Mental Health Services*. Aldershot: Avebury.
Davies, B. and Challis, D. (1986) *Matching Resources to Needs in Community Care*. Aldershot: Gower.
Department of Health (1989a) *Working for Patients*. London: HMSO.
Department of Health (1989b) *Caring for People: community care in the next decade and beyond*. London: HMSO.

Department of Health (1995) *Building Bridges: A guide to arrangements for inter-agency working for the care and protection of severely mentally-ill people*. London: DoH.
Gasson, B. (1995) 'Mental Hospital Closure, Schizophrenia and Suicide', *Mental Health Nursing*, 15, 4, 20 - 22.
Glover, G., Robin, E., Emami, J. and Arabscheibani, G. (1995) *A Needs Index for Mental Health*. London: Royal College of Psychiatrists Research Unit.
Goodwin, S. (1993) *Community Care and the Future of Mental Health Service Provision*. Aldershot: Avebury.
Johnson, S., Thornicroft, G. and Strathdee, G. (1996) in Thornicroft, G. and Strathdee, G. *Commissioning Mental Health Services*. London: HMSO.
Knapp, M. (1984) *The Economics of Social Care*. Basingstoke: Macmillan Educational.
Knapp, M. and Wistow, G. (1992) *Joint Commissioning for Community Care*. Canterbury: PSSRU, University of Kent.
Knapp, M., Cambridge, P., Thomason, C., Beecham, J., Allen, C. and Darton, R. (1992) *Care in the Community: Challenge and Demonstration*. Aldershot: Ashgate.
Leff, J., Thornicroft, G., Coxhead, N. and Crawford, C. (1994) 'The TAPS project. 22: a five year follow-up of long-stay psychiatric patients discharged to the community', *British Journal of Psychiatry*, 165 (Supplement 25), 13-17.
Lelliott, P., Wing, J. and Clifford, P. (1994) 'A National Audit of New Long-Stay Psychiatric Patients', *British Journal of Psychiatry*, 165: 160-169.
Mental Health Act Commission (1994) *Fifth Biennial Report 1991-93*. London: HMSO.
MILMIS Project Group (1995) 'Monitoring Inner London Mental Illness Services', *Psychiatric Bulletin*, 19, 5, 276-280.
O'Brien, J. (1990) *Long-term clients of the psychiatric rehabilitation services in Somerset Health District*. Taunton: Somerset Health Authority.
Oliver, J., Huxley, P., Bridges, K. and Mohamad, H. (1996) *Quality of Life and Mental Health Services*. London: Routledge.
Patton, M. (1987) *Utilisation-focused Evaluation*. London: Sage.
Pickard, L., Proudfoot, R., Wolfson, P., Clifford, P., Holloway, F. and Lindsay, J. (1992) *Evaluating the Closure of Cane Hill Hospital*. London: Research and Development in Psychiatry.
Ramon, S. (1992) *Psychiatric Hospital Closure, Myths and Realities*. London: Chapman and Hall.
Renshaw, J., Hampson, R., Thomason, C., Darton, R., Judge, K. and Knapp, M. (1988) *Care in the Community: the first steps*. Aldershot: Gower.
Somerset Health Authority/Somerset Social Services Department (1996) *Mental Health Needs Assessment*. Taunton.
Somerset Joint Strategic Planning Team - Mental Health (1994) *Mental Health Services Review (Adults 18-65 years)*. Taunton: Somerset Health Authority/Somerset Social Services Department.
Somerset Mental Illness Strategic Planning Team (1991) *A Revised Strategy for Services for Adults with Mental Illness*. Taunton: Somerset Health Authority/Somerset Social Services Department (amended 1992).
Stevens, A. and Raftery, J. (1997) *Health Care Needs Assessment*. Abingdon: Radcliffe Medical Press.
Thompson, A. and Sylvester, R. (1998) 'Care in the community is scrapped', *Daily Telegraph*, 17.1.98.
Tomlinson, D. (1991) *Utopia, Community Care, and the Retreat from the Asylums*. Buckingham: Open University Press.
Valios, N. (1997) 'Government stalls closure plan for psychiatric units', *Community Care*, 18.9.97.
Wing, J. (1997) *Mental Health in Stevens, A. and Raftery, J. (eds) Health Care Needs Assessment*. Abingdon: Radcliffe Medical Press.