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The role of housing in community care for mentally disabled people

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ABSTRACT

THE ROLE OF HOUSING IN COMMUNITY CARE
FOR MENTALLY DISABLED PEOPLE

HEATHER J. SCOTT

It is argued that housing is a fundamental element in
successful community care programmes for people who have a
long-term mental illness, but that the significance of the
immediate living environment on the individual's psych-
social well-being has been underestimated in the formulation
and implementation of policy.

Using a grounded theory approach, Part One reports an
exploratory study of the catchment area of one psychiatric
hospital, which included parts of three health districts and
three local authority areas. The study examined in detail,
with a focus on housing, the operation of services for
mentally disabled people   , the plans for creating
locally-based facilities, and the implementation of those
plans in the mid-1980's, by means of a combination of
documentary evidence and key informant interviews.

All three parts of the study area were found to have
encountered major but differing problems. Wide variations
between and within local areas in policy and resources were
found, but most stiking was the emergence of two distinct
key informant perspectives: those of policy makers/managers,
and workers in face-to-face contact with mentally disabled
people, indicative of separate discourses of rights and
needs.

Part Two sets up a model of three functions of housing based
on psychological needs, and argues for a compensatory rôle
for housing in community care, which is contrasted with the
reality of increasing difficulty in meeting even basic
survival needs. It is suggested that the emphasis on
negative rights of much mental health reform was inadequate
to ensure that needs were met when the welfare net began to
contract, and renewed emphasis on citizenship and social
rights is proposed as a means to represent more adequately
the housing needs of mentally disabled people at the levels
of policy and service planning.

THE ROLE OF HOUSING IN
COMMUNITY CARE
FOR MENTALLY DISABLED PEOPLE

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INTRODUCTION

"All of us want to live somewhere nice in a reasonable house or flat with privacy and our own things around us, yet...the very aspects of life we all hold so dear are denied to people at their most vulnerable" (Bayliss, 1987, p.5).

My interest in the housing of people with a long-term mental illness developed over the course of a number of years spent working with them as a social worker in psychiatric hospitals and area teams. It was impossible to remain unaware of the difficulties which many people faced in relation to their accommodation. Some lived in appalling conditions; many lost their homes before or during their admissions to hospital; some had had no kind of stable home for many years, and many had remained in hospital for years because they had nowhere else to go.

In those cases where the social worker's rôle involved helping the person to find or establish him/herself in new accommodation after a stay - sometimes prolonged - in hospital, three aspects stood out: the enormous amount of time and patient attention to detail which most often appeared to be essential if the person was to be helped to make a successful transition from the rôle of patient to becoming an 'ordinary person' once more (Ramon, 1989); the difficulty of achieving even a minimal degree of material comfort for people with very limited income and resources; and the consequent bleak precariousness of their lives.

Work as a practitioner centred on two main areas: detailed negotiation and liaison with a wide range of agencies and professionals, which was essential to ensure that their different policies and practices were co-ordinated in the best interests of the individual; and work with the person to accommodate a plethora of individual wishes, anxieties and difficulties.

The majority of people who experience mental illness, whether acute or chronic, have a home to which they are able to return and where they have the support of family and friends. However, my experiences led me to a conviction that, for the significant minority unable to do this, where and how they found themselves living played a key rôle in their ability to survive outside institutional care. They led equally to a conviction that this rôle and the reasons for it were barely recognised or understood by those involved in developing and implementing community care policies: Wansborough and Cooper's comment about employment rehabilitation appeared equally applicable to housing:

> "Mentally disabled people were not deliberately excluded ... they were simply not thought of" (Wansborough and Cooper, 1980, p.23).

My original intention had been to explore some of the implications of Bayliss's assertion (p.1) by documenting the 'housing careers' of people with a long-term mental illness in the community. Except for those long-stay patients discharged through a hospital rehabilitation process, evidence about where and how they lived was haphazard: where were those people who previously found themselves in mental hospitals now living?; what happened to them over time?; what quality of life did they have? and in what ways might this be related to their housing circumstances? However, the subject emerged as an increasingly complex one, involving a number of different disciplines and bodies of knowledge, levels and structures. It became clear that issues which appeared to me more fundamental had yet to be addressed, so that the idea of a prospective study was premature. I therefore decided that a different approach was preferable at this stage.

Although it could be argued that recent thinking about
community care began with the mentally ill (Busfield,
1986), its implementation in relation to this group had
encountered particularly difficult problems (and continues
to do so). Indeed, in many aspects of community care, the
situation of mentally ill people appeared to be the
limiting or paradoxical case: a recurrent impression was
that where a particular part of the welfare system found
that mentally ill people presented difficulties or
challenges, the system tended to respond by ignoring or
excluding them. They were not the only group to
experience deinstitutionalisation, but for no other group
was this process resulting in destitution or subsequent
incarceration to the same degree.

By the mid-1980's, the extent and severity of these
difficulties was beginning to be recognised in a number of
official reports (House of Commons, 1985; Audit
Commission, 1986; and later Griffiths, 1988). However,
even though the Audit Commission report in particular
contained a good analysis of **what** had happened,
recognition of the difficulties did not appear to have
been accompanied by any comprehensive analysis or greater
understanding of **why** the situation had arisen, in terms of
the position of mentally disabled people within society,
rather than those of resource distribution and
organisational complexity. Considerations of this sort
were not relevant to their task, but if the plight of
mentally disabled people was to be significantly changed
for the better, it seemed that such an understanding had
to be sought: this therefore became the focus of my
interest.

Three issues were becoming clear at this point: first, that although my starting point had been the housing situation of mentally disabled people, it was necessary to locate this within the context of community care as a whole. Second, that the concept, the policy, and the operation of "community care" were extremely confused: at the latter two levels, a comprehensive and detailed view of what was happening was lacking. Third, that in spite of the recurrence of certain themes which appeared to contribute in some measure towards an understanding of the current situation, none appeared to offer an adequate explanation of what was happening to mentally disabled people or a satisfactory conceptual basis for the formulation of policy or the planning of services.

Although, according to Dickens:

> "There is no single right way to understand the development of social systems and social practices; different theories can complement one another and work better in relation to different questions" (Dickens et al, 1985, p.5),

an acceptable unifying model was lacking and there was a need to find:

> "A way of thinking that includes all the worlds in which man (sic) lives: the material environmental world, the social world, and the world of the self" (Wilkes, 1981, p.114).

Furthermore, there was little evidence in the literature to suggest that the particular needs and difficulties in the community of people experiencing long-term mental illness were made explicit or taken into consideration by policy makers. None of the available theoretical material seemed able to account adequately for what was happening to mentally ill people: at worst, they were not considered

at all as a group; at best, conceptual frameworks and policies appeared to deal only tangentially with them. As for housing:

> "The literature specifically addressed to the provision of housing for the mentally ill is minimal, even though several authors have expressed concern over the problem" (Laws and Dear, 1988, p.91).

A large number of apparently disparate factors seemed to contribute to this, some relating to philosophy or ideology, others to policy decisions and their implementation; some with little obvious direct connection with mentally ill people, others clearly arising from a failure to recognise or respond to their needs and problems (and aspirations), whether these were linked to their psychological state itself, or to its personal and social consequences.

The economic and political context of the 1980's could be seen as an increasingly important influence. A British government committed (in the context of worldwide economic recession) to limiting public expenditure and the powers of local government, with at the same time, the promotion of the virtues of voluntarism and the individual (all of which were given reality in a range of legal and social policy measures), could all be seen as contributory factors in the worsening situation of mentally ill people.

At the local level, there appeared to be no comprehensive view of what was happening in relation to many components of community care: what resources existed? how were community care plans being developed and by whom? what was the place of housing within them? what problems were

encountered? I therefore decided to conduct a study to establish a detailed and comprehensive picture of community care for mentally disabled people in a limited local area, focussing upon their housing circumstances.

The study which follows illustrates at both policy and practice levels the shift which had taken place from a discourse of needs to one of rights. It is essentially an exercise in grounded theory in which the focus

> "is not merely on collecting and ordering a mass of data, but on organising many ideas which have emerged from analysis of the data" (Strauss, 1987, p72).

It seeks to develop a framework within which the housing needs of mentally ill people can be understood, and through which these needs can be more adequately represented in the development and implementation of policies, two realities which to date appear to have remained largely separate.

The thesis is divided into two parts. Part One begins by defining the group who are the focus of the study, estimating their numbers, and introducing a model of disability as a basis for identifying and understanding their range of needs. This chapter also contains a review of the available literature and a brief overview of the position of people with problems of long-term mental illness in the community at the time of the study.

The remainder of Part One, Chapters Two to Seven, reports the research study which attempted to document what was happening in one local area in the mid-1980's. The study focussed on how service planners and providers were

addressing the housing needs of people with mental
disabilities within the context of community care. The
organising principle of the research - the concept of
needs - emerged from the work itself; the study was
therefore exploratory and inductive in nature.

Chapter Two sets out the aims, design and method of the
research, which took the form of a comparative analysis
(using both documentary evidence and a key informant
study) of the three parts of the catchment area of one
psychiatric hospital. The findings are reported in detail
in Chapters Three to Seven. Each except Chapter Seven
deals with one part of the catchment area, and broadly the
same format is adopted for each. The final chapter in
Part One contains the views of those informants in day-to-
day contact with mentally disabled people.

Chapter Eight forms a link between the two parts of the
study by summarising some of the main research findings:
the impact of contingent events; the importance of
variation between and within local areas; and the
emergence of two distinct perspectives among the key
informants. These pointed to the existence of two
different realities - that of the policy makers and that
of the lived reality of mentally ill people - which were
taking place in parallel, and between which dialogue
appeared almost wholly absent.

Part Two therefore seeks to explain how this emphasis on
statutory duties on the one hand had arisen, and how it
operated to the detriment of mentally disabled people. I
hoped that the explanatory ideas generated by drawing on
empirical and theoretical material from a range of

disciplines would have a useful application in suggesting ways in which the two realities could be brought together.

Chapter Nine juxtaposes evidence about the effects of housing on psychological and social functioning, and evidence about the specific vulnerability and needs of people with mental disabilities, emphasising the mediating concept of stress. Having developed a model of three functions of housing which broadly correspond to different levels of Maslow's hierarchy of needs (Maslow, 1954), it is argued that where mentally disabled people live is likely to make a particularly significant contribution to their well-being. Available evidence suggests that as a minimum they shoud not be placed in accommodation which imposes high levels of known stress factors. It is argued further that in the light of this evidence, their living circumstances could be constructed to play a positive rôle in compensating for deficits in other areas of their lives.

Chapter Ten contrasts this important potential rôle of their housing with the reality of community care in the mid-1980's for mentally disabled people. Using the model of the three functions of housing, it argues that they were experiencing increasing difficulty in meeting more than their most basic need for shelter.

The concluding chapter locates their plight within the economic and ideological climate of the 1980's. It considers the problems of implementing community care in the context of both an increasing emphasis on rights rather than needs, and increasingly tight resources. The result for mentally disabled people as well as other

disadvantaged groups has been a situation which is increasingly oppressive.

The concept of citizenship, in particular the notion of social rights, is proposed as one potential means of bringing together rights and needs, to ensure that needs are adequately taken into account within the new emphasis on rights.

Finally, the urgent need for research which genuinely incorpoates the perspectives of users (and the methodological challenges this presents) if citizenship is to become a reality for mentally disabled people who may have little active capacity themselves and few advocates, is highlighted.

It will be apparent that my interest in this topic was essentially a pragmatic one, and that the study which follows reflects a process of evolution and exploration, rather than a definitive piece of work.

One further point should be clarified here: the reader might consider that the study which follows presents an unjustifiably negative and pessimistic view of mentally ill people and their situation. In particular, the criticism could be made that people with long-term problems are portrayed as inevitably passive and dependent; recipients of services who are without strengths or skills, unable to help or speak for themselves; indeed as mere objects (Stacey, 1988). This is very far from being the view that I hold. On the contrary, I believe that many people possess abilities and insights which remain largely ignored by the predominant

problem-focussed approach to care and treatment, or which they are unable to develop because of the multiple stresses which the reality of the current system of care impose on their lives. However I have at times taken 'worst case' examples and, like Marshall, deliberately used the language of cynicism in order to pursue the argument (Marshall and Bottomore, 1992).

A further possible assumption which must be discounted is that, since the views expressed about the implementation of community care in the following chapters are frequently strongly critical, the abandonment of community care in favour of reinstitutionalisation is implicitly advocated. Like Dear and Wolch, I "categorically reject the reinstitutionalisation alternative" and regard it as "a step backward in our commitment to progressive service support systems" (Dear and Wolch, 1987, pp. 203 and 254). In order to achieve such systems and remedy the mistakes of the recent past however, much greater recognition of those factors at the political, social and individual levels which facilitate or impede progress, and the interaction between them, is required. This piece of work is an attempt to contribute towards such an understanding.

Moreover, I am a strong advocate of the involvement of users at all levels in services which crucially affect their lives. However, genuine involvement by users of any health or welfare services is very difficult to achieve. It is easier still to disregard the views of people whose awareness of the world around them may be fluctuating or impaired, and whose way of life may be unstable or perceived as undesirable, but the task of seeking out and incorporating the views of service users is an essential one on which much work remains to be done. Ultimately, this piece of work is an attempt to identify a more

effective way of representing their needs - making their voice heard - at the policy making level.

Notes

1. Although reference will be made to subsequent major developments in this field, discussion throughout will focus on the situation around 1986, when the empirical study was undertaken.

CHAPTER ONE

MENTALLY DISABLED PEOPLE IN THE COMMUNITY: AN
OVERVIEW OF THEIR POSITION IN THE MID-1980'S

Introduction

By the mid 1980's, a policy of replacing institutional care for mentally ill people (and other vulnerable groups) by 'care in the community' had been advocated by governments in the UK and in most developed countries for more than 25 years. However, there were increasing expressions of concern by professionals (Lancet, 1985; BASW, 1985), academics (Jones, 1983; Walker, 1986), mental health organisations (MIND, 1985; Priestley, 1979) and the media (Central Independent Television, 1986; Guardian, 1986) about the circumstances and quality of life experienced by many of those now living outside the institution. A particular focus of concern was the growing numbers of them among the prison population and the homeless.

This chapter will outline the background to the research study which forms the basis of this thesis, and falls into two sections. It begins by defining those people whose circumstances and needs will be the focus of the study, estimating their numbers and introducing a model of disability which helps to identify the different types of difficulties they are likely to face in their daily lives.

The second part of the chapter reviews the relevant literature at the time the study took place with two aims: first, to present an overview of the diversity of factors affecting mentally disabled people at that time. These included the broad political, economic and legal climate, its manifestations in specific policy changes, and available evidence of the impact which these were having on mentally disabled people. Second, this section also

aims to summarise the status of theoretical and empirical knowledge of the relevant disciplines at that time.

Mentally Disabled People: Definitions and Numbers

Over the past 30 or 40 years, the definition and even the existence of mental illness has been widely debated by, among others, doctors, philosophers and sociologists, yet many issues relating to causation, course and appropriate responses remain unresolved. It is, however, widely acknowledged that much 'mental illness' involves "a complex mixture of social, personal and biological factors" (Lader, 1977, p. 198).

Whilst recognising its shortcomings and value implications (Goodwin, 1990), for the purposes of this study I will use the definition offered by Kathleen Jones:

> "The term 'mental illness' will be used without quotation marks to connote the condition of people who are suffering from lasting and disabling stress for no ascertainable and sufficient social or physical cause, or whose behaviour is so bizarre or so unacceptable that it is causing considerable stress to those around them" (Jones, 1983, pp. 218-9).

Until little more than a generation ago, people suffering from such a degree of disability would almost inevitably have been detained compulsorily in a mental hospital for long periods, and often for the rest of their lives.

This study will be concerned specifically with those adults under 65 years who suffer from such 'chronic'

mental illness. These have been defined as people suffering from a major mental disorder who

> "need psychiatric services indefinitely to attain and preserve the maximum possible independence from a substantially disabling mental illness and its consequences, irrespective of their diagnosis or length of stay in a psychiatric in-patient facility. Severity and persistence of disability and dependency of indefinite duration are thus the distinguishing hallmarks of chronicity in today's essentially non-institutional system of care." (Bachrach, 1984, p.13)

In practice a substantial proportion of this population have a diagnosis of schizophrenia, sometimes with other disorders such as alcohol abuse in addition. Although this group of mentally ill people have many needs and difficulties in common with adults with a mental handicap, it is argued that there are important differences between the two groups and service responses to them. This study therefore deals specifically with the position of mentally ill people, who will also be referred to as "mentally disabled", since this term is commonly used to describe those people substantially affected by long-term illness.

In seeking to understand the complex phenomenon of 'chronicity' (which is essential if needs are to be identified and appropriate service responses developed), it is relevant to consider Wing's formulation of three interacting elements which constitute psychiatric disablement (but which are equally applicable to disability resulting from other causes) (Wing, 1978b).

These elements are, first, **intrinsic impairment**: those factors which arise specifically from the disorder itself,

and which may be either acute or chronic. In
schizophrenia, an example of the former would be auditory
hallucinations, and of the latter, lack of drive or
emotional flattening. Both acute and chronic impairments
may be present together in schizophrenia, and such a
combination is likely to be severely disabling, with
profound effects upon the individual's ability to function
independently. However, these are essentially 'invisible'
handicaps which may not be recognised as such, or if
recognised, viewed unsympathetically.

The second and perhaps crucial element is that of
extrinsic disadvantage, which "has no necessary
relationship to the intrinsic type but independently
contributes to social disablement" (Wing, 1978b, p.25).
It has been shown that people experiencing poverty,
unemployment, prejudice, etc., are at higher risk of
developing many kinds of illness, both physical and mental
(e.g. Townsend and Davidson, 1982), and that these factors
are socially handicapping in themselves, even when illness
is not present (Leach and Wing, 1980). When illness is
present, evidence suggests that these handicapping factors
will influence entry into the psychiatric circuit
(Goldberg and Huxley, 1980).

Wing identifies the third element as that of **adverse
personal reaction**. This refers to the unique way in which
each individual reacts to his or her experience of having
been mentally ill, and is in some ways comparable to
Goffman's concept of 'stigma management' (Goffman, 1963).
Wing argues that the reaction takes two characteristic
forms. The individual may lose confidence, and avoid any
kind of stress or challenge through fear of precipitating
a further episode of illness, but this in itself may lead
to further loss of confidence and self-esteem "until the
person is so afraid to risk failure that he/she may be

unwilling to do almost anything" (Shepherd, 1984. p.6).
Alternatively, the person may cope by denying that he/she
has any difficulties, but instead cling to unrealistic
goals which may make necessary adaptation to changed
circumstances difficult. Wing observes that adverse
personal reactions depend not just upon the individual's
previous personality and experience of illness, but also
to a significant degree upon such factors as "the
reactions of important others and the degree of support
and help available" (Wing, 1978b, p.26).

By definition, 'chronic' patients are likely to show a
limited response to therapeutic interventions and

> "For a majority of the most severely mentally
> disabled ... rehabilitation in the sense of
> achieving competitive employment, high levels of
> social functioning, and a general return to the
> mainstream of society is probably not, according
> to current knowledge, a realistic goal.
> Unfortunately, it is just these patients, whose
> needs are greatest, who typically receive the
> least attention" (Bachrach and Lamb, 1982, p.
> 149).

Approximately 95% of all people with mental health
problems are now living in the community (Goldberg and
Huxley, 1980). The numbers of people in the population
who are disabled because of psychiatric illness are
substantial: for schizophrenia alone there is a lifetime
chance of 1:100 of developing the disorder, usually in
early adulthood, before employment patterns and adult
relationships have been established. Of those
experiencing a first acute episode, only half recover
completely; approximately 25% suffer a relapsing course,
and 25% become severely disabled (Wing, 1978a). There are
approximately 210,000 people who have been in touch with
services for more than a year (Wing and Morris, 1981).

These have been called the 'new long-term' group (Wing, 1982) and in the proportions belonging to different diagnostic groups, they resemble quite closely the 'new long stay' patients in an earlier study (Mann and Cree, 1976). Both groups are likely to suffer from intrinsic impairments and adverse personal reactions, but to experience fewer of the problems which result from having spent long periods in hospital. However, research among short stay patients showing high levels of extrinsic disadvantage, including unemployment and homelessness, indicates that many of them have already lost their social supports by the time they reach hospital (Ebringer and Christie-Brown, 1980).

Many of this group will therefore continue to require high levels of support and supervision in daily living (Hewitt et al, 1975). It is widely accepted that the bulk of such care is provided by informal sources of help (Walker, 1982). However, mentally disabled people may be disadvantaged on several counts here: many of them (60% in one study) have no relatives in regular contact (Wing, 1982); where they do, there is evidence both that caring for a mentally disabled relative is often particularly onerous and stressful (Creer and Wing, 1974) and that the nature of the emotional environment within the home is realted to relapse (Leff and Vaughn, 1985). Furthermore, the networks of non-family members of people with schizophrenia in particular tend to be small and poorly connected (Taylor and Huxley, 1984; Bulmer, 1986). The design and delivery of the services needed by this group are therefore likely to present particular challenges to policy makers and helping agencies.

The Context of Community Care in the Mid-1980's

It is now widely recognised (House of Commons, 1985; Audit Commission, 1986) that the shift towards a system of care in the community has to date been least successful in relation to people experiencing problems of long-term mental illness. This has included both the rate at which services have been created and the particular problems of homelessness, imprisonment and rejection which as a group they have encountered in the community. This is somewhat ironic given that it was their situation which provided much of the early impetus towards change in the care system.

For more than a century from the mid-1800's, "Institutionalisation of socially devalued people was a basic public policy" (Steinfeld, 1981). It was a succession of important developments - therapeutic, ideological and political - in the years immediately following the Second World War which brought about far-reaching changes in the care of mentally ill people. Developments such as the integration of mental hospitals into the National Health Service, together with the emergence of the therapeutic community and social treatment movements (Kennard, 1983; Clark,1974) began a reduction in the numbers of inpatients which was accelerated (but not caused) by the introduction of treatment methods with specific (and sometimes spectacular) effects, notably electro-convulsive therapy in depression and the phenothiazine drugs in schizophrenia (Wing, 1978a). Together these developments gave rise to a mood of optimism, even a belief that, like tuberculosis and diphtheria, mental illness could in time be virtually eradicated.

The rôle of mental hospitals as the appropriate locus of treatment was increasingly questioned (Ministry of Health, 1959) and it was anticipated that the number of beds would be halved within sixteen years was (Ministry of Health, 1960). Moreover, the Mental Health Act, 1959 made possible informal admission for almost 90% of patients and specified the powers of local authorities to provide the necessary residential and day care, training and social work services in the community.

A number of research studies quickly began to cast doubt on optimism about the response to treatment of much mental illness (Busfield, 1986), but even by the mid-1980's there was still little evidence that an adequate alternative system of community-based resources was being developed. Beds in psychiatric hospitals declined from 137,000 in 1961 to 61,500 in 1985 (DHSS, Health and Personal Social Services Statistics, 1987 and 1988). The rate of admissions continued to increase, but even so, the balance of expenditure remained heavily weighted in favour of hospital services, existing mechanisms such as joint-funding arrangements being wholly inadequate to ensure the necessary transfer of resources (House of Commons, 1985).

Tables 1.1 and 1.2 indicate the scale of the shortfalls in community-based provision:

Table 1.1

Progress to 1975 White Paper targets for mentally ill
people (England only)

| | 1974 | 1984 | Target | Progress |
		(thousands)		to target
Hospitals (available beds)	104.4	78.9	47.5	45%
Residential Places (local authority, private & voluntary)	3.5	6.8	11.5	41%
Day Hospital Places	11.2	17.0	45.8*	17%
Day Centre Places (local authority and voluntary)	5.4	9.0	28.2	16%

* Target includes day hospital provision for in-patients.

Table 1.2

Balance of expenditure for mentally ill people
(England only)

	1977	1985	Pattern implied by 1975 White Paper Target
Health	97.0%	95.5%	87.0%
Social Services	3.0%	4.5%	13.0%
Residential Care (hospitals, nursing & residential homes)	90.7%	86.2%	66.2%
Community Care	9.3%	13.8%	33.8%

(Source: Audit Commission, 1986, p.17)

Although some progress in developing resources was made in many authorities, mentally ill people were in competition for resources with other user groups, particularly the growing numbers of frail elderly people resulting from demographic changes, and abused children who were a constant focus of public and media attention.

Local authorities' expenditure on mental health services was extremely low, averaging 2% of Social Services Departments' overall budgets (CIPFA, 1988). However, this low average figure masked wide variations between authorities, with Newcastle spending £7.45 per head of population on mental health services in 1984-85, whilst four county authorities spent less than 20 pence per head (Audit Commission, 1986). Not surprisingly, the Audit Commission concluded that

> "Provision of community-based local authority support services ... in some areas ... is close to non-existent for mentally-ill people" (Audit Commission, 1986, p. 26).

It could be argued that an unintended effect of the Mental Health Act, 1983 (which replaced the 1959 Act) was to reinforce this situation because of its strong emphasis on the protection of individual civil liberties in the area of compulsory admission and detention, combined with its failure to give mandatory force to any of its substantial resource implications.

Such deficiencies were not confined to Social Service provision. This was unsurprising, even where the will existed, given the severe central government financial restraints under which most services were required to

operate by the mid-1980's. Mentally ill people in the community were also being affected both directly and indirectly by a number of wider developments and changes. In many cases these changes reflected the impact of both worldwide economic recession and the UK government's strong ideological commitment to the family, the market and the reduction of public expenditure; indeed community care can be seen both as an integral element of their philosophy and a key means of realising it (Goodwin, 1990).

Many of the changes to Social Security benefits, particularly the Board and Lodging and Single Payments Regulations, were detrimental to mentally ill people to the point that they appeared to be "working in a way directly opposing community care policies" (Audit Commission, 1986, p. 44). This position was to be further aggravated by changes introduced under the Social Security Act, 1986.

Three elements of Conservative government policies in housing had profound effects. The growth of the owner-occupied sector which had been strongly encouraged by successive governments of both parties since the 1950's was accelerated by the introduction of the statutory 'right to buy' under the Housing Act, 1980, so that between 1981 and 1986, more than one million local authority and New Town homes in Britain were sold to tenants (Newton, 1991). At the same time, public sector housing was required to bear the brunt of the drive to reduce public expenditure, with a decrease in investment between 1979/80 and 1984/85 of 54.6% (Inquiry into British Housing, 1985). There was also a continuing transfer of housing subsidy from a system of general subsidy to one of individual means-testing via the Social Security system (Malpass, 1990).

The effects of these policies (in association with other factors such as rising levels of unemployment) included:-

- a dwindling stock of public housing of deteriorating quality. The total required for repair and refurbishment of local authority housing stock was estimated at £19 billion in 1985 (DOE Stock Condition Enquiry, 1985).

- an increasingly residual rôle for public sector housing whereby it

> "moves towards a position in which it provides only a 'safety net' for those who for reasons of poverty, age or infirmity cannot obtain suitable accommodation in the private sector. It almost certainly involves lowering the status and increasing the stigma attached to public housing" (Malpass and Murie, 1982, p. 174).

- a sharp rise in the numbers of people living in houses in multiple occupation, which are frequently insecure and, by definition, of inferior standard. The precise numbers of such houses were unknown; however, the numbers of people living in bed and breakfast accommodation and receiving Supplementary Benefit increased four-fold between 1979 and 1983 (Hansard, 14th December 1984, cols. 661-662).

- a dramatic rise in the numbers of homeless people. The figure for households accepted as homeless under the Housing (Homeless Persons) Act, 1977 in England rose from 57,200 in 1979 to 93,980 in 1985 (Newton, 1991). The numbers of those homeless but not accepted as 'in priority need' were inevitably much higher (Watson, 1984). The numbers of mentally ill people in both categories were rising: following the closure of Banstead Hospital, a 59% increase in the numbers of homeless mentally ill people in Westminster (part of Banstead's former catchment area) was reported in a single year (Guardian, 1986).

At the time when I began work on this study therefore,
concern about the situation of many mentally disabled
people in the community had been growing, and was
beginning to be expressed at an official level. Although
the Audit Commission (1986) and the House of Commons
Social Services Committee (1985) disagreed about the
adequacy of existing levels of resources, both identified
major problems in the lack of short-term transitional
funding, organisational fragmentation and confusion, and
insufficient numbers of appropriately trained staff
(Appendices One and Two). From their very different
perspectives, both agreed that "The one option that is not
tenable is to do nothing" (Audit Commission, 1986, p. 4).
(1)

Whilst there was considerable literature from a wide range
of academics and groups of 'caring professionals' on both
policy and practice aspects of community care, including
issues relating to people with a mental illness, major
gaps remained.

Theoretical accounts tended to be either broadly Marxist
(Scull, 1984) or from a social-democratic perspective
(Jones, 1983). Whilst the former offered a more coherent
analysis which took account of the rôle of the state, they
tended "to ignore the considerable problems the state has
in achieving coherence of any sort in the development of
policies" (Goodwin, 1990, pp. 24-25). Explanations such
as Jones' were more useful at the level of policy
development and implementation, but generally omitted to
question why particular policies had developed.

The literature at the time the study began was problematic
in a further respect: from the late 1950's a substantial
body of theory had been developed about mental illness,
its nature and causation, by psychiatrists (Szasz, 1961;
Laing and Esterson, 1964), sociologists (Goffman, 1961)
and philosophers (Foucault, 1967). It could be argued
however that the metaphysical edifice thus created worked
against the interests of mentally disabled people,
particularly against the development of better services,
because it tended to deny or minimise their difficulties
(Sedgwick, 1982).

By contrast, both community care and housing at this time
appeared under-theorised: in the case of the former,
attention had focussed on deinstitutionalisation, but
there had been little attempt to locate this major social
process within any conceptual framework, or indeed to
define it satisfactorily (Bulmer, 1987). Similarly,
housing literature has until recently tended to focus on
practical and policy concerns in isolation from both
broader problems of welfare and wider theoretical debates
in the social sciences (Kemeny, 1992). Very recently,
some useful work has begun to emerge on issues which were
of concern to me at the beginning of the study. These
include debate about the meaning of housing (Dickens,1989;
Saunders and Williams, 1989), and the effects on personal
identity of the transition from psychiatric hospital to
the community (Ramon, 1989).

There were also major gaps in empirical work: many studies
were largely descriptive (Harper, 1980), reporting small-
scale special projects (Pritlove, 1983) or focussed on a
single element such as day care (Toke and Clews, 1977).
Whilst the evaluation of model projects yielded useful
information, the generalisability of findings was
frequently problematic, and in the UK there was a lack of

the type of evaluation studies characterised as "impact evaluation" which aimed to address such fundamental questions as:

> "What effect does the totality of existing programmes have on meeting the needs of the target population of chronically disabled persons?" (Bachrach and Lamb, 1982, p. 146).

However, more extensive evaluative studies were being initiated, of hospital closure programmes (Hall and Brockington, 1991), community living schemes (Renshaw et al, 1988) and policy co-ordination (Challis et al, 1988).

There was also a remarkable lack of studies which incorporated users' views and experiences: even the majority of studies of 'quality of life' in institutions and the community failed to include patients' perceptions as a measure (Norman and Parker, 1990; Hatfield et al, 1992), in spite of evidence of their importance (Lomas, 1987).

The absence of an explicit and thorough consideration of a housing dimension in the bulk of the literature about community care for mentally disabled people was striking. Some studies dealing with accommodation had yielded valuable information, but these were cross-sectional (Kay & Legg, 1986 - although this had the great strength of being based on users' views) or retrospective (Jones, 1986); or they were concerned with specific types of accommodation, such as hostels and group homes (e.g. Hewitt et al, 1975; Ryan and Wing, 1979; Pritlove, 1983).

Other studies provided much important data about needs and
services in the community, yet said little about housing;
for example the monograph by Wing and his colleagues
contained only two paragraphs dealing with 'Household';
and although one chapter dealt with the practices of day
and residential units, there was no discussion of the
living conditions of the 42% of the sample who were not
living in residential care (Wing, 1982). It was rare for
publications on community care to include any contribution
from housing professionals, although Reed and Lomas (1984)
was an exception. All the studies mentioned related to
people who had remained in contact with official services
in some way, however tenuous the link or unsatisfactory
the service. Little appeared to be known about the
situation and needs of those people who were no longer in
contact with services, or indeed of the total population
(Bachrach, 1980). The small amount of work which did
recognise the central importance of housing in community
care tended have a strongly practical focus (Bayliss,
1987; Harrison and Means, 1990).

Whether the housing needs of mentally disabled people were
not thought of, or housing was perceived to be
unproblematic for them, there was very little evidence of
recognition of the need to plan how the accommodation
function of the old mental hospitals was to be fulfilled
in the new, non-institutional system of care (Bachrach,
1978; Shepherd, 1984).

Although the housing of mentally disabled people in the
community clearly involved a number of different
disciplines and bodies of knowledge, the issue seemed to
lie at the intersections between them: the nature of
mental disorder and the position of mentally ill people in
society (psychiatric and sociological perspectives); the
nature of community care (drawing on concepts and

knowledge from both sociology and social policy); and
housing (involving social policy, geography and
anthropology). However, the dearth of literature and
research about the living arrangements of mentally
disabled people suggested that the issue was perceived as
marginal to the concerns of all the disciplines. Such a
discursive closure could, I thought, in part account for
the problems encountered in the implementation of
community care.

The work which follows therefore uses a detailed study of
the catchment area of one psychiatric hospital as a basis
for attempting to explore the nature of the relationship
between housing and community care, to generate a better
understanding of why housing may be significant, and to
suggest how that knowledge could be incorporated in to
policy decisions.

Notes:

1.   Since then there has been government action in a
number of areas.   The <u>NHS and Community Care Act, 1990</u>, to
which the Audit Commission's recommendations ultimately
led, via the Griffiths Report (Griffiths, 1988), contains
some recognition of the special needs of mentally disabled
people by the introduction of a specific grant and the
requirement for 'care programmes' in each district.
Additional funding to reduce the numbers of homeless
people on the streets has also been made available;
however, both the adequacy and the appropriateness of
these measures is open to question: the Mental Illness
Specific Grant amounted to only £21 million in its first
year (1991-2) (Ham, 1991); and the action on homelessness
merely addresses the problem at its end stage, rather than
attempting to prevent it (Cervi, 1992).

CHAPTER TWO

THE RESEARCH PROJECT: AIMS, DESIGN AND METHOD

<u>Aims</u>

The preceding chapter depicted the state of community care in the mid-1980's and drew attention to the multiplicity of the political and social factors influencing both the shift of services from institutional to community care and the capacity of mentally disabled people to adapt to living in the community. It also pointed to the existence of major gaps both in the literature and in the process of implementation of the policy, resulting in an impression of widespread chaos and crisis.

The range and importance of the influences identified in Chapter One resulted in substantial changes to both the conceptual approach and the empirical study originally envisaged. The original focus of the latter was intended to be an investigation of the housing circumstances of mentally disabled people by means of a prospective study of a sample of patients discharged from hospital.

It would have followed the "housing careers" of a sample of people discharged from hospital and attempted to assess their quality of life "by assessing performance and satisfaction in specific areas of individual-environment interaction" (Bigelow et al.,1982, p.363). In this way it was hoped to achieve a representative sample which included people both in contact with services and those who had lost touch for whatever reason.

However, even though there was a need for research in this area, it became clear that the plan for such a study was premature. The rapidly changing political and

organisational context at both national and local levels
meant that there were serious omissions in basic data and
knowledge about how community care was being implemented and
with what effects, even on a local basis. Each discipline
and part of the system appeared to be working largely within
its own boundaries, resulting in fragmentation in both
policy making and service delivery.

More important, the omissions in the literature in the area
of housing made me aware that my primary concern was to try
to arrive at some understanding of the relationship between
the different elements in this important social process:
"why is this happening?" as much as "what is happening?".
In particular I wanted to develop some theoretical
understanding of housing as one element of welfare, since my
experience suggested to me that its rôle in community care
was underestimated and not fully understood.

The questions to be addressed by the study therefore became:

- What is the current state of care in the community for
mentally disabled people at the local level?

- Specifically, what are the organising policies concerning
housing for mentally disabled people in the community?

- What theories can assist in understanding what is
happening?

- How might such explanations contribute towards improving
the formulation and implementation of policy?

Design and Method

In designing the research project, the basic issue became
therefore to find ways of capturing the complexity of the
reality and to make sense of it (Strauss, 1987). The
Grounded Theory approach (Glaser and Strauss, 1967) appeared
to offer the most appropriate model for the study because it
is designed to use qualitative research to generate and test
theory:

> "A grounded theory is one that is inductively
> derived from the study of the phenomenon it
> represents. That is, it is discovered, developed,
> and provisionally verified through systematic data
> collection and analysis of data pertaining to that
> phenomenon ...one begins with an area of study and
> what is relevant to that area is allowed to
> emerge" (Strauss & Corbin, 1990, p. 23).

A number of further characteristics of this approach also
appeared pertinent to my field of investigation and what I
hoped would emerge from the study. These included its
recognition of the rôle of professional experience in
theoretical sensitivity; its emphasis on creativity through
procedures which

> " ... force the researcher to break through
> assumptions and to create new order out of the old
> ... generating stimulating questions and ...
> coming up with the comparisons that lead to
> discovery" (Strauss & Corbin, 1990, p. 27);

and especially the expectations of the grounded theory
method that the implications of the theory thus generated
will have a useful application.

A research project was therefore designed with the aim of
generating data which addressed the first two questions
identified in the previous section, ie, to establish a
detailed picture of the current reality of the target group
of mentally disabled people in the community in a defined
area. The analysis and interpretation of the findings in
Part Two was then intended to generate a range of concepts
and linkages which would, it was hoped, offer some tentative
answers to the third and fourth questions, interpretations
of the data which would permit further elaboration and
verification (Strauss, 1987, p.11).

The research project took the form of a case study of
housing and community care within the catchment area of one
psychiatric hospital. St Nicholas Hospital was chosen
because its current catchment area covered parts of three
district health authorities (Newcastle, Gateshead and North-
West Durham), and it therefore lent itself to a comparative
approach in identifying both common elements and areas of
difference. The catchment area also included parts of three
local authorities; these were Newcastle and Gateshead, both
of which are metropolitan boroughs, and Derwentside, where
some services such as housing are provided by the District
Council, and others such as social services are provided by
Durham County Council. The catchment area embraced sharply
contrasting areas, from the severely deprived to the
affluent, and from inner-city to rural. A brief profile of
the hospital is included at the end of this chapter.

In spite of the well-documented limitations of the rôle of
comparative analysis in explanation (Dickens et al., 1985;
Jones,1985), this approach nevertheless appeared to offer a
useful contribution "both in terms of aiding explanation of

how structures become varied, and in stimulating images of what may be possible" (Dickens et al., 1985, p.254). It can also help in "establishing the process links between structural mechanisms and historical events" (Dickens et al., 1985,p.30).

Furthermore, given the multiplicity of professional groups involved in the implementation of community care, and therefore the diversity of perspectives and perceptions of "success", the notion of "pluralistic evaluation" developed in relation to psychogeriatric services was also relevant in planning and designing the study (Smith and Cantley, 1985).

In order to ensure that the data gathered were both comprehensive and varied, a design incorporating multiple strategies was used (Burgess, 1984). This involved two main approaches in conducting the research project, namely an extensive study of available documentary evidence, and a series of interviews with key informants. A small but important part of the material gathered in the interviews has been presented as oral research, for reasons which are discussed below.

Documentary Evidence

It was considered important to build up a profile of the different parts of the hospital's catchment area, including not only broad socio-economic data, but also information about the different agencies operating within each area,

their organisation, resources and policies, as a backcloth
against which to analyse the specific issue of mentally
disabled people and their housing.

Documentary material from a very wide range of primary and
secondary sources was identified and used. Sources included:
census data; official policy statements and plans; published
and internal reports; minutes of council and committee
meetings; letters; leaflets and booklets for service users;
press reports, and even campaign leaflets dropped through
front doors. Most of the documentary evidence was publicly
available, but in spite of strenuous efforts to be thorough,
and the large volume of material accumulated, gaps still
occurred, sometimes because material could not be located,
sometimes because it did not appear to exist. Material was
located in a variety of ways: by asking each key informant
to identify relevant documents; by searching council minutes
and reports, as well as the local studies sections of local
libraries; by following up references to further sources;
and in a few instances, by chance.

The study of documentary evidence proved to be a far more
time-consuming and significant part of the project than had
been anticipated initially.

Key Informant Study

For the key informant study, it was decided that the most
fruitful sources of information were likely to be those

people actively involved in a variety of rôles in the accommodation needs of mentally disabled people. It is inevitable that there is a subjective element in material gathered in this way, but this was seen as a postive feature at this stage of the research process, helping to identify issues requiring further examination. In designing and carrying out this part of the study, Tremblay's work on the use of key informants was very helpful, and what follows gives an account of the first two stages of what Tremblay sees essentially as a three stage project:

- Stage 1: Use of ethnographic key informant technique

- Stage 2: Use of focussed key informant technique

- Stage 3: Well-designed sample survey

(Tremblay, 1982)

It is hoped that a Stage 3 study can be undertaken at a later date.

<u>Stage One</u>: As in the Stirling County study, in Stage One informants were sought "who might be expected to have specialised information on particular topics". (Tremblay, 1982, p.99). On the basis of my knowledge and experience both of some of the issues likely to be relevant, and of potential sources of information, both locally and nationally, I undertook a preliminary series of interviews with the following people between October 1985 and January 1986.

Table 2.1: Initial Informants:

1. Head Office Staff, CHAR, London.

2. Development Officer, South East Housing Service,
    MIND, London.

3. Accommodation Development Officer,
    Single Homeless on Tyneside.

4. Housing Aid Worker, Tyneside Housing Aid Centre.

5. Senior Social Worker, St Nicholas Hospital.

6. Social Worker, St Nicholas Hospital, working
    with Derwentside patients.

7. Social Worker, Area 2, Newcastle Social Services
    Department.

8. Chairperson, Gateshead Houses in Multiple
    Occupation Group.

9. Warden, Sallyport Crescent Housing Project,
    Newcastle.

10. Officer in Charge, Hostel for recovering mentally
    ill people, Newcastle Social Services Department.

11. Community Worker, Consett.

I also had an extremely useful meeting with Charlie Legg,
joint author of a study of psychiatric patients discharged
to the community in London, while the research for that
study was in progress (Kay & Legg, 1986).

These interviews were relatively unstructured since their
purpose was to gain a wide perspective of the subject, and
to identify as many relevant issues as possible. In
addition to sharing their perceptions and considerable
experience with me, and suggesting other informants, in

almost all cases the people interviewed supplied me with a
wide range of written material which was an invaluable
additional source of information. I also had briefer, more
informal conversations over a period of several months with
a number of other individuals, including psychiatrists,
nursing officers, community psychiatric nurses,
psychologists, social work students on placement, and people
at all levels in Social Services Departments. I met these
people in connection with other aspects of my work, so that
frequently the projected study was not the primary purpose
of the meeting, but nonetheless, I gained valuable insights,
encouragement and stimulation from these contacts as well.
This stage also involved the study of the literature which
formed the basis of Chapters One.

Stage Two involved the selection and more focussed
interviewing of a further group of key informants, on the
basis of the information gathered in Stage One and the
amended aims of the project, described above.

Efforts were made to ensure that these informants were
widely representative and that the information gathered was
symmetrical, so that the aim of my strategy was to select
equal numbers of representatives from each of the three
local authorities (both Housing and Social Service
Departments); managers and practitioners in both health and
social services; statutory and non-statutory agencies
working with mentally ill and/or homeless people; a
representative of the Supplementary Benefits section of
D.H.S.S. (1); and the views of consumers themselves.

Only two areas of difficulty were encountered: firstly, two
agencies involved with homeless women said, perhaps
surprisingly, that they did not consider that they had any
relevant information and would not agree to participate.
Regrettably therefore this study, like many previous ones,
does not contain any information or discussion about the
specific needs of women (Watson and Austerberry, 1986). If
this has been true of the housing needs of women in general,
it has been even more applicable to the needs of women with
chronic mental health problems:

> ".....by lumping the chronically mentally ill
> together without thought for the needs of various
> sub groups, and by ignoring existing research,
> (planners) end up serving some mythical 'average'
> client, who more often than not is male" (Seltzer,
> 1989, p42).(2)

The second difficulty was an operational one, in that it did
not prove possible to interview a consumer from each of the
three local authority areas, as had been hoped. It was
necessary to try to contact consumers through an
intermediary, normally a professional worker who knew them,
and negotiating their agreement to talk to me required tact
and sensitivity. Several people who were potential
informants could not be seen for a variety of reasons (had
moved away; had a relapse of their mental illness, or had
other current problems), and pressure of time made it
necessary to abandon the attempt to locate one consumer from
each part of the catchment area. The three consumers who
were interviewed therefore were all currently living in
Newcastle, although each was in a different type of
accommodation: a permanent independent tenancy; a temporary
flat provided by the council for homeless people; and the
Salvation Army Men's Palace. The inclusion of only three
users of services could be seen as tokenistic. However, the
primary focus of this analysis is on the system of care and

the implementation of policy, and it is hoped that the projected Stage Three study would consist principally of a sample study of service users and their experiences.

Although their stories cannot be considered as representative or indeed necessarily accurate (Burgess, 1984), all three had very clear views about the kinds of accommodation and support services they wanted and valued. Since it is

> "...all important to respect the desires of the individual. Even when the arrangements a person chooses may seem beyond their abilities to manage, we have found that motivation and determination to make it work can make up for quite considerable lack of skills... Conversely, we have found that people rarely settled, much less developed, in housing which was not the sort of thing they wanted, even when it was well within their coping abilities" (Lomas, 1987, p.291),

the three service users contributed important illustrative material, and their detailed accounts are therefore included as Appendix Ten.

In addition to the role they occupied, key informants were also selected with Tremblay's four additional criteria in mind, i.e., knowledge, willingness, communicability and impartiality (Tremblay, 1982, p.100). In some cases, an informant's knowledge and willingness to cooperate in the study were considered more important than the formal rôle held within the employing organisation; for example, in two cases, it was considered both by their agencies and by me that hospital principal social workers were more directly involved and therefore likely to have more information than fieldwork managers.

A large proportion of the operations of voluntary
organisations was concentrated in the two metropolitan
authorities, so that the majority of their information
relates to those.   Nevertheless, it is hoped that the
basically symmetrical design adopted has helped

> "in maximising the chances of locating individuals
> who combined a high degree of knowledge with the
> ability to communicate it accurately" (Tremblay,
> 1982, p.102).

All the informants were able and willing to communicate
their knowledge, although the diversity of their rôles and
the information they provided made the task of finding a
basis for analysis and comparison of the data difficult, and
this will be discussed further below.

When first approached, two informants gave their lack of
impartiality as a reason for not participating in the study;
in each case, they (both employed by voluntary
organisations) said that they had strong criticisms of, and
a high degree of cynicism about the reality of community
care for mentally disabled people. However, such a critical
perspective was seen as being extremely useful in trying to
assess how policies and services were currently operating
and in identifying relevant issues, and both informants when
interviewed in fact provided valuable insights and
perceptive comments.   Personal biases also proved important
when they emerged in another interview, because of their
potential influence on the formation and implementation of
policy, and therefore, far from being a reason to exclude
such an informant, it was important to include these

opinions and perceptions and to try to appraise their effects.

Table 2.2 shows the twenty four key informants who were finally selected and interviewed:

Table 2.2: Key Informants

AGENCY / ROLE	INDIVIDUAL	AREAS OF INVOLVEMENT		
		N'castle	G'head	NW Durham
HEALTH SERVICE	1.General Manager, Service Planning & Operations.Mental Health Unit, Newcastle Health Authority	/	/	/
	2. Consultant Psychiatrist, St. Nicholas Hospital.	/	/	/
	3. Coordinator, Bridge Medical Centre (for homeless people) Newcastle.	/	(/)	
HOSPITAL SOCIAL WORK	4. Senior Social Worker, St Nicholas Hospital *	/	/	/
SOCIAL SERVICES DEPT MANANGEMENT	5. Principal Assistant (Adult Care) Newcastle.	/		
	6. Principal Psychiatric Social Worker, Gateshead.	(/)	/	

		N,castle	G,head	NW Durham
	7. Principal Hospital Social Worker, Shotley Bridge Hospital, Consett		(/)	/
SOCIAL SERVICES DEPARTMENT SOCIAL WORKERS	8. Social Worker Area 2, Newcastle *+	/		
	9. Social Worker Blaydon Area Office, Gateshead		/	
	10. Social Worker Derwentside District			/
HOUSING DEPARTMENT	11. Housing Needs Officer, Newcastle	/		
	12. Assistant Director, Housing Services & Principal Assistant, Allocations, Gateshead		/	
	13. Deputy Housing Manager & Senior Administration Officer (Homelessness & Health Authority Liason), Derwnetside District Council			/
HOMELESSNESS	14. Accommodation Development Officer, Single Homeless on Tyneside *+	/	/	
	15. Warden, Tyneside Cyrenians	/	/	
	16. Acting Manager DHSS Resettlement Centre, Plawsworth	/	/	/

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		N'castle	G'head	NW Durham
	17. Team Leader, Wayside Day Centre, Northumbria Probation Service	/		
DHSS	18. Assistant Manager, Supplementary Benefits, Newcastle, St. James Office	/		
NON-STATUTORY	19. Housing Aid Worker, Tyneside Housing Aid Centre *+	/	/	/
	20. Development Officer, Northern Schizophrenia Fellowship	/	/	/
	21. Development Officer, Society of St. Vincent de Paul	/		
CONSUMERS	22. Joe			
	23. Brian			
	24. Jean			

The people finally included did not differ greatly from the
initial list. A small number of people, mainly in voluntary
agencies, were not interviewed when it appeared likely that
their information would largely duplicate that already
obtained; a few others, such as Community Physicians, who

were originally included because they were expected to have a rôle in relation to homeless and vulnerable people, were omitted when it was established that they had no involvement.

It had been thought likely that as the interviews progressed, additional informants would be included as a result of information gathered, but in fact little restructuring took place since further key informants suggested during the interviews had almost always been included. This would seem to confirm that the original selection of informants had been both comprehensive and appropriate, although it might also suggest that the informants had been drawn from too narrow a circle. However, "Data collection never entirely ceases" (Strauss, 1987, p. 27), and three additional informants were interviewed much later in order to clarify or amplify issues which had emerged. These informants were:

25. Care Worker, Newcastle SSD Hostel for people recovering from mental illness

26. Deputy Chief Environmental Health Officer, Gateshead MBC.

27. Housing Aid Coordinator, Newcastle Housing Dept.

Some key informants (indicated by *) had also been seen in Stage One. The second interview was more focussed than the first, as its purpose was different; but where appropriate, informants also updated material previously given. Other informants (marked +) held more than one rôle: for example, the Consultant Psychiatrist also acted as medical adviser to the Northern Schizophrenia Fellowship; the Social Worker

from Newcastle Social Services Department was a member of
the Management Committee of Tyneside Housing Aid Centre, and
also a member of both the Houses in Multiple Occupation
Group, and the D.H.S.S. Forum. The worker from Single
Homeless on Tyneside was also a member of these last two
groups, as well as the Plawsworth Replacement Committee and
the Housing Special Needs Advisory Group. Other informants
may have held additional rôles of which I was unaware.

Where informants were involved with the housing needs of
mentally disabled people in more than one capacity, the
interview with them concentrated on their involvement
through the rôle specified in the list above, but obviously
their knowledge and perceptions gained in other capacities
were valuable and could not be excluded.

Method

The three service users were contacted personally, after the
idea of talking to me had been discussed with them by a
worker who knew them well, and they had indicated their
willingness.

In all other instances except two, informants were contacted
by telephone in order to seek their agreement to particpate
in the study and to arrange the interview. Such an informal
approach was considered appropriate, since in the majority
of cases the informant either had previously had contact
with me in another capacity or knew of the work I was doing.

In the two remaining cases, it was considered that a more
formal approach was more likely to result in agreement, so
that a letter setting out the nature of the project and
requesting an interview was sent; in both instances this met
with a positive response.

All twenty four informants in the original sample were
interviewed during October and November 1986. Of the three
informants included subsequently, the interview with the
Care Worker took place in August 1987; that with the Deputy
Chief Environmental Health Officer in Gateshead in October
1988; and that with the Newcastle Housing Aid Coordinator in
April 1989.

All but three of the interviews took place in the
informants' workplace (or in the case of consumers, in their
homes); for reasons of convenience the remaining three took
place in my office. Sometimes it was difficult to obtain
quiet and freedom from interruptions: one interview had to
be abandoned and rearranged when the informant (a social
worker approved under the Mental Health Act, 1983) was
called away urgently to a possible compulsory admission to
psychiatric hospital; and another was interrupted several
times by a user of the service, on one occasion proferring
as a peace offering for an earlier misdemeanour a bunch of
flowers apparently gathered from a nearby municipal flower
bed! It says much for their interest in the project and
their concern about its subject that very busy people were
willing to make the time to see me in spite of many other
demands on their time.

All informants were asked if the interview could be tape recorded. Only three people preferred that there should be no recording. Where the interview was recorded, some notes were also made in the course of it. Later, I listened to the tape on at least two further occasions and made more detailed notes, together with a summary of the main points. Resources did not allow a full transcript to be made of all interviews. In those cases where the interview was not tape-recorded, detailed notes were made during the interview, and as soon as possible afterwards I noted down any impressions which appeared important, together with the main points from the discussion.

Between one and one and a half hours was allowed for each interview, although many exceeded this time, because of the extensive knowledge and willingness of informants to share their views and expertise with me. I began each interview by explaining briefly the nature of the project, and indicating which mentally ill people I wanted to focus on, i.e. adults aged under 65 years with the more severe or long-term disabilities.

Interviews were semi-structured, and obviously because of the very different rôles and viewpoints of the informants, there was considerable variation in the form and content of each interview. To some extent it was inevitable that some of the questions changed in the later interviews, in the light of information which emerged in earlier ones. However, I was aware of the pitfalls both of putting words into informants' mouths and also of simply seeking confirmation of my existing perceptions; efforts were therefore made to ensure that broadly comparable areas, themes and topics were covered in each case, but without restricting the freedom of

informants to express their views about the areas they considered most important (Burgess, 1984). The interview schedule which is included as Appendix Two was helpful not only in trying to achieve this degree of uniformity but also, by means of the checklist at the end of the schedule, in ensuring that areas particularly relevant to each informant were covered.

It will be seen from the schedule that there were two main components to each interview. These were, firstly, to gather background information about the locality and all aspects of the agency and its functions. This part of the interview also included identifying relevant written material such as annual reports, policy statements and working papers to supplement that gathered through local libraries, etc. From an early stage this proved to be a time-consuming and far from simple task, but one which therefore became all the more essential. The second purpose of the interview was to elicit from each informant according to their rôle, their knowledge, experience and views about the housing needs and difficulties of mentally disabled people in the community. This included information about and perceptions of inter-agency relationships.

The study which was eventually carried out was in effect therefore an exercise in contemporary history, utilising a variety of documentary and oral techniques to explore at one point in time a particular social process, the shift from institutional to community care.

Analysis and Presentation of Findings

It was originally intended to present the findings of the
study in two separate sections, with the first part based
largely on the documentary sources, giving a profile of each
area, and the agencies within it, and including information
about political and socio-economic influences, policies,
resources and the organisation of services. This was to
provide a backcloth to the second part: the analysis and
discussion of the data contained in the interviews with key
informants.

However, such a sharp distinction did not prove possible for
a number of reasons: in some instances, important
information could not be found in written material, or
different sources gave a confusing or contradictory picture
which could only be clarified at interview. In addition,
the data gathered about different areas and agencies were
often not in a comparable form. Because of the widely
differing rôles and therefore perceptions of the key
informants, this difficulty had been foreseen in the
analysis of the interviews, but perhaps naïvely, not in the
written material.

A further issue which emerged was that some aspects of the
written data, such as the implementation of policies, were
considerably modified by information given by key
informants. Moreover, the situation was a dynamic one and
aspects of it were changing during the research process;
for example, plans for rationalising catchment areas were
accelerated, and plans for some community-based facilities
were revised sometimes to provide a better service,

sometimes because of financial constraints. In addition, a series of major changes in the Social Security benefits system was having considerable impact.

Further fundamental changes in service provision and delivery were promised by the impending Government Review of the National Health Service (DHSS, 1989b) and the Griffiths Report on Community Care (Griffiths, 1988) so that the prevailing atmosphere was one of pressure, change and uncertainty. The picture which emerged was of a complex situation which was often confused and sometimes bordering on the chaotic. This was obviously an important finding in itself, with possible implications for the nature and quality of services experienced by consumers.

Attempting to describe and analyse such a situation (in which much of the data is not in a readily comparable form) in a clear, coherent and systematic way with the minimum of repetition and discrepancies presented a considerable challenge (Burgess, 1984).

One approach considered was to discuss a succession of topics or issues across all three parts of the catchment area. This was eventually rejected because, whilst it would have highlighted particular issues, it would have tended to emphasise similarities when differences between places were emerging as an important dimension, and the service which users received appeared to be very dependent on where they lived. Data relating to the three parts of the catchment area are therefore presented separately.

The format finally chosen to present the data is essentially
one which moves from the macro level to the micro level, and
uses simultaneously a mixture of written sources and
material gathered from the interviews to focus on a number
of themes or topics in relation to each of the three parts
of the catchment area. The topics include: policies,
resources, competing priorities, relationships with other
agencies, the role of D.H.S.S., future plans, perceptions of
problems, and the elements of a 'good' service, with an
emphasis throughout on the housing dimension. Because it
was thought necessary for the sake of clarity and
comparability to treat each part of the catchment area in a
similar way, the volume of resources and activity in
Newcastle, particularly in the voluntary sector, means that
two substantial chapters are devoted to Newcastle. The
final chapter of the research findings deals with the views
of those informants whose work brought them into face to
face contact with mentally disabled people.

The analysis in general moves from a brief socio-economic
profile of each area, and the policies and organisation of
services of different agencies, through the opinions and
perceptions of the key informants, to the effects of
policies and services on individual people. As a
conclusion, these are considered against four key criteria
used to assess the quality of services for mentally ill
people: comprehensiveness, co-ordination, accessibility and
acceptability (Huxley, 1990).

The purpose of the research study was to provide a
descriptive account of a social process at one point in time
(although the pace of change both nationally and locally has
meant that on many occasions the process has had to be

followed forward in time for the sake of clarity and completeness). Such an account inevitably also involves analysis and interpretation, identifying gaps and failures as well as what is happening. The findings of the research study are presented in Chapters Three to Seven, and these are then used in Part Two as the basis for trying to identify theoretical concepts which might help to understand and explain some of the situations, problems and processes revealed by the study.

Notes

1. 'DHSS' is used to when referring to this government department before 1988; 'DoH' or 'DSS' are used as appropriate post 1988.

2. Following a symposium of the American Psychiatric Association in 1986, this situation is now beginning to change in the United States, but in Britain, the process has as yet barely begun (Bachrach & Nadelson, 1988).

St Nicholas Hospital: Profile

The hospital whose catchment area formed the basis of the
study opened in 1865 as the City of Newcastle Asylum on its
present site, which was bought by the local authority of the
time for that purpose. It is a psychiatric hospital of
traditional Victorian design, with later additions, and is
situated on two adjoining sites in an established
residential area in the north of Newcastle upon Tyne.

In September 1984, St Nicholas provided 600 beds. These
were made up of:

    a) St Nicholas Site

    Psychiatric   225 (including assessment beds)

    "Old long stay"   185 (including rehabilitation)

    Disturbed behaviour 68 (acute and chronic)

                       478

    b) Collingwood Site

    Acute rehabilitation   38

    Acute admission   66

    Drugs & alcohol   18

                       122

(Source: Newcastle Health Authority District Strategic Plan,
1984, p.D1)

In addition, day hospital facilities were provided for 40
acutely ill patients, 84 chronically ill long-stay patients,
25 people with drug and alcohol problems, as well as places
for psychogeriatric patients.

The hospital's catchment area at the time of the study is
shown on the map as Appendix 3.1. The catchment area
included the City of Newcastle, except for the western parts
which were covered by Gateshead District Health Authority
and St Mary's Hospital, Stannington (12 miles north of
Newcastle). The Department of Psychological Medicine at
Newcastle General Hospital provided 52 acute beds (including
five for Biological Psychiatry), but St Nicholas provided
the only long-stay beds in the District for patients of all
ages.

St Nicholas Hospital also served the western parts of
Gateshead Metropolitan District (which until local
government reorganisation in 1974 were the urban districts
of Blaydon and Ryton in County Durham); and the north-
western part of County Durham (mainly the former urban
districts of Consett and Stanley, which in 1974 became part
of Derwentside District of County Durham. This district is
co-terminous with North West Durham Health District).

In 1984, the population of the hospital's total catchment
area was estimated to be 368,400 (District Strategic Plan,
1984, p. D13), and clinical teams were 'sectorised' in that
year so that each team provided psychiatric services to a
particular part of the catchment area. Until shortly before

the study took place, there had been no day hospital
facilities based in the Gateshead or County Durham parts of
the catchment area; they still had no district-based beds
and much of the accommodation at St Nicholas Hospital was of
poor quality and unsuitable for current needs (District
Strategic Plan, 1984, p. D11). It was also accessible by
public transport only with difficulty from some parts of the
catchment area, which were more than seventeen miles away.

A number of events in the years preceding the study had led
to plans (some already implemented) for fundamental changes
in the organisation, location and delivery of services
throughout the catchment area. These contributory factors
included the criticisms and recommendations of the Health
Advisory Service team's visit to Newcastle in 1982 (NHS,
1982); and a consultation paper on catchment populations
circulated by the Regional Health Authority in 1984, as well
as rapid changes nationally in thinking about the needs of
mentally ill people, and the principles which should
underpin services (MIND, 1983b).

Negotiations between the Regional Health Authority and the
Districts involved had resulted in agreement for
rationalisation of catchment areas, and each District was
committed in principle to becoming self-sufficient in
services by the mid-1990's. The establishment of locally-
based services would mean that in the medium term, St
Nicholas Hospital could withdraw from provision for North
West Durham. It was planned that Gateshead District Health
Authority would take over responsibility for the west of the
borough, at the same time relinquishing their responsibility
for the west of Newcastle.

CHAPTER THREE

DERWENTSIDE

Profile

The Derwentside district of County Durham had a population
of about 87,000, with more than half of this number
concentrated around the small towns of Consett (30,600) and
Stanley (17,400) in the north of the district, with largely
semi-rural areas to the south. Derwentside was one of only
two districts in the county with a declining population,
with a projected decline of 2.9% between 1985 and 1988
(County Planning Officer, 1985 - based estimates). A
further decline to less than 80,000 by 1991 was forecast
(NHS, 1989). For more than a hundred years coal mining and
steel production were the dominant industries, creating an
area of close-knit, largely working class communities with a
strong tradition of Labour Party and trades union politics.

The district shares many of the characteristics and problems
of the Northern Region highlighted in successive surveys and
official documents (e.g. Tyne and Wear County Structure
Plan, 1979; Townsend et al., 1986), but has also faced
particular problems. According to the D.O.E. criteria
(D.O.E., 1983) of socio-economic and health characteristics,
housing conditions, concentrations of single pensionable
households and overcrowding. Derwentside at the time of the
study was clearly a 'deprived' area although none of its
wards were ranked in the 25 most deprived wards in the
Northern Region in Townsend's study (Townsend et al, 1986).

A report by the County Planning Officer (Wilson, 1984) made
a number of important points:

1) in 1981, the district had the second highest male unemployment rate in England and Wales: 26.9%, which subsequently rose to 28.5%;

2) the fact that an earlier (1971) study had already identified Derwentside as one of the most deprived districts in England and Wales indicates that the district's problems were long standing and predated by many years the closure of the Consett Steelworks in 1980;

3) although additional government funding was allocated for reclamation and factory building following the closure of the steelworks, Derwentside fared badly in terms of special aid in comparison with similarly deprived areas.

The Planning Officer's study involved a cluster analysis of all 403 districts in England and Wales on the basis of the four indicators of deprivation referred to above. In the groups which emerged, Derwentside was located in a group which contained most of the major inner city districts outside London (including Newcastle and Gateshead). The report pointed out that 13 of these 16 districts had special status (Partnership, Programme or Designated status); two others (Corby and Scunthorpe, similarly affected by the decline of the steel industry) were Enterprise Zones, so that Derwentside alone, of these areas experiencing severe multiple deprivation, received no aid as a result of special status (Wilson, 1984). In terms of the present study, this could be expected to have had implications both for the volume and nature of needs within the district, and for the capacity of the district to respond to those needs.

In a number of important ways, Derwentside differed from the other parts of the present St Nicholas catchment area,

notably in having some services provided by the district council and others by the county council; and in the rôle played by elected members in the community. These three elements - resources, structure, and the style of local politics - will recur frequently in the following attempt to depict the housing situation of mentally ill people in Derwentside.

Health Service Provision

i) Background and Catchment Area

Until the mid 1980's, services for mentally ill people within the North West Durham Health District were non-existent. All acute and long-stay beds, day hospital places and assessment and rehabilitation facilities (for all of Derwentside except the southernmost part) were located at St Nicholas' Hospital, about 17 miles away; in addition, social work services were largely provided by social workers at St Nicholas Hospital employed by Newcastle Social Services Department. The only locally based resource was three community psychiatric nurses.

People living in the south of the district were served by the County Hospital, Durham, for acute and outpatient services, and Winterton Hospital, Sedgefield. There was some confusion among key informants about the exact boundaries of the catchment areas of the respective hospitals.

These factors led to enormous problems of communication and accessibility for both service users and professionals, and according to the consultant psychiatrist interviewed, this was reflected in a much higher than average rate of acute admissions to hospital from Derwentside.

Although starting with a 'clean slate' may have some positive aspects, the shift towards a "locally based comprehensive service" - the stated aim of the North West Durham Health District's Strategic Plan (North West Durham Health Authority, 1984) - would be an enormous one. Moreover, the District suffered from a number of serious and fundamental problems of size, management and financing which were explored in detail by the Health Advisory Service team which visited the District in November 1988 (NHS, 1989).

The catchment area population is expected to be 89,000 by 1994/95; this includes about 14,000 people in the western part of Gateshead (High Spen, Chopwell and Rowlands Gill).

ii) Management and Resource Allocation

A District of this size clearly presents continuing problems of management and resourcing.(1) and there were additional problems of management and financing which tended to interact with and reinforce each other in a negative way.

The NRHA's plan to increase the amount of resources devoted to mental health in the region in the 10 years to 1995 would still leave North West Durham's level at about £14 per head, compared with a regional average of £24 per head of

population (NHS, 1989). In addition, no budget allocations were transferred from the St Nicholas Hospital budget as Derwentside's use of Newcastle services declined (from about 15% in 1982/83 to 7% in 1988/89) (NHS, 1989 para 119). North West Durham would therefore remain significantly underfunded in mental health.

The resourcing problems were further exacerbated by the size of the authority and its management arrangements, which in themselves were partly determined by size.

Within the management structure, there was no separate manager for mental health services and no separate, identified mental health budget. Management responsibilities were somewhat confusingly divided between the Community Unit General Manager (responsible for community services, including psychology, child psychiatry, and maternity services (the latter based at Shotley Bridge Hospital)) and the Hospital Unit General Manager (responsible for all other services including mental illness services and community psychiatric nurses) (NHS, 1989 para 112).

Because of its size and previous dependence on Newcastle,

> "The Health Authority does not have staff with recent senior management experience of managing and developing a mental health service". (NHS, 1989 para 113).

In order to overcome these complex problems the Health Advisory Service team made a series of recommendations:

1) an appropriate proportion of resources should be transferred from the St Nicholas Hospital Budget to North West Durham District (para 122 iv);

2) the existing level of resource utilisation should continue until the RHA agreed an appropraite mechanism for funding the transfer of services (para 122 vii);

3) because of the lack of expertise and experience within the District in managing mental health services, the District should negotiate agency arrangements with Newcastle Health Authority for the Unit General Manager at St Nicholas Hospital to be accountable for the development of a locally based mental health service in Derwentside (NHS, 1989 para 115 ii);

4) that the RHA should "reduce further the inequity in the distribution of resources affecting Districts which are already deprived of service and have above average levels of need" (NHS, 1989 para 112 viii).

iii) Health Service Plans for the Mentally Ill

On the basis of guidelines in Better Services for the Mentally Ill (D.H.S.S., 1975), 45 acute beds, and 22 'new long-stay' beds were needed in North West Durham together with 58 day places.

The District Strategic Plan envisaged:

1. The creation of a purpose built day hospital at Shotley Bridge General Hospital providing 25 places.

2. The provision of an interim day hospital with 15 places.

3. Consideration to be given to making good (in the five-year period) the shortfall of 25-30 places which will still exist with the provision of the above.

4. The provision of acute beds within the district. It was proposed that these be sited in a purpose built unit at Shotley Bridge General Hospital within the second five-year period.

5. 'New Long Stay' beds to be provided within the district by the end of the period.

6. Increase in CPN staffing complement.

(NW Durham DHA Strategic Plan, 1985-95, pp 30-31).

A number of points concerning the District Strategic Plan should be noted.

First, the section of the plan concerning mental illness services was relatively brief (only ten pages in total), and made no reference to identifying local needs as a basis for its proposals:

> "In a Health District where local mental health services have not existed, the dimension of need is unknown. No accurate assessment of need has been undertaken to enable decisions and priorities to be made, based on facts". (NHS 1989, para 131)

Secondly, all the proposed developments were located on the Shotley Bridge General Hospital site, so that the extent to which the new service would embody a genuinely different model of provision was open to question. Finally, the Plan itself pointed out that the creation of the 'new long stay'

beds would "be dependent on a transfer of resources within the Region from the larger institutions to local care" (North West Durham Health Authority, 1984 p31). As previously discussed, the Health Advisory Service report also identified this as a major problem which, four years on, was not being addressed by either the Regional Health Authority or Newcastle Health Authority. (NHS, 1989).

By the time of the study, progress was taking place at a rapid pace. Bede House, the 25 place day hospital at Shotley Bridge General Hospital (together with a similar sized unit for elderly mentally ill people), was opened in May 1986 and an interim acute unit of 21 beds was planned to open in 1989. A new consultant psychiatrist post was created, and filled by two doctors, one working half-time in psychogeriatrics, the other half-time with younger mentally ill people. The latter had responsibility for Bede House, and also held outpatient clinics. A further CPN post had also been created.

Nonetheless the new day unit experienced problems of staff resources. The Health Advisory Service team in November 1988 reported feelings of overwork and frustrations about inability to extend their rôle among the unit's nurses, as well as lack of clerical support (NHS, 1989). It was acknowledged that because of lack of opportunity in the past, interdisciplinary working was only then beginning to develop in Derwentside.

For those Derwentside residents (approximately 80) then in St Nicholas Hospital who were in need of continuing care, a continuing partnership between Newcastle and North West

Durham was envisaged. However, Newcastle subsequently hoped
to accelerate the process so that it could withdraw from
service provision for Derwentside by April 1988 (i.e. six
years earlier than planned), but partly for reasons of
resource imbalance previously described and partly for
reasons of agency priorities and a lack of joint planning
which will be discussed below, this was not achieved.
(Newcastle Health Authority, 1986).

Social Services Department

i) **Organisation**

Local Authority social services are provided by Durham
County Council Social Services Department. With its
headquarters in County Hall, Durham, the department was at
the time of the study structured into five divisions.
This structure was highly centralised (e.g. transport for
clients attending day care was organised at County level)
and created serious obstacles to the coordination of
services at the individual and local level. These
difficulties were recognised within the department and there
were plans to reorganise the department into seven districts
with specialist operational teams and in which the District
Managers would control all services within their district.

It was anticipated that this would lead to services which
were both more responsive and more efficient, but the
proposals were the subject of protracted negotiation and

repeated delays, and were finally implemented only late in
1989.

Fieldwork services were delivered through eight District
Centres, each one managed by a District Controller.

ii) Social Work Resources

District No. 1 was co-terminous with the area of Derwentside
District Council. The District Centre was at Lanchester,
with three area teams of social workers based at Lanchester,
Consett and Stanley. One social worker (who was interviewed
as part of the study) was designated the mental health
specialist for the whole district. She identified three
components to her job: she had a small caseload involving
more complex cases; she had some responsibility for training
both in the district and in the department; and she had a
developmental role in relation to community resources; this
last aspect was emphasised by her district controller, who
was relatively new in post and had an interest in mental
health.

The social work team based at Shotley Bridge General
Hospital worked with some clients from the psychiatric out-
patient clinics held at the hospital, and a senior
caseworker was appointed to work in the new interim day unit
towards the end of 1986. As the Shotley Bridge General
Hospital site was to be the focus of district based clinical
facilities, it was likely that the social work team there
would become increasingly involved with mentally ill people.
The Principal Social Worker who led the hospital team was a
former psychiatric nurse.

The resources available at district team level to support
mentally disabled people in the community were extremely
limited, consisting of 'casework' help from a social worker
and, providing the appropriate criteria were met, home
helps.

iii) Residential Resources

The Social Services Department's resources for mentally ill
people in the community had in the past been as scarce as
those of the Health Service in Derwentside; spending on
mental health services amounted to only 0.4% of the total
budget. However, there appeared to be no comparable will to
develop new resources. This reflected to some extent
different agency pressures and priorities, but it should be
noted that the Social Services Department required that any
resource developments in mental health in which it was
involved were funded through joint finance arrangements,
(i.e. there would be no additional commitment of social
services' resources). This policy had been criticised in
successive Health Advisory Service reports on County Durham.
The most recent report - on Derwentside - stated bluntly

> "The view that nothing can be achieved unless
> joint financed is all too prevalent...It is widely
> believed, and often repeated, that the Social
> Services Department has no funds for mental health
> and there is little evidence of the motivation to
> provide some through the rationalisation of their
> existing resources",

and recommended an immediate 1% cost improvement programme
in the amount of resources devoted to mental health (NHS,
1989, paras 147, 149 & 153v).

On the basis of the guidelines contained in <u>Better Services
for the Mentally Ill</u> (HMSO, 1975), there was an estimated
need for 126 residential places and 306 day care places for
mentally ill people in County Durham. In 1984 the shortfall
was calculated to be 87 and 291 places respectively
(Gosling, 1986).

The only Social Services resource for mentally ill people
within Derwentside was a group home for three people
situated in Langley Park which was empty at the time of the
study. This was a three-bedroomed house rented from the
District Council by Social Services, who guaranteed the
rent. There appeared to be a number of reasons why the
group home had failed to operate satisfactorily, including
location and communication. One worker said that local
people considered that Langley Park, a former "Category D"
village, on the border of Durham city and with poor
transport facilities, was "the end of the world." Equally
important, it came within the catchment area of the County
Hospital, Durham (and Winterton Hospital, Sedgefield, for
long-stay and a variety of specialist facilities). For the
residents, a move to this home meant a change of both
psychiatrist and community psychiatric nurse, and there were
problems of collaboration and coordination because of
reported reluctance to accept the transfer of clinical
responsibility.

It was also suggested that there had been problems of
communication between Social Services and St Nicholas'
Hospital, in that the hospital staff had only been able to
identify three potential residents among their Derwentside
patients which meant that there had been no process of
selection or matching (a case of trying to fit consumers'

needs to the resources perhaps); and more seriously, that one man put forward had previously been a patient in Rampton and had convictions for child-molesting, but that Social Services were not given this information until after he had moved in.

'Valley View', situated in the adjoining district of Chester-le-Street, was the only Social Services hostel for mentally ill people in the county. It provided seventeen beds, and nominally five day care places. It was originally intended as a 'halfway house' between hospital and more independent living in the community, and also to offer a period of rehabilitation to people who broke down at home. The hostel appeared to have experienced increasing difficulty in fulfilling these functions, and to have some difficulty in identifying an appropriate rôle. Given that it was the only facility in the county, it had tended to be used to capacity (92.2% occupancy in 1984-5 (DCC SSD Position statement, 1985, p.89)) but the first half of 1986 showed a steady decline, so that by August, only ten beds were occupied (Update, No. 114, p.37), and its use was then under review.

Many of the people then living there and being referred to it were in need of much higher levels of supervision and support than originally anticipated, so that any rehabilitation process was likely to be protracted, and the rate of turnover therefore much slower. This created difficulties for patients in St. Nicholas' Hospital from Derwentside for whom this facility was seen as being appropriate: Stowells gave the example of one of his clients who waited on an acute admission ward for nine months for a vacancy at Valley View (Stowells, 1986). Furthermore, the

attempt to rehabilitate people away from their own community created its own difficulties.

There were also problems in securing suitable accommodation for Valley View residents to move on to. In 1985 there were only 39 places in group living schemes in the county; moreover, it was suggested by two of the key informants that in some cases district councillors resisted the rehousing of people from the hostel in their area. Valley View had made attempts to develop on a 'core and cluster' basis, but some district councillors had become very concerned about a concentration of mentally ill people in single person flats in one area. This situation may have been exacerbated by the close proximity of Plawsworth Resettlement Unit. A similar problem was said to have arisen concerning mentally handicapped people. The lack of more independent accommodation is clearly likely to have adverse effects both on those people ready to move out, who are no doubt aware of reluctance to accept them, and on those people who need admission.

iv) Day Care

Although Derwentwide residents were eligible to attend Valley View for day care, in practice very few did so, since a high level of motivation was needed to make the journey by public transport. Alternative Social Services' day care facilities were very limited and indeed, official figures indicated that there were no Social Services day care places whatever for mentally ill people in County Durham at the time of the study (CIPFA, 1988, p.69). Stanley Day Centre, which was designed for elderly and physically handicapped people accepted some referrals of mentally ill people but

staffing ratios were too low to accommodate more than very
small numbers, or to provide appropriate structure for
people with behaviour problems. The Senior Caseworker
(Mental Health) and one of the CPN's ran a club at Oxhill on
one day per week for people with chronic problems.

Voluntary Organisations

The rôle of voluntary organisations in Derwentside has been
limited, but significant in a number of ways. Voluntary
organisations ran a number of small day care projects. A
MIND group was beginning to become active in Stanley and had
tried to run a small day-time club, but this quickly closed.
The group was then attempting to set up an evening club.

CALM (Consett Association for the Living Mind) ran a day
centre at Citizen House, Consett, on Tuesdays, Wednesdays
and Thursdays. A variety of groups were held, including
tranquilliser withdrawal, premenstrual tension and stress
management, together with counselling and drop-in
facilities. The project was widely seen as being a
controversial one, but one key informant commented that
whatever reservations professional workers held, users
referred themselves to it in large numbers.

The Northern Schizophrenia Fellowship also ran a day centre
at Citizen House, Consett on Mondays and Fridays, in
addition to a monthly self-help group for relatives.

The rôle of the Northern Schizophrenia Fellowship in Derwentside was an interesting one, since it had been prominent in attempting to identify needs and in putting pressure on statutory bodies to provide resources, whilst at the same time attempting to meet some of those needs itself, in a limited and short-term way.

The experience of the Fellowship in Derwentside illustrates some of the difficulties and dilemmas faced by voluntary organisations in the mental health field. As Social Work Adviser to the Fellowship, I was aware that attempts to persuade the local authority to provide resources initially met with in effect a denial that a need existed. The social worker key informant illustrated how Social Services procedures contributed to this: under the current system of computer coding, cases could only be catagorised under one client group or problem. If someone with mental health problems had children or was elderly, these catagories tended to take precedence, so that the extent of mental health needs was masked.

The day centre was therefore established in 1985 to try to demonstrate that unmet need did in fact exist. The centre was staffed by three volunteers and two part-time Community Programme workers "as funding for paid staff has been impossible to obtain to date" (Northern Schizophrenia Fellowship, 1987), and help towards other costs was also minimal (a non-recurrent grant of £7,500 (NHS, 1989)). With the ending of the Community Programme, the staffing and funding problems of the day centre, in common with many other similar projects, became even more acute.

The Health Service Advisory Team recommended that:

> "The Social Services Department should make
> adequate long term funding available to the
> Northern Schizophrenia Fellowship to enable it to
> maintain and extend the day centre facilities at
> Consett".   (NHS, 1989 para 65ii)

However, whilst the Joint Care project team for Mental
Health recognised that day care provision was needed in the
two main centres of population, Stanley and Consett, and not
only recommended the establishment of a new day care centre
in Stanley under joint finance arrangements with an
estimated revnue budget of £56,000 in the first year, but
also supported NSF's application for increased funding, the
grant made by Social Services Department for running the
Consett Day Centre in 1990-91 was only £15,000. A guarantee
of adequate funding was only made after the Fellowship had
given notice of its intention to close the Day Centre.

The Joint Project Team's report described the NSF day centre
as "fill(ing) the gap of day centre provision" and
"provid(ing) **a basic need** in the Consett area" (North West
Durham Health Authority, undated, p.13) (emphasis added).

Conflicts clearly exist for such organisations between
campaigning for the provision of adequately funded resources
by statutory agencies and responding to the urgent and often
desperate needs of its members by attempting to fill the gap
itself, an attempt which may weaken its ability to act as an

effective pressure group by taking up a substantial amount of its limited resources of time and personnel.

The rôle played by certain other voluntary organisations, such as Tyneside Housing Aid Centre within Derwentside, had also arisen partly in response to what were perceived as particular circumstances and attitudes prevailing in the authority, notably in relation to housing.

Housing

i) Background

No other agency or service mentioned in the study was the subject of criticism to the same degree as housing in Derwentside. It is acknowledged however that some changes were in progress at the time of the study, and that further substantial changes in housing policy and management practice have taken place in Derwentside since the District Council elections in Spring 1987, as indicated in the Housing Strategy Statements, 1988/89 and 1989/90 (Derwentside District Council, 1987 & 1988).

Many of the key informants concerned with Derwentside residents however remained criticial either of the District Housing Department or of the attitudes, policies and actions of elected members or both, at times expressing considerable anger and frustration on the basis of their experience of past contacts. Whilst not all of these related to mentally

ill people, a number of them did, and it is reasonable to assume that mentally ill people were likely to encounter similar attitudes and policies.

The area of attitudes in particular is notoriously difficult to assess. After a summary of housing resources in Derwentside, much of what follows constitutes the opinions of individual key informants, although they invariably supported their opinions with examples from their experience. It was not possible to check out what had happened in specific situations but it seems likely that perceptions of events, rôles and outcomes would have differed sharply in some cases. It would be necessary in a subsequent study to explore and assess those areas of conflict or disagreement more systematically, but even in the present study, they may be important as indicators and are included as such; efforts have been made to present them in as accurate and balanced a way as possible.

ii) Resources

In crude terms, there is no overall shortage of housing in Derwentside, and costs are relatively low in comparison with other parts of the country. However, there are a number of features which may have contributed to housing difficulties. There was a high proportion of local authority housing: 42.5% (at the 1981 Census), with 49.3% owner-occupied and 8.2% "private landlord, housing association or tied accommodation" (OPCS County Monitor, 1982). By 1988, this picture had changed so that 34% of homes were council owned and 63.5% were in the private sector; after 1980, around

2,800 council homes were sold to tenants. (Derwentside District Council, 1988).

The small amount of accommodation in OPCS's third category suggests that choice may be particularly limited for those not eligible (by reason of low income or personal circumstances) for either of the two major forms of tenure, especially as at the 1981 Census, only 1.3% of Derwentside households lived in Housing Association property (1981 Census, Durham County, Districts, Table 24), although this had risen to 2.5% by 1988 (Derwentside District Council, 1988).

A major problem was the unsuitability of much of the available accommodation: most was family accommodation, and there were few flats. In 1981, only 2.5% of households were in council accommodation of only one or two rooms, and most of this was purpose built for elderly people. There were small numbers of flats suitable for single people in South Stanley, Blackhill, Leadgate and Craghead, but these were seen as poor areas, with attendant risks of isolation, stress and harrassment for vulnerable people.

There were also a number of houses in multiple occupation in the district which formerly catered mainly for working men, but which after the closure of the steelworks increasingly took in unemployed and mentally ill people.

There was a high proportion of poor housing conditions: more than one third of the stock was built before 1919 (Fullen,

1986) and the proportion of households without a fixed bath
or inside toilet was twice the national average in 1981
(Wilson, 1984). In addition, 50.7% of people had no car,
compared to a figure for England and Wales of 38.5% (Durham
County Planning Department, 1986), and more than 70% of
council tenants were in receipt of Housing Benefit (Fullen,
1986).

Wilson argued that since local authority housing is usually
assumed to have good amenity provision, the quality of other
housing must be very poor (Wilson, 1984, p.6); but an
experimental housing aid 'Surgery' in Derwentside found that
almost a quarter of enquiries concerned repairs to council
properties (Fullen, 1986), indicating a high level of
dissatisfaction among tenants about the maintenance of their
homes. This situation was later confirmed by the Housing
Department's own figures (Derwentside District Council,
1988).

iii) Housing Policy and Management

It might be expected, given the strong socialist traditions
and the high proportion of local authority housing in
Derwentside, that the local council would have taken a broad
view of the rôle of public sector housing, and been
committed to providing for groups with special needs,
including people with mental health problems. The key
informants from Housing Department stated that they "did not
really have a housing problem," and that they had "a very
enlightened policy for single people"; and certainly many
people appeared to obtain a tenancy with relatively little
difficulty.

In the view of a number of informants, the rôle of housing management was regarded in a very limited way only as maintaining property and balancing accounts, rather than also involving a human dimension. The lack of basic advice offered by the Housing Department to tenants and applicants was given as one indicator of this; it was said that there was no back-up service to inform people about what benefits could be claimed or how, and that discretion was not exercised in cases of 'technical' rent arrears.

The key informants from Housing Department said that elected members were very much involved in the work of the department on a day to day basis, and spoke of "antipathy" and "bias", not least towards county councillors. They saw themselves, as officers, "bringing the (district) councillors to a more enlightened position". However, as this interview progressed, words such as "contrived homelessness", "battlelines", "unscrupulous", and "dishonest" were used by the officers in relation to tenants and especially applicants.

The Housing Department's policies towards homeless people and rent arrears were identified by a number of informants as particular areas of difficulty.

Homelessness:

In 1982, THAC together with Durham Shelter Group released a report (THAC, 1982) which was strongly critical of

Derwentside Council's policy towards homeless people. It suggested that the Council was not fulfilling its duties under the <u>Housing (Homeless Persons) Act 1977</u>, and was failing to comply with the spirit of the Act by disregarding the accompanying <u>Code of Guidance</u> (DOE, 1977). THAC's attempts to meet with councillors and officers to discuss the situation were not successful.

Shelter argued in a national report that the concept of 'intentionality' was being wrongfully applied by some councils to evade responsibility for housing people in priority need, and that

> "The evidence...is that far from deterring people from becoming deliberately homeless, the 'intentional homelessness' clause has provided a gap through which many people in genuine need are falling" (Widdowson, 1981, p1).

This was considered to be the case in Derwentside, and THAC's casefiles contained a small number of specific examples concerning people with mental illness, who may face particular difficulties in relation to this clause.

The number of cases deemed intentionally homeless in Derwentside was extremely high:

Table 3.1

Numbers deemed intentionally homeless

Enquiries into homelessness in quarter

District	Enquiries completed	Deemed not homeless	Accepted	Intentionally homeless (new cases)
Gateshead	192	2	82	-
Newcastle	624	92	345	-
Derwentside	94	36	18	11

From: Homeless Households: L985 Second Quarter. DOE

The figures for the number of households deemed intentionally homeless appear even more striking when compared to the fact that, in the five metropolitan districts in Tyne and Wear in the same period, only one case out of 1,928 enquiries completed was deemed intentionally homeless.

Arrears

One factor which several key informants considered was strongly associated with this high number was the District Council's policy on rent arrears: not only did the council consider anyone evicted for rent arrears (or homeless and in mortgage arrears) to be intentionally homeless, but late in 1985, it introduced a policy of sending in bailiffs to

remove tenants' property to pay off arrears (Consett
Guardian 17th October 1985).

Tenants in arrears received a series of three letters (see
Appendix Four), the first letter being sent to anyone who
was two weeks in arrears. In one case, an elderly woman
received the letter when she had arrears of £10. In
another, a neighbourhood worker in South Stanley found that
200 copies of the first letter had been sent out on the same
day (Fullen, 1986). It is not difficult to imagine the
alarm and distress which the receipt of such a letter might
provoke in vulnerable people whose ability to survive in the
community may already be precarious.

Whilst in no way condoning the accumulation of rent arrears,
several informants considered that the existence of such
policies derived from attitudes prevalent among some
councillors and officers towards people in need and help for
them. District councillors in Derwentside were seen
traditionally to have exercised considerable influence and
power within their community, and to operate on a narrow
basis of 'looking after their own':

> "In Derwentside the local decision making process
> has always been traditionally paternalistic, and
> community   involvement   has   been   shunned"
> (Derwentside Unemployed Workers Group, 1985).

However, an informant involved with the experimental housing
advice service in Stanley said that many of the people who
sought advice there were "fed up with councillors promising
the earth"; and whilst some councillors were acknowledged to
be sympathetic and to try to help, many councillors were

believed to perceive access to independent advice as a
threat to their power. Some of the attitudes attributed to
councillors in both the Derwentside and Chester-le-Street
districts concerning eligiblity for housing were reminiscent
of the Poor Law notion of settlement.

iv) Housing and Mentally Disabled People

Key informants gave conflicting opinions about whether
housing for people with long term problems of mental illness
constituted an area of need or difficulty in Derwentside.
However, the Health Advisory Service report noted that the
District had "almost no special housing provision for people
with mental illness" (NHS, 1989 para 134), and it was not
until the Housing Strategy Statement of 1989/90 that
reference was made to any policy towards this group:

> "The Council will cooperate with appropriate
> agencies and the County Council, in meeting the
> needs of the mentally ill, and will play its part
> in the efforts which are being made to
> deinstitutionalise clients" (Derwentside District
> Council, 1988, p.24).

It was suggested by one informant that firstly, the majority
of psychiatric patients from the area already had a home
there to return to; and secondly, most of those people who
could cope with some degree of independence in the community
were already living there. Those people remaining in
hospital were likely to need intensive (24 hour) support, so
that neither housing nor the lack of provision for
rehabilitation was seen as a problem. These perceptions
suggestion that people's needs were being seen in 'black or
white' terms of total independence or complete support,

rather than requiring a range of supportive provision which will vary between individuals and over time.

More importantly, a number of other key informants indicated that in their experience the housing needs of mentally ill people in Derwentside were not being recognised or met. These conflicting perceptions may perhaps best be explained by the hospital social worker in the first round of interviews who was mainly responsible for working with Derwentside patients. He initially said that he could not identify any problems with Derwentside Housing Department. On reflection he said that this was because he in fact had almost no dealings with them, firstly because he was aware of the lack of both statutory and voluntary resources in the area, and secondly because Housing were not perceived as being helpful. His usual response was therefore to avoid contact with the Housing Department, approaching a voluntary agency or a housing association in the Newcastle area as a matter of course. He commented that Derwentside Housing would be much more of a problem (in trying to obtain suitable accommodation for people discharged from hospital) if it could not be circumvented by using resources in Newcastle.

This view was given support by the Development Worker for the Society of St Vincent de Paul who said that the Society's accommodation schemes were sometimes seen as a 'back door' into council housing in Newcastle: he was sometimes asked to take - and accepted - people coming out of St Nicholas Hospital who originally came mainly but not exclusively from Derwentside, and who in this way established an address in Newcastle. (This informant felt very strongly about what he saw as discrimination against

mentally ill people in terms of restrictions on their
freedom to move to another area and use services there). It
was not clear whether, given a choice, people from
Derwentside would have preferred to return to their home
area, but this is one aspect of the well-documented drift of
mentally ill people to the inner-city 'zones of transition'
where both formal and informal resources are more plentiful
(Dear and Wolch,1987).

It can be seen that the fact that more resources are
available in neighbouring authorities (whether the result of
historical accident or deliberate policy) may lead to a
vicious circle in which needs are not presented to the
appropriate bodies because both individuals and agencies are
aware that little or no provision exists, or that a narrow
interpretation may be taken of duties and policies. As a
result, since needs are not being presented to them, an
authority is able to argue - with some justification - that
needs do not exist in the area and that it is therefore
unnecessary to provide resources.

Attempts to intervene in this vicious circle in Derwentside,
either by challenging policies and their interpretation, or
by helping local people to articulate their needs and
wishes, were said to be met with hostility, notably in the
case of Tyneside Housing Aid Centre (THAC).

With regard to the housing needs of mentally disabled
people, housing officers said that the council wanted
assurances about the ability of individuals to care for
themselves, the safety of other people, and the provision of
social work support. In this they identified differing

priorities between themselves and Social Services (see following section). Management problems were not seen as resulting from a person's mental illness per se, but officers were concerned that after a "bad case", councillors would be reluctant to help people in similar circumstances in the future.

The lack of suitable housing stock, especially one person flats, obviously posed difficulties all round which could not altogether be resolved by allocating available family sized accommodation to single people: for vulnerable people who have low incomes and possibly limited domestic and coping skills, the responsibility of furnishing, heating and looking after a house (and perhaps also a garden) may cause considerable stress, particularly when the support services available to them are very limited.

According to the Senior Caseworker (Mental Health), the lack of appropriate accommodation for mentally ill people in Derwentside was a major problem. She said that she knew of numerous examples of people having to move out of the area, to Newcastle and Gateshead, to get suitable accommodation; and that Plawsworth Resettlement Unit was widely used (including referrals from Social Services) because of the lack of any alternative; the Salvation Army, Bed and Breakfast, and even Youth Hostels, had been used for the same reason.

This key informant also said that in her experience many people with mental health problems who were living with their families were breaking down because Social Services were unable to provide suitable alternative accommodation

and help. People had to be readmitted to hospital because there were no short-term crisis beds. She regarded the lack of security of tenure in most forms of accommodation occupied by mentally disabled people as a further precipitant in repeated breakdowns: what was needed was a range of accommodation between hospital and complete independence; Social Services was hoping to develop a homefinding team and a landlady network to begin to fill some of the present gaps in provision, although no progress in this area was recorded at the time of the Health Advisory Service visit.

Housing Officers considered that additional single person independent accommodation with extra support was needed. They indicated that, in the case of homeless, mentally ill people who were vulnerable under the 1977 Act, Housing Department saw themselves as being responsible even if council accommodation was not an appropriate solution.

Relationships between Agencies: Coordination and Communication

All key informants spoke positively of dealings with the local DHSS office in Stanley, where staff were seen as being consistently sympathetic and helpful in dealing with claims. Specifically, the general manner of staff in talking to claimants at the counter and on the telephone was praised. This situation was attributed by one key informant to the considerable amount of groundwork undertaken in the past

between the local Social Services Department and DHSS to
establish good working relationships.

However, it may be that the repercussions for the whole area
of the closure of Consett Steelworks had contributed to
there being greater acceptance and less stigma attached to
receiving benefits, both among claimants and among DHSS
staff. One key informant drew attention to what may be a
practical consequence of the generally depressed economic
level: furniture, carpets and household items could be
bought more cheaply in the area, so that benefits,
especially single payments, stretched further.

The key informants from the Housing Department
understandably looked to social services and health
personnel to give continuing support to vulnerable people
who were rehoused by them, and one of the consultant
psychiatrists was specifically praised because he was
considered to give realistic assessments about the
capabilities of individuals.

However, these informants indicated that the priorities of
Social Services Department differed from theirs, and clearly
felt that the nature and amount of support given was often
inadequate. An example was given of a situation where
"good" (sic) neighbours had objected to the housekeeping
standards of one couple known to social workers who were
rehoused; this was seen as a failure by social workers to
give adequate support. Even if the need for Housing
Department to balance the needs and well-being of all its
tenants is acknowledged, there appeared to be considerable
emphasis on physical standards.

This impression was reinforced at another point in the
interview when criticism was made of social workers who
"promised a lot and then didn't deliver", and it became
clear that Housing's expectations of social workers included
at least an element of 'policing' to ensure the upkeep of
the property to standards acceptable to Housing Department
when in the example given this included clean curtains and
windows. The key informant who was the Senior Caseworker
(Mental Health) for the district shared their concern about
the inadequacy of support available, but defined the nature
of the necessary help very differently: not only more social
work time, but also a range of stable accommodation (so that
individuals could be placed in a setting which minimised
rather than increased stress for them), together with a
variety of social and occupational facilities were
essential.

Relationships between Social Services in Derwentside and
staff at St Nicholas Hospital were acknowledged to be a
problem by several informants, notably social workers in
both places. The considerable distance between hospital and
district created a major obstacle to communication. For a
Derwentside social worker to attend a case conference about
a client in the hospital was time-consuming and required
advance notice and planning which was often not practicable
because of much shorter hospital time scales and competing
demands on time.

However, the social worker key informant from Derwentside
said that even when a social worker had a statutory
involvement with an inpatient (e.g., someone admitted under

Section 3 of the <u>Mental Health Act, 1983</u>), requests to the consultant to be involved in planning and decisions, especially about discharge, received no response. There was now no regular or formal contact with either consultant at St Nicholas Hospital; liaison meetings used to be held with one of them, but these were not seen as being productive, by Social Services at least, and had lapsed.

The consultant psychiatrist who was interviewed cited constant changes of nursing staff on the wards as one obstacle to communication, but thought that good relationships existed with the few Derwentside social workers who were involved in mental health, as well as with the local community psychiatric nurses and with Housing Department.

The social worker key informant attributed the better relationships between the hospital and the community psychiatric nurses not only to the informal links they were able to establish through being attached to local health centres and general practitioners, but also to the fact that they, unlike the social workers, could not be asked to provide material resources which did not exist and which therefore created a source of frustration and friction.

Conclusion

Resources for mentally disabled people in Derwentside fell short on all the criteria for comprehensiveness,

coordination, accessibility and acceptability. The
foregoing account shows that this part of the St. Nicholas
catchment area started from a position of disadvantage in
trying to create a comprehensive mental health service: this
related particularly to the minimal resource base and the
absence of necessary mechanisams for co-ordination.

Where problems in relationships between agencies were
identified, there tended to be contributory factors at an
organisational as well as an individual level. The Health
Advisory Service report criticised the fact that until the
proposed establishment of separate Joint Consultative
Councils and Joint Care Planning Teams for each Health
District in the County in January 1989, decisions about
joint finance had been made by the Social Services Committee
on a county-wide basis, and that

> "The historical dependence of the District on
> mental health services provided from Newcastle has
> caused the Social Services Department to have no
> detailed planning mechanisms with the Health
> Authority". (NHS, 1989, para 59)

There was a similar lack of established mechanisms involving
the large number of organisations necessary to provide a
range of facilities, such as Housing Department, voluntary
organisations, and housing associations.

The fact that housing in Derwentside is provided at district
level whilst Social Services are accountable to the county
council was clearly a further structural complication, but
whilst relationships between the two at a local level were
agreed to be improving, both in general terms and in

relation to individual cases, problems of coordination and communication remained.

These appeared to be primarily the result of a lack of a common value base and conflicting rôle perceptions between staff of different agencies, especially Social Services and Housing personnel. In general, needs in Derwentside were perceived in a limited way, or in some cases not recognised at all, as in the omission of housing considerations from the District Mental Health Plan, and the lack of any specific Housing Department policy in respect of mentally disabled people. As a result, according to the social worker key informant, many people with mental health problems in the district did not present to services at all, because they knew that few resources were available to help them, or because those that existed were either inaccessible or unacceptable by reason of inappropriateness, poor quality or stigma.

Notes

1. In Autumn 1988 the Regional Health Authority raised the possibilty of amalgamation with an adjoining District. This led to the freezing of a number of senior management posts (including that of District General Manager) pending a decision, and obviously a protracted period of uncertainty was likely to have an adverse effect on performance and morale in the district.

CHAPTER FOUR

GATESHEAD

Profile

Gateshead is one of the five metropolitan district
authorities formed in Tyne and Wear in 1974, from the old
Gateshead borough and former urban districts of Felling,
Whickham, Blaydon and Ryton. In 1985 it had a population of
208,780 (Report to Planning Committee, September 1986). The
population is declining, with the 1981 Census showing a
decrease of 6.1% since the previous Census (OPCS County
Monitor: Tyne and Wear, 1982), and an estimated continuing
average loss of 1,100 people per year. The five wards which
were included in the catchment area of St Nicholas Hospital
(Blaydon; Chopwell and Rowlands Gill; Crawcrook and
Greenside; Ryton and Winlaton) had a total population of
45,830 (Report to Planning Committee, September 1986).

Gateshead lies on the south side of the Tyne opposite
Newcastle. It could be said to have suffered to some degree
from being in the shadow of Newcastle's identification and
status as 'regional capital', and the local authority and
health services were always in the past disadvantaged in
terms of facilities and resources, by comparison. The lack
of resources of many kinds was attributable in part to a
tradition of keeping rates at a low level, and to a long-
standing antipathy among many members of the council to
professionally orientated services. Gateshead shared in the
problems of the region caused by the decline of traditional
coal mining and heavy industries and an additional burden
was the 'ratecapping' of the Labour-controlled council in
April 1987.

Although there are pleasant suburban districts and semi-
rural areas, particularly to the south west, large parts of

Gateshead suffer from levels of deprivation sufficiently
high to result in inner-area status. However, the wards
whose psychiatric services were based on St. Nicholas
Hospital are among the less deprived areas, as Table 4.1
shows. The deprivation ranking for each ward, taken from
the report Inequalities in Health in the Northern Region
(Townsend, Phillimore & Beattie, 1986), was based on four
key indicators taken from the 1981 Census: percentage of
people unemployed; of households without a car; of non
owner-occupier households; and of overcrowded households.
The highest and lowest ranking wards in Gateshead (Felling
and Whickham South respectively) are included for
comparison. The unemployment rates given are those for April
1987.

In recent years, there have been some imaginative
initiatives aimed at bringing new sources of wealth and
employment to the area. These have been mainly in the
retail and service industries, the most notable to date
being the creation of the Metrocentre shopping and leisure
complex on derelict industrial land at Dunston, the first
phase of which opened late in 1986. Other initiatives aimed
at 'putting Gateshead on the map' have included the
development of International Athletics Meetings and the
National Garden Festival in 1990. There have also been some
comparable innovations by a number of departments in the
local authority aimed at improving both the range and
quality of services available to people in the area.

Table 4.1

Gateshead: Deprivation Rankings of Selected Wards

	Blaydon	Chopwell & R. Gill	Crawcrook & Greenside	Ryton	Winalton	Felling	Whickham South
Deprivation Ranking							
a) Gateshead (out of 22)	9	14	19	18	20	1	22
b) Region (out of 678)	135	233	380	324	407	7	589
Unemployed (Gateshead = 15.6%)	18	15.2	10.7	11.4	9.9	22.8	7.2
Occupational Class 4/5 (Gateshead = 26.8%)	25.7	27.9	20.1	23.0	18.5	37.1	9.7
Council Housing (Gateshead = 47.9%)	63.7	41.2	23.5	35.3	40.2	76.7	13.1

(From: Gateshead Ward Profiles, Policy Review and Development Team, Chief Executives Department 1987)

Health Service Provision

i) Catchment areas and resources

The population of Gateshead District Health Authority (which
is co-terminous with Gateshead Metropolitan District) was,
when the research took place, served by three psychiatric
hospitals run by three different health authorities, with in
addition, some patients referred to regional specialist
services in Newcastle. Most of the population (148,000) was
served by St Mary's Hospital; approximately 46,000 people in
the west of the borough were served by St Nicholas Hospital
(with some of these by then attending Shotley Bridge General
Hospital run by North West Durham Health Authority for out-
patient clinics); and a small number, around 4,000 people in
the Birtley/Kibblesworth area came under Winterton Hospital,
Sedgefield, run by Durham District Health Authority.

St Mary's Hospital, the major mental health resource of
Gateshead Health Authority, is situated at Stannington,
Northumberland, approximately 12 miles north of Gateshead,
and in 1984 had 583 beds. Its catchment area, with a total
population of 330,000, included most of Gateshead and part
of South Tyneside metropolitan district, as well as the
rural Tynedale district of Northumberland (the largest
district in the country in terms of area), and the western
parts of Newcastle. It was "unique in that it does not, to
any significant degree, serve local communities" (NRHA,
1984, p.51). Because of its location, the Regional Strategy
envisaged the ending of Gateshead's and South Tyneside's
reliance on it by the end of the current plan in 1994.
Although its future remained unclear for a considerable

time, it was finally decided in 1989 to close it by 1994-95
(Gateshead Health Authority, 1989).

The only Health Service facilities for mentally ill people
based in Gateshead at the time of the study were at Dryden
Road Hospital which housed a forty-place day hospital, out
patient clinics, a treatment centre for injections and
E.C.T.; and the regional service in psychotherapy. It also
served as a base for the community psychiatric nurses and a
small number of social workers.

Although the community psychiatric nurses were aligned to
family doctor practices in October 1986, and this was said
to have been very well received (Brown, 1987), one key
informant reported difficulties in those parts of the
catchment area currently served by St. Nicholas Hospital.
Gateshead Health Authority did not allocate CPN's to this
area, and Newcastle Health Authority no longer allowed its
nurses to cover it, so that in effect, the western part of
Gateshead then had no CPN service and patients were
dependent on the goodwill of Newcastle nurses.
Sectorisation of psychiatric services was still only at the
discussion stage at the time of the study (Brown 1987).

It can be seen that the prevailing situation for Gateshead
concerning both catchment areas and the quantity and
location of facilities was far from satisfactory, and plans
were in progress for rationalisation and improvement.

Negotiating and planning for change is obviously an
extremely complex process, not least because of the
involvement of a number of authorities, agencies and

interests. Even taking this into account, however,
Gateshead Health Authority's planning and achievement of
facilities within the district appeared to have progressed
rather more slowly than in either Newcastle or North West
Durham, and there appeared to be a number of puzzling
aspects to the way in which plans were being developed.

The Regional Strategic Plan included a number of important
points regarding catchment areas. The first objective of
the Plan in relation to mental illness was

> "To establish in those Districts where it is
> lacking, a local mental health care service,
> accessible with the minimum of formality and
> delay, and minimizing disruption to everyday life"
> (Northern Regional Health Authority 1984, p.39).

This objective underpinned the plans to rationalise
catchment areas, so that each Health Authority (and Local
Authority) would eventually be self-sufficient in resources
for the population in their area as far as possible.
However the Regional Plan also pointed to

> "the general need for consistency between planning
> populations for District acute services for
> geriatric medicine and for mental illness
> services. This consistency reflects the inter-
> dependence of these various services in providing
> care for individual patients and the desirability
> of having consistent referral patterns between
> general practice and the hospital specialist
> services"
> (Northern Regional Health Authority,1984, pp46-7).

These two aims may sometimes conflict with each other: for
example people in the Rowlands Gill/High Spen area of
Gateshead traditionally looked to Shotley Bridge General

Hospital for acute medical services, and those in the Ryton area similarly looked either to Newcastle or to Hexham in Northumberland. The situation concerning mental illness services was resolved in the case of Gateshead (in negotiation with the Regional Health Authority and neighbouring Health Districts) by the creation of new cross-boundary flows. Rather than aiming for eventual self-sufficiency in acute and geriatric medical services as well as mental illness services, Gateshead opted to look to Shotley Bridge and Hexham - who have not previously had any facilities - for future mental illness services in addition.

In the case of people living in Ryton and Crawcrook, a further complication arose: Northumberland Health Authority drew up plans to provide locally based services in Tynedale (notably in Hexham and Prudhoe) to replace services currently provided by St. Mary's Hospital, but these were dependent on adequate funding being made available (Hexham Courant, 22/1/88). If Tynedale was unable to provide its own resources, Northumberland envisaged the possibility of transferring responsibility for in-patient services to Newcastle (NRHA, 1984); and Newcastle agreed that discussions could be reopened if necessary (NHA, 1984).

If a lack of funding were to mean that new services could not be created in Tynedale, the curious possibility would arise that Newcastle might end up by regaining responsibility for provision for part of west Gateshead! (It was also planned that a small number of Sunderland residents living in Washington would continue to attend services in Gateshead, (Gateshead Health Authority 1987)). (See Appendix Five for maps of present and projected cross-boundary flows).

The report "Services for the Mentally Ill in Gateshead"
stated that

> "this patient flow happens in all other patient
> services and does not pose any particular
> difficulty in liaising with community or other
> services"
> (Gateshead Health Authority 1987, p.2).

This assertion appears open to question in the case of
mentally ill people (and arguably in the case of other
groups as well, particularly elderly people), and there is
evidence that "divided responsibility for care increases the
possibility of breakdown in the continuity of care" (Huxley,
1990, p29). This point was raised in the Joint Care
Planning Team's comments on the consultative documents, and
a number of opposing views expressed during the study will
be set out below.

2. <u>The planning process</u>:

Planned new health service resources included: for acute
services, a new 90 bed ward block on the Queen Elizabeth
(District General Hospital) site, which should have been
commissioned by 1991-2 but which was postponed because of
overcommittment of the Regional Capital Programme; 50 day
hospital places on the same site to serve in-patients; and
three Community Mental Health Centres which would provide,
among other facilities, a further 30 day places for people
requiring less intensive treatment (Henley, 1987). Services
for 'new long stay' patients would comprise 30 beds located
at Dunston Hill Hospital together with a further 24 beds on
the Queen Elizabeth site. Seven possible options for
continuing provision for existing long stay patients at St
Mary's had been identified, but none had so far been
explored in depth (Henley, 1987).(1) It was also planned to

increase the number of Community Psychiatric Nurses in the authority from seven to sixteen by 1991.

However, Gateshead did not envisage producing a "comprehensive plan, including community and other support services" even in draft form until January 1988, with a consultative document on these and the future of St. Mary's Hospital to be presented to the Authority in September, 1988 (Gateshead Health Authority 1987, covering note). It was thought likely that a forum of Health, Social Services and Housing Authorities and voluntary organisations to plan the development of care in the community would not be set up until the financial year 1988-89 (Brown, 1987, para 6.2). By September 1988, this was not yet in operation, although the Health Authority had entered into an agreement with the Richmond Fellowship to provide residential places in the community on its behalf.

The Unit General Manager commented that

> "one positive aspect of Gateshead's slowness to
> progress towards community care is that some of
> the pitfalls made by other authorities can be
> avoided"
> (Brown, 1987, para 3).

There may, of course, have been other reports containing important relevant material, which it was not possible to locate or study, but available evidence about the planning process to date suggested that the view expressed above might be somewhat sanguine. Beyond a statement that "the Authority is committed to the development of a locally based service in Gateshead for the mentally ill", (Gateshead Health Authority 1987, para 1), no clear statement could be found about a number of crucial issues:

* the aims of the service;

* the identified needs of people in the catchment area;

* the nature of the service envisaged to meet those needs.

In his early paper, Brown referred to MIND's <u>Common Concern</u> (MIND, 1983b) and included a summary as an appendix to his report, but none of the other documents referred to principles underlying the service (Brown, 1987). Such omissions could be seen to affect service planning and resource allocation in a number of fundamental ways.

In his paper about long-stay patients, Brown gave a definition of community care and suggested a range of services and facilities to support people with long-term disabilities in the community. This was based on the assessment, using the Hall and Baker model (Baker & Hall 1984), of all current long-stay patients in St Mary's Hospital. Brown also stressed the need to take note of the literature and experience of Community Mental Health Centres in both America and Britain in arriving at a model of services for Gateshead. In addition, he emphasised that the principles and policies should involve inter-agency and inter-disciplinary consultation; that they should take account of the socio-demographic and epidemiological characteristics of Gateshead and should "aim to address the issue of countering inequality in health care", (Brown, 1987, para. 6.4).

A number of puzzling issues nevertheless remained. Brown gave an account of the results of the Hall and Baker assessments, showing numbers of patients and their levels of functioning and independence in the hospital setting in a

number of key areas. The next main section of the report was headed "Future Plans and Action" and most of what followed related to people with severe long-term problems who would be discharged from St. Mary's to Gateshead, although there was no detailed discussion of the kinds of residential provision or support needed.

However, this section then continued with a sub-heading: "Community Mental Health Teams" and also referred to both Community Mental Health Centres and Mental Health Advice Centres. None of these was defined further, but facilities of this kind are often geared towards people with milder, more transient problems rather than those with substantial, long-term needs (Huxley, 1990).

A number of the benefits of Community Mental Health Teams identified by Brown (e.g. greater consumer initiatives; shorter waiting periods; earlier and therefore preventive intervention) suggested that he envisaged such teams or centres providing a service for those people with less severe problems. Obviously, an integrated and comprehensive service must provide for the whole range of mental health needs within the community, but if each element of the service is to function effectively, its aims and rôle must be clearly defined.

Some of the benefits of Community Mental Health Teams which were cited made assumptions which are not always justified: improved interdisciplinary communication, collaboration and a supportive team (Brown, 1987, para 6.4), are not the automatic result of staff being based together (Gilchrist et al, 1978; Bruce, 1980; and Corney, 1980). There is little evidence that they lead to improved outcomes for users either (Test and Stein, 1980; Hoult, 1986).

Brown proposed the establishment of an experimental Community Mental Health Team, which would be evaluated over the period of a year. The experiment should be on a modest scale

> "in order that scope for evolving optimal procedures by trial and error is built into the experiment"

and further,

> "The experience of the experimental Community Mental Health Team could be used in evolving a clear picture of the spectrum of care settings and support networks required to provide a comprehensive mental health service in Gateshead. This experimental approach should be used as a basis for evolving a set of principles concerning Gateshead Community Mental Health Services"
> (Brown, 1987, para. 6.4).

Whilst planning should always be based on identified local needs, and services created which are responsive to those needs, it was perhaps rather surprising not only that a substantial amount of research on the planning and evaluation of community psychiatric services (e.g. Wing & Hailey, 1972) did not appear to have played a part in the planning process up to this stage, (although later consultative documents made some references to research), but also that service developments were planned in order to identify the principles on which they should be based. This would seem to be an inversion of customary good procedure.

Such an arguably idiosyncratic approach to planning also appeared to play a part in other developments which were taking place in the health services in Gateshead. These

included the commissioning of the new ward block and the siting of the proposed Community Mental Health Centres.

The letter accompanying the discussion paper "Services for the Mentally Ill in Gateshead: Proposals Relating to Hospital Services" emphasised that the paper was

> "not intended to be a comprehensive strategy but seeks to obtain views on those aspects of the services which require capital building (i.e. for inpatients and day patients)"

and that this was the first stage in the process of developing a comprehensive strategy (Gateshead Health Authority 1987). The Regional Strategic Plan envisaged a new department providing acute beds on the site of the Queen Elizabeth Hospital, Gateshead, "with the associated development of day-hospital, out-patient and long stay facilities within the District" (Northern Regional Health Authority 1984, p.41). Clearly some beds for acutely ill people would be needed and a further paper from the Mental Health Unit correctly stated that "the whole pattern of local services will be strongly influenced by the size of the admission unit and its operational policies" (Henley, 1987).

However, the discussion paper stated that although those services requiring major capital expenditure would only be part of the total range range of services,

> "In view of the relatively long planning and building period that may be required, it is important that these proposals are finalised as soon as possible to enable detailed work to progress"

and that proposals for community and other support services would only be incorporated into the strategy at a later

stage (Gateshead Health Authority 1987, p.1). It would
appear therefore, that the decision to build a new unit of
specified size had been taken in the absence of an overall
plan, any attempt to identify local needs, or even a clear
concept of different kinds of services. This would appear
to be the planning equivalent of the cart before the horse,
and, as stated by the Health Advisory Service team in
relation to North West Durham:

> "The number of beds must depend upon the provision
> of a range of appropriate resources in the
> community. Since there is at present very little
> provision within the community, it is possible
> that a vicious circle could develop in which
> increasing resources are put into inpatient
> provision, to the detriment of community services"
> (NHS, 1989 para 82).

Other evidence in the available documents, relating both to
the proposed new ward block and to other elements of the
service, reinforced the impression that the suggested
developments were not based on any clearly defined
principles and that they would perpetuate a traditional
approach to mental illness (in which in-patient facilities
are the cornerstone), incorporating few of the current,
widely held values about services for people with mental
health problems, beyond the aim of a service which was
locally based.

Two examples from the documents will be given to demonstrate
this.

1. <u>Provision for long-stay patients</u>: The discussion paper
stated, rather surprisingly, that "most patients who will
require continuing care have needs that are similar to each

other", (Gateshead Health Authority, 1987, p.4), although these needs were not identified further. The paper went on to say that

> "as there has been little time to assess the needs of this group (i.e. 'new long-stay' patients), it is not possible to draw upon experience of services developed elsewhere that point to a single conclusion....Each method adopted so far has had its benefits and its problems and no clear view has yet emerged on which method may be most successful as a long term arrangement" (Gateshead Health Authority, 1987, p.4).

Whilst it may be true to say that there is no single conclusion (indeed, in the interests of responsiveness to individual need and local circumstances, a single conclusion would be undesirable), studies which evaluate different types of facilities for this group are available (e.g. Wing, 1982). Even though the discussion paper stated that any new accommodation should be "along the lines of domestic housing", it also contained a number of comments and proposals which might be considered illuminating in terms of values and priorities. The covering note emphasised that the paper referred to services requiring major capital investment, although no details of costings were given.

In discussing future care for the estimated 155 'old long-stay' patients from Gateshead then living in St Mary's Hospital however, the paper pointed out that: "Building new accommodation for this sort of number would clearly cost many millions of pounds...and other options clearly need to be considered" (Gateshead Health Authority 1987, p.5). Among the options put forward is: "Transfer the patients to vacant accommodation in **any** hospital in Northumberland or Tyneside" (Gateshead Health Authority 1987, p.5) (emphasis added). It appeared that issues of community care or

individual needs and preferences were barely to be considered, even nominally, for the most disadvantaged people in institutions.

2.   Community Mental Health Centres: As stated above, Brown in his paper (Brown, 1987), drew on the principles for a comprehensive local mental health service identified by MIND, (MIND, 1983b). The discussion paper envisaged that the three proposed Community Mental Health Centres would be

>"small, relatively informal centres...
>It is hoped that they will develop as 'drop-in'centres for patients with problems......"
>(Gateshead Health Authority 1987, p.8),

but went on to suggest that one of the centres might be located on land within Dunston Hill Hospital at Whickham, which accommodated long-stay elderly patients. This might be seen to be somewhat at odds with the creation of an easily accessible, non-stigmatised service.

The lack of explicit principles in the available documents, together with instances of contradictory or inappropriate use of terms which were often undefined, was both puzzling and worrying. Concern about these factors was expressed by a number of those individuals and organisations who sent responses to the consultative document. As a result, the Health Authority somewhat belatedly organised a two-day "Consensus Forum" in April 1989 (See Appendix Six).

The question arises of whether this situation was fortuitous, or if not, why it might have occurred. Any response to such questions must inevitably be speculative.

However, there were suggestions, both by key informants and
in some documents, that issues of shifts in power and
control which were implicit in a different model of services
might be particularly important in Gateshead. It is
possible that where sharply differing views existed, a lack
of precise definition might allow any 'progressive' group to
believe that its ideas were being considered and adopted,
whilst currently powerful, more conservative elements could
be equally confident that there was no serious challenge to
the status quo.

Social Services Provision

The Social Services Department in Gateshead, although in the
past hampered by historical lack of resources and financial
constraints similar to those of the Health Authority,
nevertheless had begun to develop its services to all client
groups in a coherent way on the basis of explicit principles
and aims.

The pattern of provision in the department had been uneven,
with widely praised schemes such as the Community Care
Scheme for frail, elderly people (Luckett, 1991) contrasting
with serious deficiencies such as the absence from 1981 to
1987 of out-of-hours cover (the lack of which may
particularly affect people with acute mental health
problems), scant resources allocated to training and hence
low numbers of qualified residential and day care staff
(GMBC, 1987).

From 1987-88, some of these gaps were rectified, but in
spite of a number of positive developments, Gateshead's

spending per head on social services, relative to other authorities, was falling, so that its position declined from 27th highest spender in 1976/77 to 42nd in 1986/87 (Bromley, D., quoted in GMBC, 1987).

Gateshead Social Services Department was at the time of the study organised on the basis of four divisions of Fieldwork, Residential, Community Services and Administration, each headed by an Assistant Director. Fieldwork services were based in six district teams which were located in their districts, although the two teams covering the central area were both based in the Civic Centre. The teams varied in size, (between nine and fourteen social workers with one or two social work auxilliaries), and the teams were generic, although in practice, social workers within them developed specialisms. Also accountable to the Assistant Director (Fieldwork) were the two teams of social workers based at the Queen Elizabeth Hospital and St. Mary's Hospital, as well as the staff of the Day Centres and Hostel for the mentally ill. The Home Help Organisers were based in the District Offices, but were not accountable to the District Managers, and their areas did not always coincide with the District boundaries.

In order to remedy these and other anomalies which resulted from incremental changes and developments, the Department was restructured in May, 1988. Discussions about restructuring began in 1981, so that the process was a protracted one with repercussions on decision-making and staff morale. The principles underlying the restructuring were the creation of a locally based service specialised according to client group, with integrated management of services and a compact management structure with clear lines of accountability (Information derived from GMBC, 1987).

Social work services for people with mental illness, even for those who lived in the catchment area of St. Mary's Hospital and who were served by the team of social workers based there and at Dryden Road, could until restructuring be described as patchy and there were considerable organisational problems. One key informant (the Principal Social Worker, Mental Health Services) led the team of social workers at St. Mary's Hospital and also had responsibility for residential and day care services for mentally ill people throughout the borough.

However, social work services in the community for St. Nicholas and Winterton patients were provided by the district teams, whose social workers were accountable to their district managers. People in these areas, in principle, were served by hospital social workers employed by Newcastle and Durham respectively for in-patients, with referrals being made to the appropriate district for out-patients and on discharge; however, pressures on these authorities had led to a contraction of their services.

A further complication was that many people from the western area had begun to attend the psychiatric out-patient clinics at Shotley Bridge General Hospital, which were serviced by Durham Social Services. Although a small number of social workers in district teams were approved under the 1983 Mental Health Act (including one in the Blaydon office), there were no Approved Social Workers in three of the six districts at the time of the study. For the purposes of duties under the Act including compulsory admissions to hospital, an authority-wide duty rota was operated by the district based Approved Social Workers and those based at St. Mary's/Dryden Road.

Although the mentally ill had been identified as the top priority group for five years in successive reports, such reports also showed that only 1.5% of Social Services annual budget was devoted to their needs (e.g. Gateshead MBC Annual Report, 1984-85, p.26). In the view of the Principal Officer, Mental Health Services, only one district-based Approved Social Worker was at the time of the study operating as a mental health specialist and the level of interest in and priority accorded to this area of work in district teams was low.

Under reorganisation, a community-based group of eight Level Three social workers was established to form the nucleus of a more coherent and comprehensive mental health social work service in the borough. All four key informants in Gateshead referred to competition with other client groups for resources. This was seen to range from lack of priority accorded to mentally ill people in the Regional Strategy (in comparison to mentally handicapped people whose problems were considered to be more easily identifiable), to a recognition at local area level for ongoing social work support, but a failure to provide it because of greater priority given to other areas of work, especially child care.

Residential and Day-Care Provision

Before 1980 there were no Social Services resources for people with mental illness in Gateshead, although on the basis of the guidelines in Better Services for the Mentally Ill (DHSS, 1975), it was estimated that fifty beds in

residential accommodation and 123 day care places were needed (Gosling, 1986). However, since that date, a number of facilities and services had been established, all of them funded under Joint Finance or Inner Areas Partnership arrangements.

Carlisle House Day Centre, opened in 1980, provided 35 places but had around 40 people attending each day. This was an indication of its popularity with users who valued "its warm, friendly environment which offers social interaction either with (sic) recreational or occupational activities" (Gray, undated). It could offer a variety of responses to user needs: individually structured programmes to develop specific skills in areas such as budgeting or home management; a drop-in centre; and a valuable point of contact for some people with fairly severe mental health problems.

One feature was the capacity to provide transport on a short term basis for people who might otherwise have difficulty in attending.

Baltic Road Day Centre opened in 1986 and offered more work-centred activities for twenty people each day. In addition, a day centre for around twenty people operated on one day per week in the community room of the Wrekenton District Office. This facility was staffed by members of the psychiatric social work team and staff from Carlisle House and was intended to serve those people who found it difficult to travel to the other centres. A club held once weekly in the reception area at Dryden Road Hospital was the only evening facility in Gateshead. Its main aims were social and recreational, but the psychiatric social workers

who staffed it were also able to offer counselling and to
refer people to formal sources of help when appropriate.

Social Services provided one residential scheme for mentally
ill people: **Bircholme** was set up under Joint Finance
arrangements and provided fourteen places including two in a
'training flat' in a nearby Housing Department property.
The hostel aims were defined as offering:

1) long-stay provision;

2) rehabilitation training;

3) short-stay provision for assessment and/or relief care;

4) crisis provision (Gray 1987),

but the extent to which the hostel was able to fulfil all of
them was unclear.

A number of new resources, in terms of personnel, had been
funded through the Inner Areas Partnership Scheme (the post
of Principal Officer, Mental Health Services) and Joint
Finance (an Activity Resettlement Officer for Carlisle
House; the clerical/administrative support to the social
workers using Dryden Road; and the Resettlement Officer, for
people leaving hospital; the rôle of this worker will be
discussed further below in relation to housing).

Two further schemes were also of benefit to mentally ill
people within the community. One of them, the Home Care
Scheme, was designed "to maintain and support people in
their own homes" (Gray, 1986, p.3) and offered flexible
domiciliary services to people with a range of physical and
mental disabilities and their carers. The second, a

Resettlement Scheme, included the provision by Social
Services of a grant to 'top up' any Social Security grant
entitlement when someone was discharged from psychiatric
hospital to a new home of their own. This was a
particularly important resource which, for coherence, will
also be discussed below in relation to rehabilitation and
the Housing Department.

Voluntary Organisations

The resources provided by voluntary organisations within
Gateshead were relatively limited, although because of
proximity, some facilities in Newcastle for mentally ill
people were accessible. The Northern Regional Office of
MIND was located within the borough, but did not deal
specifically with Gateshead. The major voluntary providers
of services were the local branches of MIND. These
facilities included a sheltered workshop which renovated
furniture, a number of drop-in centres including one in
Blaydon, and a Community Support Scheme.

The Community Support Scheme was established in April 1987
and was short-lived, but is described here because it
appeared to offer an acceptable and accessible service to
users. It was funded by Inner Areas Partnership and the
Community Programme and consisted of twelve part-time
support workers, together with a co-ordinator (a qualified
social worker), supervisor and administrative worker. The
project aimed to help people with mental health problems to
improve the quality of their lives and to use community
resources rather than having to rely on special services, as
well as to demonstrate a gap in existing provisions

(Gateshead MIND, 1987). Users were actively involved in identifying their personal aims and assessing their progress towards those aims and by the end of the first year, more than 45 people were receiving regular support, with between 60 and 80 people attending the associated groups and drop-ins each week (Brown, 1988).

The scheme quickly made a significant contribution to supporting people in the community but, like many others, it faced severe staffing difficulties when the Community Programme ended in September 1988 and was eventually forced to close.

The Hardman Centre, a church-based organisation in Low Fell providing community facilities for elderly people and mothers and toddlers, also ran a house with a resident staff member for five older men with long-term psychiatric problems. These men attended the Hardman Centre for day care, although they mixed very little with other, mainly elderly, attenders. The group of men had a separate lounge, where they seemed to spend much of their time smoking and watching the television. The quality of life offered by this resource was criticised by both key informants from Social Services.

The Northern Schizophrenia Fellowship ran a monthly support group for carers with a regular core of about ten or twelve attenders, some of whom were from Newcastle, although there was another well-established self-help group there (Bond, personal communication). Conversely, because of the proximity of Newcastle, some Gateshead people with mental health problems chose to use resources there, such as the New Way Out Club and the Wayside Day Centre, which are described in Chapter Six.

Housing Provision

The housing situation in relation to mentally ill people in
Gateshead had a number of very positive aspects, reflecting
the active and relatively enlightened policies of the
Council towards people in housing need. At the same time it
demonstrated the difficulty of creating systems which ensure
consistency and effective communication even where
commitment and goodwill exist.

The Housing Department was organised into nine areas
(compared with Social Services' current six and projected
four districts), each providing a comprehensive housing
service including allocation, repairs, rent collection,
estate management, welfare benefits, advice, etc.

Like other authorities in the Tyne and Wear area, Gateshead
had an above average amount of council housing (47.9%) and a
correspondingly low proportion of owner-occupied property
(38.6%) (OPCS County Monitor: Tyne and Wear, 1982, Table H).
However, there was considerable variation between different
wards and in four of the five wards served by St. Nicholas
Hospital, the proportion of council housing was below the
borough's average: Crawcrook and Greenside had only 23.5%,
although Blaydon had 63.7% council accommodation (Gateshead
Ward Profiles, Chief Executive's Department, 1987).

There was also wide variation in the distribution of
different types of housing stock within the borough, with a
predominance of good quality, traditional family housing in
the western areas, although Blaydon also had some non-

traditional building. In the central Gateshead and Felling areas there was a greater mixture of traditional and high rise accommodation. Although some of the latter was of good quality, around 800 units on two estates in Felling, built in the 1960's, were being demolished because of major structural problems.

In addition, there was an increasing trend towards selling off large numbers of the Tyneside flats in central Gateshead which had traditionally been an important source of private rented accommodation in the borough. Parallel to these developments were both a substantial increase in the numbers of houses in multiple occupation in the area and an increase in activity by housing associations, some of which (e.g. North Housing Association in the Avenues Project) were providing accommodation for single people.

Many of these factors had implications for people with mental health problems, particularly those in the west of the borough served by St. Nicholas Hospital. Until the early 1980's, the housing stock for single people within the borough as a whole had been generally adequate, although its location was problematic. In Area 2, the Housing Department area covering Blaydon and Ryton, for example, there were only 296 one-bedroomed properties (excluding bungalows) out of 6,540 tenancies (Gateshead MBC, Dept. of Housing Annual Report, 1984/85). This meant that anyone from the west of the borough needing non-family accommodation (whether council or privately rented) almost inevitably had to move out of the immediate area and away from any established support network. The need to demolish substantial numbers of defective flats combined with an absence of any new council building as a consequence of government policy, had led to a marked worsening of the housing situation locally

for those unable to buy or pay a market rent for flats. For
many such people in Gateshead, including mentally ill
people, the only alternative had become houses in multiple
occupation.

Houses in Multiple Occupation

The key informants in the Housing Department reported that
in the previous four years the Council had become
increasingly concerned about the housing situation of, and
demands from single people, the majority of whom were under
25 years of age. Since 1985 there had been a policy of
priority rehousing for homeless single people, but with a
reducing stock, the local authority found it difficult to
satisfy demand.

Gateshead, like many other authorities, had experienced a
dramatic increase over recent years in the number of houses
in multiple occupation (H.M.O.'s), with a rise from 25 known
properties in 1981 to an estimated 200 in 1984. However, in
contrast to a national picture where 75% of accommodation
consisted of bedsits and only 8% of bed and breakfast
accommodation, in Gateshead around 90% of properties were
estimated to provide bed and breakfast accommodation. It
was recognised that this type of accommodation was generally
both of a poorer standard and more difficult to control
(GMBC, 1987b).

A few HMO's in Gateshead had been set up specifically for
people leaving psychiatric hospital, sometimes by
psychiatric nurses, and provided a good standard of
accommodation with meals and services appropriate to the
individual's level of independence. However, concern had

grown among both statutory and voluntary bodies (including Gateshead Law Centre) about poor standards in the majority of establishments.

The outcome of such concern was a policy decision that "the full range of powers available to the council should be used diligently, consistently and where necessary, with determination" (GMBC, 1985b), in order to achieve satisfactory conditions in all multiply-occupied properties in the borough.

This policy recognised two important factors: firstly, that the improvement of standards would require the co-operation of many departments and agencies. Accordingly, in April, 1986, a Houses in Multiple Occupation Action Team was set up, comprising the Directors of Housing (Chair), Finance, Social Services, Engineering Services, Planning and the Chief Environmental Health Officer, with representatives from the Fire Service, the Probation Service and the Health Authority in attendance (GMBC, 1985b), with responsibility for the preparation of a scheme of Registration and Code of Management for adoption by the Council (GMBC, 1985b). The Registration Scheme, (which was both informatory and regulatory), came into operation in April, 1987.

The second important factor was the recognition of the resource implications of effectively implementing such a scheme, leading to the establishment of an additional full-time permanent post of Environmental Health Officer, and the earmarking of substantial capital sums to meet the mandatory grant entitlement of owners served with Statutory Notices.

The results of the policy were impressive: in the first two years, 68 Direction Orders (requiring a reduction in occupancy by means of natural wastage), 74 Amenity Orders (requiring the upgrading of bathroom and kitchen facilities, etc.), 66 Fire Safety Notices, and fifteen Management Orders (to deal with properties in a filthy or unsafe condition), were issued. It had not yet been necessary to issue a Control Order (GMBC, 1988). The Environmental Health Department reported a high degree of compliance with these orders because, officers believed, owners realised that the Council was prepared to use all statutory powers to enforce them. Owners either undertook the necessary work (sometimes with spectacular improvements, as photographs taken by Environmental Health Officers show), or closed down the properties. Few owners had taken advantage of the mandatory grant assistance, which suggested high levels of profit.

By March, 1988, the number of registered HMO's had fallen to 96, which meant that around 400 beds had been lost (GMBC, 1988). Many of the people thus displaced were helped by the Councils' SPHEAR Project, which offered accommodation for young single people in a supportive environment (GMBC, 1988). At the time that the bulk of the interviews with key informants took place, it was widely believed that significant, but unknown, numbers of people with psychiatric histories were living in HMO's, experiencing poor and stressful living conditions. The Principal Officer, Mental Health Services, felt that no-one was addressing the problems of those people who slipped through the net of the psychiatric services - perhaps because of repeated brief admissions - and found themselves in board and lodging accommodation, where their quality of life was "abysmal". Their only contact with social or psychiatric services was at a point of crisis, but given the difficulty experienced by many of them in caring for themselves and a lack of more

suitable supported accommodation, they had no alternative
but to return to board and lodgings.

Whilst the key informants from Environmental Health
recognised that their rôle was limited to regulating
physical conditions, and that their concern was officially
with buildings rather than directly with the people who
lived in them, they nevertheless considered that their work
had had a very positive effect on the quality of life of
residents, particularly those - including some with mental
health problems - who felt too powerless and afraid to
complain about conditions which may have been at best dismal
and at worst appalling. They were aware however, that some
problems of misuse of benefit books, etc. persisted, but
considered that most residents of HMO's in Gateshead were
now happy to live there because of the generally good
standards of accommodation.

The policy regarding houses in multiple occupation has been
described in some detail for two reasons: first, Gateshead
is one of the few authorities in the country to have adopted
a positive policy and achieved a marked improvement in
living standards for the often vulnerable people who reside
in them, although it is recognised that the problem is small
by comparison with many other areas, particularly Inner
London. Secondly,as a consequence of this policy,
Environmental Health Officers may be having an important,
but largely unrecognised, influence on the quality of life
of significant numbers of mentally disabled people in the
local community. For those who fall through the net of
social and psychiatric services, the key professional may in
some cases indirectly be the Environmental Health Officer
who inspects and regulates their accommodation, even though

he or she may have no contact with them on an individual
basis.

The Resettlement Scheme

The Resettlement Scheme was an important innovative joint
project between Housing and Social Services. In the five
years from 1981, more than one hundred people with long term
psychiatric problems had been rehoused into Gateshead from
St. Mary's or from Bircholme (Gray, 1986). In some ways,
the arrangements and relationships between the Health
Services, Social Services and the Housing Department which
made this Scheme possible were unique. According to the
Housing Department key informants: "Really, it's a case of
mutual trust and respect built up over a number of years",
but a number of additional significant elements could be
identified.

The stated objectives of the Resettlement Scheme were:-

a) To support the application for and acquisition of,
suitable accommodation within a given community.

b) To co-ordinate a planned, sustained support service.

c) To create a "home" from the allocated housing unit.

d) To ensure early preventative intervention at the time of
emerging psychiatric or social crises (Gray, 1986).

Gray's paper went on to identify the processes by which
resettlement was achieved and the relevant paragraphs are

included as Appendix Seven. Some key factors could be identified as fundamental to the success of the Scheme:-

1) Every person took part in an individual rehabilitation programme as preparation for more independent living.

2) The Chief Lettings Officer was a member of the multi-disciplinary review team making decisions about an individual's readiness to move, accommodation needs, location, etc. He was able to meet the patient in hospital and to consult with her/him, as well as with staff. It appears to be extremely unusual for a senior member of a Housing Department to be involved in individual cases in this way on a regular basis.

3) The identification of and commitment to clearly defined rôles and responsibilities, such as preparation for discharge, time-limited contract for housing allocation, follow-up support, etc.

4) The provision of financial help, in addition to any Supplementary Benefit entitlement, in order to create a "home" from the tenancy. The recognition of the importance of maximising the person's choice and participation in the creation of her/his home and of the part played by a comfortable and secure base in maintaining mental stability, seemed to be a crucial element but one which has rarely been recognised or made explicit.

The maximum grant payable was around £900 in 1986, although many people did not require the full amount. The items

covered fell into four categories - furniture, household
equipment, decorating materials and carpeting - based on a
list of needs identified in consultation with the Principal
Occupational Therapist at St. Mary's Hospital (Gray, 1986).
The purpose of the grant was not simply to provide a higher
standard of material comfort, important though this is, but
also to allow individuals to participate fully in the
process of creating a home of their own.

5)   Rôle of the Resettlement Worker. This post was funded
under Joint Financing arrangements and the worker was
responsible for

> "liaison with Housing Services in order to secure
> appropriate accommodation and subsequently with
> individual clients with whom she creates a
> personal home from the allocated accommodation".
> (Paper on Social Services Resources for the
> Mentally Ill, undated).

This worker also undertook supportive aftercare with many of
the people whom she had helped to move. The Resettlement
Worker therefore provided a crucial link between the person,
the hospital and their new home; between hospital, Social
Services and Housing; and between the individual and the
local community.

Thus, in this Scheme the responsibilities for liaison and
continuing support which are frequently left to chance, were
made explicit and allocated to a specific person at the
level of the individual clients, although clearly other
workers sometimes also had rôles to play in this area.

Other important elements of the Scheme included the Housing Department's emphasis on offering 'ordinary' housing in areas where people had links, although the location of suitable stock sometimes made this difficult, especially in the western parts of the borough. Further, no-one being discharged from hospital was offered a tenancy in a multistorey block without the explicit agreement of their consultant, and it was also policy that they should not be placed in 'difficult to let' accommodation.

These factors probably contributed to the lack of adverse public reaction to the rehousing of people from psychiatric hospitals in Gateshead, in contrast to the vociferous opposition to some attempts to provide homes for people with a mental handicap locally (Gateshead Post, 1987a, p.1).

Equally important, however, may have been the very positive attitude of housing staff that mentally ill people did not create management problems. The success of this carefully considered and well co-ordinated Scheme was such that only one of the one hundred people so far rehoused had created difficulties, by threatening a caretaker.

Like any Scheme, however, it had shortcomings, many of which were identified by those involved. Points identified by key informants included the fact that the Scheme so far had dealt with the people with the least difficulties, who required the least support. The Scheme did not really meet the needs of those people who did not remain in any part of the system long enough for consistent planning to take place or, because of a lack of suitable resources (particularly money for the payment of staff), of those people who needed higher levels of support in their accommodation. More fundamentally, all the key informants expressed concern that

the Scheme did not operate on a borough-wide basis and identified communication problems with a number of agencies.

Relationships between Agencies

All the key informants stated that there was serious disparity between services available to those people served by St. Mary's Hospital and those received by people who lived in the catchment area of St. Nicholas and Winterton Hospitals. The Resettlement Scheme, although officially borough-wide, in effect operated only in relation to St Mary's; indeed at interview, the key informant who was the Approved Social Worker in Social Services, Blaydon District Team, was not aware of the existence of the 'topping up' payments, even though he had clients who would have benefitted from them. This suggested a communication problem within Social Services Department. He said there was a division between services for patients in his area and the rest of Gateshead.

Key informants, both in Gateshead and at St. Nicholas Hospital, considered that having to communicate across authority boundaries severely affected the service to clients, because of the organisational problems and the difficulty of creating and sustaining any liaison mechanisms. As a result and in contrast to the good relations between Housing and St. Mary's, the Chief Lettings Officer's contacts with St Nicholas Hospital were "spasmodic and ad hoc". This was associated with a degree of professional mistrust and unease, indicated by comments made by two Gateshead key informants that St Nicholas Hospital was "not playing the game" and that they did not like the

way social work staff there operated; there seemed to be a
suspicion that patients were being discharged
inappropriately into Houses in Multiple Occupation in
Gateshead with the approval of hospital social workers.
Housing Department staff indicated that patients in St.
Mary's from South Tyneside were similarly disadvantaged by
organisational problems, in that it was claimed that such
patients were not taken on to Rehabilitation Programmes
because hospital staff believed they would not be offered
rehousing by South Tyneside afterwards.

The Social Worker key informant indicated that although his
relationships with senior Housing Department staff were very
good, difficulties sometimes arose with local area staff
responsible for allocations who, he felt, were less
understanding of his clients' problems and tended to dismiss
explanations, considering that the clients were in some way
morally responsible for their problems. For him and his
clients, an additional difficulty was the fact that the
Blaydon and Ryton area was covered by three DHSS offices
(Bede House in Gateshead, Hexham & Stanley).

Like social work staff in Derwentside, he found staff at
Stanley sympathetic but he felt that the other offices saw
their rôle as giving out as little money as possible; he
described his contacts with them as "a constant ongoing
battle", although the existence of a "very good" Welfare
Rights Officer in the Department was helpful here. The
Social Worker key informant described his day-to-day working
relationship with one of the consultants at St Nicholas as
"very good", and they met on a monthly basis; he was,
however, concerned at the tenuous CPN support to Blaydon and
Ryton patients which currently depended on the good will of
staff employed by Newcastle Health Authority.

Conclusion

Clearly organisational complexities had a serious effect on the nature and quality of mental health services available to people in the western part of Gateshead. The planned continuing lack of co-terminosity of catchment area boundaries in western Gateshead was likely to have an adverse effect on the co-ordination of services.

Resources available in the area were minimal and access to what resources were available across the borough was hindered by problems of communication, liaison and transport; issues of accessibility and especially acceptability appeared to have received little consideration in the planning process.

However, in the Resettlement Scheme, Gateshead also provided a strikingly good example of collaboration at the level of service delivery, and inter-agency efforts to create a service acceptable to users.

The fact that a Joint Care Planning Team did not become operational in Gateshead until July 1986 suggests that relationships between different agencies operating within the borough, particularly health service and local authority, have not in the past been characterised by close collaboration and communication. This also suggested perhaps the existence of differing views and visions amongst workers in different sectors and it was clearly essential

for the sake of the quality of future services, that this
should be remedied as work continued on developing plans.

Notes:

1. The Health Authority eventually decided that these
patients should be transferred to either Ponteland Hospital
or Wylam Hospital (both due for closure by Newcastle Health
Authority and both situated in Northumberland, albeit nearer
to Gateshead) when St. Mary's closed (Gateshead Health
Authority, 1989).

CHAPTER FIVE

NEWCASTLE: HEALTH SERVICES

Profile

The present metropolitan district of Newcastle upon Tyne was
formed in 1974 from the former Newcastle city and parts of
the neighbouring authorities of Northumberland and North
Tyneside. Although it does not have the largest population
(a position held by Sunderland), Newcastle has traditionally
been seen as the most influential authority in the region.
As a city and a centre for education, medicine and business,
as well as accommodating a number of government departments
and voluntary organisations, Newcastle holds something of
the position of regional capital. It also shares some of
the characteristics of other major cities, such as the
current trend towards the replacement of industry and
working class housing in inner areas by expensive private
housing; and its function as a magnet and zone of transition
for people from neighbouring areas.

In many respects Newcastle also shares the characteristics
and problems of the region, although there are some
important differences. Like most other authorities in the
region, it has a declining population: in 1981 the
population was 277,829, a decrease of 9.9% since 1971 (OPCS
County Monitor: Tyne and Wear, 1982). Newcastle has the
highest percentage of people of pensionable age (19.5%
compared with 17.5% for Tyne and Wear as a whole) and the
highest percentage of people either born outside the United
Kingdom or in households with a head born in the New
Commonwealth or Pakistan (5.9% compared with 2.9% for Tyne
and Wear as a whole). (City of Newcastle Policy Services
Department, 1988: Results from 1986 Household Survey).
Newcastle City Council and Newcastle Health Authority were

the only authorities at the time of the study to have well-
established Equal Opportunities policies.

The pattern of housing tenure was similar to that of the
region, with 46% owner occupiers, 40% council tenants and
14% in private rented/housing association property. However
these averages conceal some striking contrasts between
wards, with 84% of households in Walker living in council
property, compared with 1% in Jesmond ward; and 82% of
households in Westerhope and South Gosforth being owner
occupied compared with only 3% in West City ward (City of
Newcastle Policy Services Department, 1988: Results from the
1986 Household Survey). Similarly in 1981 the overall
unemployment rate for Newcastle was 16.2%, but in West City
ward it was 29.8% and in Scotswood, 26.5% (Townsend,
Phillimore and Beattie, 1986).

According to the report by Townsend and his colleagues, four
Newcastle wards (West City, Walker, Monkchester and
Scotswood) ranked in the twelve wards with the greatest
overall deprivation in the Northern region, making Newcastle
the most deprived of the three local authority areas in the
study, in spite of also having residential areas of obvious
affluence.

Like both Gateshead and Derwentside, the local council has
been Labour controlled since 1974. However, the council
also had a tradition of high spending on services, reflected
in high rate levels. In 1985/86 the domestic rate was
328.23 pence in the pound, compared with 206.76 pence
average for Metropolitan Districts (Audit Commission Profile
of Newcastle City Council, 1985/86). One example of the

high level of spending was the expenditure by Social
Services Department on mental health care. In 1985-86 net
expenditure was the highest in the country (Audit
Commission, 1986), and was estimated to be £2.07 per head of
population, compared with 11 pence and 10 pence per head in
Durham and Gateshead respectively (Richardson, 1988).

As a result there were considerably more mental health
resources in terms of both facilities and personnel in
Newcastle, and this applied to resources in all sectors.
There may be a number of reasons for the large amount of
provision by voluntary organisations, including the
attractiveness to such bodies of the city as a regional
centre, a greater awareness of identified need, and the fact
that Newcastle had in the past been generous to voluntary
organisations operating within its boundaries: in 1985-6,
Newcastle Social Services made grants totalling £28,000 to
voluntary organisations concerned with mental health,
compared with Gateshead's £2,000 and Durham's nil
(Richardson, 1988).

After April 1986 however, Newcastle was subject to
ratecapping, with inevitable consequences for existing
levels of provision, and especially for service development.

Health Service Provision

Until the development of the District Strategic Plan for
Mental Health Services (Newcastle Health Authority, 1984)
services for mentally ill people in Newcastle - both those

provided by the Health Authority and by Social Services -
were almost entirely institution based. Health Service
provision was centred on St Nicholas Hospital with, in 1984,
600 beds providing acute as well as long stay care for both
elderly people and younger adults, a drug and alcohol unit
and two wards (total 41 beds) for people with disturbed
behaviour, all of which served the whole of the catchment
area. The Department of Psychological Medicine at Newcastle
General Hospital provided a further 52 acute beds for non-
elderly patients, with an additional nineteen beds for
acute/psychotherapy patients located at Claremont House (17)
and the Royal Victoria Infirmary (2). As previously
indicated, psychiatric services for the western parts of
Newcastle (notably Newburn and Westerhope which until 1974
formed part of Northumberland) were provided by Gateshead
Health Authority and St Mary's Hospital, Stannington. By
the time of the study the catchment area had been sectorised
for new and acute referrals, so that St Nicholas Hospital
then took such referrals from Social Services Areas 1, 2 & 3
only, together with Blaydon, Ryton and North West Durham.

Impetus for change came from a number of sources including:
a consultation paper on catchment populations circulated by
the Northern Regional Health Authority in 1983 which gave a
real prospect of rationalisation, with Newcastle eventually
losing its responsibility for service provision for
Gateshead and North West Durham and providing only for the
city itself (plus, for mainly historical reasons, the
adjacent areas of Longbenton in North Tyneside and Heddon in
Northumberland); the report of the Health Advisory Service
Team visit to Newcastle in 1982 (NHS, 1982), including a
recommendation that clinical teams in Newcastle should be
sectorised; "very critical reports" from the English Nursing
Board (Newcastle Health Authority, 1985a, p.1); and perhaps

most importantly, a recognition that "Mental Health services
in Newcastle have suffered from decades of neglect by a
society and an NHS which has given such services a low
priority" (Newcastle Health Authority, 1986, p.8).

The results of chronic underfunding in the Health Service
were identified as being levels of staffing which were
unacceptably low and unsuitable buildings in a poor state of
repair. However,

> "the D.H.A. has now formed a firm resolution to
> attempt to remedy this situation by progressive
> allocations of revenue. The D.H.A. is doing this
> despite a background of an acute cash crisis".
> (NHA, 1985a).

The District StrategicPlan for Mental Health

By the time the District Strategic Plan was completed, some
progress had already been made, particularly in negotiations
about realigning catchment areas; the sectorisation of
clinical teams based on Social Services Area Team boundaries
in order to facilitiate interagency and interdisciplinary
collaboration on the development of local services.

The need for joint Health Authority and local authority
responsibility was recognised when the Joint Planning Team
(Mental Health), made up of both Health Authority and Social
Services members and chaired by a Social Services
representative, was given the responsibility of drafting the
Strategic Plan.

Notwithstanding these important incremental changes, the
Strategic Plan proposed the development of a pattern of
services which was radical, even daring, in both its aims
and its methods. The key to almost all future development
was that

> "the capital element of these proposals is largely
> dependent on income accruing from sales of land
> owned by the District Health Authority,
> particularly at St Nicholas Hospital" (Newcastle
> Health Authority, 1984, p.1).

The consequences and implications of this will be discussed
in some detail after summarising the main features of the
Strategy and associated developments.

Newcastle's Strategic Plan for mental health services was
impressive in its scope and thoroughness. Of all the
documents studied, it was by far the most detailed and
explicit in defining the principles, aims and functions of
the service, as well as identifying the obstacles to their
achievement, before setting out the intended future pattern
of provision in terms of material resources.

The principles were that future services should be:

- personally focussed

- comprehensive

- integrated. (Newcastle Health Authority, 1984, pD6)

The Strategic Plan also analysed the functions of the developing service and identified obstacles to the achievement of the stated aims and functions. These were:

1.   The fragmentation of the organisation of services

2.   The unsuitability and poor quality of much of the existing accommodation

3.   A shortage of resources in some areas

4.   The absence of some components of services

(NHA, 1984, p.D10).

Possible difficulties with the local planning authority were not apparently among the obstacles anticipated.

To overcome the obstacles identified (of which organisational fragmentation was seen as the greatest) and succeed in achieving the declared aim of "significantly (improving) the scope and quality of services for mentally ill people" clearly required far-reaching changes in the type and location of services, as well as a real increase in the resources allocated to them: the District Strategic Plan advocated both of these.

Acute beds would ultimately be provided by new units at St Nicholas Hospital, the Department of Psychological Medicine at Newcastle General Hospital and the Royal Victoria Infirmary. St Nicholas Hospital would continue to provide a small number of specialist and regional services (alcohol and drug abuse and forensic psychiatry) and continuing care beds for a relatively small number of people (a number which would steadily decline further because of death through old

age), but almost all the remaining services would be locally based.

Management Structure and the Development of Local Services

It was recognised that if the services created were to be genuinely responsive to local need, plans would have to be made at a local level (i.e. by sector teams), and that this would require a radically different management structure and style.

During 1985 and 1986 there was "significant progress in pursuing the implementation of the Strategic Plan" (NHA, 1986, p.128), and indeed its scope was further extended to include plans to reduce the number of beds at St Nicholas Hospital to 215 by 1995, by creating 300 alternative residential places in the community.

In September 1985 a new General Manager of the Mental Health Unit was appointed who was strongly committed to a devolved management structure and to overcoming the inertia apparently inherent in most institutions and individuals in the face of change. Further impetus was thus given to planning at local level and to change in the continuing care area.

The key principles of the new management arrangements were to be:

1.   Clear individual accountability

2.   Devolution of decision making

3.   Lack of rigidity in management arrangements

4.   Openness and effective communication.

(NHA, 1985a, pp2-3).

Thirteen 'divisions' of services within the Mental Health Unit were identified, of which those most relevant to the present study are:

1.   Adult acute services to Social Services' Area 1, 2 and 3.

2.   Adult acute services to Blaydon, Ryton and North West Durham.

3.   Long stay patients in St Nicholas Hospital and chronically mentally ill patients living in Newcastle.

It was proposed that each division

> "should be managed in conjunction with a
> multidisciplinary management team (MDMT) with a
> constitution and a remit specifically tailored to
> that service" (NHA, 1985a, p.5).

The new post of General Manager carried responsibility for "the line management of all those concerned in the delivery of one service" (NHA, 1985a,p.5). This considerably

shortened and simplified the existing management hierarchy,
as the proposals noted, particularly for nursing staff (NHA,
1985). Membership of each MDMT comprised all the
professions involved, including a standing Social Services
representative (usually at Area Director level), although in
carrying out their responsibilities for planning services in
their division (with the assistance of the General Manager,
Service Planning), it was anticipated that teams might

> "wish to involve other Social Services
> representatives, voluntary agencies or consumer
> representatives....'Joint Planning' with all that
> implies should take place as close to the
> patient/client/relative as possible" (NHA, 1985a,
> Section 12).

The future rôle of the Joint Care Planning Team alongside
the new management arrangements was unclear.

The MDMT's developed plans for services in their area,
although inevitably some progressed more quickly than
others. The two teams dealing with acute adult services in
Newcastle made the establishment of Community Mental Health
Centres a key feature of their plans. The first such
centre, located in Jesmond and staffed by both Health and
Social Services personnel, opened in April 1988. As a pilot
scheme, it was evaluated for the benefit of subsequent
schemes. By late 1989, two further centres had opened.

The plan to provide alternative living arrangements for
large numbers of people with severe mental disabilities
currently in hospital carried major implications in at least
two areas: firstly preparing patients themselves for major
change in their lives and deciding on the levels of support
they would need and secondly, obtaining and funding
appropriate accommodation.

Reorganisation of Continuing Care

Major developments took place from the mid 1980's in the area of rehabilitation/continuing care at St Nicholas Hospital, partly arising out of the realisation by some staff that people were living "in wards which at the moment appear to be disabled by the diversity of their patients' needs and problems" (NHA, 1985b, p.1); in other words that St Nicholas, like many other psychiatric hospitals, had rehabilitation units yet lacked a coherent philosophy not only about "how patients were assessed or selected as suitable and prepared for discharge" (NHA, 1985b, p.51), but also about what should happen to those patients left behind.

Arising from these concerns, the behavioural assessment package REHAB (Baker and Hall, 1984) was used to assess patients throughout the continuing care wards of the hospital early in 1985 (NHA, 1985b).

The information generated by this exercise enabled both individual and ward profiles to be produced, and on the basis of these a new tiered system of care was proposed which "incorporated a progression....from high dependence to potential for discharge" (NHS, 1985b, p.44). This was implemented in January 1986 in what was a major reorganisation of all the long stay wards in the hospital. As well as bringing together patients in new groupings according to their levels of dependence, the changes created more mixed sex groups, and also made use of unoccupied staff houses in the hospital grounds to provide more independent

but supported living schemes (NHA, 1986). It was intended
to use the REHAB package as a continuing means of assessment
to ensure that care for patients remains as flexible and
responsive to individual need as possible.

As a result of the REHAB exercise, nursing staff became much
more actively involved in rehabilitation and follow up care
for those people who would move out of the hospital.

There were some problems associated with the developments in
the continuing care sector, notably perhaps the fact that
the acute services were organised on a sector basis whilst
continuing care was not, and the Consultant Psychiatrist
interviewed reported a lack of coordination between the
acute and chronic areas. In addition, the two "disturbed"
wards were excluded from the REHAB scheme, when some of
their patients might well have benefitted by the kind of
programmes it offered (Newcastle Health Authority, 1985b).

A further reservation concerned the appropriateness of using
a tool developed in clinical settings and which emphasised
deficits rather than strengths, in assessing and preparing
people for life outside the institution.

Financing the new model of service: Newcastle Health
Authority and the City Council

The sale of hospital land for redevelopment was central to
the realisation of the Strategic Plan. Since St Nicholas

Hospital occupied two large adjacent sites totalling around
120 acres in a desirable residential area, the sale of
surplus land and buildings was seen to offer "a 'once in a
generation' (1) opportunity to transform the mental health
services" (NHA, 1986, p.9).

A ten year capital programme to replace poor quality and
inappropriate buildings with the kind of facilities
described above was drawn up with a total estimated cost of
£11.05 million. It was recognised that not all of this
could be met from land sales, but it was not clear where the
anticipated difference of £2.5 million would be found beyond
a statement in the Strategic Plan that "additional capital
resources need to be identified early in the Plan period"
(NHA, 1984 pD35).

The District Health Authority was nevertheless committed to
making the planned community developments not a cost
reduction programme as much 'community care' elsewhere was
seen to be, "but rather as a means of improving the scope
and quality of services" (NHA, 1986, p.49); and also to
injecting £1.5 million additional revenue over the plan
period to meet strategic objectives including the
improvement of staffing levels (NHA, 1986, p.128).

It was anticipated that around 80 acres, or even possibly
the whole St. Nicholas site, would eventually be sold
(Newcastle City Council, Development, Planning & Highways
Committee, Minutes, 13/11/86). In 1986 the first 20 acres
of land bordering Salters Road were sold for residential
development for £2.6 million. However, the estimated value
of the surplus land (and hence the scale of the capital

programme) depended on part of the site being sold for commercial development. In the event plans for both types of development encountered major obstacles which demonstrated graphically the different priorities, pressures and responsibilities of the Health Authority and the Local Authority, and the lack of adequate structural mechanisms to resolve them.

As a Crown Agency, the Health Authority did not require planning permission to develop land it owned, although under Circular 18/84 it was required to have formal consultations with the Planning Authority. The need for a "constructive dialogue" between Local Authority and Health Authority, partly in order to identify other suitable sites and properties not currently owned, was recognised by both bodies in Newcastle (Newcastle City Council, Development, Planning & Highways Committee, 13/3/1986).

The Health Authority had kept the City's Development, Planning and Highways Committee informed of relevant aspects of its plans with reports to the Committee on a number of occasions in 1985 and 1986. It was also closely involved in discussions with the Housing and Social Services Committees to identify available council-owned properties which might be suitable for its development of locally-based facilities; the Health Service Advisory Committee also played an important role in liaison. The proposals for the "Care in the Community" programme were welcomed in principle by the City Council.

Major problems nevertheless arose in three areas:

1. Public opposition to proposals to develop new small residential projects and associated supporting facilities in residential areas around the city (Report of City Planning Officer, 13/3/1986).

2. The future use of former hospital land.

3. The scale of the changes and their likely effects on the immediate area.

The Issue of Commercial Development

The first issue was initially the main focus of concern. However, both public and Council attention quickly shifted to the sale of hospital land when it became known that a bid of £3 million for a six acre site alongside Kenton Road had been made by Fine Fare, who applied for planning permission to build a 65,000 square feet supermarket and filling station. A study of local press reports clearly shows that the creation of large supermarkets was a major issue of public concern in the city at this time. Three applications by Fine Fare for supermarkets in the Gosforth area had already been turned down (Evening Chronicle, 9/4/86).

Even more significantly, the application for the land at the hospital was the ninth application for such a development in the city to be made in the early months of 1986, and the third simultaneously in the Gosforth area: two were within a mile of St Nicholas Hospital (Evening Chronicle, 10/2/1986), and there was also an application to build a 95,000 square feet superstore and filling station at Kingston Park, adjacent to Gosforth.

There was initially optimism that the Fine Fare application would succeed (Journal, 9/4/1986) but such optimism proved to be misplaced and the planning application was rejected:

"The Planning Committee's decision was based on the grounds that the scheme was against existing shopping policies, would lead to shop closures and job losses elsewhere, and would have a major impact on the surrounding area". (Evening Chronicle, 1/8/1986).

The applications for the two other Gosforth sites (both sports fields) were also rejected. All three potential developers appealed against the decisions, and a Public inquiry into the three proposals was held in January/February 1987. The reported arguments put forward during the inquiry centred on the likely impact of the supermarkets on existing local shopping facilities (especially Gosforth High Street) and on the environment (Evening Chronicle, 10/2/1987 and 13/2/1987).

In October 1987, the Council's decision to reject all three applications was upheld by the Secretary of State for the

Environment. In the case of Fine Fare, it was said that the scheme would generate too much traffic in a residential area (Evening Chronicle, 23/10/1987, p.1).(2)

Pressure from developers for out-of-town shopping complexes nevertheless continued, with the Evening Chronicle reporting an application from a Lancashire-based firm of developers for a superstore on 50 acres of Green Belt land near the Gosforth Park Hotel (Evening Chronicle, 11/5/1988).

The immediate consequence of the failure of the Fine Fare application was a loss of more than £2 million to the Mental Health capital programme, since the estimated value of the land for residential development was only £800,000 (NHA, 1987).

It had been envisaged that more than £3 million which would not be needed for mental health projects until 1988/9 to 1990/91 could be "borrowed" by the District Health Authority on a short term basis to undertake capital projects elsewhere in its programme, so that the loss of a commercial sale had wider implications.

It "removed at a stroke an expected capital receipt in 1988/89 of £3 million", and forced not only "a radical revision of the Capital programme", but also "a careful re-assessment of the Mental Health programme" (Newcastle Health Authority, 1987,p.46). This problem was compounded by other financial difficulties in its revenue budget (NHA, 1986).

However, the conclusion of a revised Capital Programme stated that the loss of the Fine Fare Sale could be absorbed by, among other modifications, "a range of adjustments in the Mental Health Programme **which do not inflict any strategic damage**" (Newcastle Health Authority, 1987, p.51) (emphasis added); and the Health Authority remained committed:

"The foundations on which the Unit's strategy is based remain unchanged and the commitment of the Authority remains undiminished" (Newcastle Health Authority, 1987, p.9).

The Search for Alternative Funding

With the loss of expected revenue from the Fine Fare sale, the Health Authority looked for other ways to finance alternative facilities in the community. One way was through a shift in the focus of spending under joint funding arrangements to mental health. Until 1986 only 2% of available funds were spent on mental health projects. This was revised to 7% in 1986/87 and it was hoped to direct an even greater proportion to this area in the future (Newcastle Health Authority, 1987, p.98). A more significant source of capital funding was sought through extensive collaboration with voluntary organisations and Housing Associations for residential projects. One attraction of this approach was that people living in the proposed schemes were likely to be eligible for a range of Social Security benefits to meet their costs of daily living and care (NHA 1986). It was envisaged that capital funds for setting up each scheme would be provided by the Health Authority, but that it would then be wholly managed by the voluntary

organisation, although with "professional staff support being provided by the Mental Health Unit" (NHA, 1986 p9).

40 Grainger Park Road, opened in December 1987, was the first venture of this kind and was intended as a model for future schemes. This was a hostel set up in a former nurses' home in the West End of Newcastle to provide long term accommodation and care for thirteen patients from St Nicholas Hospital. It was a joint venture between the Health Authority and the Northern Schizophrenia Fellowship who took over ownership and management, supported by a project management committee comprising representatives from the Health Authority, local Social Services and the Fellowship. Some staff, including the Project Manager and his deputy, were employed by the Fellowship, with three nursing staff seconded on a full time basis. A projected second phase, involving a Housing Association as well as the Fellowship, would provide twelve flats on the adjoining land where residents would have independent tenancies, with support available as needed from the hostel staff. Further schemes were under discussion with a variety of Housing Associations (NHA, 1986 p.64).

The Grainger Park Road project encountered significant problems in relation to staffing and management (Hildrew, 1988). These were probably predictable when staff working together in the same small establishment were employed on different salary scales and conditions of service, and although the anxieties of nursing staff and their unions about the loss of Health Service jobs can be readily understood, it would seem to be essential for these issues to be more satisfactorily resolved in future.

However, uncertainties over the Government's intentions for the longer term eligibility for social security benefits of mentally ill people living in the community also called into question the viability of further similar collaborative projects.

The Issue of Residential Development

The plans to sell substantial amounts of surplus hospital land for residential development (involving the construction of as many as 1400 new houses over five to ten years) also ran into increasing and apparently unanticipated difficulties. In the Council's view, these proposals

> "would still represent a **most significant change in the environment** of the Gosforth/Kenton/Coxlodge Area. (Report of the Chief Planning Officer, 9/10/1986 p 1)', and "The proposed scale of change....is such that the study will need to extend to City wide considerations, particularly in respect of housing and other major land use issues." (Report of Chief Planning Officer, 13/11/1986,p.1) (emphasis added).

In order to assess the implications of the changes, an informal Local Plan involving full public consultation was proposed. It was expected that this study would also focus on the implications for education and other supporting facilities; recreation and open space; employment opportunities; and infrastructure capacities and development constraints, thereby involving several other council

departments. Public consultation would include
questionnaire leaflets to local homes, exhibitions and
public meetings, before the final proposals were put to the
Committee in April 1987 (Report of Chief Planning Officer,
13/11/1986).

However fundamental disagreements between the Health
Authority and the Planning Committee led to substantial
delays. Whilst the latter's position was that

"In line with established City Council retail
policies....the draft report of the Local Plan
made no provision for any substantial retail
development within the plan area",

the Health Authority continued to insist that

"without the very significant financial
contribution which would be made by a major retail
disposal there was no reasonable basis on which it
could proceed with the envisaged programme of Care
in the Community developments" (Report of Chief
Planning Officer, 9/4/1987, p.2)

It was therefore concluded that, pending the outcome of the
Fine Fare Inquiry, "there is no satisfactory basis to
progress work upon the plan" (Report of Chief Planning
Officer, 9/4/1987,p.2).

It is possible to speculate that this was a tactical move by
the Health Authority to put pressure on the Planning
Committee (or indeed on the Public Inquiry which took place
in late January/early February 1987) to reconsider
commercial development. If so, the tactic was not
effective.

The recommendations of the draft guidelines finally
presented to the Development, Planning and Highways
Committee in July 1988 were first that, having been "a green
lung" in a built-up area, the hospital land should be made a
Conservation Area, with a tree preservation order on the
Collingwood site. This was because

"The environmental quality of the site is unique
in the City with its extensive mature parkland
grounds dominated by the imposing Victorian
buildings". (Evening Chronicle, 11/7/1988)

Second, it was recommended that retail, industrial and
speculative office development should not be allowed.
Third, development of housing, small scale businesses and
"high class office development" was considered possible for
some parts of the site (Evening Chronicle, 11/7/1988).
After protracted negotiations between the City Planning
Department and Newcastle Health Authority, agreement was
reached in February 1989 for a scheme to sell 50 acres of
the St Nicholas/Collingwood sites for housing, recreational
and small business development for around £8 million.

However, in June 1989 the City Council was still pressing
for the site to be designated a Conservation Area, in order
to retain a degree of control over the development of the
land, and the hospital Assistant General Manager was quoted
as saying that the declaration of a conservation area

"would mean difficulty, frustration and delay.
The whole programme to put Newcastle into the
forefront of care for the mentally ill could be
put back for years" (Evening Chronicle,
14.6.1989).

The issue was finally resolved, after a number of public meetings, in September 1989 when the City Council granted planning permission for 750 houses on 58 acres. By this time, the sum expected from the sale of the land was put at £15 million (Journal, 15.9.1989).

From the Health Authority's point of view the final agreement appeared to be a very satisfactory resolution of the situation, which meant that their original capital programme could not only be fulfilled but extended, as a result of the substantial increase in land values.

It was "now regarded to be both desirable and potentially affordable" to develop new purpose-built facilities in the community for the frail elderly group of "old long-stay" patients who, under the original plan, were to remain in St Nicholas Hospital; the difficulty of finding appropriate community-based sites and buildings was however recognised (Newcastle Health Authority, 1989).

Conclusion

It will be clear from this case study of the attempts to sell off surplus hospital land that it proved extraordinarily difficult "to translate the fine sentiments of the Strategic Plan into action" (N.H.A.), 1986, p57). Newcastle's experience demonstrated the enormous

difficulties to be encountered in trying to implement even
apparently well-thought out plans to create better services
and living conditions for people with mental health
problems.

Two major issues arise from the experience in Newcastle:
firstly, the relationship between Health Authority and Local
Authority with regard to policy and planning issues; and
secondly, the effects of the loss of, or delay in realising,
the expected capital sums on the pace of the hospital
rundown and discharges of mentally ill people to the
community.

From the standpoint of the Health Authority it appeared that
a way had been found to overcome the persistent obstacles to
change caused by lack of adequate capital funds. However, a
number of critical factors had a major influence on the
progress of the land sales: the dissonant priorities of the
Health Authority and the Local Authority; the lack of
appropriate systems to reconcile or resolve these; and the
impact of apparently unrelated events outside the control of
the Health Authority. It seemed that present local
authority planning processes were ill-designed to give
adequate consideration to all the implications of
developments of this nature and in particular were unable to
recognise and balance the needs of competing groups.

The patients of St Nicholas Hospital experienced a double
disadvantage in the attempt to provide improved, locally
based facilities. Not only did the attempt encounter

efforts of the type well-documented in the work of Dear, among others (Dear and Taylor, 1982) by certain groups of residents to prevent facilities being sited in their localities, but similar "exclusionary behaviour" of the suburbs" (Dear & Wolch, 1987,p.250) arose in response to the proposed residential development of the hospital land. Indeed the reasons put forward in opposition to executive housing were very similar to those usually raised against local welfare facilities: nuisance and danger (because of increased traffic); a deterioration in the environment (due to the loss of open space) and hence the threat of a decline in property values. Nowhere in the process of planning and negotiation did mentally disabled people and their interests appear to be directly represented.

The outcome of the plans to sell surplus hospital land for development appeared to have been ultimately satisfactory; indeed in the long term, the Health Authority benefitted financially from the enforced delay in selling off the land. However, the fact that this was due to an entirely extraneous event (a fortuitous increase in land values) merely emphasises the arbitrary nature of the planning process in the way it responds to the needs of mentally ill people.

The short-term impact of the loss of the commercial sale on the strategy's capital programme has been noted. Given that between 1984 and 1989 the number of beds at St. Nicholas Hospital fell from 600 to 472 (a reduction of more than 20%), it is important also to consider how people with severe mental health problems leaving hospital and in the community might have been affected in the short term by the delay in creating alternative resources. Little film

evidence was available but one inference would be that some
people must have been discharged to less than appropriate
accommodation in the community, with less than adequate
preparation or follow-up care, since it had not yet been
possible to create the resources and facilities they
required.

Such a situation would be at variance with the Health
Authority's declared commitment to

"a very much improved, more accessible and
responsive range of services which will be to the
benefit of Newcastle residents" (Newcastle Health
Authority, 1986, p.49).

The 'front line', views reported in Chapter Seven will help
to illuminate what was happening to them in that period.

Notes

1. Elsewhere in the same document, the opportunity is "once
in a century"!

2. The ASDA application for a supermarket on the
Northumberland Rugby Club land was approved after the
requirements of the Inquiry Inspector had been met (Journal,
16/7/1988), and the application for the Tesco store at
Kingston Park was also eventually approved. Approval for
housing rather than retail development on the Gosforth Rugby
Club site was later given (Journal 1/4/1988).

CHAPTER SIX

NEWCASTLE: LOCAL AUTHORITY

AND VOLUNTARY SERVICES

Social Services Department

Newcastle Social Services Department was at the time of the
study structured into six divisions. Newcastle had
traditionally been seen to have a generous establishment of
social work posts, and in 1988 had a total of 215
fieldworkers compared with 110 in Gateshead (Stephenson,
1988).

Fieldwork services were, at the time of the study, divided
into five area teams, plus Health Service teams and
specialist services which included: Fostering and Adoption,
Court and Intermediate Treatment, social workers in special
schools and with deaf and blind people. The Fieldwork
division also included the Home Help and Occupational
Therapy services. Each area team operated from a base
located in its catchment area with one or two sub-offices in
addition. Each area office was headed by an Area Director
and included social workers, social work assistants and home
help organisers, (although home help areas were not always
co-terminous with area team boundaries). There was some
variation in the organisation of each office, reflecting the
differing characteristics and needs of each catchment area,
although there was a movement here as in other authorities
towards specialisation of teams according to client group.

Each area team included a number of social workers who were
approved under the Mental Health Act (as did each hospital
team), although the extent of mental health specialisation
in their workload varied, and relatively few social workers
were involved in adult care work as a whole. Area team
boundaries have subsequently been realigned to create a

sixth area team in the west of the city. Social Services also had a small but active Welfare Rights Service, which operated mainly in the Scotswood & Walker areas. In the year ended March 1986, this service dealt with more than 2,OOO new cases, and it was anticipated that the workload would increase further with the reform of the Social Security System (Newcastle City Council, 1986b).

There were substantial numbers of hospital-based social workers in Newcastle, partly because of its position as a regional medical centre. At the time of the study the mental health social work team consisted of one senior social worker (team leader) and twelve social workers, headed by a principal social worker, (with a further worker employed for historical reasons by the University). Of these twelve, four worked in psychogeriatrics and two were involved with the regional service to substance abusers at Parkwood House. The Principal Assistant (Health Services), through whom the hospital teams were accountable to the Deputy Director, had a strong mental health background, having formerly been the Principal Social Worker at St Nicholas Hospital and having also served as a Mental Health Act Commissioner.

Although St Nicholas' social workers had traditionally provided a significant service to patients from the Gateshead and Durham parts of the catchment area, by the time of the study it had become Newcastle's policy to withdraw gradually from such involvement until the hospital social workers ceased to undertake active work outside the city boundaries. This was in accordance with the changes envisaged in the District Strategic Plan (Newcastle Health Authority, 1984), but also in response to ratecapping.

Since the study took place a social worker and a senior social worker have been appointed under joint financing arrangements to work in the rehabilitation and continuing care area, where it was recognised that social work had been largely unrepresented. Also since the study, social workers from area teams have begun to work on a part-time basis at the newly established Community Mental Health Centres.

The Annual Report of the Social Services Department for 1985-86, identified three broad categories of social work services to mentally ill people:

1. Services provided to people undergoing treatment in hospital, in specialised units, and out patient clinics. This includes work for people with a drug or alcohol problem.

 2. Aftercare for people recovering from chronic mental illness; including care, shelter and retraining for work and independent living.

3. Services of a preventative nature which support individuals and families under stress or at risk of suffering a mental illness.

(Newcastle City Council, 1986b, p.12)

The same report estimated that there had been 440 referrals categorised as "mentally ill" out of a total of 20,492 in the year; this represented less than 0.5% of the total and would suggest either that some referrals were categorised under other headings (2,020 referrals were classed as 'Single Person', yet one key informant from Social Services estimated that around 70% of her clients living in bed and

breakfast hotels (i.e. mainly single persons and the majority of her caseload) had significant mental health problems); or that a low priority was attached to such work.

The latter view was given support by the key informant from Social Services management who noted that people with mental health problems were in competition with, and suffering from, numerous initiatives and pressures in respect of other client groups. There was pressure from DHSS to move people with mental handicaps out of hospital as well as pressure at a local level to improve services for older people, (Newcastle City Council, 1984a), together with a continuing emphasis on child abuse: mentally ill people were therefore "running in about third place".

Residential Provision

The most significant part of Newcastle's residential provision for mentally ill people was located in two long-established hostels which had a total of 47 beds. In addition, there were about twenty small group living schemes at the time of the study, providing a long-term home for between 70 and 80 people. The exact number of such homes was unclear since they tended to be local initiatives, set up and supported by area teams and the two hostels in association with the Housing Department or a variety of Housing Associations.

Summerhill in the West End, and 49 Scrogg Road (previously
known as Sunnycrest) in Walker were both set up to provide
rehabilitation and an intermediate step between hospital and
the community for psychiatric patients. Already in 1982 the
Health Advisory Team praised the

> "a very imaginative and professional approach
> being taken by Newcastle Social Services
> Department to the development of residential
> facilities in the community for mentally ill
> people" (NHS, 1982,p.64).

However, both hostels subsequently underwent considerable
changes in philosophy and rôle in line with the District
Strategic Plan (Newcastle City Council, 1984b).

A discussion document produced by the Mental Health Forum, a
group of residential, daycare and field workers identified
"a number of serious defects" in the current provision.

1. - Rôle confusion: the two residential units were
expected to fulfil a wide range of sometimes conflicting
roles, including assessment, rehabilitation, crisis and
emergency placements, sheltered accommodation for people
with long term problems and day care for both ex-residents
and "new" clients.

2. - Because provision was in relatively large units, it
tended to be institutional in character, and not
sufficiently flexible to meet individual needs.

3. - There was a perceived lack of integration with other agencies and professions which impeded thorough multi-disciplinary assessment.

4. - Existing provision was geared overwhelmingly to providing after-care for people who were in hospital at the time of referral, whereas the majority of people with mental health problems were already in the community and without access to appropriate facilities.

The document supported the establishment of a number of Community Mental Health Centres as a key element of future services, identifying their functions as short term assessment, respite care and crisis intervention. It clearly envisaged that the centres would have some short term residential facilities and would have a multidisciplinary team available on a 24-hour basis. They would also have an outreach role with vulnerable people living in less supported units in the community.

In addition the discussion document identified a range of day and residential services which were intended to meet widely varying individual needs. These included small rehabilitation hostels of six to eight beds, where emphasis would be placed on "self help and the development of personal responsibility". Two main groups of futureclients of the hostels were identified:

> "Those chronically institutionalised within previous hospital or family system (sic) and those usually in their late teens to mid-thirties already embarked on a psychiatric career with a history of frequent admissions often with self abusive behaviour as a feature" (Newcastle Social Services Department, 1984b, p4).

It was also envisaged that the hostels would be able to call on the resources and expertise of the Community Mental Health Centres on a 24 hour basis. Other types of residential provision identified included: group homes with varying levels of support, with staff accountable to the Community Mental Health Centre; a range of individual and shared living schemes; and sheltered housing and boarding out schemes, although reservations were expressed about the suitability of many hotels and guest houses where people with serious mental health problems were currently living.

Because of the subsequent financial difficulties identified above, progress towards the changes suggested in the discussion document was much slower than anticipated. In particular, the Community Mental Health Centres which were seen as playing such a crucial role were slow to develop, and operated on a comparatively restricted basis only during normal working hours. It was not clear which user groups were finding the centres most appropriate to their needs.

In spite - or possibly because - of these setbacks, the two existing hostels were very active in developing their rôle and enhancing the services offered. Both benefitted from energetic, enthusiastic and largely qualified staff teams, and the strong support of a committed Principal Officer as their line manager in the Civic Centre. Although the

hostels were encouraged to develop their individual
approaches and to respond to local needs, they developed and
changed in very similar ways.

Both hostels offered single rooms to all residents and
emphasised individual privacy, despite the unsuitable design
of the buildings; there were also flatlets where a small
number of residents could experience living more
independently, budgeting and cooking for themselves, in
preparation for moving out to their own accommodation. Both
hostels had for many years offered day care and outreach
support to former residents, including support for ex-
residents in nearby group homes.

Both hostels hade a clearly defined philosophy based on
MIND's "Common Concern" (MIND, 1983b) and operated on a
social, as opposed to a medical, model in order to encourage
greater personal choice and responsibility. Weekly meetings
for all staff and residents to discuss and make decisions
about issues affecting daily life in the unit - including
the admission of new residents - were seen as a key element
in this. There was also considerable emphasis on involving
residents in deciding on their individual plans and
programmes, and a key worker system was in operation.

As the staff at St Nicholas' Hospital became more actively
involved in rehabilitation programmes for patients in the
hospital and support for them subsequently in the community,
the two hostels, particularly 49 Scrogg Road, tended to take
in more people who had very disturbed lives, of which
repeated admissions to psychiatric hospital had been a part
(although they did not always have a diagnosed mental

illness), and people in the community who were experiencing
severe personal distress and who were referred directly to
the hostels rather than to the psychiatric services. Among
both these groups were people who had previously been
discharged from hospital to the community and who, because
of inadequate or inappropriate support, had reached the
point of breaking down again. In recent years, a number of
families with young children have been admitted to Scrogg
Road at a time of crisis because no other suitable
facilities existed.

In a number of ways therefore the two hostels could be said
to be taking on the rôles of prevention and intensive
intervention previously identified as appropriate to the
planned Community Mental Health Centres. They had staff
skilled in mental health work available around the clock;
they were able to provide respite on both a residential and
daily basis; they could also offer reliable outreach support
from a base that was well established and accepted in the
local community by both local residents and other agencies
such as Housing Department.

In times of staff cutbacks, non-statutory work with adults
tends to have low priority in area teams, so it is possible
that these residential workers, by their innovative approach
and desire to improve the service they provided, were also
taking over much of the rôle previously seen as belonging to
fieldworkers and were becoming the key workers in a
developing 'core and cluster' system of care in the
community. The difficulty and quality of their work was
recognised in the Annual Report 1985-86.

Day Care

Newcastle's principal day care resource was the Welford Day
Centre. This purpose-built centre opened in 1968 on land
adjacent to and previously owned by St Nicholas Hospital.
It was designed to provide industrial therapy for 140 people
on a five day per week basis. However, the intensive and
structured organisation of the centre was quickly found to
be unsuited to many people who needed day-care in a more
flexible and supportive environment.

The centre was also not attractive to many younger mentally
ill people and did not meet the needs of "the behaviourally
disordered whose unhappy and disruptive lifestyle alienates
them from existing facilities" (Newcastle City Council,
1985c, p.5). Rising levels of unemployment and changing
ideas about the aims, size and location of day care
facilities also helped to make the centre's location,
original design and purpose increasingly inappropriate, but
since it was an expensive resource which could not easily be
replaced or disposed of, considerable thought was given to
modifying its role and character. Accordingly, day care for
40 mentally frail old people was provided in part of the
building, and the programmes and activities available for
the other attenders were gradually diversified.

Plans were drawn up to develop a range of smaller, locally-
based day-care facilities with an emphasis on user
involvement. Welford was to remain as a specialist resource
and assessment centre (Newcastle City Council, 1985c, p6).

These plans, like those for developing residential services, were severely curtailed as a result of the financial pressures on the Local Authority.

Other Social Services Resources

Social workers had been involved in establishing and running a number of clubs in the community. Some schemes had resulted from the local resource development project which each social worker taking part in the "Skillmill" mental health training course is required to undertake. Many social workers were keen to extend their involvement in such activities, but financial cutbacks led to the imposition of increasingly strict priorities on work undertaken which not only made it extremely difficult for workers to set up new projects, but also according to key informants, threatened the continuation of some existing ones.

Provision by Other Statutory Agencies

Two further agencies in Newcastle were closely involved in providing help and services to significant numbers of people with chronic mental health problems, although this was not the primary purpose of either.

Northumbria Probation Service maintained a team of four
Probation Officers and a day centre at Pitt Street,
Newcastle, to meet the needs of homeless clients,
particularly those people of 'no fixed abode' appearing
before the city's courts. The Wayside Day Centre began in
1973 as a voluntary project run by Probation Officers and
volunteers. The centre was located on the Quayside until
1984 when it moved to its present premises with much better
facilities. It had been fully funded by the Probation
Service since 1975, and at the time of the study had a staff
of seven, including a team leader and a specialist
resettlement worker, plus 50 or 60 volunteers who performed
a wide range of tasks. The centre's objectives were:

"1. To provide physical comfort and shelter,

 2. To act as an advice and referral centre for a variety
of problems, e.g. homelessness, welfare rights, alcohol
and psychiatric difficulties, etc.

 3. To encourage the building of relationships between
users, staff and volunteers through an informal friendly
atmosphere and a variety of social activities, outings and
interest groups."
(Wayside Day Centre: Information leaflet).

The centre operated every day except Saturday and was open
to both men and women, although few women used it. Not all
users were ex-offenders but the key informant from the
project estimated that as many as 75% of users had
significant psychiatric problems. Users varied widely in
age, although the numbers of young people were increasing.
Most tended to be living in the Cyrenians or Salvation Army
hostels, or in a variety of bed and breakfast accommodation,
and most were local people.

The Probation Officers at Pitt Street saw themselves as having an important educational function on behalf of homeless people, particularly by challenging in the courts the popular myth of the tramp.

Staff of the Haven Project, a voluntary organisation run in close collaboration with the Probation Service, shared the Wayside offices. This project provided temporary (up to one year) supportive accommodation to homeless people known to the Probation Service, and in 1987 it provided 21 places in four houses (Haven Project Annual Report, 1986 - 87).

The Bridge Medical Centre had been operating since March 1981 and arose out of the 1976 DHSS Circular on the Health Care Needs of Homeless People. SHOT (Single Homeless on Tyneside) and the specialists in Community Medicine played leading rôles in establishing the centre, which aimed to meet the health care needs of homeless people who were frequently unable to gain access to medical services through the normal route of being registered with a general practitioner. The project was planned as a joint Health Authority/SHOT service, funded under Inner City Partnership arrangements, although it had received mainstream funding since 1983. The full-time post of centre co-ordinator continued to be funded by Inner City Partnership monies through SHOT, so that the co-ordinator was accountable to the voluntary organisation, rather than the Health Authority. The co-ordinator at the time of the study was a nurse who also had experience of working at Wayside.

At the time of the study the services provided by the centre, which is located in an old Coroner's Court building

beside the Swing Bridge, included a full-time nursing auxilliary; five general practitioner sessions per week (i.e. one two-hour session per day, including two run by a community physician); five district nurse sessions running at the same time as the general practitioner sessions, and five sessions by community psychiatric nurses. The high involvement of the latter is a reflection of the extent of significant mental health problems among users, estimated by the co-ordinator at around 50 - 55%.

The experience of the Bridge Medical Centre was similar to that of Wayside in that the majority of users did not conform to the traditional stereotype of the tramp, with half of their users coming from the Northern Region and a further 21% from Scotland.

Like Wayside too, the Bridge Medical Centre saw an important rôle for itself in educating other agencies about homeless people and their needs. However, this sometimes presented problems, firstly of confidentiality, and secondly (and perhaps surprisingly) because in the centre's experience homeless people who needed admission to hospital were more likely to be admitted if they were dirty and unkempt, conforming to the stereotyped image, whereas the co-ordinator felt it was important for their self-esteem to offer them the opportunity to shower and have a shave before they attended hospital.

In the co-ordinator's view, acute mental health crises tended not to present problems because they could usually be dealt with by short term admission to hospital. Chronic problems and needs were generally more difficult to

recognise and to meet, because of a lack of understanding or collaboration (or both) by others within the mentally ill person's network, be they other agencies, carers or other users. The co-ordinator saw identifying and representing users' needs as an important part of his rôle.

Although initially referrals from other agencies had predominated, by the time of the study 75% of users of the Bridge Medical Centre referred themselves, having heard about it by word of mouth. This suggested that the centre is succeeding in its aims of accessibility and acceptability to potential users.

Local Authority Housing Provision

The housing situation in Newcastle was noteworthy in a number of respects, some of which were relevant to mentally ill people. As previously noted, Newcastle offered sharp contrasts between poverty and affluence and this was reflected in its housing.

As in other major cities there was a visible problem of single homeless people walking the streets. However, unlike many other cities, Newcastle had no public sector or large scale commercial lodging houses (Newcastle City Council, 1986c). Many of the Tyneside flats in Newcastle (which as in Gateshead had traditionally provided a substitute for bedsits) were being sold or demolished, especially in the inner city areas, and replaced by accommodation for families

or expensive apartments. This process of the displacement
from the inner city of existing residents was being
accelerated by major redevelopments schemes on the Quayside
and in the West End, intended to create "yuppie-style flats"
in a "major new housing, office and leisure complex"
(Evening Chronicle, 30/6/1987). Such gentrification,
following the earlier concentration of welfare facilities in
the poorer, inner-city areas described above, clearly
reflected the process of the displacement of mentally ill
and other vulnerable people which has been well documented
in North America (Dear and Wolch, 1987).

Collaboration with private developers in schemes of this
type reflected the City Council's basically pragmatic
approach to housing in the city, and had increased as the
council's own resources had decreased, but there was also a
tradition of extensive involvement with Housing Associations
and voluntary organisations. Those aspects of the current
housing situation which will be discussed here include the
policies, organisation and management of the Housing
Department; houses in multiple occupation; homelessness, and
the role of Housing Associations. The important rôle of
voluntary sector provision in the city will be discussed
below.

According to the Housing Annual Report for 1987/88, "the
central problem for housing in the City remains one of
underinvestment rather than one of tenure" (Newcastle City
Council, 1988 p62). The City Council then owned 46,000
dwellings out of a total housing stock of 115,000. The
Council stock varied from houses and tenements built soon
after the First World War to deck access flats and numerous
multi-storey blocks built in the last twenty years. As in

Gateshead, a variety of design and structural faults had led
to the demolition of a number of blocks in recent years.
9.7% of the stock (mainly better quality family houses) were
sold after 1980 under the right to buy. This relatively low
figure may have been due to the fact that 75% of current
tenants were in receipt of housing benefit (Newcastle City
Council, 1988). It also meant that the City's capital
receipts from sales were very low, which carried
implications for future capital programmes (Pickstock,
1987).

The major concern of the Housing Committee and Department in
recent years had been to try to maintain and improve the
quality of its housing stock despite severe restrictions on
spending. It was estimated in 1987 that £176 million was
needed to bring existing stock up to standard (Newcastle
City Council, 1987). However, between 1979 and 1987,
allocations by central government to Newcastle under the
Housing Investment Programme fell by 65% in cash terms, and
for the year 1987-88 (in spite of being one of only eight
authorities still receiving Housing Subsidy) the City
received only £8.4 million, which represented 20% of its bid
(Newcastle City Council, 1988). As a result, the new build
programme, which in 1979-80 accounted for £10.2 million (45%
of total spending), came to a standstill in 1986.

The two main aims of the City's housing policy therefore
became: to devote what capital resources it had available
"to repair, improve and replace the City's housing in order
to arrest the deterioration in the existing stock" and to
provide "a focus for effort and positive direction for
others, including housing associations, builders and

building societies" in meeting emerging needs (Newcastle
City Council, 1988, p60).

In an attempt to improve its stock in the face of chronic
underinvestment, the Council made use of a number of
innovative ideas. These included the leasing of the central
heating systems installed in council properties, the
disposal of land which the City could not afford to develop
itself to private developers for 'build for sale' schemes,
and partnerships with housing associations to improve
existing dwellings for rent and for sale. (e.g. the
Rochester and Cowgate Estates and Northbourne Street)
(Newcastle City Council, 1988, p61). The improvement and
subsequent sale of previously hard-to-let stock inevitably
further reduces the accommodation available for people, such
as the mentally ill, who have little realistic prospect of
buying a home.

Housing Associations

Given that the Housing Investment Programme Allocation for
the city in 1986/87 was £9.75 million, the total figure of
£4.8 million for Housing Association investment for the same
period indicated the significant rôle then played by this
sector in housing in Newcastle and

> "reinforces the benefits of the City working
> closely with Associations and the Housing
> Corporation in order to ensure that investment is
> directed in line with the City's priorities"
> (Newcastle City Council, 1987, p17).

Equally however, the ability of the council to identify clear rôles for Housing Associations within the City's housing strategy had encouraged the allocation of funds by the Housing Corporation (Newcastle City Council, 1986a). Some of the ways in which the City Council worked with Housing Associations - renewal, investment in older properties, low cost home ownership - have been indicated above. A further important rôle resulted from "the Authority's general policy....not to provide special needs or emergency housing itself but to support its provision by the voluntary sector" (Newcastle City Council, 1986c p18), which included Housing Associations.

By 1986, Housing Association properties represented 10% of the City's rented stock and this stock was increasing by around 80 new-build units a year, a contribution which was particularly significant when the City Council lacked the resources to maintain a new house building programme itself. (Newcastle City Council, 1986a).

Houses in Multiple Occupation

"The Authority is committed to enforcing the standards it has set for multi-occupied property throughout the HMO sector, with the aim of securing gradual improvements in conditions in the sector" (Newcastle City Council, 1986c, p3).

It was known that substantial numbers of people in Newcastle (including many students) were living in multiply occupied accommodation, but in spite of the above declaration, the City Council's policy towards them appeared to be unclear in some respects.

There was considerable uncertainty about the exact numbers of such houses. In 1986 the Environmental Health Department was aware of more than 1,100 properties occupied as shared accommodation or houses in multiple occupation, but estimated that the figure might be as high as 2,000 properties. (Newcastle City Council, 1986c). In 1987, 40 establishments offering boarding accommodation to homeless people were known to exist (Newcastle City Council, 1987a).

Conditions in many of the HMO's were known to be poor: a major report in 1986 stated that:

> "Of 160 properties which have been inspected by the Environmental Health Department as a precursor to registration 148 were found to fall short of the standards required by the Authority (Newcastle City Council, 1986 b, p13).

The City Council devoted substantial resources to the HMO sector. In 1986 it was estimated that there was

> "the equivalent of 12 full-time officers in 6 departments involved in local authority activity which is directed specifically at controlling and monitoring conditions in the HMO sector". (Newcastle City Council, 1986c, p2).

The departments involved were: Environmental Health, Engineers, Planning, Housing, Social Services and Administration (Newcastle City Council, 1986c).

This report (Newcastle City Council, 1986c) recognised that the need for greater interdepartmental cooperation, but advised against the formation of a single multidisciplinary team to deal with houses in multiple occupation. However, a later report by the City Planning Officer indicated that problems of policy and interdepartmental coordination persisted (Newcastle City Council, 1987b).

A registration scheme was introduced in 1985 and "owners are now taking advantage of (this)" (Newcastle City Council, 1988 p.16). Legal action had resulted in some cases: in 1986 Control Orders were made on six properties, all managed by one person (Newcastle City Council, 1987a) and the Housing Annual Report 1987-88 stated that "It is anticipated that the level of statutory action to remove some of the worst housing conditions will increase" (Newcastle City Council, 1988 p16).

The appointment of a Tenancy Relations Officer recognised the need to anticipate and deal effectively with the effects on residents of illegal eviction or harrassment by landlords as a result of enforcement action by the Council (Newcastle City Council, 1986c). In 1986-87 he dealt with 60 allegations of harrassment or illegal eviction in the private sector, and three cases were successfully prosecuted (Newcastle City Council, 1987a).

One further way in which the Housing Department attempted to address the problems of poor quality accommodation in the HMO sector was by itself providing furnished flats to rent. In 1986 there were 60 such units, and additional units, some offering more intensive management services, were planned (Newcastle City Council 1986c). Such flats would seem to offer a real alternative (albeit at the cost of some individual choice) to people whose only other option was to live in HMO's. They also provided a solution to the increasing difficulties in furnishing a tenancy faced by people dependent on Social Security benefits.

In spite of these positive aspects of the Council's approach to the HMO sector, its policies had been the subject of criticism, especially by the Newcastle Houses in Multiple Occupation Group.(1) Criticisms centred around two major explicit qualifications to the Council's policy. Firstly, although the objective of

> "the activity is to control conditions for tenants in the HMO sector.....Emphasis has recently been shifted from serving notices which can result in the payment of mandatory grants or the Authority undertaking work in default towards the use of a registration scheme to achieve the same effects without either the use of grants or the need to do work in default" (Newcastle City Council 1986, p20).

This position was in sharp contrast with Gateshead's policy and commitment of additional resources, described in Chapter Four. Whilst it was obviously prudent for any authority not to spend its scarce resources when other sources of financing were available, it could be argued that this shift in approach cast doubt on the strength of the Council's committment to enforcing better conditions in the HMO

sector. This impression was reinforced by the context in which the conclusions and recommendations of the 1986 report on houses in multiple occupation were set:

> "The private HMO sector is likely to remain as a feature of the local housing market for the foreseeable future. It is a flexible and adaptive response of the market to changing conditions which provides accommodation for certain groups who are not provided for elsewhere in the system" (Newcastle City Council, 1986d p3).

The Newcastle Houses in Multiple Occupation Group criticised this statement on the grounds that:

> "This implies that the Local Authority see HMO's as playing a role....that they themselves are unable or unwilling to meet. The role of the local authority is implicitly seen as a role of providing primarily for the traditional needs, that is for the family, and therefore the HMO sector is needed and no major initiatives to tackle the needs of those in the sector are required; merely tinkering with the present system is seen as sufficient." (Newcastle HMO Group, 1986 p2)

The group further criticised the Council's lack of clarity about its objectives and means of achieving them, as well as its reluctance "to use the full legal powers available" (Newcastle HMO Group, 1986 p4), and in spite of some positive aspects of its policy towards this sector, the Council's repeated references to the risks relating to the success of its enforcement action suggests a degree of equivocation (Newcastle City Council, 1986 c & d).

Homelessness

The numbers of people presenting and accepted as homeless in
Newcastle have been far higher than in either Gateshead or
Derwentside as Table 6.1 shows:

Table 6.1

Homelessness in the Study Area

	N'castle (1987)	G'head (1988)	Derwentside (1987)
Numbers claiming homelessness	2574	1057	253
Numbers accepted as homeless	1416	393	17

Note: 1988 Figures for Derwentside not available.
        1987 Figures for Gateshead not available.

Source: CIPFA (1987): Homelessness Statistics, 1987-87
Actuals.
CIPFA (1988): Homelessness Statistics, 1987-88 Actuals.

Separate figures were not kept of those people in priority
need and vulnerable through mental illness, but the key
informant from the Housing Advice Centre estimated that
between 130 and 150 of the 217 people recorded as vulnerable

because of physical or mental disability in 1987 were
mentally ill (ie. up to 70%). These were mainly older,
single people.

Policy on Homelessness

Newcastle in general made a broad interpretation of
vulnerability under the homelessness legislation, including
young people aged 16 and 17 years and people living in night
shelters or bed and breakfast accommodation (Newcastle City
Council, 1986).

According to the key informant from Housing Department,
policy concerning vulnerability had never been codified, and
operational decisions were made by management staff:

> "Basically, if a professional with responsibility
> for you says this person should have a local
> authority guarantee of accommodation, they
> (Housing) will accept that".

However, according to this key informant, the Council did
not recognise people with problems of drug and alcohol abuse
as being vulnerable, because it was considered politically
unacceptable to do so, in spite of evidence that they were
vulnerable to financial and sexual exploitation and were
unable to compete in the housing market.

All homelessness applications were dealt with by the Housing
Advice Centre. The Housing Department itself provided a
variety of accommodation for people accepted as homeless.
There was a total of 49 furnished flatlets in three blocks
at Hill Court, Pitt Street. The third block was bought into
use in 1987 in order to reduce the need to use commercial
bed and breakfast accommodation (Newcastle City Council,
1987a). In addition New Bridge Street Hostel provided 22
beds for both single women and women with children. The
extensive temporary accommodation which was also provided by
a wide range of voluntary organisations will be discussed in
the section on voluntary organisations below.

Around a quarter of all applicants were rehoused directly by
the City Council (Newcastle City Council, 1987a). Others
were placed in temporary accommodation, including commercial
bed and breakfast accommodation. In the eighteen month
period up to September 1987, there was an average of 30
households in such accommodation at any one time (Newcastle
City Council, 1988). Thanks to efforts to reduce this
(detailed below), average numbers fell to less than six in
the six months to March 1988, and it was hoped to reduce
this still further (Newcastle City Council, 1988).

The key informant from the Housing Advice Centre commented
upon Newcastle's rôle as a magnet for homeless (as well as
non-homeless) people in the region, and put forward two
specific reasons for this, in addition to the dearth of
provision in some neighbouring local authority areas.

Firstly, the catchment area of most Newcastle-based
voluntary organisations extended beyond the city itself;

therefore these organisations were involved with significant
numbers of people outside the city who tended to be drawn to
their facilities within it. Secondly, Newcastle Housing
Department operationally defined a 'local connection' under
Section 18 of the <u>Housing (Homeless Persons) Act</u> 1977 as six
months residence only or, in the absence of a residential
connection, took a broad view of the other types of local
connection specified in the same section. In the experience
of this informant, if people were able to establish
connections with more than one local authority, they would
almost always choose to be rehoused in Newcastle.

Housing Department Structure and Management

The City Council had in recent years attempted to create a
more efficient and accessible housing management service
which involved a fundamental restructuring of the Housing
Department. At the end of 1988, the last of 23
neighbourhood offices, each housing a neighbourhood team,
was opened. These offices were the key element in the
creation of a decentralised, locally based service, and
dealt with all aspects of rent collection, repairs,
allocations and housing benefit. The Audit Commission
commented on the restructuring:

> "....In all well managed housing authorities,
> there is a distinctive management style....such an
> attitude is reflected in the Neighbourhood Offices
> in Newcastle upon Tyne". (Audit Commission, 1986).

The 23 neighbourhood teams were accountable to six Area
Housing Sub Committees, which had ward councillor

representatives and delegated budget control, and one of
whose aims was to provide specific responses to local
problems (Newcastle City Council, 1987a).

The attempt to develop a more responsive style of housing
management involved a number of other developments,
including 'Estate Action Schemes' which introduced the
intensive management of some 'hard to let' blocks of flats
(where mentally ill people were frequently being offered
tenancies); tenant participation in the design of some
improvement schemes with particular efforts to involve
residents from ethnic minorities; and better monitoring of
the waiting list.

The Housing Annual Report for 1987/88 stated that:

> "Efforts to update the waiting list for applicants
> have been intensified, and contact is now made at
> least once every three months with single people
> in less secure accommodation, and every month with
> people in short stay or emergency accommodation"
> (Newcastle City Council, 1988 p24).

In addition regular housing advice surgeries were held at
the Salvation Army Men's Palace and the Cyrenians
Nightshelter. Other applicants were contacted every six
months. As a result of this closer scrutiny, the numbers on
the waiting list fell from 12,469 in 1986 to 5,389 in 1988.

Equally there was far greater contact with those people in
insecure types of accommodation who were often in the
greatest housing need but often lost their place on the list
by having to move on. At the same time, there were changes

in the points allocation system so that the household's
points total reflected housing need rather than simply
length of time in the queue. These steps also resulted in a
reduction in the length of time that people had to spend in
temporary accommodation between being accepted as homeless
and in priority need, and being offered a permanent tenancy.

Improved monitoring of the waiting list was made possible by
the computerisation of Housing Department records, and this
was to be backed up by an "extensive" training programme for
staff in the Neighbourhood Offices, including training in
interviewing (Newcastle City Council, 1988).

One further aspect of changes to housing management was the
attempt to minimise the negative effects of the discretion
exercised by staff at local level. As one of the key
informants in Housing Department reported:

> "We recognise that you need discretion, but
> prejudices are inevitable. What we try to do is
> to formalise the areas that they are going to
> affect in the policy and monitor them".

However another informant made a number of criticisms about
the way in which these intentions were being implemented in
practice. He said that although decentralisation had been a
major priority for a number of years, little consideration
had been given to the resulting increased demands from local
people. In addition insufficient resources had been made
available to make either monitoring or training effective.
In the former case, there were no clear guidelines for the
allocation of discretionary points and there were no
systematic checks on individual managers at a local level;

in particular there was no monitoring of points allocation.
In this person's view, strong monitoring was essential
because the same individuals were responsible for both
allocation and management of tenancies.

According to the same informant, it was departmental policy
not to have a training officer. Although some training on
the organisational change, race issues and implementation of
the revised lettings policy had taken place, responsibility
had been given to individual local managers. Left to
individual effort and with a lack of necessary back-up and
resources, the training programme was said to have petered
out.

Special Needs Joint Sub-Committee

In addition to the six Area Housing Sub-Committees, there
were a further four sub committees of the main Housing
Committee, of which the Special Needs Joint Sub Committee
was of particular interest to the present study.
Representatives from Housing, Social Services, Environmental
Health and Administration Departments attended this group,
as well as those from a wide variety of voluntary
organisations concerned with housing issues in the city.
This sub committee dealt with issues concerning homeless
people and houses in multiple occupation. It also carried
responsibility for the Single Persons Support Scheme, and
had promoted the adoption of specific policies towards a
variety of identified vulnerable groups, including women and
mentally ill people.

The **Single Persons Support Scheme** had been set up in 1983 to offer help during and for a limited period (between three and six months) after rehousing by the City Council, in recognition of the fact that people who have been homeless or in insecure accommodation may face particular problems in re-establishing themselves in a permanent home.

The scheme claimed to differ from apparently similar schemes in other cities in "very significant ways". These included: in the Newcastle scheme, the decision about readiness for rehousing and the assessment of the individual's needs lay with the applicant rather than the worker; and the scheme "trie(d) to treat all applicants as potentially successful tenants" in the belief that

> "the vast majority of applicants are ordinary
> people who happen to be homeless. They do not
> need social working or counselling outside the
> expertise of the SPSS" (Newcastle City Council,
> 1985a, para.1.6).

The scheme operated on the basis of the individual's expressed preferences, but in practice the major rôle of the three support workers was in negotiating, or helping the applicant to negotiate, with DHSS and the wide range of other agencies involved in the detailed and time-consuming tasks of setting up an independent home. They were involved in helping applicants with budgeting as well as maximising income and entitlements.

In spite of the fact that the report stressed the need to respect individuals' existing social networks, suggesting

that it might save management resources if people were rehoused as near as possible to a familar area, around three quarters of people referred to the scheme were rehoused in only three areas of the city - Cruddas Park, North Kenton and Walker (all "hard-to-let" areas).

All the support workers were trained in welfare rights work with single people, but faced with diminishing Social Security benefit entitlements for furniture, etc., and workloads of between 25 and 35 tenants each, it had become increasingly hard for them to give sufficient time, particularly to complex problems. There had been two major responses to these increasing pressures: support workers had concentrated on providing advice sessions in local housing offices, and at the Housing Advice Centre (Newcastle City Council, 1988); and the Council had considered the creation of more furnished tenancies (Newcastle City Council, 1987a).

The Single Persons Support Scheme had made continuing efforts to measure its effectiveness in comparison with similar schemes elsewhere. Significantly, a report on the opeation of the sheme noted that:

> "Only in Glasgow do the results vary significantly from (SPSS), and **this appears to be because of the very favourable worker-applicant ratio, and the high standard of offers made to applicants".** (Newcastle City Council, 1985 a, para 14.4) (Emphasis added)

This comment would seem to indicate a recognition that successful outcome for some vulnerable people was related to the quality of accommodation and level of support received. Although the report indicated an encouraging level of

success in its ability to help single people to resettle into permanent tenancies, the level and duration of the support which its workers were able to offer were clearly limited. Although there was an obvious need to increase the numbers of staff involved, there had been no suggestion of this in published reports. Equally, there had been no indication of how the work of this scheme was complemented or continued by the intensive housing management schemes which operated in some of the properties where single people were likely to be rehoused; and the Council had not adopted housing management of the style and intensity successfully operated at the Sallyport Crescent project by Tyneside Housing Aid Centre (see below).

Policy towards Mentally Ill People

The SPSS Progress Report noted:

> "There is only one group that causes special difficulties....a number of people experiencing multiple problems including mental illness or disability". (Newcastle City Council, 1985 a, paras 14.6 & 14.7).

Newcastle City Council accordingly developed an explicit policy relating to the housing needs of people with mental health problems. A report to the Special Needs Joint Sub Committee by the Director of Housing and the Director of Social Services recognised that "accommodation is a significant part of the community care programme" for mentally ill people, and made two proposals:

"(i)   That because of the particular needs of the
mentally ill, the Housing Department and the
Social Services Department should jointly
determine the nature of accommodation within the
existing stock which would be most appropriate for
individual clients and the priority which should
be accorded in attempting to secure such
accommodation.

(ii)   That accommodation offered, which may be
single units or group living units, be let not on
the medical points system but outside of the
constraints of the points scheme giving regard to
the special needs of the individual." (Newcastle
City Council, 1985b, para 4).

These proposals were agreed, and working arrangements to
implement them were published in January 1986, including
detailed requirements for a "Care Package Statement". The
working arrangements are included as Appendix Nine. The
implementation of this policy will be discussed further
below in considering relationships between agencies and
departments.

Voluntary Organisations

The proliferation of voluntary organisations of all kinds in
Newcastle and their rôle in overall service provision
contrasted sharply with those in the other two areas of the
study. Some indication of their scale and importance within
the city could be gauged from the provision of a large
modern office building in the city centre to house voluntary
organisations; and the existence of a large and long-
established Council for Voluntary Service, with a number of
paid staff and a training unit for social work students.

A number of national organisations such as NSPCC and
Barnardo's had regional offices based in Newcastle; other
national organisations such as the Family Service Units and
Save the Children Fund operated projects or units within the
city. There were also numerous local voluntary
organisations of varying size and budgets. Apart from the
obvious suitability of Newcastle as a regional base, the
number and variety of voluntary organisations would seem to
be directly related to the City Council's past policy
towards them.

In some instances, it was Council policy that certain
services or resources should be provided by voluntary
organisations rather than the Council. This particularly
related to the provision of special needs or emergency
accommodation (Newcastle City Council, 1986c), and in
1985/86, the Housing Committee allocated £275,000 (including
Inner City Partnership monies) to voluntary organisations
involved in homelessness.

In many other cases the Council actively encouraged the
provision of services which complemented or supplemented its
own by making grants to a wide range of voluntary
organisations. Thus in 1986/87, Social Services Committee
grants to voluntary organisations totalled £725,000. This
represented a reduction of £100,000 from the previous year
(the result of rate-capping), and did not include £396,000
Inner City Partnership grants. Ten organisations received
grants of £20,000 or more. After 1985 the City Council also
gave rate relief to a number of charities in order to reduce
the need for grant aid (Newcastle City Council, 1986e). In

addition the Health Authority contributed to voluntary organisations through grants and the joint funding of some projects, such as the Newcastle Association for Mental Health Advocacies Project (see below).

It should be noted that, whilst the City Council itself made a level of provision for mentally ill people which was above the national average, it also spent significant amounts on voluntary sector provision. The services offered by voluntary organisations to people with mental health problems in Newcastle was extensive, and the list which follows is unlikely to be exhaustive, not least because projects changed and were being initiated at a rapid rate. Inevitably, the discussion is selective and certain projects or services which appeared to be particularly significant as examples of good practice, or which offered an important perspective on the situation of mentally ill people are discussed in more detail than others.

The resources of the voluntary sector will be discussed in two sections: firstly, those specialised organisations which provided services specifically for people with a mental illness; and secondly, those organisations not specifically concerned with mental illness, but for whom people with severe mental health problems made up a significant proportion of their users, most notably those organisations working with homeless people.

Organisations providing for mentally ill people:

There were three principal organisations which made
substantial contribution towards providing services for
people with mental health problems. For two of these
(Newcastle Association for Mental Health and the Northern
Schizophrenia Fellowship) the problems caused by mental
illness were their raison d'être. They are discussed here,
although both were also involved in the direct provision of
accommodation for people with mental health problems. The
third body, the Society of St Vincent de Paul, is a
nationwide Roman Catholic philanthropic organisation which,
in response to perceived local needs, had developed a
significant involvement in mental health services in
Newcastle and other parts of Tyneside. Since it is
primarily involved in developing accommodation for mentally
disabled people, its activities will be discussed in the
section on housing, below.

The Newcastle Association for Mental Health was established
in 1971 as Newcastle's local association of MIND. By the
end of 1988 the association was involved in a number of
projects, each of which was based on the principles of
supportive rather than a medical model of service; the
encouragement of self help; and complementing, rather than
duplicating, existing services. Each project had a
Management Committee made up of professionals, users and
volunteers, which is accountable to the Association's
Executive Committee. Projects at the time of the study
were: Forest House Hostel, the Tosson Terrace Project; the
Dilston Road Centre and the Newcastle Advocacies Project.

Forest House, Forest Hall, was a staffed hostel opened in 1975 which provided bedsit accommodation for eight former psychiatric patients. The aim of the hostel was to give them "a stable environment in the community to enable them to learn to readjust to life outside institutions" (HAS, 1982, p66). The hostel also had a two bedroomed flat above the premises used by the Tosson Terrace Project as an intermediate resource for people almost ready for independant living.

The Tosson Terrace Project was established under joint financing arrangements in 1982 in a corner terraced house in Heaton. Staffed by a full-time co-ordinator, a substantial number of volunteer helpers and until August 1988, two part-time Community Programme Workers, the project's activities varied. At the time of the study they included a drop-in centre, individual supportive counselling, several groups (including a young person's group, a women's support group and a depression management group) and a task-befriending service.

The Dilston Road Project in the West End of the City was, at the time of the study, a recent innovation, aimed specifically at providing help to local people from ethnic minorities.

The Newcastle Advocacies Project came into operation in August in 1988 with the appointment of a full-time advocacy worker after more than two years' planning and negotiation with the Health Authority. Although the scheme was only in preparation at the time the study took place, it is described in some detail because it was concerned

specifically with patients in St Nicholas Hospital and
because of its obvious relevance to some of the issues
arising from the study.

The project was financed under joint funding arrangements
until April 1991 and was based on the St Nicholas Hospital
site, although its brief related to the whole of the Mental
Health Unit. The aims of the project were twofold: to
assert the rights of users of mental health services, and to
promote user views and support users in obtaining a greater
voice within the service (Whitehill, 1988). According to
the Advocacy Worker who had herself experience of using
mental health services:

> "Advocacy has come to symbolise the 'empowerment'
> of service users. In other words, a means by
> which users are enabled to:-
> -make their own choices
> -articulate their needs to service providers
> -create structures within which these needs can be
> represented and acted upon.
> (Whitehill, 1988, pp2-3)

The project focussed on developing three main areas. These
were: self advocacy (encouraging users to speak up for
themselves wherever possible and exploring ways to do this);
collective advocacy (based on the principles of traditional
self help groups, and now developed by encouraging the
creation of Patient's Councils) and Citizen Advocacy, which
recognised that some patients were so disabled by age,
psychiatric condition or institutional living that they
found it virtually impossible to express their own needs.
In order to ensure that the needs of these patients received
consideration, the project planned a scheme whereby

volunteers were trained and matched with individuals so that they could speak on their behalf.

The Advocacy Worker and the project's Management Committee recognised that:

> " 'Empowerment'for service users alone will not bring about a change in mental health services. Both service users and providers need to feel valued. A dialogue must be maintained to enable users and providers to work together to develop a more valued service, responsive to the needs of those it serves." (Whitehill, 1988, p3).

Despite early indications that the project had been "positively received by patients, staff and management" (Whitehill, 1988, p5), the increasing problems which the project encountered demonstrated the challenges which genuine involvement of users in mental health services presents.(2)

Northern Schizophrenia Fellowship

The Fellowship's activities within Newcastle have been varied and the Newcastle self help group was the first in the area. At the time of the study, the Fellowship was involved in two projects in Newcastle: the hostel at 40 Grainger Park Road, discussed in the previous chapter, and the New Way Out Club. The club operated on one afternoon and evening, and it differed from other Fellowship

activities in that it was set up by a number of young men diagnosed as having schizophrenia who were dissatisfied with the formal day care provision in the city. It therefore had the advantage of being very much their club, and volunteer helpers (and Fellowship staff) were present on the users' terms.

Voluntary Agencies and Housing

Emergency and special needs accommodation provided by voluntary organisations with the help of grant aid from the City Housing Committee was extensive, as Table 6.2 shows. It will be noted from the table that Newcastle "provides considerably more hostel spaces for women proportional to male accommodation than the national average" (Newcastle City Council, 1985a).

The schemes listed in the table fulfilled a number of different rôles. Some, such as Project 900 and Elswick Lodge, offered medium term hostel accommodation with specific therapeutic aims (preparing young people for independent living, helping people to deal with their substance abuse and its associated problems, etc.); Elswick Lodge in fact described itself as a therapeutic community. Others, such as Women's Aid and the Cyrenians, offered direct access accommodation for people who had literally nowhere to sleep. However, some also ran longer term hostels for those users who wished to re-establish a settled home, and most of the organisations above combined the provision of accommodation with an active campaigning rôle.

Table 6.2

<u>Voluntary Agencies' Housing Provision, Newcastle</u>

		<u>BEDS</u>	<u>NOTES</u>
Single Women Only	Portland Project	23	
	Salvation Army (Hopedene)	40	
	Catholic Rescue	16	
Mixed Single Women & Women with Children	Women's Aid	22	
Mixed Men & Women	Project 900	9	For young people leaving care
	Stepping Stones	9	For under 21's only
	SHOT (Armstrong Road)	13	
	Carr-Gomm	24	Infrequently used by women
	Elswick Lodge	18	For people with drug/alcohol problems – infrequently used by women
Men Only	Cyrenians Nightshelter	60 *	
	Salvation Army Men's Palace & Jubilee Lodge	130	
	St Christopher's	19	) Used as bail
	Ozanam House	19	) hostels
	Haven Project	16 **	For men known to probation

* Decreased to 55 beds in 1986
** Increased to 21 places in 1987

(Based on Special Needs Joint Sub Committee, Report on
Single Homeless Women in Newcastle, 24/10/1985) .

One of the organisations most prominent in the North East as a campaigning and pressure group was **Single Homeless on Tyneside**, which played a major rôle in establishing the Bridge Medical Centre and in work with residents of Houses in Multiple Occupation. However, because of the expiry of their grant from Inner City Partnership, SHOT suffered a 25% cut in income in 1987. This obviously led to a curtailment of their activities; it was decided that in the future their work in the area of HMO's would be reduced, and that they would, regrettably, not be able to take the lead in campaigning work as they had done in the past.

The work of two further agencies which provided accommodation and which formed part of the study will be discussed in some detail here: the Cyrenians because of their extensive experience in working with men in the most immediate and desperate need; and Tyneside Housing Aid Centre because of its rôle in setting up an exemplary project which had important lessons for those involved in both housing and mental health provision.

Tyneside Cyrenians was an independent organisation affiliated to the national body. The Cyrenians recognised that the reasons why people become homeless and destitute are varied and complex, and their philosophy was stated as:

> "We try to accept a man as he is, whether he is
> 'deserving'   or   not,   whether   he   can   be
> 'rehabilitated' or not and whatever his problem."
> (Tyneside Cyrenians, Publicity Leaflet, 1986)

Their primary aim was to establish centres where homeless
people could find acceptance, shelter, and support. These
took the form of overnight shelters, and short-term and
long-term residential homes (Tyneside Cyrenians, Publicity
Leaflet, 1986).

 At the time of the study the direct work of the Cyrenians
consisted of a nightly soup run in Newcastle; an overnight
shelter with 55 beds, and three staffed hostels (including
one in Gateshead), each offering short or long term
accommodation to ten or twelve men. The Cyrenians also had
nomination rights to sixteen single person flats provided by
North Housing Association, where men could live
independently but with support.

Around 80% of men in the hostels came there via the night
shelter, but according to the warden of the nightshelter,
who was one of the key informants, only a fairly low
percentage of nightshelter users wanted to be resettled.
Nevertheless at the time of the study, the resettlement
programme was working well, and a Housing Aid worker from
the City Council visited the nightshelter weekly to assist
men who wanted to move into a council tenancy.

Users of the nightshelter varied in age from 14 to 80 years,
and the warden estimated that around 55% of them had
significant psychiatric problems, including alcohol abuse
which was often secondary to other problems. Some of the
men's psychiatric problems were gross, although the warden
also felt that the mental health problems of some men
probably went unnoticed because their behaviour caused no
problems to others in the shelter.

The night shelter itself was housed in an old tobacco warehouse near the city centre, and physical conditions there were generally acknowledged to be poor. It was scheduled for closure in January 1989 because of expiry of the lease and planned redevelopment of the area. Already at the time of the study, there had been fierce local opposition to the possibility of relocating the shelter in four different properties around the city, and the question of the future was clearly a cause for concern on a number of levels: staff were very aware of hostility towards the organisation and the men who used it. They (all unqualified) showed some feelings of vulnerability to public and professional criticism. One key informant from a voluntary organisation, whilst acknowledging that the Cyrenians (and the Salvation Army) had a lot of knowledge about homelessness and people with mental illness, described the Cyrenians as being "goodhearted but lacking analysis".

Staff felt considerable concern about what would happen to present and potential users when the shelter had to close, and a fear that no-one at an official level was dealing with the issue.

However, most concern was expressed about the disturbing effects of the threat of closure on some of the users: some who saw the shelter as a refuge were showing considerable anxiety, and for one man with schizophrenia, the additional stress of the uncertainty was believed to be exacerbating his delusions.

Sallyport Crescent was an important project run by Tyneside Housing Aid Centre with the aim of demonstrating that

> "single people with difficult or chaotic housing experiences can live in their own permanent accommodation which is also independent" (Tyneside Housing Aid Centre, 1984, p78).

According to the project worker, many of the tenants had or had had significant mental health problems, although not always formally diagnosed.

The project's 42 flats became operational in August 1982, and its background and history are included as Appendix Twelve.

The three key elements of the Sallyport Crescent scheme were: firstly, that people should be offered independent, permanent tenancies "with all the rights and responsibilities that go with that" (THAC, 1984, p8). The project worker considered that security of tenure was an important factor in enabling people to change their previously unsettled lifestyle, and commented that there was no reason why "people cannot be mentally ill in good secure housing".

The second element was the style of housing management: the location of the project worker on the premises meant that management could be more intensive but also more flexible and sensitive, and that any problems - of rent, repairs, debts, etc., - could be picked up and resolved at an early

stage. The project worker's rôle also explicitly included a
community work component: "Although the work is management,
the method is that of community work" (THAC, 1984,p8).

This complemented the third key element of the scheme, self-
help, and in some respects, the development of this had been
the most positive and encouraging aspect of the project.
One of the flats had become a tenants' common room, managed
by them. It was well used for social contacts, and as a
source of advice and mutual help.

The scheme also recognised that, to be effective, "support"
must be multi-faceted and could not come from one person
only. In the project, support came from professionals; from
home helps, whose befriending rôle was often as important as
the practical help they gave; from the project worker, who
believed that "support" included the way in which a tenant's
request for repairs was responded to; and from other tenants
who provided companionship, practical help (eg, cooking
meals for someone discharged from hospital), and useful
advice (eg, where to shop, cheap local cafés) for each
other. Because some of the tenants had previously held
council tenancies but had allegedly been harried out of them
for a variety of reasons, the project worker believed
strongly that such a "community feel" was essential.

The project was not without problems at a number of levels,
including management difficulties and conflicts with and
between tenants. However, after the first two years of the
project, while twelve tenants continued to need "close
ongoing support", the remainder managed well with only about
ten of them needing occasional help with matters such as

filling in forms, budgeting, etc., and with tenants being increasingly able to turn to each other for help. This would indicate that the primary aim of demonstrating that many people previously considered unable to manage a tenancy could in fact do so had been fulfilled.

It was a further aim that the style of intensive housing management which helped to make this possible should be adopted by the City Housing Department in other properties. This appeared to have taken place only to a very limited extent, and without explicit recognition of Sallyport Crescent as the model. In 1987/88, for example, McCutcheon's Court, an estate of 200 single persons flats built in the 1950's, where people discharged from psychiatric hospital were often offered the 'hard to let' flats, a scheme involving a combination of physical, security and environmental improvements, a site-based Estate Officer and Resident Superintendent, together with the establishment of a community centre, "transformed the image of this estate" (Newcastle City Council, 1988, p.11).

The Society of St Vincent de Paul

Members of this Society have been undertaking voluntary visiting and befriending of long stay patients in St Nicholas Hospital for more than twenty years. Through this, some volunteers became aware of the difficulties faced by vulnerable former patients trying to survive the stresses of life outside the hospital. As a result, in 1981 two supported group homes were established in houses leased

through the Health Authority. The aims of the scheme were
to provide comprehensive care and a "home for life" in the
community for the residents.

At the time of the study the Society had ten properties
offering a variety of accommodation in the Wingrove Road
area of the city; suitable properties were obtained through
Enterprise 5 Housing Association, who were praised by
several key informants for the high standards of their
properties. The accommodation then offered by the Society
included three group living schemes, as well as independent
flats and a number of "mini flats", where each resident had
a separate bedroom and living room, but shared kitchen and
bathroom facilities with two or three others. In total
there were 23 residents. (In addition, late in 1986 the
Society opened a scheme in South Tyneside providing 22
places ranging from full board to independent living). The
Society also offered support to a number of vulnerable
people living in the North Kenton area of Newcastle.

The project was staffed by the Development Officer (whose
initial voluntary coordinator rôle had become a full-time
joint-funded post) together with at the time of the study,
eight part-time (25 hours per week) care workers, one full
time care worker and a supervisor, all funded by the
Manpower Services Commission. (The Society had already
developed contingency plans to ensure that the scheme could
continue even if workers were no longer available from this
source). Clearly, the numbers of staff involved meant that
high levels of support, far in excess of those usually
available in group homes, could be provided. None of the
staff was professionally trained.

According to the Development Officer, the care workers' rôle was to offer help at a personal level; they might help individuals with a variety of tasks such as cooking, shopping and budgeting according to need, but the focus was on helping people to live and work together, and to derive support and strength from each other. The importance of identifying and enhancing individuals' strengths was emphasised, and it was felt that busy professional workers were unable to devote the time or attention to detail which this required.

Of the 38 residents who had been accommodated in the five years since October 1981, 26 had been referred by psychiatric hospitals and a further eight from Newcastle Social Services' two hostels for mentally ill people. The 38 people bore a variety of diagnostic labels, but in all cases their problems were chronic and disabling. Twenty people remained settled within the scheme; six others had moved on to independent accommodation; three had died and only one had returned to hospital. Eight people had left the scheme because of "behavioural problems", nearly all of which were associated with alcohol abuse. A small number of residents came originally from Derwentside, and the Development Officer was happy to accept such referrals because of the lack of appropriate accommodation in Derwentside, so that such people could use the Society's homes and flats as a "back door" to services and eventual rehousing in Newcastle.

In general, the Development Officer considered that the scheme was working well, particularly at the level of

integration into the local community. Residents of the
project had also formed their own Residents Association. He
was critical of what he saw as the inappropriateness of much
hospital-based rehabilitation, and described the service
offered by the Society as "a natural form of rehabilitation"
in which people were able to grow in confidence and
independence, secure in the knowledge that they would not be
obliged to move on.

Whilst acknowledging the important rôle which the Society's
work had come to play in mental health provision in
Newcastle, a number of other informants expressed criticism
of what they considered were excessive levels of support,
which in their view some residents did not need and which
risked encouraging inappropriate dependence.

Relationships Between Agencies

Many key informants spoke positively of relationships with
other agencies or individual workers, and in many cases
formal links existed, with statutory agencies represented on
voluntary agencies' management committees, and voluntary
organisations taking part in aspects of Health Service
planning, etc. However, they also identified difficulties
in a number of areas. These included: problems with local
DHSS offices; between voluntary organisations and statutory
bodies, particularly the Health Service; and between the
Social Services and Housing Departments. The majority of
these problems were the result of differing policies on

priorities at an organisational rather than a personal
level.

Experiences of working with DHSS varied widely. The staff
of the Pitt Street Probation Team and the associated day
centre had clearly established close working relationships
with the local DHSS office, St. James, which had a
designated Probation Liaison Officer. At the other extreme,
the key informant from one voluntary organisation said that
they "never even attempted" to obtain help with furniture,
etc., for someone being rehoused by them because the
obstacles were so great and the process so time consuming.
The organisation instead had set up its own store of
furniture and houshold items, and this was much in demand by
workers from other agencies (including Social Services) as
well.

The hospital social worker key informant reported that
relationships varied a great deal with different offices.
There was "reasonable goodwill" with St. James, but many
problems with Saxon House because they were "breaking at the
seams", and staff there were under enormous pressure. This
informant said that the financial problems which could build
up during hospital admissions, especially where the person
had repeated brief admissions, were a particular worry; she
felt there was a need for a more routine package of direct
deductions (including heating as well as rent) for people
who were trying to manage on a low budget although she
recognised the possible conflict with a commitment to
maximising the individual's independence and control over
their affairs. At the time, deductions could only be made
once debts had built up. This informant said that dealing
with clients' financial needs and entitlements was "a huge

problem", the result of the conflicting aims of government departments. Her own team relied quite heavily on applications to charitable trusts, but not only were these becoming increasingly overburdened themselves, resulting in delays in obtaining a response, but she felt strongly that they should not have to be used routinely to obtain essentials for clients.

The enormous amount of time spent liaising with Social Security staff, acting as advocate for their clients and trying to obtain correct entitlements, as well as their frustration at the inadequacy of those entitlements to provide a home with even basic facilities, was stressed by all the key informants involved in direct work with service users.

However, in the opinion of the key informant from DHSS who was, among other duties, responsible for liaison with other agencies in the area, "the mentally ill are treated substantially more favourably under the regulations than the day to day claimant". Social Security offices had instructions to try to help the mentally ill, and Special Case Officers were appointed to do this. He recognised that there were difficulties in coordinating benefits payments on discharge and had asked St Nicholas Hospital for at least two weeks notice of discharge, especially for people being rehoused; this would enable his staff to make enquiries about the person's likely eligibility so that the benefits to which they were entitled could be made available on the day of discharge.

He felt that this was the best that could be achieved under
the regulations and that nothing more could be done to
lessen the stress of this situation for the individual.
Although direct payments for rent, fuel, etc., could only be
made when arrears had built up, his staff kept a watching
brief, and were prepared to consider deductions "at the
first signs of mismanagement".

This informant expressed some frustration about the effects
of recent Welfare Rights campaigns aimed at increasing take
up of single payments and additional requirements,
particularly in cases where, in his view, there was little
likelihood of entitlement. He said that his Department's
emphasis was rightly on processing weekly benefits, and
large numbers of special claims impeded this. In general he
felt that his office had good working relationships with
other agencies (which most of them endorsed), but that
formal liaison mechanisms were only in their infancy.

In some respects, this was for me the most frustrating of
the key informant interviews, since this informant, unlike
all the others, seemed to consider it inappropriate to
analyse or question the present system and its regulations
in any way, and that his rôle was simply to administer them.

In spite of - or perhaps because of - the substantial
resources allocated to them by both the City Council and the
Health Service, voluntary organisations in the study
reported that they experienced some difficulties in their
working relationships with statutory bodies, particularly
the Health Service. These problems were mainly on two
levels: that of the individual client, where cooperation,

information or indeed interest were not always forthcoming, and this problem will be explored in greater detail in the next chapter; and also at the level of financial control.

There were indications that some voluntary organisations, especially those whose work included a campaigning element, sometimes found their freedom of action constrained by their dependence on a statutory body for funding. This was a widespread problem not confined to organisations in the mental health field (Community Care, 4/5/1989).

The existence of the Special Needs Joint Sub Committee, had not removed some significant problems in working relationships between the City's Housing and Social Services Departments. Relationships at an individual level were often reported to be very good, with mutual goodwill and a willingness to listen, although this was not universally the case; one Social Services informant complained of the negatives attitudes towards potential tenants among local housing office staff, and their lack of willingness to listen.

Even those who spoke favourably of working relationships indicated that there were discrepancies between policy and practice. Problems here included those of availability of suitable tenancies, which resulted in delays in allocation and sometimes unrealistic promises. This created particular problems when someone was in hospital and there was pressure from the ward for discharge; this was a perennial source of friction between social workers and nursing and medical staff. The location of stock could also be problematic, although this was reported to be less so since Housing staff

had begun to look more sympathetically at the person's need
to be housed in a particular area. The lack of suitable
council accommodation in the immediate area of one of the
two Social Services hostels had led to much closer links
with a number of Housing Associations, and indeed a
preference for working with them.

Organisational problems could arise if an individual's
papers needed to be transferred from one neighbourhood
office to another, and contact with a committed individual
officer was lost. The boundaries of the five Social
Services areas and 23 Housing Neighbourhoods were not
coterminous.

The most serious instance of difficulties between Housing
and Social Services occurred, perhaps surprisingly, in
relation to the working arrangements for the policy of
rehousing mentally ill people. The experience of one
informant pointed to an obvious need for such arrangements,
but at the same time to a serious failure to implement them.

The working arrangements recognised clearly that each
individual required a range of services and support to
achieve or sustain community based living, and that these
services and supports required commitment and coordination
by all the professionals and agencies involved. Further,
this had to occur at all levels within agencies but there
were indications that this did not always happen.

One key informant gave the example of a single parent of two
children whose psychiatrist specified adverse environmental
conditions as a major trigger of her depression. The
workers of the residential hostel assessed the family's
accommodation needs in some detail (e.g. need to be close to
a supportive network of friends and other women; need for a
small, easy to run property with reasonably economic
heating, etc.). However, when the workers approached the
local housing office to negotiate on this basis, they met
with a very negative response. They felt that they were met
with "a wall of past-history as a bad tenant" and that the
local Housing Manager was not prepared to listen to
explanations of why previous difficulties might have arisen.
It was only after three meetings that Housing staff accepted
that long-term support from the hostel would be guaranteed,
and that it might not be "a case of throwing a tenancy
away". Eventually the woman was offered a tenancy in an
acceptable (though not her chosen) area, and since being
rehoused, "there have been no problems for anyone".

One key informant had been very frustrated by the apparent
lack of any formal channels of communication between
residential and field social workers and local housing area
managers. He only became aware of the existence of the
'care package' document (Appendix Nine) by chance in the
Summer of 1987 and subsequently established that almost no
workers in either Housing or Social Services who were in
direct contact with clients had any knowledge of it either:
this was almost 18 months after the working arrangements had
been accepted by both departments. With two colleagues,
this informant had initiated a small project in one social
services area to identify detailed examples of the
difficulties within the existing system, as a prelude to
developing more effective systems and channels of

communication. He commented that although good working relationships sometimes developed on an individual basis, there was a lack of processes, or even sound working principles between departments.

Conclusion

The account of the situation in Newcastle has been very extensive for two reasons. First, Newcastle had a far greater number and range of resources, particularly in the voluntary sector, than either of the other two areas. Second, in spite of these resources and the scale and thoroughness of its plans for developing care in the community, there were a number of difficulties which only emerged through a detailed analysis.

The levels of provision by both statutory and voluntary agencies of resources needed by mentally ill people were in general substantially higher in Newcastle than in the other areas of the study. Newcastle's plans also came closest to a genuinely comprehensive and multidisciplinary model of services. Nevertheless, problems persisted in maximising the co-ordination, and therefore the effectiveness, of those resources both at the level of the individual service user and at the policy level.

The conflict between the health authority and the local council demonstrated dramatically the lack of effective systems to ensure coordination at the level of service

planning. The lack of a unified approach among council departments to the problems of HMO's contrasted with Gateshead's response.

Some services appeared to be very successful on the criteria of accessibility and acceptability to users: the predominance of self-referrals to the Bridge Medical Centre was one indication of this. Sallyport Crescent was another example, and the two Social Services hostels also attempted to achieve this. However, it was recognised that some services, particularly Welford Day Centre, presented serious problems because of their location, size or style.

Services in Newcastle at the time of the study were the most comprehensive of the three study areas in terms the ability to offer a range of resources at the level of the individual, but these were sometimes less than effective because of lack of coordination. In the example of the joint Housing/Social Services Mental Health Policy, there appeared to be no method of monitoring whether this new policy, which had the potential to make a signficant contribution to the well being of mentally ill people, was being implemented; no attempt to inform those who should be involved in its implementation about it; and indeed no system to do so.

This discrepancy between what policy makers and managers initiate and believe to happen, and the experience of practitioners, will be explored further in the next Chapter.

Notes

1. "This group was formed early in 1984 to campaign to
improve conditions in the HMO sector in Newcastle. The group
consists of ex-residents of HMO's and workers from various
organisations including: THAC, SHOT and the Wayside"
(Newcastle Houses in Multiple Occupation Group, 1986, p.1).
Representatives from these organisations are also in
attendance at meetings of the Special Needs Joint Sub
Committee.

2. The project in fact experienced increasing difficulties,
and regretably was suspended in January 1990.

CHAPTER SEVEN

FRONT LINE VIEWS

The preceding chapters have shown that considerable changes
had taken place in recent years in those statutory agencies
in the area of the study which were primarily concerned with
the welfare of mentally disabled people in the community.
In many instances, new policies had been adopted, strategies
for their implementation had been developed, and some of
these had by the time of the research took place been in
operation for some time. Much of the foregoing account of
the study findings has been derived from reports and papers
and therefore to an extent represents an 'official' view of
what was happening. Most of the key informants quoted so
far were in the position of policy makers or managers, and
although most were self-critical and only too aware of the
work still to be done, they generally expressed a degree of
satisfaction with the progress achieved so far in bringing
about a shift from institution-based care to care in the
community.

The views of those key informants whose work gave them
detailed knowledge of policy implementation at the level of
individual recipients of the services tended to be in sharp
contrast. This group of informants was drawn from a range
of agencies both statutory and voluntary, although they were
all in face to face contact with the most severely
disadvantaged people. Some of them (such as informants from
St. Nicholas Hospital Social work team, Northern
Schizophrenia Fellowship and the Society of St Vincent de
Paul) were entirely concerned with people with mental
disabilities, whilst for others, such people formed a
significant proportion of their clients; for example,
informants estimated that approximately 55% of users of the
Bridge Medical Centre, and 75% of users of Wayside Day
Centre (both providing services to homeless people) had
psychiatric problems. There was a striking degree of

similarity between the analysis of the problems, criticisms of present services and elements considered essential for an improved service in the views express by this group of key informants. In virtually every case, informants backed up their statements with detailed examples from their experience.

Some comments were severely critical:

"Community care does not exist".

"There is a government directive which is to get people out {of hospital} and a financial system which makes it just about impossible for them to get out".

There was some difference of opinion about the numbers of people involved, with one informant saying that there existed "a substantial circuit" of people with mental health problems for whom nothing was being done and who had an "appalling" quality of life at all levels, but another estimating that the number of people with multiple problems was probably fairly small. However, this informant also said that "Community care is not working at all" and stressed that the personal trauma for the individuals involved could not be exaggerated.

Agency and Public Attitudes:

One informant from a voluntary agency described "a degree of blindness to the problems in all the local authorities".

Another said that mentally ill people "were not wanted by
any agency":   although one or two individuals within a
department or organisation might show concern, because of
limitations on funding and the fact that mentally ill people
were not regarded as a priority, responsibility and
provision for them was generally deemed to be someone else's
problem.

According to one informant, people with long term mental
health problems were not wanted by the Health Services
because they could not be cured, by Social Services because
they could not be changed, and by Housing Departments
because they were seen as bad tenants. Mentally disabled
people often appeared to be in a marginal position in
systems and sevices.

Another informant said that agencies rejected people whom
they considered were not "committed to treatment". This
informant added that he considered that an individual's act
of walking through the door of the agency indicated a
commitment, and he tried to build on that.

The perceived negative attitudes of statutory agencies were
bitterly resented by some informants, particularly those in
agencies working with homeless people, who complained that
they were used inappropriately by health and social services
agencies as a suitable place to which to discharge people
with problems of mental (and sometimes physical) illness.
Several informants felt that psychiatrists and social
workers showed a lack of realism and a degree of naïvety
about the level of support which they expected projects for

homeless people and bed and breakfast hotels to be able to provide.

However, workers found the process was largely one way and that health and local authority services made strenuous efforts to exclude people who were perceived as difficult to manage or treat. When an individual's mental health deteriorated, they found it extremely difficult to gain readmission to hospital for the person, or in some cases even to obtain a consultation with a psychiatrist. In some cases where the person was readmitted to hospital, often after a period of severe stress for themselves and other users, they were then discharged back to the same inappropriate temporary accommodation as soon as their acute symptoms had subsided.

One informant summed up the situation for the agency by saying: "They {i.e. doctors and social workers} use us for one reason only: to dump people". Another informant said bluntly that statutory agencies told lies in order to get people they were dealing with admitted to accommodation projects. However, a third said that for homeless people with mental health problems, it was essential to achieve some stability in life style before rehabilitation could begin.

Reports of public responses varied considerably. One informant said that the integration into the community of the people rehoused from hospital by his orgaisation into group homes or flatlets in one small area of the city (an established residential area) had worked very well, and that suspicion among local residents had been broken down. The

absence of problems with neighbours and the local community
was also commented upon in Gateshead.

However, another informant who worked in a shelter for
homeless men described two recent incidents in which
children had attacked a resident, in one case with spray
paint, and in the other with paving stones, resulting in a
broken arm, and said that similar attacks were not uncommon.

Preparation for Community Living

The most frequent criticisms concerned the adequacy of help
given to people to prepare them for more independent living,
and continuing support for them, although there was a range
of opinion about the former.

One informant said that planned discharges did not usually
cause problems, and that the majority of poorly planned
discharges did not arise from Newcastle. Whilst all agreed
that those people with mental health problems who were not
closely involved with either psychiatric or social services
(such as those who had repeated brief admissions, or those
who discharged themselves) presented the greatest problems,
some also had criticisms about currently available
rehabilitation or preparation programmes on a number of
counts. These included the nature of the preparation given,
the staff involved, and the location of the programmes.

The criticisms centred around the issues of precisely what abilities were needed in order to survive in the community, and how agencies providing the programmes perceived the recipients of them. In general, the informants considered such programmes were not sufficiently responsive to individual need, and focussed on the process rather than the person.

The crucial factor identified by three informants was "starting where the person is": it was essential to involve the person throughout, taking into account his or her wishes and perceptions. It was argued that hospitals in particular often attempted to effect change in an individual's circumstances or behaviour without doing this, and therefore without understanding the individuals' needs, for example whether he or she was ready to change, or indeed capable of changing. This could put pressure on individuals, leading them to relapse quickly, or to flee.

These informants indicated that, because of this, individuals sometimes went through rehabilitation programmes without understanding the reasons for either the whole process (having lacked any real choice in deciding whether to move out of hospital in the first place) or particular aspects of it: in their words, the process lacked meaning for them. One illustration given of this concerned someone who had obediently taken regular baths for years in hospital when instructed to do so by a nurse: the informant argued that such a person might well fail to bath regularly when discharged to more independent accommodation if he or she had never been helped to understand why it was necessary. Without such understanding, the rehabilitation programme could easily become a series of hoops through which

individuals had to jump in order to attain a goal they had not chosen, i.e. discharge from their familiar surroundings.

Two specific criticisms related to the fact that much rehabilitation took place in hospital. It was argued that it was difficult for people to transfer skills learned in the artificial setting of a hospital (even in a rehabilitation flat or house within the grounds) to the "real world" outside. The second objection concerned the fact that most staff involved in the programmes were hospital based and clinically orientated. The consequences of this were considered to be that, being used to working with severely disabled people, yet assessing patients' suitability for discharge in the relatively protected environment of the hospital, staff tended both to overestimate the abilities of people in the rehabilitation programmes, who were invariably among the most able of the long-stay hospital population, and to underestimate the difficulties and complexities of coping in a more exposed living situation.

Informants repeatedly said that rehabilitation programmes paid insufficient attention to detail, such as how to cope with trivial incidents (for example, dropping something in a shop) which may be very stressful to people unused to dealing with them, and to social skills. Examples of the latter included learning how to function alongside and in cooperation with others (particularly important for those moving on to shared accommodation), learning how to use leisure time, and how to reduce isolation.

At the same time, a number of informants considered that because people had a background of mental health problems, official bodies frequently required them to jump hurdles and to conform to higher standards than other people, in order to obtain a home. Examples given of this included the high degree of insecurity inherent in knowing that one was required to "move on" after a limited period, and the level of scrutiny to which their home-making abilities and standards were subjected. It was felt that some vulnerable people therefore had the double disadvantage, of having to demonstrate higher standards, and also to do so in situations of greater stress.

One informant said that the fact that people usually faced a move to unknown accommodation at the end of the rehabilitation process created a source of anxiety which often impeded the individual's progress. His organisation tried to overcome this problem by offering "a home for life" in the community. He argued that this brought about "a natural form of rehabilitation" and increasing self confidence born out of the sense of security which individuals gained when they knew they would not have to move on unless they chose to do so.

Most informants considered that facilities such as the two Social Services hostels in Newcastle provided more appropriate and thorough preparation for independent living than hospital programmes. Informants cited a number of important differences in the service offered by these hostels: they were located in the community, they adopted a social rather than a medical model of functioning, and they offered continuing outreach support after rehousing. It was generally felt that there should be more facilities of a

similar kind, and the few criticisms which were made about them were generally linked to the limited number of places available and the consequent difficulty in securing admissions.

Two other areas which were widely criticised by "front-line" workers in the study were those of accommodation and support, and adverse comments related not only to the quality and quantity of such services, but also to the way in which they were provided, as a reflection of the low status and priority accorded to people with mental health problems.

Accommodation and Support

A number of informants emphasised the need for the provision of mainstream resources, particularly accommodation, for mentally disabled people. In their experience, the majority of people wanted their own (sometimes shared) permanent tenancy in ordinary housing, and to receive whatever support services they needed there. They made a variety of criticisms of the current situation, including the rôle special projects, the types of properties offered and the relationship between housing and support.

Two informants were very critical of the effects of special projects. One argued that health and local authorities tended to think that, having established one special project (or a very small number of them), all needs were thereby

met, even though some special projects specifically excluded
people with high support needs. There was a failure to
recognise the flow of people through the project, and their
needs for continuing support.

These comments echoed Bachrach and Lamb's views on the
limitations of model programmes:

> "Generally too few in number to have any
> widespread effect, and too limited in concept to
> be reproduced in other settings, model programmes
> must be viewed as interesting and informative
> experiments (but) systems must serve all who are
> in need, not only those persons who happen to fit
> some predetermined experimental aims" (Bachrach
> and Lamb, 1982, p.155).

This informant also argued not only that the housing and
care needs of disabled people tended to be viewed as one,
but also that the voluntary sector had collaborated in a
disservice to vulnerable people by further marginalising
them in special projects, when their preference was for
ordinary housing.

Another informant argued against such projects on the
grounds that for voluntary organisations to accept often
inadequate, short-term funding to set up facilities which in
his view should be provided by statutory bodies themselves,
was not in the long-term interests of either the users or
the employees of the projects.

Although key informants recognised the constraints placed on
Housing Departments by the available stock, several of them

voiced criticisms of the quality and location of tenancies
allocated to mentally vulnerable people. One said bluntly
that Newcastle Housing Department offered tenancies in
"Apache Country", where poor amenities, isolation and often
hostility made it difficult for people to survive. To
overcome this problem, one of the Newcastle Social Services
hostels had turned increasingly to Housing Associations
because they were more flexible and had good quality flats
in the local area. Comments about the quality and location
of tenancies offered by Gateshead Housing Department were
generally positive.

Some informants said that rehousing to a council property
was in fact too easy in Newcastle, because problems resulted
if people were rehoused without adequate preparation and
continuing help, and similar comments were made about
Derwentside.

Most of this group of informants were very critical of the
adequacy and suitability of the support currently available
to mentally ill people rehoused in the community, and
ensuring appropriate support appeared to present a problem
equal to, or greater than, that of securing suitable
housing.

One informant was critical of campaigning organisations in
the housing field who suggested that lack of suitable
housing was the only problem; according to this informant,
some of people "will need two crutches put under them till
the day they die". The need for continuing high levels of
support for some people, as well as suitable housing, was
endorsed in different terms by other informants.

The support needed by a mentally disabled person may involve
workers from a range of different agencies. Some
informants, including local authority social workers
themselves, criticised the low priority given to people with
long-term mental health problems in Social Services
Departments, which frequently meant that social workers did
not become involved until the person and their situation
were near to breakdown, which often resulted in irreparable
damage to both their social situation and their confidence.

Whilst support is not primarily the responsibility of the
Housing Authority, the Housing Departments in the study
varied in the extent to which they saw a continuing
supportive rôle for housing management.

Informants in contact with Derwentside were critical both of
the very narrow view taken by the Housing Department of its
own rôle, and its expectation of the appropriate
contribution of Social Services.

One informant said that the policies and aims of Newcastle
Housing Department were sound, but that the practical
problems of rehousing were not sufficiently acknowledged.
These included the time scales of allocation of the tenancy,
visits by DHSS staff and payment of any grants, and
discharge from hospital. This was a critical period for the
individual and could be extremely stressful. The same
informant and others suggested that, as most mentally
disabled people in the community had low incomes, a more
routine 'package' of financial deductions from benefit at

source was desirable in order to prevent debts from building up, but at the same time acknowledged the important issue of individual choice.

There were criticisms of Newcastle Housing Department's Single Person's Support Scheme on a number of counts: firstly that the scheme was in effect aimed at enabling people to survive in undesirable accommodation, and secondly that the scheme only offered support for twelve weeks and therefore did not meet the need for continuing support which many people had. The scheme was not in fact designed to offer such support, but some informants saw this as an example of services not being directed to those people with the greatest needs.

Towards an Effective Service

The strength and extent of the criticisms voiced by the "front-line" workers interviewed may give an impression that their attitude towards service providers in the health and local authorities was simply negative and focussed only on "worst case examples", but this would not be accurate. At interview, all informants were asked to identify what they considered to be the elements of a good service, and readily did so.

Their ideas and suggestions broadly corresponded to the essential characteristics of services which have been identified in different terms by a number of recent writers

(Audit Commission, 1985; Stockford, 1988; Huxley, 1990), and
endorsed by the emerging body of evaluative research
(Renshaw et al, 1988; Stein et al, 1990). Most informants
indicated that they were aware of the dangers of merely
reproducing isolated schemes, however successful,
emphasisimg instead the essential characteristics rather
than any specific form that the services should take.

Informants identified a number of elements essential to
effective support services, including housing. These
included: that agencies and society must recognise their
responsibilty towards mentally disabled people; that support
must be multidisciplinary, co-ordinated, and without limit
of time if necessary. It should be unstigmatised; and must
involve spending time (if necessary, substantial amounts of
time) with the individual so that it provides an easily
available "sounding board" which helps to prevent crisis
rather than provide rescue in an emergency.

All were concerned to create a comprehensive service which
would be of real benefit to the most severely disabled
people who were the most badly served in the present
situation.

Informants envisaged that support could take many forms from
informal befriending by local residents to more sensitive
and intensive housing management, to substantial personal
assistance with the basic tasks of daily living. It was
generally considered that a diversity of support,
individually adapted and flexible over time, would help
further the aim of enabling individuals to live in society
with the freedom to live as they choose.

As well as providing some striking examples of the adverse
consequences of de-institutionalisation (e.g. Bassuk et al,
1984), the United States offers some models of community
care which appear to be notably successful in their
redistribution of resources, effectiveness and acceptability
to users, and which appear to have incorporated many of the
characteristics considered important by key informants.

A summary of one such programme, described at the 1985 World
Federation of Mental Health Congress by Dr Bill Stockdill of
the National Institute for Mental Health is included as
Appendix Ten because the programme appeared to have dealt
successfully with many of the problems identified by key
informants, and to be based on a model which could be
applied more broadly.

The creation of client-centred outreach services, backed by
a legal requirement to provide them and the resources to do
so, as in Wisconsin, was a formula advocated in different
ways by a number of key informants, but which to date had
not happened in Britain. The proposals in the Griffiths
Report (Griffiths, 1988) provided an opportunity to change
this situation, but the delay in implementing the subsequent
legislation to promote community care must again cast doubt
on the likelihood of real improvement.

In some respects the views expressed by the "front-line" key
informants reflected the idea of deinstitutionalisation as
one type of protest movement,

> "ideologically committed to improving the lot of persons who are seen as helpless in gaining access to life's entitlements" (Bachrach and Lamb, 1982, p.142).

However their comments indicated that they were acutely aware of many of the problems which had arisen as a consequence of the philosophical assumptions of the movement (Bachrach and Lamb, 1982).

Much of their frustration arose from what they perceived as a failure at policy level to recognise the high and continuing levels of dependency and the correspondingly low levels of social and psychological functioning, and vulnerability to stress and relapse of many mentally disabled people. They were also frustrated by the consequent failure to provide appropriate and adequate resources, as well as by fragmentation at the levels of both policy making and service delivery. Their experience of the daily lives of mentally disabled people frequently seemed at odds with the perception of government that

> "There is a great deal to be proud of in the progress that has been achieved" (DoH/DSS, 1989b).

CHAPTER EIGHT

CONCLUSION TO PART ONE

Introduction

This chapter will summarise the major issues to emerge from the research study, highlighting those which were particularly fruitful in generating the ideas and arguments which are developed in Part Two. The research project was primarily a mapping exercise, an attempt to establish not only a comprehensive picture of a major social process at a specific point in time within a limited local area, but also how the various actors in this situation understood what was happening. Because the implementation of community care is both a multi-stage and multi-agency process, analysis of the data began by drawing on a policy analysis framework (Hogwood and Gunn, 1984), noting also the extent and apparent importance of variation and contingency (Cochrane, 1987; Bagguley et al, 1990). However, the inadequacy of a single discipline perspective led on to more specific consideration of the findings about the housing of mentally disabled people which emerged from the research.

This, combined with the insights derived from Siegal and Doty's contrast between 'advocacy research' and 'management review' styles of evaluation (Siegal and Doty, 1978), drew attention to the possible significance of two distinct perspectives among key informants. This became the starting point for developing an explanation of the present position of mentally disabled people, particularly in respect of their housing and identifying possible ways forward, which was the basis for Part Two.

The Research Findings: Policy Dimensions

The considerable amount of detail in which the research
findings have been reported, particularly the process of
developing and implementing the community care plans in each
part of the study area, is justified by the levels of
complexity thereby revealed which may not have been apparent
in more broadly-based approaches. In spite of the
substantial amount of data produced by the study, and
efforts to be both systematic and comprehensive, the picture
inevitably remains incomplete, not least because of the
rapid pace of changes which were taking place at that time,
and the paucity of systematic monitoring or evaluation in
any of the study areas.

The comparative analysis of the three local areas served to
identify those policies and processes operating at the local
level, and the inter- and intra-agency mechanisms and their
interaction which facilitated or hindered implementation.
It was impossible to know to what extent the three areas
studied were typical of other areas across the country in
their moves to create community-based services. Given the
important influence of local structures and local processes
which emerged from the study, the probability is that every
local area faced comaparable though differing challenges in
creating services which would provide care in the community.
Whilst some areas would be faced with additional dimensions
such as an ethnically more mixed population or more acute
housing shortages, it seemed likely the difficulties they
faced would represent simply further permutations of the
attempt to cope with inadequate resources, rather than
inherently different ones.

In the main, the picture which emerged from the case studies was the complex and confusing one of a system in total transition, a vast uncontrolled experiment. The data suggested first, that no agency or individual had a comprehensive view of what was happening, even within a local area; and second, that no coherent or agreed conception existed at that time of what a unified model of service should be, or of how the process of deinstitutionalisation should be managed.

By the time that the study took place, each of the three parts of the catchment area had embarked on the process of replacing institution-based provision for mentally ill people with a range of smaller scale, locally-based services, and each had encountered major obstacles in attempting to develop and implement plans for such a service, but almost any similarity between them effectively appeared to end there. Although each part of the study area encountered difficulties in the corporate, collaborative and intersector areas (Challis et al, 1988), a very different set of problems arose in each case.

The areas were geographically adjacent and appeared to have some important common links, notably the use of the same psychiatric hospital, and each operated within the limits of the same national policies and legislation. In addition to those specifically relating to the promotion of community care, these policies were wide-ranging, and included those concerned with the organisation and management of the health service (with new emphasis on cost-efficiency and entrepreneurial management); income maintainence; housing;

and local government finance. In practice, the areas bore
out the claim that "Basic structural mechanisms actually
produce widely varying outcomes in different times and at
different places" (Dickens et al, 1985, p.1), to the point
that any basis for comparison between them at times seemed
hard to identify.

The way in which the local authority planning process and
the co-incidental emergence of public concern about
supermarket development disrupted the implementation of
Newcastle Health Authority's plans for several years
demonstrated that planning is seldom a rational process and
that much of what happens is driven by contingent events.
Newcastle's strategy itself depended fundamentally for its
realisation on a further contingency, namely the possession
of land which could be sold for speculative building.

Important national contingencies which had repercussions at
local level included the ending of the MSC Community
Programme, which had been used to finance the development
and staffing of many resources for mentally disabled people,
and changes in Social Security benefits.

Variation among Localities

It could be argued that in an important sense locality is
the pivotal concept in community care because it involves,
in essence, the relocation of resources for mentally
disabled people from large monolithic institutions to

smaller, locally-based, dispersed facilities, and a consequent relocation of people, both users and employees of services. (It has however been shown that, what has in fact occurred in many instances is a new concentration of services and users in particular inner-city areas, rather than dispersion (Dear and Wolch, 1987)).

From the study of the three areas the concept of the history of places also appeared central, in that each area was to a substantial degree the product of its own history, and this accounted for much of the wide variation between the localities. Despite their proximity to each other, Newcastle, Gateshead and Derwentside emerged as very different places.

Although all three local councils (as well as Durham County Council) were Labour controlled, the style and character of local politics were very different in each area, and these differences had and continued to have major effects on the nature and development of resources in the respective areas. Newcastle had a tradition of liberal, predominantly middle-class commitment to welfare services for its citizens, and this had contributed to high profile, high expenditure provision in both health and local authority services. As a relatively affluent city and the acknowledged regional capital with a long-established medical school, it had established itself as a regional centre for research and many specialist services, as well as providing general medical and psychiatric services for large parts of the surrounding area. Social Services in Newcastle had for many years enjoyed the dual benefits of having both a charismatic and powerful director and a committed chairperson, and this had contributed to a level and quality of service provision

which had earned for Newcastle a degree of national
prominence and indeed prestige.

Derwentside stood in marked contrast to this with many
disadvantages. It suffered from not being a unitary
authority, which meant that the District Council had no
control over some of the services which were most important
to its people, notably social services, which were provided
by the County Council. Because responsibilty for services
resided at different administrative levels, contact between
Housing and Social Services in Derwentside had been
restricted, with relatively little mutual interest. This had
been exacerbated by a degree of historical antipathy between
District and County councillors.

As a non-metropolitan authority, Derwentside tended to be
somewhat homogenous in character, and many of its resources
lacked range (e.g., the vast majority of council housing
consisted of two- or three-bedroomed houses (Forrest and
Murie, 1988)); and people who were different in whatever way
tended to be highly visible. Equally important, politics in
Derwentside had in the past tended to be characterised by a
rather narrow petty communalism among both members and
officers which showed little interest in developing its own
resources, and a mistrust of outsiders, including
professionals.

Such a combination of factors led Derwentside to become in a
sense a victim of services provided centrally by Newcastle,
notably those for mental illness: because the district had
almost no services of its own, but had relied on Newcastle,
Derwentside people often had to move the considerable

distance to Newcastle, sometimes permanently, in order to gain access to the resources they needed. These resources could be either official (designated hospital beds) or unofficial (greater range and availability of affordable accommodation).

The absence of a history of providing resources influenced current developments in both the health and local authority in important ways: there was a lack of experience and expertise in planning or managing mental health services, with potentially adverse effects on the quality of future provision. Also, because of the difficulties of redressing imbalances between districts through the redistribution of resources, for which mechanisms such as R.A.W.P. appeared inadequate particularly in times of financial stringency, considerable disadvantage was likely to remain for Derwentside/North West Durham in the future.

The position of Gateshead lay somewhere in between: although sharing inner-city problems similar to Newcastle's, Gateshead also in the past had a political style somewhat akin to Derwentside. However, having been reorganised into a large unitary authority in 1974, its character had changed, leading to some notable recent examples of political volition and interdepartmental co-operation within the local authority.

Such differences in history and tradition between the three places were associated with the wide variations identified in welfare provisions for mentally disabled people which existed at the time of the study, and which will continue to

have a formative influence on future services. These were
reflected on many levels.

1. One of the most obvious examples of variation was the
twenty-fold difference in expenditure per head on mental
health services which existed between neighbouring local
authorities, and this was reflected in uneveness of
provision to the point where some services (such as day care
and supported accommodation in Derwentside) virtually did
not exist in some areas.

Both Gateshead and Derwentside/County Durham were
handicapped by a very restricted rating base which had
limited income, as well as having a tradition of low
spending on rates. Therefore, as each health district
became responsible for service provision in its own area,
Newcastle started from a much stronger base in both health
and social service provision.

However, whilst Gateshead Council had tried to improve its
level of resource provision in a number of different
services in recent years (and incurred the penalty of rate-
capping), Durham County Council had taken a decision over
several years not to make any increase in its minimal
expenditure on services for mentally ill people.

Furthermore Derwentside, unlike both Newcastle and
Gateshead, did not have the advantage of being an urban
programme authority and therefore did not benefit from
special grants which, because they represented 'new' money

which was not tied to existing budgets, permitted a degree
of innovation and flexibility in spending which was
particularly valuable at a time of severe spending
restrictions.

The distribution of Health Service resources (in part the
legacy of where centralised institutional provision happened
to be located) reflected a comparable imbalance. The Health
Advisory Service team raised the issue of the transfer of
revenue expenditure from Newcastle to North West Durham as
the latter took over responsibility for its own services,
but the question of the distribution of capital resources
remained: should Newcastle Health Authority retain all the
proceeds from the sale of the St Nicholas land because it
was originally bought by, and was located within, the City
of Newcastle; or would it be more equitable for the proceeds
to be shared by the different areas presently served by the
hospital? Similar issues arose in relation to the probable
closure and sale of St Mary's Hospital. Without such a
sharing of resources, the development of services which were
even adequate from a very low base would be extremely
difficult in areas like Derwentside.

2. The quality and progress of community care plans varied
enormously in the extent to which principles and aims were
made explicit and policy objectives, based on firm evidence
of local need, were clarified. There were also considerable
differences in scale and comprehensiveness: North West
Durham's new services, although based in the District, were
to be centralised on the site of the District General
Hospital and modest in scale, whilst Newcastle aimed for
fundamental change in the nature and quality of its
services; these variations in scope reflected the

differential access to resources, both material and human. Gateshead Health Authority's plans were much less developed and the underlying principles at times hard to discern.

3. The plans of the three authorities involved different levels of participation by other professionals and agencies and this reflected day to day relationships between them, varying from firm trust and considerable rôle flexibility to suspicion and hostility. (The latter characterised particularly the feelings of some voluntary organisations towards statutory bodies). Newcastle's Strategy for the Mentally Ill was jointly produced by the Health Authority and Social Services Department; in contrast, Gateshead Social Services encountered considerable difficulty in involving health workers, especially psychiatrists, in any of their plans to develop services. However, effective co-ordination at the level of policy making did not neccesarily imply co-ordination at the level of the individual service user (eg, Newcastle's policy for the housing of mentally ill people) or vice-versa (Gateshead's Resettlement Scheme).

4. Numerous variations concerning local policies, and the interpretation and implementation of national policy at a local level were identified. In some instances, policies relating to particular issues did not exist: at the time of the study, Derwentside District Council had no explicit policy about the housing of mentally disabled people, although "A policy can consist of what is not being done" (Helco, 19872, in Hopwood and Gunn, 1984, p.21). Where policies did exist, they were not necessarily appropriate to service needs, as in Durham Social Services' decision not to increase the budget share allocated to mental health services. Inappropriate policies may also result from a

lack of clarity about principles or a conflict between
strategic and operational considerations (Challis et al,
1988). Available documents suggested this to be the case in
some aspects of Health Authority planning in Gateshead.

Even where policies had been adopted, the will to implement
them was sometimes lacking, and this seemed to be often
linked to a reluctance to provide the necessary resources:
local examples of this were the Durham Social Services'
policy referred to above, and the tendency of some Housing
Departments to offer 'hard to let' properties to mentally
disabled people, rather than accommodation suited to their
needs. In contrast, the results of the policy towards
houses in multiple occupation in Gateshead was a good
example of the effectiveness of political will allied to
adequate resources.

Policies might be adopted but, as both Gateshead's and
Newcastle's joint Housing/Social Services policies for the
housing of mentally ill people showed, they were not
necessarily communicated to staff at lower levels who were
responsible for implementing them. Even where staff were
aware of policies, their attitudes or lack of training could
impede appropriate implementation; this seemed to be the
case with certain aspects of Newcastle's system of
neighbourhood housing offices.

5. In addition to numerous differences between the three
areas, the study identified marked variations within the
areas, which tended to be associated with different
organisational structures. The Resettlement Scheme in
Gateshead with its important financial aid was the most

striking example of the variation in service provision which
could exist even within the same administrative area where
in principle the same policy operated: Gateshead residents
within the catchment area of St Mary's Hospital received
this important service; those in the area of St Nicholas
Hospital did not, partly because the necessary working
relationaships arrangements between local Authority and
hospital staff did not exist.

Gateshead residents within the catchment area of St Nicholas
Hospital were further disadvantaged in the standard of
service they received by two other factors: the haphazard
arrangements for community psychiatric nursing; and the
uneven distribution of council accommodation across the
authority: those needing one- or two-person flats often had
to move to other parts of the district because of the lack
of this type of accommodation in the western part.

Throughout the study areas, sound working principles and
appropriate mechanisms between departments and agencies
frequently seemed to be lacking areas, and this compounded
the effects of the scarcity of resources.

6.   There were also variations in the level at which
decisions were made: in general terms and particularly in
housing matters, more decisions were made centrally or by
elected members in Derwentside than in the two metropolitan
authorities. It was clear that there were certain
situations where officers' discretion (and hence their
attitudes) could come into operation, and there were
differences between authorities and departments in the
extent to which aspects of policies (such as criteria for

vulnerability) were codified: Newcastle Housing Department,
for example, tried to minimise individual discretion both by
codifying policies and criteria, and by making explicit
those areas where exercise of discretion was likely to
occur. Whilst areas of discretion undoubtedly existed,
these seemed to be of relatively limited importance in the
context of the other constraints within which individuals
and their authorities had to operate.

Analysis of the organisational and political context of
community care was helpful in clarifying the "bewildering
mesh of interactions and ramifications" which the
formulation and implementation of policy involves (Hogwood
and Gunn, 1984, p.26), but explanation at this level did not
appear sufficient to account for the housing circumstances
of mentally disabled people.

As analysis of the data proceeded, two issues became clear:
first, where satisfactory housing for mentally disabled
people had been achieved, this did not appear to be related
to the variations identified above in any consistent way;
and second, the contrast between the views of policy makers
and service managers on the one hand and those of 'front-
line' informants and consumers on the other came to appear
increasingly significant, and indicative of the existence of
two separate discourses.

Mentally Disabled People and Their Housing

Variations between the three areas could readily be
identified in numerous aspects of housing. These included
the philosophy of the local housing department and its
perceptions of the rôle of housing management. These in
turn were reflected in the existence and nature of explicit
policies (as in Derwentside policies concerning mentally
disabled people, and rent arrears respectively). There were
also variations in lettings policies (such as the allocation
of hard-to-let properties to mentally disabled people in
Newcastle and Gateshead), as well as the suitability and
location of the available stock of dwellings.

A marked lack of resources - such as supported accommodation
in Derwentside, or small units in Western Gateshead -
clearly placed severe limitations on the care options
available, but beyond this common factors linked to
successful housing were not easy to identify.

The accommodation of mentally disabled people was perceived
by a number of systems, agencies and schemes to create
particular problems, including reluctance of other residents
to accept facilities for them in their areas (Newcastle
Planning Committee); their standards of housekeeping and
need for supervision (Derwentside Housing Department); and
their needs for long-term support (Newcastle Single Persons
Support Scheme and Durham Social Services). However there
were also some notable examples of people with long-term
disabilities being helped to establish themselves more
independently in the community, and a number of schemes
which were successful in helping them could be identified.

These were: the Gateshead Resettlement Scheme; the Sallyport
Crescent Project; Newcastle Social Services' Summerhill and
Scrogg Road hostels and (notwithstanding some reservations
which were expressed by a number of key informants) the
project run by the Society of St Vincent de Paul.
Demonstrably successful practice in housing people with
mental disabilites was therefore spread across both
statutory and voluntary agencies. Schemes were not
necessarily located in suitable facilities (eg, Scrogg Road
hostel), or using trained staff (St Vincent de Paul).

Whilst some of these (such as the Gateshead Resettlement
Scheme or Newcastle Social Services' two hostels) were
specifically for mentally disabled people, others (including
the Sallyport Crescent Project) were not. Furthermore, some
specialist mental health projects (40 Grainger Park Road and
Valley View) encountered considerable problems in fulfilling
their intended rôles.

On the evidence of the study, therefore, the success or
failure of the different ways in which mentally disabled
people were accommodated appeared to be haphazard, and the
factors which determined the outcome unclear if the varying
types of provision were considered in terms of agency
function and type of accommodation. If there were any
common characteristics, they had to be sought elsewhere.

A Needs-based Discourse?

At this point I returned to the data provided by the 'front-line' informants and the consumers themselves.

In many ways, Jean, Joe and Brian represented only themselves because their individual experiences were unique. Nevertheless, those experiences, and their perceptions of them, highlighted many of the problems faced by mentally disabled people, and the ways in which policies affect them. All three were striking for their isolation, their protracted and frequent stays in hospital, the length of time they had been without a settled home and for a plethora of interacting health, personal and social problems and misfortunes of many years' standing.

It would have been interesting to compare their perceptions of professional involvement in their lives with the views of the workers themselves; however this was not possible and the important thing to note was the strong impression conveyed by all three that they felt they had often been treated arbitrarily, inconsistently and insensitively by the helping professionals they had encountered, and felt bewildered and powerless in consequence. They conveyed a feeling of being controlled by professionals, yet at the same time let down by them.

Nevertheless all three talked warmly of at least one professional worker whom they felt had been of real help, and were quite clear about the kind of future life and home

they wanted. It is tempting to suggest that Joe and Brian's expectations of their own abilities and the help which others could offer were not entirely realistic. Yet Jean's experience would indicate that, given sensitive and personally-focussed responses from a range of helping agencies, even very long established patterns and problems can be changed and alleviated to a way of life which is much more satisfying to the individual.

A concern with the needs and wishes of individual service users was a preoccupation of both the three consumers and the 'front-line' workers. Needs included both those for suitable (and as far as possible, preferred) accommodation, and for the range of support services which were a consequence of their mental health problems. These informants frequently talked about needs in terms of intangible factors: for the wishes of individuals to be taken into consideration, for greater flexibility, consistency and reliability on the part of immediate service providers. Their experience seemed to indicate that the extent to which these factors were accepted and acted upon in creating a 'package of care' was critical to the outcome for the individual.

However, as the previous chapter showed, the failure of formal systems to recognise and respond to what they perceived as the needs of those whom the services were intended to help, was a continuing cause of complaint to the front-line informants.

In the interviews with those informants concerned with policy-making and management, such considerations appeared

almost wholly absent. In some cases, particular needs were
not recognised (as in the time-limited support offered by
Newcastle's Single Persons Support Scheme), or elsewhere,
were effectively subordinated to the needs of other groups
(e.g., Newcastle's Planning Committee's response to local
residents' opposition to the siting of alternative
facilities).

Welfare policies must clearly be based upon many
considerations other than a simple aggregation of individual
needs (Spicker, 1988). The difficulties of defining need
and establishing reliable data on which to base estimates of
need are well documented (Bradshaw, 1972; Webb and Wistow,
1986). However, decisions about which needs will receive a
response also involve value and moral judgements. In the
case of mentally disabled people, the responses to need on
the part of many agencies frequently appeared to be limited
to the minimum required by statute, as in the accommodation
of homeless people who were vulnerable under the terms of
the Housing (Homeless Persons) Act 1977. In the absence of
a statutuory duty, provision was often minimal or non-
existent (sheltered accommodation and day-care in
Derwentside, for example). Furthermore, there appeared to
be not only a failure to recognise housing as an integral
element of community care provision, but a lack of a
mechanism - almost a perceptual deficit - which would enable
the range of needs of mentally disabled people to be
recognised at the policy level.

My task therefore became to attempt to explain why this
situation had arisen, in terms of both individual factors
and socio-political changes, and thereby to identify some
mechanism which would be capable of effectively mediating

between the two.   This involved bringing together research concepts and ideas from a variety of disciplines, and forms the second part of the thesis.

CHAPTER NINE

HOUSING AND MENTALLY DISABLED PEOPLE:

SHELTER, HOME AND RESIDENCE

Introduction

> "The architectural environment can play a significant role in our lives. People create it, and it in turn has a great deal of impact on their behaviour... Not all settings are equally significant or central in terms of behavioural impact, but primary environments, those in which we spend most of our time, are very important factors in our psychological well-being and our actions" (Fisher, Bell and Baum, 1984, p265).

Anthropologists have shown that the significance of where a person lives varies greatly between cultures; in some, for example, settlement patterns appear to be more important than the dwelling itself. It has been argued that in most traditional cultures, individual identity expressed through dwellings is relatively unimportant, and that identity communicated by means of clothing, ritual, rules of hospitality, etc., may be more significant. However, by contrast, in contemporary western culture where "individual identity is paramount", the house has come to be seen as "a symbol of self" (Rapoport, 1981, p.11). Indeed, "The objects with which a person surrounds himself (sic) produce his self in an important sense" (Duncan and Duncan, 1976, p.213), and this has created an important link between identity, self-esteem and housing which may not exist in other cultures.

In contemporary Britain, the meaning of housing includes a number of dimensions: it indicates status by symbolising economic independence and wealth, and it also encloses a private social world, whose significance is related to both economic factors and changes in social networks (Bulmer, 1987).

The relationship between an individual and his or her environment is complex, involving interactions between physical, social and psychological factors, and both objective and subjective elements (Fisher, Bell and Baum, 1984). This chapter accordingly falls into two parts. In the first, three principal areas of the work of developmental and environmental psychologists into the effects of the individual's living situation on mood and behaviour will be explored. These are: evidence about the ways in which individuals in western society are influenced by their living situation, and the concepts of environmental stress and a hierarchy of needs. In order to facilitate discussion in subsequent chapters about the actual and potential rôles of housing in community care for mentally disabled people, the chapter uses Maslow's hierarchy of needs to propose a model of three identifiable (though not discrete) dimensions of housing in the well-being of the individual.

The second part of the chapter draws together knowledge about the psychological and social situation of mentally disabled people. It considers, within the framework of Wing's model of disability introduced in Chapter One (Wing, 1978b), research about the extent of different types of disadvantage; networks and family support; and vulnerability to stress, as well as attitudes towards mental illness.

In the light of the empirical evidence from these different fields, the essential characteristics of the services

required by mentally disabled people are identified, and the case for an enhanced rôle for their housing within the pattern of services in the community is argued.

Common Human Needs

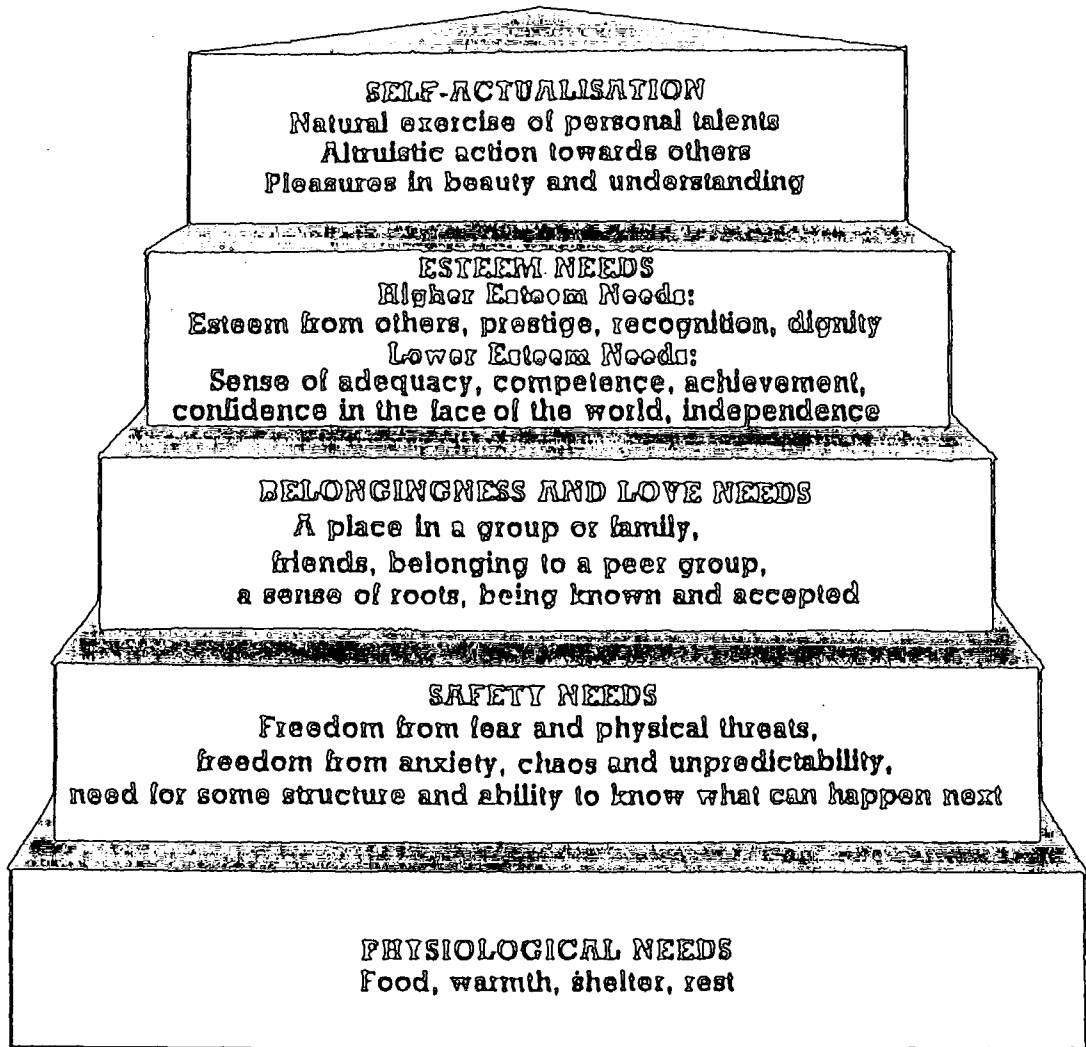There is now substantial research evidence which indicates that:

> "Despite wide individual and group differences in human motives...there does appear to be a common core of psychological strivings related to maintainence and actualisation" (Coleman, Butcher and Carson, 1980, p.96).

Figure 9.1 shows the hierarchical model of strivings or needs developed by the psychologist Abraham Maslow (Maslow, 1954).

Maslow argued that the level which commands the individual's attention and effort at a given time is the lowest one on which a need is unmet. Thus ordinarily, if the needs for food and shelter are not reasonably well satisfied, the individual's behaviour will be dominated by these needs. Only when they are gratified is the person able to devote time and energy to meeting her/his needs on the higher levels. Although both the existence of a hierarchy and its applicability to the provision of welfare have been challenged (Spicker, 1988), Maslow's formulation provides a useful starting point in attempting to understand the ways in which the living circumstances of an individual, their level of functioning and satisfaction may be related to each other.

Figure 9.1

ABRAHAM MASLOW'S HIERARCHY OF NEEDS

SELF-ACTUALISATION
Natural exercise of personal talents
Altruistic action towards others
Pleasures in beauty and understanding

ESTEEM NEEDS
Higher Esteem Needs:
Esteem from others, prestige, recognition, dignity
Lower Esteem Needs:
Sense of adequacy, competence, achievement,
confidence in the face of the world, independence

BELONGINGNESS AND LOVE NEEDS
A place in a group or family,
friends, belonging to a peer group,
a sense of roots, being known and accepted

SAFETY NEEDS
Freedom from fear and physical threats,
freedom from anxiety, chaos and unpredictability,
need for some structure and ability to know what can happen next

PHYSIOLOGICAL NEEDS
Food, warmth, shelter, rest

From Lomas (1987)

The function of housing which corresponds to Maslow's lower
level "deficiency needs" will be called **shelter**. Housing is
obviously a key element in meeting some of the most basic
physiological needs. It can also meet the individual's
needs for warmth, safety and security, but does not
invariably do so: uncertain income, transient accommodation,
long and indeterminate periods of waiting and eventual
housing in unfamiliar areas of high deprivation and
vandalism all militate against the basic needs for security
and safety.

It has been pointed out not only that feelings of adequacy
are very dependent on the individual's intellectual and
social competence, but also that the need for a sense of
adequacy and the need for security are closely related:

> "...Pervasive and chronic feelings of insecurity
> typically lead to fearfulness, apprehension, and
> failure to participate fully in one's world"
> (Coleman, Butcher and Carson, 1980, p.97).

Where the individual lives plays an important rôle in
determining not only the degree of such structure and
freedom from anxiety, but also the sense of having a place
and roots which Maslow calls "belongingness". This second
function of housing will be called **home**, since it is
concerned primarily with the dwelling itself, and its
internal characteristics of design, furnishings and comfort.

However, "housing" includes not just the dwelling, but also
the immediate built environment or locality. The "home"
provides an important base from which the individual relates

to the external world and the wider community. The concept
of "community" itself is not limited to ideas of
geographical proximity, but includes

> "... networks of informal relationships between
> people who may be connected with each other by
> kinship, common intersts ... friendship,
> occupation or the giving and receiving of
> services" (Barclay, 1982, p.199).

The spatial element is important, and this third function
of housing will be characterised as **residence**, to indicate
the qualities of both location and permanence which it
encompasses.

Central to both "home" and "residence" is the concept of
identity. Because of its implications for mentally disabled
people in the community, the available research evidence
about the ways in which housing has been found to shape
individual identity either positively or negatively will be
discussed in some detail.

Identity, Self-Esteem and Housing

It is acknowledged that the concept of identity - which has
much in common with Maslow's "belongingness" - is difficult
to define. However, Rapoport has highlighted two
components:

> "The unchanging nature of something under varying
> aspects or conditions; and the condition of being
> one thing and not another...the latter notion
> seems to be at the heart of the concept"
> (Rapoport, 1981, p.10).

Rapoport and others have distinguished a number of aspects
of the concept of identity, including: group and individual
identity; internal and external identity; the involvement of
both a content (the distinctiveness of the individual or
group contrasted with others) and a boundary (which may or
may not involve territory); and the possibility that
identity may be either positive or negative, markedly
negative identity constituting stigma.

Many aspects of an individual's experience can contribute
towards his or her sense of identity, including employment,
with its opportunities to develop and use skills and to be
part of a team, as well as the financial rewards it offers.
These in turn facilitate access to other identity-enhancing
opportunities, such as recreational and social activities.

In western cultures, and particularly where other sources of
identity are limited, external identity is seen to be
critical and is communicated to those outside one's group by
means of cues: "Place identity, which communicates social
identity, becomes extremely important" (Rapoport, 1981,
p.16). Both Rapoport and Steinfeld emphasise the
personalisation of one's dwelling and the possession of
personal property as potent means of expressing one's
identity (Steinfeld, 1981).

This process also involves issues of choice, control and
competence; and a variety of research studies have indicated
that having a choice in where one lives and involvement in
preparations for the move, including selecting decorations
and furnishings, enhances the individual's sense of well-
being in their home. (Fisher, Bell and Baum, 1984;
Steinfeld, 1981). A recognition of the importance of this
process of creating such a sense of "home" underpinned the
Gateshead Resettlement Scheme. The feelings of control and
competence, which result from the exercise of choice, are
seen as crucial components of self-esteem, and hence of the
concept of identity. Indeed,

> "The needs for self-esteem and self-actualisation
> are expressed and pursued through the purchase of
> commodities" (Leiss, 1976, quoted in Pratt, 1981,
> p.144).

The ultimate consequence of perceived loss of control over
one's situation, according to the "Behaviour Constraint"
approach to understanding relationships between environment
and behaviour, is learned helplessness, and "Restoring
control enhances performance and mental outlook" (Fisher,
Bell and Baum, 1984, p.71).

Moreover, "Attractive environments ... make people feel
better" (Fisher, Bell and Baum, 1984, p.273), and a number
of research studies have also pointed to factors other than
choice and control, but linked to them, which influence
well-being in the living situation. These factors may
relate to either the internal or external aspects of the
dwelling, although many people, such as those who live in
public rather than privately owned housing, may have little

opportunity to influence the latter. Level of income is fundamental to the ability to affect either.

It has been demonstrated across a wide variety of settings that behaviour is affected by a number of elements of interior design. These include functional aspects such as the size and layout, efficiency of heating systems and kitchen facilities, all of which affect the ease with which basic tasks can be performed. Lighting, windows, colour, and quality of furnishings have all been found to have an influence on mood and behaviour.

Privacy is also important and is related to both internal and external aspects of design. Defined as "The selective control of access to the self or one's group" (Altman, 1975), and thereby related to identity, it involves notions of both personal space and territory. Privacy includes both the ability to withdraw and the ability to control information about oneself. Problems arise when individuals are obliged to interact with others where there is too much or too little personal space, or where their personal space is invaded. The consequences of such unwelcome contacts may be aggression, flight, or attempts at perceptual withdrawal.

Environmental Stress

One theoretical approach in Environmental Psychology which helps to understand the relationship between individuals and their environment is that of "environmental stress". Stress is the physiological, emotional and behavioural reaction to

aversive stimuli, such as noise or overcrowding, which
threaten the well-being of the person (Fisher, Bell and
Baum, 1984). Stress as a process is a useful intervening
concept because it helps to account for individual
differences in reactions to similar situations
(Schorr,1970), and also has some predictive value,
"(accounting) for the combined effects of many environmental
and social stressors that are present at the same time"
(Fisher, Bell and Baum,1984, p.80).

The theory developed by Lazarus and his colleagues (Lazarus,
1966) shown in Figure 9.2 is useful in describing the
relationships between factors in the environment (stressors)
and the responses they evoke.

Coping is defined as

> "Cognitive and behavioural efforts aimed at
> managing conditions that tax and might exceed our
> resources" (Rotton, 1990, p.511).

Lazarus and Cohen (1977) identified three categories of
environmental stressors - cataclysmic events, personal
stressors and background stressors - the second and third of
which are relevant to the purposes of the present study.

Personal stressors include the death of a close relative,
and other types of losses. These are very similar to "life
events" which have been shown to be related to the onset or
relapse of both depression and schizophrenia, and their
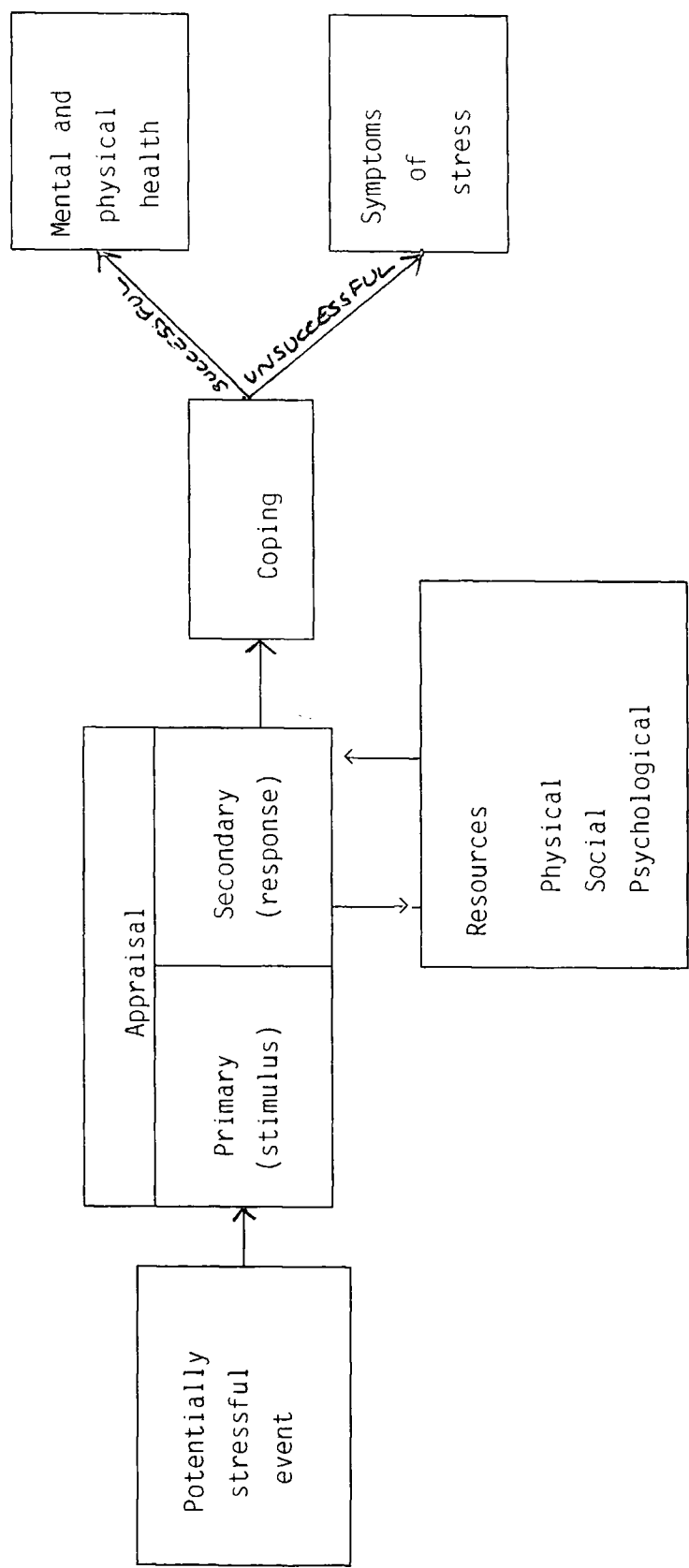significance will be discussed in more detail below.

Figure 9.2

Cognitive-phenomenological theory of stress

(from: Rotton, J. (1990), p.511)

Background stressors are "persistent, repetitive and almost routine". Chronic stressors such as unemployment or poverty impose particular strains on coping abilities, partly because they involve undesirable social rôles. In addition, a range of so-called microstressors or "daily hassles" such as losing things, having too many things to do, or unwelcome noise, which are relatively trivial in themselves, can when a number of them occur together pose a serious threat to coping ability (Fisher, Bell and Baum, 1984, p.86).

Numerous factors which affect the individual's appraisal of stresses in their environment have been identified. These include: the characteristics of the condition (how loud a noise is, and the type of noise); social and psychological differences; coping styles, and the degree of perceived control. One significant factor is the availability of social support: "The feeling that one is cared about and valued by other people" mitigates the appraisal of the threat (Cobb, 1976; Fisher, Bell and Baum, 1984, p.87).

There are a range of responses to stressful situations or events. The physiological responses to threat are well-documented, but there may also be important behavioural (avoidance; aggression) and cognitive (inability to concentrate; narrowing the field of attention) reactions as well. The effects of stress are not invariably negative: in many cases the person who has been exposed to stress and has been able to deal with it adequately will meet future stresses with enhanced coping capacities.

However, the notion of "limited adaptive energy" which holds that as exposure to stress increases, adaptive

resources are depleted, causing a reduction in subsequent coping ability, is important (Selye,1976; Fisher, Bell and Baum, 1984). Even more so is the conclusion drawn from numerous research studies:

> "If the total of all stresses at any one time exceeds the capacity of the individual to cope with them, some sort of breakdown, physical or mental, is almost inevitable" (Fisher, Bell and Baum, 1984, p.79).

Where a person lives - both the dwelling and the immediate neighbourhood - thus contributes significantly to individual well-being. Although establishing the nature and direction of a causal relationship is extremely difficult,

> "In one direction, the evidence is overwhelming: extremely poor housing conditions perceptibly influence behaviour and attitudes" (Schorr, 1970, p.320).

Equally, evidence cited above indicates that it is likely that living arrangements which are "good" (ie, safe, comfortable and free from undue stress) can enhance functioning. The factors shown to affect feelings and behaviour include those easily recognised, such as physical design and furnishings, but less tangible factors such as perceived control and choice also play a part. There is also some evidence from studies by symbolic interactionists that the meanings communicated by where the person lives may be crucial (Steinfeld, 1981).

Mentally Disabled People: Needs and Difficulties

There is now a substantial body of research which would indicate that people with mental disabilities are likely to experience particular difficulties in attempting to live in the community.

i) **Social disadvantage**

The most obvious of their difficulties is the high levels of extrinsic disadvantage they face (Wing, 1978b). Studies have shown that they experience significant problems of unemployment, homelessness, physical ill-health and lack of social support.

A study by Ebringer and Christie-Brown found high levels of these adverse factors. Among newly-admitted patients in their study, 13.7% came from transitory accommodation or no fixed abode, and 28.7% of those discharged either changed address during their hospital stay or left with no known accommodation. In addition, of those patients in the wards and day hospital on one day, 28.4% came from transitory accommodation or no fixed abode (Ebringer and Christie-Brown, 1980). Studies showing high and increasing numbers of people with mental illness among users of temporary accommodation confirm the link between homelessness and mental illness (Leach and Wing, 1980; Bassuk et al, 1984).

64.7% of patients in the study by Ebringer and Christie-Brown were unemployed, and the House of Commons' Social Services Committee starkly summarised employment prospects: "The likelihood of those recovering from mental illness finding paid employment out in the community is remote," (House of Commons, 1985, para 94), a fact confirmed in my earlier study which found that only 17% of the sample were in employment for any part of their stay in temporary accommodation; moreover, even these were in low-paid and insecure jobs such as barwork, factory work and labouring (Scott, 1986). Because they are unemployed, they are likely to be poor, and growing concern and dissatisfaction about the inadequacy of Social Security provisions were expressed by most of the front-line informants in the research study.

A more detailed study of 'long-term' patients undertaken in Camberwell found that nearly half the sample of chronically disabled psychiatric patients in the community suffered in addition from "some quite severe physical disability varying from obesity to cancer." (Wing, 1982, p.14).

This study also demonstrated significant difficulties in carrying out the basic activities of daily living, and consequently the need for high levels of support and supervision for many people. On the basis of detailed interviews with their carers:

- over half needed help with household chores

- over half needed help (sometimes total) with budgeting

- 62% needed some help with self-care

- 19% needed <u>much </u>help with self-care (including toileting and supervision of hygiene)

- 40% needed attention because of socially difficult behaviour.

However, the same study found that only 40% of the people in the sample had relatives able to help and in regular contact (Wing, 1982). For a large proportion of mentally disabled people therefore, family support is not available. The networks of people with schizophrenia in particular have been found to be small (especially in relation to non-family members) and poorly connected (Taylor and Huxley, 1984). In one study, 50% of short-stay patients lived alone and 36.5% received no visitors during their stay in hospital (Ebringer and Christie-Brown, 1980), suggesting that many are isolated with few social supports; the experience of the three service users in the research study reflected a similar picture.

ii) Attitudes towards mental illness

The effects of such social deprivation are likely to be exacerbated by a further type of extrinsic disadvantage: unfavourable public and professional attitudes towards mental illness. These also have a strong influence on personal reactions to the experience of having a mental illness (Wing, 1978b). Psychological research has produced substantial evidence that people who have, or have had, a mental illness are persistently viewed by others in society in an extremely negative way, though reactions may be complex and sometimes contradictory:

> "Mental illness seems to elicit special responses
> of fear and rejection far exceeding in intensity
> responses evoked by physical illness" (Miles,
> 1981, p.60).

A Dutch study by Swarte found a public belief that mental patients are easily distinguishable from other people; that they are unpredictable and potentially dangerous with a propensity to crime, particularly violent crime and sexual offences (Swarte, 1969). Nunnally's study confirmed the perception of dangerousness and in addition found that low intelligence, insincerity and 'worthlessness' were seen as factors contributing to mental illness (Nunnally, 1961). This is comparable with the belief in a highly generalised trait of incompetence which Sarbin found (Sarbin, 1969). In contrast with physical illness, therefore, mental illness is widely seen as indicative of a lack of willpower, a condition for which the individual is in some way morally responsible, and which does not strike people indiscriminately (Rabkin, 1974). Similar attitudes were reflected in the research study in certain practices and responses in Derwentside Housing Department.

In his study of public attitudes towards mentally ill people, Phillips found that disturbed behaviour was more severely sanctioned if the person was known to have been a patient in a mental hospital, although he argued that the social importance of continuing disturbed behaviour should not be underestimated (Phillips, 1966), and the importance of deviant behaviour rather than history of mental illness in labelling and rejection has been confirmed in later studies (e.g. Segal & Aviram, 1978 and Clausen, 1980).

There may also be a discrepancy between actual behaviour of respondents and the attitudes expressed by them in surveys,

and Rabkin found that behaviour towards individual mentally ill people was generally more favourable and positive (Rabkin, 1974). A number of factors have been identified as influencing attitudes and behaviour, with younger and better-educated people generally expressing more favourable and accepting attitudes. It also appears, however, that the greater the degree of personal involvement or intimacy required, the greater the reluctance to associate with former patients (Whatley, 1968).

These findings would suggest that mentally ill people in the community are at risk of being highly stigmatised, shunned and treated with hostility because of their experience of mental illness, although there is a lack of follow-up studies to provide empirical evidence of this. However, Miles argues that if the stigma of being mentally ill is avoided by not claiming this rôle, the equally damaging stigma of being 'bad' may replace it, so that someone who is permanently unemployed and withdrawn from social contacts because of mental illness may be called lazy and workshy (Miles, 1981). It is possible to speculate, therefore, that community care policy may reduce still further what little public sympathy exists for mentally ill people, by suggesting that they are not in fact 'ill' at all.

More recent research suggests a somewhat less pessimistic picture. These studies differ in important ways from earlier ones. Studies carried out at a time when a far greater proportion of severely mentally ill people were long-term hospital inpatients inevitably examined attitudes to hypothetical situations, whereas more recent work has concentrated on attitudes resulting from contact and proximity. Furthermore, a new area of research has

developed: the investigation of community reactions to local psychiatric facilities. In their study in Toronto, Dear and Taylor found that attitudes to local facilities were generally favourable. One interesting finding was that only 36% of respondents who lived within a quarter of a mile of an existing inpatient or outpatient clinic were aware of its existence (Dear and Taylor, 1982). A telephone study in New York city produced a similar finding, and the author comments that, where it exists,

> "Community opposition to psychiatric facilities has less the quality of prejudice than of a general attitude of resistance to the intrusion of any public service in a cohesive community" (Rabkin, 1984).

However tolerance of facilities and their users was related to their spread throughout the community, and such a spread is untypical:

> "... Well-to-do neighbourhoods have used zoning laws and planning procedures, and sometimes even vigilante groups, to repel even those facilities states have sought to provide" (Hudson, 1992).

The successful mobilsation of socially cohesive neighbourhoods to oppose the location of facilities within their boundaries has led to the concentration of facilities in certain localities, typically rundown inner-city areas (Dear and Wolch, 1987). The research study of Newcastle produced examples in line with the findings of both Rabkin and Dear and Wolch.

On the basis of present evidence, there appears to have been
a shift towards generally more positive public attitudes
towards mentally ill people, although considerable diversity
remains. Negative attitudes tend to be not solely a
response to the individual's status as a mentally ill
person:

> "Those most apt to be visible to the community
> tend to be handicapped not only by deficiencies in
> social judgements and social supports, but often
> by the further burdens of low social status and
> meagre personal resources....It is the more or
> less permanently disabled people who are visibly
> different and less competent, and who require
> intermittent or long-term support from non-family
> sources to maintain themselves in the community,
> who are more likely to be the objects of aversion
> or avoidance" (Rabkin, 1984, pp 328-329).

There is an obvious risk that the most disabled people will
find themselves trapped in a vicious circle in which their
visible difference and social isolation continually
reinforce each other.

It might be expected that the attitudes of mental health
professionals towards mentally ill people would differ
markedly from those of the general public. However,
although they may be better informed (for example, Swarte
found that psychiatrists estimated only 2-3% of psychiatric
patients to be dangerous (Swarte, 1969)), there is evidence
that they hold at least some negative views in common with
the general public:

> "Physicians   often   unknowingly   share   general,
> sometimes negative attitudes towards illness -
> particularly chronic illness" (Lamb, 1984, p.309).

Clare reported that:

> "The attitudes of family doctors to psychiatric
> patients and problems vary from intense personal
> interest to active dislike" (Clare, 1980, p.419).

and Goldberg and Huxley endorsed the existence of stigma
concerning mental illness:

> "It is considered more respectable to have a
> physical illness. Many doctors share this view
> and may communicate it to the patient" (Goldberg &
> Huxley, 1980, p59).

Despite a training which normally places greater emphasis on
issues such as the social consequences of illness and
disability, social workers may share such negative
attitudes: Fisher and his colleagues found that "isolated
clients were sometimes at the receiving end of (social
workers') moral disapproval" (Fisher, 1984 et al p.129), and
Goldberg and Huxley stated bluntly: "The social work role in
relation to the chronic patient is virtually non-existent"
(Goldberg & Huxley, 1980, p.147). Key informants from all
three parts of the research study area referred to the low
priority accorded to work with mentally disabled people in
comparison with other client groups.

A number of factors which contribute to the existence and
persistence of negative attitudes among professionals may be
identified. One important factor may be the great social
distance which separates many chronically mentally disabled
people from professionals, particularly psychiatrists: as
Bachrach, writing of homeless mentally ill people in America
succinctly states: "...for all practical purposes, they live

in a different world" (Bachrach, 1984, p.35), and this must inevitably limit understanding. At the same time, work with mentally ill people, like work with elderly or mentally handicapped people, is perceived as low in status, which may contribute towards a vicious circle of poor recruitment of staff both in numbers and quality, difficulty in attracting other resources and low staff morale.

Lamb has argued that the "roots of neglect" of severely mentally ill people result from the fact that their needs clash with those of professional staff (Lamb, 1979, p.201). Further, Bassuk and Lauriat claim that many professionals feel uncomfortable in assuming the rôles which are necessary in helping chronically disabled people in the community - activity, outreach, persistence, advocacy and patience - "particularly when they involve confronting the irrationality of traditional systems and functioning at times as political activists" (Bassuk & Lauriat, 1984, p.310). Such attitudes and reluctance may have far-reaching effects on the quality of services received by chronically disabled people.

iii)   **Stress and mental illness**

Given the combination of marked social deprivation and negative public attitudes that he or she is likely to encounter, the mentally disabled person's ability to cope with stress - particularly of a chronic nature - becomes very significant.

One important type of stress which has been shown to be related to the onset of both depression and schizophrenia results from 'life events'. These have been defined as constituting "a change in an individual's life, necessitating readjustments" (Miles, 1981, p174). Although the concept, (particularly the personal meaning attributed to events), presents great methodological difficulties, a number of studies have found that people suffering from psychiatric illness have frequently experienced a high number of stressful events in the period immediately prior to onset. In the case of schizophrenia 'life events' were twice as common, and in depression, events rated as 'severe' were four times as common among sufferers. In the case of depression, these events would normally be regarded as clearly unpleasant (loss of home, relationship, etc.), whereas in schizophrenia, events such as getting engaged, birth of a child, etc., which are perceived as positive by most people, could also be experienced as stressful (Brown & Harris, 1978; Birley & Brown, 1970).

In their detailed investigation into the social origins of depression in women in London, Brown and Harris identified two additional stress factors: major difficulties and vulnerability factors. They found that difficulties - in housing, employment, finance, etc., - were not only more severe and lasting among people suffering from mental illness, but were much more common among working-class women, compared to middle-class women, and tended to be more closely related to structural factors. Vulnerability factors - for women, notably lack of a confiding relationship - were not capable of producing depression in themselves but increased the risk when life events and difficulties were present (Brown and Harris, 1978).

Stress, therefore, may result from both physical surroundings and the emotional atmosphere, so that mentally ill people would appear to be particularly vulnerable to the impact of their environment.

This vulnerability appears to operate in two specific directions, especially for people who have schizophrenia. Studies in hospitals have shown an increase in 'clinical poverty syndrome' (blunting of emotion; poverty of speech; social withdrawal, etc.) in socially deprived environments (measured by a variety of indices including the number of personal possessions owned by the patient; contacts with the outside world; amount of time spent doing nothing) (Wing and Brown, 1970). This is true of all social environments where people with schizophrenia are living (Brown et al., 1966): that is, the worst features of 'institutionalisation' can occur in non-institutional settings, including family homes.

However, studies of families (Vaughn and Leff, 1976), and of rehabilitation (Wing et al, 1964) point to the equal danger of excessive social stimulation as a precipitant of relapse, and this has led to the development of the concept of 'high expressed emotion.'

In a controlled study, Vaughn and Leff found that people who had suffered from schizophrenia were more likely to relapse if they lived in homes in which they were in close contact (35 hours per week appeared to be the maximum level of face to face contact) with relatives rated as showing high expressed emotion (measured by the number of critical comments made and/or emotional over-involvement) than those

who lived with relatives rated as showing low expressed
emotion: 48% of the former group relapsed within nine
months, compared with 6% of the latter (Vaughn and Leff,
1976.)

Mentally ill people may therefore in effect have to walk a
psychological tightrope in maintaining a balance between the
perils of both over- and under-stimulation, often in
situations in which they may exercise little choice or
control.

An Enhanced Rôle for Housing?

Evidence presented in the first part of this chapter showed
that the individual's immediate living situation makes an
important contribution to social and psychological
functioning by helping to meet their needs in three major
areas. These dimensions of housing were characterised as
shelter, home and residence.

In the second part, a picture emerged of substantial numbers
of people with varying degrees of relapsing illness or
chronic disability who are striking in their isolation,
poverty, physical ill-health, inadequate accommodation and
lack of work opportunities. There is an interactive effect
between their psychological problems and their social
circumstances, with stress in one area of life having
markedly adverse effects in other areas, so that adjustment
and ability to cope with the complex tasks of daily living
may be very precarious.

The juxtaposition of research findings from these different fields brings about fresh insights concerning mentally disabled people and their housing, and leads to two contentions. First, that because of their established heightened vulnerability to stress, the living arrangements of mentally disabled people should be the focus of specific attention by agencies and professionals responsible for their welfare in order to try to ensure that, as a minimum, they do not place them under additional, avoidable stress.

It is argued secondly that, since there is evidence that "housing may affect behaviour by contributing to or dissipating stress" (Schorr, 1970, p.319), housing could be used to create a compensatory or "prosthetic" environment for them.

As a result of their experiences of both psychiatric illness and institutional care, with consequent lack of opportunities to exercise control over their own lives (Goffman, 1961 and 1963; Liem and Liem, 1978), many mentally disabled people are likely to have a weak or damaged sense of identity and poor self-esteem.

Particular psychiatric conditions may in addition present specific problems: depression usually involves feelings of worthlessness; and the belief that one's thoughts and actions are being controlled by an external force is one of the clinical "first rank symptoms" of schizophrenia. Further, people with schizophrenia are particularly vulnerable to the effects of both over- and under-

stimulation; and there is increasing recognition of the importance of cognitive disorder in schizophrenia (Venables, 1987).

In addition, people with a mental disability are likely to find their opportunities to satisfy their needs much more restricted than those of other people: they are unlikely to have a job, with its opportunities for independence, achievement and satisfaction; they are likely to be relatively isolated socially, partly through intrinsic impairment and partly because low income restricts mobility and access to most recreational activities. They are therefore likely to spend substantially more time in their accommodation than many other people through a lack of alternatives.

Where they live can therefore be seen to hold a key rôle in the well-being of mentally disabled people, both because other avenues for the satisfaction of a range of common human needs are limited, and because their sense of identity and feelings of self esteem are often fragile following their experience of illness. Furthermore, many people who have experienced serious mental illness are likely to find the social and psychological stresses of their daily lives difficult to cope with, given that

> "The severity of stress depends on the relationship between the size of the demand and the individual's resources for coping with it" (Coleman, Butcher and Carson, 1980, p.107).

Therefore, with thought and careful planning, their housing
- whether individual or shared - could be used in a very
positive way to help mentally disabled people to compensate
for these difficulties and deficiencies by providing an
environment which maximises the positive functions of
"home", and minimises some of the stresses. This in turn
would enable them to participate more fully (if they chose
to do so) in the life of the community and would also
accord with an important principle in the field of mental
health that services should

> "Follow a hierarchy of psychological needs, aiming
> to anticipate difficulties and concentrate on
> prevention, rather than intervention in the event
> of a crisis" (Lomas, 1984, p.135).

In reality it appears that the reverse is frequently the
case: instead of having the benefit of a benign or
compensatory home situation (which would be a token of their
social worth (Ramon, 1989)), people already trying to cope
with the problems of mental illness often find themselves in
the poorest accommodation (in both material and social
terms) and the most stressful living conditions.

The following chapter contrasts the positive potential of
housing's rôle with the reality of community care for
mentally disabled people.

CHAPTER TEN

THE REALITY OF COMMUNITY CARE

Introduction

It is ironic that the term 'environmental psychology' arose out of research into the influence on treatment outcomes and social interaction of psychiatric wards designed to create a therapeutic atmosphere (Proshansky, Ittelson and Rivlin, 1970). Even though this work incorporated a number of assumptions, it produced evidence that the quality of the immediate living environment had significant effects on the individual's behaviour and well-being within the institution. However, notwithstanding examples such as Gateshead's Resettlement Scheme, the implications of this work for the same group of people living outside hospitals do not appear to have received sufficient or consistent consideration in developing community care policies. Indeed in many ways, the situation at the time of the study was the antithesis of what was known to be beneficial: whilst evidence about the important functions and meanings of where one lived was accumulating, mentally disabled people were in many instances finding it increasingly difficult to meet even their most basic needs.

This chapter summarizes some of the major features of this reality for mentally disabled people in terms of the shelter - home - residence model introduced in the previous chapter. The picture which emerges from the mid-1980's is of a range of policy changes leading to a marked worsening of the likelihood of their needs being met in any of the three areas. As a result of the process of documenting the actual situation of mentally disabled people, a central dichotomy between needs and rights is highlighted, the origins and implications of which will then be developed in the concluding chapter.

Shelter

In attempting to identify the range of needs which had to be met by community provisions, Shepherd made use of Bachrach's formulation of eight functions performed by the old psychiatric hospitals (Shepherd, 1984; Bachrach, 1978). The inclusion of an 'accommodation' function recognised that the hospitals had always provided shelter and food, and continued to do so for significant numbers of people who remained in hospital for social rather than clinical reasons.

One of the major challenges of community care was to find ways of fulfilling the functions identified by Bachrach which were more humane, flexible and responsive to individual needs than the régimes of traditional mental hospitals. However, there has been widespread failure both to recognise the important housing rôle of the hospitals and to substitute it adequately in the new system.

This was attributable in part to the fact that, whilst appropriate housing may be essential to psychiatric well-being, it represented a non-psychiatric need. It therefore fell largely outside the remit of the health service (although many hospitals have developed schemes for people with high care needs jointly with housing associations and voluntary bodies, 40 Grainger Park Road in Newcastle being one such example), but responsibility for ensuring that housing needs were met was not fully accepted by any other agency. In one survey concerned with planning 'tailor-made'

local services, only one respondent (a community nurse) out of more than 70 suggested that increased liaison between the health services and the housing department would be desirable (Cunningham, 1984).

Even Department of Health guidance on the 'Care Programme Approach', which was intended to improve discharge and after-care arrangements in response to criticism (House of Commons, 1985) and due to be introduced in all health authorities by April 1991, referred to local authorities only in terms of Social Services Departments and social care services (DoH, 1990). The criticisms expressed by 'front-line' informants in the research study reflected this marginal position of mentally disabled people in relation to many agencies.

In spite of the House of Commons Select Committee's declaration that "Access to ordinary housing is plainly essential to community care" and call for "Stricter enforcement of the existing duties of housing authorities towards mentally disabled people" (House of Commons, 1985, paras 136, 137b), access to housing was problematic for many at the time of the study. Obstacles included lack of financial resources and lack of eligibility, as well as more covert means of deterrence.

By virtue of their poor employment prospects and dependence on state benefits, many mentally disabled were (and continue to be) excluded from any hope of home ownership, the principal form of tenure, with its attendant subsidies. This placed severe limitations on their available choices and also on their status since they were unable to share a

widely held and approved, indeed "normal" (MHLG, 1965)
aspiration, together with the "access to credit and
accumulation of wealth (which) are significant attributes of
home ownership" (Forrest and Murie, 1983, p.464).

Housing Associations had become an increasingly important
source of housing for mentally disabled people because of
their two main perceived advantages: the provision they made
for groups with special needs who did not normally qualify
for local authority housing (and who local authorities "may
find it politically difficult to provide for" (Donnison and
Ungerson, 1982, p.198)); and in their potential (not always
realised) for more flexible, less bureaucratic allocation
and management.

In practice, many mentally disabled people were until
recently effectively also denied access to public rented
housing, as well as ownership, since eligibility was largely
determined by arbitrary criteria of residence qualifications
and points systems. As Gray pointed out,

> "Selection does not take account of factors such
> as 'social' need and differential vulnerability in
> particular housing conditions" (Gray, 1979,
> p.215).

The Housing (Homeless Persons) Act, 1977 placed an important
new duty on local housing authorities to accept
responsibility for a number of vulnerable groups (including
mentally ill people) in urgent need of accommodation, "even
where these are people that they would rather not have as

tenants under other circumstances" (Malpass and Murie, 1982, p68).

Only small numbers of mentally disabled people (less than 1,700 people in 1984, or only 2% of all those accepted as homeless in England) benefitted from their rights under the Act, in part because:

> "Services for the homeless and unemployed have always been provided in ways which are intended to deter the 'undeserving' claimants from seeking help" (Foster, 1983, p.14).

Thus, every person seeking help under the Act had to negotiate a number of "eligibility filters" which were likely to present problems to all people experiencing the stress of homelessness or threatened homelessness, but which were likely to be particularly hazardous for mentally disabled people.

The major hurdle presented by the 1977 Act for mentally disabled people was meeting the criterion of vulnerability. Any or all of John Wing's three elements of disability (Wing, 1978b) were likely to make it more difficult for any person with psychiatric problems to obtain and retain accommodation and to cope with daily living in it. If someone has no legs, some at least of their difficulties are obvious, but the difficulties of a mentally disabled person may be much harder to specify, and much harder to relate to their accommodation needs (Wing, 1965). It appeared that many of them were obliged in effect to walk a clinical tightrope to avoid a "Catch 22" situation, in which evidence

was required to show that their health made it more
difficult to get or keep housing, but that at the same time,
they would be able to manage in independent housing
(Sullivan, 1979).

There was some evidence of this dilemma becoming more acute:
in evidence to the Short Committee, Manchester Night Shelter
reported that in many cases, ability to survive in a night
shelter appeared to be taken as evidence of lack of
vulnerability (House of Commons, 1985).

The two remaining "filters" in the Act - the concept of
"intentionality", and the requirements regarding a local
connection - were also liable to make it more difficult for
mentally disabled people to establish eligibility.
"Intentionality" proved the most controversial part of the
Act, because of the very arbitrary interpretation placed
upon it by some authorities, apparently as a way of
minimising their obligations under the Act (Murie, 1983).
In some circumstances, mentally disabled people could be
seen to have made themselves "intentionally" homeless in
spite of losing their accommodation as a consequence of
their mental state (e.g. delusional beliefs or hypomania).

In a similar way, they could find themselves particularly
affected by the requirements regarding local connection on
two counts even though, in general, lack of a local
connection proved to be infrequent, with 84% of homeless
households in 1984 having been resident in the same
authority for over a year (D.O.E. 1985). A small number of
mentally disabled people however, partly because of their
unstable mental state, lead very unsettled lives, drifting

from one town to another with admissions to a number of
different hospitals. By contrast, some people have lost any
meaningful local connection because of the length of time
they have spent in the institution. The revised Code of
Guidance (D.O.E. 1983) referred to this problem (para. Al,
11), but merely advised that "close co-operation will be
needed between the housing and social services authorities
concerned."

My previous study (Scott, 1986) highlighted a further area
of concern. The sample of people accepted as homeless and
vulnerable on the grounds of mental illness by one inner
London housing department resembled in a number of respects
the population found in short-stay rehabilitation hostels
(Hewett et al, 1975). Since a significant number presented
major management problems to the Homeless Persons Unit in
terms of their behaviour or level of self-care or both, the
question arose as to why they had not been admitted to
hostels. However, many such hostels operated a high degree
of selectivity in admissions (1), although the criteria for
selection were largely negative:

> "Voluntary bodies and local authorities alike
> appear to be more certain about who they do not
> want than about who they do want" (Hewitt et al,
> 1975).

Some people could therefore be excluded from hostel
accommodation because of their lack of competence, but since
the 1977 Act gave Housing Departments a residual
responsibility for the homeless, not from independent
accommodation. Thus paradoxically, it was possible that
those most handicapped and with least skills in daily living
might be rejected by supported accommodation because they
were considered to be too disabled or disturbed, and

therefore had to be placed in the type of accommodation which placed most demands on them and offered least support and supervision.

The legislation on homelessness enabled some mentally disabled people to obtain accommodation through local authority housing, although this could result in accommodation which was unsatisfactory and provided little more than basic shelter.

In recent years, as local authority housing has taken on an increasingly residual rôle, many housing departments have extended their eligibility criteria to include single people and those with special needs. However, even if mentally disabled people were offered council housing, they were likely to find themselves allocated the poorer types of accommodation for a number of reasons.

Housing management "remained an uneasy amalgam of book-keeping, building maintenance and social work" (Newson and Potter, 1985 p.38), and the meeting of individual housing need was only one of a number of sometimes conflicting management tasks facing a housing department.

The principal constraint on allocation was the available housing stock which might not be suitable in size or design, nor desirable in quality or location in a particular case - or indeed in any case.

However, if another major management task - that of
maximising revenue through high levels of occupancy - was to
be achieved, mechanisms had to be found to ensure a supply
of tenants for the least desirable property, and to maintain
the quality of the more desirable. The most widely used
mechanism was a grading system.

There was little reliable evidence about how mentally
disabled people fared within this allocation process, but a
number of studies which examined council housing and
applicants from minority ethnic groups highlighted the
difficulties faced particularly by the powerless, the
inarticulate or the desperate (Sarre, Phillips and
Skellington, 1989; Simpson, 1981).

Many mentally disabled people shared the characteristics
identified by Carina as being common to tenants offered
accommodation on a run-down and stigmatised estate (Carina,
1976). Indeed, there were some indications that mentally
disabled people were seen as being among the least desirable
tenants: Popplestone referred to three "types of behaviour
sufficiently out of line with other people's expectations to
cause perennial headaches for housing managers." These were
mental illness, those who were dirty, smelly, noisy and/or
scruffy and those who had conflicting life styles
(Popplestone, 1979 quoted in Murie, 1983, p.220).

They were, therefore, likely to be offered properties deemed
unsuitable for, or undesirable by others, i.e. substandard
flats in tower blocks on peripheral estates. These might
not be suitable for their needs either, but because of a
lack of choice (particularly the normal practice of only

making one offer of permanent accommodation to homeless people), they might have no alternative but to accept. Thus,

> "obtaining a council tenancy is no longer necessarily a way out of housing deprivation, but it may involve continuing use of physically or socially obsolete dwellings" (Murie, 1983, p.176).

Because of their increased vulnerability, identified in Chapter Nine, this risked imposing intolerable stress for mentally disabled people.

For those ineligible for council housing and unable to afford a privately rented flat, the choices were few, and at the time of research study, even the option of last resort - the Resettlement Units - was under threat. It was proposed that the duty of the DHSS under the Supplementary Benefits Act, 1976 to provide direct access emergency accommodation should be replaced by voluntary sector provision. In spite of their serious criticisms of the existing Resettlement Units, many organisations involved with homeless people opposed this, arguing that such accommodation must be provided by local housing authorities, so that facilities for single homeless people became part of mainstream provision.

The other major alternative left to mentally disabled people was houses in multiple occupation. The short-comings of both the physical and psychological environment of much accommodation of this type were well-documented. They included lack of security of tenure, with a continuing

threat of arbitrary eviction, and harrassment. Residents
had few rights and were reluctant to complain through fear
of losing their accommodation, however inadequate, or worse.
Harrassment could take a variety of forms, including
pressure to hand over benefit giros to landlords and sexual
harrassment (Gateshead Single Homeless Group, 1984; Conway
and Kemp, 1985; SHOT, 1986).

The general lack of privacy and the restrictions inherent in
such living conditions were extremely stressful, and any
kind of normal lifestyle or social contact was very
difficult:

> "... It is impossible to quantify, or even
> adequately to convey in words the squalid,
> depressing, debilitating life facing the residents
> of such accommodation" (Conway and Kemp, 1985,
> p27).

> "People need to be coping extremely well with all
> aspects of their lives in order to be able to
> handle some of the conditions which prevail in bed
> and breakfast accommodation" (Conway and Kemp,
> 1985, p30),

yet people with such coping capacities were least likely to
be living there (Drake et al, 1982). For people who, as a
consequence of mental illness, might have difficulties in
coping with day-to-day living, who might find close contact
with others stressful, and who might be particularly
vulnerable to both over- and under-stimulation, the
pressures of such conditions could be over-whelming. The
lifestyle and conditions imposed by bed and breakfast
accommodation were clearly the anithesis of the well-
structured environment providing neutral stimulation and

avoiding excessive emotional stress in which Wing and Brown suggested mentally disabled people fared best (Wing and Brown, 1970).

Home

The cramped and insecure conditions experienced in many HMO's clearly militated against any possibility of creating a 'home'. However, those who were successful in obtaining the tenancy of a flat also faced formidable obstacles to achieving this in many instances.

Even though the quality of accommodation provided by local authority housing departments varied, at least it offered security of tenure in a self-contained unit. However, the tenancy of an unfurnished flat is far from being a 'home' in the widely accepted sense, although it provides the basis for creating one. As indicated in Chapter Nine, a wide range of furnishings and equipment is necessary not simply in order to live, eat and sleep, but also in order to create an environment which allows social relationships and activities to develop and which reflects its occupant's individuality. Many mentally disabled people had no alternative but to look to the Social Security system to provide what they needed.

Payments have always been restricted to essential items, but in the past, the regulations incorporated elements of discretion which allowed some degree of flexibility, and the

advice of organisations such as CHAR to specify all the
items needed under specific broad headings such as
"sufficient storage units for clothing, food and household
goods" or "minor items such as cleaning implements, cooking
utensils, crockery and cutlery" helped to maximise the
payments made (CHAR, 1984). The August 1986 changes
eliminated such discretion although scope for discretion in
decisions about eligibility, etc., persisted.

The April 1988 changes restricted eligibility still further,
and people moving into independent accommodation have been
progressively disadvantaged by the Social Security system,
which "appear(ed) to be working in a way directly opposing
community care policies" (Audit Commission, 1986, p44).

For some mentally disabled people, whose behaviour might
have become passive and lacking in initiative as a result of
their illness, it was likely to present particular
difficulties. In addition, they might experience the same
reluctance and difficulty about giving information about
their mental health problems as in establishing
vulnerability under the Housing (Homeless Persons) Act.

Further, since the existence of mental illness tended to be
equated with having been a patient in a psychiatric
hospital, young people who had benefitted from the community
care policy might now be less readily categorised as
"mentally ill", especially if they had multiple problems,
and might therefore have found it harder to establish
eligibility for particular benefits.

Lack of financial resources frequently made the task of furnishing and equipping a flat to even a minimum standard extremely difficult. CHAR had warned those dependent on Single Payments under the Supplementary Benefit Regulations

> "There will almost certainly be a violent mismatch between your image of your home and what the DHSS payment will cover, even if generously interpreted" (CHAR 1984, p9).

At the time of the study, the 1986 changes were causing great concern to those working directly with mentally disabled people (and other vulnerable groups) since the maximum help that they could hope to obtain from DHSS under the revised regulations to establish a permanent home was a bed and bedding; a cooker; a heater; and £75.00. Clearly this was totally inadequate to provide even the most basic necessities. It was no longer possible for someone entirely dependent on state benefits to set up a home of even a minimum standard, let alone comfort.

Some local authorities and probation offices had begun to hold furniture stores, but concern was expressed that social workers were having to spend considerable amounts of time and effort trying to obtain furniture and equipment for their clients from a variety of charitable sources, to enable them to make a reasonable beginning in their new homes, and have some chance of settling successfully there. However, not only were charities and trusts finding their resources stretched by such increased demand, but making good the deficiencies in social security provision would seem to be an expensive and inappropriate use of local authority (and other) social workers' time. According to the head of one residential unit, clients and staff were now

forced to "beg, steal or borrow" everything that the individual in this situation needed; this was felt to be an untenable rôle, and was a source of great frustration and anger (Dugdale, 1989).

Indeed a number of workers in the field gave examples of people in this position either suffering a relapse requiring hospital readmission, or giving up the allocated tenancy without moving in and returning to temporary accommodation because they felt unable to cope with the stress of trying to set up a home using single payments, thus adding to their difficulties by a damaging experience of "failure":

> "Many claimants (will) simply give up any attempt
> to gain their own accommodation and furniture and
> resign themselves to a life of insecurity and
> dependence in either hotels, hostels or
> nightshelters" (Price, 1984, p.11).

The chance for them to re-establish a secure base and perhaps break a pattern of instability was thus lost.

At the root of their difficulties in creating a home which might begin to meet their needs for security and identity lay two problems; firstly that

> "Certain social security policies are designed to
> protect people with mental disabilities, but their
> criteria are so restrictive that they exclude
> large groups of vulnerable claimants, and are so
> stigmatising that they are thought to act against
> the normalising objectives of community care"
> (Stewart, 1988, p.10).

Perhaps even more fundamental was the fact that

> "The root of the problem for many claimants is the
> cumulative impoverishment arising from long-term
> subsistence on inadequate levels of benefit"
> (Stewart & Stewart, 1989).

Accommodation in schemes provided by health or social
service authorities or voluntary organisations usually
offered a higher standard of material comfort. However, the
extent to which this alone enhanced residents' sense of
'home' was sometimes open to question. The majority of
people when asked expressed a preference for an independent
tenancy (Kay and Legg, 1986, and the three service users in
the study). However, in spite of the tendency, described
above, to adopt restrictive selection criteria, there has in
the UK been an emphasis on shared living schemes for people
who need continuing support. The elements of choice and
control - particularly about the people one lives with -
could thereby be reduced, and the element of conformity
increased, even though in general these aspects of the
living situation represent a very great improvement on
hospital life (Norman and Parker, 1990).

Experience in the US showed that only a very small
proportion of chronically mentally ill people (65 out of
1,000 in one study) were unable to manage with support in
independent accommodation (Stein, Diamond and Factor, 1991).
This would suggest that the emphasis here on shared schemes
reflected the choice of service providers, rather than
service users, and yet it is

> " ... all-important to respect the desires of an
> individual. Trying to meet someone's 'dream' of

how they want to live can be the best guide to
success ... Conversely, we have found that people
rarely settled, much less developed, in housing
which was not the sort of thing they wanted, even
when it was well within their coping abilities"
(Lomas, 1987, p291).

In reality, many people were offered little opportunity for
discussion and less choice about where they would go after
discharge (Kay and Legg, 1986); even asking those destined
for shared accommodation who they would like to live with
appeared unusual (Norman and Parker, 1990).

Residence

The two preceding sections have identified some of the
factors which resulted in many mentally disabled people
finding themselves in poor quality accommodation, lacking
basic comforts in the least desirable areas. It was not
surprising in these circumstances that their relationships
with the neighbourhood should also be problematic on a
number of counts.

Evidence presented in Chapter Nine showed that many mentally
disabled people were isolated and lacked social supports.
For many (and also large numbers of people with a mental
handicap), 'community care' involved the process of
deinstitutionalisation, and on discharge from hospital their
links with the area where they were rehoused might be
tenuous at best. They also risked finding themselves the
focus of neighbourhood hostility rather than concern (Dear

and Wolch, 1987). As Jones pointed out, the 'community' now seen as the answer to the problems of mentally ill people is in fact the same 'society' which according to writers such as Laing, Goffman and Foucault contributed substantially to their problems in the first place (Jones, 1988).

Bulmer identified locally-based informal social networks and a sense of belonging as the two elements central to the definition of 'community' in the context of social care. He argued that whilst personality is integrated into the community by means of social networks, many mentally disabled people were likely to lack the capacity for reciprocity which underpins a wide range of social relationships. He also stressed "the delicacy and fragility" (Bulmer, 1987, p.138) and lack of objectivity of such networks, and

> " ... the extent to which informal caring grows out of existing social relationships. It is not something to be 'engineered' in a mechanical way, for example, by 'upholding' or 'plugging into' networks" (Bulmer, 1987, p.171).

Furthermore, the nature and intensity of the help provided by relatives in the Camberwell study (Wing, 1982) called into question the likely ability and willingness of neighbours and volunteers to take on such a demanding rôle. Indeed, given Bulmer's argument that "there is good evidence that one of the most important factors fostering ties between neighbours is length of residence" (Bulmer, 1987, p.138), help from neighbours, particularly for people moving out of hospital, might not be a realistic expectation.

Given the lack of informal support from both relatives and friends available to many mentally disabled people, formal support became more significant, and there was some evidence that mentally disabled people relied more heavily on this type of help (Audit Commission, 1986). However, preceding chapters have documented the existence of drastic shortfalls in resources at both national and local levels, and the associated development of service-dependent ghettoes (Dear and Wolch, 1987). Sources of funding such as the Manpower Services Commission Community Programme, imaginatively used in efforts by organisations concerned with mentally disabled people to provide for some of the social elements of community care, proved fragile and unreliable. Inevitably therefore, many mentally disabled people did not receive the type or level of support they needed from either formal or informal networks.

When all these factors were set alongside further evidence of widespread low self-esteem and poor sense of identity among mentally disabled people, together with the fact that for many of them 'community care' had also involved the experience of deinstitutionalisation, the existence of any sense of belonging to or participation in a community must be in question. If this were the case, serious doubts arose about the extent to which 'community' - and therefore community care - could be considered a meaningful concept for mentally disabled people.

Conclusion

In the process of trying to describe the reality of the plight of mentally disabled people in the community in terms

of the shelter - home - residence model, and identifying an
organising framework for the material, I found myself
repeatedly returning to the question of rights, and what
rights they possessed.

In practice their rights appeared to be minimal, and the
dichotomy between their needs (identified in terms of
shelter, home and residence) and their rights seemed to
provide a possible key to the understanding of the position
of mentally disabled people. It became clear that this lay
at the heart of the differing perspectives of the two groups
of key informants: the front-line workers talked primarily
in terms of the needs of individuals with which they were
immediately confronted, whilst the frame of reference of the
managers and policy makers was generally the more limited
one of fulfilling statutory obligations.

Needs were often unrecognised and unspecified at both policy
making and individual levels. Whilst recognising that

> "Handicaps which (prevent) a person from living
> easily with others in an ordinary domestic
> setting...(are) much more difficult to define
> (than work handicaps)" (Wing, 1965),

assessment before discharge appeared to be the exception,
yet the key to a mentally disabled person's successful
resettlement in independent (or indeed any) accommodation
would seem to lie in thorough and comprehensive assessment
of his or her needs.

However, my own study (Scott, 1986) indicated that only one out of 36 mentally ill people accepted as homeless and vulnerable under the <u>Housing (Homeless Persons) Act</u> had received the benefit of a detailed assessment of their level of functioning, skills and deficits in daily living, and present or future needs by the psychiatric or social services. Even when assessment took place

> "Not only is each agency likely to undertake its own idiosyncratic form of assessment (very often in ignorance of factors familiar to other agencies, so that decisions made by one group will not be accepted by others) but, because there is no co-ordinating mechanism, even decisions potentially acceptable to all may not be put into effect" (Ryan and Wing, 1979, p94).

In a context of growing pressure on resources of all kinds, the situation was becoming increasingly oppressive: far from benefitting from the 'prosthetic' environment which they arguably needed, mentally disabled people in many cases found that little more than their most basic survival needs were met, since their legal entitlement was restricted to a roof over their heads and a minimum income from Social Security.

Beyond the individual, at the broaders level of policy development and service delivery, Bulmer referred to the

> " ... vacuum at the heart of care policy which is likely to lead to ineffective or deteriorating provision of services, to the extent that care is transferred to 'the community'" (Bulmer, 1987, p.ix).

The result, in Britain as in the US, appeared to be that:

> "For many, the right to deinstitutionalisation has become a new legitimacy for neglect" Dear and Wolch, 1987, p26).

Notes

1. Gaining admission to psychiatric hospital also became more difficult due to the tightening of admission criteria (with strong emphasis on 'dangerousness' and 'refusal of treatment'), and the increasing complexity of admissions procedures (Hudson, 1992).

CHAPTER ELEVEN

CONCLUSION

Introduction

The aim of this piece of work has been to examine in some
detail the housing circumstances of mentally disabled
people. In order to explore this relatively undocumented
element of their lives it has been necessary both in the
research project and in discussion in Part Two to consider
also the broader context of community care. Since no
suitable theoretical framework appeared to be available,
Part Two has used the evidence of the research study and the
ideas generated by it to begin to construct one possible
framework.

Using a model of three components of housing need, the study
has argued on the basis of available evidence for an
important compensatory rôle for the housing of mentally
disabled people in the community, and contrasted this with
the reality of increasing difficulty in meeting even their
basic shelter needs. This final chapter will attempt to
account for the discrepancy between their needs and the
resources they are able to secure. To do so, it will begin
by reviewing some of the assumptions, influences and
confusions surrounding the concept and implementation of
'community care', in particular tracing the emergence of a
dominant discourse of rights.

The chapter goes on to explore how the needs of mentally
disabled people (specifically their housing needs, the
importance of which were strssed by the front-line
informants) could be better recognised and represented at
policy level, proposing increased emphasis on the notion of
social rights as a way of achieving this and linking

Marshall's early ideas of 'citizenship' and the currently
popular notion of the 'citizen' as consumer. It suggests
that the voice of the inarticulate and the powerless will
continue scarcely to be heard unless they are enabled to
make effective demands, and highlights the need for more
research focussing on user perspectives to contribute to
achieving this.

Community Care as Humanitarian Movement

It has been argued strongly that

> "No group of patients in need, most particularly
> chronic patients who cannot defend themselves and
> who are characterised by impotence when it comes
> to advocating on their own behalf, should be
> placed in the position of having to compete for
> scarce services" (Bachrach and Lamb, 1982, p157),

and yet the preceding chapters have shown that this is
precisely what happened. At the time of the research study,
more than 25 years after the Mental Health Act, 1959,
'community care' remained an elusive goal: in spite of the
lack of fundamental objections to the principle, there
remained strong reservations about the practicality of
achieving standards of provision which were even adequate.

There would appear to be a large number of apparently
disparate factors which have contributed to this situation,
some relating to philosophy or ideology, others to policy
decisions and their implementation; some with little obvious
direct connection with mentally ill people, others clearly

arising from a failure to recognise or respond to their needs and problems (and aspirations), whether these were linked to their psychological state itself, or to its personal and social consequences. However, an over-riding influence could be seen in community care's development as an uneasy but powerful "coalition of therapeutic radicals with fiscal conservatives" (Shepherd, 1990, p17).

The impetus towards deinstitutionalisation has been characterised as a type of civil rights protest movement (Bachrach, 1980). In many respects, the shift to community-based services represented a reaction against institutions, and in a sense therefore was a negative philosophy, with some of its tenets being ill thought-out. In Britain, as elsewhere in the Western world, the idea of 'community care' was enthusiastically welcomed as the antithesis of and the antidote to the evils of incarceration and institutional care. "Community" was seen by implication intrinsically good, positive and therapeutic (Busfield, 1986). However,

> "The idea of community is beguiling, but as a ...
> guide to policy it is almost wholly indefinite"
> (Plant, 1988, p20),

and as Wilkes pointed out:

> "Abstract ideological thinking, when put into
> practice, can have disastrous consequences for the
> individual" (Wilkes, 1981, p2).

At the same time, the emphasis in legislation relating to mental health, and notably in the UK the campaign led by

MIND to reform the <u>Mental Health Act, 1959</u>, was on ensuring greater protection for individual rights. The resulting 1983 Act introduced a number of provisions (including increased rights of appeal against compulsory detention, consent to treatment regulations and the creation of a Mental Health Act Commission) designed to protect the civil liberties of individuals before and during compulsory detention. However, it could be argued that increased emphasis on individual rights may have unfortunate consequences, including more defensive practice by professionals afraid of litigation, and a further reluctance to work with those "difficult" patients whose problems are the most complex and intractable. Whilst recognising the "honourable and indeed essential rôle" of the civil libertarian position, Sedgwick pointed out that "it has the crucial defect of being unable to focus therapeutic policy on any question other than the misuse of medical power", and was therefore primarily a reactive and negative stance (Sedgwick, 1982, p.217). The alignment of those who opposed institutions with the anti-psychiatry viewpoint reinforced this (Ramon, 1991, p182).

Freedom from incarceration in practice exposed mentally disabled people to a position of permanent disadvantage, including "conditions of life injurious to health" (Tawney, 1952, quoted in Marshall and Bottomore, 1992, p69).

Emphasis on negative freedoms was the correct discourse at a time when the net of welfare provision was expanding, since the problematic for those concerned about mentally ill people was to decide on the appropriate limits of intervention. However, this argument failed to recognise change in the political context, and the need for critics of

policy to address not the expansion but the withdrawal of welfare. In a changed political context, the argument became inadequate to ensure that the needs of vulnerable and powerless groups such as mentally disabled people were met; furthermore, it provided ideological support to justify the actions of those who sought to reduce provision. There was a considerable risk that the most severely disabled people were, in an evocative American phrase, "being left to rot with their rights on".

Community care and the control of public expenditure

Moves towards more liberal legislation concerning mentally ill people were paralleled by increasing emphasis among professionals and policy makers on change and cost-effectiveness, and it is essential to locate what was happening to mentally disabled people within the context of broader political and economic processes. The most important of these was the worsening economic situation worldwide from the mid-1970's, and associated government attempts to contain public expenditure (O'Connor, 1973). In Britain the drive to do this was characterised by marked hostility towards local government by successive Conservative governments after 1979. It was also associated with the adoption of a "New Right" ideological commitment to the free market, enterprise and the citizen as consumer, as well as extolling individual and family values at the expense of the "culture of dependency", arguments which

> " ... strike at the heart of the normative assumptions of the post-war welfare state" (Plant, 1991, p73).

The increasing numbers of the very poor have borne the brunt of these changes, particularly cutbacks in expenditure (Taylor-Gooby, 1988), but each of these factors can be seen to have worsened the position of mentally disabled people, who are likely to lack power as a result of their psychological impairments, isolation and deprivation, identified in earlier chapters.

Cost has long been a major factor in determining the nature of provision for mentally disabled people. In the nineteenth century, large public asylums were seen as being the cheapest way to deal with their growing numbers. Now instead, a policy of "community care" was advocated since its widespread reliance on non-professional and/or unpaid carers made this appear to be a cheaper alternative than trained staff and the need to maintain or replace large outdated buildings.

i) The mentally ill as 'therapeutic failures'

Both growing emphasis on cost-effectiveness and the rise of bio-technical medicine contributed to the perception of the mentally ill as therapeutic failures (Busfield, 1986; Stacey, 1988). Mental illness was embraced late in the day by the biomedical model, but in spite of the developments in drug treatments and early optimism about their potential, much severe mental illness defied attempts at "cure" or indeed rehabilitation (Bachrach and Lamb, 1982).

Consequently, many patients with mental disabilities were seen as unrewarding, unco-operative and ungrateful, rather than ill, and the health services tended to turn their interest and resources increasingly towards problems which appeared more amenable to resolution, to some degree within psychiatry itself but especially towards those in other areas requiring highly sophisticated techniques and technology.

A comparable situation developed in social work, where the achievement of change became the criterion for involvement. The prevention of deterioration, maintaining or making the situation tolerable by "showing concern and respecting human dignity" (Wilkes, 1981,p. 27) was in most cases no longer acceptable as sufficient reason for involvement. In a climate of cost-effectiveness, all undervalued groups - those whose lives or circumstances cannot be changed - lose out because

> "Change and development must result from professional social work intervention if time spent on it is to be justified" (Wilkes, 1981, p.10).

The concentration on those who were economically or therapeutically rewarding was reflected in the type of new resources created, particularly by Social Services Departments. Day centres and accommodation with short-term programmes, small group projects, etc., were often geared principally towards people with relatively mild or self-limiting difficulties. Such facilities were either inappropriate for severely disabled people or specifically excluded them (Hewett et al, 1975). Obviously there were powerful arguments in favour of offering preventive help at

an early stage (Caplan, 1969), but the resulting provisions could not be considered as appropriate alternatives to hospital for the more severely disabled people who continued to need a range of long-term and intensive help. When the resources they required to enable them to survive did not exist in their local areas (whether because locally elected bodies gave a low priority to their needs, or because other residents successfully mobilised to oppose the creation of facilities in their neighbourhood), many were forced into service-dependent ghettoes (Dear and Wolch, 1987).

ii)   The care-treatment divide

When in 1961, in the period of therapeutic optimism in psychiatry, the Government announced its intention to halve the number of mental illness beds, the implication was that hospital services would in future be for acute patients who would be discharged, treated and cured, after a brief admission, and not for those with needs for long-term care, which would be met by informal carers (Jones, 1972). Although the discharge of those who did not need in-patient care was seen as part of the humanitarian movement, it could be argued that the medical profession at this point in effect signalled its rejection of those people whose problems could not be promptly cured.

From the late 1970's onwards, demographic changes (e.g. increasing numbers of frail elderly people and single parent families) and deepening economic recession combined with government demands for cost-effectiveness led to severe

restraints on public expenditure and a renewed desire to
reduce the costs of formal services.

This had two major consequences in the fields of mental
illness and mental handicap: firstly, a government decision
to embark on a major closure programme for psychiatric
hospitals (up to one third of the total within 10 years)
(DHSS, 1981b); and secondly, intensified official interest
in the rôle of the informal sector. Community care would
mean

> "drawing on the resources of family, neighbours
> and voluntary groups rather than **over-reliance** on
> the services of full-time professionals in
> hospital" (DHSS, 1981b, p.22, emphasis added).

In the interests of cost-cutting, the government reinforced
the distinction between care and treatment, and claimed that
a substantial increase in the former was possible by the
informal sector (Walker, 1986).

Evidence from both the research study and the literature
gives little support to the existence of substantial
untapped resources in the informal sector (i.e. relatives,
neighbours, and volunteers) which could be used to provide
low-cost care. Moreover,

> "...it is largely forgotten or ignored that the
> relative is carrying out tasks that would
> otherwise be undertaken by a professional worker
> ... the examples given of problems of self-care
> and of difficult behaviour are sufficient to
> illustrate the fact that relatives often have to
> cope with the same kinds of problems as the staff

of residential and day units" (Wing, 1982, pp36-38).

The expectation that relatives themselves should continue to provide help at this level is questionable. For those people without relatives and with only the tenuous links to neighbours and community described in the previous chapter, it would appear unlikely that members of the community would be willing to take on such a heavy responsibility. Since

"There is good evidence that one of the most important factors in fostering ties between neighbours is length of residence" (Bulmer, 1987, p138),

help from neighbours, particularly for those moving out of hospital, may not be a realistic possibility. As Walker pointed out, the current official enthusiasm for 'neighbourhoodism' was ideologically naïve, since the formal and informal sectors were not alternatives, but inter-dependent with an infra-structure of formal services being essential to the operation of the informal sector (Walker, 1986). Moreover, reliance on the informal sector "does not eliminate dependency, but only redistributes it (away from the state)" (Plant, 1991, p87).

iii)   The paradox of community care

If it was indeed the case that certain groups were required to bear a disproportionate share of recent cost limitation policies (Taylor-Gooby, 1988), then community care posed a fundamental problem for mentally disabled people. If this

different model of service provision was to succeed in fulfilling one of its original major aims - offering a more satisfactory and humane way of providing for their needs - it would inevitably require an increase in the past very low levels of expenditure. Yet the necessary increase would not be forthcoming because the policy played a key rôle in limiting public spending. Indeed, one of the major costs to be saved by the Health Service as a result of transferring care to the 'community', but which needed to be substituted in other ways - the 'hotel' or accommodation cost - was the very area (housing) which bore the brunt of cutbacks in local government expenditure.

The fiscal crisis, the pressures of the curative ethos, and family values thus combined to interact in a multiplicative way to the detriment of mentally disabled people, and because community care was perceived to offer substantial opportunities for cost reduction by transferring many costs out of the public sector altogether, "financial constraints hasten(ed) rather than delay(ed) the move to community care" (Busfield, 1986, p350). The bulk of what resources were available went to the powerful, the therapeutically rewarding or those able to construct themselves as consumers.

This highlighted a fundamental conflict: bringing about the comprehensive and humane mental health service envisaged by the early advocates of community care (e.g. Royal Commission, 1957), and the present government's aim of "helping people to lead, as far as possible, full and independent lives" (DoH, 1989, Foreword), not only involved substantial costs (House of Commons, 1985; Hall and Brockington, 1991), but also depended on the very values of

interdependence and collective responsibility currently despised. The problems of creating a satisfactory service based on a community care model in which, in contrast to the institutional system, "professional advantage, humanitarian concerns and the economic and political interests of the state" do not coincide, would appear intractable as long as this inherent paradox remained unacknowledged (Busfield, 1986, p363).

A Way Forward?

The White Paper <u>Caring for People</u> stated that "suitable good quality housing" was considered to be "essential" to social care (DoH, 1989, p9), but realisation of this will be dependent on an understanding and acceptance of **how** housing contributes to individual well-being (i.e., the psychological and social needs which housing fulfills), and then on committing the necessary resources. Given that the effects of housing circumstances are well documented, the question arises as to why this has not been a focus of policy. The first part of this chapter has indicated that mentally disabled people did not fit easily into any of what could be argued were the limited rôles currently accepted by the state, namely those of change, control and consumerism. Because they did not fit, they were largely ignored, often until their mental state caused them to be either compulsorily detained or arrested and put in prison (Hudson, 1992).

If the official aim of the fullest and most independent life possible is to be realised, the challenge must be to find some means of ensuring more adequate provision of the care, treatment and resources needed by individuals with mental disabilities than the renewed emphasis on a limited notion of rights has achieved.

The concept of citizenship ("a formal recognition of the claims and responsibilities of individuals as members of a society" (Spicker, 1988, p65)) has the potential to do this by bringing together rights and needs. In his original formulation of civil, political and social rights, Marshall' defined the social element as

> "The whole range from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilised being according to the standards prevailing in the society" (Marshall and Bottomore, 1992, p8).

This has been criticised on grounds of vagueness, its implicit assumption that the process of development of citizenship rights was gradual and inevitable, and its reference only to state welfare provisions (Mishra, 1977). However, as well as referring to social rights as a basis of social policy, the notion of citizenship also refers to the exercise of citizenship, and the problem of

> "... the gap between formal enjoyment and existence of rights and their actual utilisation or enjoyment; between formal equality of status as citizen and the substantive inequality resulting from the facts of stratification" (Mishra, 1977, p31).

Although fifteen years ago, Mishra could suggest that western Europe had moved beyond a stage in the development of social policy in which the concept was relevant, he conceded that "it may still be useful in the struggle against a residual social policy" (Mishra, 1977, p31). For this reason, as dissatisfaction with the shortcomings of the market as a mechanism to allocate "the basic goods of citizenship" has become more widespread, there has been renewed interest on the left in the notion of citizenship as a means of ensuring the rights to resources of disadvantaged individuals and groups (Plant, 1988; 1991).

It would be facile to suggest that any single factor could be sufficient to redress all the shortcomings of the present situation. Attention to many other elements will clearly be essential in attempting to realise the enormously complex task of establishing satisfactory standards of community care for mentally disabled people and other vulnerable people. These include the reconciliation of conflicting priorities and interests among the many different agencies involved; the creation of organisational structures and systems which are flexible and responsive but clearly accountable, as well as material and human resources which are both adequate and appropriate.

A number of government decisions and statements since the research study took place could be seen to demonstrate political commitment to improving the position of people with long-term mental disabilities, but the strength of this commitment has been belied by other events and actions such as the two-year postponement in implementing community care legislation.

The "thoroughgoing" rejection of the concept of social
rights in the UK since the late 1970's has been linked to
the exceptionally severe nature of the economic and social
problems which are currently faced, in comparison with other
western European countries (Marshall and Bottomore, 1992).
Further, it is implied that the abandonment of citizenship,
and particularly social rights, has been damaging at a
collective as well as an individual level, i.e., that this
shift is questionable on grounds of efficiency as well as
moral grounds.

However, whilst arguing for a society based on citizenship
as a means of empowering all citizens to achieve their
rights (and accept concomitant responsibilities), Plant
cautions that after years of being undermined, commitment to
the "community" by its members can no longer be assumed, and
must be rebuilt (Plant, 1988).

Equally, since it has been found that long-term users of
mental health services overwhelmingly "experience themselves
as powerless to make housing choices (Hatfield et al, 1992,
p70), many may need to be enabled to translate the simple
possession of rights to housing and other "basic goods of
citizenship" into an effective claim.

Although "intervention in the life of another for their own
good may be just as inimical (as coercion) to individual
freedom" (Wilkes, 1981, p.57) and intervention inevitably
raises complex and important issues of ethics and values, it
could be argued that the case of people with impaired

intellectual or cognitive functioning presents special
problems: it may be that intervention - carefully considered
and sensitively carried out - is necessary if the individual
is to possess freedoms such as choice in any meaningful
sense. The importance of this seems to have been recognised
to a far greater extent in work with people with learning
disabilities, where the principles of normalization are
extensively applied, and the need to take active steps to
enable some people to share in socially valued experiences
is well established (Williams, 1985).

To date research has largely ignored the views of mentally
disabled people in the community, perhaps because
researchers share widespread societal attitudes, perhaps
because this type of research presents considerable
methodological challenges. Because of their particular
problems of communication and vulnerability to stress, as
well as the other personal and social consequences of their
experience of mental illness, the methods of the positivist
tradition tend to produce unreliable results and frustration
for researchers. However, research studies have the
potential to make a significant contribution towards
ensuring that the views and wishes of mentally disabled
people are in future better represented in issues and
decisions which affect them. The rules in such studies need
to be those of careful, traditional ethnography,
incorporating an empathetic approach and willingness to
adapt styles of communication to the user (Norman and
Parker, 1990).__The picture of specific needs which emerges
can then be drawn into service design and planning (Kingsley
and Towell, 1988).

Greater attention to the voice of mentally disabled people
is however not simply desirable. It is vital since

> "We have no doubt that the worst results occur
> when service planning is indifferent to the needs
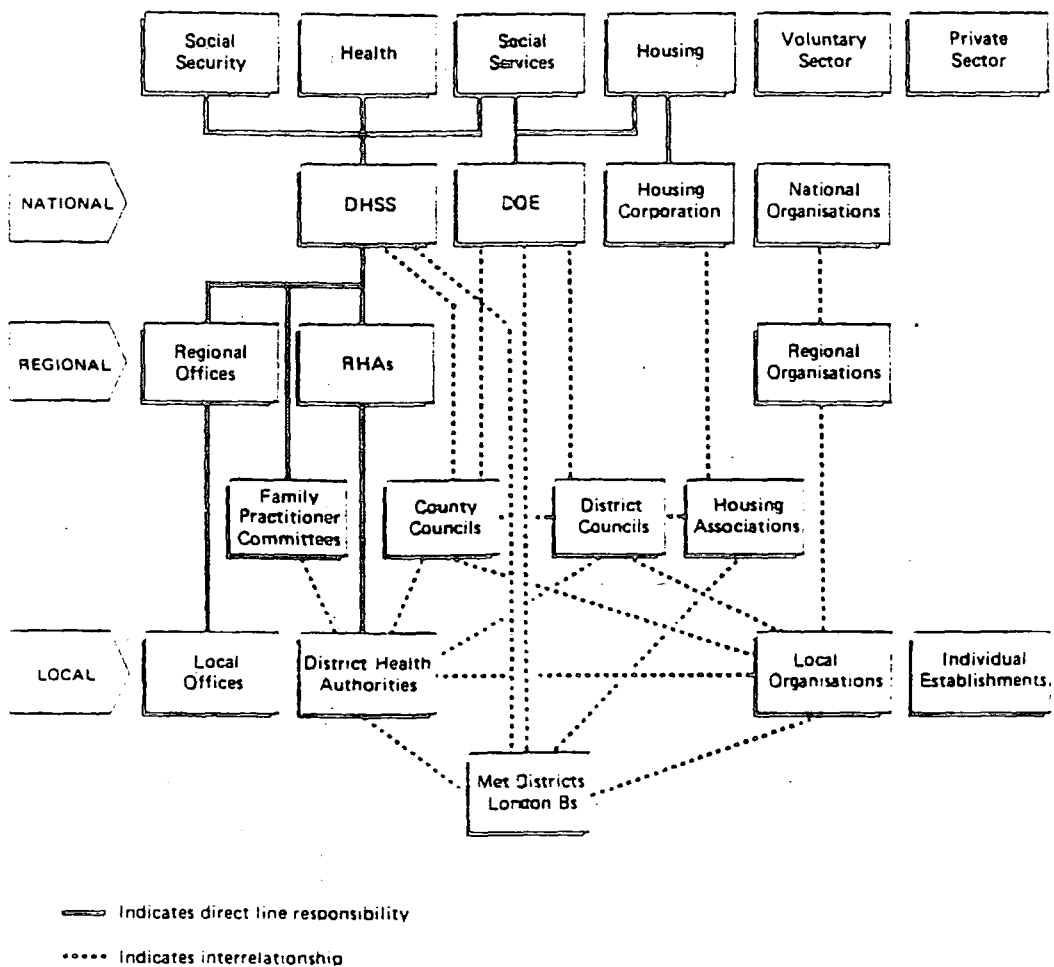> of mentally ill people" (Huxley, 1990, p2).

Notes

1. Housing Departments are not alone in using territorial
arguments in this way. A recent editorial in the British
Medical Journal reported that "Many hospital specialties
deny responsibility for the homeless by using catchment area
restrictions", and included psychiatry in this (British
Medical Journal, 28.1.1989, p.3)

LIST OF APPENDICES

APPENDIX 1.1

PRINCIPAL AGENCIES INVOLVED IN COMMUNITY CARE

━━━ Indicates direct line responsibility

••••• Indicates interrelationship

Source: Audit Commission, 1986

APPENDIX 1.2

MAIN CARE AND ACCOMMODATION SERVICES

AGENCY	FORM OF CARE	SERVICE	VARIATIONS
Health Authorities	Hospitals	— In-patients	— Long-stay — Short-stay/respite
		— Day	
	Residential	— Community units — Nursing homes	
	Community Services	— Nurses	— Qualified — Auxiliary
		— Health visitors	
		— Therapists	— Physiotherapists — Chiropody
Family Practitioner Committees	Primary Health Care	— GPs — Nurses — Dental and opthalmic services	
Social Services	Residential	— Residential homes	— Long-stay — Short-stay/respite
	Accommodation	— Staffed group homes	
		— Unstaffed group homes	
		— Sheltered lodgings	
	Day Care	— Workshops	
		— Day centres	
		— Training centres	
		— Drop-in centres	
	Domiciliary	— Social workers	
		— Good neighbours	
		— Home helps	
		— Therapists	— Occupational
Housing Authorities	Housing	— Sheltered housing	— Wardens — Alarm systems
		— Hostels	
		— Group homes	
		— Flats/houses	— Improvement grants
Education	Training facilities for adults		
Voluntary Sector and Housing Associations	Residential Housing	— Residential homes — Group homes — Sheltered housing — Flats/houses	— For special needs
	Day Care	— Luncheon clubs — Drop-in centres	
	Domiciliary	— Care attendant schemes — Volunteers/good neighbours	
Private Sector	Residential	— Nursing homes — Residential homes	
	Housing Domiciliary	— Sheltered housing — Domestic agencies	

Source: Audit Commission, 1986

APPENDIX 2

INTERVIEWS WITH KEY INFORMANTS

NAME: DATE OF INTERVIEW:

POSITION HELD:

ROLE:
1. INTRODUCTORY: IDENTIFY GROUPS OF MENTALLY ILL PEOPLE)

2. BACKGROUND INFORMATION

    (including: description of agency,
    - role and functions
    - structure and organisation
    - area covered (including MAPS)
    - statements of policy
    - resources provided by agency
    - other resources in area
    - changes/developments planned.

3. WHAT IS YOUR VIEW OF THE HOUSING SITUATION OF MENTALLY
    DISABLED PEOPLE?

    (including: - any problems: please specify
        - size of problem?
        - what specific circumstances cause difficulty?
        and why?
        - whose responsibility?
        - what action/changes are needed to improve
        situation?

4. WHAT CONTACTS/LINKS EXIST WITH OTHER AGENCIES?

    a) Official

    b) Day to day

5. WHAT CONTACTS/LINKS EXIST WITH D.H.S.S. (INCOME
    MAINTENACE)?

6. IN YOUR OPINION, WHAT CONSTITUTES A GOOD HOUSING
    SERVICE TO MENTALLY DISABLED POEPLE?
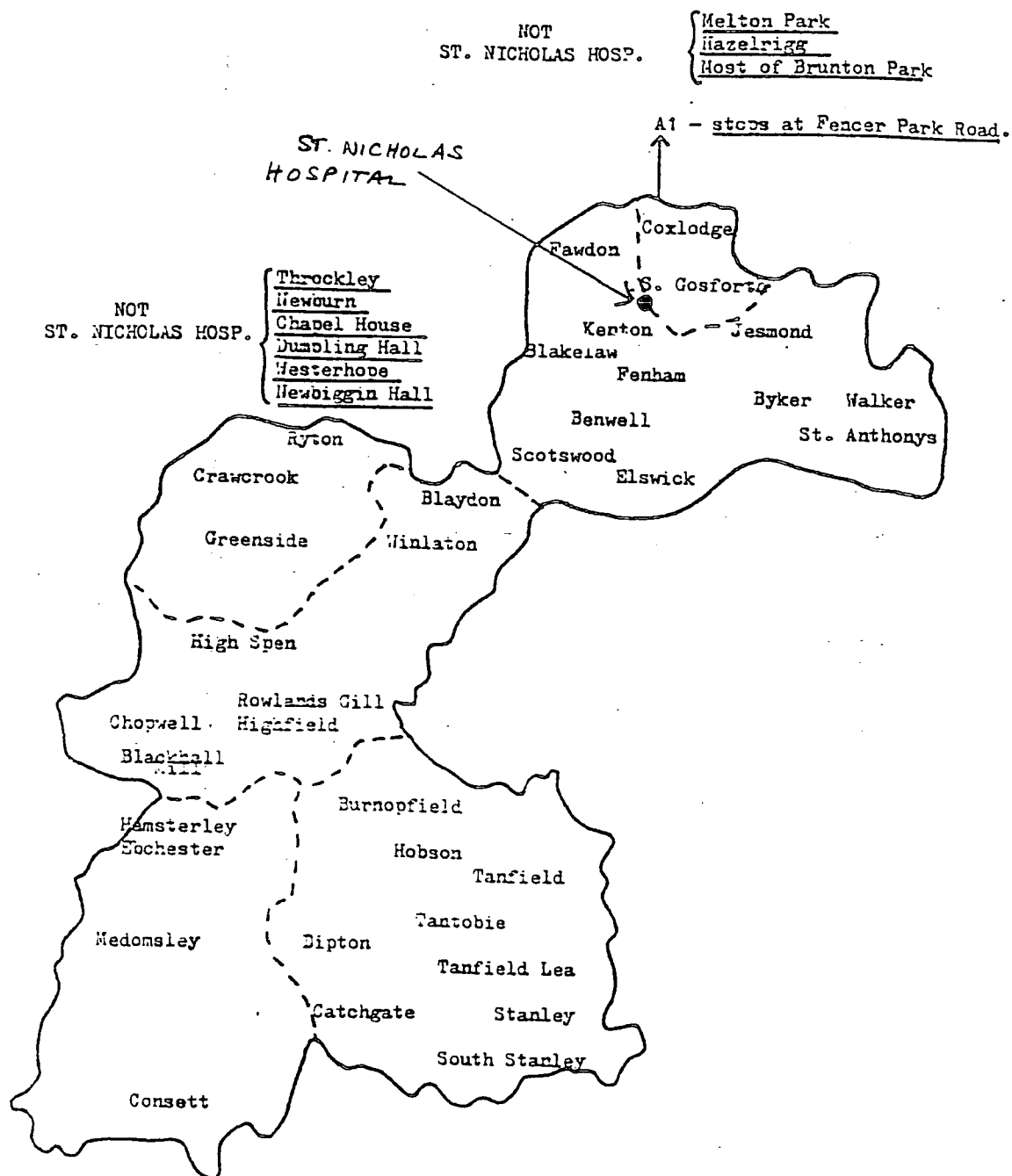
7.   ADDITIONAL COMMENTS/INFORMATION

SPECIFIC QUESTIONS/AREAS TO BE COVERED WITH DIFFERENT
AGENCIES

1.   MENTAL HEALTH UNIT: Overview – current and future.
     GENERAL MANAGER   Finance, especially joint-funding.
                          The role of Local Authority
                          Housing.

2.   HOSPITAL AND AREA S.W. MANAGERS:
                          Joint funding;
                          priorities

3.   SOCIAL WORKERS: Day to day difficulties
                          What other agencies/personnel do
                          they liaise with?

4.   HOUSING DEPARTMENTS: Housing stock
                                  Lettings / allocation policy –
                                  Sec 44 / eligibility
                                  Policy re: single people
                                  Policy re: mentally ill

                                  Who makes decisions re:
                                  allocation ?
                                  medical priority ?
                                  vulnerability ?

                                  Role of community physician

                                  Homeless people (H(HP)Act)

                                  Long term hospital patients
                                  local connection

                                  Types of property allocated

                                  Official liaison mechanisms
                                  with Health and SSD's/joint
                                  funding

                                  What happens to people not
                                  accepted ?

                                  HMO's and B&B - numbers?
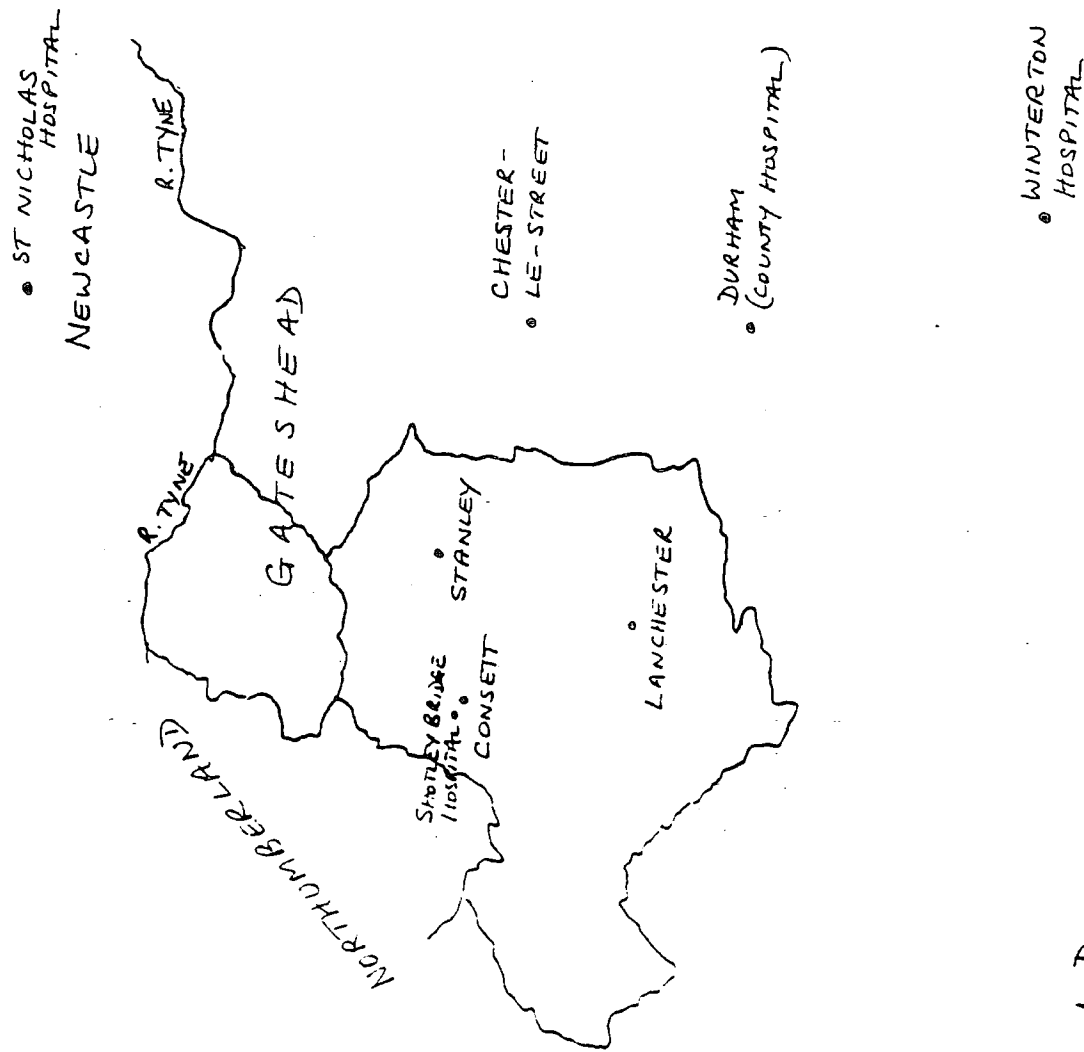   quality? problems?

5. D.H.S.S.   Effects of Social Security changes -
especially single payments.
Effects of Suitable Alternative
Furnished Accommodation rule.

6. VOLUNTARY AGENCIES/HOMELESSNESS:
Proportion of mentally ill people among
their clientele.
Provision made by their agency for M.I.
Problems arising from housing situation
for individuals.
Do they vary between different Local
Authorities.

7. CONSUMERS: Their experience of discharge/ being
rehoused - difficulties, if any.
What helped/would have helped?
Satisfaction with present accommodation
(type of accommodation)
Changes/improvements?

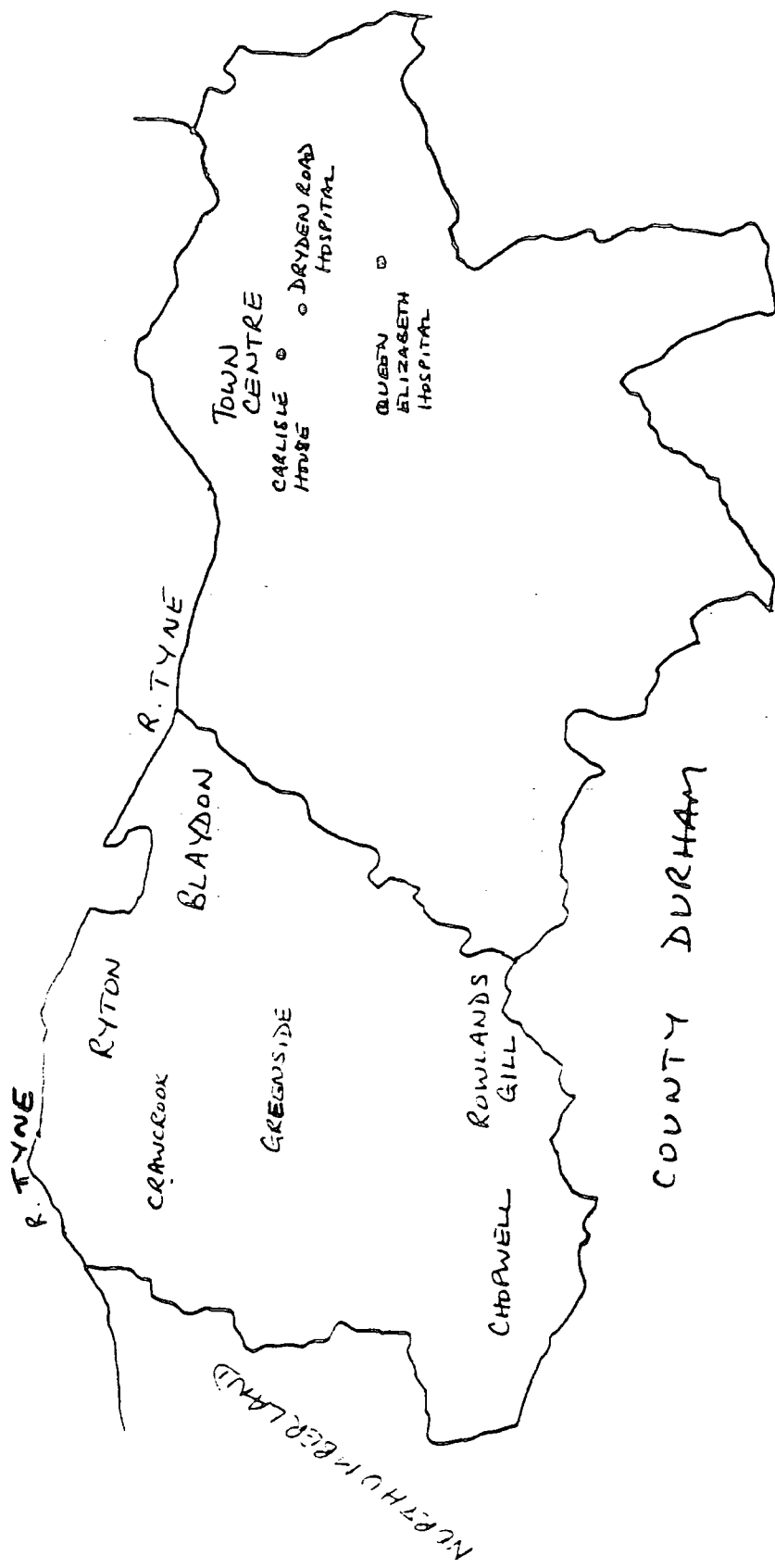APPENDIX 3.1

CATCHMENT AREA – ST. NICHOLAS HOSPITAL, COSFORTH

NOT
ST. NICHOLAS HOSP.

{ Melton Park
Hazelrigg
Most of Brunton Park

A1 – stops at Fencer Park Road.

ST. NICHOLAS
HOSPITAL

Coxlodge

Fawdon

S. Gosforth

NOT
ST. NICHOLAS HOSP.

{ Throckley
Newburn
Chapel House
Dumpling Hall
Westerhope
Newbiggin Hall

Kenton   Jesmond

Blakelaw

Fenham

Benwell

Byker   Walker

St. Anthonys

Scotswood

Elswick

Ryton

Crawcrook

Blaydon

Greenside   Winlaton

High Spen

Rowlands Gill

Chopwell ·   Highfield

Blackhall
Mill

Burnopfield

Hamsterley
Rochester

Hobson

Tanfield

Medomsley   Dipton

Tantobie

Tanfield Lea

Catchgate   Stanley

South Stanley

Consett

APPENDIX 3.2

DERWENTSIDE / N.W. DURHAM

APPENDIX 3.3

GATESHEAD

APPENDIX 3.4

CITY OF NEWCASTLE UPON TYNE
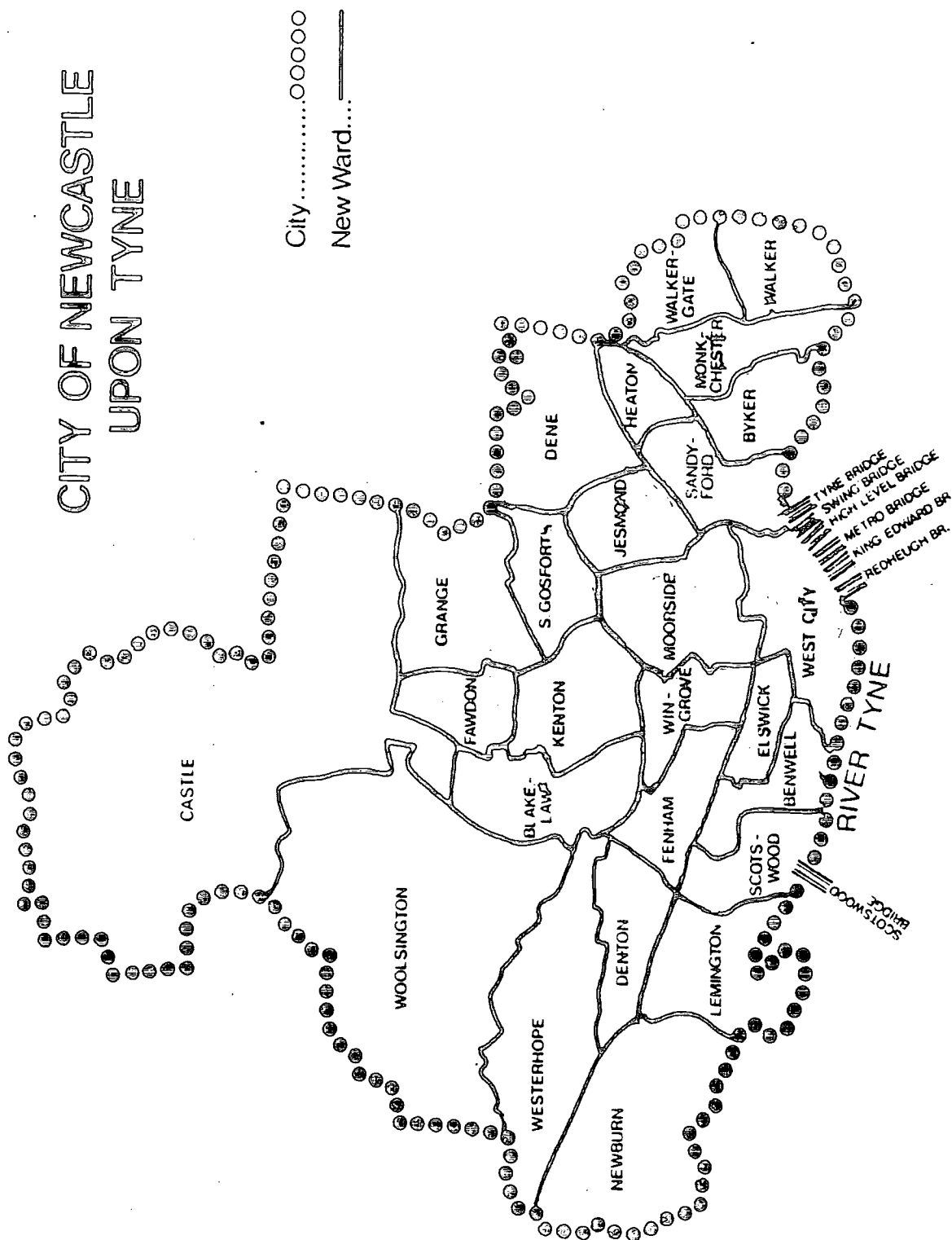
Chief Housing Officer
J.M. HALL. D.M.A.. F.C.I.S.
Civic Centre.
Consett,
Co. Durham.
DH8 5JA

DERWENTSIDE
DISTRICT
COUNCIL

Telephone · Consett 505211/5034
STD Code 0207

District Office
Front Street, Stanley
Telephone · Stanley 234911

Your Ref:
My Ref: Letter 1/
Ask For: Arrears Office
Ext: 266

Dear Sir/Madam,

I have to remind you that for the rent period expiring on the

.... fortnight ....
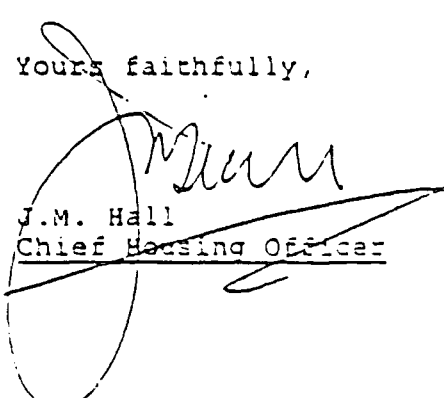
an amount of £.............. was outstanding in respect of rent
arrears. Please arrange to pay this amount together with the
rent for the current rent period by the end of the present
fortnight.

I am required to inform you of one of the Conditions of your
Tenancy which requires you to pay your rent every fortnight,
the latest date for payment being the second Friday of each
fortnight and would point out that unless payments are made
fortnightly in future further action will be taken.

If you dispute the arrears figure quoted above or you require any
further information in respect of your rent arrears you should
immediately, on receipt of this letter, call at or telephone one
of the Housing Offices, the addresses and telephone numbers of
which are shown above.

You are reminded that the Council operates the national Housing
Benefit Scheme (formerly known as rent and rate rebates schemes)
and if you are not already in receipt of benefit but feel that
you may qualify you are urged to make application on the
appropriate form which can be obtained from any Housing Department
Office.

Yours faithfully,

J.M. Hall
Chief Housing Officer

DERWENTSIDE
DISTRICT
COUNCIL

Chief Housing Officer
J.M. HALL. O.M.A.. F.C.I.S..
Civic Centre.
Consett.
Co. Durham.
DH8 5JA

Telephone · Consett 505211/503434
STO Code 0207

District Office
Front Street, Stanley
Telephone · Stanley 234911

Your Ref :
My Ref   : Letter 2
Ask For : Arrears office
Extn   : 266

Dear Sir/Madam,

ARREARS OF RENT

My records indicate that as at .... fortnight..........

an amount of £............ was outstanding in respect of rent arrears.
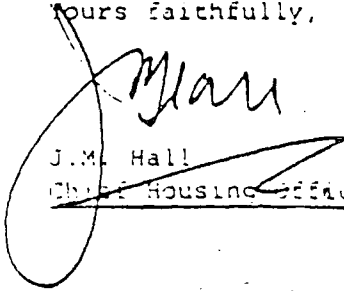
Please note that unless the arrears are paid in full and your rent account cleared
by the end of the current fortnight the Council will issue a Notice of Seeking
Possession which is the first step in the legal process of obtaining possession
of the property you occupy and will consider referring your case to the Bailiff.
(Further information regarding legal proceedings and the involvement of a
Bailiff is contained in the attached notes.)

If you dispute the arrears figure quoted above you should contact the Arrears Office
on the above extension.

HOWEVER, I WOULD REMIND YOU THAT IT IS A CONDITION OF YOUR TENANCY THAT RENT IS PAID
EVERY FORTNIGHT AND IF ANY FURTHER PAYMENT IS MISSED WITHIN THE NEXT SIX MONTHS A
NOTICE OF SEEKING POSSESSION WILL BE ISSUED AND CONSIDERATION GIVEN TO REFERRING THE
MATTER TO A BAILIFF WITHOUT FURTHER REFERENCE TO YOU.

You are also reminded that the Council operates the national Housing Benefit Scheme
(formerly known as rent and rate rebate schemes) and if you are not already in
receipt of benefit but feel that you may qualify you are urged to make application
on the appropriate form which can be obtained from any Housing Department Office.

Yours faithfully,

J.M. Hall
Chief Housing Officer

N O T E S

1. LEGAL ACTION

The issue of a Notice of Seeking Possession is the first step
in a legal procedure which could result in you being required
to vacate the Council dwelling you occupy. The legal procedure
involves certain costs which are the tenants responsibility and
which are related to the amount of rent arrears involved and
frequently amount to £30 - £40. It is in your own interests
to avoid the need for legal action and therefore costs by clearing
the arrears before the end of the current fortnight.

2. USE OF BAILIFF

The Council has decided to retain the services of a Bailiff in
an effort to combat the increase in rent arrears.

When a case is referred by the Council to the Bailiff, he (or
his representative), will call at the property in question and,
in the company of the tenant, make a list of such items of
furniture and equipment which - if sold by public auction - are
likely to realise sufficient money to cover the rent arrears in
question. The Bailiff will then try to come to an arrangement
with the tenant for the payment of the arrears over a period of
time (normally between five and twenty days). If an arrangement
is made and kept the Bailiff will take no further action other
than the collection of monies owed and his costs (see below).
If an arrangement is not kept the Bailiff will report back to
the Council. The Council will then decide whether or not to
authorise the Bailiff to remove furniture/equipment and sell it
and use the proceeds of the sale to pay off the arrears.

If a case is referred to the Bailiff certain costs are incurred
and these are the responsibility of the tenant concerned. It
is difficult to give a precise estimate of costs as they vary
from case to case but on a debt of £100 paid to the Bailiff over
a 20 day period the costs would be approximately £12.

DERWENTSIDE
DISTRICT
COUNCIL

Chief Housing Officer
J.M. HALL, D.M.A., F.C.I.S?,
Civic Centre,
Consett,
Co. Durham.
DH8 5JA

Telephone · Consett 505211/503434
STD Code 0207

District Office ',
Front Street, Stanley
Telephone · Stanley 234911

Your Ref:
My Ref:
Ask for:
Ex:

Date _____

THIS NOTICE IS THE FIRST STEP TOWARDS REQUIRING YOU TO GIVE UP POSSESSION OF YOUR DWELLING. YOU SHOULD READ IT, AND ALL THE NOTES, VERY CAREFULLY.

HOUSING ACT 1980, Section 33.

NOTICE OF SEEKING POSSESSION

1.   To:

2.   The Derwentside District Council intends to apply to the Court for an order requiring you to give up possession of:-

3.   Possession will be sought on Ground 1 of Schedule 4 to the Housing Act 1980 which reads:-

      Any rent lawfully due from the tenant has not been paid or any obligation of the tenancy has been broken or not performed.

4.   The reasons for taking this action are:-

      That you have failed to pay your rent in accordance with the terms of your Tenancy Agreement (Clause 1), and your rent is in arrears.

5.   The Court proceedings will not be begun until after _____

Signed

      Chief Housing Officer

┌   ┐

                                    On behalf of Derwentside District Council

└   ┘

IMPORTANT · SEE NOTES OVERLEAF

NOTES

GROUNDS FOR POSSESSION

1.   If you have a secure tenancy under the Housing Act 1980, you can only be required to leave your dwelling following an order of the Court on one or more of the grounds set out in the Act. Paragraph 3 of this Notice tells you on what Grounds an order is sought against you and paragraph 4 gives the landlord's reasons for believing those Grounds apply. If you do not agree that they apply, you will be able to argue your case at a hearing in Court.

DOES THE COURT HAVE TO GRANT THE LANDLORD POSSESSION?

2.   Before the Court grants an order on any of the grounds 1 to 6 or 10 to 13 it must be satisfied that it is reasonable to require you to leave. This means that, if one of these Grounds is set out in paragraph 3 of this Notice, you will be able to argue to the Court that it is not reasonable you should have to leave, even if you accept the Grounds do apply.

SUITABLE ALTERNATIVE ACCOMMODATION

3.   Before the Court grants an order on any of the Grounds 7 to 13 it must be satisfied that there will be suitable alternative accommodation for you when you have to leave. This means that the Court will have to decide that, in their opinion, there will be other accommodation which is reasonbably suitable for the needs of you and your family, taking into particular account various factors such as the nearness of your place of work, and the sort of housing that other people with similar needs are offered. Your new home will have to be let to you on another secure tenancy or a private tenancy under the Rent Act of a kind that will give you similar security; There is not requirement for suitable alternative accommodation where grounds 1 to 6 apply.

4.   If your landlord is not a local authority, and the local authority gives a certificate that they will provide you with suitable accommodation, the Court has to accept the certificate.

5.   Whatever Grounds for possession are set out in paragraph 3 of this Notice, the Court may allow any of the other Grounds to be added at a later stage. If this is done, you will be told about it so you can argue about the new Ground if you want to.

TIME LIMITS

6.   Court proceedings cannot be begun until after the date given in paragraph 5 of this Notice. This date cannot be earlier than the date when your tenancy or licence could have been brought to an end. This means that if you have a weekly or fortnightly tenancy, there should be at least 4 weeks between the date this notice is given and the date in paragraph 5.

7.   After the date in paragraph 5, court proceedings may be begun at once or at any time during the following twelve months. Once the twelve months is up the notice will lapse and it will be necessary for a new notice to be served before possession can be sought.

LEAVING WITHOUT A COURT ORDER

8.   If you are willing to give up possession without a Court order, you should notify the person who signed the notice as soon as possible and say when you would leave.

FURTHER ADVICE

9.   If you need advice about this Notice, and what you should do about it, take it as quickly as possible to the Housing Department or to a Citizens' Advice Bureau, a Housing Aid Centre, a Law Centre, or to a Solicitor. You may be able to receive Legal Aid but this will depend on your personal circumstances.

APPENDIX 5.1

PLANNING POPULATIONS

CROSS BOUNDARY PATIENT FLOWS FROM GATESHEAD
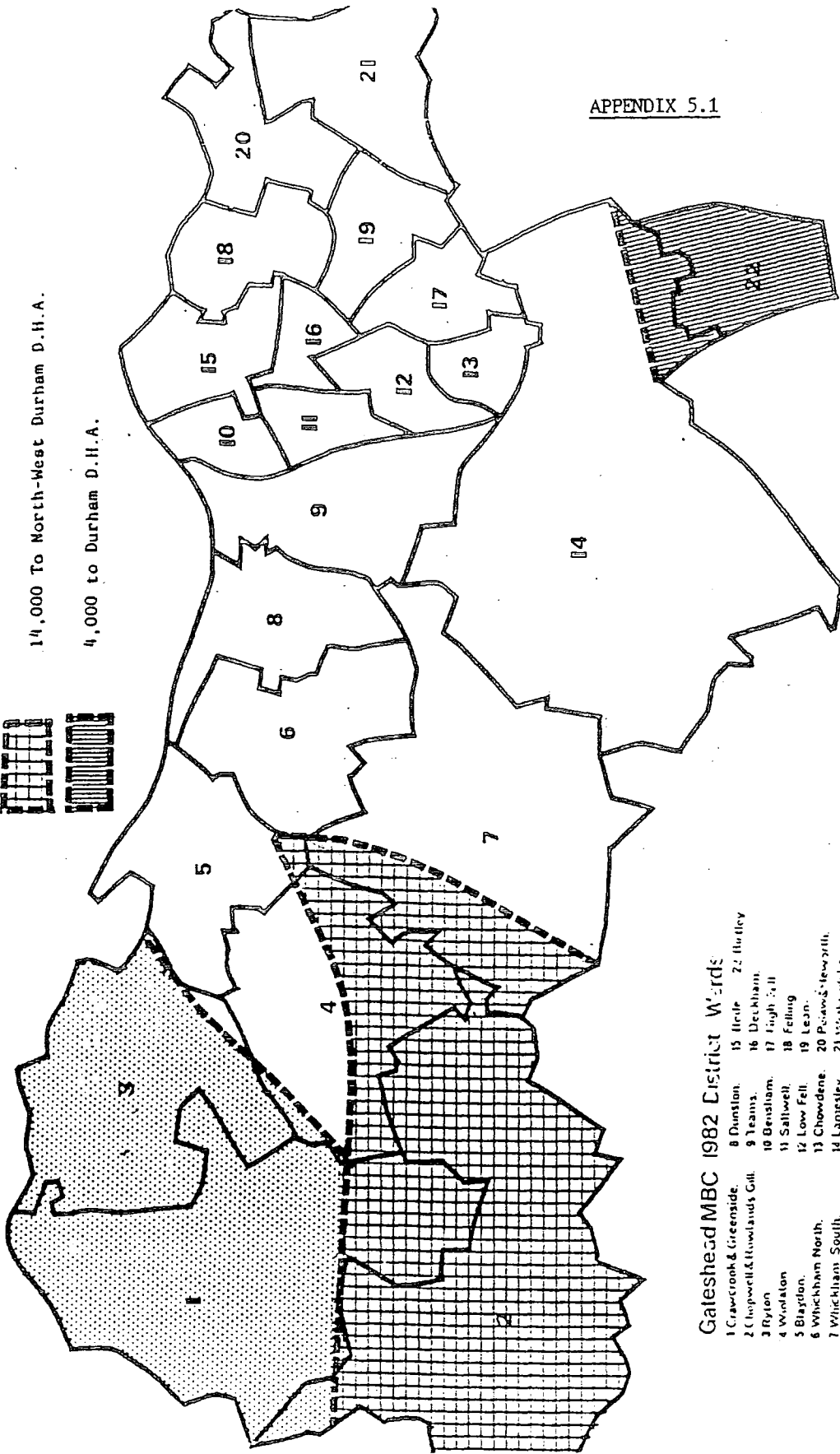
ACUTE SERVICES 1986
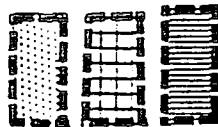
9,000 to Northumberland D.H.A.

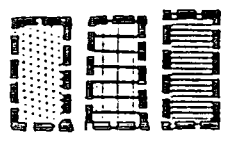14,000 To North-West Durham D.H.A.

4,000 to Durham D.H.A.

Gateshead MBC 1982 District Wards

1 Crawcrook & Greenside.
2 Chopwell & Rowlands Gill.
3 Ryton
4 Winlaton
5 Blaydon.
6 Whickham North.
7 Whickham South.
8 Dunston.
9 Teams.
10 Bensham.
11 Saltwell.
12 Low Fell.
13 Chowdene.
14 Lamesley.
15 Hyde.
16 Deckham.
17 High Fell.
18 Felling.
19 Leam.
20 Pelaw & Heworth.
21 Wrekendyke.
22 Hurtley

APPENDIX 5.2

PLANNING POPULATIONS

CROSS BOUNDARY PATIENT FLOWS FROM GATESHEAD

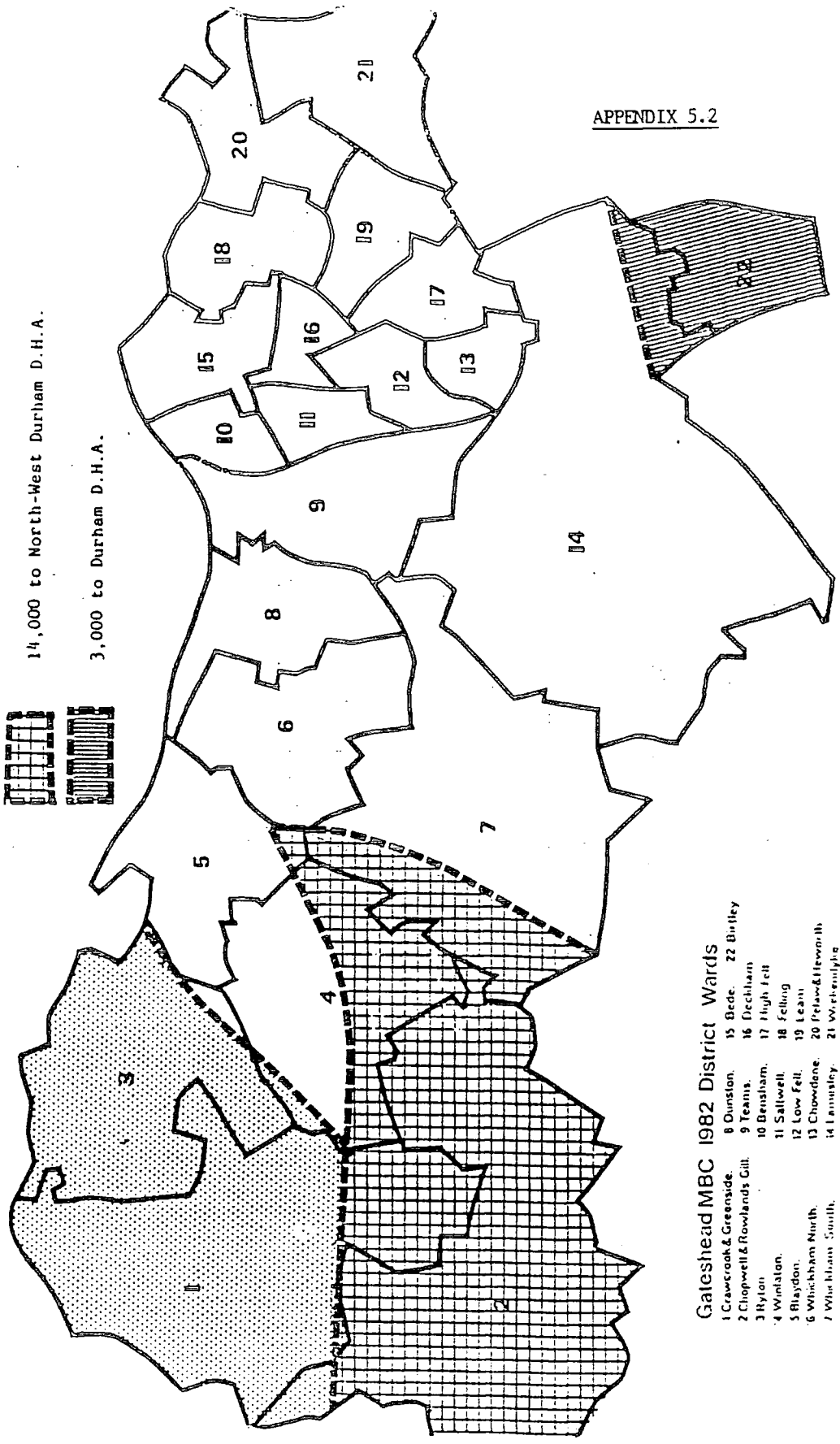ACUTE SERVICES 1995

9,000 to Northumberland D.H.A.

14,000 to North-West Durham D.H.A.

3,000 to Durham D.H.A.

Gateshead MBC 1982 District Wards

1 Crawcrook & Greenside.	8 Dunston.	15 Bede.	22 Birtley
2 Chopwell & Rowlands Gill.	9 Teams.	16 Deckham.	
3 Ryton.	10 Bensham.	17 High Fell	
4 Winlaton.	11 Saltwell.	18 Felling	
5 Blaydon.	12 Low Fell.	19 Leam	
6 Whickham North.	13 Chowdene.	20 Pelaw & Heworth	
7 Whickham South.	14 Lamesley.	21 Wrekendyke	

PLANNING POPULATIONS

CROSS BOUNDARY PATIENT FLOWS FROM GATESHEAD

MENTAL ILLNESS 1986
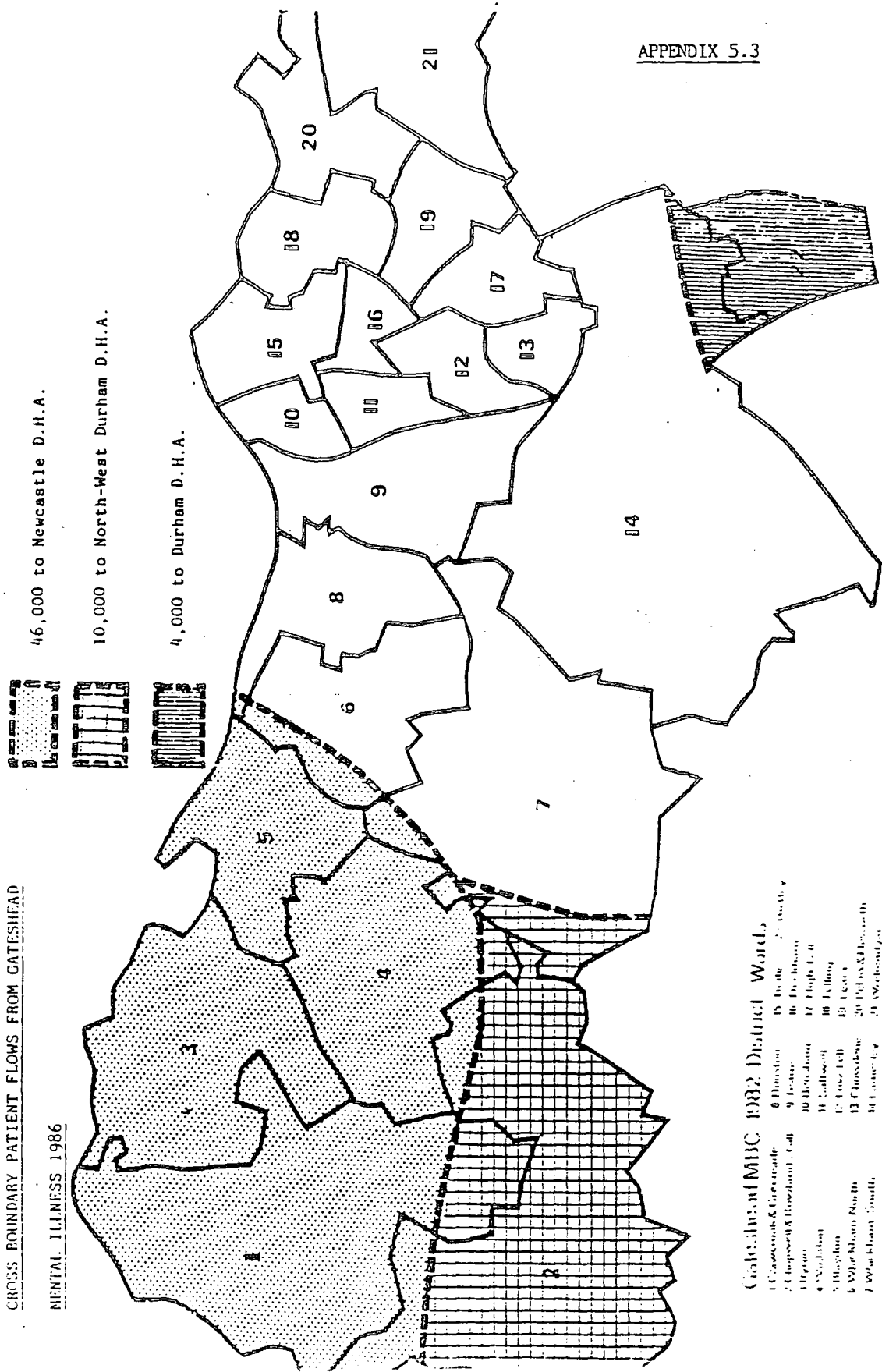
46,000 to Newcastle D.H.A.

10,000 to North-West Durham D.H.A.

4,000 to Durham D.H.A.

Gateshead MBC 1982 District Wards.

APPENDIX 5.4

PLANNING POPULATIONS

CROSS BOUNDARY PATIENT FLOWS FROM GATESHEAD

MENTAL ILLNESS 1995

9,000 to Northumberland D.H.A.

10,000 to North-West Durham D.H.A.

Gateshead MBC 1982 District Wards:
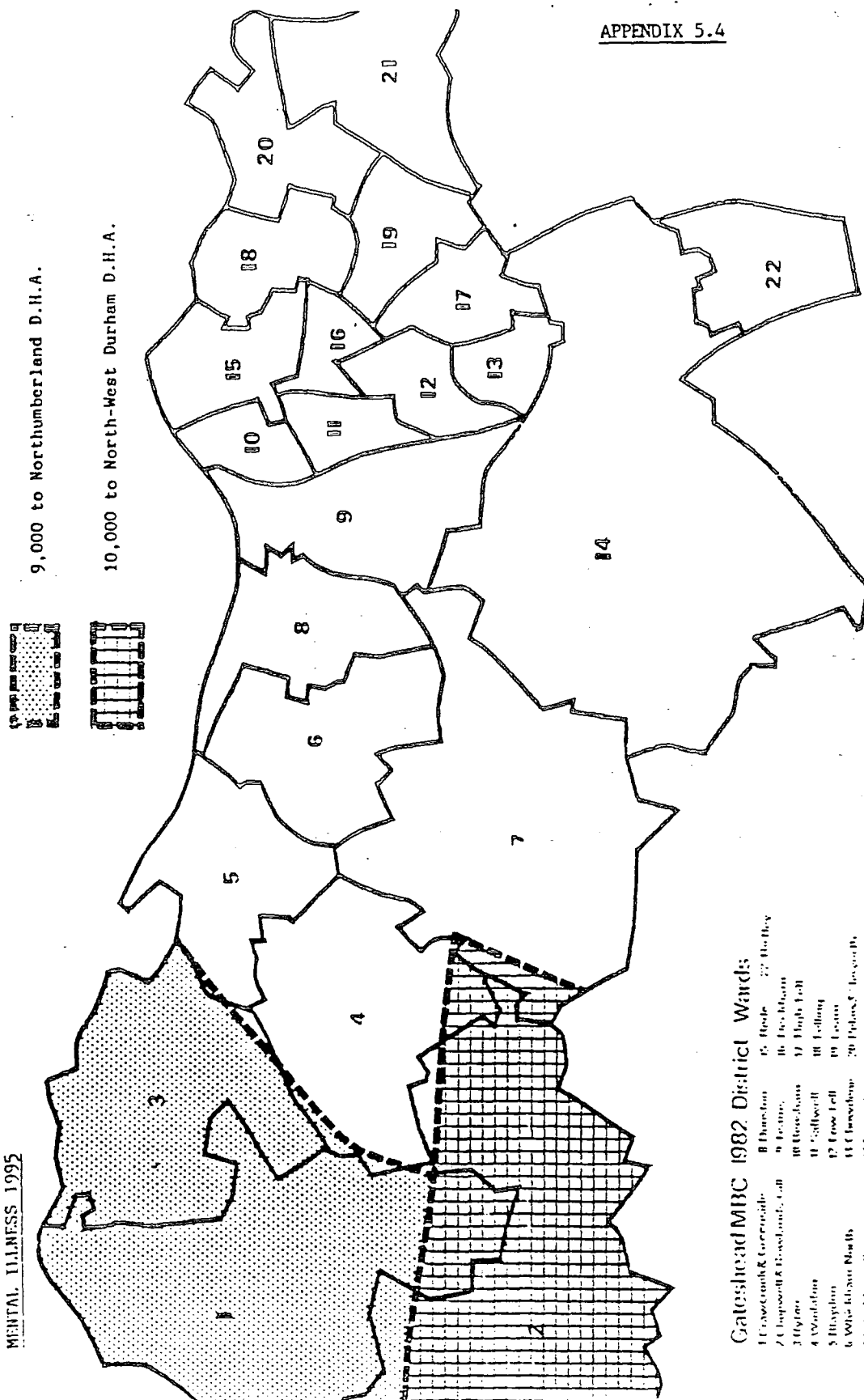
St. Mary's Hospital

Gateshead Health Authority

APPENDIX 6

Telephone:
Stannington 333
(STD Code 067089)

Stannington
Morpeth
Northumberland
NE61 6AA

Your Ref:
    DB/JS

Our Ref:
   13 March 1989

CONSENSUS FORUM - GATESHEAD MENTAL HEALTH SERVICES

Dear Colleague

CONSENSUS FORUM

I am organising a Consensus Forum in connection with the Health Authority's Mental Health Strategy in conjunction with David Towell, King's Fund.
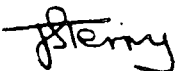
As you will know the Authority consulted a wide number of people in the summer of 1988 concerning the Mental Health Strategy. There have been a number of requests from several of the respondents suggesting that one way forward might be to have some kind of open meeting/workshop with various interested parties represented. I now intend to do this in the form of a Consensus Forum with David Towell, King's Fund.

We have established that a large number of participants are agreed on the main points of the strategy. It is clear, however, that when reviewing the responses a major component is missing and that is the values and principles which lie behind the service. There is a need to have explicitly stated and agreed values and principles around which all the proposals for locally based services can be viewed.

I am inviting a number of individuals and organisations to be represented at this Forum on the **28/29 April 1989**, which will take place at the Whinney House Resource Centre. I enclose a draft programme for the event.

I would be grateful if you could let me have, by the end of March, an indication as to whether you will wish to attend or be represented at the event.

Yours sincerely

D Brown
Unit General Manager

Enc

APPENDIX SEVEN

GATESHEAD METROPOLITAN BOROUGH COUNCIL

DEPARTMENT OF SOCIAL SERVICES

Extracts from: Progress Report of Resettlement Services for
the Mentally Disordered. (G.J. Gray, July, 1986).

Acquisition of suitable accommodation

In order to manage an effective resettlement service, access
to appropriate accommodation is essential. Herein lies the
success of this venture as Gateshead housing authority have
acknowledged a shared repsonse to this and have co-operated
fully. This progressive attitude by a department of housing
is singularly noteable among regional housing authorities
and their co-operation with this department of social
services goes far to meeting the needs of this disadvantaged
client group.

A process of application and allocation was agreed upon by
senior personnel and is as follows:-

1. The resettlement officer/social worker is contacted when
an individual is nearing the end of a rehabilitation
programme and has been assessed by a multi-disciplinary team
as being able to manage a more independent life style.

2. A housing application with the client is completed and a social report sent to the Chief Lettings Officer of the housing department. A case review is arranged.

3. The review body consists of all involved agencies including the senior housing officer. The issues of professional importance are discussed and all relevant aspects of the case are identified including problematic areas.

If the consensus regarding housing is in agreement, with the final affirmation resting on the housing officer, an appropriate housing unit will be identified and allocated within twelve weeks.

The housing department have agreed on a policy of two such priority applications at any one time.

NB It is essential that such a time limited contract is agreed upon as timing is a crucial aspect of the end product of rehabilitation in order to allow individual clients to work to an identifiable end. A long delay is counter-productive and destroys the elements of progress to independence.

The allocated housing unit acknowledges the personal preferences of the individual involved to a maximum, but realistic degree and always to the most suitable housing environment possible.

Bircholme hostel is an integral part of the resettlement process for many. It provides a system of graduated rehabilitation experience in co-ordination with other professionals and agencies.

Co-ordinated support services

Co-ordination is a vital part of after-care services as without such agreements a confused, inconsistent support network may well fail.

Community care workers include the resettlement officer, community psychiatric nurses, social workers, day care workers, domiciliary visitors, housing wardens and medical/general practitioner personnel.

Experience suggests that maximum day care allocation may be necessary in the early stages of independent living, both to monitor the health of the individual and to provide him/her with a grasp of social relationships and activities offering stability and continuity. This is obviously voluntary and usually reduces to nominal, casual attendance after some time.

The various community workers are identified as having primary roles which are task centred and purposeful. The resettlement officer continues as key worker until such time as all workers withdraw or perhaps a specialist agency maintains contact. Regular interdisciplinary communication

is necessary, particularly in the early days and this is achieved.

As the reasons for continued involvement diminish the individual is made aware of how and where an immediate response may be secured if any difficulties or problems arise.

Creating a "home" from a house

The castigation of the mentally disordered extends into the availability of the welfare benefits to equip mentally disordered people with the finance to create a new home. If supplementary benefits were available for some, they merely allowed for the purchase of spartan, rather bleak goods and materials. Such an equipped home in no way compensates for standards experienced in hospital or residential care, and obviously militated against the client's social integration.

It was agreed that in order to overcome this, welfare benefits, if available, would be "topped up" in order to create a "home" for the individuals concerned. This is expensive but essential and promotes the feelings of self-esteem and worth necessary to support people in a new situation.

The complete process of home making is shared between client and resettlement officer (who by now would know the client by introduction at an earlier stage of rehabilitation training).

The self direction of the individual is maximised as they choose paint, decoration, furnishings, floor coverings, etc. with guidance, and work is then started on preparing the home. This can be carried out with friends, family, Carlisle House day centre attenders, volunteers or manpower sergvices commission personnel, but at all times the client is primarily involved in the work. The end product is a home of individual character which reflects the client's wishes.

During this activity period the resettlement officer introduces the individual to key people in the new environment, e.g. general practitioner, post office, newsagent, grocery shop, neighbours, etc., in order to aid their social integration. This is completed at all times in a confidential manner and requires sensitive handling by the resettlement officer.

As the client moves into the property, the tenancy and contents become his/her own personal responsibility and affords them the right to determine their future.

Early intervention and problem solving

This is vital for both clients and housing services for many reasons. It relies on co-ordination and planning at an early stage, good interdisciplinary communication and early access to psychiatric and medical services. Difficulties can therefore be managed in a discreet manner which does not damage client/community relationships and maintains social

services/housing relationships, e.g. housing wardens
ultimately may be faced with difficulty when responsible to
a small but close community.

APPENDIX EIGHT

REGIONAL RESOURCES

The remit of a small numberof resources and organisations
extended to all three parts of the catchment area. These
were:

1. <u>Plawsworth Resettlement Unit</u>, run by DHSS, was located
near Chester le Street, Co. Durham, and was a regional
resource, providing direct access accommodation for homeless
men. The unit was housed in buildings originally used as a
wartime military camp, and at the time of the study provided
118 beds with an average occupancy of 65 men per night; of
these about 45 wouldremain for some time. However,
according to the Unit Manager, who was one of the key
informants, there was a large turnover of men, with around
70% leaving for an unknown destination.

Early in 1985 the government announced the intended closure
of all Resettlement Units. Plawsworth was to close in 1988
butthis date was deferred along with those for many other
units because ofresistance among voluntary organisations to
providing substitute direct access accommodation on the
terms proposed by the government.

According to the Unit Manager, for almost all the men who
used the Unit,housing was not their only problem. They had
a variety of other long-termdifficulties, including a
substantial number of mental health problems, andthis is
consistent with the findings of a number of studies of such
units(eg,   Leach and Wing, 1982). However, the Manager

reported that most of themen were not without skills and
for this reason the Unit had for some yearsprovided a
Homemaker Scheme in one part of the premises, offering
medium-term accommodation to those men who wished to relearn
self-care skills or regain their confidence, before being
rehoused.

The Manager expressed frustration though, not only at
official obstacles to and discouragement from extending this
area of work, but also at the very protracted periods that
men who were ready for independent living hadto wait for a
flat: in one case for more than eighteen months.
Considerable concern was also expressed about what would
happen to the menwho would be displaced when the Unit
closed, because of fears that eventualreplacement provision
would in many areas be even more inadequate.

The remaining regional resources are all voluntary
organisations, of which two are primarily concerned with
mental health.

Northern MIND

The regional office of MIND, the National Association for
Mental Health,is based in Gateshead. Its roles are
primarily educational and campaigningand it is active in
these areas throughout the region. It aims to promote high
quality services and greater user involvement in all aspects
of service planning and delivery. It has also produced a
number ofimportant reports, particularly Let's Not Mince
Words, which was extremely critical of mental health

services in the region and received wide publicity
(Richardson, 1988).

Northern Schizophrenia Fellowship

In 1983 the former Northern Regional Office of the National
Schizophrenia Fellowship was succeeded by the Northern
Schizophrenia Fellowship as an independent charity.

The aims of both organisations were to provide an
information and adviceservice for relatives and sufferers;
to facilitate the emergence of self-help groups and links
throughout the region; to provide an educational
andtraining resource for professional training courses; and
to explore waysand means of improving services and
facilities for mentally ill people andtheir families in the
area (Northern Schizophrenia Fellowship, 1988).

The Fellowship expanded with the establishment of a range of
projects including daycentres and a sheltered workshop, as
well as new self-help groups in anumber of Local Authority
areas, and involvement in professional education and
training.

The Special Needs Housing Advisory Service (SNAG)

This was established on a voluntary basis on Tyneside in
1982 in responseto the Housing Corporation's Hostels
Initiative. It was funded by theHousing Corporation and

charitable trusts, and provided an advisory andconsultancy
service to voluntary groups about the provision of special
needs housing. Among its aims, that most relevant to this
study was: To encourage the co-ordination of special needs
housing provision in the region, within a framework of the
local authority housing strategies (SNAG, 1986).

By 1986, the Gateshead-based service was in regular contact
with more than 80 voluntaryorganisations throughout the
North East, as well as statutory agencies andmore than 20
Housing Associations. At that time there were around
75special needs housing schemes in the region, with a
further 55 ateither the development or discussion stages.
Since then the number ofschemes has continued to increase
rapidly in response to funding changes and the quickening
pace of deinstitutionalisation.

After the establishment of aResource Centre in September
1986, SNAG became a source of increasing expertise and was
widely used for advice by agencies at all stages of
thedevelopment of special needs schemes, including those
catering for mentallyill people. It also played an
increasingly valuable role in training and information, as
well as in helping to co-ordinate the efforts of statutory
and voluntary organisations in the field.

Three other voluntary organisations were based in Newcastle
but had a regional remit. These were: Tyneside Cyrenians,
who received funding from both Newcastle and Gateshead
Councils; Tyneside Housing Aid Centre (THAC), whose
involvement in Derwentside had been very limited in the
past, but who at the time of the study were attempting to

develop their role there; and <u>Single Homeless on Tyneside</u> (SHOT), whose work was centred on Newcastle but who maintained strong links with organisations with similar concerns in other parts of the area, such as Consett Law Centre Steering Group.

APPENDIX NINE

WORKING ARRANGEMENTS FOR OFFICERS OF HOUSING/SOCIAL SERVICES DEPARTMENTS TO MEET ACCOMMODATION NEEDS OF MENTALLY ILL PEOPLE IN THE CITY

These proposed arrangements arise from the agreed joint report to the Special Needs Sub-Committee on 24th October 1985.

PRINCIPLE

That accommodation is an intrinsic part of a Care Package agreed by the Sector Clinical Teams, for individual patients.

PROCESS

1. All referrals must be made by the Sector Clinical Teams to Mr C. Wilson, Principal Housing Officer, Room 244, Housing Department, Civic Centre, (extension 5740).

2. All referrals must be in writing and consist of -

    (a) a completed Housing Application form:

    (b) a Care Package Statement - this should be in letter form, addressed to the Principal Housing Officer, describing the Care Package devised by the Clinical Team. The Statement should cover all relevant issues such as preferred location; reasons for a particular kind of

accommodation; support that will be provided and by whom; name of the key worker and, most crucially, how accommodation fits into the total Care Package.

3.   On receipt of the referral by the Housing Department, it will be given priority.

4.   The Principal Housing Officer will then negotiate with Area Housing Managers who will liaise directly with the key worker.

14.1.86.

APPENDIX TEN

PROGRAMMES OF ASSERTIVE COMMUNITY TREATMENT

During the period 1967 to 1981 when U.S. federal legislation encouraged the establishment of Community Mental Health Centres, more than 750 such centres were set up. However, they were unable (and indeed were not intended) to meet all the needs of people with chronic mental health problems, and therefore Community Support Programmes were introduced in each state. There have been many different initiatives, but the essential elements of all programmes are seen as:

1. Outreach to chronically mentally ill people.

2. Assistance in meeting basic human needs.

3. Provision of out-patient services.

4. Availability of 24 hour crisis help.

5. Provision of psychosocial and vocational counselling.

6. Supportive housing.

7. Counselling and education for families and community.

8. Recognition of natural support systems.

9. Recognition of rights/establishment of grievance procedures.

10. Use of a case-management system.

Clearly, such programmes view and attempt to respond to need in a far more comprehensive way than merely treating psychiatric symptoms, and than most schemes to date in

Britain. These programmes imply both decentralised
services, and professional roles, activities and attitudes
which are far removed from traditional institution-based
ones.

The state of Wisconsin is a particularly interesting
example, as it was the first state to introduce legislation
making mandatory the provision of support systems for
chronically mentally ill people, with the aim of ensuring
minimum baseline standards of service provision. This can
be contrasted with the situation in England and Wales under
the Mental Health Act, 1983, which emphasised the "least
restrictive alternative", but failed to ensure the necessary
provision of resources.

Programmes of Assertive Community Treatment (PACT) were
initially developed in Dale County, Wisconsin, in 1975 and
are now established in more than 50 counties, both urban and
rural. These programmes are characterised by:

1. Personal concern for people and their families

2. The avoidance of categorisation and screening-out

3. The involvement of consumers in planning and management

4. Flexibility of response to individual needs using a
problem-solving approach.

Because of their highly individualised approach, about 75%
of work is undertaken in people's homes or in other 'on-the-
job' settings.

These programmes appear to be very successful in engaging
and helping those people who have failed to benefit from
either hospital treatment or contact with Community Mental
Health Centres. The drop-out rate from the programmes is
low, yet hospitalisation levels after two years of
involvement in PACT had been reduced by 90%.

There has been a corresponding major shift in the allocation
of resources: whilst 70% of the U.S. mental health budget
continues to be spent on institutional care, in Dale County
only 17% is now spent on hospital care, with more than 80%
being directed to resources in the community.

APPENDIX ELEVEN

CONSUMER PROFILES

These accounts of their experiences by three people with long term mental health problems are included because in my view they add a vivid and important dimension to the issues under discussion. They follow as closely as possible what Joe, Brian and Jean (which are pseudonyms) told me, although they are not given verbatim. I recorded the information they gave and did not attempt to verify its accuracy with any of the health and welfare professionals with whom they may have been in contact, since this would have been an abuse of their confidence in agreeing to talk to me. Moreover, regardless of any inconsistencies or "facts" which might be disputed by professionals, these accounts represent the perceptions of vulnerable people who directly experience policies and services, and whose views are all too often disregarded (norman and Parker, 1990). These accounts therefore illuminate some of the other material in the study and are vitally important for that reason.

It is difficult to know how best to report material of this nature, but the work of Tony Parker in this field was perhaps most useful (e.g., Parker, 1969 and 1972). There was some re-ordering for the sake of coherence and the frequent repetition which occurred has been omitted. In

addition to giving a brief biography, each account attempts
to include the individual's views of his or her difficulties
and wishes, together with their perceptions of their
dealings with professionals, their ability to manage in
their own home; their networks, and the help and support
both that they had received and would like.

I hope nevertheless that the "flavour" of the conversations
remains. Joe and Jean both agreed to talk to me through the
mediation of a worker who knew them well, and I saw them
both in their present homes. Brian happened to be visiting
his friend Joe when I arrived for my appointment with Joe,
and he agreed to talk to me about his experiences at the
same time.

Joe was described to me by the worker as being "mentally
handicapped, chronic schizophrenic and epileptic", but I had
no prior information about Brian and Jean, other than their
names. The two interviews were recorded in different ways:
in the case of Brian and Joe, the discussion was tape-
recorded, and no notes were made during it; I later made
detailed notes from the tape. The interview with Jean could
not be taped owing to a technical problem, so I made
detailed notes during the interview, with Jean helpfully
speaking at dictation speed when necessary, and checking
frequently that I had got everything down!

JOE was a single man who, I would guess, was in his late
thirties, perhaps a little older. He spoke quickly in a way
which was sometimes very difficult to follow or interrupt in
order to clarify points. He and Brian talked to me in his
present home, a flat in a rundown, post-war city centre

block used by the City Housing Department for temporary
accommodation for homeless people. The decoration was poor,
the furnishings were basic and the atmosphere was bleak.
Joe had been there for a year, and during my visit, a number
of people from other flats came to the (open) door,
apparently with the intention of "borrowing" things.

Joe said that he was born in Newcastle and lived with his
parents until he was six. He was then admitted to Northgate
Hospital, Morpeth (for mentally handicapped people) where he
remained until he was 15, although he also mentioned being
in a variety of children's and convalescent hospitals. Joe
said that the death of his mother had unsettled him.

He had a stepmother but had never got on with her; in fact,
when he was 16, and his father was in bed drunk, his
stepmother stole some money from her husband, for which she
blamed Joe. He said he "got a hiding" for this, and his
father also contacted the police; as a result he was
arrested and charged, and spent a year in Durham prison and
a year in a locked ward in Northgate. Whilst in Northgate,
Joe bought the "Evening Chronicle" and looked for jobs in
hotel and catering work. He found a job as a kitchen porter
at the Gosforth Park Hotel, and asked his psychiatrist to
discharge him. He agreed, and Joe returned to live at home
for a time.

In his twenties, he went to London for two or three years,
and had kitchen portering jobs in a number of different
hotels. He came back home to the North East, and worked as
a general labourer for a firm in City Road, but he had to
give up because he had fits while working. He went back

again to London, and had a job as a kitchen porter at Buckingham Palace for a year. Joe talked about this with obvious pleasure and pride, recalling how the Queen "took everyone for a pint one night" - which seems to have been the staff Christmas party!

Joe lost this job because of a "bad illness" which he did not specify and then went to work at a hotel in Finsbury Park for a year. He left there after a new manager took over, who, Joe claimed, deducted money from all the staff's wages to buy food for his Alsatian dog.

After this Joe came back to Newcastle and kitchen portering at the Gosforth Park Hotel for three years, but left there because of problems with the shifts and buses, and has not had a job since.

The interview with Joe was dominated from the beginning by his worry about his problem of "damping down" and its consequences: his epilepsy was not completely controlled and he said he had two fits most nights; during these he was incontinent ("I damp down") and his enormous concern about trying to manage this was like a leitmotiv in the conversation. Joe said he was ashamed of "damping down" and what other people must think about it; he was preoccupied with trying to maintain reasonable personal hygiene, and his efforts to do so meant going through enormously complicated and time-consuming procedures to obtain bathing and laundry allowances, incontinence aids and adequate suplies of bedding from DHSS and elsewhere. Currently he was trying to claim an extra £1.50 per week allowance from DHSS towards the cost of a daily bath, for which he had to see his G.P.

to get a letter supporting his application, which he then
had to take to DHSS.

Moreover, Joe claimed that the incontinence associated with
his fits was the reason why he had become homeless in the
first place: he had had bedsitters but "no-one likes that in
their own place so they just hoy you out", and had also been
banned for life from the Salvation Army Men's Palace because
of his incontinence.

At one point, Joe and Brian began comparing psychiatric
symptoms and diagnoses. Joe explained that he was
schizophrenic and suffered from delusions. He heard voices
of people threatening to knife him. As a result, he had
threatened to strangle himself, and tried to jump off the
Tyne Bridge. He said he no longer hears voices.

Joe had been in one of Social Services' two hostels for
mentally ill people years ago but "I had trouble with staff
- I got a right bollocking off (the officer in charge)"; a
couple of days later he was taken back to Northgate, and "I
couldn't get back out", so he was there for two years on
that occasion.

Later he was in Social Services' other hostel and this was a
help "but I had a fight with the deputy warden and they told
me not to come back any more" except for day visits. Joe
explained that he loses his temper and gets into fights. He
struggled to control his temper but could not do so: the
trouble was he thought people meant the things they said to

him so he used to get upset and lose his temper. He said he
had been banned from the Cyrenians for getting drunk.

He had slept rough "for years". Eventually he was found a
place in a bed and breakfast hotel, and then his present
flat.

Joe had recently been offered a council flat nearby and he
was very pleased because this was what he wanted. However,
"I hate being on me own" and wanted to share, so a lad whom
he had been allowing to sleep on the floor of the present
flat was going to move in with him; Housing had said this
was alright. Joe was hoping to move in shortly, and with
the help of the day-centre for homeless people across the
road had applied for Housing Benefit and furniture payments.
He was hoping the day centre would give him extra sheets and
blankets because he needed such a lot. Joe said he would
keep in touch with the day centre every day after he moved,
and clearly he valued the high level of support he had
received from the staff there and wanted it to continue.

Joe said that he went to the Bridge Medical Centre (for
homeless people) for his long-acting injections, and he
thought they were very good because he could get a
disinfectant bath and a change of clothes there. The
community psychiatric nurse also visited him at the flat,
and he had arranged for Joe to go back into Northgate for a
couple of weeks to try and get his incontinence sorted out,
but Joe had kept cancelling the arrangements. He thought he
would go the next time it was arranged though, because he
felt the G.P. was not doing anything for him.

Although Joe said he had a number of relatives still living in Newcastle, including his father, the only contact he had was with an aunt and uncle who he saw now and again. With the exception of his friend Brian, all his help and support seemed to come from professionals.

Joe said that he had had help about getting a home again from his social worker at the hospital (who had previously got him into the Social Services' hostels), and from his psychiatrist and community psychiatric nurse. At the hospital, he had had help with learning how to manage and knew he could cook and look after himself alright. However, when Joe went into the kitchen to make us all a cup of tea, Brian told me that Joe could not look after himself: "I give him a bit of a hand, but look at the state of the place. He's never had a chance, the poor bugger".

My impression was that, given his many disadvantages, particularly the social and financial costs of his epilepsy and incontinence, together with indications of considerable vulnerability to exploitation by other people, the task of coping even with frequent outside support would be an uphill struggle for Joe - nevertheless he was very clear that a flat of his own with continuing help from the people he was familiar with was what he wanted.

BRIAN's early life had clearly been very different from Joe's, even though in more recent years the pattern of alternating periods of hospitalisation and homelessness was similar. At several points in the interview Brian became

very distressed and cried when talking about his experiences, but at other times he showed wit and a sense of humour.

I would guess that Brian was then in his fifties. He came from Newcastle and had a brother and three sisters. He had seen one of his sisters about two months previously, but there was no contact with the others even though he indicated that they lived locally. Brian said that he had spent four years in the Royal Air Force (signing on after his National Service) and had worked on helicopters; when I asked whether he had been posted abroad, he said with a smile that his overseas service had been one day in Gibraltar!

Brian broke down as he said that he had been happily married for fourteen years, but that when he became mentally ill and was admitted to St Mary's Hospital, his wife had found another man, and that was when he had lost his home. He had had two fairly brief admissions (during which the marriage broke down), followed by a twelve year stay.

In 1979 he was discharged and went to the Salvation Army Men's Palacde and then to a series of "dosshouses" including Simpson's Hotel at Hebburn and Plawsworth Resettlement Unit. Since 1979, he had had two admissions to Winterton Hospital, Sedgefield, each lasting about eighteen months. He had discharged himself about four months previously and had gone to the Salvation Army "off my own bat - It's pretty good and clean, like". At the time of the interview, he came to Joe's flat every day for his dinner, in return for which he bought cigarettes, lent Joe money and generally helped him.

Brian said that no-one in hospital had ever talked to him about where he would go on discharge: "You were just discharged and that was it, you had to find your own place".

He said that help had never been mentioned, but that he would have liked a flat on his own in 1979 and still wanted one: in tears he said "I've never had a home for 20 years". Brian's name was now on the council waiting list, and the Housing Aid worker visited the Salvation Army every Monday but he (Brian) did not know how long he would have to wait. Brian was confident that he could "live nicely" on his own as long as he had a TV: he could cook for himself and would be alright.

Two subjects caused Brian considerable distress during the interview. The first was that he had lost contact with his two daughters. The younger one he had not seen for 20 years and did not know where she was. The older one, he said with obvious pride, was a staff nurse: "But" (in tears) "She doesn't want to know us, me own bonny bairn. Her mother's filled her head with rubbish about mental hospitals. I thought she might have pulled round with working in a hospital herself......"

The second topic arose when I asked Brian what kind of help he would have liked in the past, and would like in the future. He mentioned that he had kept in touch with his Probation Officer although his Probation Order had ended over a year previously. Brian said that when he first became ill, he had shoplifted, "But I have a much worse

complaint as well. I don't want to frighten you....I'm
liable on occasions to interfere with women which is a nasty
thing. I'm a very mild offender, mind, I just maybe run my
hand up their leg". According to Brian, psychiatrists had
told him that he had brain damage as a result of
encephalitis which gave him a behaviour problem and made him
act irresponsibly. "But for the last four months I haven't
done it, I'm combatting it well. I'm very pleased with
myself, I hope I can keep on for the rest of my life. I'm
doing very well just now". He added that he felt his
problems with regard to women might be easier if he had a
settled home.

Brian offered some interesting comments about psychiatric
hospitals: "They aren't bad places these days. There's no
violence or anything. Occasionally you get a bit kicked up
the backside. I've been kicked about a bit, but not much,
for doing something wrong, but normally they're all right,
like. They help a bit, you learn the error of your ways".

When I commented that this made them sound like prisons,
Brian said that they were a bit like prisons and he
indicated that he had been in prison on a number of
occasions.

The specific nature of Brian's psychological problems was
unclear, in that when comparing symptoms and diagnoses with
Joe he said that he was not schizophrenic: "I simply have a
behavioural problem", but indicated that he received long-
acting injections, and I also wondered whether he had had a
problem with alcohol abuse. Brian said that he did not know
what might have helped him in the past, but he was quite

clear about what he would like now: he wanted a place of his own; he would like someone to remain in touch in case he had any problems, and spoke very favourably of the workers at the Bridge Medical Centre: "They're a couple of right nice lads"; he also wanted the hospital and help to be nearby, so that he did not have to go all the way to Morpeth when he was in need.

JEAN was 47 at the time of interview, and had been living in a one-bedroomed flat in the Sallyport Crescent project for a year. She said this was the first home she had had since the age of 19, and although her present circumstances were considerably better than those of Joe and Brian, she told a very similar story of repeated prolonged stays in hospitals, periods of destitution and problems of mental and physical health.

Jean was brought up in Newcastle, and on leaving school worked for a firm in Blyth who made paper hats, her only job. When she was nineteen, Jean spent seven or eight months in Newcastle General Hospital. She said she was "very ill", although could not say what had been wrong. By the time she was discharged, both her parents were dead, and two weeks after discharge, her brother had taken her to St Nicholas Hospital because she was "bad with nerves". She had remained there for 9 years before being allowed to go to a cousin for weekend leaves.

A hospital social worker arranged for Jean to go to one of the Newcastle Social Services Hostels, but Jean said that the officer in charge, who had previously worked at St Nicholas, did not like her and she was very unhappy there.

However she remained there for two years before being readmitted to hospital, then she was discharged back to the hostel, and readmitted again to hospital, where she learned to cook in a rehabilitation house. Following this she was offered a place at a Social Services home for adults with a mental handicap in Byker, and spent nine years there, with no admissions to hospital.

However, she then had an argument with the Officer in Charge during which she "stuck a knife in his arm" because, she said, he was gripping her tightly. As a result she was thrown out of the hostel, "just put on the street". Jean claimed that she had to leave behind all her clothes and possessions, and no one told her social worker what had happened. She then began to sleep rough in the Shields Road area, and eventually met Alice.

They went together to London, and lived in a hostel for a while. Jean was then offered a hostel place in Hastings but was thrown out after only three weeks: Jean said that the Matron was "awful, arguing and pushing me around". Jean then slept rough again for about two months. One night she was nearly run over by a car driver who called the police, and when it was found that she was sleeping rough, it was suggested that she went to hospital. She remained in this hospital in Sussex for nine or ten months, and had liked it there because she was well looked after.

Jean said that it was then suggested she should go back to Newcastle, which she wanted to do. She was given clothes and money, taken to Kings Cross and put on the train for Newcastle.

When she reached Newcastle, there was no social worker to
meet her: "They should've done that". She was upset because
she did not know where to go. She went into a bar and by
mistake left her bag containing her money, which was then
apparently stolen. She sold her case and clothes for £2 to
buy food, and then lived rough around the Haymarket for
about seven months, during which time she was readmitted to
St Nicholas Hospital, but discharged herself after about two
months because she was again offered a place at the first
hostel she had been in.

The police became concerned about her sleeping rough (Jean
was fairly disabled by arthritis) and contacted an area-
based social worker who arranged for her to go to a bed and
breakfast hotel in the West End of the city. She remained
there for seven weeks before her social worker got her a
flat at Sallyport Crescent. Initially she had an upstairs
flat, but subsequently moved to the ground floor because of
her arthritis. Her social worker had helped with getting
the flat decorated and obtaining furniture. She continued
to have a Family Aide twice a week to help with cleaning,
and her boyfriend (who called during my visit) did her
shopping. Her boyfriend also lived in the project and Jean
had got to know him since moving in. Without him, she said
she would have had to eat in local cafes because she is
unable to manage shopping.

Jean was full of praise for her present home. She said she
loved it, and it was the right size for her because couldn't
do much housework. She was alright for money and could
manage. She would not like to live in some areas such as

Cruddas Park where there were a lot of break-ins, but she was happy where she was, and it was wonderful having the project worker there, who would help you to make phone calls. Jean summed up very eloquently what her first home for nearly 30 years meant to her when she said :"For once in my life I'm me own gaffer".

APPENDIX TWELVE

BACKGROUND AND HISTORY OF THE SALLYPORT CRESCENT PROJECT

Sallyport Crescent was acquired from Newcastle City Council in August 1981 on a long lease on condition it was refurbished and used to provide homes for the North East single homeless.

Historically Sallyport Crescent is very significant as it was the first council housing in Newcastle, built in 1895. At that time it comprised 44 two-roomed units in two storeys, with deck access. Through the years it had been subject to neglect and physical degeneration. In 1980 a report was compiled by Newcastle's City Council Social Services Department showing that the housing was at best primitive and at worst diabolical. It had gone to the point of no return - houses had been used by squatters for some considerable time, the few remaining tenants were terrorised by thefts, burglaries and violent attempts by the meths drinkers who gathered there to get money to support their habits. No refuse was collected for more than a year, it lay eighteen inches deep and rats and other vermin over-ran the place.

The council were reluctant to spend on the buildings and had virtually decided to demolish them when THAC presented a study showing it was feasible to refurbish them. In June 1981 THAC was given the go-ahead and with the condition that 30% of the tenancies were allocated to the council the work commenced. It was estimated that the work would cost in the

region of a third of a million pounds and after negotiation the council agreed to provide 90% of the costs through Improvement Grants, and Innner City Partnership money, and this left 10% to be raised from charitable sources.

The work was completed in July 1982 and the project worker who was in the post by then began the allocation of the 42 units, 38 for single people, and four for childless couples. Nominations were taken from many interested groups including the local authority, THAC, Salvation Army, Cyrenians, social workers and probation officers. By August 1982 the project was fully tenanted and let to people in three categories:

"(a) people who were capable of coping alone,

(b) people who would cope after an initial period of support,

(c) and finally people in need of more structured supervision."

(Tyneside Housing Aid Centre 1984, p.7)

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