British Journal of Psychiatry (1992), **160**, 103–107

The Worcester Development Project

RICHARD TURNER and GLENN ROBERTS

"The philosophy of Community Care has resulted in the closure of several mental hospitals in this country. The ethos of the Worcester Development Project saw the closure of St Wulstan's and Powick Hospitals, and their replacement by a community-based service. This paper briefly describes the outcome of a three-year retrospective study completed in 1988 following the closure of both hospitals. The findings provide a comparison of the two hospitals, including details of the destination of all the patients. It is suggested that the term 'hospital replacement' might be preferable to 'hospital closure'."

"The Worcester Development Project began in 1968 when the Department of Health and Social Security brought together the Worcester and Kidderminster Hospital Management Committee and the County Council in a co-ordinated joint planning venture. Powick Hospital was chosen as the location for testing the hypothesis that closing a mental hospital and replacing it with general hospital psychiatric units, supported by a variety of community facilities, would provide a more economical and better service. This paper describes the outcome of this unique opportunity to study the problems involved in closing a mental hospital and its replacement with other facilities."

The summaries quoted above are from articles by Khoosal & Jones (1990/91) and Milner & Hassall (1990/91), respectively. The present authors were invited to comment upon the studies.

Richard Turner

The Worcester Development Project began in 1968, when the Department of Health & Social Security brought together the Worcester & Kidderminster Hospital Management Committee and the County Council in a co-ordinated joint planning venture. Powick Hospital was chosen as the location for testing the hypothesis that closing a mental hospital and replacing it with general hospital psychiatric units, supported by a variety of community facilities, would provide a more economical and better service. Milner & Hassall (1990/91) describe the outcome, and Khoosol & Jones (1990/91) provide details of the destination of all the patients discharged both from Powick and from St Wulstan's Hospital.

Tooth & Brook (1961) showed that the long-stay population in psychiatric hospitals in England and Wales had declined between 1954 and 1959 by some 34 000 patients. By projecting these figures, they concluded that none of the long-stay patients resident in 1954 would be in hospital in 1970. This led Mr Enoch Powell to present the Hospital Plan for England and Wales (Ministry of Health, 1962), which envisaged the closure of all psychiatric hospitals within ten years, and their replacement with units within district general hospitals (DGHs). However, by the late 1960s, it was clear that the closure of mental hospitals was not taking place; hence the government's need to demonstrate the feasibility of such a scheme.

Powick Hospital was opened in 1851 as a city and county asylum for 178 patients; by 1902, it housed 1100. At the time the plans for closure were formulated, however, there were 784 patients and it provided the in-patient psychiatric service for the Kidderminster and Worcester districts – a total population of 320 000. Worcester is ranked 146th and Kidderminster 159th out of 192 on the Jarman scale (Jarman, 1983). Thus, the application of results from this closure programme to deprived urban areas is questionable. Khoosal & Jones remind us that much media attention has been paid to the plight of ex-patients who, without the attenion of caring staff, have fallen prey to exploitation once discharged from hospital. They state that such has not happened to patients in the Worcester area, but Worcester is not like London, or any other large urban area.

St Wulstan's Hospital was opened in 1961 as a regional rehabilitation centre for the chronic and difficult to place mentally ill; it originally admitted from 12 mental hospitals in the region. By the time the plan for its closure was formulated, 250 patients, instead of returning to their referring hospitals or districts, had been discharged locally, thus occupying much spare accommodation in the area and earning Malvern the dubious title of the 'sierra psychotica'.

It is the experience of many mental health services, whether or not hospitals are closing, that patients

https://doi.org/10.1192/bjp.160.1.103 Published online by Cambridge University Press

are more easily discharged to accommodation in certain localities than in others. Often, these are near to the base hospital, where the community has learned to be more accepting and tolerant of the mentally ill, but the problem is that this produces a concentration of accommodation for those with enduring problems. Khoosal & Jones set out both the two Cs (community care) and the three Rs (rehabilitation, resettlement, and relocation). They ask the important question – are we aiming for 'community care' (where local residents show an interest and help to support the mentally ill), or more simply for 'care in the community' (where patients move out of hospital into different accommodation, but continue to be cared for by staff employed by the same mental health services that cared for them in the hospital)? The reality is that the latter is often what is happening.

But what of the process? Are we rehabilitating the discharged patients such that they function more effectively outside hospital than within, and thus find a new life for themselves? Are we resettling the patients (taking them from familiar surroundings, disturbing them, and settling them in newer and hopefully more conducive surroundings)? Or are we merely relocating patients (moving a group of patients from one place to another)? If all we are doing in closing mental hospitals is disaggregating the hospital and replacing patients in scattered facilities, the question must be asked whether the process is worth the cost and effort, and – more importantly – whether the patients' lifestyles improve.

What was supposed to happen in Worcester and Kidderminster? In 1964, the Worcester Development Project was launched to promote a model of re-organisation of services. The DGH units and community-based services were to be developed to take all new admissions from Powick Hospital after 1973, but in fact admissions did not cease until 1978. The closure of St Wulstan's Hospital was in fact announced in 1984. Much of 1985 was spent assessing patients and trying to allocate as many as possible back to the parent hospital areas. When it closed, 54 patients were left and were transferred to Powick Hospital. In 1986, the 190 patients left at Powick were reassessed and relocated into a range of domestic-style hostels and units, as well as to accommodation with 24-hour nursing care; all the hostels and units were managed and staffed from the mental health unit. Two-thirds of these patients were over 60. At Powick, 42% of patients had been in-patients for over 20 years: 36% were relocated in National Health Service (NHS) homes for the elderly, 29% in NHS hostels, 8% in in-patient units, and the remainder moved to group homes and other housing provision. Only five patients were discharged to social-service units. It is plain that the funded provision provided by the mental health unit was an important plank in the replacement facilities, and that the majority of patients were relocated rather than rehabilitated. Such a process is plainly more easily undertaken when funding and management are controlled by the same unit.

What problems were faced? Two are highlighted – delay and staff morale. While delay in implementing any replacement programme can be frustrating, it does give opportunity to evaluate the process and, if necessary, to alter course to meet changing needs and circumstances. The Worcester Development Project coped with three changes in the management structure of health regions and social services departments, but despite this the process continued. Underprovision for the needs of the elderly mentally ill was recognised and rectified. The number of beds for adolescents was reduced. The size of acute wards was reduced from 30 to 20. The total bed complement within the area is now 420 – only 20 fewer than in the hospital before the moves occurred – but there has been a 40% increase in staff.

Managing staff morale was given priority. The psychological adjustment of staff to the demise of the old system, to the loss of valued status, and to possible redundancy were all important issues which were faced. In spite of this, some staff thought that the hospitals would never close, and refused to face the new world.

The total revenue cost for services is £11.2 million (1988 prices). It is estimated that if Powick Hospital had continued to provide services as before, the cost would be £4.7 million, so that the new services are considerably more expensive. The capital cost to the NHS was £17.5 million. It was anticipated that £10 million would be obtained from the sale of Powick Hospital and the site, but at the time of writing no sale had been agreed.

At present, mental health teams are undertaking local care, with the assistance of day hospitals. Since relocation and the opening of the DGH units, there has been a 50% rise in admission rates – higher than at other centres with case registers (Wing, 1989). Why this has occurred is not clear, but the average length of stay of patients is short, and there have apparently been very few new long-stay patients requiring transfer to long-stay facilities.

How are we to measure the benefit of the hospital closure and the relocation of patients? A study of patient satisfaction is proposed, but of more interest is whether the new-style services will be of benefit for future patients who will not become institutionalised in hospital.

https://doi.org/10.1192/bjp.160.1.103 Published online by Cambridge University Press

These papers describing the Worcester Development Project do not contain any surprises. How transferrable the experience is to other districts remains questionable. Local factors and conditions influence the shape of any service, but the experience in Worcester and Kidderminster demonstrates what can be done, with increased staffing and at a price. Softer data on the experience of patients and staff during the closure and relocation programme would be of great interest. The trouble is that most of those involved in such programmes become so taken up with bricks and mortar, finance, and staffing that the psychological sequelae of the process become easily forgotten.

Glenn Roberts

The 150th anniversary of the origins of the Royal College of Psychiatrists has stimulated many historical reflections, including some timely reminders of the appalling way in which many mentally ill patients previously functioned 'in the community'. The development of a national network of mental hospitals provided at least a minimum standard of care and treatment. However, government policy, since 1961, has been to replace asylums with general hospital units and community facilities – a policy slowly implemented in recent years amid a volatile mix of controversy, enthusiasm, and scepticism. It is perhaps inevitable that the rehabilitation of psychiatry itself will progress rather hesitantly, and that practical progress will lag well behind assent to the philosophy of community care. This is not merely a new chapter in the history of psychiatry, but the opening pages of a new volume. The broad assertion that care in the community is best has become the new orthodoxy. However, as Kuhn (1970) emphasised, basic shifts of paradigm are more a matter of faith, philosophy, and conviction than of rational reappraisal. The reasons for community being 'best' have largely rested on criticism of the old – on articulate observations of the morbidity and experiential poverty of institutional care – rather than on demonstrations of the superior merit of the new.

Since its inception, the Worcester Development Project has been a source of clinical experience and practical wisdom. It was established both as a unique service and as a clinical crucible to test hypotheses, the last of which involved the rehabilitation of the service itself. These elegantly presented papers describe its evolution from the experimental and pioneering stage to the dispersal of patients into the community. The Worcester studies certainly demonstrate greater activity and involvement, but whether this does more than conform to a 'better ideology' is uncertain. More confident support for the changes would be derived from a demonstration that the recipients have their needs better met, that their problems are more substantially alleviated, and that their treatment involves fewer unwanted effects.

A further paper concerning quality of life is promised and will be awaited with interest, since there is far too little indication that a 'better' service according to present values delivers a better service in the experience of those receiving it. A consumer dimension is missing. Also, given the low base morbidity rate of the district and the considerable migration of chronic psychotic patients into the locality (at St Wulstan's), it would have been interesting to have some comment on how the community reacted to these people being settled in their midst.

As a regional centre for rehabilitation, St Wulstan's contributed greatly to our understanding of how the potential of institutional care could be exploited. The phenomenon of the long-stay patient has, in fact, become a centre-piece in arguments over future financing and over the provision of appropriate services for the severely ill. Achieving 'long-stay' status was clearly an artefact of the structure and context of the previous service, but simplistic notions that the chronically ill could be favourably influenced simply by shutting the institutions that had been developed to care for them has proved to be nonsense. The early days of rehabilitation were marked by confusion between 'resettlement' and 'rehabilitation', the first implying that all that long-stay patients needed was to have their stay brought to an end and be relocated outside hospital. To a varying extent, this has been replaced by an emphasis on producing a carefully tailored programme of care, based on "individualised assessment of need and a sensitive understanding of the inner world of the patient" (Holloway, 1988).

Although the asylum culture may have gone (Jones, 1991), what may be needed to replace it has been largely a matter of dispute and speculation; and there has been too great a focus on closure rather than reprovision. The stated aim of the changes described in these papers was to be a government-sponsored demonstration of the wisdom and practical implications of these policies, seeking to gain support for the relatively untested principle that community services would be 'better' and cheaper. However, much 'closure' talk has been little more than the naïve application of anti-psychiatry thinking.

The economic argument for change is testable (although not yet adequately tested), but in what sense might the service be 'better'? The Victorian enthusiasm for moral treatment, which sponsored

https://doi.org/10.1192/bjp.160.1.103 Published online by Cambridge University Press

the expansion of asylums, has been replaced by a new morality arguing for deinstutionalisation, dealienation, and reintegration with society, and has at its core an antipathy to the mental 'apartheid' which segregated the chronically ill and extruded them from society. This desire to overthrow any vestige of paternalism in care has been accompanied by a confusing revision of parenthood, and has sponsored an intriguing semantic shift. The popular relabelling of patients as 'clients', 'consumers', 'customers', and 'users' carries a mixed loading of compassionate acceptance, fellowship, and equality. It is alloyed with a denial of the reality of mental illness, which can too easily lead to the withdrawal of staff when their 'client' does not appear to value continued contact. However, although the cause of most chronic mental illnesses remains a mystery, there has been broad agreement on the principles of good clinical practice for at least 40 years, and where the services to provide this have been limited, the primary obstacle has been inadequate resources.

These papers are reminders that where placement outside hospital is based on comprehensive assessment of need, a network of varying types of accommodation is required. When neglected, this results in inappropriate placement, often followed by breakdown in the community and readmission. Economising on the provision of any necessary component results in mismatching elsewhere in the therapeutic network, compromising the service as a whole.

The service initiatives reported were apparently implemented with "the close cooperation of all interested parties". They appear to have been supported by adequate finance and clear-sighted planning, which allowed for change to be managed at an appropriate pace for healthy growth. The authors have effectively replaced the phrase 'hospital closure' by 'reprovision of adequate services in community settings', some of which are necessarily equivalent to small asylums. In doing so, they raise the fundamental question of whether service planners and managers will accept the needs of the most disabled patients as the guiding influence on the shape of community psychiatric services, or whether this fledgling will have its wings clipped by financial expediency.

As a demonstration project, these studies make several vital points:

(a) closure and reprovision progressed gradually, over more than ten years, against a clear, consistent, and articulate plan which remained responsive to change
(b) the reprovision involved a "considerable increase" in total staff establishment, including many skilled professionals
(c) the total bed complement was only 20 less than that in the original hospital
(d) new services are considerably more expensive, and will continue to be so
(e) patients appear to need much of what they currently receive; the notion of gross overprovision of care within the older-style institutions may simply be false.

Many of those who staff the new services bring commitment and enthusiasm, but to build adequate provision within the new philosophy of community care, society is required to take two difficult steps. The first is to welcome back into its midst those suffering from chronic mental illness, after more than a century of expatriation. The second is to regard the continued care and treatment of these patients as an enhanced priority in allocating resources.

These papers are written at a transitional stage; the promise of further evaluation, of what happens next, will be of great interest and importance. In particular, it remains to be seen whether they will discover a new natural history of chronic mental disorder lived out within a free-market system. While the age distribution of the remaining Powick patients is skewed towards the elderly, one is left wondering how many nonagenarians will be found in a future community sample of long-term patients?

The government discussion document *The Health of the Nation* (Department of Health, 1991) identifies mental illness as a major health problem and a 'priority' in health service development. However, this welcome emphasis remains linked to continuing the hospital-closure programme; unless the findings of such studies as these are taken to heart, it will only be a matter of time before the wheel turns full circle. There will be scandals paralleling those of the 1950s, and '60s, but this time of community neglect, of lost, exploited, and discarded patients, and of cascades of resulting morbidity in the families and informal carers of the chronically mentally ill.

References

DEPARTMENT OF HEALTH (1991) *The Health of the Nation*, cm 1523. London: HMSO.

HOLLOWAY, F. (1988) Day care and community support. In *Community Care in Practice* (eds A. Lavender & F. Holloway), p. 182. Chichester: Wiley.

JARMAN, B. (1983) Identification of underprivileged areas. *British Medical Journal*, **246**, 1705–1709.

JONES, K. (1991) The culture of the mental hospital. In *150 Years of British Psychiatry* (eds G. E. Berrios & H. L. Freeman), pp. 17–28. London: Gaskell.

KHOOSAL, D. & JONES, P. (1990/91) Worcester Development Project: where do patients go when hospitals close? *Health Trends*, **22**, 137–141.

https://doi.org/10.1192/bjp.160.1.103 Published online by Cambridge University Press

KUHN, T. (1970) *The Structure of Scientific Revolutions*. Chicago: University of Chicago Press.

MILNER, G. & HASSALL, C. (1990/91) Worcester Development Project: the closure and replacement of a mental hospital. *Health Trends*, **22**, 141–145.

MINISTRY OF HEALTH (1962) *The Hospital Plan*. London: HMSO.

TOOTH, G. C. & BROOKE, E. M. (1961) Trends in the mental hospital population and their effect on future planning. *Lancet*, *i*, 710–713.

WING, J. K. (ed.) (1989) *Health Services Planning and Research: Contributions from Psychiatric Case Registers*. London: Gaskell.

Richard Turner, MD, DPM, FRCPsych, *Consultant Psychiatrist, University Hospital, Queen's Medical Centre, Nottingham NG7 2UH*; Glenn Roberts, MB, ChB, MRCPsych, *Consultant Psychiatrist, North Devon District Hospital, Raleigh Park, Barnstaple, Devon EX31 4JB*

https://doi.org/10.1192/bjp.160.1.103 Published online by Cambridge University Press