SOCIAL AND COMMUNITY PSYCHIATRY GROUP

PSYCHIATRISTS AND THE PLANNING OF HEALTH AND SOCIAL SERVICES

This document has been prepared by the Social and Community Psychiatry Group for the guidance of members of the College. Members are asked to bring it to the attention of District Community Physicians and Directors of Social Services.

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ENGLAND AND WALES

Introduction

The recent reorganization of the National Health Service in England and Wales has provided an opportunity for psychiatrists to take part in the planning and development of their local health services. Since extra resources are unlikely to be made available to the mental health services during the next few years this devolution of part of the responsibility for planning means that decisions concerning priorities will more often be made at local level and that psychiatrists will be able to influence them. Each District of a Health Authority area has a Management Team (DMT) with overall responsibility for guiding the Area Health Authority (AHA) in the economic and efficient use of existing resources in the health supporting services in order to meet local needs, and for identifying sections of the services which require expansion, modification or innovation because of unmet need. In order to help them carry out these responsibilities DMTs will appoint 'Health Care Planning Teams' (HCPTs) which will consider certain aspects of the services or the needs of any client group thought to require systematic and detailed consideration. The most relevant topics for psychiatrists are mental retardation and adult mental illness, though there will be overlaps with several others, notably geriatrics and child health. Temporary HCPTs may be set up to consider particular issues.

The present paper is intended to provide an outline of the functions of HCPTs in the field of 'adult mental illness' in order to give psychiatrists who wish to take part in local planning some ideas as to how they may best contribute. It is not intended as a guide to HCPTs in general, since the Department is issuing a circular on the subject. Relevant extracts from the document on 'Management Arrangements in the Reorganized NHS' are given in Annex 1.

Aims of the HCPT

Four main aims are laid down:

(1) Continuously reviewing the needs of client groups, and the services provided for them, in order to identify gaps and opportunities for improvement.

(2) Contributing to policy recommendations and developing the annual District plan which in turn is submitted by the DMT to the AHA. Medium and long-term planning will also be an important part of the work.

(3) Undertaking special studies in order to identify improvement opportunities.

(4) Assisting the DMT to implement, co-ordinate and evaluate innovations.

These aims can only be defined more precisely if the term 'need' is given more precise content. Although some general principles can be laid down, this process of definition can only be undertaken locally. Each District has its own unique pattern of resources, services and traditions. Local professional people have their own special interests. Community health councils generate their own local pressures. Public opinion varies from one area to another. Pressure groups representing service users vary in strength, skill and effectiveness. The prevalence of morbidity depends upon social and demographic factors which also vary a great deal. It is inevitable and right, therefore, that national guidelines should be used flexibly, and that the process of interpreting the needs of each District should be undertaken by local people.

This paper attempts to set out the nature of the decisions that will have to be taken, and to indicate in broad outline the sort of information that will be necessary in order to make the decisions as rational as possible. Annex 2 contains a discussion of the concept of 'need', which is basic to administrative and clinical planning, and illustrates one way in which the HCPT could think systematically through the problems of the District. Annex 3 outlines the kind of information the HCPTs would probably find of practical help in decision-making.

It should be emphasized that no District community physician could undertake the work involved in setting up numerous HCPTs if each one of them attempted to do everything considered in this document. Nor could any one team possibly hope to fully survey, monitor, evaluate and plan the services needed even by a single client group. How the team

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sets about its business and how it allocates its members' limited time must be a matter for local discussion and decision. All we have attempted here is a review of the various topics that must be considered, at least briefly, in order to select those issues which need concentrated attention. Annex 3 illustrates the preliminary stages of this process, using a predominantly rural area in Yorkshire as an example.

Achieving the aims

In order to achieve their overall aims, HCPTs will need to adopt a series of more limited objectives, some of the more obvious of which are listed below:

(1) Describing any features of the District that are likely to indicate a particularly high referral of certain types of patients. Students, old people, immigrants, unmarried mothers, delinquents, homeless single persons or families, people in isolated areas, and so on, are obvious 'high-risk' groups.

(2) Surveying the existing services (a) at primary care level, (b) at specialist care level (including referral and follow-up procedures: general practitioners, general hospitals, social service departments, walk-in clinics, voluntary agencies, etc). Clearly, not every HCPT will have the resources to undertake its own surveys, but some will be able to do so. The community physician is responsible for providing statistical information.

(3) Looking for gaps in these services, compared with national norms or clinical expectation or reports from areas acknowledged to have good services. If necessary, conducting surveys or obtaining information about aspects thought to be particularly vulnerable to criticism. Particular client groups may need special attention, particularly the new and the old long-stay, those requiring secure conditions or compulsory treatment, those needing rehabilitation, day care or hostels, those dependent on drugs or alcohol, those seen in general hospital casualty departments, etc. Those in chronic sick institutions, Part III accommodation, community hostels for young people on remand, and other special accommodation are also likely to be considered. For example, the psychiatric needs of people over 65 years of age who are receiving care in various types of residential accommodation (not only in hospitals) will require discussion.

(4) Deciding whether there are any substantial areas of need among people not at the moment in touch with services at all. High-risk groups who have fallen out of contact should particularly be considered. Patients who readily move from one area to another are also of special interest.

(5) Recommending priorities among these various needs, in the light of the severity of the condition under consideration, the level of demand, and the resources available.

(6) Monitoring the changes after any particular innovation has been introduced in order to discover whether its purpose has been fulfilled.

(7) Considering the number of professional people available in the District, and their training and deployment, in order to make recommendations about the most efficient use of the manpower available and any needs for further education. For example, would some nurses benefit from special training courses in the community management of chronic psychiatric illnesses, in behaviour therapy, in social work or in social therapy? Would some social workers benefit from short courses learning to cope with chronically ill patients in order better to appreciate relatives' problems? Would psychiatrists benefit from management courses? What is the value of the team concept and how can it be made to work effectively and economically? How far are the various professional groups ready to receive ideas about further education?

(8) Making contact with representatives of client groups and potential users of the services in order to learn from their experience and ensure that the local community is well-informed. It is particularly important that the Community Health Council should be closely aware of the HCPT's ideas and plans and that the CHC, in turn, should make its views frankly and frequently known to the HCPT. The team has a role in public health education.

(9) Maintaining close liaison with other professions and other service organizations, particularly with the Social Service and other departments of the local authorities, the employment service of the Department of Employment, and any voluntary services. This will be particularly important where local authority and health service boundaries do not coincide.

(10) Considering the organization and management of the available services, i.e. the links and communication between agencies, the problems and delays involved in transfer, the difficulties that arise when different professional hierarchies are involved (e.g. nurse and occupational therapist, industrial supervisor and DRO, social worker and community nurse, psychiatrist and clinical psychologist), the management problems within agencies and the state of morale throughout the service. The relationships between large hospitals and DGH units serving the same catchment area need particular attention. Links with other HCPTs will also be very important, since the needs of clients cannot easily be sub-divided between separate teams.

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Initiative for setting up HCPTs

The community physician has responsibility on behalf of the DMT for setting up HCPTs. However, anyone in the District who can make a strong case for setting up such a team is at liberty to make this proposal to the community physician, and psychiatrists should in fact do so if no initiative has already been taken. Since team work is fundamental, it would be best if psychiatrists could work to produce a climate of awareness in which a joint initiative would arise.

Membership of HCPTs

As a basic minimum, the team might consist of District community physician, or his representative, administrator, two psychiatrists (e.g. one working mainly in the District service and one mainly in the mental hospital, especially if the latter is situated outside the District), general practitioner, nurse, clinical psychologist and social worker, appointed for three or four years and selecting their own chairman. Representatives of other professional groups may usefully be co-opted when certain topics are under consideration. Indeed, some questions can only be considered if, for example, *all* the local psychiatrists are consulted. The team approach has the advantage that each member will bring a different range of skills, so that the whole spectrum of expertise and facilities locally available will be brought under consideration. This means that planning is likely to be more balanced than in the past, with both hospital and community experience and needs being taken into account.

Continuity is essential, but so is rotation so that every psychiatrist who is interested in planning has the opportunity to gain experience and to contribute. The ideal situation is one in which the psychiatrist in the team is there by consent of all the consultants in the District and in which changes similarly occur by consent. No election procedure has yet been laid down. Psychiatrist members of the team should keep in touch with others in neighbouring Districts in order to compare progress and problems and to learn from each other's experience.

Recommendation

It is recommended that psychiatrists in each District should consult with each other, and with the community physician, as to the best way of setting up an HCPT for 'adult mental illness'. There will be a good deal of local variation: eg in some cases there will be an overlap with other teams (such as geriatrics, child health or mental retardation) or one team may deal with more than one topic or client group. Although the details will be different, HCPTs concerned with mental retardation, adolescent and child psychiatry, geriatric psychiatry and other subspecialties will probably need to adopt a similar approach to the one suggested here. The outcome should be a more efficient, co-ordinated and humane service.

Annex 1

Management Arrangements for the Reorganized National Health Service DHSS, HMSO 1972, Extracts Relevant to Health Care Planning, Slightly Modified

2.46 The DMT will be responsible for identifying gaps in its services in relation to needs and for developing ways of improving its services to use existing resources better. For example, it will examine ways of changing existing patterns of care, by alterations in operational policies and procedures and in priorities between services. This team activity will relate both to the operational health-care services and to the related supporting services. In order to carry out the planning of the operational health-care services, the DMT will establish a number of multidisciplinary health-care planning teams to concentrate on planning services to meet particular groups of needs.

2.47 The health-care planning team could take a *permanent* form for those groups which require a high level of interaction between hospital and community care. These will require continuous planning and monitoring, e.g. for the elderly, the mentally ill and the mentally handicapped.

It is desirable that there should be some uniformity in the scope of the teams set up on a continuing basis, and hence national and regional policies may be developed to guide DMTs in setting up their teams.

2.48 The composition of these health-care planning teams will need to be adjusted to particular situations, but there will probably have to be representation of general practitioners, consultants, hospital and community nurses, health visitors, relevant paramedical staff and representatives of local authority services, particularly social services. They will be supported by the District community physician and an administrator.

2.49 The role of the health-care planning teams will be to assess needs in order to effect changes in services. This involves four kinds of activity.

a. Continuously reviewing needs of particular groups and the services being provided to meet these needs. The purpose will be to identify gaps in service provision and the opportunities for improvement.

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b. Contributing to policy recommendations and to development of the annual District plan. The teams will advise the DMT on the policy recommendations to make to the AHA. They will, for example, examine the relevance of new national policy guidance to the local situation. They will also develop the relevant part of the annual planning proposals for the District.

c. Carrying out special studies to establish ways of bringing about beneficial change. They will develop plans and programmes of action to implement identified improvement opportunities. The DMT will examine their proposals and decide on priorities.

d. Assisting the DMT to monitor and co-ordinate the implementation of projects and assess results. All members of teams will be responsible for assisting with the proposed changes. They will do this as a service to the DMT. After implementation they will assess the effects of the change.

2.50 Team members will take part both in the formulation of plans and in their implementation. They will bring to the planning process their own particular knowledge and skills. They will form a link with professional opinion in their own disciplines, bringing representative views to the team and advising on what is practical and acceptable. Thus the consultant to the team will be responsible for ensuring that relevant medical issues are raised and discussed at meetings of the appropriate District Medical Committee. Team members will also be expected to inform their colleagues of new developments.

2.51 Data must be gathered and analysed if teams are to work effectively, and the teams must have administrative support to draw up reports and co-ordinate their meetings and work. The District community physician will be a member of each team and will contribute his knowledge of the epidemiology of the District. He will carry out special studies and analyses for the teams. Each team will be supported by an administrator who will provide a service both to the community physician and to the planning team. The teams should also be supported and advised by specialist planning staff from Area headquarters.

2.52 Each team should have a chairman, selected from among their number by the members. His role would be to secure the good working relationship necessary for co-operating and planning.

3.10 . . . Within a District, initiatives for changes in the various parts of its plan should to a large extent be expected to come from the various standing or *ad hoc* planning teams.

3.16 Here and elsewhere, it is stressed that plans should be prepared on a District basis. It is hoped that plans will be developed by staff working at this level with guidance and help from Area, Region and Department. However, it would be naive to imagine that all Districts will immediately become fully competent in a difficult process. Thus higher levels must develop this competence and, in the early years, provide it . . . .

3.19 Discusses the comprehensive District health plans and suggests the following periods of planning:

a. The short term, within which it is possible to bring about changes through redeploying or changing the use of existing resources or changing working procedures.

b. The medium term, within which it is possible and realistic to estimate the resources that will be available, and plan their deployment, within the context of the constraints imposed by the existing major buildings etc. This period is about four years.

c. The long term, within which it is possible to implement radical changes in the District's health services—in particular, changes that require the design, building and commissioning of major new buildings. This period is about ten years.

The clinical role in the management process

4.4 The first duty of a clinician is to practise clinical medicine. But in doing so, every doctor makes demands upon resources which have to be reconciled one with another, and his clinical actions interact in complex ways with the work of others, in both the health and personal social services. Clinicians are important innovators, and their ideas must be picked up by management, upon which they therefore unavoidably make an impact. The benefits of this impact will be greatest (and the ill-effects least) if the clinicians can:

a. take an active part in the management process.

b. carry out their clinical duties with an understanding of the effects on other parts of the Service.

c. be committed to proposed changes and developments.

4.8 The DMT have both advisory and executive roles, and its functions will include the endorsement of medical views expressed by doctors on health-care planning teams.

4.22*a* . . . Doctors, both clinicians and specialists in community medicine must play a fundamental part in the planning of operational health services . . . the specialist in community medicine will draw together the planning work of clinicians and will also contribute his epidemiological and other knowledge of local health circumstances. He will thus be accountable for the formulation and content of operational health-care plans . . . .

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Annex 2

Suggestions for a General Strategy to be Followed by HCPTs

The concept of need implies an assumption of value: that the availability of an acceptable form of treatment or care, of proven efficacy for a given illness or disability, automatically creates a state of potential need in anyone who could benefit from it. Whether that potential need is recognized and met depends on the attitudes and awareness of the individual concerned, those who are important to him in his immediate social environment, and those who control access to the services which provide diagnosis, treatment and care (including, of course, those who control public funds). The degree of consensus between all parties as to whether any given individual is 'in need' will increase with the severity and visibility of the illness or disability. HCPTs may find it useful to begin with a consideration of the factors in their own Districts that are likely to affect severity and visibility. These include the age and sex structure of the population, general social factors such as poverty, unemployment, social isolation, immigration and overall trends in population size, and more specific local problems connected with housing, industry, motorways, noise and so on.

It must, of course, be recognized that central and local government will not undertake to meet all the needs so identified, but the fact that systematic consideration is being given to these matters at District level will at least ensure that professional opinion is articulated, and it must eventually influence the formulation of government policy.

The next step, logically, is to consider the primary care services which act as the first official screen for recognizing need—those provided by general medical practitioners and by local social work teams. So far there is little formal liaison between these two sets of primary care services, but the need for co-ordination between them is perhaps most evident in the field of the psychiatric disorders. Surveys suggest that some 15 per cent of those who consult general practitioners during the course of a year are given some sort of a psychiatric label. Most of these people have to be treated, if at all, by the general practitioner himself. Some obtain idiosyncratic treatment; many have to treat themselves. The question of primary care teams needs consideration; also that of high-risk groups who are known to local medical practitioners (unmarried mothers, students, school-leavers and drop-outs, homeless people, those in single-person dwellings or lodging houses, old people, those in special residential or day accommodation not visited by a psychiatrist, eg probation hostels, units for the chronically physically handicapped, etc). What extra training, or liaison, is required to ensure satisfactory screening, diagnosis, treatment and care? Can psychiatrists usefully spend sessions in health centres? Are domiciliary visits requested often enough, and do the general practitioners get adequate reports? Do family doctors appreciate the sort of expertise a psychiatrist has and when his advice is not likely to be useful?

Only 5 per cent of people seen by the family doctor during the course of a year are referred to a psychiatrist; i.e. less than 1 per cent of the population. The processes of selection, first to the general practitioner and then to the specialist, need to be considered in order to be sure that the most efficient use is being made of the services provided.

At the specialist level, in addition to those referred during the year, most of whom are treated as out-patients, there is a roughly equal number who have accumulated from previous years—many of them long-stay in-patients. The HCPT will need to collect information concerning the numbers of people in touch with specialist services and their problems. The main headings are: 'old' long-stay patients (say, those who have been in hospital more than five years); 'new' long-stay (those in hospital more than a year but less than, say five years); medium and short-stay in-patients in various types of unit; people attending hospital daily, out-patients, and those seen in other types of contact (emergency, ward referral, domiciliary, etc). It will be important to gather data on the overlapping residential and day services provided by the local authority, DOE and voluntary organizations.

Those contacting these services can be subdivided into various client groups and their needs estimated. The judgement as to need will always take into account the views of the individual, those of people in the immediate social environment, and those of the professionals who control access to or who maintain the services. It is always a value judgement and a compromise. In each District there will be fairly evident clues as to where the main gaps in the services are and where needs are most obviously unmet. CHCs and voluntary organizations should be consulted. Criticism, even when unfair, may be useful in directing attention to areas where further inquiry is necessary. DHSS guidelines are useful in indicating when to consider whether a particular service has too large or too small a share of local resources, but it should be recalled that they *are* only guidelines; not mandatory instructions. Local needs vary a great deal.

Local case-registers can be very useful sources of information for planning purposes. A case-register is complicated to set up and maintain and in most areas it will not be necessary to attempt to establish one.

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However, simple statistics ought to be available concerning the numbers and types of patients contacting the various clinics, and these figures can be compared with those from case-registers and from national information systems in order to provide a degree of assessment. Special collections of data or even surveys should be undertaken when there is a particularly obvious problem about which information is inadequate; for example, the numbers of patients referred for short-term hostel care or the numbers needing Part III accommodation.

The problem of unmet need among people already in touch with services should probably have priority (this is one of the questions the team will need to consider early on), but attention must also be given to the needs of those who are not in touch with services. Are they similar or different? Is it a matter of providing more of the existing services or a quite different type of service? There are two main groups for consideration:

(a) those who drop out of care, e.g. following discharge from hospital, or who fail to keep an out-patient appointment;

(b) those not yet identified. It is doubtful whether HCPTs will be able to undertake population screening, but there are groups of people who are obviously at high risk and it may be worthwhile considering methods of obtaining information about them.

Once a list of unmet needs has been drawn up, the team will have to consider recommending priorities for modifying services or introducing new ones. Here the members will have to be closely acquainted with what is available in the District, the strength and weaknesses of agencies and leaders of all kinds, and the potentialities for new development. It may be that changes in organization, co-ordination or management will give better results than the introduction of new services. It may be that retaining or redeployment may be more useful than trying to increase the numbers of staff. On the other hand, it may be that only an increase in resources can meet a high-priority need. The underlying principle is always the same. A need cannot be said to exist unless the illness or disability can be recognized and there exists an acceptable and effective method of treatment or care. If serious needs exist and are unmet, the problems of demand and utilization must be considered in relation to availability of services and a case made out for gaps to be filled. Other things being equal, the better documented the case the more persuasive it will be. Labour-intensive schemes, however, will usually be at a disadvantage.

It is plain that no hard and fast dividing line can be drawn between the responsibilities of the medical and other caring professions. The needs of the acutely ill will be most immediately recognizable to doctors, but there are many other forms of care which require deliberate consideration. Among them are psychological and behavioural treatments, counselling on the management of long-term disability (both patient and relatives may need this), supervision to prevent wandering or self neglect or deterioration, social and domestic and occupational rehabilitation, provision of shelter or retreat or asylum; and provision of security because of a danger to self or to others. In each case, accurate clinical assessment is the key to effective prescription of form of treatment or care and therefore delivery of services. A canvas of the professional manpower in the area will give rise to questions about training, redeployment and liaison.

Finally, the HCPT, through its careful consideration of all these matters, together with its attempt at self-education through contacts with client groups, other professionals, CHCs and voluntary organizations, will be in a unique position to promote health education within its District. It may be hoped that in due course the public in general and psychiatrists as a professional body will help to educate each other, to their mutual benefit.

Annex 3

An Example: Services Based on Psychiatric Unit, Airedale District General Hospital, Keighley, Yorkshire*

General characteristics

The following example deals with part of one District which is by no means characteristic of others except in that each one is unique. The catchment area of 113,610 people (mid-1973) is served by the Airedale Psychiatric Unit. It is partly urban, partly rural. Keighley (55,000) has its principal industries in textiles, machine tools and retail distribution, and Skipton (12,000) is a market town. The remaining population is in scattered villages and farms. Keighley is 4 miles from the hospital and the furthest village is 32 miles away. Age and sex structure is as overleaf, with figures for England and Wales (1971) in brackets.

There is a small excess of people aged over 65 years, compared with England and Wales. This is particularly true of women, and is most marked in some rural areas. The unemployment rate in early 1975 was 3·4 per cent compared with the national proportion of 3·3 per cent. Information will need to be gathered on indices of rural poverty, housing

* This Annex has been produced by the authors as an illustration and is not the product of the Airedale Health Care Planning Team.

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Age	Males (1971) %	Females (1971) %	Projected population change 1971–1981 Male and female
0–14	12·0 (12)	11·2 (12)	+ 5·4
15–44	18·1 (19)	18·1 (18)	+13·8
45–64	11·8 (12)	13·3 (13)	−11·2
65+	5·6 (5)	9·8 (8)	− 1·5

problems, employment opportunities, immigration, suicide rates, and so on, but there is no pocket of great social deprivation within the district.

Primary services

It is not known what proportion of the population visit general practitioners during the course of a year because of psychiatric disorders. If the figures of Shepherd *et al* (1966) are applied, a prevalence rate of 140 per 1,000 persons at risk would produce 15,904, and an inception rate of 52 per 1,000 persons at risk would be 5,907.

There are 4½ area social work teams who also see some people with primary psychiatric problems. Staff numbers are fairly well up to establishment with mainly trained social workers. There are virtually no direct referrals to psychiatrists. The quality of liaison depends upon the individual social worker and varies from excellent to non-existent.

General practitioners are well established, with little use of GP emergency call services, and are mainly well known to the psychiatrists. Relations are good, but there is considerable scope for development and clarification of joint care of patients. There has been no experiment with primary health and social care teams.

Possible high-risk groups

The over-65 population form 15·4 per cent, compared with the national average of 13 per cent. Only those with functional mental illness have been cared for in the psychiatric unit, leaving a heavy burden on the geriatric services and the community.

There is no particularly socially deprived area containing groups of people with damaged personalities, drinking problems or chronic untreated psychoses. Presumably there is a tendency for such people to drift to larger population centres.

There are few student problems referred. This may be partly due to the lack of special referral facilities or walk-in clinics, but is mainly a reflection of the small student population. Drug problems of the young are rarely seen.

The small Asian immigrant population of Keighley is under-represented in the in-patient population, with virtually no out-patient referrals. This merits investigation.

Approximately one patient per year is transferred to another hospital on grounds of being a severe, long-standing security risk.

Specialist services

The psychiatric unit is part of the 650-bed general hospital block comprising two standard general wards plus a recreation/meetings/ECT area and day hospital facilities. There are 62 beds (plus two protection rooms), a ratio of 0·5 per 1,000 population. The staff establishment comprises two consultants, two registrars, two SHOs, one senior and one basic grade social worker, one senior and one basic grade psychologist, one senior and 1½ basic grade occupational therapists with one assistant, one nursing officer, 18½ trained staff and 18 auxiliaries. All establishments are up to strength except nursing which has five vacancies currently.

The unit is fully recognized by the Royal College of Psychiatrists for registrar training and takes an active part in the general practitioner vocational training scheme—the SHOs being members of this. It is hoped that eventually a mental nurse training school will be established here. Community psychiatric nursing on a small scale is well established, effective and accepted by the community services.

The unit was opened in mid-1970 as part of a new general hospital. Before this psychiatric patients were admitted to either High Royds Hospital or Scalebor Park Hospital. There is now no direct access to these hospitals, but long-stay patients admitted before 1971 have remained there. There are 93 patients from the catchment area currently in High Royds Hospital and 29 in Scalebor Park, five of whom were admitted since 1971. The two mental hospitals provide a background support to the unit which would be swamped by these patients were they to be discharged. The bed numbers for the district are thus as follows:

	M	F	
Airedale 'Old long-stay'	(not fixed)		62
High Royds	46	47	93
Scalebor Park	6	18	24
'New long-stay' (since 1.1.71) Scalebor Park	1	4	5
			184 (1·62/1,000)

The DGH unit provides a comprehensive psychiatric service without gross overcrowding of the 0·5

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beds per 1,000 population. This would not be possible without the above long-stay support, the separate provision for patients with dementia and the social advantages in the catchment area population noted above.

During 1973 there were 429 admissions to Airedale Hospital, i.e. 378 per 100,000 population. This is higher than the 1971 average of admissions to RHB psychiatric hospitals and units (359) but well within the ordinary range (288–435). Of these admissions, 109 (96 per 100,000) had not been admitted before; nearly double the national average (51) and close to the top of the range for England and Wales (22–104).

On the other hand, day-patient attendances were lower than average (2,219 per 100,000 compared with 3,979), though the number of new day-patients during the year was not much lower than average (333 compared with 365 per 100,000). This is largely due to the day hospital still being in early stages of development, though distance prevented some attendances. Out-patient attendances were a little higher than the average rate (2,722) compared with 2,447 per 100,000). There are three new psychiatric out-patient sessions and ten follow-up sessions per week. There were 275 general hospital ward referrals in 1973, 200 because of parasuicide and the rest for a variety of reasons.

Local authority services

The two local authorities concerned (Metropolitan Bradford and North Yorkshire) provide no day centre places and no alternative residential accommodation. Two voluntary hostels are being developed and should soon provide places, but the local authorities have withdrawn their own plans because of financial restrictions. Bradford has planned a day centre but building has not yet started.

Needs of those not in touch with services

So far no survey has been undertaken but one is currently under consideration.

Options for innovation

In the near future, there are plans for another consultant psychiatrist to be appointed who will spend half his time dealing with psychogeriatric problems. High on the list of priorities is the need to plan jointly with Scalebor Park Hospital, which has a separate catchment area within the District and also provides a comprehensive service. A review of case-records will also be undertaken in order to see whether more useful statistics can be kept, providing updated tables for planning purposes. The possibility of a case-register, including a risk-register, is being considered. This would provide more detailed accurate and up-to-date tables, allow the separation of person statistics from event statistics, and make it possible to trace the relationship between the different agencies which the same patient attends. It has already been decided to start building a psychogeriatric assessment unit during 1975.

In the medium term, it is likely that experiments with a community psychiatry team will be undertaken, but its exact relationship to primary medical and social care teams has not yet been worked out.

In the longer term, the obvious needs for alternative day and residential care in the district, including group homes, hostels and possibly sheltered housing will need to be tackled if the present low accumulation of 'new long-stay' patients is to continue. The 'old long-stay' group on the whole do not wish to be resettled outside hospital, and it would be difficult to transfer staff and resources to provide the kind of rehabilitation effort which might be successful. However, the priorities will be re-assessed year by year.

The development of the psychogeriatric services and the results of surveys and increased links with the community will have an influence on the pattern of referrals, domiciliary consultants and out-patient work, but fundamentally these will probably remain unchanged.

The HCPT is only just in the course of formation in this District but at least a simple framework of information is available to aid decision-making and the assessment of priorities.

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