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Day Hospital Care for the Mentally Subnormal

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The care of the mentally subnormal in Britain has quite suddenly become a live and prominent issue, but public indignation fades quickly and political interest is soon transferred to other issues that are constantly arising. The time seems ripe to re-think the overall philosophy of provision for the mentally subnormal in a developed industrial society, and in particular, the place of the large institution (Craft, 1970; and McKeown, 1970). These institutions resulted from conditions which no longer exist, and they now attempt to carry out a variety of functions, which many think ought to be separated. However, the subject remains a very controversial one (Shapiro, 1969, 1970; Freeman, 1969a).

Fundamentally, the problem must be seen as one aspect of the overall network of medical, social and educational services. There may be nationally 2,500 children and 2,000 adults (5/100,000; 4/100,000 children and adults respectively) on subnormality hospital waiting lists, but this may reflect the failure of local authorities to provide adequate hostels, training centres, transport and social work services or the failure of the hospitals to explore other than in-patient forms of service which might deal better with the situation. Some might benefit from day care at a subnormality, general or paediatric hospital, and this paper is concerned with exploring to what extent this is possible.

In its 1965 circular on subnormality hospital services, the former Ministry of Health stated that: 'Ultimately, continued hospital care will be necessary only for patients who require special or continuous nursing, and for those who because of unstable behaviour need the kind of supervision and control provided by a hospital.' Day hospital care was recommended, but has been carried out in but few places, perhaps because the recommendation lacked specific financial help. The merits of day care have been discussed by two of us previously (Craft, 1958, 1959; Freeman, 1959, 1960, 1965). The flexible use of expensive facilities, e.g. through part-time hospitalization, is surely one of the cornerstones of modern psychiatric practice.

In this paper we use 'day hospital care' as applying to two main groups of patient. The first group are those who are undoubtedly a hospital responsibility, requiring nursing care perhaps for incontinence, non-ambulance, or behaviour disorder, but whose parents still wish to maintain them at home by night providing they can be assisted with their treatment and management by day. Those in this first group are not suitable for local authority day care centres because they require too much nursing care and attention. Whilst some adult training centres and junior training centres have special care units to care for the severely spastic non-ambulant, or the incontinent non-ambulant child, this form of provision is still rare. Many of such people in them are a nursing responsibility, commonly require drug treatment and psychiatric supervision for epilepsy, and are proper subjects for hospital care by day. This group includes adolescents and young people with severe behaviour disorder with restlessness, aggressiveness and lack of concentration, and whose behaviour upsets training centre staff and other trainees and their relatives. They may require such heavy doses of tranquillizer that they are better under close nursing and psychiatric supervision by day. The second group of patients are those who have no relatives to look after them by night and whose local authorities are either unwilling or unable to care for them, but who can live in residential accommodation provided that there is somewhere to go each day in the local subnormality hospital.

It is beyond the scope of this paper to attempt a full analysis of the residential and other needs of the mentally handicapped. However, apart from a home, facilities for assessment and any specialized treatment, their needs are for work training, education, social training, and recreation and social activities. Day care is therefore a means of hospitals supplying needs of patients requiring the above, in addition to medical treatment and nursing care on a daily basis.

Present Provision of Day Care

Since 1965, an attempt has been made by the Department of Health and Social Security to measure the facilities—including out-patient and day hospital activities—which are provided by mental subnormality hospitals. This has been done by a questionnaire in which day hospitals are defined as 'a special building or block set apart for the use of patients who attend at the hospital other than as out-patients, but who return home at night. These patients will mostly stay within their separate building and will not spend any time in the in-patient wards.' This definition was designed to elicit any day hospital which was quite detached from a parent subnormality hospital, but the 1965 returns showed that there were no day hospitals, as so defined, in England and Wales.

However, the 1967 returns showed two separate day hospitals, each associated with a subnormality hospital. The first was South Side Home, associated with Queen Mary's Hospital, Carshalton, which had ten places, but there is also a day unit in the hospital itself, with a further twelve places. This has dealt with a number of children who had previously been very disturbed and regarded as untrainable, but their behaviour was modified to such an extent that they became acceptable in a training centre or even in a special school. The second detached day hospital was at Llwyn View, Dolgellau, which will be described in more detail below.

For many years, a number of mental subnormality hospitals have made provision for day patients, and in an attempt to measure this activity, the return suggested that 'these patients are to be distinguished from day hospital patients by the fact that they use the in-patient wards alongside the in-patients, and not a building set aside for their use. Alternatively, in some hospitals they may use the school, workshop or occupational therapy department, working there in the day and returning home at night.' In 1965, only four subnormality hospitals recorded twenty or more places for day patients as defined above.

By 1968, from a total of 139 mental subnormality hospitals and units making the return, 57 had day patients attending the main hospital and a total of 564 day patients (1·2/100,000 general population) were attending these hospitals on the last working day of the year. Apart from the above, those having more than twenty day patients attending were:

Northgate and District Hospital	33 patients (Newcastle Region)
Prudhoe and Monkton Hospital	33 patients (Newcastle Region)
The Manor Hospital, Epsom	71 patients (South West Metropolitan Region)
Borocourt (including Wayland, Cumnor Rise and Style Acre)	72 patients (Oxford Region)
Sandhill Park (including Farleigh, Norah Fry and Selwood)	25 patients (South Western Region)
Chelmsley Hospital	22 patients (Birmingham Region)
Monyhull Hospital	32 patients (Birmingham Region)
Offerton House	59 patients (Manchester Region)

In some cases, these day patients were attending a subnormality hospital unit because local authority facilities appropriate to their needs were not available, whilst others attended because travelling to the hospital was easier than going to the nearest local authority centre.

Local authority junior training centres are now providing increasingly for children's nursery groups, and the need to provide for the two to five year age-group is being increasingly recognized, both to relieve families and to provide social experiences and training at a critical period of development. Recent years

have also seen the expansion of special care units within them, providing for children who on account of severe subnormality (often with associated physical handicap and behaviour disorder) cannot fit into the normal regime of a training centre.

Special care units have probably arisen for two main reasons. Firstly, for severely subnormal children not so severely handicapped as to demand hospitalization and whose parents elect to keep them within the family; and secondly, for those children on hospital waiting lists whose admission is likely to be remote. At the end of 1968 there were 178 such units within training centres, providing 2,434 places (5·0/100,000 population), and there were 29 self-contained special care units, with a total of 607 places (1·21/100,000). A further 283 places (0·56/100,000) were being made available to local authorities by voluntary organizations. Some of these children may pass into the junior training centre stream, but others, on account of the severity of their handicaps, will never do so. Children are therefore growing up in them, and on this account, some local authorities have wished to provide adult special care units.

It may well be that such local authorities have, in effect, provided a day service (including nursing) for a number of children for whom a day hospital might be equally appropriate if it were geographically possible for them to attend one.

It has been suggested that subnormality day hospitals should provide for the non-ambulant adult, since long-term care for these cases is likely to remain largely a hospital responsibility. Clinically, it is found that surprisingly few subnormal or severely subnormal adults are non-ambulant; only 168 of all in-patients (13·8 per 100,000 population) from North and Mid-Wales were incapable of taking more than three steps unassisted (Craft, 1970, *op. cit.*). Of these non-ambulant cases, two-thirds were children aged fifteen years or under, and over half could walk considerably more than three steps with help. The same survey showed that by 20 years of age most non-ambulant subnormals in that community had been hospitalized. Therefore, in this particular area, at least, day hospital provision was little used for this group because of the ready availability of beds and also because of the mountainous geography.

The situation is likely to be different in heavily urbanized areas, where the special care units referred to above are virtually providing the equivalent of day hospital care. However, as there are very few subnormality hospitals situated in or near such areas, both geographical distance and density of population are relevant factors. Also, there may be ambulant but nevertheless profoundly retarded cases—incontinent, hyperkinetic or unable to wash, feed or dress themselves—who might be appropriate candidates for hospital day care if it was available. In fact, the 1965 Circular (*op. cit.*) indicated that the main criterion for special care provision was a patient's need for nursing rather than ability or inability to walk. It appears, however, that recruitment of staff for this kind of work is often easier at training centres than in hospitals.

Facilities in North Wales

We propose to illustrate the question more specifically by reference to the North and Mid-Wales subnormality hospital group, to which one of us (M.C.) acts as consultant and another (H.L.) as social worker (Craft, 1963; Craft and Miles, 1967). One of the hospitals became an independent school for speech-defective children in 1962, so that its day attenders are now, strictly speaking, E.S.N. school-children (Craft, 1969). Two others will be referred to here as illustrating particular aspects of day care.

Llwyn View Hospital, Dolgellau, for adult females, has a large recreation hall, which was previously used by the local authority as a junior training centre. Since 1966, this hall has been a combined day hospital and senior training centre, both for discharged hospital in-patients and for new day patients, transport being provided by the local authority; four males and four females (17·6/100,000) were attending regularly in 1969. Premises and meals only are supplied by the hospital, whilst staffing and occupational therapy service is financed by the local authority. This arrange-

ment has proved to be extremely successful for subnormal adults. This illustrates a situation where the local authority is so far unable to provide a comprehensive service of day training, but takes advantage of hospital facilities for one age group.

A different concept, covering both groups described earlier, has been developed at Oakwood Park Hospital, Conway. The two day hospital units at Oakwood Park were intended to be complementary to local authority provision in the area, rather than being a joint-user arrangement, as at Llwyn View. However, a purpose-designed unit is to be included in the new 500 place subnormality hospital at Bryn-y-Neuadd (which is to replace Oakwood Park). There are to be up to 150 day places, so that about one-third of the hospital's patients are expected to be living in the community outside and two-thirds sleeping in, all using day facilities alongside each other, as at Gheel, Belgium. The reason for such an apparent over-provision of day care is that local authorities and the hospital have rather different clinical responsibilities here, the local authority providing for the needs of subnormal people in their local populations and the hospital mainly for those of its discharged patients who live within daily travelling distance. Many of the hospital patients are 'stateless' in the sense that they originated from distant areas, which have since disowned responsibility for them, or else plead insufficient alternative facilities when hospital treatment is no longer needed.

Between 1962 and 1968, some 150 subnormal and severely subnormal adults were discharged from Oakwood Park to lodgings in North Wales. Discharged hospital patients, who are mainly severely subnormal, are lodging both in urban and in more rural areas. Some go daily to senior training centres in Wrexham, Caernarvon and Mid-Wales from their home areas, whilst those boarded out near Oakwood Park mostly have day care at the hospital. In April, 1968, Oakwood appointed a part-time social worker (H.L.) to supervise the hospital guardianship scheme of boarded out-patients attending the day hospital daily. More lodging places could be filled if additional social work and hospital resources were available, because increasing numbers of boarding houses and local people are anxious to participate in a successful scheme.

In fact, there seems to be no immediate limit to the number of patients who could be discharged into lodgings in North Wales if only practical issues like domestic help for landladies, transport to hospital for day care, social work supervision and evening social activities could be solved. But in contrast to this situation, there has been very little movement of patients to lodgings from hostels in Lancashire, though many of these residents had graduated to the hostels from hospitals (Boswell—personal communication). On a national scale, there seems little likelihood that lodging care will expand unless it becomes a major policy objective and unless there is a staff with this as a special duty, e.g. the Residential Services Officer of the Croydon Mental Health Service.

However, transport is also a continual major problem in day care—at Oakwood Park, as elsewhere. Caernarvonshire residents who are in lodgings come in by bus, at the expense of that authority, whilst other day patients who are living in their own homes are brought in by private taxi. Fifteen patients in lodgings, who are the responsibility of no local authority, travel by hospital transport, but there are ten further lodgers who should come in daily but cannot at present because of insufficient transport and day space.

Sixteen adult females now attend as day patients for industrial or occupational therapy, under the care of two supervisors. The male day hospital has about twenty patients and four in-patients are also prepared for discharge by spending their day with this group. Of the remaining 114 discharged in earlier years, some were discharged to boarding houses in Rhyl and Wrexham to attend local adult training centres there, whilst some forty patients boarded out near Oakwood would attend daily if there was transport. Day patients have meals, discussion meetings, social activities and educational training as a group, under specially selected staff. A number of the men do useful work, for which they earn up to 50s. weekly. Since outside jobs are generally not available

in the area, it might be better if these day patients could be transferred to the status of regular hospital employees and the hospital wages account adjusted to cover them. (This would still be cheaper than in-patient care and could save supplementary benefits in other cases.) Though the hospital beddage has technically fallen from 201 to 169, there are actually more patients attending daily. Day patients, of course, require almost as much hospital activity as in-patients, although because of the fewer nurses required at weekends and overnight the cost might be slightly less. Costing brings into consideration the type of day hospital patients attending. For the first group described early in the article, those requiring intensive nursing care because of incontinence, inability to walk or severe behaviour disorder requiring medication, actual staffing costs would be great even though they slept at home each night. Of the second big group those boarded out in lodging houses at night but attending for work daily because of lack of local authority provision, the cost of staffing is slight. At Oakwood Park, one of the adult females and two of the adult males attend because of severe behaviour disorder, and in fact live at home with their parents; if there were no day hospital accommodation they would have to be admitted as in-patients. It is probable that these three cases would be too much of a burden for an adult training centre even if one were provided in the area. Of the remaining 33 patients most could attend a local authority centre were one available in North Caernarvonshire, except that none are Caernarvonshire citizens, and they could not, therefore, be boarded out in the locality by the hospital authorities as a charge on Caernarvon rates. It is felt that adult training centres and hospital-staffed day hospitals have complementary functions to each other. Ideally, local authority adult training centres should provide work training, care and supervision, whilst hospitals' day hospitals provide intensive nursing care, drug and medical treatment for those who would otherwise need in-patient admission. It could be that if intensively staffed local authority special care units were provided in all localities, there would be no need for day hospitals, but this seems likely to be a dream of the future, and the needs are for the present.

Evening and weekend activities are organized by one of us (H.L.) for day patients lodged out of the hospital in local villages. There is also an occupational therapist who visits some patients in local lodgings twice weekly. The aim throughout is to ensure that ex-patients actually benefit by return to the outside community, and continued stimulation and activity are needed to prevent small units becoming small institutions, with less to offer than the patients' previous hospitals (Apte, 1967).

It may sometimes be wondered what is actually gained by a transfer from in-patient to day hospital status; the expense may be no less, or conceivably even more. A similar position occurred in respect of day care in general psychiatry, which was originally claimed to be 'cheaper' than in-patient cost (Farndale, 1961). Certainly, the taxpayer is likely to get better value for money and the hospitals can operate more therapeutically with a smaller number of full-time residents. But in addition, two of us, having seen patients in North Wales change significantly by a transfer to day care, would claim that they appear to gain principally in terms of dignity and happiness, though these are notoriously difficult to quantify. Nevertheless, Campbell (1968b) found that hostel care was generally preferred to hospital by the mentally subnormal themselves.

It will be seen from the above that day hospital care has been used in two quite different ways within the North and Mid-Wales subnormality service. A substantial element of boarding out has been associated with the facilities of the main hospital, but in each case there has been flexible use of limited resources.

Future Development

The material in this paper indicates both the potential value of day hospital care for the mentally subnormal and the very inadequate progress that has been made in this direction on a national level. In particular, it should be noted that the North and Mid-Wales area

is managing with some two-thirds the number of hospital beds for subnormality required by other areas (84·5/100,000 compared with a national average of 130/100,000 in 1969) and that waiting lists for admission there have been eliminated. Surveys (Craft and Miles, 1967, *op. cit.*) have shown the incidence of subnormality to be at least as high as elsewhere in the U.K. McKeown's survey in the Birmingham Region (1967) suggested that half its subnormal in-patients (160/100,000) could be better cared for in the community; in North Wales this prediction has already been verified. Making full allowance for social, cultural and geographical factors which are not applicable to Britain as a whole, it would still seem reasonable to conclude that day hospital care can substantially help to reduce the demands made for institutional places for the subnormal.

In the long run, the aim should be for those mentally handicapped who require specialist medical services to be cared for within each major area, primarily by a comprehensive community mental health service (Freeman, 1968, 1969) acting in close collaboration with the local education services. Particular problem groups should be dealt with by a relatively small number of specialized hospitals, operating on a regional or national basis. Present indications suggest that catchment populations for each district service will generally be in the region of 200/250,000, at least in urban areas. Rehabilitation services and sheltered accommodation can be organized to serve both the subnormal and the mentally ill, any separation being along the lines of level of achievement, rather than of diagnosis. Such a policy has already been initiated in Salford (Freeman and Mountney, 1967).

Also, the families of the mentally subnormal generally need the same kind of social casework as those of mentally ill patients, and it is preferable for this to be undertaken by a unified body of social workers. However, a survey conducted among the families of subnormal patients in Salford by Leeson (1960) showed that many basic needs were not being met adequately, even though the local service was much in advance of that provided in many other areas. The long-term handicaps of the subnormal, with their associated family and social problems, have many features in common with those of chronic schizophrenia and senile deterioration. For all of these, a Continuous Care system of monitoring will be needed to replace the largely random arrangements of referral and provision which exist in most areas at present. Progress towards such a system has begun in Salford, where an ongoing register of the mentally subnormal was begun in 1960 and has been followed by a total census of all mentally ill and subnormal patients receiving any form of care (Fryers, Freeman, and Moutney, 1970). In the Wessex Region a start has been made on a wholly new system of residential and day care for the subnormal, based on small units (Kushlick, 1967); an analogous system of small group homes serves Denbighshire (Craft *et al.*, 1970).

The expansion of day care by existing subnormality hospitals—as much as their geographical situations allow—might well be one of the most economical means of reducing the pressure on their in-patient facilities and of fostering 'community care' (however defined). But even this would require additional finance, particularly for transport and for extra social workers and supervisory staff. Whilst there are still 65,000 patients in subnormality hospitals in England and Wales, only 17 hostel places per 100,000 general population are predicted for 1976—provided that local authorities meet all their scheduled targets. Kushlick's (1969) figures suggest that 70/100,000 non-hospital beds are needed, whilst Craft's Denbighshire and other figures show that 85/100,000 small group home beds and 85/100,000 hospital beds are actually needed to satisfy need in 1970 in North Wales. Supervised lodgings and day care—as described above—could be most helpful in dealing with this enormous shortfall. In fact, we believe that greatly increased day hospital provision should be one of the primary aims of the efforts now being made to improve the care of the mentally subnormal in this country. At the same time, if some large subnormality hospitals achieve the hoped-for reduction in numbers of in-patients, and if they retain appropriate

facilities and staff, day care would be a logical additional use for these resources. As such, it could be a useful factor in preserving morale, at a time of institutional change.

Whilst we have emphasized the value of associating day care with boarding out in supervised lodgings (for the less severely handicapped patients), this is not to cast any doubt on the value of greatly increased hostel provision. So far, the most impressive programme of this kind has been in Lancashire, which has 22·3 beds per 100,000 population, and where the development has been subject to a comprehensive research programme (Campbell, 1968a, b, c, d). However, as we have already emphasized, present plans give no suggestion that hostels generally are likely to be developed to such an extent that lodgings would be unnecessary, and the two are in no sense to be seen as rivals.

Finally, we have already referred to the use at Oakwood Park of day care for *in*-patients as a preparation for discharge. This possibility has been strongly supported by Morris (1969), who suggested that much of the accommodation in existing subnormality hospitals might be turned into more informal, hostel-type units, from which patients would go daily to the main hospital 'care'. At a later stage, some of these residential units might be taken over by local authority social service departments and their residents would then become either hospital day patients or training centre attenders. Clearly, there are many exciting possibilities in this direction, if conventional habits of thinking and administration can be discarded sufficiently to take advantage of them.

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