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A Haven for the Severely Disabled Within the Context of a Comprehensive Psychiatric Community Service

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The priorities accorded severely disabled or disturbed long-stay patients in Regional and District planning strategies vary enormously. A scheme to cater for the needs of this group is described. The scheme includes: non-stigmatising housing; a domestic regime, daytime occupation and leisure activities offering forms of enabling and caring that foster the highest possible levels of functioning; a secure home; private and peaceful outdoor space; and graduated steps towards independence that allow for the possibility of relapse. The central concept is the establishment of a Community for people with severe difficulties in making social contacts. The importance of integrating the scheme into a comprehensive District psychiatric service is emphasised.

The term 'asylum' has both benevolent and pejorative connotations, and motives for establishing sheltered institutions have usually been mixed. Lunatic asylums were established both for humanitarian reasons and because the community at large was frightened by manifestation of insanity and understood that protection worked both ways. The extraordinary strength of this combined motivation is evident from the volume of resources put into building and maintaining the county asylums. They still stand: a visible index of the capital and revenue needed to create a new system of care for mentally afflicted minorities, and a challenge for our own time. In this paper we discuss, in the context of evidence that the build-up of 'community' alternatives for the long-term mentally ill is at best half-hearted compared with the speed of rundown of the hospitals (Social Services Committee, 1985), what is to be the fate of people who need to be offered a haven.

Planning for the needs of the disabled

The concept of 'need' is based on that of 'social disablement', which in turn is derived from a concept of normal social functioning and expected quality of life. 'Disablement' is defined in terms of the degree to which an individual falls short of the level of performance that is generally expected within a given society, as interpreted by the afflicted individual or those closely connected with him or her. The more severe and general the departure from 'normal' social functioning, the more likely is agreement to be reached that social disablement is present and, potentially, that help is needed.

A full analysis of the concept of need requires consideration at three levels:

(a) the causes of social disablement, which can be summarised under the headings of intrinsic impairment, social disadvantage and personal distress or demoralisation.
(b) specific, effective and acceptable forms of care (including treatment, training, rehabilitation, shelter, security, and welfare) for problems defined under (a)
(c) the service that will prevent, ameliorate or contain these problems, through the 'delivery' of specific, acceptable and economic forms of care (Wing, 1972).

The application of this kind of analysis across a district allows comprehensive 'bottom-up' planning, based on the aggregated needs of individuals. Within a geographically based national health service, planning and provision should be based on three principles—identification of individuals in need through the application of epidemiological knowledge, provision of a wide variety of service components to deliver packages of treatment or care in accordance with fluctuating need; and organisation and management that ensures integration and continuity in a system that could otherwise become fragmented (Wing, 1978).

Systematic surveys provide data that demonstrate needs for a wide variety of methods of help, and therefore a wide variety of services. The latter can be illustrated by the analogy of three stairways with landings (see Table I), each representing a major functional area of everyday life: occupational, residential and recreational. Disability in one of these areas does not necessarily (or even usually) imply disability in all. This analogy provides a reminder of the interaction between the functions of services

TABLE I

The stairway analogy. Service and needs can be likened to three stairways (columns) with landings (horizontal lines)

Dependency	*Occupation*	*Residence*	*Recreation*
Low	Can occupy self	Maintains own home	Own and shared activities
	Sheltered paid work	Supervised flat or lodging	Accompanied to public amenities
Moderate	Industrial therapy unit	Group home	Reserved hours e.g. at swimming pool
	Occupational therapy unit	Staffed hostel	Restaurant and social club
	High dependency day unit	High dependency hostel	Private grounds for exercise
		Sheltered Community	
High		Secure Unit	

N.B. An individual can be highly dependent in all three areas but living at home with relatives.

(movement up and down, respite on the landings, and the use of artificial aids to help people climb) and their structures, which should be subordinate to function. Towards the top of each of the stairways, individuals are able to make use of the options available and to help chart their own paths through the system. We are concerned in this paper with those with high dependency needs, who remain on the lower steps in spite of prolonged efforts to decrease the severity of their social disablement. Unless the rest of the service is in place, however, the chances of their moving towards greater independence, or of moving down according to need (rather than precipitously), will be substantially fewer.

The high-dependency group

The term 'dependency' is non-specific and provides no guidance about requirements for particular forms of service; it simply indicates a high all-round level of need for care which has hitherto usually been equated with a need for long-term residence in hospital. There are many causes of high dependency, and systematic surveys have always revealed complex causal patterns of multiple impairments, social disadvantages and adverse personal reactions. Because each individual's pattern is unique (and often changes over time), each needs an individually oriented programme of care.

The characteristics of patients (other than those with severe mental retardation or dementia) who have recently had hospital stays of over one year, in spite of current trends to avoid such long stays, can be used to describe the wider group of people with which we are concerned (Mann & Cree, 1976). Chief among the common factors is a record of contact that stretches back long before admission. Very few have put down roots in an outside community, have recently been employed, are married and in touch with their husbands or wives, or have a home that can accept them (although most have relatives somewhere). Most are middle-aged to elderly.

The most common diagnosis is schizophrenia, but up to half have other conditions such as short-cycle manic-depressive psychoses, chronic depression, or personality disorders. Many patients have multiple disabilities such as epilepsy, mental retardation, brain damage, sensory deficits, and neurological disorders. Physical diseases of all kinds are common, and have a high frequency in the elderly. In many cases, social disablement has remained severe and intractable in spite of the fact that the quality of assessment and care has been as good as possible. This is mainly due to five factors which complicate treatment and set limits to the degree of independence that can be achieved:

(a) risk of harm to self or others
(b) unpredictability of behaviour and liability to relapse
(c) poor motivation and capacity for self-management or performance of social roles
(d) lack of insight
(e) low public acceptability.

These factors interact with each other. Each may be assessed differently, in any particular case, by a stranger, a caring relative, a member of staff or an afflicted individual. Staff who act as gatekeepers to services have to try to assess all of these factors and allocate a degree of priority to each. The less experienced and skilled the observer, and the shorter the acquaintance with a chronically afflicted individual, the less visible many of the problems appear to be.

Those people with high dependency needs tend to present problems that are complicated by several of the five factors, acting either together or within short intervals of one another. Dangerousness is complicated by unpredictability and by lack of insight, or by a degree of insight that is sufficient to control behaviour in one setting (e.g. an out-patient clinic or at a domiciliary visit) where compulsory action could be taken, but not in another (e.g. at home with relatives) where no such power exists.

Self-harm not only includes immediate self-injury or suicide but may arise from poor self-management by reason of neglect of physical health (nutrition, personal hygiene, exercise, smoking, alcohol, exposure to cold or other dangers), and from lack of awareness of the value of medication or of attendance at a day centre. A complicating factor is public hostility due to socially embarrassing behaviour or to deterioration in the environment; for example, when a flat falls into disrepair, begins to smell and constitutes a fire hazard. A lack of motivation makes it impossible for some disabled people to imagine how problems can be overcome and leads to an apathetic acceptance of a drift into destitution (Lamb, 1980; Leach & Wing, 1980). A less obvious consequence is that the individual becomes easily exploitable.

These extremes of behaviour occur much less frequently in a well regulated and protected setting. Hence, characteristics of the environment are an important part of treatment. The question is one of how far caring environments can be prescribed for people whose lifestyle is gradually deteriorating through apathy, in a way that is unacceptable to their relatives and to the public in general. This lack of concern for one's own welfare is similar to that of long-term residents in old-fashioned mental hospitals, who were either indifferent to discharge or actively wished to stay, even when their intrinsic impairments were not severe. Such gradually acquired negative attitudes to discharge from hospital ('institutionalism') were hypothesized to be part of a process of development of adverse self-attitudes and decreased motivation that can occur in any setting characterised by 'social poverty', and is potentiated by the cognitive deficits of several psychiatric disorders (Wing, 1964; Wing & Brown, 1970). The process is still occurring in socially impoverished 'community' settings, now that most of those at risk no longer become long-stay hospital inmates. The most readily influenced of the environmental factors, both for good and harm, is the quality of social environment provided.

The size of the high-dependency group

There is still a sizeable group of people who need security, protection or shelter in two or more of the three major areas of life, whether or not that protection is currently being offered or taken up. Calculating the size of need by extrapolating from hospital bed occupancy is problematic, because some long-term in-patients could be discharged if lower dependency facilities existed elsewhere, and some of those 'in the community' would have a better prospect of a reasonable quality of life if they were in a sheltered community.

The statistics of rundown of the 'old' long-stay group and build-up of the 'new' are best summarised in Robertson's note of guidance to regional statisticians (1981). His higher estimate (which most closely fits the trends) suggests that, if there are no radical changes in service practice, an average health district will be using 140 in-patient beds per 100 000 inhabitants by the end of 1991, of whom 80 would have stayed for a year or more. For those without a diagnosis of dementia, the long-stay rate would be 53 per 100 000 (Robertson, 1981; Wing, 1986).

The survey by Mann & Cree (1976) suggested that 34% of long-stay (1–3 years) in-patients under 65 needed further hospital care, 25% needed 'hospital-hostels', and 32% needed other types of supervised residence. One hospital in each health region in England and Wales was visited, but in nearly all cases the alternative accommodation did not exist. Dependency becomes substantially higher the longer people stay and the older they get.

Two factors, acting in opposite directions, could upset any estimate of numbers. On the one hand, the discharge of long-stay patients might accelerate; on the other, a recognition that adequate non-hospital facilities were not being provided might lead to a greater use of long-term hospital care. Neither contingency is predictable with any confidence, but

such calculations are in any case irrelevant to the questions that interest us, which are concerned with meeting need wherever it occurs.

Surveys of day attenders, hostel and group home residents in Camberwell have not demonstrated any substantial unmet need for long-term high dependency care, but the local services are generally well above average and the results cannot be regarded as representative (Wykes *et al*, 1982). On the other hand, surveys of families known to organisations such as the National Schizophrenia Fellowship (Creer & Wing, 1974) and of single homeless people (Leach & Wing, 1980) have shown that an unmet need for a good quality of sheltered enviroment is not confined to hospital in-patients. Register data suggest that some Health Districts, particularly those with a declining population near the centre of conurbations, are likely to have high rates, while Districts in attractive areas with increasing populations will have low rates (Gibbons *et al*, 1984).

Sociodemographic indices such as age, social isolation, poverty and ethnicity have important implications, as have geographical factors and local traditions in the provision of services. There can be no such thing as a national or even a regional norm. Our best estimate of 50 places per 100 000 population for an 'average' District is not intended to be taken as more than a starting point for better-informed local calculations. In particular, we urge that the fact that some (usually privileged) Districts appear to have a low order of need should not uncritically be used to set a standard for the whole country.

Appropriate caring environments

Large–C and small–c communities

The term 'community is often used loosely, but two particular uses are common. The word is often used to create an image of a well-integrated village or neighbourhood whose residents know and care for each other, where few inhabitants feel isolated or remote from help should they need it. This would be a 'large—C' Community. 'Small—c' communities lack this cohesion. Examples are inner city areas, which are notoriously deficient in these respects. Even the residents of affluent suburbs may be preoccupied with material standards that demand a conventional normality. Moreover, rural villages may fall short of romantic expectation. A recent study of attitudes towards mentally retarded children showed that urban mothers were more likely to be favourable than village mothers (Sinson, 1985). Neighbours do not always help or even sympathise with the problems of families with a mentally disabled member. Formal systems of service delivery developed "because the informal networks of mutual aid in local communities were manifestly incapable of meeting the kinds of personal need which arise in complex industrial societies" (Pincus, 1982). Public attitudes, as the last White Paper on services for the mentally ill pointed out, need to become more favourable before it becomes feasible to give sufficient spending priority to them (DHSS, 1975).

We share the view commonly held throughout the caring professions that severely disabled and disturbed people should, as far as possible, be helped to use public amenities and facilities, to live in ordinary houses in ordinary streets, to undertake the same activities, and to receive the same personal support from friends, relatives and neighbours as those who are physically and mentally fit. However, implicit in some influential formulations of this position is the assumption that virtually everyone, no matter how severely afflicted, can achieve an acceptable integration while dispersed in 'the community'. 'The institution' (i.e. any structure that implies a degree of segregation) is thus seen as inherently harmful.

The term 'normalisation' is often used to express the underlying thrust of this argument. From this point of view, to begin with an analysis of the causes of social disablement, particularly if this includes the concept of physical or mental impairment, is regarded as counter-productive. The term has most frequently been used in discussions of services for the mentally handicapped, and is now appearing in plans for long–term residents of mental illness hospitals. The danger in both instances is that the underlying good intention may be thwarted by the fact that becoming 'as normal as possible' (a more modest but more realistic formulation) depends on particular kinds of help from people and agencies familiar with the varied causes of social disablement, and therefore with specific needs. Trying to apply a general standard of 'normality' without starting from the concept of impairment can lead, in spite of the best intentions, to a drop in the quality of life of disabled people.

A different use of the term 'Community', explicitly with a large C, is to denote a group of people coming together because of a shared interest, in order to pursue through personal relationships and the exercise of special skills some common purpose—moral, artistic, political, or therapeutic. The Steiner Communities, for example, represent the first and last of these purposes. Few people who have visited them would deny the sense of real Community, even for those residents who are so disabled as to be incapable of understanding the full meaning of the word, and for whom it must be partially artificial. This sense is created by the beauty and simplicity of the buildings and surroundings, the shared

motivation of the staff, the significance given to each activity of daily living, and the evident quality of life of the residents. Nevertheless, each Community is an institution. There is also an inherent element of segregation. Moreover, such charitable organisations do not accept what has hitherto been the final responsibility of the National Health Service—not to select. (It must be said that the NHS does not always accept this responsibility nowadays.) People who are disruptive or socially impaired are no more welcome than they are in most local authority hostels.

However, the success of the Steiner Communities demonstrates that a semi-detached house in an urban street is not the only alternative to a hospital ward, particularly fo those people who cannot (and do not) use community amenities and who are unable to create any sense of Community around themselves because their social skills (in spite of adequate efforts at training) are lacking.

Open versus custodial care

Erving Goffman (1961) introduced the concept of the 'total institution'. He argued that American state mental hospitals in the 1950s resembled other segregated communities in which inmates were isolated from the everyday life of the community such as prisons, orphanages, concentration camps, and even battleships at sea. The staff and inmates had fundamentally different points of view and perceived each other in terms of narrow, hostile stereotypes. Inmates slept, worked and played in one place, and an overall rational plan guided all behaviour. Even the smallest details, such as when an inmate should bath or go to bed, were decided by authority. Inmates were no longer looked upon as fathers, or employees, or customers, and their abilities to play social roles atrophied from misuse.

Although British mental hospitals, even then, did not much resemble this picture (for a comparison with an American county hospital see Wing & Brown, 1970), an image of hospitals as globally and inherently custodial has stuck and the term 'institution' is now, in this context, almost exclusively pejorative. Table II illustrates the two extremes of custodial and open systems of care. Attempts to measure the degree of restrictiveness indicate substantial variation and overlap within and between care settings. Custodial care cannot be equated with hospital wards, nor open care with non-hospital alternatives (Rawlings, 1985*a*,*b*; Ryan, 1979; Wykes *et al*, (1982). Moreover, the term 'restrictiveness', whatever the setting, carries a connotation of arbitrary authority that may be unjustified (Hewett, 1979). The proper question, in respect of particular individuals, is whether help is being given that will reduce the causes of social disablement to the minimum possible level and maintain them there. If so, needs for asylum functions will be met with the minimum segregation and dependence, always taking into account that some people need solitude more than others.

The haven concept

The idea of Haven Communities arose from two kinds of experience. One was with a hostel-ward ('hospital-hostel' or 'ward in a house') set up at the Maudsley hospital for people from Camberwell under the age of 65 who had been living in hospital wards for 1–7 years (Garety & Morris, 1984; Wing & Hailey, 1972; Wykes, 1982). The results suggested that virtually all such people could benefit from the greater personal attention and gradual introduction to responsibility that such an environment made possible. A subsequent, better controlled, evaluation of a hostel-ward in Manchester, and an uncontrolled study of one in Southampton, confirmed most of these findings (Gibbons, 1986; Goldberg *et al*, 1985). These two hostel-wards were off-campus, and hence had to be selective; some other unit would still be

TABLE II
Custodial and open care

Characteristic	*Custodial settings*	*Open settings*
Power and staff attitudes	Oligarchic, authoritarian and arbitrary	Democratic; team working to clear guidelines
Boundaries	Impermeable, whether visible or not	Human scale; flexible security
Stigma	Concentrated	Diluted
Outside influences	Easily evaded; occasional scandals	Open access; elected committee; inspectorate
Milieu	Social poverty; pauperism; inactivity; unnecessary dependence	Socially rich; local standards; choice for growth

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required for the most disturbed. The second experience was that of a mental hospital that (even in the late 1950s) provided a social environment that was markedly above average in quality, and where the greatest priority and prestige was accorded the long-stay wards (Freudenberg, 1970). From the statistics given earlier, it is clear that several such houses would be needed in many Health Districts.

Though there are a few exceptions, non-NHS alternatives currently tend to reject the most severely disabled and disturbed people, and therefore do not come into consideration. We rule out the use of District General Hospitals as sites for communal living; they are busy, crowded, and lacking in space and opportunities for occupation and recreation. The orientation of the wards (which are not, in any case, satisfactory living environments) is not conducive to gradual healing over years; and often there is not a tree or blade of grass to be seen.

This leaves three possibilities: use of part of a mental hospital site, if conveniently situated near the District it serves and managerially independent; conversion of some other equally convenient site within the District; and dispersal of the component elements throughout the District. The first two of these are in most respects similar.

The haven project

An opportunity to set up a first Haven Community has arisen in the NE Thames Health Region as part of plans to close the large Friern Hospital and to use part of the site to serve the borough and Health District of Haringey. The underlying principles described below could be adapted to other situations.

Candidates for the Haven will be adult Haringey residents of all ages (excluding those with severe mental retardation, dementia or primary addictions) who have spent more than one but less than fifteen years in hospital, are chronically mentally disabled or disturbed in behaviour, and are seriously impaired in ability to care for themselves. Initially, 50 places will be provided to serve West Haringey (population 110 000).

Range and style of housing

Based on a survey of Friern patients eligible for the Haven Community, we estimate that a core group of four houses will be needed for those needing most care and shelter. One house (or hostel) with twelve residents will serve as the heart and resource centre of the Community. It will provide for patients who need frequent short readmissions and younger persistently disturbed people. The three other core houses will each have six residents: one will cater for the long-term severely disabled with physical problems such as severe epilepsy or Huntington's Chorea, another will provide treatment and containment for those who tend, if unsupervised, to wander without regard to common danger, and the third will provide for frail elderly people with long-standing functional psychiatric disorders. The remaining 20 residents will live in a range of houses and flatlets with a lower degree of supervision. They will provide a gently graduated range of facilities, so that maximum independence can be developed and maintained in those whose disorders necessitate lengthy care, e.g. those with unpredictable behaviour, those detained on Home Office regulations and those with major dependency problems.

Staff offices, an occupational therapy store, a visitors' room, and recreation rooms with a beverage bar for the whole Community will be provided adjacent to the central house. Staff will use the same accommodation as residents. Each resident will have a personal bedsitting room, and each house will have the usual domestic offices and living arrangements. Residents will participate in running their own houses, including cooking, cleaning and repairs. Each house will be allocated a weekly or monthly budget, so that the responsibilities of domestic management can gradually be acquired.

The choice of site for this group of houses is important. It should be clearly separated from hospital buildings, and have its own identity and access from a public road. Fortunately, the Halliwick part of the Friern estate provides a most attractive area for this development, and recently built local housing is pleasant enough to serve as model so that the Haven can merge into the background of the community. All houses could readily be converted for other uses if, in due course, they became redundant.

In addition, linked to the Haven but scattered among the local housing estates would be peripheral group homes and supervised apartments, set up in association with the local authority or charitable organisations, in order to provide for graduates who still need various degrees of Haven support and also for people who are a rung or two up the ladder but highly vulnerable to relapse. This arrangement has proved successful in connection with the first hostel-ward at the Maudsley Hospital (Wykes, 1982).

Administration

The Community would be administered from the central hostel and offices, with a single manager who would be part of the multi-disciplinary team

(including nursing, medical, occupational therapists, psychology and social work staff) responsible for running the Haven. The central hostel would be staffed day and night by trained and experienced staff, who would also be available to help when problems arose elsewhere in the Community. The other three core houses would also need some cover at night. Day-to-day running would be left to the houses themselves. The lower dependency houses would function with the help of a housekeeper during daytime hours and call buttons for emergencies at night or weekends. Staff would be aware of situations where problems could arise, and organise their rounds accordingly.

Since the Haven Community will be serving a designated population it is essential that it has clearly established links with other parts of the district services. In particular, it must provide an integrated service with those units that form steps, on the three 'stairways' described earlier, that are within reach of Haven members. Rehabilitation for this group consists of numerous small advances separated by pauses for consolidation. Continuity of care is therefore vital. Ease of movement into and out of the Community is essential. Haven staff would all take part in off-site activities both in following up and supporting ex-members and in developing links with people who might need their help in future. Close contact would therefore be kept with families, relatives' organisations and other community groups, so that early intervention can be achieved when necessary. Co-ordination will also be required with acute hospital services, psychogeriatric facilities, and primary and secondary medical services. Staff will be selected because of their interest in and aptitude for creating a living Community in partnership with residents and families. Because of its innovative aspects, the Haven Community would be an ideal setting for staff training.

Occupation and day care

In part, Haven members will be occupied within the Community, and domestic experience is part of the function of the houses. Those who have reached retiring age may not wish to engage in many formal activities. However, the exercise of all one's faculties is a necessary condition of physical and mental health, and Community members will be given a choice of opportunities. The Health District will be served by industrial and occupational day units, both in and away from the Friern site, which will facilitate continuity and flexibility of occupation for those members who can make use of these opportunities. A market garden is also planned. At the other end of the spectrum, an intensive day–care facility will be required for those people who need a degree of security, usually during a prolonged day-care period from breakfast to supper time, including weekends. Disturbed behaviour is usually less evident in the later evening and at night. A small unit will be attached to the hostel to cater for this need, and to provide more organised domestic re-training to enable members to retain their daily living skills.

A further type of provision is also being considered. As part of the outreach links to the wider community, it is proposed to set up a charitable trust in association with local church and citizens groups to establish and administer a community centre that will serve a membership drawn from the local neighbourhood, Haven residents, relatives' organisations and staff. The centre would include meeting, recreation and dining rooms, a kitchen and bar, and sheltered workshops, such as printing and upholstery, that could provide some revenue and be of general use. In due course, an arts centre would be an appropriate addition.

Opportunities for recreation will also be needed by people who cannot make use of public amenities or who, because of their slow or odd or indecisive behaviour, may not be welcomed. There will be space where people can wander in private and where oddities of gesture or demeanour will not incur arrest or public ridicule. Ideally, some amenities would be created that were shared with the locality.

The Friern estate

The fate of the large Friern estate has yet to be decided, although approximately one third (known as present as the Halliwick site) is likely to be retained for Haringey District Health Authority and 'supra-District' functions. The rest will probably be sold and, in view of the Secretary of State's assurance (*The Times*, 17 February, 1986), the money thus raised will be earmarked for the further development of services for the mentally ill. The main hospital building is in poor repair, and it is difficult to see what purpose most of it could serve once better alternatives had been provided. The Regional Health Authority has given assurance that priority will be given to the development of services for the most severely and chronically disabled—including the Haven Community for which funds have already been allocated. We strongly support this point of view, and would like to see it adopted by other Health Regions.

The opportunities offered for improving the quality of life of mentally disabled people by the redevelopment of the Friern estate are tremendous, and it would be a tragedy if they were missed. The

overriding principle of planning should be to regard the site as a precious public amenity and to open its parkland to wider community use. Any commercial development should be limited to the provision of facilities that would attract the public onto the site. Possibilities include a centre for indoor and outdoor sports and leisure activities, a shopping complex, an arts centre, and a restaurant. Some industrial development might be considered if this included provision for sheltered work. The scale of any new building should not take up much more space than the present main hospital complex. The central administrative block, which has a certain Victorian charm and is listed Grade II, should be preserved and converted for other uses, including a museum and archive. However, there would be room for a small housing estate, which could incorporate some houses for staff and ex-patients. Local new housing is already of a good standard and appearance. Imagination and a coherent architectural plan is required to combine visual attractiveness with convenience of access and use.

The area set aside for health services would include substantial private areas, but there is no reason why the public should not use paths that crossed it. Similarly, members of the Haven Community and other users of the Halliwick site would be able to benefit from the facilities in 'Friern Barnet Park' as members of the public in their own right.

Hospitals such as Friern Barnet, which are in the middle of busy urban areas, have achieved over the years a status in the neighbourhood that is not entirely unfavourable to their residents. The sight of patients using local shops and pubs and strolling round local streets is familiar, generally accepted and, in certain respects, welcomed. Such stigma as is due to the inappropriate attribution of characteristics such as unpredictability and violence is likely to be diluted by bringing 'Community' and 'community' together in the way we suggest. The sympathies of those who are able to appreciate something of the problems caused by mental disablement could be engaged. On the other hand, geographical dispersal in small units is most unlikely to dilute the stigma that is aroused by truly socially embarrassing or unacceptable behaviour and could actually provide a series of nuclei around which stigma became concentrated.

A different kind of solution to the one proposed here has been suggested for the Claybury Hospital site, which is also in the NE Thames Region (*Architectural Review*, January 1986; Burrell, 1985). The proposal is to transform "the existing hospitals into urban quarters" that are fully integrated into the surrounding area. Ward blocks will be converted into shared flats and houses. We welcome this idea, and hope that there will be competition throughout the country to develop imaginative and practical solutions to the varied planning problems presented in different localities.

The context of district planning

The three principles of Health District planning described earlier can be applied to the case of any particular group of people in need. The first principle is identification of individuals living within a defined geographical area of responsibilty who are in need of various forms of care. This includes people who have only transient geographical links, or who drift from one place to another, never establishing 'residential rights' in any one location. Resources should be allocated to Health Districts and to local authorities on the basis of local requirement, including the needs of those who are homeless. We argue that responsibility for the most severely disabled and disturbed group (of which those we have discussed form a substantial part) should be given high priority rather than left as a residual group to be provided for only when all other services are in place. This means, as the Social Services Committee pointed out (1985), that the budget currently available to this group should be identified and should not be used for any other purpose unless there is clearly a surplus. This is most unlikely to be the case during the next decade or two.

The second principle—flexible, comprehensive and varied service provision—means that members of a Haven Community will have the opportunity to move towards independence by easy steps and stages as and when improvement occurs. By the same token, access down the 'stairways' to haven membership will also be simplified.

The third principle—sound management and organisation—ensures the maximum degree of autonomy for individual components (such as the Haven houses) of a District service, while maintaining an overall operating policy that ensures continuity of care and smooth working relationships between all units. Good administration will also ensure that staff numbers and staff training are appropriate to cope with the levels of difficulty likely to be encountered. Ideally, one executive body, with an identified budget, should eventually be made responsible for co-ordinating all care for the mentally disabled. For the moment, the District Health Authority should be regarded as the lead authority and given the duty of initiating and maintaining a co-ordinated service that will meet the needs of the population it serves.

Evaluation

The NE Thames Regional Health Authority has had the foresight to set up the Mental Health Services Evaluation Committee and to support a small research team for assessment of psychiatric services based at Friern, under the honorary directorship or Dr Julian Leff. The value of the Haven Community will be independently assessed in comparison with that of other, more dispersed, core and cluster schemes and in the context of more general evaluation of the rundown of Friern and Claybury hospitals and the build-up of various patterns of new community services, particularly in the boroughs of Islington and Haringey. It is greatly to be hoped that other Health Regions will follow this example.

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