Social Psychiatry in the United Kingdom: The Approach to Schizophrenia

by John K. Wing

Abstract

British contributions to theoretical and applied social psychiatry have been determined in large part by a traditional empiricism and by developments in social welfare legislation over the past 70 years. The establishment of a national health service covering the whole population and the attempt to provide comprehensive social services have created special opportunities for epidemiological research and for practical community psychiatry. These developments have by no means been uniform throughout the country, and there has been plenty of scope for individual initiative. Open-door policies, domiciliary visiting, social and occupational rehabilitation, therapeutic communities, and long-term continuity of care were first introduced in pioneering centers and subsequently adopted elsewhere. The idea that disorders such as schizophrenia not only have the character of acute illnesses but can also take the form of chronic disabilities has led to recognition of the fact that services must be tailored to the needs of individuals, and to an emphasis on the importance of the family and other social environments. There is a readiness to capitalize on successes and to learn from mistakes, assisted by a wide range of evaluative studies, which promises well for the future.

In view of the many and varied influences that British psychiatrists have received from their colleagues in the rest of Europe, notably in France, Germany, Holland, and Scandinavia, and in view of their close relationship to psychiatrists in the United States of America, the task I was given—to write a brief essay on the British contribution to social psychiatry, with special reference to schizophrenia—appears quite impossible. What that is specifically British can I describe? The best I can do is to suggest that we have incorporated these powerful influences into our own empirical tradition in philosophy and science (the tradition of Locke, Berkeley, Hume, and Russell; of Newton and Darwin) and into our empirical approach to social action (the tradition of James and John Stuart Mill, Jeremy Bentham, and Beatrice Webb). Empiricism is not, of course, an atheoretical philosophy, but it does entail a critical stance toward theories, which are seen solely as a source of ideas to be tested, in the hope (though not, it must be admitted, in the expectation) that they might turn out to be useful.

British psychiatrists have not always been successful in applying such exacting standards, as we shall see, and a substantial minority would deny that they were the right ones to apply, deriving their inspiration instead from what Karl Popper would call historicist doctrines, such as psychoanalysis or Marxism. But British psychiatry, in general, has been resolutely empirical, and that is true of social psychiatry as well. We tend to assume (until proved wrong) that people who hold theories do so because they want them to be true, not because they have weighed the evidence for and against. It can be an irritating stance, but it has preserved us from being carried away by the popular irrationalism of recent years.

"Social psychiatry" I take to include the same mix of ingredients as "social medicine" (not at all the same thing as "socialized medicine"). On

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the academic side, it includes epidemiology, the study of social factors influencing the onset and course of psychiatric disorders, the formulation and testing of social methods of treatment and prevention, the analysis of concepts such as "illness," "disability," and "deviance," the history of medical and social services, and their organization and evaluation. It also includes "community psychiatry": the application of these ideas in practice.

Epidemiology

Concepts of "Schizophrenia." The essence of the epidemiological approach is to count the number of "cases" in some unit of population during some specified period of time. J. N. Morris (1964) has set out the uses of this technique under seven headings: Study of historical trends, description of community health, operational analysis of health services, determination of individual risks, completion of the clinical picture, identification of syndromes, and discovery of causes. Before comparisons between rates can confidently be made, problems of calculation in the numerator (case finding) and in the denominator have to be overcome.

Morton Kramer (1961, 1969) pointed out that the age-adjusted first-admission rates in 1960 to U.S. mental hospitals for schizophrenia and affective psychoses were 24.7 and 11 per 100,000, respectively, compared with 17.4 and 38.5 in England and Wales. Even larger differences were evident in prevalence data from psychiatric case registers in Baltimore, Aberdeen, and London (Wing et al. 1967). Kramer's observation led directly to the United States-United Kingdom Diagnostic Project (Cooper et al. 1972), which demonstrated that much of the difference in rates could be explained by differing diagnostic concepts rather than real variations in incidence. The concept of schizophrenia used by many New York psychiatrists was wider, and their concept of affective psychosis (and neurosis) narrower, than that of London psychiatrists. The International Pilot Study of Schizophrenia sponsored by the World Health Organization (WHO 1973, 1975) confirmed this result. A relatively limited concept of schizophrenia was used by centers in Aarhus, Agra, Cali, Ibadan, London, Prague, and Taipei and a relatively broad one by centers in Moscow and Washington.

These two international studies used a standard form of psychiatric interview. The U.S.-U.K. project used a combined interview incorporating the Psychiatric Status Schedule (Spitzer, Endicott, and Fleiss 1967) and the Present State Examination (PSE; Wing et al. 1967). The differences between the two schedules and, even more, between the computer programs designed to classify the rated symptoms (DIAGNO: Spitzer and Endicott 1968; CATEGO: Wing, Cooper, and Sartorius 1974; Wing and Sturt 1978) illustrate the different approaches very precisely. Perhaps the reason is that Eugen Bleuler's expansion of Kraepelin's concept has not been so influential in Britain as in the United States. Diagnoses such as pseudoneurotic, pseudopsychopathic, simple, borderline, and latent schizophrenia are much less frequently used, and conditions such as early childhood autism (Rutter 1970; L. Wing 1976) and Asperger's syndrome are differentiated from schizophrenia instead of being incorporated into it. British psychiatrists have given much more attention to the differential definition of different kinds of delusions and hallucinations, whereas their American colleagues have tended to regard them all as aspects of a unitary condition (see glossary in Wing, Cooper, and Sartorius 1974).

This respect for the clinical details of differential diagnosis, which Britain shares with many other European countries, is very much in the medical tradition. Theories of causation, treatment, or prevention cannot be tested unless syndromes are precisely and reliably delineated (Wing 1978*a*). This attitude is just as strongly held within social medicine and social psychiatry, where the interaction between social and clinical events is seen as the main focus of interest, both theoretical and applied.

Another model commonly used is that of disability. Acute episodes of schizophrenia are often preceded, accompanied, or followed by longer term impairments, of which two are particularly prominent. One is the "clinical poverty syndrome" of slowness, underactivity, reduced emotional responses, and impaired ability to use verbal and nonverbal means of communication (wooden expression, monotonous voice, lack of gesture, and poverty of content of speech). The other is a difficulty in thinking straight and to a purpose, manifested in oddities of speech and behavior. In combination, these impairments constitute a serious impediment to social performance, not only because patients lack the skills needed for ordinary human relationships and therefore tend to avoid companionship, but because they are not able to keep up average work speeds, particularly at complicated tasks.

Part of the unreliability of international diagnostic comparisons reflects the fact that these longer term impairments, which are difficult to recognize when present in mild degree and therefore depend a good deal on the subjective judgment of the clini-

cian, have sometimes been regarded as sufficient evidence for a diagnosis of schizophrenia, even when no acute episodes have occurred. The result is that studies of cause, course, and response to treatment are often not comparable with each other. Further studies using the PSE-CATEGO system have suggested that substantial comparability is, in fact, possible (Scharfetter, Moerbt, and Wing 1976; Wing et al. 1977; Wing and Nixon 1975; Wing and Sturt 1978).

Social Causes of Schizophrenia. British research workers have put several hypotheses concerning the causation of schizophrenia to searching test. This is particularly true of theories suggesting that the condition was generated by living in conditions of poverty and isolation; being single, living in the center of cities, having only unskilled work, etc.—the so-called "breeder" hypothesis. Hare (1956*a*, 1956*b*) and Stein (1957) showed that poverty and isolation did not go together in the center of English cities like Bristol and London, as they did in Chicago (Faris and Dunham 1939). Thus it was possible to demonstrate that only isolation was associated with a higher incidence rate and that this was actively sought by the individual instead of being a cause of the breakdown. Goldberg and Morrison (1963) showed that the "drift" hypothesis also accounted for the occupational distribution. This work (see also Norris 1956) was very much in the Scandinavian tradition (Odegård, 1932, 1946, 1956) and was confirmed by Dunham (1965) in Detroit.

A more intensive study was designed specifically to test a hypothesis put forward by Wynne (1968, 1971) and his colleagues suggesting that communication deviances are more common in the parents of patients with schizophrenia than in the parents of patients with other psychiatric disorders or with none. Hirsch and Leff (1975), in a carefully controlled design that included standardized interviews and diagnoses, made blind ratings of speech samples using the same technique as the American authors. They failed to find the same clear-cut differences. Part of the reason may be diagnostic differences between the studies.

Studies of more immediate social precipitants have been more fruitful. It has been observed that intensive forms of social treatment can lead to relapse in an acute schizophrenic episode (Goldberg et al. 1977; Stevens 1973; Stone and Eldred 1959; Wing, Bennett, and Denham 1964). A series of studies in London suggested that pressure from relatives could have a similar effect (Brown et al. 1962; Brown, Birley, and Wing 1972; Vaughn and Leff 1976). In these studies, schizophrenic and depressed patients were examined shortly after their hospital admissions. A standard technique was used to describe and classify their symptoms and to ensure that the processes of clinical selection were unambiguous. A key relative was interviewed while the patient was still hospitalized, and ratings were made of hostility, emotional overinvolvement, and criticism. Of these three factors, the last proved most important and could be measured very reliably by counting the number of critical comments made about the patient during the interview. All three factors were combined into one index of "expressed emotion." This index was associated with previous work history and with the amount of disturbance in behavior during the 3 months before admission. It was also highly significantly, but quite independently, related to relapse rate during the 9 months after discharge.

Two other factors were important in predicting relapse. One was the amount of time that patient and key relative spent in face-to-face contact with each other (itself affected by whether the patient was working or attending a day center); the other was whether the patient was taking phenothiazines.

Thus a hierarchy of risk of relapse could be set up. Those at most risk (over 90 percent) were living at home in constant face-to-face contact with highly involved relatives and not protected by taking phenothiazines. If they were taking medication or if they had little contact with the involved relatives (another protective feature), the risk was much lower (40 to 50 percent). If both protective features were present, the risk of relapse (15 percent) was the same as if they had returned to a low-emotion family. Approximately half the families came into the high-emotion and half into the low-emotion category. The association of high-emotional expressiveness in the relative with previously disturbed behavior and poor work history in the patients suggests that, at least in part, there was a "vicious circle" effect of patient and relative on each other. Further light is thrown on this by Vaughn's analysis of the content of the criticisms made about patients by relatives (Vaughn and Leff 1977). Less than a third of these were concerned with symptoms of the florid attack; the criticisms were also not usually associated with a poor previous relationship between patient and relative. Over two-thirds of the criticisms were directed at longstanding personality traits that had been present before the first onset of florid symptoms. These traits were mainly lack of sociability, communication, and affection. So far as could be judged, such earlier indications of negative

impairments were not found only in patients whose relatives were critical about them, but the measurement of previous personality is notoriously difficult, and the relatives were the main source of information. The question of cause and effect must therefore remain open.

A different kind of social precipitant was described by Brown and Birley (1970), who found that there was a marked increase in the frequency of occurrence of certain events, compared with control groups, during the few weeks immediately before the first onset or an acute relapse with florid schizophrenic symptoms. Excluding events that could have been the result rather than the cause of a recrudescence of symptoms did not diminish the extent of the association. Some of the events would be expected to have been experienced as pleasurable, others as unpleasant: becoming engaged to be married or receiving a promotion at work, for example, compared with hearing about the death of a relative or being involved in a traffic accident. Nearly all the events were familiar ones, in the sense that most people would expect to be affected by them during the course of their lives. People who had previously had attacks of schizophrenia seemed more vulnerable to common stresses than most people. The relapse was usually characterized by the same sort of florid schizophrenic symptoms that had been manifested in earlier attacks.

It is difficult to see a single common factor underlying all these situations associated with relapse, except the very vague one of "stress." One possibility is social intrusiveness; i.e., an environmental agent (whether an eager therapist, an accidental contact, or an overinvolved relative) that does not allow a sufficient degree of protective withdrawal, so that an individual with inadequate equipment for communication is forced into interaction in a social situation, and an underlying cognitive disorder becomes evident.

Social Factors Maintaining Chronic Disabilities. The fact that closed institutional regimes, with their common accompaniments of authoritarianism, pauperism, and neglect, were not only inhumane but harmful was pointed out by Belknap (1956), Cumming and Cumming (1962), Dunham and Weinberg (1960), and Goffman (1961). Goffman (1959) and Scheff (1964) incorporated their observations into a theory that discounted any element of past psychological abnormality but suggested that purely social mechanisms could create the symptoms they were supposed to be controlling—the psychiatrist acting simply as a legitimating agent. The activities of Rosenhan (1973) and his colleagues, who got themselves diagnosed as schizophrenic and admitted to American hospitals by pretending to hear a voice saying "empty," "hollow," and "thud" without any further fabrication of symptoms, seemed to confirm Scheff's labeling theory.

Two English surveys of long-stay schizophrenic patients are relevant to this formulation (Wing 1962; Wing and Brown 1970), since they showed that the clinical poverty syndrome was made worse by socially understimulating conditions. Symptoms like flatness of affect, long thought to be characteristic of schizophrenia, could be increased or decreased by environmental means (see, also, Wing and Freudenberg 1961). In addition, the longer the patients had been hospitalized, the more likely they were to want to stay there, and this was true irrespective of the quality of the social milieu. A patient might therefore continue to be hospitalized even though not very severely disabled, simply because he or she had lost any desire to leave. This secondary type of handicap was named "institutionalism." It occurred to an even greater extent in an American state hospital that was studied at the same time and compared to the English hospitals (Wing and Brown 1970, chapter 9).

Fortunately, it was discovered that the increase in social withdrawal, slowness, etc., due to living in a poor hospital could often be reversed by improving the opportunities for activity, and that the attitude change of institutionalism could also be reversed in many cases by providing work and residential environments in which patients could acclimatize themselves to conditions outside the hospital (Wing 1960; Wing, Bennett, and Denham 1964). However, the very success of these methods meant that the people who did not respond were severely handicapped. The law of diminishing returns began to operate (Catterson, Bennett, and Freudenberg 1963). Even many of those who were discharged had to have environments with various degrees of protection provided for them. Moreover, too much pressure, as we have seen, was likely to lead to acute relapse.

These results are not compatible with that form of radical labeling theory which states that all schizophrenia is created by a social process in which minor behavioral nonconformities are regarded as evidence for the disease and a justification for prolonged incarceration in a total institution. A condition called "schizophrenia" could certainly be created in this way (see, for example, Wing and Brown 1970, chapter 10), but such a process would not explain the vast majority of even "old long-stay"

schizophrenic patients in British hospitals in the 1950s and 1960s. Still less could it be shown to hold in the conditions of the 1970s. A more moderate version of the theory, however, which states that certain kinds of mental disorder (particularly, disorders affecting communication skills, such as schizophrenia, dementia, mental retardation, and autism) render the individual highly vulnerable to an understimulating environment, can be shown to have a good deal of support, and it gives rise to useful ideas about social treatment. This moderate version of the formulation can be generalized to the theory of secondary deviation which Lemert (1951) applied to conditions such as blindness (Wing 1978*a*, chapter 5).

Conditions Other Than Schizophrenia. A brief essay does not allow me to give other examples of this epidemiological approach, in which the interaction between clinical and social events is studied in order to test hypotheses about social causation and to generate further hypotheses about methods of social treatment and prevention. Studies of dementia, manic-depressive disorder, autism, mental retardation, and minor neurosis could be used by way of example. The application of ideas in practice will be illustrated in the second part of the article, still using schizophrenia as the main focus of interest.

Applied Social Psychiatry

The Development of Community Care. The Mental Treatment Act of 1930, which broke the stranglehold of the lunacy laws and allowed the majority of patients to be admitted voluntarily rather than under commitment, also heralded a new emphasis on short-term treatment followed by ambulatory care. A wind of change was blowing at that time. Dr. G. M. Bell unlocked the doors of Melrose Hospital in Scotland before the Second World War, consciously harking back to the era of "moral treatment" and "no restraint" of a century earlier. Although the war delayed matters in some respects, it accelerated the acceptance of the idea of the welfare state. Progressive legislation was passed on insurance, education, social welfare for the disabled and disadvantaged, and above all, a national health service (NHS).

The main value judgment underlying the NHS was that everyone who needed medical care or treatment should be able to receive it, irrespective of the ability to pay. The mental hospitals, which formerly had developed separately, were incorporated, with hospitals for the acutely ill and chronic sick, into one system. This enabled hospitals situated several miles from their catchment areas to set up outpatient clinics in the local general hospitals, staffed by the same psychiatrists who looked after inpatients, thus ensuring continuity of care and a close liaison with the primary health system. The three administrative principles underlying the NHS were community responsibility (everyone living in a given district equally entitled to use the local services), comprehensive care from a variety of facilities, and continuity of personal care resulting from an integration of services.

There was a small private sector, but office psychiatry and psychoanalysis were not prominent influences. British psychiatrists prided themselves on an eclectic education, firmly grounded in the principles of diagnosis and treatment of the European schools but, as we have seen, with a strong and characteristic emphasis on the social aspects of their discipline—social causes, social effects, social treatments.

Two main currents of reform flowed strongly. One was the therapeutic community movement (Clark 1964; Jones 1952; Main 1946). It was assumed that groups of people with common problems could help each other, that an authoritarian approach was out of place when treatments could not be specified precisely, and that psychodynamic interpretation of events occurring in the group would provide useful insight. The movement provided fresh impetus and encouragement to psychiatry at a time when many older ideas about treatment were coming to be regarded as of little value, and the first two assumptions have proved of lasting value.

An even stronger progressive element was the introduction of methods of social and vocational rehabilitation and resettlement, and the development of the view that many long-stay patients were handicapped rather than ill. Paid work was provided instead of diversionary arts and crafts or maintenance work on the institution. Locked doors were opened, and transitional environments of various kinds were provided in order to bridge the way back to full community life. At the same time, there was an emphasis on early discharge to avoid the effects of institutionalism (Bennett 1975; Early 1960, 1965; Freudenberg 1967; Rees 1957).

These developments led to a rapid reduction in the numbers of patients at hospitals like Mapperley in Nottingham (Macmillan 1970), where pioneering psychiatrists had long anticipated the new trends, well before the phenothiazine drugs were introduced. From 1954 on, the national total of beds in mental hospitals began to drop. At its peak, it was

344 per 100,000 in England and Wales; at the end of 1974, it was 188 per 100,000. (The numbers in Scotland and Ireland have always been higher and the decline less rapid.) The use of the new phenothiazine drugs added to the effect of the social treatments and made it easier to introduce them universally.

Although similar trends occurred elsewhere and British psychiatrists learned a great deal from other European countries about the use of residential and occupational environments for rehabilitation and shelter (Carstairs, Clark, and O'Connor 1955; Wing 1957), much of the worldwide impetus toward community care was derived from the pioneering work carried out in our mental hospitals during the 1950s. Since over half the patients in these hospitals were long-stay schizophrenics, the impact was greatest on schizophrenia, but the new ideas were applied in many other fields as well. Another reason the British experience is worth considering is the opportunity offered by the NHS for national planning.

Government Plans. The decline in numbers of patients in mental hospitals received considerable attention in England (Tooth and Brooke 1961) as elsewhere (Brill and Patton 1962). The government accepted the obvious explanation for these statistical trends—that early and effective treatment, together with the rehabilitation of longer stay patients, had transformed the prognosis in hitherto chronic conditions such as schizophrenia. The 1962 Hospital Plan looked forward to a time in the relatively near future when the numbers would be reduced by one-half, to 180 per 100,000 population. Subsequent experience convinced the planners that 50 beds per 100,000 or even fewer would be sufficient. This was a small enough number to be accommodated in psychiatric units attached to general hospitals, and it was thought that the large mental hospitals could be phased out altogether. It was recognized that some groups, notably patients with dementia, would continue to require accommodation for up to 5 years, but this could be provided together with other provision for patients with geriatric problems. Any other long-term needs could be met by opening hostels, homes, and day centers in the community. This would be the responsibility of the Social Service Departments of local government authorities (counties and boroughs).

Before assessing the effectiveness of this plan, it will be useful to consider some of the evaluative research that has been carried out during the past 25 years.

Evaluative Research. Early comparative research suggested that community care systems were at least as effective as the traditional mental hospital in treating acute psychiatric disorders and alleviating the social problems that frequently accompany them (Grad and Sainsbury 1966; Hoenig and Hamilton 1969; Sainsbury and Grad 1966). These studies did not, however, consider the difficulties caused by more chronic conditions, since they dealt chiefly with referrals early in the course of psychiatric disorder. There has always been a recovery rate in acute schizophrenia. Mayer-Gross (1932) found that one-third of the schizophrenic patients in his 16-year followup study were functioning reasonably well outside the hospital, although they had none of the benefits of modern treatment and had survived at a time when the risk of mortality was high. Harris et al. (1956) found that 45 percent of their series of schizophrenic patients treated with deep insulin comas were socially well 5 years later. Brown et al. (1966) estimated that 55 percent of schizophrenic patients first admitted to three mental hospitals in 1956 and treated with phenothiazines recovered socially after 5 years. Patients readmitted in 1956 did not fare nearly so well. Even in the area with the best community social work services, the most severely disturbed or disabled patients were not necessarily in contact with any professional helper. Much of the burden of care fell upon relatives.

Further research therefore concentrated specifically on the problems of severely disabled patients, two-thirds of whom, in most studies of people of employable age, turned out to be schizophrenic. In one epidemiological and experimental investigation, a series of 75 patients aged 18–54 (44 per 100,000 total population) with a diagnosis of functional psychosis, who had been unemployed for a year but not hospitalized during that time, was drawn from a local case register (L. Wing et al. 1972). Among these patients were 28 who were both suitable and willing to attend a rehabilitation workshop that had just been set up. Half of these, chosen at random, did in fact attend for a preparatory period at a day hospital, and six of them moved on to the workshop. The total series was followed up after a period of 2 years. There were six deaths, five of them by suicide. Very little change in level of disability or in social performance could be detected over the followup period, and the outcome was not noticeably more favorable in the experimental group. Indeed, there were some unfavorable reactions to the increased level of expectation (Stevens 1973). What many seemed to need,

instead of rehabilitation, was day or residential care that recognized the fact of lasting disability.

Two of the 75 patients, at the time of followup, were destitute or nearly so. Several studies of destitute men have been carried out (Edwards et al. 1968; Leach and Wing 1980; Lodge-Patch 1970; Priest 1970; Tidmarsh and Wood 1972; Whiteley 1955; Wood 1976). All found a substantial proportion who had been in and out of mental hospitals. In the case of men with alcoholism or personality disorders, hospitalization was just an incident in their careers, but men with schizophrenia had often lived stable lives until the onset of the disorder (Tidmarsh and Wood 1972). Mentally disabled men could be helped to remain off the streets by providing long-term hostel accommodation (Leach and Wing 1980).

Other studies concentrated on the "new" long-stay population accumulating in mental hospitals (Mann and Cree 1976; Mann and Sproule 1972). This is a relatively small group, but it is not one that can easily be accommodated in the psychiatric departments of general hospitals. What is needed, as well as care and supervision, is a domestic scale of living and plenty of opportunities for sheltered work and recreation. At the moment, local authorities and voluntary bodies are reluctant to provide small staffed hostels for the most severely handicapped patients, and these patients continue to accumulate in hospitals. Hostels and group homes for moderately disabled patients, on the other hand, have been found to provide a satisfactory environment, without the disadvantages that used to be found in the large institutions (Hewett, Ryan, and Wing 1975; Wing and Olsen 1979). The main problem now is that there is insufficient accommodation of this kind. However, the work on institutionalism discussed earlier suggests that the principles of prevention are much the same for all types of environment, and constant vigilance is required to ensure that community homes do not develop into small back wards.

Living With Schizophrenia. Most people with schizophrenia continue to live at home, and the main brunt of the social problems associated with acute psychotic episodes or with chronic disability is borne by relatives. Very little study has yet been made of methods of realistic counseling aimed at helping patients and relatives to recognize the social and psychological factors that can alleviate or exacerbate disability or disturbance. Some patients achieve considerable understanding and even insight into their problems and learn how to manage them in much the same way that people with severe and chronic physical illnesses do (Wing 1977). About half of the relatives in the studies of "expressed emotion" were found to be providing a warm and supporting family atmosphere, although there had often been a long period of distress and instability before trial and error suggested the best way to react (Creer and Wing 1974; Wing 1978*b*). It should be possible to capitalize on this knowledge in order to minimize the difficulties that inevitably occur when living with schizophrenia. Experiments along these lines are now being conducted in London.

Prospects for the Future. The latest government statement on the mental health services (Department of Health and Social Security 1975) recognizes that the high hopes of the 1960s have not materialized in practice. Looking back on the optimism shown by planners at that time, one sees an uncharacteristic departure from our usual empiricism. The results of evaluative studies were not taken into account. No mental hospital has yet been closed. Because of financial constraints, few new psychiatric departments in district general hospitals have been opened. Chronically handicapped people continue to accumulate, in spite of early and adequate treatment. Meanwhile, mental hospitals have continued to run down. Staff are more reluctant to accept severely disturbed patients who cannot benefit from a "therapeutic environment," thus generating a requirement for separate "secure units," and the concept of asylum has become confused with that of the total institution. Local authorities and voluntary bodies have been unable to provide all the alternative day and residential accommodation needed. Pressure groups of relatives have come into being in order to try to counteract a falsely optimistic view that running down the hospitals was, in itself, a positive act instead of (as it should have been) an accompaniment to the setting up of other types of service (National Schizophrenia Fellowship 1974).

I think it fair to say that these lessons have been learned and that a new phase of planning has begun that will be both more restrained and more realistic. Evaluative studies are being commissioned to try out new ideas about counseling, sheltered environments, cooperation between medical and social welfare authorities, the use of voluntary work, the employment of disabled people, the use of community nurses, and the strengthening of primary care services. Very similar developments are taking place in other countries in Europe, and in North America. We can also learn from the efforts being

made in developing countries to create humane services for the acutely ill and chronically disabled without the expenditure of enormous capital sums.

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