MEDICAL PRACTICE

*Contemporary Themes***“New chronic” patients**

THOMAS H BEWLEY, MARTIN BLAND, DEREK MECHEN, ELIZABETH WALCH

Abstract

A five-year follow-up of 1467 mental hospital patients showed that 501 had died, 449 had been discharged, and 517 were still resident. During this period 81 “new chronic” patients aged under 65 were admitted: 49 were readmissions and 15 of 32 first admissions had had previous periods in other psychiatric hospitals. Many new chronic patients were old chronic with intervals of community care, and one-third of them were likely to require permanent care. These findings provide no comfort for those who believe that present DHSS plans for mental health services can ever be realised.

Introduction

In all branches of medicine treatment, care, and the sensible planning of services depend on knowledge of outcomes of various methods of treatment. Mental illness is no exception, particularly as many conditions are chronic relapsing disorders. It is essential to consider carefully what happens to those who respond unfavourably. If patients with chronic illnesses are not

likely to be discharged from hospital the length of time they are going to survive is of crucial importance (particularly for any long-term planning of the service). Over a five-year period we have studied a cohort of patients in a London mental hospital. Those who had died were analysed separately from those who were discharged from the inpatient population, and the likelihood of each occurring was predicted. This follow-up study aimed to predict the decline of the inpatient population. We reviewed the accumulation of the new population and, in particular, some of the “new chronic” patients (those who were admitted and remained in hospital for one year or longer).

Method

In May 1973 a census of all patients in Tooting Bec Hospital, a large South London mental hospital, was carried out. This cohort was reviewed at 10 and 20 months to estimate the number of patients likely to require permanent care for the next 20-40 years.¹ To assess the accuracy of the original prediction of future discharge, and to see whether the predicted numbers of those expected to survive in hospital were still there, a third review was made after five years. The aim was to estimate how many patients would require continuing inpatient care and for how long.

During this five-year period all patients aged under 65 who had been admitted and remained in hospital for one year or longer were also studied. This group was defined as new chronic patients.² The methods used to categorise this group and estimate the likelihood of discharge were the same as for the original census. It was hoped that this might give some information about the incidence of new patients likely to require very long-term care.

Follow-up was carried out using hospital admission registry card data, and patients were classified in three groups:

- (1) those who had died in hospital;
- (2) those who had been discharged and were still out of hospital; and
- (3) those who had remained continuously in hospital or had been discharged but had been readmitted.

The group of new chronic patients consisted of all those under 65 who had been admitted since May 1973 and who in May 1978 had been inpatients for one year or longer—that is, all new chronic

Tooting Bec Hospital, London SW17 8BL

THOMAS H BEWLEY, MD, FRCPsych, consultant psychiatrist (also at St Thomas's Hospital)

ELIZABETH WALCH, BSc, CertAss, principal social worker (present position: social worker, Cluain Mhuire Family Psychiatric Service, Blackrock, Co Dublin, Eire).

Department of Clinical Epidemiology and Social Medicine, St George's Hospital Medical School, London SW17 0QT

MARTIN BLAND, MSc, PhD, lecturer

South Western Hospital, London SW9 9NU

DEREK MECHEN, unit administrator

patients under 65 admitted in a four-year period. Information was collected on age, sex, date of entry, diagnosis, the possibility of discharge (estimated by social workers), and the need for further support, rehabilitation, and demands on nursing services. The same questionnaire was used as in the earlier study.¹

Results

The original predictions in 1973 were found to be reasonably accurate and of value in assessing the future provision for the patients. At the five-year follow-up 82% of those considered "likely to be discharged" had been discharged, 43% who were considered as "possible discharges" had also been discharged, and 89% of those thought "unlikely to be discharged" remained as inpatients or had died. (This group included those who had been discharged but had been readmitted.)

The previous report¹ predicted the number of patients who would survive as hospital inpatients and for how long. All patients with organic brain syndrome were classified as one group while the other group included all other diagnoses. This distinction was made because mortality was known to be very high in patients with organic brain syndrome. The death rate of those with organic brain syndrome had been estimated from follow-up surveys at 10 months and 20 months. Based on these mortality data two projections were made (fig 1). It

Projected survival curves for patients who were rated unlikely to be discharged. A = Maximum survival and B = known survival.

was found after five years that 23% were still inpatients, 10% had been discharged, and 67% had died. A prediction that none of those with the diagnosis "organic brain syndrome" were likely to be discharged would have been more than 90% accurate. The maximum possible number of survivors (those still in the hospital plus those discharged) was 33% (table I). The outcome appears to be consistent with the projection based on the known survival rates at 20 months.

Survival for those patients without organic brain syndrome was estimated and projected using the *English Life Table No 12 (1960-2)*.³ As psychiatric inpatients may not have the same death rates as the general population, an artificial life table was constructed by doubling the age-specific death rates of life table 12, which appeared to give a reasonably good fit to the follow-ups at 10 and 20 months (fig 1). After five years 40% were still inpatients, 39% had been discharged, and 21% were known to have died (table I).

TABLE I—Outcome for all patients at five years. (Row percentages in parentheses)

	Inpatients including readmission	Discharged	Died	Total
Organic brain syndrome	94 (23)	38 (10)	272 (67)	404 (100)
Predicted discharge:				
Likely	25 (11)	200 (84)	12 (5)	237 (100)
Possible	130 (42)	140 (45)	39 (13)	309 (100)
Unlikely	268 (52)	71 (14)	178 (34)	517 (100)
Total	423 (40)	411 (39)	229 (21)	1063 (100)
Other diagnosis				
Total	517 (35)	449 (31)	501 (34)	1467 (100)

YOUNG NEW CHRONIC PATIENTS

In the five-year period 81 patients aged under 65 came into the new chronic category. Forty-nine of these, however, had had an earlier admission to Tooting Bec Hospital during the previous 24 years (table II). Of the 49 so called new chronic patients, nine had

TABLE II—New chronic patients: admissions

No of years since first admission to Tooting Bec	First admission to Tooting Bec	Readmission to Tooting Bec	Total
1	7	2	9
2	11	4	15
3	6	—	6
4	4	4	8
5	4	3	7
6-10	—	20	20
11-15	—	9	9
>16	—	7	7
Total	32 (15)*†	49 (11)*	81 (26)*

*Figures in parentheses indicate the number of patients with a history of previous periods in hospital in other psychiatric hospitals or units.

†These 15 patients were transferred directly to Tooting Bec Hospital: eight from South Western Hospital, four from the special hospitals (3 Broadmoor, 1 Rampton), and three from other hospitals.

TABLE III—New chronic patients: major diagnoses

	First admission to any psychiatric unit	First admission Tooting Bec	Second and subsequent admissions Tooting Bec	Total
Schizophrenia	5	6	26	37
Affective disorder	3	1	11	15
Subnormality	1	—	3	4
Personality disorder	1	2	—	3
Alcoholism	—	—	3	3
Organic brain syndrome	7	6	6	19
Total	17	15	49	81

TABLE IV—New chronic patients: serious associated physical illness

Epilepsy	5
Hemiplegia	4
Diabetes	2
Total deafness	2
Pressure sores	1
Gross obesity	1
Birth trauma with epilepsy and hemiparesis	1
Malunited fractured hip	1
Gastric ulcer	1
Asthma (after tuberculosis)	1
Multiple sclerosis	1
Pneumonia	1
Total	21

had one previous admission, seven had had two, six had had three, six had had four, eight had had five, and 13 had had six or more. The remaining 32 were admitted to Tooting Bec Hospital as a first admission, though 15 of these had been transferred directly from other psychiatric units. Only 17 of the 81 patients in the new chronic group were first admissions to any psychiatric unit. Sixty-four had been in either Tooting Bec or another psychiatric hospital. Two patients who were previously in Tooting Bec Hospital for over 20 years had been discharged to a boarding house on the South Coast to spend their declining years there, but they did not settle, their condition deteriorated, and they were readmitted (as "new" having left as "old" chronic patients). There were also patients who had been discharged for treatment of tuberculosis but returned after successful treatment. Four patients who had been transferred to the special hospitals had returned.

Tables III and IV show the main diagnoses and associated physical illnesses of these new chronic patients. All these patients were assessed by social workers using the same instrument as for the first census. We concluded that 11 of this group were likely to be discharged, 32 might possibly be discharged, and 38 were not thought likely to be

discharged (table V). The follow-up of the original cohort would suggest that 54 of the new group might be discharged, and that 27 might remain as inpatients indefinitely.

TABLE V—*New chronic patients: social worker's assessment*

	First admissions (n = 32)	Second and subsequent admissions (n = 49)	Total (n = 81)
Discharge:			
Likely	5	6	11
Possible	7	25	32
Unlikely	20	18	38
Employable	5	8	13
Possibly employable	3	11	14
Not employable	24	30	54
Open employment	5	7	12
Sheltered employment outside hospital	—	5	5
Industrial therapy	1	7	8
Occupational therapy	6	6	12
Hospital employment	2	7	9
Not possible to rehabilitate	18	17	35
Nursing dependence:			
Independent	21	45	66
Partly dependent	9	2	11
Totally dependent	2	2	4
Ambulant	30	47	77
Chairridden	2	1	3
Bedridden	—	1	1

Discussion

Wing⁴ has estimated that the accumulation of "new long-stay" patients in psychiatric hospitals amounts to at least 50 per 100 000 population and that there were 120 per 100 000 population of "old long-stay" patients. Both these groups will require a long-term protected environment elsewhere if mental illnesses are to be treated in district general hospital acute units with 0.5 beds per 1000 in the future. It has been suggested¹ that in some districts it was not likely that services could be provided within DHSS guide-lines as there was no realistic possibility of alternative provisions.^{5 6}

There are limits to extrapolation from a census of this type, but our initial review of the life expectancy of those patients not likely to be discharged suggested that almost half would be alive and in need of hospital or other care after 10 years. The five-year survival figures (35% inpatients, 31% discharged, 34% dead) suggest that this may be an overestimate. As we did not follow up all patients—for example, those who were discharged and were not readmitted—it was not possible to test this projection properly. It seems reasonable to assume, however, that a fairly large proportion are still alive, and the overestimate may not be very great. If half of them were still alive then we could roughly estimate (from the figure) that about 200 (40%) would be alive 10 years after the initial census.

The review of younger patients admitted to the hospital in the five-year period suggests that the crude classification of long-stay patients as "new" or "old" chronic patients may not be very useful. Many patients classified as new chronic were in fact old chronic patients (spending some of their time outside a hospital or institution or moving from one hospital to another). A first-ever admission to a psychiatric unit, or a sum total of two years of inpatient treatment, might be better pointers towards incidence and impending chronicity.

Goldstone⁷ has pointed out that if the rate at which the population of a mental hospital is likely to decline can be predicted with reasonable accuracy, policies and plans could be put on a realistic basis. All methods of forecasting rely on some degree of guesswork. Some of this was unduly optimistic, hoping (unrealistically) that other bodies than the NHS would provide adequate alternative care.

Long-term planning for the mental health services is chaotic. Jones⁸ has described an atmosphere of "low-level thinking and highly charged enthusiasm leading to myths about the possibilities of community care flourishing." Hawks⁹ also challenged some of the assumptions. The hospital plan for England and

Wales¹⁰ suggested that the mentally ill should be cared for in units in district general hospitals. It was hoped that better treatment would lead to less chronic illness and that many existing mental hospitals would have no place in the new patterns of service. This policy led to neglect of existing services for those with chronic relapsing disorders, which has resulted in a serious lack of development in mental hospitals, loss of morale, and a plethora of inquiries.

Fottrell *et al*¹¹ have suggested that within every population of long-stay patients in mental hospitals there is a group that presents special problems of rehabilitation and discharge. The White Paper *Better Services for the Mentally Ill*¹² accepted that it had not proved possible to provide a total range of services in any district general hospital. No mental hospital was closed in the 1960s when money was available to develop alternative services. There is no evidence that all chronic mental illness with severe handicap can be prevented, hence some of these patients will need long-term continuing care and treatment. Such care can be provided in either hospitals or hostels provided that these are adequately funded and staffed. In the past two decades the hospital service has been contracting and patients who might otherwise have been in hospital are now in the community. Little increase in community facilities has meant, as the White Paper pointed out, that chronic patients are discharged without adequate arrangements being made for aftercare. In the foreword to the White Paper the minister pointed out, "the policy can only be achieved if there is a substantial capital investment in new facilities and if there is a significant shift in the balance of services between health and local authority."

The reduction in mental hospital beds has been paralleled by an increase in prison inmates. Penrose¹³ pointed out that in all developed countries there was an inverse relationship between the number of psychiatric beds and the number of prison places. Perhaps the time has come for the Home Secretary (a very senior minister and head of one of the great departments) to lean on the Secretary of State for Health and the Social Services (traditionally a more junior minister and lesser department) and insist that the responsibility for providing these services should not be evaded, pointing out that exhortation and unrealistic hopes are no substitute for the adequate provision of services.

A problem in providing adequate community care is that it costs money. The health service hopes that local authorities will provide it. Local authorities do not understand why the authority responsible for those who are ill should expect others to provide for their care. It is futile for the NHS to exhort local authorities to provide facilities for health when they do not have the resources to provide adequately for those many other services for which they have a mandatory statutory duty. They do not have a similar statutory responsibility to provide psychiatric aftercare.

The arguments about the relative value of community care and hospital care for the chronic psychiatric patient continue. Bennett¹⁴ has pointed out that what is needed is that both should be combined to provide a continuum of treatment, rehabilitation, and care, for these complement rather than replace one another. In practice the current plans for the mental health service include pushing some patients out into the community without adequate support or treatment. This neglect leads to vagrancy, destitution, and an increase in the prison population, already overcrowded and under stress.

There is no evidence that the DHSS have totally abandoned earlier plans, though some of these have been modified.¹⁵⁻¹⁷ Instead of planning to close 100 hospitals (without yet succeeding in closing one) it is now proposed that 30 will be closed.¹⁸ It is good to know that in these dark days of financial cutbacks the DHSS remains a source of veritable optimism, believing that local authorities will somehow find the resources to provide sufficient support in the community for those poor, sick, mentally alienated souls for whom the DHSS at present have the statutory duty of care. Since it is unlikely that local authorities will ever be able to cope with this group, it would be desirable to make it possible for the NHS to extend their hospital services

into "nursing homes" in the community¹⁹ if the term "community care" is to be more than piffle before the wind.²⁰

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Innovations in medical records in the United Kingdom

FRANCIS AVERY JONES

Good medical records help clinical decision-making in diagnosis and treatment. In addition they serve as the means of communication between the clinical teams treating the patient, both in hospital and in primary care; they play a key part in facilitating clinical and epidemiological research; they provide the history-taking discipline that plays an essential part in the education of medical students and junior doctors; they allow an assessment of the quality of medical care services; and they furnish the evidence which may be needed for medicolegal purposes.

The department of community health in the University of Nottingham Medical School was commissioned by the King Edward's Hospital Fund for London to study recent innovations in the keeping of medical records. This fund makes a continuing contribution to the efficiency and effectiveness of the NHS, concentrating particularly on the Cinderella aspects, one of which is medical records. The resultant report, *The King's Fund Gazetteer on Medical Records*, brings together the innovations and special studies at present in progress in primary care, hospital practice, and health service administration.

Problem-orientated medical records system (POMR)

The traditional standard pattern of medical history-taking was admirable while the focus of attention remained on diagnosis; the clinician had to be right even if there was no effective treatment. Today, the many effective treatments really make an impact on disease, and Weed was the first to realise that

traditional medical records did not place sufficient emphasis on managing the patient and particularly on looking at the patient as a whole. He therefore put forward his "problem-oriented medical records system" (POMR). The ideas are simple and sensible, but the terminology can be irritating. Weed's "data base" is more structured than is traditional history taking, with more emphasis on the patient's life profile. The "problem list" not only contains medical problems but also includes background social problems. The third component is the drawing up of plans for each problem and, finally, the introduction of structured progress notes. In this form the notes provide continuity of care and make it much easier for one doctor to take over from another. They also encourage logical thought, and above all they provide an invaluable aide memoire for the doctor each time he sees the patient. All this needs more discipline and a little more time.

The *Gazetteer* gives the main centres where POMR has been introduced and the ways in which it has been modified. The introduction of POMR has been slow, with more progress in Scotland than in England. While it is important to identify all problems during the patient's stay in hospital, it is not necessary or indeed possible to deal with all the problems during that time, but they should be passed on clearly to the general practitioner. At Ninewells Hospital, Dundee, the prescription form for patients being discharged provides a space for a problem list to be written in by the houseman. The structured discharge summary has been widely accepted as a simple and logical way of transmitting information back to the family practitioner. The registrar or consultant who dictates such summaries is therefore motivated to encourage his junior staff to structure the records so as to facilitate the writing of the summary.

The department of medicine at Newcastle has implemented a form of POMR with the production of a useful summaries problem card for use in the continuing medical care in the outpatient department. For this purpose, the problem list

Central Middlesex Hospital, London NW10

Sir FRANCIS AVERY JONES, MD, FRCP, consulting physician