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After the Asylums

Who needs long term psychiatric care?

Trish Groves

Why does the debate on community care focus on the plight of severely mentally ill people, given that most people with psychiatric problems are not psychotic? Although most patients with "minor" disorders such as anxiety seek no help beyond their general practitioners,¹ not all can be dismissed as the "worried well." Planners of community services should remember that some of these patients may be chronically incapacitated and may need specialist help, preferably in general practice² and community mental health centres.³ But having acknowledged that, there is the risk that those who also need long term social care may be neglected by new psychiatric services: in the United States community mental health centres have tended to concentrate on psychological treatments for people with minor disorders.⁴ Similar failures of community care in Britain⁵ lend strong support to the argument for positive discrimination in favour of patients with severe disabling mental illness.

But who are the people with such severe illness? To avoid the mistakes of the past, policy makers must know who needs specialised long term care. Perhaps they could use Wing and Furlong's practical definition,⁶ which states that those who need long term care include:

Mentally disordered adults, in addition to those with mental handicap and dementia, who are highly dependent on others and have a high all-round need for care which has hitherto been equated with a need for long term residence in hospital.

To professionals this may seem obvious, but to people such as politicians who have to make decisions about care but have no formal knowledge of psychiatric diagnoses it is valuable. The commonest diagnosis among people with such high dependency is schizophrenia, followed by manic depressive psychosis, chronic depression, and personality disorder. In some, these disorders are complicated by mild mental handicap and neurological disorders such as epilepsy. But the greatest disability is often social: even new long stay patients who may have been in hospital for only one year lack close relationships, jobs, and homes that can accept them. Because social care is an essential part of managing long term disability the government proposes to give local authorities overall responsibility as the "lead agency" for community care.

Welfare entrepreneurs

From April 1991 local authorities are expected to develop a mixed economy of community care, includ-

Case managers

Caring for People defines a case manager as a nominated professional worker who:

- Identifies people who need formal care
- Assesses individual needs
- Acts as a broker by planning care and ensuring that it is delivered
- Monitors quality of care
- Regularly reviews the need for care.

Social workers, home care organisers, and community nurses may be particularly suitable case managers. A less used alternative term is "care manager," which explains what the job entails and avoids the potentially pejorative term "case."

ing private and voluntary services. Authorities must appoint, or at least liaise closely with, key workers called case managers (box).

Experience in the United States, Canada, Australia, and Britain has shown that case management may have three advantages: it may improve patients' use of and satisfaction with both inpatient and outpatient services; it may enhance their social lives; and it may be economical, costing no more than traditional models of care.⁴

Case management was a feature of Britain's biggest experiment in community care.⁷ In 1983 the Department of Health and Social Security provided over £21 million (at today's prices) to look at different ways of moving nearly 900 long stay patients from hospitals into the community. The money was used to set up 28 pilot projects around the country and run them for three years. All the projects used case management but each interpreted it differently. Patients in 11 schemes were mentally handicapped, mentally ill in eight, elderly and mentally infirm in four, elderly in three, and physically disabled in one. One scheme was for severely disabled children.

The Personal Social Services Research Unit at the University of Kent evaluated each project by asking three main questions: does the project improve the wellbeing of the patients moved? What does it cost? How does it work? They found that most of the projects were highly successful. Of the former long stay psychiatric patients over 200 had moved from hospital within nine months (table).⁸ One of the

psychiatric projects is described in more detail in the box.⁷ Mentally ill people who left hospital showed no clinical or behavioural deterioration and had higher morale, greater social contact, and more say in deciding how to spend their time than previously. And community care was no more expensive than hospital care. Thus the research unit found encouraging answers to their first two questions.

But several problems emerged when the third question was asked. Projects were slower to set up than anticipated, particularly for day care. Housing associations were not always able to provide buildings for hostels because they had many other priorities. It was sometimes difficult to find patients to fit strict criteria for the new hostels, and sometimes there was local opposition to the plans.

The greatest problems, however, concerned staffing. Closing wards often led to redundancies, the costs of which were underestimated. Both the skills demanded by community care and the narrower scope offered for career progression were so different from those in

*Places of residence of former long stay patients nine months after leaving hospital**

Accommodation*	Long stay patients		
	Those with mental illness	Those with learning difficulty	The elderly and physically handicapped
Residential home	25	13	91
Hostel	66	126	
Sheltered housing		25	51
Staffed group home	33	129	
Unstaffed group home	56	20	2
Foster home or supported lodgings	12	20	3
Independent living	27	13	89
Incomplete data	7	13	5
Total	226	359	241

*After nine months or immediately before readmission to hospital in some cases.

This group home in Brent looks just like any other house

The Brent care in the community project⁷

Aims:

- To resettle in Brent—their home borough—60 psychiatric patients from Shenley Hospital in Hertfordshire
- To provide a range of accommodation
- To establish a new network of day facilities and domiciliary services.

Achievements, 1984-8:

- Multidisciplinary assessment of 127 patients from 23 wards under the care of seven consultants—60 patients were found to be eligible for the move
- Appointment of a case manager for each patient
- Preparation before discharge in a rehabilitation ward and a cottage in the hospital grounds
- Opening of a mental health resource centre offering continuing rehabilitation and treatment, leisure and social activities, meals, and a central point of contact for patients, relatives, and staff
- Resettlement of 48 patients—seven patients in a new staffed hostel, three in local authority hostels, two in other hostels, 24 in unstaffed but supervised group homes, six in accommodation under a home funding scheme, and four in their own flats
- Three patients did not cope with resettlement and were readmitted to hospital for long term care.

hospitals that the research unit recommended changes in training for community care staff. Terms and conditions of service were poorer than in hospital in some instances. Nurses suffered a kind of culture shock when they left the wards: many seemed to develop burnout, given the absence of the structured support that they were used to in hospital hierarchies, and left prematurely.

Finally, different professions tended to disagree about the nature and causes of mental illness. Strictly medical models of care were criticised for being too limited, concentrating on patients' deficiencies rather than their capabilities. The research unit found that these differences could cause deep divisions within teams but concluded that the best solution was to encourage diversity and keep the debate open. Their final word on case management was that although no definitive version had emerged during the programme some kind of "welfare entrepreneur" was essential to successful community care.⁸

Psychiatrists' views

The Royal College of Psychiatrists hardly relishes the prospect of such entrepreneurs, making it clear that consultants will still have overall responsibility for patients under their care. Its recently announced guidelines on the discharge and aftercare of former psychiatric patients recommend case registers so that even those vulnerable patients who are not covered by the Mental Health Act (1983) can be followed up (figure). Until now health and social services authorities have been required under section 117 of the act to provide aftercare only for patients treated in hospital under sections 3, 37, 47, and 48. Consultants will be held responsible for keeping case registers up to date and for ensuring that when their responsibility for community care is delegated it is to named key workers. Interestingly, the guidelines do not acknowledge the concept of case management, and at a recent meeting on needs assessment held at the Institute of

Guidelines on discharge and aftercare of psychiatric patients

Psychiatry the term was barely mentioned. With their emphasis on consultants' powers the guidelines will form the basis of the psychiatric care programmes that all district health authorities must introduce by April 1991. If, on the one hand, health authorities advocate a consultant led service and, on the other hand, local authorities propose a case management model there is obvious scope for confusion and confrontation, and joint working will be uphill all the way.

Power structure is not the only bone of contention in the reorganisation of community care. The Royal College of Psychiatrists also doubts whether it is wise to plan tailor made services only from the bottom upwards. It agrees that individual patients need

thorough assessment but warns that planning based solely on patients' needs and capabilities might deprive doctors and health authorities of important epidemiological data. Planners need to know which disorders are prevalent in the populations they serve and what medical services will be needed. Thus, the college says, the Griffiths report proposes better social care at the expense of proper medical care.¹⁰

There is a serious oversimplification of the division between acute and chronic health care. This is deleterious to the care of patients and the education and practice of doctors. There is increasing evidence that, in the more stimulating surroundings of ordinary life both the mentally ill and the handicapped are at times more psychologically unstable. Thus they require sophisticated supervision to avoid the "revolving door" type of treatment.

In the middle of these disputes stand the patients. Can their general practitioners bridge the gap?

Primary care

Although *Caring for People* acknowledged that general practitioners are the first port of call, it devoted only three paragraphs in its 97 pages to their role in future community care.⁹ This section discussed the assessment of elderly people and the terms of the new general practitioner contract and did not mention mentally ill people. Yet last year the Royal College of Psychiatrists stated that primary care will be the main setting for mental illness services and that it is discussing with general practitioners formal schemes for shared care. Already a fifth of consultant psychiatrists conduct clinics in general practitioners' surgeries.² General practitioners might even act as case managers at times: after all, "ensuring that individuals' needs are regularly reviewed, [that] resources are managed effectively, and that each service user has a single point of contact"⁸ echoes much of their existing role. To act as case managers, however, they would need detailed knowledge of all local community care services, including those in the voluntary sector. This would be a tall order because, as I will explain in further articles in this series, services often work in isolation and are not always easy to find. General practitioners have enough on their plates with a new contract and with the changes proposed in *Working for Patients*. Their increased participation in arranging community care seems unlikely in the near future.

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