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After the Asylums

What does community care mean now?

Trish Groves

Relatives and friends provide the bulk of community care for about two million chronically ill and disabled people under 65 in England and Wales.¹ Nobody knows how many care for people with mental illness nor how many find that job difficult, though the experiences of voluntary organisations such as the National Schizophrenia Fellowship give some idea. The fellowship has over 6000 members and 150 local groups and in 1988 received more than 5000 appeals for help and advice (table I) from schizophrenic people and their relatives.²

One of the hardest things about caring for mentally

TABLE I—Number of calls to the National Schizophrenia Fellowship in 1988 according to topics of concern

Deficiencies identified	No of calls
General advice	3066
Community care and treatment	678
Family support	546
Accommodation	315
Social services	282
Obtaining benefits	198
Legal inquiries	153
Hospital care	84
Total	5322

"He has spent half of the 13 years of his illness in and out of hospital and prison for minor offences, set fire to his mother's house, and attempted suicide three times in one year. The third time, the hospital tried to send him home on a bus with his pills. He is seen once a week by a psychiatric nurse who administers his anti-psychotic injections. The brief visit is the only support he and his mother receive. He refuses to go to a day centre because he thinks that people are staring at him.

'He was discharged into a community care system that turned out to be me,' says his mother."—One schizophrenic patient's story, reported in *The Times* on 12 July 1989.

ill relatives and friends at home is that it is often a forced choice (box). A young patient with chronic schizophrenia may have only two other options on leaving hospital—a hostel or bed and breakfast accommodation. Middle aged patients may have even less choice if their parents are old and their siblings are too busy with careers and children. Even when living at home is the first choice, it may not be good for patients or relatives: in schizophrenia it can worsen prognosis³ and can hasten relapse if it engenders an emotionally charged atmosphere.⁴ Relatives may become anxious and depressed and shunned by embarrassed friends,⁵ so that they have to turn to strangers for help.

The government recognises these stresses and expects social services authorities to arrange support for these informal carers. But it also states that its first aim in reorganising community care is to enable more ill and disabled people to live at home whenever possible.¹ For many severely mentally ill people living at home will not be possible unless they and their carers can get help during crises as well as in the long term. This means that there must be properly funded emergency clinics, out of hours social work teams, respite care beds, and special family therapy^{6,7} in addition to less formal support. And for those who cannot cope alone or live with relatives there must be suitable accommodation.

NHS provision

The exact number of hospital beds for people with long term mental illness is not known. Perhaps this deficiency is predictable because data on admissions, bed use, and discharges are notoriously inaccurate in

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Hostels can be happy and healthy places to live. But how many are there, and how many more do we need?

all health specialties. Some are based on number of beds and others on number of patients occupying them, and mental hospital data do not always distinguish between acute, long stay, and psychogeriatric beds.

When the National Schizophrenia Fellowship tried to find out the number of beds remaining and the number due to close it found many inconsistencies in government statistics. But it seems to have had more luck than the opposition health spokesman (box). The fellowship established that 30 mental hospitals closed between 1980 and 1989 and that a further 38, with 12 500 beds, were earmarked for closure before 1995. Presumably these hospitals have now shelved their plans because the government has halted the closure programme. It began in 1954 when the number of psychiatric beds peaked at 148 000 and it aimed at reducing beds to a target of 47 900: about 64 000 now remain.⁸

Accurate data on outpatient services are just as hard to find. The Department of Health cannot quantify hospital day care after 1986, when there were 18 660 places for mentally ill adults including those who were elderly and demented.

Nationwide surveys by psychiatrists suggest yawning gaps in some parts of the country.^{9,10} Kingdon requested copies of strategic plans for mental health made in 1984 from England's 192 district health authorities.¹⁰ Of the 127 districts that responded a half had no mental hospitals and a third were planning to close them. Rehabilitation teams were mentioned by only a third. Most failed to mention plans for new long stay patients, although nine described entirely community based care for them and 11 mentioned intensively staffed hostels on hospital sites. Interestingly, the Department of Health is aware of only three hospital hostels, even though it has been advocating them since 1975.¹¹ The survey showed a more encouraging picture for day care: day hospitals were provided by half of the districts and planned by the rest, and although there were few community mental health centres, two thirds were planning them.

Uneven distribution of psychiatric services might reflect different rates at which old asylums are closed,

TABLE II—Residential provision for mentally ill adults in England in 1987

	Local authority homes		Registered homes		Total
	Staffed	Unstaffed	Voluntary	Private	
No of homes	166	476	165	208	1015
No of places	2676	1957	2103	2432	9168

TABLE III—Regional summary of local authority provision for mentally ill people in England in March 1987. Figures are numbers of places/100 000 population aged ≥ 16 years

Region	Local authority day centres for the mentally ill	Local authority homes		Registered homes	
		Staffed	Unstaffed	Voluntary	Private
England	15.6	7.1	5.2	5.6	6.5
Northern	15.3	8.1	5.6	2.2	3.8
Yorks/Humberside	18.5	9.8	4.4	1.7	8.9
North Western	14.4	9.2	4.4	4.1	4.7
West Midlands	20.7	9.1	4.5	5.8	4.6
East Midlands	15.3	4.9	7.1	0.8	11.6
Thames/Anglian	1.6	3.0	4.4	4.4	5.5
Inner London	53.6	17.8	3.4	13.9	1.7
Outer London	27.3	11.5	7.6	11.1	1.4
Southern	8.9	2.9	5.3	10.0	11.0
South Western	6.9	1.5	5.9	2.7	8.2

"The closure programme has been so rapid that ministers seem to have had difficulty keeping abreast of it. Last year I tabled a parliamentary question inviting ministers to list the mental health hospitals for which there were no closure plans... it included four which had already closed at the time of the answer and two others which had closed during the time it took to carry out the survey."—Robin Cook, opposition health spokesman, speaking in parliament on 26 June 1989.

with those districts that have relatively few beds having better community care. Sadly, this does not seem to be the case—the Royal College of Psychiatrists says that most districts with high numbers of beds also have more community nurses and more day places.¹² The college and other mental health organisations¹³ have produced detailed blueprints for ideal psychiatric services but have not estimated how many long stay beds will be needed in future.¹³

Community care provided by social services

The Department of Health derives all of its data on residential care for mentally ill people, even the care provided by voluntary organisations, from England's 109 social services departments (table II). Unfortunately the data imply that there are many private sector homes for chronically mentally ill people when in fact this holds true only for those aged over 65. In the past year or two a few small private places have opened for younger people, usually as lodgings in nurses' own homes.

The same problem of age mixing distorts the data on social services day centres and makes it impossible to tell whether the services offered in old asylums are being replaced adequately. There were 163 centres with 5889 places in 1987, but it is not clear how many were used by recently demented elderly patients and how many by adults who would otherwise have been long term psychiatric inpatients. And, like health services, social services are unevenly distributed around the country (table III). The Scottish Association for Mental Health says that the situation is particularly bad north of the border. The association estimates that a third of Scotland's 13 000 mental hospital patients could be discharged if there were adequate facilities in the community; Scotland has only one local authority day centre for mentally ill people.¹⁴

Voluntary organisations

Caring for People gives the impression that there is a wide range of voluntary services for people with mental illness and that it just needs coordinating.¹ Certainly there are many different organisations,¹⁵ but not all provide services that equate to the long term residential care previously offered by the NHS.

One of the largest providers of residential care and psychiatric rehabilitation is the Richmond Fellowship. It has nearly 30 houses nation wide, run by its own trained staff, that offer both temporary and long term care for people with severe mental illness. The houses are run as therapeutic communities in which residents are given as much personal and communal responsibility as possible. The Richmond Fellowship also has a range of group homes (supervised but unstaffed) in 11 cities and several special units for children and adolescents, families, and misusers of alcohol and drugs. In total it houses nearly 500 residents.

MIND (the National Association for Mental Health)

is another large provider. Unlike Richmond Fellowship houses MIND hostels are not run by one central office—its local groups (nearly 200 in total) are affiliated, or effectively franchised, and do not rely on the organisation's central headquarters in London for administration. Such local control probably has many advantages, but one big disadvantage is that the central office has no data on the number, size, or distribution of MIND hostels. Groups vary around the country: in the next article I will look at one in the north of England that does not offer accommodation but contributes a range of other services such as day centres and a befriending scheme.

There are other smaller, less publicised organisations, such as the Psychiatric Rehabilitation Association and the Mental After Care Association, that provide hostels and day centres. These voluntary sector services develop in response to local need, often intending only to fill temporary gaps in statutory services. They make do with an eclectic mix of staff and with funding sources that include central government, health authorities, social services departments, housing associations, charities, and residents' social security benefits. On the one hand, case managers could use the new community care structure to encourage these organisations and to rationalise their administrative complexities. On the other hand, however, the proposed competitive market could squash small organisations in favour of bigger and more established groups, particularly if groups are expected to plan ahead and provide services for many years. And contracts between social services departments and the voluntary sector will probably concentrate on the most concrete schemes (accommodation and day care) at the expense of less visible, more innovative ideas such as user participation¹⁶ and advocacy. While the new policy may reasonably divert public money towards services that have proven track records, it may unreasonably narrow consumer choice and impoverish community care.

The national picture

To understand what the new proposals for community care might mean we need more information about existing services. It would be useful to draw a map of Britain and mark on it the areas that still lack adequate community care for people with long term mental illness. With current knowledge it is impossible to do so. The Department of Health had well over a year to consider its response to the Griffiths report¹⁷ but did not gather together a clear national picture of the services it was proposing to organise. Last autumn, when its proposals were already decided, the Department commissioned such a survey. Let us hope that it finds enough care in the community with which to work.

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