Community care: rhetoric and action

Community care has been said to represent the first big policy change in psychiatry since the early nineteenth century, when the horrors of private madhouses led to the creation of the public asylums. But if planned on the cheap—or not planned at all—community care may be worse than the services it has been replacing for the past 30 years. The Social Services Committee has spoken of the “decanting” of patients from mental hospitals in the past without sufficient services for them. In addition to those leaving mental hospitals new chronic patients, who would in the past have spent long periods in hospital, need services that must be supplied in the community. In the short and the longer term more not less money will be needed.

Community care is, then, much more than “deinstitutionalisation”—which indeed does not in itself abolish institution type practices and attitudes. It calls for planning at several different levels as much as for resources. A conference held recently at the North London Postgraduate Centre, Haringey, looked at planning for rehabilitation and resettlement in the context of the closure of mental hospitals. Discussions were given a focus by the plans for closing Clifton Hospital completely and Friern Hospital partially and in particular by developments in the Borough of Haringey. These closures, planned for 1993, will be the first to affect inner city areas in Britain. The experience of Hackney, however, is relevant: its psychiatric services stopped depending on a mental hospital (Long Grove, Epsom) in 1974 and it has evolved comprehensive district based facilities. Camberwell, moreover, is a London borough with a well researched pattern of community services, though centred on the Maudsley Hospital; and the meeting drew on the experience of Netherne Hospital in Surrey, with its long tradition of rehabilitation and its present prospect of cutbacks.

We must develop services to fit the patients instead of hammering patients into a shape to fit the services, as one participant put it; and clearly this means establishing or expanding a wide range of facilities with plenty of time to prepare those leaving hospital and to make arrangements for staff. But it also means more underpinning of information and research than might be supposed. Even the questions of numbers are not straightforward. How accurately can planners predict the numbers needing different types of facility five or 10 years hence, given that a different pattern of services may generate genuinely different needs? For example, the large number of people apparently needing inpatient care at present reflects the past reliance on long term hospital beds. Long stay patients are already being discharged from Friern and Clapton Hospitals and matched groups of “movers” and “stayers” will be compared in a study under the auspices of the North East Thames Regional Health Authority Mental Health Research Committee. This research will help in assessing the value of the community services and in future planning. A computerised psychiatric services register (with safeguards to protect confidentiality) is being set up at the Community Psychiatry Research Unit of St Bartholomew’s Hospital Medical College. This will help coordination between different parts of the service—in particular, people with psychiatric disabilities will be less likely to fall through the net and get lost in the community—and it will provide a database for planning and research.

More generally, changes of such magnitude in the pattern of services call for research on the long term outcome for those concerned. This should include not only the broad outlines but also a more secure base of knowledge of how well people with these chronic disabilities actually live in the community—do they eat adequately, for instance; what satisfactions do they have in their lives; and what do they themselves want? The Community Psychiatry Research Unit has many projects in hand, but salaries are funded only on a yearly basis, and long term research is not guaranteed. This is not good enough. Vast numbers of long term patients have been discharged in the past three decades and it is truly remarkable that we do not know what proportions have settled successfully in the community with family or other support, have struggled on in a lonely abyss, have lived a life of destitution, and have returned to hospital.

Running through the many recommendations thrown up by the meeting were a few common themes: firstly, provision of comprehensive local services (including the long term beds and day hospital places needed for the most seriously disabled) with the flexibility to meet the needs of individuals; secondly, more effective planning, with coordination among health, social, and other services and voluntary agencies and some strategy for “getting their act together”; and, thirdly, monitoring and long term research, aided by computerised registers. But government itself has to take on board the increased demand for resources if community based services, with if necessary lifelong commitment to individuals, are to work; and it cannot be expected to do this without more precise information on needs and on outcome than is available.

The value of such meetings lies not so much in the novelty of the proposals as in the detailed discussion of practical issues between miscellaneous workers and administrators who are treading these thorny paths and those who have already travelled them and found answers—perhaps the hard way. As the select committee put it, “the rhetoric of community care has to be matched by action.”

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