

Correspondence

Community-based programmes on intervention in mental illness

DEAR SIRS

Looking at the progress made by schemes in various parts of the world in transferring the chronic disabled mental patient from an institution into a community based support, one is struck more by the stories of failures than by successes. Indeed one should perhaps ask how one best helps the chronically psychiatrically disabled and for whose benefit are present schemes of community care being pursued. Is the community a caring place or are we simply turning the clock back 200 years?

In 1744, King George II enacted a statute in which the preamble states "whereas the number of rogues, vagabonds, beggars and other idle and disorderly persons daily increases to the great scandal loss and annoyance of the kingdom, for remedy therefore be it enacted by the King's most excellent majesty by and with the advice and consent of the Lord's spiritual and temporal and commons in this present parliament assembled, and by the authority of the same, that all persons who not having the wherewith to maintain themselves shall be deemed idle and disorderly persons and it may be lawful for a Justice of the Peace to commit such offenders to a house of correction for any time not exceeding one month". In Section 20 it states "whereas there are sometimes persons who by lunacy or otherwise are furiously mad or so far disordered in their senses that they may be dangerous to be permitted to go abroad be it therefore enacted by the authority aforesaid that it shall be lawful for any two or more Justices of the Peace to cause such a person to be apprehended and kept maintained and cared for, and this shall be for and during such time as the lunacy or illness shall continue".

Why did King George II see fit to amend the Vagrancy Act and ensure the care of lunatics? The answer is that the community then had little concern for caring for the mentally ill and preferred to dissociate themselves from the eccentric, peculiar, or those who might pose a threat or embarrassment. This act was the first attempt to provide care for the mentally ill by Government in England. It was not until a century later however, with the advent of the reforms set in motion by Lord Shaftsbury, that proper hospitals within each county were developed and the Parishes relieved of the ill-carried out duties previously required of them. Private madhouses had flourished where individuals could be placed and kept out of the way. The community had recognised that control had to be exercised over the care of the mentally ill and that the centralising of facilities was the most efficient and cost effective way of dealing with what had become a national problem. In the last 100 years in Britain, and most other countries, the

institutional treatment of the mentally ill has reigned supreme.

In York the service is currently engaged in reversing this process and moving back to community care of the mentally disabled. This letter will be a discussion of the arguments for and against such a change and examining whether this is but a swing of the pendulum.

York is a city of 90,000 inhabitants with a district community serving 250,000 people and is fortunate that, for historical and geographical reasons, it has been a centre of excellence for psychiatric treatment, and three psychiatric hospitals exist within its present district boundaries. These hospitals, now required to serve a community of 250,000, previously served the County of North Yorkshire with some 800,000 individuals. This has meant that, as the need for in-patient long-term beds has run down the planned closure of one of these hospitals (Naburn) has proceeded with financial savings so that money can be used to develop a community based service.

However, certain snags are already developing. With present cutbacks the money to be saved is already being scrutinised by general medical colleagues. There is a danger that the money allocated to mental health could be lost to another branch of the service.

The community planning has caused the district to be divided into four sectors of 60,000 people each, each developing its own Community Mental Health Team with psychiatrists, social workers, community psychiatric nurses, clinical psychologists and occupational therapists. Each sector is charged with developing its own resource centre within its community and in maintaining a register of patients at risk. In addition, small community units being developed for those who require a higher level of help will in effect be mini hospitals in the community. Community units for the elderly, with day and in-patient provision, will deal primarily with problems of Alzheimer's disease and an expansion of sheltered workshops and other daily activities which will be community based.

Nevertheless, it is deemed necessary to retain in the long-term Bootham Park Hospital with some 120 beds to continue to provide for those more acutely ill who require a period of time out from the community during the more extreme phases of their illness and where more intensive care or specialised investigations and treatment may be carried out. It is also recognised that there will need to be a core unit for young long-term disabled who will still exist, though in smaller numbers than the old long-stay, and special arrangements will be needed in each district for the 'furiously and dangerously mad'.

It is essential in planning such a service that funds are available for the development of the community facility before the institutional facility is closed. Thus capital must be provided by bridging loans, the closure of hospitals while retaining others as we have done in York, or by other means. Running a proper service which is peripheralised is

more time-consuming, more expensive, and more difficult to staff than a centralist policy with the facilities on one campus. Only if money and staff are available can peripheralisation be justified.

The development of a community unit for the elderly costs £250,000. Before the central facility closes £2,000,000 will be needed therefore for the hundred places these units would provide.

Another difficulty is the finding of appropriate sites or property for community units and resource centres. The value of adjacent dwelling places may go down and this causes resentment and resistance from neighbours so that the council may refuse planning permission. The community still do not like the chronically mentally disabled living next door. Another problem is the quality of life for ex-patients during the day. Again there are staffing implications and the need for proper day facilities with sheltered workshops and various ranges of options must be considered as also cover for staff during sickness and vacations, additional travelling time from the effects of peripheralisation and job satisfaction for staff. Centres of excellence attract staff but it is difficult to see how peripheries of excellence can be developed.

The question arises therefore whether we can best help the long-term mentally disabled and avoid institutionalisation in the home or whether a central campus still remains the most logical means of dealing with this sizeable problem. Where do we as psychiatrists wish to work?

It is necessary to look therefore at the evidence accruing from earlier community schemes already in motion. This survey tends to make for sober reading. Ten years ago Blackburn studied discharges from an adjacent district (Middlesbrough) and formed ominous conclusions.¹ Although discharge of the long-stay was continuing apace the social services department had not been able to provide hostel or day centre placements. The non-enthusiastic community did not want such people living next door and the day hospital was choked up. Blackburn felt that what had been achieved was nothing more than a conjuring trick. In 14 years 236 long-stay patients had been discharged but virtually all continued to need care on a daily basis. The rest of the time was spent in aimless drifting, often to the public house. The dilapidated bed sitters many patients lived in were in twilight areas undergoing redevelopment and many were on the verge of being homeless. Twenty-nine were living in a church army hostel and many had become vagrants.

At Friern Barnet Hospital in London, patients had been taken out of the institution and placed in hostel accommodation which was a conversion from the old disused fever hospital. In the latter daily activities, social groupings, and adequate trained staff to deal with problems that might occur were not available nor employed, and there was no way back since the main hospital was being demolished.

The study of patients discharged from hospitals in York showed that, of 50 long-stay patients discharged between April 1982 and March 1984, only seven had been readmitted to the mental hospital, though this was a matter of policy

rather than of need. Only five were in their own homes and the rest scattered between local authority homes and hostels, private registered homes (the new version of the private madhouse), lodgings and group flats with a small number living rough.

Of the 100 elderly confused who had been discharged during the same period, 35 had died but 23 had returned to hospital; only 10 were living in their own homes or with families. Many were in private homes, some of good quality, but others more dubious. Some patients in their own homes were in a deteriorating situation, particularly where care fell on equally ageing marital partners, and the quality of life of many in private homes was not as good as it would have been in hospital if properly staffed and funded.

In the last two years articles have increasingly drawn attention to the continuing need for asylum and the plight of many discharged from mental hospitals to a community that did not care.^{2,3}

The Kings Fund⁴ held a forum in 1987 on 'The Need for Asylum in Society for the Mentally Ill or Infirm'. They state that "the evidence of history indicates the existence of an enduring body of disordered people with a need for care who have proved resistant to treatments of the day, and who are not tolerated in their society. The development of replacement local services concurrently with hospital closures is essential in maintaining the confidence of recipients, carers and professionals alike in a new local service. While we are fully committed to the policy of care in the community there is however clear evidence that a product of the change is often a quite unreasonable burden being placed on the carers. This burden can lead to great distress and even emotional breakdown. In the planning of resource allocation the interests of carers have not been taken properly into account".

What conclusions then should be drawn? Planning should be very carefully carried out before the mentally ill and mentally handicapped are forced into situations which can produce neglect and a society which boycotts them. Whether such schemes will reduce the prevalence of mental illness is doubtful. That they will reduce readmission is more certain but there must be care not to allow the chronically ill to be neglected while catering for the more interesting neurotic. The clinician must be in on the early planning of any such scheme. Funds must be available and the community educated in advance. This latter may be the impossible task.

Does the community care? Does it care any more than it did in 1744? Are we in fact creating more problems, and more dis-ease than we correct? This remains an open question.

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- ²BRITISH MEDICAL ASSOCIATION (1987) An affront to a civilised society. *British Medical Association News Review*, 13, June.

³WALLACE, MARJORIE (1987) A caring community? The plight of Britain's mentally ill. Colour Supplement, *Sunday Times Magazine*. 3 May.

⁴KINGS FUND FORUM (1987) *The Need for Asylum in Society for the Mentally Ill and Infirm*. King Edwards Hospital Fund for London.

De-institutionalisation in Australia

DEAR SIRS

There have been many papers lately in the *Bulletin* describing de-institutionalisation in the USA and other countries. I would like to describe a similar situation in New South Wales which has 5½ million inhabitants, most of whom live around Sydney. The treatment in psychiatric hospitals is provided free of charge by the State Government. There is also a Federal Government Compulsory Health Insurance Scheme called 'Medicare' which provides for 85% of a doctor's fee if the patient wishes to be treated in a private hospital. There are 10 psychiatric hospitals, three of which are in rural areas. Most psychiatric practice in New South Wales has been traditionally centred around large psychiatric hospitals with in-patient and out-patient facilities which catered for a range of disorders including psychosis, mental retardation, organic disorders and drug problems. They also had people needing accommodation over a short period due to social problems. Patient ages ranged from adolescence to the elderly, often lumped together regardless of age or diagnostic category. This resulted in a typical public attitude toward these institutions which were seen as providing a custodial care.

The condition of these hospitals has worried the profession and led to the enquiry in late 1982 which resulted in the *Richmond Report*.¹ The main recommendations included separation of services for mentally ill and developmentally disabled (mentally retarded), a plan to move long-stay patients from hospital to the community, transfer of acute beds from psychiatric to general hospitals, setting up more services in the community and reducing the number of beds in psychiatric hospitals. Two further documents later gave a detailed plan of how to implement these recommendations.

The process started slowly in 1983 and met with problems straight away.

Firstly there was lack of co-operation by the staff employed by psychiatric hospitals, especially nurses. They felt threatened by the report as they saw this as an exercise to close these hospitals altogether and the real aim of the Report was misunderstood.

The second problem was relocation of acute care from psychiatric to general hospitals. The staff at these hospitals were not quite ready for this and found psychiatric patients difficult to deal with.

The third problem, the most difficult, was the transfer of long-stay patients from the hospital to the community. The public was not ready and found it difficult to accept someone they thought of as a hospital patient living next door. This resulted in protests and incidents where public anger was directed at patients.

The fourth problem was financial. As different areas had different approaches to budgeting, some got into serious problems.

Separation of services for mentally ill and developmentally disabled presented difficulty. Some patients with problems in both areas were moved back and forth several times.

In some areas targets were set in that it was decided to move a certain number of patients in a given time which caused difficulty and some had to come back to hospital.

In summary, the *Richmond Report* is a brilliant piece of work and has the aim to improve treatment facilities for mentally ill and developmentally disabled people but its implementation is presenting considerable difficulties. The following steps will be necessary to implement it properly:

- consultation with the employees of State Psychiatric Hospitals, especially the nursing staff, to relieve their anxieties and have their full co-operation. Some consultation has taken place, but more is needed;
- to educate the public about the real aim of these changes and the rights of the mentally ill with the aim of achieving a more flexible attitude;
- to modify the plan of services for the developmentally disabled with more involvement of a psychiatrist rather than leaving the whole to paediatricians and physicians;
- to provide advice to the general population and specialists about their roles;
- above all, to allocate more money for community services and provide a better patient support system.

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Admission for assessment or treatment?

Sections 2 and 3 in perspective

DEAR SIRS

Recent correspondence from Dr Aaronricks (*Bulletin*, June 1987) and Dr Bermingham (*Bulletin*, November 1987) emphasises the confusion and diversity of practice concerning the compulsory admission of the mentally disordered into hospital.

Many social workers with the support of some consultants and apparently with the approval of the Mental Health Act Commission apply for admission for assessment (S.2) in preference to admission for treatment (S.3) even when the nature and degree of the mental disorder is known, and the real purpose of the admission is for a continuation of a programme of treatment well established during previous admissions of the patient suffering from the same disorder.