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Correspondence

Continuing care provision for the mentally ill

DEAR SIRS

Profound anxieties are evident among practitioners in old age psychiatry and other psychiatric specialties that appropriate long-term care for the most severely disabled/disturbed is becoming increasingly difficult to ensure as health authorities have closed long-stay beds and assumed or arranged that alternatives will be provided by 'independent', non-hospital agencies.

It may be helpful for practitioners to know of letters issued from the Department of Health and NHS Management Executive earlier this year.

24 January 1992. Stephen Dorrell wrote from the Department of Health to the Chairman of Newcastle Health Authority rejecting that Health Authority's plan to 'reprovide' services of Ponteland and Lemmington Hospitals through a collaborative scheme with Anchor Housing.

"I recognise that your proposals would have provided an improved physical environment for the elderly people concerned, and I welcome imaginative proposals for co-operation between the Health Service and the independent sector. Your proposals would, however, have involved a wholesale switch of financial responsibility from the Health Authority to the Department of Social Security. The patients concerned would therefore have effectively been discharged from NHS in-patient care not as a result of a decision by the clinician responsible for their care, but as a result of a shift of financial responsibility from the Health Authority to the Department of Social Security.

Health Authorities should not, of course, assume responsibility for people who do not have continuing health care needs. Health Authorities do, however, have – and will continue to have – a responsibility to provide or secure long-term care for those people who need it by reason of the predominance of their continuing ill-health. This point is made clear in the White Paper 'Caring for People' (paragraphs 4.20–4.21) of which I attach a copy."

7 February 1992. Andrew Foster wrote to all Regional General Managers identifying four 'must be done' issues in the implementation of 'Caring for People':

(1) clarifying and agreeing with Local Authorities continuing care arrangements
(2) agreeing and preparing for health involvement in needs based assessment
(3) ensuring the robustness of discharge arrangements
(4) clarifying the roles of GPs and primary care teams

and amplifying consideration of these in an accompanying paper.

'*Continuing Care*'. DHAs to establish a clear policy in relation to the NHS purchase of continuing care (continuing care beds, respite care, rehabilitation and community services), identifying and quantifying their current commitments including all those which they share with other agencies e.g. Section 64 grants and protecting those resources. As part of the 1993/94 community care plans DHAs must agree with LAs an overall strategy for the commissioning of continuing care and covering; service volumes, service types, service quality, information requirements and any joint commissioning arrangements. *It is not acceptable for DHAs to take unilateral decisions to withdraw from continuing care*'.

It is all too easy for practitioners to feel left out of the planning dialogue – some will find 'possession' of the information contained in these letters helpful in contributing their advice locally. I am asked by our Executive to draw attention to them through the columns of the *Psychiatric Bulletin.*

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NHS managers and clinical management

DEAR SIRS

A 19-year-old schizophrenic student appealed to the managers against detention under Section 3 Mental Health Act. At the time of her appeal her mental state was beginning to improve both in terms of her self care and sociability. In addition she had stopped acting on the delusional belief that her father had stolen her face. Prior to admission she had been very angry with him for this and had tried to hire a private detective to assist her in obtaining the restoration of her features. She had not washed or changed her clothes for several weeks and on one occasion had attacked her mother with a pair of scissors.

Her improvement had been slow and the multidisciplinary team considered that she needed to remain in hospital for a few more weeks so that depot rather than oral medication could be commenced (previous failed compliance with oral medication had led to this admission). The team also wished to

make plans for her future and a hostel placement was being considered with the patient and her parents.

An appeal held by the managers' lay representatives was held after she had been in hospital for approximately two months. She presented herself well to the panel. Although written and oral evidence of the patient's mental state and progress was provided by six different members of the multidisciplinary team, the panel did not enquire whether she still believed her father had her face (she did). The panel failed to make a decision at their first meeting but, one week later, we were informed indirectly that the patient had been discharged home. I received a brief written statement to this effect one week later.

I was also told, again indirectly, that the panel had obtained an assurance from the patient that she would see her social worker weekly, take medication and attend the Day Hospital. On the basis of her agreement to these conditions they terminated her Section and she returned home. Her parents had not received any information from the review panel regarding her discharge and were naturally very concerned. On leaving the in-patient unit she refused depots and was soon reducing her oral medication. Her attendance at the Day Hospital had been unplanned as full consultation with the staff had not been possible before she started, and she soon sought to reduce the number of days she should attend.

The Code of Practice is vague about the managers' role in reviewing sections. The MHO Commissioners consider that the managers' responsibility should be to ensure that the legal documentation and procedures have been correct and that consideration of the patient's discharge should remain with the full Mental Health Review Tribunal which includes expert clinical opinion.

In this case the clinical team and the patient's family were given very little information about the patient's early discharge from Section. Not only was communication poor, which interferes with the long-term management of a severely mentally ill young woman, but the lay panel also took upon itself matters regarding the clinical management of the patient. This is a serious infringement into areas where they do not have expertise to the detriment of patient care. As well as the right to be freed from Section, consideration must also be taken of the rights of severely ill, insightless individuals to assured and optimal treatment. Only a property constituted Mental Health Review Tribunal has the expertise to evaluate such matters.

This case is illustrative for two reasons: first, this is yet another example of the increasing intrusion of NHS managers into areas of clinical responsibility. Second, the case highlights the deficiencies of the MHA Code of Practice failing to clarify managers' role with regard to reviewing Sections. It is our view that these matters should be debated further within our profession.

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Hidden differences between psychiatric treatment in the USA with respect to UK

DEAR SIRS

The major differences in treatment strategies between the United States and the United Kingdom are a direct function of rising health care costs, increasing demands by persons requesting care and the changes in attitude by insurance companies which finance the treatment offered.

Health care costs in the USA have risen at a rate greater than inflation and consequently have forced the delivery of psychiatric care to be governed more by cost containing strategies than clinical judgement. National health expenditure rose from 7.4% to 11.1% GNP between the years 1970 and 1987. Taking into account the size of the US GNP, this is a vast amount of money.

These trends have led to a shift from a separate public and private system of hospital care to a quasi joint public-private system which relies mainly on the financial support of the insured or private patient for its funding. The chronically ill (who are costly to treat) and the un-insured (who have no means of paying) are unwanted or unwelcome in this system.

The level of privatisation within the health system is significantly greater than in the UK, with more than 50% of hospital beds owned by investor operated systems which are, or strive to be, profit-making. The proportion of diagnostic categories treated depends on, or is determined by, ease and speed of treatment with a view to rapid reimbursement. Hence there is a tendency to treat fewer schizophrenic and more depressive patients than would be the case in the public system.

Within the US system the trend is towards treatment of patients in scatter beds throughout a general hospital. This has been found to be 3–20 times less expensive than treatment in an organised psychiatric unit but the benefit of the ward milieu is sadly lost.

Managed care (quality care at low cost) and utilisation review (whereby reimbursement may be denied for services deemed unnecessary) regulate the behaviour of doctors and other health care providers resulting in little initiative in treatment procedures and a lack of enthusiasm for experimenting with new but unproven methods of care.