

# The discharge of mentally disordered people and their continuing care in the community

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As a rallying call for psychiatrists, 'community care' has taken on all the appeal of 'back to basics' or the 'poll tax'. Its opponents present it as a new, financially driven dogma associated with a draconian decrease in the number of in-patients beds and an inevitable increase in suicide and homicide (Coid, 1994). In fact, the majority of people with serious mental health problems have always lived in the community and the number of psychiatric in-patient beds has decreased steadily since 1954 (Thornicroft & Bebbington, 1989). This reduction in beds has not been party political, has not been shown to be associated with an increase in the numbers of mentally ill people in prison or who are homeless (Maden *et al*, 1994; Geddes *et al*, 1994), and predates service delivery innovations such as home treatment. Increasingly it has been recognised that hospitals, especially long-stay institutions, can aggravate some psychiatric disabilities and be the focus for gross neglect and malpractice (Martin, 1984). Furthermore there is mounting evidence from both demonstration projects and ordinary services that proactive community services reduce the problems associated with an over reliance on in-patient services in both the long and short term (Harrison *et al*, 1994; Burns *et al*, 1993).

Achieving co-ordination and balance between existing hospital services and developing community services is currently high on the agenda of politicians, clinicians and managers. In order to address these issues and as a response to intense media coverage of what were portrayed as failures of 'community care' Mrs Bottomley issued her Ten Point Plan. The guidelines on discharge are a part of the Ten Point Plan, and are timed to form a reply to the recommendations of the Clunis Report.

## The guidance

The guidance has three stated aims, which seek to ensure:

- (a) that psychiatric patients are discharged only when and if they are ready to leave hospital
- (b) that any risks to the public or to patients themselves are minimal and are managed effectively
- (c) that when patients are discharged they get the support and supervision they need from the responsible agencies.

Guidance on achieving these aims is provided in six areas: discharge from hospital, the care programme approach (CPA), patients who present special risks, if things go wrong, supervision registers, and responsibilities of purchasers (see Table 1). These areas bring together, reiterate and reinforce a number of existing statements on policy and good practice from a variety of sources, including the College. As a result, many of the elements within the guidance have already been debated, are widely accepted as good practice, and have, to a varying degree, been supported by research.

Although originating from Whitehall, the discharge guidelines address fundamentally clinical issues. In effect, they advise psychiatrists on how to practise psychiatry in a way that is unprecedented in other areas of medicine. This should be a cause for embarrassment, not because of the nature of the advice, the guidance differs in no significant way from the College's own guidelines on discharge (Royal College of Psychiatrists, 1991), but because it suggests that psychiatrists themselves are unable to put their own house in order. Consequently, these guidelines will be adopted as a result of purchaser contracts rather than being left to clinical discretion.

Ironically the weaknesses in the document are in essence political. These relate to resources; organisational relationships, especially between health and social services; and the wider political context.

Table 1. Discharge and continuing care guidelines

1. **Discharge from hospital**  
Discharge should not occur until it is confirmed that proper supervision and care are available, and all those concerned identified.  
There is a "fundamental duty to consider both the safety of the patient and the protection of other people". Admission to hospital under the Mental Health Act 1983 may be for a patient's *health* alone.
2. **The care programme approach**  
Introduced in April 1991.  
Applies to *all* mentally ill patients considered for discharge who are accepted by the specialist mental health service, including those with dementia. The same principles apply to those with personality disorders and learning disabilities.  
Essential elements are: systematic assessment (including risk of violence and suicide); an agreed care plan; allocation of a key worker; a regular review; contingency plans if the patient fails to engage in treatment; an assertive approach to maintaining contact with the patient; a commitment to ensure co-ordination within a team and between teams at times of transfer.  
Need for links with appropriate supra regional services and criminal justice agencies.  
Legislation relating to supervised discharge still awaited.
3. **Patients who present special risks**  
Assessment should be detailed; multidisciplinary; cover risk of both violence to others and suicide, reflect current good practice and learn the lessons of previous inquiries.
4. **If things go wrong**  
Learn lessons for the future.  
Purchasers to judge when an independent inquiry is warranted, always indicated in cases of homicide.  
Guidance on setting up an independent inquiry.
5. **Supervision registers**  
Details in HSG9(94)5.  
To include those at most risk of suicide or serious violence to others or severe self neglect.
6. **Responsibility of purchasers**  
Purchasers to ensure that key elements in this guidance are specified in contracts with providers.

### Resources

The overall approach to discharge is one of caution. This is reflected by the detail devoted to risk assessment and the emphasis given to the use of the Mental Health Act to admit patients for their health alone. The latter should finally remove the excuse used all too frequently by psychiatrists that "the patient was not ill enough to section". This conservative strategy is likely to increase the pressure on in-patient beds, a particular concern in inner city areas, although the extent to which this pressure arises out of poorly co-ordinated aftercare services is unclear.

Some funding may be available for opening or keeping open existing beds in London, but not elsewhere. Even this is not new money – £10 million from the primary care budget for the London Initiative Zone will be ring-fenced for psychiatric services. Allocation of this money will only follow a review of both the hospital and community services in a particular area, thus providing an incentive for senior clinicians and managers to ensure that community services are being actively developed.

The components of the discharge guidance; the CPA, supervised discharge and supervision registers will create a significant increase in administrative and clinical workload. While some new resources will be required, especially in information technology, there will also need to be a greater emphasis on reviewing the care of patients living in the community. In many services a disproportionate amount of time is spent managing in-patients compared with community patients. This will have to change, but is a change that may be managed relatively simply and cheaply by developing, for example, community ward rounds (Burns, 1990).

It will also be necessary for an increased workload to be shared by all members of a team. Each team member should have a similar sized case load of new assessments and continuing care clients. It may be that the latter client group will have to be more narrowly defined than at present to ensure that resources are not swamped. All members of the specialist mental health services should be focusing strictly on those with severe mental disorders.

## Organisational relationships

The CPA is the administrative cornerstone of the government's approach to community care. In turn, a close relationship between disciplines and agencies is central to the effective working of the CPA. This particularly applies to the role of social services. There is evidence that most re-admissions to hospitals are related to social factors (Kent & Yellowlees, 1994) and that case management leads to global improvement only if case managers are able to influence both medical and social aspects of people's problems (Shepherd, 1990). Unfortunately, conflict rather than harmony between health and social services has characterised community care in many areas. It is vital that social workers and their associated resources become an integrated part of community mental health teams (CMHTs). Some integration may occur by local agreement; for it to occur universally will require central influence.

Closer working relationships between health disciplines, especially in agreeing ways of prioritising patients' needs and sharing caseloads, are also required. The Mental Health Nursing Review is understandably concerned that only 20% of people with schizophrenia are seen by community psychiatric nurses. The nature of the contribution of other professions also requires review. Mrs Bottomley proudly asserts that the number of clinical psychologists has doubled in recent years – but what has been their impact on the management of the long-term seriously mentally ill? Too often these disciplines are neither part of CMHTs nor hospital services and so do not share the same goals. Likewise the division between hospital and community services needs to be broken down. If the two aspects of the service are managed and staffed separately discharge will inevitably be delayed and problematic.

## Politics

The political conflicts between community care initiatives and other government policies have already been identified (Holloway, 1990; Thornicroft, 1994; Weich, 1994), the most pernicious consequence being GP fund-holders' antagonism to locality based multidisciplinary mental health teams (Kendrick, 1994). The government actively promotes the use of private health care providers; however, their place in an integrated mental health service is uncertain. Which purchaser will ensure their compliance with the CPA or establishment of supervision registers? The popularity of Mrs Bottomley herself is also important. While her approach to community care is in line with the views held by

many psychiatrists, the same cannot be said of the NHS reforms in general. As a result, her intentions and motives are always likely to be questioned.

## Implications for services

Perhaps of greatest importance are the implications the guidance has for the development of psychiatric services in general and the role of the psychiatrist in particular. To achieve the aims of the guidance it is evident that psychiatric services should be based on multidisciplinary teams; which embrace in-patient, community and social services; which relate to a specific locality; are proactive, assertive and target the most severely ill.

More controversially, the team should be led (but not necessarily managed or co-ordinated by) a consultant psychiatrist, who will be responsible for both the management of individual patients and also strategic developments of the service. This has long been the College's view, but is now given further support by both this guidance and the Clunis Report. Only the consultant is responsible for admission and discharge, assessment of risk, and inclusion on the supervision register. It is responsibilities in these areas that underpin the current policies and it is unthinkable that there should be such responsibility without power.

## Conclusion

The guidelines on discharge, together with the remainder of the Ten Point Plan, provide an acceptable framework on which community and hospital mental health services may be developed. However, it must be recognised that the limited range of therapeutic interventions currently available mean that there will always be individuals whose mental illness culminates in tragedy. It is to be hoped, however, that in future this will not be the result of someone 'slipping through the net'. Ultimately, the guidelines alone will not be enough. Psychiatrists will have to change attitudes, workloads will need to be shared between disciplines and politicians may even have to open their wallets.

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