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Facilities and services for patients who have chronic persisting severe disabilities resulting from mental illness

A Working Party Report on behalf of the Executive Committee of the General Psychiatry Section of the Royal College of Psychiatrists

Since the early 1960s, it has been official policy to develop locally based alternatives to the mental hospital for the care of people suffering from persistent severe mental illness. This Working Party Report identifies the major shortcomings of the implementation of this policy for people with persistent mental illness and sets out a number of recommendations to redress these deficiencies.

The report concerns patients who are reluctant to engage in treatment, patients who present complex care demands involving combinations of physical and psychiatric disability and those exhibiting challenging behaviours of a degree which requires long-term supervision. Such patients are dependent on high levels of nursing and medical care and may require residential care in the medium to longer term. Estimates of the numbers of patients with these characteristics in an average district are hard to come by, partly because of difficulties in making generalised statements about 'average' districts, and partly because of a dearth of published surveys of disability and service utilisation. The report reviews a number of such surveys from which it appears that the accumulation of chronic patients is best predicted by indices of social deprivation, notably the Jarman score, social class and unemployment rate. With suitable caveats concerning the disparate nature of the source data, it appears that the 'average' health district gets by with around 80 staffed residential places per 100,000 population, but that in addition, 11–15 patients per 100,000 are resident in acute care for six months or longer and that a further four per 100,000 require care that can currently only be provided within a hospital setting for even longer periods.

The report acknowledges the broad consensus that the run-down and closure of the old asylum is both desirable and achievable. But it also stresses that closures should only proceed in the context of an adequate provision of alternative community care services. In recent years, there has been growing concern that the two processes have drifted out of phase so that closures are now proceeding in the absence of adequate community alternatives. The main problems seem to lie in developing systems of care for people with relatively recently acquired illnesses, who in the past would almost certainly have been admitted to hospital for a protracted period, but who now are more likely to experience multiple, brief hospital stays interspersed with periods of minimal care and supervision. Concerns are expressed that the shortage of long-stay alternatives to the mental hospital have resulted in some patients with chronic disabilities being unnecessarily detained in acute hospital settings where they are at risk of being neglected by staff who are more used to dealing with the acute phase of illness and where they are possibly at increased risk of assault. Concerns are also expressed about the pressure on acute beds in London, where occupancy is often over 90% and premature discharge to bed and breakfast or other temporary accommodation followed by repeated breakdown and readmission seems to be the norm.

A number of factors are believed to be associated with this overall service deficiency:

1. *A shortage of non-hospital based residential care places for the most severely disabled patient.* The majority of voluntary and local authority residential care homes have low staffing levels and are not designed to manage patients with multiple disabilities or challenging behaviours. Furthermore, in most hospital closure programmes, the most difficult cases tend to be the last to be resettled, either as a planned decision or because of initial failures of community placements and subsequent readmission.

2. *The first step in many hospital closure programmes has been to stop the admission of new cases into long-term care.* This has resulted in an accumulation of patients in acute services who formerly would have been transferred to long-term accommodation but

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who now suffer repeated brief admissions or 'block' acute beds.

3. *Hospital reprovision programmes have so far concentrated on existing long-stay patients.* Typically the number of places in the reprovision schemes exactly matches the numbers of existing long-stay patients and the places are provided on a 'home-for-life' basis. This effectively means that it is not possible to transfer patients between settings of varying levels of support and that vacancies only occur if the patients die or decide to move on themselves.

4. *The philosophy of community care has tended to play down the seriousness of the disability that some patients' experience.* For many years, the optimism of the district general hospital approach with it emphasis on rapid intensive treatment and the extension of this to even more ambitious community mental health centre preventive programmes has tended to hide from view the slow accumulation of severely disabled clients who now form the revolving door population.

5. *Political and economic pressures make it less likely that health authority residential care has any viable future.* Because of changes in Social Security financing, monies which have until recently been used to provide residential facilities will be transferred to mainstream local authority allocations with an encouragement to find non-residential alternatives to care. Taking into account the lack of experience in local authorities, the danger is that because mental illness funds have not been 'ring-fenced', other client groups may become of greater priority, while services for patients with severe mental illness fall by the wayside.

In considering these obstacles, the report acknowledges the need to place residential care in perspective. Structured day activity, sheltered work, welfare right advice, crisis treatments and support for carers are essential ingredients of any adequate modern care package. With such comprehensive care, even severe cases of schizophrenia can be expected to improve in the longer term and some will be able to move on to less intensively staffed environments. But a gloomier perspective reminds us that in the absence of such care, stasis or even deterioration is likely.

The report concludes with a number of recommendations for future policy and practice.

1. Persistent nature of the disability of some mentally ill people needs to be acknowledged in service provision. The needs of this group of patients should be specifically recognised by both purchasers and providers.
2. Plans for the closure of hospitals should not proceed until a clear and realisable plan is in place to provide adequately for both the identified and expected number of severely disabled patients.
3. Services need to be comprehensive, and the distinction between health and social care and the consequent funding separation is artificial and unhelpful.
4. Health and social services should jointly establish clear operational mechanisms to finance and manage services for the persistently disabled mentally ill.
5. At the very minimum, money currently being spent for long-term mentally ill should be wholly preserved for the development of appropriate modern facilities and care.
6. Multidisciplinary teams comprising both social service and health service personnel appears to produce the most favourable outcome and minimises the demand for medical input from acute psychiatric services.
7. The lack of adequate residential provision for chronic mentally ill with persistent difficulties is now a major problem for acute psychiatric services.

To conclude, this report contains little that will come as any great surprise to the majority of practising psychiatrists. However it serves to underline the importance of adequate community care planning for the most disabled members of our society. It draws attention to real deficits in care despite the rhetoric of providers and policy makers. Purchasers and providers need to recognise the existence of the problem and enable solutions which encompass the need for long-term, adequately staffed residential care for a sizeable number of individuals.

The full report is available from the College Publications Department. This summary has been prepared by Professor T.K.J. Craig.

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