

Discharge into the community from a mental handicap hospital

Sir: We would like to relate the findings of a study into the resettlement of ten men with learning difficulties and challenging behaviour into the community from a large hospital for the mentally handicapped. The findings demonstrate the need for specialist care and services in the community for such patients to ensure proper care and prevent re-admission to hospital. The study looked at changes in behaviour, self-care skills and communication skills six weeks after discharge into the community. The mean length of stay in hospital had been 18.2 years and the mean age of the clients was 34.6 years. Each had at one time exhibited challenging behaviours such as self injury, faecal smearing, rectal probing, injury to others, violence to objects and absconding, and each had either moderate or severe learning difficulties. Behaviour, self-care and communication skills were assessed before discharge and six weeks post discharge. Communication skills were unchanged, self-care skills deteriorated and behaviour worsened (continence, self injury, violence to objects and people, absconding and disturbed sleep).

While only a small study it supports the view that maladaptive behaviours increase immediately after discharge into the community. We wonder if others are having similar experiences as our large institutions for the mentally handicapped close.

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Telephone follow-up in mental handicap

Sir: Recently I had to cover the work of a consultant colleague absent for some weeks on account of illness. It was not possible to take over all her community clinics and I had to determine the priorities among her case-load. Newly referred out-patients and patients with continuing problems warranted the most urgent attention. Telephone communication with the patients or their carers proved helpful in decision-making.

The convenience of a telephone follow-up practice makes it useful in routine follow-up cases, especially where the carers are responsible and dependable. Attendances at clinics can be made less frequent, saving carer's time and expense, and also reducing the time the patient has to take off from day care centres or work.

A corollary to the telephone follow-up is the need to have a reciprocal 'Helpline' number which patients and carers can use. A pleasing

result of the calls was that carers expressed satisfaction that somebody was concerned enough to get in touch with them.

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Community legislation: is it psychiatrists who should be committed?

Sir: I take issue with Drs Pierides' & Casey's grounds for rejection of a community treatment order (CTO) (*Psychiatric Bulletin*, 1993, 17, 300). They argue a CTO would be "unenforceable", as guardianship is. In the same issue (p. 276) Symonds describes two cases where the committed use of guardianship facilitated successful treatment and improved compliance. Guardianship is not widely used because professionals are unfamiliar with it, not because it is "unenforceable".

Pierides & Casey go on to say "compulsory treatment in the community is . . . unacceptable to the patient and to the clinical team" and support Professor Sims' rejection of scenarios involving injections "on the kitchen table". Forced administration of injections is never acceptable to the patient whatever the location; yet is acceptable to clinical teams in hospital under section 2 or 3 of the Mental Health Act or "common law" when clinical assessment judges it desirable.

Pierides & Casey describe the virtues of the care programme approach (CPA). In practice when subjects of CPA relapse they are readmitted under section 3 of the Mental Health Act, often after a period of deteriorating mental health and concern to families and professionals alike. CPA has no supervisory 'clout' in legislative terms and is not in itself community care.

Pierides & Casey conclude "if resources continue to trickle down slowly to these . . . patients whatever legislation is introduced will be . . . window dressing". I draw attention to Professor Leonard Stein's view that as psychiatrists we concentrate on episode-oriented care for schizophrenia which has a clinical profile involving both acute relapses and chronic long-term impairment. Unless we commit to both episodic and continuing care to establish a stable community population of patients, funds will continue to be concentrated in episode oriented hospital care.

Why is compulsion only acceptable in hospital? Patients are frequently ready for discharge before the expiry of their section 3 and use of extended leave in the past has been a response to recognition that, faced with poor compliance, some clout is required in supervision. Extended leave affords the opportunity to work with