Eleventh Annual TAPS Conference

Hugh Freeman

The 1996 Conference of the Team for the Assessment of Psychiatric Services attracted a larger audience than ever, including many from overseas. Dr Douglas Bennett looked at the historical evolution of community services over a 50-year period, in which no grand plan can be found. It has been a step-by-step process in which each step has followed either a successful innovation by pioneering psychiatrists, some advance in medical treatment, or a political or social change in our society. In his own experience of working with Dr Maxwell Jones at Belmont Hospital, he had not realised at first how revolutionary it was then for the staff to meet in groups. Wartime experience, when some of the traditional restrictions had to be given up, influenced some medical superintendents to open the doors of their hospitals in the 1950s. When industrial therapy introduced paid work, it provided an adult social role to those from whom nothing had been expected up to then. For chronic patients, social changes were the most important ones; in the 1950s, these started to release both patients and staff from the separate world they had inhabited up to then. The mental hospital ceased to be seen as the centre of psychiatric care; it was replaced by the comprehensive mental health service for a district.

Professor Julian Leff took the opportunity to review the findings of the TAPS project over the past 11 years. These were divided according to the groups of patients studied. Firstly, the long-stay non-demented gained a much less restricted environment, where their negative symptoms decreased, but a high proportion were readmitted during their first year in the community. By the fifth year, levels of immobility and physical ill-health had increased considerably and contacts with relatives had decreased. Those using day activities fell from 81% in the first year to 28% in the eighth year; most of the disabled residents wanted unstructured activities. 'Graduates' who had grown old in the hospital with functional psychoses benefited from discharge to community homes, resulting in an improvement in their behaviour, while patients with dementia also found community homes a better environment than the wards, as judged by their relatives.

When Friern Hospital closed, 72 longstay patients out of a total of 550 were considered too disturbed to be managed in community homes (which had an average of nine residents each). These patients were characterised by aggressiveness, poor compliance with medication, and socially disinhibited behaviour; they were placed in highly staffed facilities (with a ratio of 1.7 to 1), mostly on hospital sites, and were by far the most costly of the long-stay patients to manage. Following the closure of Friern Hospital, the number of admission beds available in other local hospitals was reduced for no rational reason. In fact, for every 100 patients discharged, nine acute beds are needed, but this was not taken into account. Both patients and nurses who had experience of acute care in the mental hospital preferred it to that in the general hospital. After the closure of Friern, more than 50% of out-of-hours admissions were not admitted to the NHS locally, but referred to private facilities. Because of this problem, there was a change in the use of the day hospital, with more psychotic patients being managed there and a shorter period of attendance.

Professor Martin Knapp looked at the 5-year results of the TAPS survey from the economic point of view. Over this period, the costs of both accommodation and day care increased significantly, although the numbers attending day care actually fell. The costs of community services, on the other hand, were reduced; this was particularly true of social work, mainly because there were no staff in post. In the community reprovision programme, successive cohorts have been steadily more expensive. Whereas the cost of the total group to the NHS fell from 65% of the total to 56%, the cost to Social Security increased from 20% to 30%. Total costs are dominated by the cost of accommodation. Although no links have been found between costs and outcome, costs have been linked to individual needs.

Professor David Mechanic, of Rutgers University, New Jersey, said that economic evaluation of 'assertive' community care showed that it is more expensive than conventional psychiatric care. However, there is little indication as to which of the components of 'assertive' care are really effective. The effectiveness of clinical services is the critical factor in relation to outcome. In New York State, efforts had been

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made to change the priorities of care by reform of the reimbursement system. In Medicare, prospective payment had been related to the DRG (Diagnosis Related Group), irrespective of a patient's length of stay or a change in diagnosis. A major problem had been that out-patient costs had risen, while in-patient costs had fallen. Change depends on the expectations of behaviour; changes had occurred at the unit level, but reimbursement is made to the hospital. The new reimbursement system had been introduced into a complex managerial environment, but 'incentives' have to be understood by all those involved and behavioural changes need to be reinforced in a way that is understood by the staff. New York State has come to depend on 100 general hospitals for all acute psychiatric care, and is continuing to close mental hospitals. Current initiatives are to absorb Medicaid patients into managed care programmes, reducing in-patient care wherever possible, but managed care has little experience of chronic illness. Faulty assumptions and poor implementation strategies made the failure of the New York reimbursement reform inevitable.

Turning to the UK, Professor Mechanic said he found excessive optimism that modest managerial changes can put right major problems in services. Gatekeeping by primary care is placed high among the priorities, but will services be sufficiently comprehensive and coordinated? The problem is how to pay for a comprehensive mental health programme in each district; GP fundholders are unlikely to have the interest to pay for this. Private insurers are adopting a 'utilisation management' system, but it is not clear how this may shift costs to the family or community. While the USA is struggling to bring funding schemes together, the UK is breaking them up.

Discussing rehabilitation, Sir David Goldberg said that 'the market' posed a severe threat to these services, particularly in inner cities. Community psychiatrists still have not resolved the problem of whether specialised rehabilitation services should exist, and form part of other community facilities. Various compromise solutions exist, but proper evaluations appear not to have been done. Rehabilitation services need to be adapted to local needs: services in the country will be unlike those in an industrial city. However, as unemployment rates rise in Europe, the advantages of home-based rehabilitation are becoming apparent.

Reporting on the Sainsbury Centre Acute Care In-Patient Study, Beadsmore and colleagues stated that most of the debate on 'community care' has focused on the community elements, but acute in-patient care will still be required. Information was collected on acute services in a nationally representative sample of 38 NHS Trusts in England and Wales. The provision of acute adult beds averaged 0.28 per 1000 population; average bed occupancy was 93%. Services were located solely on DGH sites in 40% of the sample and solely in mental hospitals in 29%. Services in areas of higher social deprivation had a significantly higher proportion of 'new long-stay' (with a length of stay exceeding 6 months). The prevalence of new long-stay patients was also higher in services with DGH-based sites only. Only three services had a 24-hour crisis service available, and only a different three had community intensive support teams (case management).

The conference revealed that comprehensive provision of mental health services throughout the UK remains a very distant goal.

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