

Original articles

The future of services for the chronically mentally ill: a priority case?

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Research into delivery of psychiatric care has shown that the chronic mentally ill (CMI) patients continue to pose major difficulties not only in terms of economic cost to patients, their families and the state but also in the ability of authorities to provide adequate facilities in the community. The latter is especially important now because of rapid discharge of patients into the community from long-stay wards of mental hospitals, often with little rehabilitative preparation and even less consideration of the effects of the environment into which they are relocated. Although follow-up in some cases has been of exceptionally high quality, a majority have filtered through the network into inadequate residence; this surely is unacceptable. The high prevalence of mental illness among the homeless and the difficulties of providing care for them by an inflexible health service have been highlighted by a recent report of the Royal College of Psychiatrists (Bhugra *et al.*, 1991). This paper attempts to define the possible adverse consequences of the recent reorganisation of National Health Service (NHS) on the care of the chronic mentally ill.

The chronically mentally ill (CMI)

Many people suffering from schizophrenia develop social and functional deficits which, in all probability, are non-progressive and susceptible to improvement with intensive therapeutic measures. Several patients with affective psychosis also show incomplete resolution to their pre-morbid levels of functioning with inter-episodic symptomatology and personality deterioration. To these may be added patients with severe dysfunction due to non-psychotic disorders and brain damage.

CMI patients are, probably, the least vocal of the service users because of negative symptoms such as lack of motivation, social withdrawal and a disinclination to benefit from the available facilities. These

deficits ensure that they cannot come together as a cohesive group which can lobby hospital authorities, government or other relevant agencies and the recent appreciation of the need to involve users in health care planning is a welcome development (DOH, 1993). Added to this is the stigmatisation of mental illness and the lay idea that all forms of madness are associated with aggressive and violent behaviour. It is not surprising, therefore, that they are often overlooked during planning; a recent report revealed large inconsistencies in spending by local authorities on patients with CMI ranging from 4p to £15.87 per head with an average of £1.77; this compared with £9.76 for people with learning difficulties and £19.70 per head on the elderly.

Current reorganisation of the National Health Service

The necessity of a radical restructuring of the NHS stems from the spiralling cost of health care, which in recent years has escalated alarmingly, and the need to ensure high levels of efficiency savings. The *National Health Service and Community Care Act 1990* was aimed at fundamentally altering the way in which services are delivered generally; its implications for psychiatric services remain unclear. In principle, the reforms converted the NHS into a closed economy in which the general practitioners (GPs) act as purchasers of health care and can hold individual budgets with the right to purchase health care from any hospital or facility, including privately run institutions, which need not be local to their practice. The opted-out hospitals act as individual NHS trusts with budgets to manage the delivery of health care. It is proposed that consultants play a leading role in management along with supporting managers who implement clinically based administrative decisions. All forms of community care are separated from

hospital services and placed in the hands of the local authority who can purchase any or all elements of community care from facilities within or outside their geographical districts.

This reorganisation has several theoretical advantages which are worth recounting so that the drawbacks can be put into perspective: a form of market economy would improve the delivery of health care since inefficient and 'sick' units would go under; budget-holding GPs, who are better placed to assess local needs, could dictate the services required and shop for the best/cheapest service for their patients; the active involvement of clinicians in management and budgeting would ensure that the services developed would be based on clinical decisions; the element of competition in the NHS would encourage sound management and cost savings; and the transfer of responsibility for community care to local authorities would enable a rapid response to local needs. Although several aspects of the current reorganisation appear attractive, their success is contingent on a number of factors.

Areas of concern

Budget-holding general practitioners

Sectorisation of services and establishment of community mental health centres have been the end product of crystallisation of an ethos which dictated that mentally ill patients should be cared for in comprehensive, integrated, locally-based facilities. GPs now have the freedom to choose a service they prefer and if their choice dictates a centre away from the local facility, then the latter's survival must be in doubt. Rehabilitation procedures are labour intensive and beneficial only if they are provided on a continuous basis (Wing, 1989). Advances such as cognitive rehabilitation, which are now being increasingly espoused for chronic schizophrenic patients and the brain damaged, will only be developed if there are incentives for and willingness on the part of the purchasers to include them on their shopping-lists.

Psychiatrists are considerably more expensive than community psychiatric nurses (CPNs) or even psychologists who in turn are more expensive than unqualified counsellors. GPs could conceivably want to refer patients to the cheaper options even though such referrals run contrary to the currently accepted practice of multidisciplinary decision making for developing care plans. Some general practitioners may refuse the services of the local facilities for reasons that have little to do with clinical needs or financial constraints; personal likes and dislikes of psychiatric professionals in the past may result in vengeful placement of contracts with extra-territorial services.

Trust hospitals

Unlike other disciplines in medicine, psychiatry cannot always provide profitable services or can do so only if it decides to ignore the needs of the CMI. Better facilities for these patients, although expensive, can significantly improve their personal welfare and productivity by reducing psychiatric morbidity resulting in lower long-term costs of maintaining them in the community (Andrews, 1991). Careful secondary prophylaxis in this group can reduce the risk of further relapses (Falloon, 1985) thereby reducing the cost of repeated hospitalisations. However, market economies, even closed ones like the NHS, do not look beyond current profits and investments and usually follow ventures which make a 'quick buck'. Managers of trust hospitals are unlikely to be any different because, in the case of CMI, the returns are not easily audited in the short term.

Many psychiatric units still have tangible assets in the form of land and buildings which can be sold to generate income. In those districts where the psychiatric units have elected to form independent trusts, these funds can be ploughed back into the development of community or hospital psychiatric services. These assets, however, are non-renewable and once used up, the psychiatric units may find themselves hard pressed to develop remunerative services resulting in reduction of care for the CMI. In districts where the psychiatric units opt to join other medical disciplines in their application for trust status there is real concern that their capital incomes may be poached by others depriving them of much needed cash. Such raiding of resources by hospitals is not unknown at least with respect to community services.

Community services/hospital care dichotomy

The distinction between hospital care of a psychiatric patient and his continuing community care is unclear. Thus, several chronic patients in remission may not be successfully managed in the community and require hospital care perhaps of the nature of an asylum or respite (Wing, 1989) especially if they have unremitting productive symptoms in the form of delusions, hallucinations and thought disorder. On the other hand, acutely relapsed patients can often be managed on an out-patient basis in the community if their illness is of a mild to moderate severity and there is a good network of support at home or in a hostel.

Since local authorities are at liberty to purchase services from any one, it is not inconceivable that, if the local psychiatric team is unable to agree a mutually acceptable contract, other agencies may be asked to provide health care in the community. This is perhaps acceptable if the providers are carefully scrutinised and monitored and guarantees obtained about the nature and content of service being offered.

Underfunding and escalating costs of service provision for this group may result in local authorities pruning funds for reasons of financial expedience; these arguments particularly apply to the homeless, the difficult-to-place and the CMI.

Resource management initiatives/clinical directorates

Theoretically, clinical directorates offer an opportunity for the clinicians to take a leading role in the provision of health care. In practice, this depends much on the willingness of the managers to relinquish control to which they have become accustomed. In some districts visited by the authors, the managers have actively encouraged consultants and other clinicians to lead the management team with the provision of support management staff. In many, however, managers have contrived to remain in control of budget(s) as well as all current and forward planning, with clinicians being left with the responsibility of carrying out decisions to which they are not a party. Although lip service has been paid to the need for consultants with management responsibilities to receive adequate remuneration and re-allocation of clinical duties, this has often been ignored or limited to increasing their salary by one or at most two extra paid sessions.

Cost improvements in the community

It is generally accepted that the NHS is inefficient in several areas and that significant cost-improvements ('efficiency savings') can be made with careful auditing and appropriate budgeting; these, however, have often been imposed without any specific directions. To produce significant savings, cuts have to be directed at reasonably large units such as a whole ward; in one newly opened acute psychiatry unit, cost improvements resulted in a quarter of the beds (one whole ward) being closed after only eight months! Certain areas such as staff retrenchment cannot be used for this purpose because of political sensitivity and even if posts in various disciplines are frozen, many get converted to managerial positions; there has been a 900% increase in personnel costs of administrative relative to clinical staff over the past five years, most of it since 1990. The idea of a blanket freeze on renewal of posts to produce efficiency savings may be convenient but is unrelated to clinical requirements and, therefore, more harmful to the service. Clearly, if clinicians have to decide on savings, they can carefully consider the pros and cons of any post in relation to the local service and decide which posts are least indispensable.

Comment

The importance of developing care plans for the CMI is now accepted; the possible impact of the new

proposals for restructuring the NHS on this group of under-privileged patients is not yet clear although several areas need careful consideration *The Health of the Nation* (DOH, 1993) defines several areas in which there is an imperative need to identify basic information about mental disorder.

The needs of CMI are ongoing (Wing, 1989); it follows that the remedial therapeutic procedures for them should be sustained in one form or another and their long-term needs must be defined during the process of service development. Statistics about the emergence rates of new long-stay patients and the staffing implications for rehabilitation units and depot neuroleptic clinics are either already available, or can easily be collected, to make a reliable assessment of budgeting requirements; these should be incorporated in the early stages of forward planning. The expense involved in the development of such programmes requires a mechanism by which these costs can be protected. It is appreciated that ring-fencing for psychiatric care was rejected during the formative years of the current proposals but it should still be possible to 'protect' these budgets in some way locally, perhaps through a commitment at the executive level.

Most CMI patients will continue to suffer relapses whether through social factors, non-compliance or poor implementation of secondary prophylaxis; facilities for acute psychiatric care should be given high priority in the development of services. Short-term admissions for acute relapses are probably the most cost-effective method for treating acute relapses; irresponsible closure of acute wards or day centres for short term adjustment of monetary deficits are a recipe for disaster both in terms of distress it causes the patients and relatives, high risks of suicides and persistence of uncontrolled psychoses in the community. Finally, it is essential that the control of service delivery should be in the hands of clinicians who have contact with patients and an understanding of their needs. Abrogation of this responsibility to the managers who will make decisions on financial expedients would produce a service that is far removed from the needs of the community. These arguments also apply to care programmes developed by local authorities; managerial control under whatever guise has a long history of failure in this field.

References

- ANDREWS, G. (1991) The cost of schizophrenia revisited. *Schizophrenia Bulletin*, 17, 389-394.
- BHUGRA, D., BULLOCK, R., MARSHALL, J., TIMMS, P. & KINGDON, D. (1991) *Homelessness and Mental Illness*. Working party report on behalf of Executive Committee of the General Psychiatric Section of the Royal College of Psychiatrists, London.

DEPARTMENT OF HEALTH (1993) *The Health of the Nation: Mental Illness Key Area Booklet*. Heywood, Lancashire: BAPS Health Publications Unit.

FALLOON, I. R. H. (1985) *Family Management in Schizophrenia*. Baltimore: John Hopkins University Press.

WING J. K. (1989) The concept of negative symptoms. *British Journal of Psychiatry* (Suppl. 7), 155, 10–14.

A full list of references is available on request to Dr Soni.

Psychiatric Bulletin (1993), 17, 585–586

A community treatment order in practice

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The Island of Jersey is a separate country from the United Kingdom and has its own laws. In the Jersey Mental Health Law, 1969, there is a community treatment order in which the guardian appointed has the powers of a father over a child (under 16). This law was implemented on 1 January 1972 and in this paper we look at the way in which it has been used in the 18 years between 1 January 1972 and 31 August 1990. We are not suggesting that the way in which we have used it has been the right or only way. We are engaged in description not prescription.

We have not found that the order gives rise to difficulties or controversy in practice. The guardian may act in a preventive manner and can intervene before a crisis develops. Incidentally, in the Jersey Law, the mentally handicapped patient is described as a "person requiring special care".

Between 1 January 1972 and 31 August 1990, 126 patients were placed under Guardianship Orders, and the patients were in five diagnostic categories: 31 patients needing special care; 31 patients with schizophrenia; 37 patients with dementia; 17 patients with alcoholism; and 10 patients with affective disorder, chiefly manic depression.

Most of the patients with alcoholism and manic depression under Article 21 willingly submitted to the order (the consultant usually promising to discontinue it if the patient, when well, so requested) because they themselves felt the need for some external control, seeing the havoc the illness was wreaking in their lives.

The order failed to achieve its purpose in 12 cases (one special care, four schizophrenic, three dementia, three alcoholic, and one affective) and was therefore discontinued.

The order was successful in achieving its purpose in 108 cases. The order was partly successful in six cases (all alcoholics who reduced but did not stop their drinking: the degree of improvement was

judged worthwhile by all six patients and their families). In the successful cases it has often been possible to allow the order to lapse after a few years when new patterns of behaviour and habits have been established and good relationships with community nurses formed and consolidated. This has happened in seven cases in need of special care, six cases of schizophrenia, 22 cases of dementia, one case of alcoholism and seven cases of affective disorder.

So, this order has been found to be useful in 90% of cases for whom it was thought suitable, and it has been allowed to lapse, with preservation of the benefits gained, in 33.3%.

Before giving case reports as examples it is necessary to point out limitations of the order, particularly its use for the administration of medication to schizophrenic patients who, from previous experience, would not otherwise take medication. The typical patient is on depot antipsychotic drugs and, at the time of his first refusal of an injection, will usually be mentally too well to justify admission under an order; in Jersey, the community psychiatric nurse (CPN) faced with this situation, reminds the patient of the existence of the order (which will have been clearly explained at the time of its inception) and points out that continued refusal will almost certainly lead to readmission and re-establishment of medication: the CPN makes no effort or threat to force the patient to have the injection or to readmit immediately. In the elegant phrase of our nurse author "the order is used to enhance and reinforce the ability of the nurse to persuade". It is obvious that much depends on the community nurse. The existence of an order does not prevent the forming of a good relationship as can be seen daily in any well-run admission ward.

If the nurse is unsuccessful in persuasion then, as in the UK, we have to wait until a crisis develops to remove the patient to hospital forcibly: in such a