Psychological Medicine

MONOGRAPH SUPPLEMENT 2

Long-term community care: experience in a London borough

edited by J. K. Wing

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Psychological Medicine

J. K. Wing (editor):
Long-term community care:
experience in a London borough

Part I. A survey of long-term users of the community psychiatric services in Camberwell

Part II. A hostel-ward for 'new' long-stay patients: an evaluative study of 'a ward in a house'

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Foreword

J. K. WING

Studies of the psychiatric services in Camberwell carried out up to 1971 by members of the MRC Social Psychiatry Unit in association with local colleagues in the helping professions were presented or summarized in a collection of papers published in 1972. Much of this work was based on samples, or presented within the context of statistical data, drawn from the Camberwell Register, established in 1964 and maintained continuously since (Wing & Hailey, 1972). A comparison of statistics from the Camberwell and Salford Registers, covering the psychiatric and mental retardation services, has subsequently been published (Wing & Fryers, 1976). More recent work on the epidemiology of mental retardation in Camberwell (L. Wing *et al.* 1976; L. Wing & Gould, 1979; L. Wing, 1981) and on the distribution of mental disorders and mental ill-health in the general population of the area (Bebbington *et al.* 1981*a*; Wing *et al.* 1978, 1981) has required the development of new techniques of measurement in order to allow more rigorous tests of hypotheses concerning aetiology or treatment. This work has also contributed to an understanding of the similarities and differences between the needs of people with various kinds of disorder and of the ways in which services can be made more responsive to those needs.

Work with the group of people designated by the Department of Health and Social Security as the 'adult mentally ill' has continued along several lines, notably in studies of non-hospital accommodation such as hostels, hotels and group homes (Hewett *et al.* 1975; Ryan & Wing, 1979), of the problems of 'living with schizophrenia' for patients and relatives (Creer & Wing, 1974; Leff *et al.* 1982; Vaughn & Leff, 1976; Wing, 1978), and of the relationship between mental illness and destitution (Leach & Wing, 1980). A summary of this work is given in Wing & Olsen (1979).

Two issues in community care are particularly important in the context of the current run-down of bed-occupancy in large English psychiatric hospitals, from about 350 per 100000 at the peak in 1954 to about 170 per 100000 at the end of 1978. (The run-down in Scotland has been much slower, reaching about 330 per 100000 at the end of 1979.) One of these issues concerns the needs of people recently admitted to hospital who are still spending periods longer than a year as in-patients in spite of all efforts to prevent this happening. Unit members carried out two studies – one in Camberwell, the other nationally – in order to make at least a crude estimate of the proportion of such people who might be able to live in alternative accommodation if this were provided (Mann & Cree, 1976; Mann & Sproule, 1972). Although such estimates are bound to be subjective and variable, it seemed clear that many such patients were more severely disabled than those living in non-hospital accommodation provided by local authority social service departments and voluntary organizations, or in private or commercial settings such as hotels and nursing homes. This, together with financial constraints limiting the provision of additional community facilities, meant that further hospital accumulation was likely. The idea that health authorities should provide suitable domestic-scale accommodation within the locality seemed a sensible one, and this suggestion was put forward in 1973. The first such 'hostel-ward' was opened by the joint Maudsley and Bethlem Royal Hospital in 1977 and provided an opportunity for the study described in Part II of the present monograph.

The other major issue concerns the needs of people who are not long-stay in-patients but nevertheless continue in long-term contact with community services of various kinds, including day or residential units. This is an important group because of the likelihood that many of the people concerned would, in the past, have been at high risk of becoming long-stay hospital residents, and there has been much disquiet as to the adequacy of the alternative services now being provided. It is difficult to carry out such a study without using a case-register as a sampling frame, and little work of the kind has been published. The study described in Part I of this monograph was an

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exploratory survey intended to provide information on which tentative recommendations for local service innovations could be made.

The two surveys described in this monograph have wider than purely local implications because, with modifications due to different socio-demographic characteristics and patterns of service, the problems dealt with are universal in countries where large populations of residents have previously built up in psychiatric hospitals or where they are still doing so. A key calculation can be made on figures given in the two parts of this monograph. The rate for long-stay patients (over one year stay) in English hospitals at the end of 1978 was 114 per 100000 population (see Table 1, Part II). The unduplicated rate for Camberwell people in other residential care (i.e. short-stay in-patients, hostel and group home residents), or in day care, who had been in contact with psychiatric services of some kind for at least one year, is 139 per 100000 population (see Table 2, Part I). If the two figures are added together, the resulting rate of people utilizing hospital and community services – 253 per 100000 – can be used as a very approximate estimate of the numbers of people with chronic psychiatric disorders of the kind that used to result in a high risk of long-term hospitalization. The rate is minimal, at least for conurban areas, because not everyone at risk could be included in the Camberwell sample. Even so, it represents 71% of the peak (1954) bed-occupancy rate.

Thus, though English planners are rightly reluctant to accept the Scottish bed-occupancy rates as an accurate indication of present-day need for in-patient services, the results of the two surveys described here are highly relevant to the provision of adequate alternatives. They may also be of interest to Scottish planners. We do not at all claim that the specifics of the Camberwell experience can be applied directly to other localities, but we are quite sure that our conclusions and recommendations, tentative and parochial though they may be, address issues that all clinicians and administrators, throughout Europe and North America, will recognize and that few of them can regard as satisfactorily solved.

Finally, a point made in detail in the text of both parts of the monograph deserves re-emphasis here. Evaluative research, like other forms of research, relies on replication for the accumulation of knowledge. Exploratory studies, even those with an epidemiological base, specified samples and a replicable methodology, cannot supply final answers to the questions they are designed to investigate. Indeed, they are of little use unless they lead to further studies, including some with more controlled designs, which will put to the test the ideas and hypotheses they have generated. Fortunately, there is an increasing interest in this kind of research and a better understanding of its limitations as well as its advantages. The advantages, which are considerable, cannot be obtained except by carefully recognizing and respecting the limitations when interpreting the results and by ensuring that more rigorous tests do follow.

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PART I

A survey of long-term users of the community psychiatric services in Camberwell[1]

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We should like to acknowledge the help given by Jane Hurry in designing the sampling frame used in the study and supplying the names of patients. We should also like to thank Paul Bebbington, Jane Hurry and Christopher Tennant for permission to use data from their community survey for purposes of comparison. We are grateful for the cooperation of medical staff, those working in the community facilities, and relatives of the patients. Lastly, we should like to thank the patients themselves for talking to us.

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