The Maudsley Daily Living Programme

A controlled cost-effectiveness study of community-based versus standard in-patient care of serious mental illness

ISAAC MARKS, Professor of Experimental Psychopathology, JOE CONNOLLY, Consultant Psychiatrist and MATTIJS MUIJEN, Research Worker/Honorary Senior Registrar, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5

This paper outlines a three-year controlled study, funded by the Department of Health and Social Security, which started at the Maudsley Hospital in October 1987. The research will compare seriously mentally ill patients maintained outside hospital on the daily living programme (DLP) with standard hospital-based care, and devise a multi-disciplinary training course in DLP for mental health care providers. It will be the first UK attempt at controlled replication of successful controlled studies from North America and Australia, and the first anywhere to devise systematic training in the approach.

Background

In the last 20 years many controlled studies have compared the treatment of serious mental illness (SMI) in the community as an alternative to standard in-patient care. Several randomised controlled trials were completed in the USA, Canada and Australia. In the UK a quasi-experimental design was executed[1] comparing a service which relied on in-patient beds with a service which expanded community resources. The controlled studies allow the most reliable conclusions.

The most extensive controlled studies were those in Madison, Montreal and Sydney.[2-4] All three studies included patients with SMI in need of hospitalisation. These patients were randomly allocated either to care in the community or orthodox hospital care. Only patients with brain damage or substance abuse were excluded. Minor differences between the studies were present, such as the exclusion of patients without fixed abode by the Montreal study.

Community care was based on a combination of problem-oriented crisis intervention, rehabilitation maintenance, with slight variations in emphasis between the studies. Brief periods of admission occurred in all these studies for high suicide or homicide risk, intolerable social burden or severe disturbance.

All three studies found that, compared with standard in-patient care, treatment based mainly outside hospital yielded similar or superior outcomes on various measures. It reduced the clinical symptoms of SMI at least as much or more so, improved daily role function more quickly, and reduced or did not increase the burden on other people; it was also less expensive, the added cost of support outside hospital being outweighed by the lessening of in-patient costs. None of the more than 10 controlled studies found better outcomes in the standard hospital care group.

The good results of such studies must be put in perspective. The cost savings of DLP were worth having but not huge—4%–25%. Clinical and social gains were real but nonetheless limited—many SMI patients continued to be anxious, depressed, and inactive; only a minority could achieve employment on the open market, live with relatives, and come off medication. When this was withdrawn after 14 months of support in the natural setting the gains were steadily lost. To be effective DLP had to be long-term, though the amount needed might fall over several years. Patients were not cured by DLP. Rather, despite some continuing deficits, they became able to function in the community and cope with occasional stresses while consuming fewer health care resources.

DLP support for patients and their existing network (families, neighbours, landlords, employers and others) usually averted the need for admission (in-patient time dropped by 75%) and improved the quality of care at lower cost. Emergency cover was on offer 24 hours a day, but calls for help came mainly during normal working hours and less so in the early evening, while the midnight shift was called infrequently. Nevertheless, even though help was little used, the knowledge that it could be had whenever needed reassured supporters outside hospital and prevented many admissions.

The Madison study achieved its results even though at the time its catchment area had *no* outreach support such as emergency crisis beds, hostels, group homes, or other special residential facilities, and it had no day hospital. At the time Madison had only a conventional mental hospital, YMCA-rented rooms, and hotel rooms. Later, a halfway house and sheltered apartments were added.[5] Madison care now aims to help SMI patients to live in their own homes with DLP outreach support, and to provide a few group homes with no other specialised living arrangements.

The Madison training in community living programme, as they call DLP, has continued to maintain a high standard of care at low cost over 13 years—length of in-patient stay and readmission rate are less than half the national average.

https://doi.org/10.1192/S014007890001899X Published online by Cambridge University Press

Its outcome thus cannot be attributed to a brief burst of research enthusiasm. Other permanent psychiatric services based on DLP principles are being run in the large city of Sydney, Australia, in Spokane, Washington, in Kent County, Michigan, and in inner city Chicago.

Results in Sydney and inner Chicago suggest that DLP could be applied to the deprived inner city area local to the Maudsley Hospital. If the DLP model succeeds in South Southwark and nearby it should also be applicable to other UK inner city areas.

The treatment model to be used at the Maudsley

The controlled work yielded a model of care like that for diabetics or rheumatoid arthritics, who require not long-term admission but a daily living support network to deal with the crises and give ongoing aid throughout illnesses (schizophrenia, severe affective disorder) that tend to be lifelong with periodic remissions and relapses. A comprehensive service for SMI would include 24-hour access for crisis resolution (at home, work or elsewhere if necessary), out-patient clinics, some long- and short-term in-patient facilities, day care, and specialised living and work aids.

Ongoing support has to be given not only to the patient but also to people who have regular contact with him/her at home, work and elsewhere—families, neighbours, landlords, employers, police, shopkeepers. Programmes must be individually tailored according to patients' particular needs for housing, finance, socialisation, and medication. Many patients in hospital fail to generalise their skills; in the DLP each patient has to be taught at the site where he will need his skills—in the particular home he will live in, shop he will buy food at, site where he will work.

Patients are often lost to follow-up, so determined follow-up is essential to prevent relapse. It is necessary to monitor all cases and give carers access to an up-to-date information pool to prevent patients from slipping out of the support network. A co-ordinated system of carers and resources is crucial, with flexible deployment of resources to where they are needed.

The study

The study will take in all local cases aged 17–64 of SMI (schizophrenia or severe affective disorder) who have not been in touch with the Maudsley over the last year at the moment a psychiatrist decides that they require immediate admission. The psychiatrist will then phone the research office in the Emergency Clinic (EC) to signal the patient's entry into the study, will be told whether random assignment is to DLP or control (standard hospitalisation), and act accordingly. Severely ill and involuntary patients and those of no fixed abode will all be included. The only exclusions will be cases with organic brain syndrome, mental handicap or substance abuse.

At study entry cases will be randomised to either standard in-patient care or DLP. Most DLP will be outside hospital, but DLP patients will not be kept out of hospital at all costs—sometimes brief emergency admission for a few days will be the most humane and safe management in the initial stages of a crisis, and these will be under the care and part of the cost of DLP.

About two cases a week are expected (one to DLP and one to control). Every case will continue to be followed up and cared for by the team for the rest of the three-year study period. A clinical cohort of steadily increasing size will thus build up, reaching its maximum two and a quarter years after the controlled phase starts at the end of the first three pilot months.

All cases will be assessed by a psychologist with assistance from an economist at trial entry, 3, 9, 18 months and beyond, on clinical and social function, family burden, and resource utilisation.

The great bulk of Maudsley emergency first admissions come through the Emergency Clinic (EC) which is directed by Dr Connolly. The DLP would thus avoid the problem that consultants who agreed to collaborate failed to refer patients to their project.[6]

Staff loads in the Maudsley DLP project will be similar to those in the Madison controlled study and in the Chicago inner city uncontrolled study. The DLP project staff will not be involved with the 100 control patients, only with the 100 DLP patients, of whom 20 will probably need little input after the first three months. The available staff of eight nurses, one social worker, and a training psychiatrist yield a staff : patient ratio of 1 : 10 to carry out crisis resolution, mobile community outreach, and out-patient work. Other care components will be covered by existing Maudsley services—EC to run the 24-hour phone-in service, brief emergency admissions, day care on wards and some community outreach under the responsibility of Dr Connolly for those who need it, and long-term care from the District Services Centre.

The nurses, social worker and psychiatrist will provide most of the full-time crisis resolution, mobile community outreach and support for day care that SMI cases in the study will need. Some existing other staff (nurses, social workers and psychiatrists) will contribute to the DLP programme as needed, including the midnight shift of the 24-hour phone-in service.

The study will allow an analysis taking clinical, social, family and economic issues into account.

This project hopes to provide further evidence that patients with SMI can be treated in their own community, avoiding the 'revolving door syndrome' by strengthening their coping strategies when and where they are most needed. It also hopes, together with other research currently in progress in the UK, to produce some guidelines about how community psychiatry can be implemented humanely as well as cost-effectively and how to train staff in such care.

References

[1] Grad, J. & Sainsbury, P. (1968) The effects that patients have on their families in a community care and control psychiatric service: a 2-year follow-up. *British Journal of Psychiatry*, **114**, 265–268.

[2] Stein, L. I. & Test, M. A. (1980) Alternative to mental hospital treatment. *Archives of General Psychiatry*, **37**, 392–405.

https://doi.org/10.1192/S014007890001899X Published online by Cambridge University Press

[3]FENTON, F. R., TESSIER, L., STRUENING, E. L., SMITH, F. A. & BENOIT, C. (1982) *Home and Hospital Psychiatric Treatment*. London: Croom Helm.

[4]HOULT, J., ROSEN, A. & REYNOLDS, I. (1984) Community orientated treatment compared to psychiatric hospital orientated treatment. *Social Science and Medicine*, **18**, 1005–1010.

[5]TEST, M. A., KNOEDLER, W. H. & ALLNESS, D. J. (1985) The long-term treatment of young schizophrenics in a community support program. In *The Training in Community Living Model: A Decade of Experience*. New Directions for Mental Health Services, no. 26 (Eds L. I. Stein & M. A. Test) San Francisco: Jossey-Bass.

[6]PLATT, S. D., KNIGHTS, A. C. & HIRSCH, S. R. (1980) Caution and conservatism in the use of a psychiatric day hospital: Evidence from a research project that failed. *Psychiatry Research*, **3**, 123–132.

A full list of references is available from the authors on request.

Miscellany

New and re-launched journals

Sexual and Marital Therapy is the official journal of the Association of Sexual and Marital Therapists. It is an international journal for professionals from all disciplines who are concerned with helping people with marital and sexual difficulties. It publishes original research, review articles, therapeutic innovations, counselling techniques and leading comments by authorities on the subject. Short communications, book reviews and a critical review of recent literature are also included. There is a discount of 50% on the subscription rate for individuals. Readers of the *Bulletin* can receive an order form and free inspection copy of the latest issue of the journal by writing to the publishers: Carfax Publishing Company, PO Box 25, Abingdon, Oxfordshire OX14 3UE.

The *Irish Journal of Psychotherapy and Psychosomatic Medicine* was re-launched in September 1987. It began in September 1982 as the *Irish Journal of Psychotherapy*, was published for three years, and has now recommenced with expanded title and concept to encompass general psychiatric and psychosomatic topics. The Journal will accept relevant original articles, review articles, case reports, book reviews and letters to the editor when manuscripts are prepared in accordance with the Vancouver style. Instructions to authors are given in Volume 4, No. 1, September 1987. It is published twice yearly in March and September. Subscription rates are IR10.00 annually. Submissions and correspondence should be sent to the Editor, Irish Journal of Psychotherapy and Psychosomatic Medicine, St Brendan's Hospital, Rathdown Road, Dublin 7, Republic of Ireland.

New title for Cruse

Cruse, formerly the National Organisation for Widows, Widowers and their Children, has become Cruse—Bereavement Care. Founded in 1959 to help younger widows with children, Cruse's help—through counselling, advice and information on practical problems and opportunities for social contact—is now available to all those bereaved by death.

Bereavement Care journal is published by Cruse three times a year for all counsellors and others who wish to deepen their understanding of bereavement. It is available on subscription only (1988 subscription in UK: £4.65, including postage).

Further information: The Information Officer, Cruse, Cruse House, 126 Sheen Road, Richmond, Surrey TW9 1UR.

Award

Dr Simon Wilkinson has recently been awarded the first Merck prize for research in child psychiatry. This prize is awarded under the aegis of the European Society of Child and Adolescent Psychiatry for "the distinction of extraordinary work in the range of child and adolescent psychiatry" by those under 40 years old. The title of Dr Wilkinson's paper was 'Pretend Illness': an analysis of how communication patterns foster particular forms of complaining.