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Keynotes

Services for the severe mentally ill – a planning blight*

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The College has become increasingly concerned about the failure to achieve what has for many years been a reasonable policy for the chronic mentally ill. This paper will outline the significant effect that the blight in provision of services for this group of patients has had on mental health services as a whole, the extent of the shortfall and the effect on the patients themselves.

Failure to provide appropriate facilities in the community and in hospitals for the long-term mentally ill is beginning to cause severe shortfalls in the availability of services for the acute mentally ill as acute mental hospital beds are increasingly occupied by this chronic severe group. Although plans have been outlined by the Department of Health and existed for many years in many if not most districts in the country, economic shortfalls and priorities have failed to provide the anticipated facilities in the community for this group of patients who, though small in number, make a large demand on services. The result has been an excessive and inappropriate use of the in-patient facilities for people who do not require to be in hospital while at the same time failing to plan and provide for the in-patient care which is really needed.

The survey of East Lambeth Health District's use of psychiatric beds by Holloway *et al* (1988) examined use of all psychiatric beds available for East Lambeth District 12–18 months after access to long-stay beds at Cane Hill Hospital ceased in 1986. They found that 59% of in-patients could have been cared for more appropriately in the community if there had been a full range of extra-mural services. Even allowing for uncertainty due to the subjective nature of the judgements required, this finding reveals an inappropriate discrepancy between patients' needs and the services provided. The 41% of beds occupied by chronic patients who might better be cared for in the community represent an expensive use of hospital facilities in a way that does not best meet patients' needs.

Indeed, the accumulation of increasing numbers of chronic psychiatric patients in *acute* hospital beds was anticipated by the Audit Commission's 1986 review of community care services which stated that the reduction of National Health Service hospital provision for the mentally ill and mentally handicapped had run ahead of a build-up of community services although the situation varied considerably from one district to another. This adverse report and that of the Parliamentary Social Services Committee (1989/90) were thought to have triggered Sir Roy Griffiths' review and recommendations that Social Services become responsible for securing community care services for the chronic mentally ill in the community. This legislation, subsequently delayed, came into force in April 1992 with funding to be met by a specific Community Care grant which is now going to be only partly supported by government to a level which the Parliamentary Joint Social Services Committee regards as grossly inadequate.

Psychiatric beds have progressively decreased since 1954 with a 30% decrease between 1979 and 1989. The rate and extent of bed closures in the United Kingdom is only equalled by that in Italy, while psychiatric bed provision in most continental countries has decreased only slightly. The reduction of some 20,000 psychiatric beds since 1980 was accomplished by the combination of natural attrition due to the high proportion of elderly among the old long-stay population, together with a policy of not placing new patients with persistent illness in long-stay beds. Indeed, all studies that we know of demonstrate that most chronic patients can be cared for better in the community and that the majority who have moved from hospital to community residences function better and do not wish to return to hospital when interviewed, regardless how meagre the nature of their new facilities might be regarded by others.

We do not have accurate figures to indicate what proportion of the decrease in beds can be accounted for by attrition but the increase in Day Hospital facilities has been only 7,000 in the ten years that 20,000 beds have closed and new cases of chronic mental illness have continued to accrue during this period. MacMillan *et al* (1986) reported that there were 3,871 first admissions for schizophrenia in 1986 of whom 40% can be expected to have severe or chronic conditions. The increase in residential accommodation for the mentally ill in the community

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was not dramatic – under 6,000 places during the same ten year period. Most of these were due to an increase in provision in the voluntary and private sector during the past ten years, with a negligible increase from local authorities. This falls short of an estimated 15,000 new cases of schizophrenia who can expect to be seriously disabled during this period and that group makes up only one half to two-thirds of psychiatric patients requiring long-term community support. However, many of these will be cared for at home until their parents become too old or frail, or die.

There is an increasing problem of homeless people who have high rates of mental illness, as well as up to 30% of the prison population who have been estimated to be psychiatrically disturbed, and a quarter of people in the Salvation Army Hostels. These organisations have given evidence to the select Social Services Committee.

The current situation has arisen from a combination of factors.

(a) A proper desire to provide patients suffering from chronic mental illness with a place they can regard as home. (The evidence suggests that with financial support costing no more on average than uninspired chronic hospital care, this should be feasible for most patients.)

(b) Failure to recognise the nature and severity of the persisting problems of at least a minority of patients.

(c) The pressure of government policy, now 30 years extant, but with a new determination to close all psychiatric hospitals, particularly in the past 10 years.

(d) The desire by managers to recoup monies invested in the running of large psychiatric hospitals and shift the running costs to other services, or as is often the case, redirect the savings to help alleviate financial shortfalls in the acute services.

(e) The financial problems experienced by most health districts in the UK as the hidden rising costs of the management surpasses the modest financial increases that have been granted to the NHS.

The hidden crisis for the acute services

Recent surveys point to the problem of the new long-term mentally ill (note that after 15 years the term "New Long Stay" has become paradoxically misleading). These studies indicate that a third of the new long-term mentally ill have organic brain damage from a variety of causes including head injury or alcoholism superimposed on chronic functional psychosis. Up to a half are dangerous to others or would cause serious problems if allowed to circulate unsupervised in public and about half are multi-handicapped with, for example, poorly controlled fits, diabetes or refusal to take thyroid supplementation, or, for example, a patient who continues to require frequent operations because she thinks that by eating nails she will turn into butter, or a man who has had six admissions over three years but after each discharge either locks himself in his room or is never there when the carer visits, and abuses alcohol, and avoids taking his medication, and has frequent readmissions to hospital.

These patients accumulate slowly so that the problem does not become visible for perhaps five or more years after access to chronic beds has been cut off. The problem is one of multiple admissions, failed placements in supervised hostels, and eventual referral to a district rehabilitation team through which they are transferred back to the acute ward some 18 months later because of the failure to find placement in the community.

In their study of five Surrey mental hospitals, Clifford *et al* (1991) estimated the rate of accumulation of such patients as about 2.5 per 5 years per 10^6 population. Other studies, none of which have included a follow-up of more than two years, find that up to 11 patients per 10^6 population require higher dependency asylum care, or 15 beds per 100,000 population if so-called "graduate" over 65-years-old former chronic psychiatric in-patients are included (Holloway *et al*, 1988).

All studies of high dependency facilities with two or more nurses on duty on a 24 hour basis find that a proportion of the new long-term (perhaps one third) cannot be maintained in a ward in the community while another one half will move out to less intensively staffed accommodation over a five year period leaving a third who are there, unable to move on, and need to be supported indefinitely in the intensively staffed facility.

Estimates from various sources suggest that 11 beds per 100,000 population are required in a highly staffed hospital-like setting which offers relatively long-term active treatment. In addition 40 beds per 100,000 are required for acute psychiatric services, and 50 per 100,000 for community places spanning a wide range of levels of dependency ranging from residential care with 24 hour staff supervision to group homes or clusters of flats with minimal staff supervision.

The government have apparently planned for local authorities to receive a specific grant of two thirds the cost of the upkeep of such patients through a grant administered by regional health authorities. Unfortunately up to now most of the new long-term mentally ill group are only getting these facilities by default by remaining in acute beds. This hidden group needs to be planned for because in the end it will infringe on any modern psychiatric service, blocking acute beds and preventing acute admissions. It is the group which managers and clinicians fail to notice until their stand-alone services have been

operating some three to five years, a group who often do not even have the luxury of being currently planned for, which can at least be said of those high dependency mentally ill who are likely to respond to short-term rehabilitation. This is a problem which members of the College have a responsibility to bring to the attention of the new purchasing authorities.

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A full list of references is available from the author on request and the paper has now become the subject of a College report, prepared by a sub-committee of which the author was Chairman.

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Original articles

Are psychiatric case-notes offensive?

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During the last decade there have been a number of legislative changes establishing and extending the rights of patients to have access to their own medical and social service records. The Data Protection Act 1984, as modified by the Subject Access Modification Order 1987, gave patients access to computerised medical records with certain restrictions, in particular for information thought to be harmful to patients. The Access to Personal Files Act of 1987 granted access to Social Services Records. Again there were restrictions, e.g. to protect clients from serious harm or to protect confidential staff judgements. Finally, the Access to Health Records Act of 1990, which took effect on 1 November 1991 gives patients access to their own medical records and enables them to correct inaccuracies which they may find. Information likely to cause serious harm to the physical or mental health of the patient or of any other individual who could be identified can be withheld.

Since the late 1970s there has been an increasing number of publications on patients' access to medical records. Most have explored the attitudes of medical and psychiatric patients and a few the attitudes of doctors towards patients' access to their own notes. Patients were reported to be mainly in favour of access, although not all would want to exercise this right to see their own records. Doctors, on the other hand, were divided in their opinions, some being opposed in principle.

In its guidelines on the Access to Health Records Act 1990, the Royal College of Psychiatrists (1992) emphasised the importance of avoiding "offensive pejorative comments" and encouraged case-note audit of this problem. We now report the first study of offensive comments in psychiatric and medical case-notes. In particular, we wanted to find out the following:

(a) the nature and extent of comments which might cause offence to patients reading their own notes
(b) whether psychiatric case-notes contain more offensive comments than general medical case-notes

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