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Annotation

Community Care

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Community care has lost its innocence. Critics and evangelists vie for television space and newspaper headlines. The Chief Medical Officer had to beg for clarification of a term that had developed too many meanings and an "ethos of virtue" (Acheson, 1985). How should it be defined? Can a hospital be part of the community? Does it mean care 'in' or 'by' the community? The Department of Health and Social Security (DHSS) definition seems to be "the provision of alternatives to long-term institutional care for the chronically sick or those suffering from long-term handicaps or disabilities" (Hunt, 1985). Lord Trefgarne (1984) put the policy aim, more simply, as "to move out of hospital those people who do not really need to be there".

Yet while comment and initiatives are numerous, specific and valid research into the effects of deinstitutionalisation remains limited (Braun *et al*, 1981). Stein & Test (1980) in Madison, Wisconsin, used a clear conceptual model and random assignment, and only excluded those with severe organic brain syndrome or primary alcoholism. Otherwise, everyone between 18 and 62 years, from a defined area, and seeking admission to the local mental health facility, was included in the experimental or control cohort. The former were cared for by a retrained ward staff team, available 24 hr a day, providing intensive and 'assertive' support to patients at home, at work, and with their families; the latter went through routine hospital or out-patient services. At 14 months, the experimental, 'community-treated' group had enhanced personal functioning, better compliance with medication, less personal distress, and greater satisfaction with their lives. Discontinuation of the programme led to a sharp deterioration and marked increase in hospital usage. The researchers concluded that comprehensive and ongoing care, aimed at maintaining patients in the community, was the most effective treatment strategy. Their parallel cost-benefit analysis (Weisbrod *et al*, 1980) also showed that this involved larger (by about 10%) treatment costs, but "smaller costs in every other form: indirect treatment, law enforcement, maintenance, and family burdens". The difficulties of assessing the economics of mental health care are, of course, notorious, and liable to increase if cuts affect data collection (British Medical Journal, 1987).

Another study (Hoult, 1986) in North Sydney, Australia, reflects much of the Madison group's findings. Again, an enthusiastic and "assertive" community team, providing 24 hr support and with a psychiatrist "on call continually", was compared with the traditional hospital-based care. However, high initial admission rates and neurotic syndrome scores for the control group, broader exclusion categories, and a less clear-cut costing analysis make this work questionable. While overtly contrasting hospital and community care, it might equally be said to have emphasised the need for active and personalised treatment regardless of the setting. (For example, 40% of the experimental group were hospitalised at some time during the study.) The notion of continuous treatment teams, and the problems of job descriptions, working patterns, and patient dependency, have also been reviewed by Torrey (1986).

In Britain, the major work has been in terms of planning and policies. From *Better Services for the Mentally Ill* (Department of Health and Social Security, 1975), to reports by the Social Services Committee (1985) and the Audit Commission (1986, entitled *Making a Reality of Community Care*), the emphasis has been on pushing psychiatric services out of the ageing Victorian asylums. The needs for bridging finance, joint planning by health and local authorities, changes in social-security provision, and appropriate staffing have been regularly stressed. There have been numerous conferences propounding the same message, to a perhaps wearisome degree, and the varying ethical, sociological, nursing, and administrative problems have been usefully discussed (e.g. Reed & Lomas, 1984). Work on the "new long-stay" or the "new chronic patients" (Todd *et al*, 1976; McCreadie *et al*, 1983), patients' preferences (Abrahamson & Brenner, 1982), and small experimental units (Goldberg *et al*, 1985) has been supplemented by an increased focus on rehabilitation (Wing & Morris, 1981; Clark, 1984), and active community programmes seem to be working (Robertson *et al*, 1986). Examples of community care from India (Skultans, 1986) and Italy (Lovestone, 1986) have a more idealistic tone, but the prevailing assumptions of a gradual switch away from a hospital locus continue to receive official support (McCarthy, 1986).

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There are, of course, considerable deficiencies in much of this philosophy. The work of Stein & Test (1980) and Hoult (1986) was carried out in 'non-industrialised', middle-class communities. It has not been repeated, yet, in poorer, inner-city areas, although developments in Hackney have evolved in a similar pattern (Reed, 1984). The effects on medical training and practice have yet to be dealt with. Local availability, front-line clinical management, personal communication with social and community-health workers, and lack of a hospital base, may be unwelcome to many consultant psychiatrists. Furthermore, routine out-patient clinics, and reliance on ward-based junior staff, may have to be abandoned, and more attention paid to the role of the GP (Clare, 1984). There is certainly a need for a new community mental health order to supplement the present Section 3 of the 1983 Mental Health Act. No community-care philosophy can logically prevail if hospitalisation remains part of the legal basis for treating those most persistently and severely ill. It is also reasonable to consider such patients as having a right to treatment, and to view "external controls" as "a positive and often crucial therapeutic modality for those who lack the internal controls to deal with their impulses and to organise themselves to cope with life's demands" (Lamb, 1984). Grasping such a nettle and researching appropriately the effects of such changes is an urgent priority, not least because of the groundswell of public and professional concern as to the 'reality of community care'.

Such criticism has taken various forms. The increases in vagrancy, bed-sit isolation, and prison populations have attracted important media attention (Wallace, 1986; Cohen, 1987) as well as more clinical analyses (Bassuk *et al*, 1984; Haslam, 1986; Weller *et al*, 1987). Watt (1986) has drawn attention to the sheer miscalculation of demand for psychiatric beds and the problems arising from this. The positive aspects of asylum care (Weller, 1985) and the burden on relatives coping with a psychotic family member (Fadden *et al*, 1987) have been stressed. More than ten years ago, Hawks (1975) reviewed a number of assumptions behind the community-care movement and suggested that expectations of the efficacy of social work, the caring nature of the community, and the form and treatment of mental illness were not uncontentious. He viewed it as more of a moral enterprise, the "latest diversion of the psychiatric conscience". There is certainly widespread unease about the motives behind the Government's drive to close mental hospitals, which have been on the hit list ever since Enoch Powell's much quoted 'water-tower' speech of 1961. A historical perspective in these matters is instructive (Turner, 1985) and the examples of Italy and the United States are regularly quoted to warn us of the consequences of inadequate resources (British Medical Journal, 1985). Last, but not least, the spectre of violence cannot be ignored (Tardiff, 1984; Taylor & Gunn, 1984).

Caught between these opposing tides of reform and reaction, what is the concerned clinician to think, let alone do? Should one reread *Institutional Neurosis* (Barton, 1976) and *Asylums* (Goffman, 1961) and join in the dismemberment of those brooding Victorian piles (they are out-dated and many need replacing anyhow), or should one refuse to abandon the solid reality of a capital asset for the idealistic dream of community action?

Perhaps one has to do neither. The essence of the present changes lies not in polar opposites but in realigning the focus of psychiatric care. As specialist medical practitioners, we are trained in the diagnosis and management of mental illness, not in the superintendence of large institutions or the organisation of occupational or social activity. It is also far more sensible that the hotel costs of the chronically ill should be met by DHSS payments to suitably staffed hostels and group homes rather than by National Health Service-funded pseudo-hospitals. The task of the psychiatrist is to ensure that the right balance of acute wards, day-care centres, and long-stay facilities is provided for a given locality, and that this is based on clinical need. At the turn of the century, psychiatrists were mocked for paying too much attention to "papers on an improved variety of Chubb lock" (Jones, 1954), and we are in danger of similar criticism.

But if community care of the mentally ill is to succeed, there must be a regular programme of sound and practical research along the lines of those studies carried out in Australia and the USA. We need to know how best to train and support community mental-health workers, how to assess the effects of psychotic symptoms on social behaviour, how to treat most effectively those unable to comply with necessary medication (compliance may be a key function in itself), and how to use behavioural and rehabilitative techniques to promote independence and prevent relapse. It may be that asylum is needed, especially for some with chronic brain damage (e.g. dementia), but the emphasis on community care can sharpen clinical skills and promote an active treatment philosophy. One hundred years ago, in his Presidential Address, Clouston (1888) described "dements" as "the great lowering agency in asylums, against which we have to put our own minds to struggle, and to inspirit our staffs also to resist". Chronic mental illness remains the major clinical

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challenge for psychiatry, and changes that focus enthusiasm, research, and public interest should not be rejected. Our aim should be good psychiatric practice, so that our views are respected when public decisions as to where our patients' lives are made.

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