

“Difficult to place” psychiatric patients

The game of pass the parcel must stop

Before the introduction of phenothiazines most county asylums had a “refractory” ward for patients who were chronically difficult to manage and intermittently dangerous. Many believed that such difficult patients were products of the institutions themselves and that as wards were unlocked these difficult patients would no longer exist.^{1,3} This idea took such firm root in psychiatry and mental handicap that some health districts no longer have long stay beds.

Day has criticised the “gap between rhetoric and reality” and the uncritical adoption of a philosophy of health care which, despite its merits of compassion and humanity, remains untested.⁴ As psychiatric facilities become based in district hospitals and “the community,” a model of acute treatment has been uncritically adopted at the expense of long term care. That there are casualties of this policy is becoming increasingly apparent. Some patients are so intractably disturbed that they cannot be cared for by an army of support workers in hostels or in their own homes. Sadly, more energy is expended in diverting these patients elsewhere than planning for their unmet needs.

Disagreeing over diagnosis and appropriate placement, many consultants dispute clinical responsibility. For example, a chronic, intermittently assaultive patient blocking an acute admission bed may eventually be referred to a regional secure unit. The unit will be at pains to avoid committing a bed to a patient who cannot be rehabilitated within a reasonable time scale. A special hospital will not admit him unless the patient is a grave and immediate danger. If the patient absconds he may become someone else’s responsibility in a different catchment area. On the other hand, if he commits an offence, readmission can be refused from the magistrate’s court, and he will be remanded into custody. Unacceptable back on hospital order, he may drift into prison or merely be released on to the streets, having served his sentence on remand. A fortunate few are sent to the private sector, which has profited in recent years from spotting this lucrative gap in the market. The problem then becomes one of financial responsibility. Although some regional health authorities see this resting with districts, some districts refuse to meet these patients’ needs without additional regional funds. The result is that many patients are currently caught up in a game of “pass the parcel” from one agency to another.

Who are these patients, where are they, how many are there, and what should be done about them? As they may be widely dispersed and often on the move, these questions are exceptionally difficult to answer. Studies of chronic

institutionalised populations are a starting point, showing that most patients have schizophrenia. A few may have unusual chronic variants of affective disorder, personality disorder, or have brain damage severe enough to require prolonged institutional care.^{5,6} Closing mental hospitals has progressively shown the inadequacy of reprovision,⁸ with bleak prospects for some in community facilities,^{8,10} and burgeoning costs.¹¹ Furthermore, after those whose rehabilitation is likely to be easy have been “creamed off,” a residue of severely handicapped patients may remain without any viable alternative.¹² This subgroup, however, makes only a small contribution to the “difficult to place” patients as new generations continue to present to the acute psychiatric services. Many of these “new long stay” patients do not cooperate with community facilities, are frequently hospitalised, and are increasingly visible on the streets of our cities.¹³⁻¹⁶ Among them are people with severe, treatment resistant conditions and behavioural disorder requiring semisecure facilities. Though uncommon in our “centres of excellence,” they are still found in the remaining asylums,^{6,8,9} special hospitals,¹⁷ remand prisons,¹⁸ hostels for the homeless,^{19,20} and the private sector (in small but increasing numbers).²¹

Unfortunately, policy makers heeded the rhetoric rather than the reality of the long term course of mental disorders. For example, the natural history of schizophrenia shows that its severity lessens with age.^{22,23} It is therefore unremarkable that aging schizophrenics can be successfully moved to hostels: by then most are compliant and docile. But the level of disturbance provoking their original admission may be forgotten. Furthermore, up to half of them will do badly early in their illness and will need considerable support,²⁴ especially those with exceptionally severe presentations such as “catastrophic” schizophrenia²² who may need indefinite hospital admission.

Psychiatrists may be dismayed by the clinical problems of catastrophic schizophrenia, but managers are dismayed by catastrophic costs.²⁵ Under a resource management system consultants accepting responsibility for one or two of these patients could see the closure of beds to meet the costs of their private care. Whether this will change with the NHS and Community Care Act remains uncertain. In theory, districts prepared to invest in providing services for local purchasers might see reasonable returns from efficiently managed specialist units. Consortia of neighbouring districts could cooperate in setting them up. The private sector’s continuing investment in beds for difficult to place patients indicates a

lack of confidence in the NHS organising itself to meet this challenge. The private sector will realise, however, that purchasers will have finite funds and care will be rationed. Providing these facilities on a large scale may therefore be a risky investment.

A new lead from the centre is needed. The existence of these patients needs urgent recognition followed by an acceptance that providing them with services remains the responsibility of local mental illness and mental handicap services. Some deprived inner city areas seem to have more than their fair share of such patients,^{21,26} further supporting arguments against the current allocation of resources on a per caput basis.²⁷ University departments of psychiatry, which have previously lent academic respectability to some of today's disastrous policies, should turn more of their attention to the casualties of community care and as different models of care evolve they should be properly evaluated.²⁸⁻³⁰ The biggest problem, as always, is money. Without adequate capital for providing the necessary facilities any new policy will ultimately flounder.

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Health check ups for all?

Given time, the results of Japanese screening might provide the answer

Two radical changes are in train for the NHS. Firstly, health authorities will be responsible not simply for health care but for the health of their populations. And, secondly, under their new contract general practitioners have to practise preventive medicine. These changes pose interesting and fundamental questions that are linked. How much can health authorities influence health? And what contribution might preventive medicine make?

Since McKeown we have been wary of making extravagant claims for the benefits of health care. Although it may reduce disability, pain, and suffering—frequently used measures of medical outcome¹—McKeown argued that improvements in life expectancy have been secondary to improved nutrition and environmental conditions.² Supporting his thesis are the socioeconomic differences in health in Britain³ and the improvement in life expectancy in countries such as Japan⁴: differences in health care are unlikely to explain them.

The time has therefore come for health authorities to consider how they might affect the determinants of health—one aspect of the "new" public health medicine. Complementing this public health activity is preventive medicine. There are grounds for optimism in primary care: evidence of efficacy of general practitioners' advice on cigarette smoking and alcohol consumption^{5,6} and on the treatment of hypertension.

Screening has come under critical scrutiny of both its costs and benefits.⁷ Studies in the elderly have focused more on

functional and social assessments than on biochemical screening or medical examinations. A randomised trial in Copenhagen, using checks at three month intervals, suggested that such checks result in reductions in mortality and lengths of hospital stay.⁸ A study in south Wales showed an apparent reduction in mortality in one of two centres,⁹ and other studies have shown improvements in morale.¹⁰ By discovering unreported illness, however, screening may make things worse. Detecting disease early does not mean that we can alter its course or improve the quality of life.

The paper of Tatara *et al* (p 615) is relevant to these issues.¹¹ In 1982 a new law was passed in Japan that provided periodical physical examinations, health education, and counselling for all Japanese residents aged 40 and over. Where the service was not provided by the place of work, local government provided it. In 1988 nearly a third of the population received health check ups under this scheme. To evaluate its effect Tatara *et al* surveyed all 509 Japanese cities with a population between 30 000 and 200 000. They report an inverse relation between the uptake of health check ups in adults aged 40 and over and hospital use by those aged 70 and over.

Unlike the randomised trials, this was an "ecological" study, comparing groups rather than individuals. Attempting to avoid the problem of confounding (the groups might differ by more than their rates of health check up), the authors examined changes over the four years since the check ups