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Countdown to Community Care

Hunting the gowk?—psychiatric community care in Scotland

Ian Pullen

This is one of a series of articles looking at the forthcoming changes to community care.

The implementation of the community care changes throughout the United Kingdom from 1 April will mark the culmination of a series of major health and social care reforms. The avowed aims of achieving value for money and improved consumer choice through the introduction of competitive internal markets have yet to be tested. The political complexion of Scotland means that any proposed change to the NHS has tended to be greeted with a mixture of suspicion and resistance. As a result very few self governing trusts and fundholding general practices exist north of the border. And although Scotland has not had a wide reaching policy of moving psychiatric patients out of hospitals, community care for mentally ill people has advanced spontaneously.

Last October Lord Fraser of Carmyllie, minister of state for health and social work at the Scottish Office, announced what was described as "the last of the major building blocks for full implementation of the government's community care policy"[1]—the finance for provision of community care by local authorities in the coming year. A total of £41m will be transferred from central government to Scottish local authorities in 1993-4 with a further £20m towards implementing assessment and care management. The Mental Illness Specific Grant, which had a tiny budget before 1991, will be increased to £21m.

From the psychiatrist's perspective it is important to remember that these sums are "in support of not only the elderly, mentally ill, mentally handicapped and physically disabled people but also drug and alcohol abusers, homeless persons . . . mothers and babies in registered specialised accommodation, terminally ill people in nursing homes, people on probation and ex-offenders in registered accommodation."[1] The sums of money are large, but so too is the level of need in Scotland.

Scotland has a population of approximately 5 million, most of whom live in or close to cities or towns. An important minority of the population lives in far flung, sparsely populated areas such as the highlands and islands. The provision of psychiatric care to these areas must, necessarily, be different from that for densely populated cities. In rural areas community psychiatric nurses are more autonomous than their urban counterparts and all psychiatric staff have to travel to see patients. This diversity of service presents particular challenges for planning.

Most people with mental illness are treated in the community by general practitioners. But in Scotland, as elsewhere, most of the mental health budget has been consumed by services based at mental hospitals. In recent years psychiatrists in Scotland have peered over the border, somewhat bemused by the speed at which psychiatric long stay beds have been emptied in England. Visiting speakers from England have chided their Scottish colleagues for their slow pace of change, citing bed numbers in Scotland and the building of an entirely new psychiatric hospital in Aberdeen as examples of outmoded practice. In fact such simplistic comparisons are misleading.

Caution is needed when attempting to interpret cross national data on psychiatric hospitals because of many confounding factors, demographic and geographical, as well as the pattern and availability of alternative services. Over the past two decades the resident population in Scottish mental hospitals fell by 20%[2] but the proportion of residents aged 65 or over rose from 45% in 1970 to 66% by 1988.[3] The number of old and very old people in Scottish psychiatric hospitals accounts for much of the difference in bed numbers on the two sides of the border and reflects the poor provision of local authority run places for elderly confused people in Scotland. For example, in 1985 only 238 places in local authority and registered nursing homes for mentally ill people were recorded in national statistics in Scotland, a shortfall of 1000 places from the number recommended by the government's guidelines.[4]

History of Scottish community care

Despite such criticisms, Scottish mental health services have often been in the vanguard of community care developments, with services evolving locally for pragmatic reasons. But many of these services have not been evaluated effectively. At Dingleton Hospital in the borders a community model based on teams for home visiting and treatment has been used for the scattered population of 100 000 since the 1960s when Dr Maxwell Jones extended from the hospital his ideas about therapeutic communities.[5,6] Dingleton's practice of seeing all patients in their own homes (or occasionally the general practitioner's surgery) has never been systematically evaluated. Yet this continuing service predates the better known crisis team at Napsbury Hospital, St Albans, by at least eight years.

Scotland has also led the way in moving psychiatrists into primary care. Exactly 40 years ago the first general practice health centre in Scotland was opened at Sighthill in Edinburgh. Three years later the first psychiatric clinics were held at Sighthill.[7] By 1987 more than half of Scottish consultant psychiatrists were spending some time each week in primary care settings[8] compared with fewer than a fifth in England

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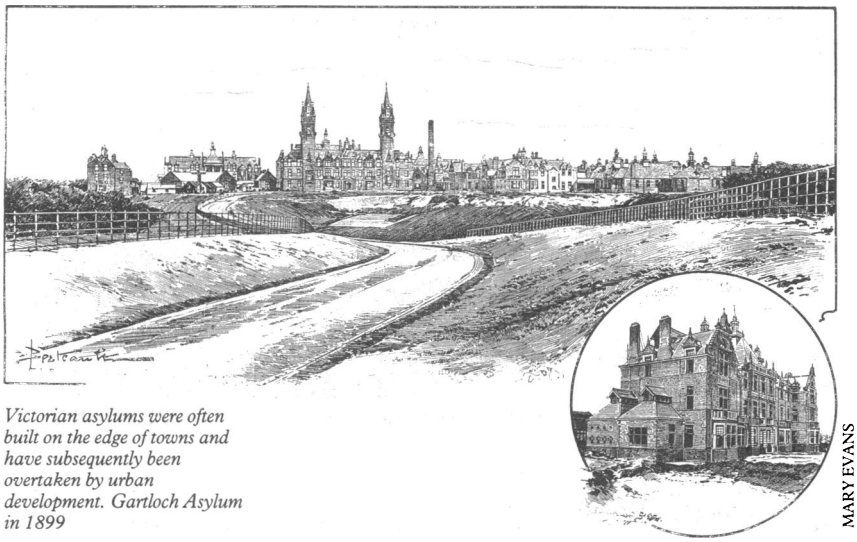

Victorian asylums were often built on the edge of towns and have subsequently been overtaken by urban development. Gartloch Asylum in 1899

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and Wales.[9] This move of resources into the community was entirely unplanned and arose from local initiatives.[8] Because it did not reflect Scottish Office policy its development went unrecorded, such work being undifferentiated from normal outpatient sessions for statistical purposes. This type of work represents a hidden shift of resources into the community[10] because its considerable costs are generally attributed to the budget for psychiatric hospitals.

The development of psychiatric services in Scotland has been influenced greatly by the sites chosen for the Victorian asylums. Many were built on the edge of towns or cities and have subsequently been overtaken by urban development. For example, the Royal Edinburgh Hospital is just 3 km from the city centre in a pleasant residential area (Morningside), and Gartnavel Royal Hospital is on the edge of Glasgow's equivalent suburb (Kelvinside). In England and Wales the policy encompassed in *Hospital Services for the Mentally Ill*[11] sought to overcome the problem caused by the many mental hospitals built at a considerable distance from their catchment populations by opening psychiatric units on district general hospital sites. This policy was not adopted in Scotland, where there are few such psychiatric units. Indeed, a report by a working group of the National Medical Consultative Committee in 1989[12] saw "merit in the development in Scotland of the concept of inpatient care based on a 'mental health campus' " which would include units for assessment and short term care, medium to long term care, and special facilities for adults with behavioural problems due to brain damage combined with multiple physical disabilities.

In 1980 the report *Scottish Health Authorities Priorities for the Eighties (SHAPE)*[4] was published. Care of mentally ill, mentally handicapped, elderly, and elderly mentally disabled people was grouped by the report under category A, which was given priority for health boards' spending. A main objective was to work towards a community based service for people with mental illness through joint planning by the NHS, local authorities, and voluntary agencies. Five years later *Mental Health in Focus* described the mental health services in Scotland as "a deprived area of care" and noted "a serious shortfall, in Scotland, of community alternatives to inpatient mental health care."[13] The report warned that failure to develop comprehensive locally based mental health services "can be remedied only if the necessary initial resources are forthcoming."[13] In 1987 an unpublished report, known as SHARPEN (*Scottish Health Authorities Review of Priorities for the Eighties and Nineties*), pointed out the deficiency of local authority provision for mentally ill people and noted local authorities' particular responsibilities under the Mental Health (Scotland) Act 1984. This report suggested the development of community teams with community psychiatric nurses based in primary care, and health boards were finally persuaded of the desirability of psychiatric units in district general hospitals.

Current problems

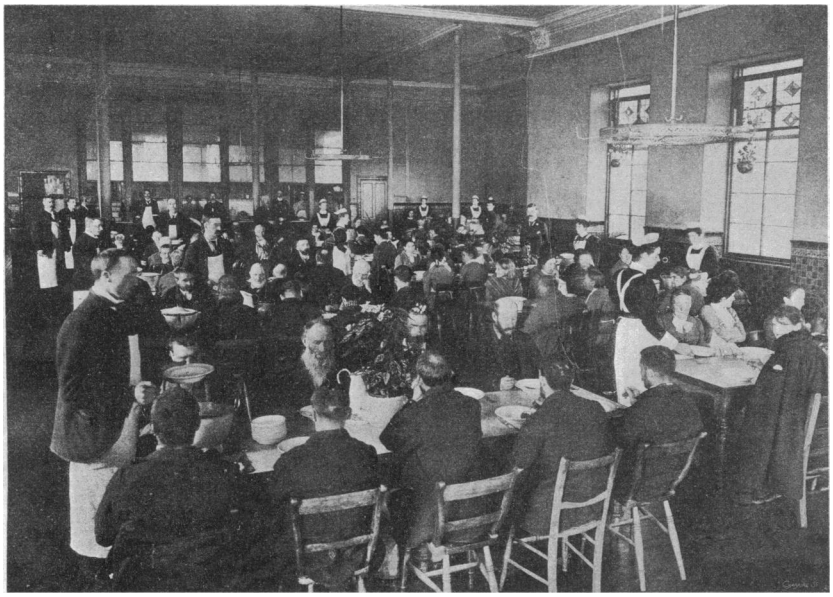
Some current problems reflect decisions made many years ago. In the 1970s, when comprehensive resettlement services were first developed and psychiatric wards were emptied by the steady resettlement of low dependency patients into group homes, the opportunity to close beds was not always taken. Instead a growing number of elderly demented people were admitted because of the local authorities' failure to provide alternative care. Thus, low dependency psychiatric patients were replaced by patients who required much higher levels of staffing without a commensurate increase in funding.

Over the past five years the pace of discharges from psychiatric hospitals has accelerated as elderly patients have been transferred to the community. In fact they have been moved into nursing homes funded by the Department of Social Security. This raises the question of what constitutes the community. Do the private "nursing homes" such as that with up to 240 beds on one site proposed for the West of Scotland really count as community care? If such a home places its residents under the care of a consultant psychiatrist, surely it should be called a hospital. If the consultant withdraws and the residents come under the care of a general practitioner, who might from time to time call in a psychiatrist, the home is called a nursing home in the community. This seems similar to the semantic juggling reported by Jones and Poletti when visiting Italy after the introduction of Law 180 in 1978, which forbade the admission of any new patients to mental hospitals.[14] They saw some "family homes" which looked like ordinary mental hospital wards and although patients in some wards were referred to as "guests," this did not prevent them from being confined by locked doors.

Some former long stay patients have been discharged to supported accommodation run by housing associations and others to hostels. It makes good sense for housing associations to buy several houses in adjoining streets for ease of monitoring and staff support. But these cluster developments have proved unpopular with local residents and with local general practitioners, who often feel relatively unsupported in taking responsibility for up to 20 recently discharged chronically mentally ill people. It is quite clear that community care developments in Scotland have failed to keep pace with discharge of patients and the closure of long stay beds, although the range of facilities has improved together with the liaison between the statutory and voluntary sectors. The number of community psychiatric nurses has increased, but nowhere in Scotland do their numbers approach those in many English districts. Day hospital places have also continued to increase, but in many districts clinical psychology services are underresourced. Finally, the impact of the SHAPE and SHARPEN reports on health boards' spending has been disappointing.

The new reforms

By 1 April 1992 all local authorities and health boards in Scotland were required to produce community care plans. This has led to a closer working relationship with the adoption of coterminous boundaries between health and social work departments in many areas. Some professional groups, especially general practitioners, felt that they had been left out of this



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Comprehensive resettlement policies were developed in the 1970s—too late for these patients at Larbert Asylum

planning process. To redress the balance the Scottish Office held a workshop in Crieff in June 1992 on the role of the general practitioner in the primary care team. The chief executive of the NHS in Scotland, the chairman of the Scottish General Medical Services Committee (BMA), and 100 general practitioners held a vigorous debate on the need to clarify the role of the general practitioner in the assessment process, the need for training and education, and involvement in the planning process.

In many ways Scotland is in a strong position to benefit from the community care reforms. Because of the slower pace in the rundown of hospital beds than in England, there is a smaller pool of homeless former patients in the community and a larger reservoir of resources in mental hospitals, and now there is a greater possibility of discharging elderly patients to nursing homes. The close working relationship that has developed between psychiatrists and general practitioners[8] should support general practitioners in their role as primary carers for former inpatients. The leave of absence arrangements allowed under section 18 of the Mental Health (Scotland) Act 1984 enables the psychiatrist and mental health officer to ensure a higher level of supervision of vulnerable patients in the community than is permitted under the Mental Health Act 1983. The community supervision orders proposed for England and Wales would permit a similar level of supervision if enacted.[15]

Implications for training

General practitioners already deal with up to 95% of identified psychiatric morbidity in the community without reference to specialist psychiatric services.[16] Increasingly they will be asked to take care of people with more serious mental illnesses. Although vocational training for general practice has been mandatory for almost two decades, only 40% of general practitioners registering with the General Medical Council have had a psychiatric attachment.[17] General practitioners will require a higher level of knowledge and expertise in psychiatry than has previously been the case.

Psychiatrists may increasingly be working alongside general practitioners, but there are few training posts in community psychiatry. Consultant psychiatrists in Scotland do, at least, take an equal number of psychiatry trainees when they work in primary care settings.[8] In England and Wales only half of all psychiatrists working in primary care are accompanied by trainees.[9]

Conclusion

Scottish psychiatric services have developed at a different pace and in a somewhat different form from those south of the border. In many ways Scotland is in a strong position to face the challenge posed by the community care reforms. In recent years, however, for financial reasons social work departments have restricted their work almost exclusively to statutory tasks, people with mental health problems having a very low priority. The new lead role for social workers as assessors and purchasers of community care will effectively remove any prospect of direct social work casework with the mentally ill.

The changes, however, come hard on the heels of the introduction of clinical directorates and new unit structures, the NHS internal market, and a reorganisation of social work departments. These reforms, untested by pilot evaluations, represent a leap of faith. It remains to be seen whether they turn out like "hunting the gowk."

A gowk in Scotland is a cuckoo, a Scots equivalent of "un poisson d'avril" in France or an April Fool. Hunting the gowk is a fool's errand.

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