

The Development of Community Care in Psychiatry

by

T. BUCHAN

*Professor and Head of Department of Psychiatry, UZ,
P.O. Box A 178, Avondale, Harare, Zimbabwe*

SUMMARY

The theoretical considerations underlying the transfer of psychiatric care from the mental hospital to the community are discussed.

The principal provisions of the British programme are set out, viz.

1. The establishment of acute psychiatric units in District General Hospitals.
2. The construction of hostels and day care centres by local authorities.
3. The provision of a substantial increase in personnel.
4. The gradual rundown of the large mental hospitals.

Some of the difficulties encountered in each of these 4 areas are enumerated. The relevance of these problems to Zimbabwe is discussed and two local developments, viz. the establishment of psychiatric follow-up services and the opening of a rehabilitation unit are described.

INTRODUCTION

In Britain the construction of vast asylums sometimes with as many as 2 000 beds, commenced in the 19th century and reached its apogee in the middle of the 20th century. By the end of 1955 there were 153 000 mentally ill patients detained in hospitals as compared with 187 000 in general hospitals. Respective admission rates were 63 per 100 beds per annum for the psychiatric patients as compared with 1 802 per 100 beds per annum for the general patients. Put another way, psychiatric patients accounted for only 3% of admissions but occupied 45% of the total number of hospital beds.¹ In some mental hospitals 86% of the patients had been there longer than 2 years.²

Unfortunately large institutions tend to develop social structures of their own with patients thrust into subordinate "sick" roles.³ Consequently many of the symptoms exhibited by long stay patients such as apathy, inertia and lack of initiative are adaptations to this social system rather than the inevitable sequelae of chronic illness.

The phenothiazine drugs were introduced by the French in 1952 to prevent surgical shock amongst their casualties in Indo-China.⁴ Their application in psychiatry was a subsequent serendipitous discovery which, together with the recognition of the therapeutic ineffectiveness of large asylums, set the scene for a new departure in psychiatric care.

The British Experiment

New and potent methods of treatment and the transfer of the emphasis of psychiatric care from the mental hospitals to the community, provided the twin pillars on which both the enabling 1959 Mental Health Act and Mr. Enoch Powell's subsequent 1962 Hospital Plan were constructed.⁵

The hospital plan provided for:-

1. The establishment of acute psychiatric units in District General Hospitals (DGH).
2. The construction of hostels and day hospitals by local authorities.
3. The provision of a substantial increase in medical ancillary workers.
4. The gradual run down of mental hospitals.

Between 1954 and 1963 the population of the mental hospitals decreased by 20 000⁶ and superficially the plan seemed to be working, but these bald figures concealed a situation which was little short of disastrous.

Each of the 4 provisions of the hospital plan led to unforeseen difficulties:

1. Acute Units in D.G.Hs.

Early reports were enthusiastic^{7, 8} and only later was it appreciated that whilst phenothiazines shorten the period of hospital treatment, they prevent neither relapse nor chronicity without considerable support from a therapeutic environment.⁹ Consequently a growing number of new chronic patients accumulated,¹⁰ who were not suitably managed in D.G.H. units.

Further, the units tended to develop a "surgical" kind of psychiatry with rapid turnover and impressive short term results¹¹ - achieved only at the expense of the time consuming analysis of personal and family problems which is the cornerstone of the management of chronic patients. A study of chronic patients in Birmingham revealed that 64% had long term needs which might be difficult to meet in the D.G.H. units.¹²

Finally the problems associated with treating all kinds of patients, including the violent, in small short-term units had not been fully appreciated.¹³

2. Lack of local authority facilities

Despite a statutory obligation and the provision of government funds, by March 1974, 31 of the 173 local authorities had no residential accommodation and 63 had no day facilities.¹⁴

3. Shortage of staff

In 1977 the Royal College of Psychiatrists called for the provision of one consultant per 40 000 population for the treatment of adult mental illness. This target implied a need for 330 additional consultants but in reality the number of unfilled posts increased from 15 in 1970 to 58 in 1979.¹⁴ Similar shortages in the United States led one author to describe psychiatrists as "an endangered species".¹⁵

4. Run down of the large mental hospitals

(a) Estimates of the number of beds required predicted a decline from 340 per 100 000 population in 1961 to 180 per 100 000 in 1975.¹⁶ Attention was drawn to inaccuracies in these estimates as early as 1963¹⁷ but the warning went unheeded and 24 000 beds were lost between 1960 and 1969.¹⁸ A more realistic estimate put the number of beds required by 1982 at 230 per 100 000, supposing the provision of extensive community care facilities.¹⁹

(b) There was a tendency to develop a high concentration of resources in D.G.H. units at the expense of truncated mental hospitals;¹⁹ similar trends were observed in the United States.²⁰ This process led to continual staffing problems, low standards of care, a decline in morale and consequent ill-treatment of patients.^{13, 21}

Fortunately there is recent evidence that the "bubble of rapid expansion of DGH units has now burst."²² The most recent government report (DHSS 1980) suggests that in about 70 districts a well sited mental hospital should continue to provide in-patient care; only about 30 other hospitals are scheduled for closure.

(c) Many long stay patients were inappropriately discharged to community care which had two significant effects:-

(i) Recurrent readmissions. Between 1949 and 1960 the annual admission rate more than doubled from 55 000 to 114 000 per year.²³ Second admissions also doubled from 12 330 to 24 680 but the number of patients entering hospital for the seventh or subsequent admission increased

sevenfold from 460 to 3 500. There were similar sharp increases for 3rd to 6th admissions so that by 1964, 25 000 out of 36 000 (almost 70%) admissions for schizophrenia were readmissions. It became evident that many patients were merely being "recycled".

- (ii) Marginal community adjustment. It was known that patients of "no fixed abode" could account for up to 30% of the admissions to hospital.²⁴ With the loss of the sanctuary provided by the mental hospitals these people were cast adrift in the community to become "rootless wanderers"¹⁸ "drifting through lodging houses."²⁵ By the end of 1965, some 27 000 men and women were resident in 550 lodging houses. Surveys revealed that 59% of the men had lived in this manner for more than 5 years²⁶ and that about 28% of such residents were psychiatrically ill.²⁷

A distressing number of the mentally ill became incarcerated in prison: "frustrated judges have had to award inappropriate prison sentences to men because there were no available beds in special hospitals, and local hospitals declined to accept them."²⁸

Notwithstanding these difficulties and criticisms community care based on a DGH unit was shown to work effectively in places as diverse as London²⁹ and Blackburn,³⁰ provided there were adequate levels of medical staffing (at least 1 consultant and 2 junior staff per 30 beds) together with extensive community facilities.

Developments in Zimbabwe

With its paucity of resources (e.g. about one psychiatrist per million population) Zimbabwe quite obviously could not afford the costly mistakes made in Britain. Accordingly the development of community psychiatric services has proceeded much more cautiously, but there have been two important developments.

1. Psychiatric follow-up services

This kind of service was first developed in Matabeleland in the early 1970s. In collaboration with the provincial and municipal Medical Officers of Health the service was extended to 40 rural and 4 urban clinics by 1973. Details have been set out elsewhere.³¹

but a prime objective of the service was the prevention of readmissions by providing maintenance medication for discharged patients.

Measures which included a more aggressive discharge policy and the introduction of a waiting list in 1966, reduced the population of black patients at Ingutsheni Hospital from something over 1 000 in 1965 (the 1 252 in-patients were not classified according to race) to 773 by 1968 and 684 by 1971.³²

As far as could be ascertained this reduction was not accompanied by any increase in the readmission rate which remained constant at about 34% between 1969 and 1971. No assessment could be made of marginal social adjustment but there was some slight tendency to deal with patients who were social misfits by arresting them and charging them with a minor offence (e.g. "found by night"). Such cases accounted for 27 out of 256 criminal mental patients admitted over a 5 year period.³³ Similar follow-up services were subsequently introduced into Mashonaland and Manicaland.

2. Half-way House (Tariro Centre)

A survey of a sample of admissions to Harare Psychiatric unit in 1980 showed that 93.6% of cases were eventually discharged in remission and 92.5% were discharged within 3 months.³⁴ This latter figure was very close to the 93.1% obtained for DGH units in Britain²² suggesting that the Harare unit served a similar function. Nevertheless 7% of patients remained longer than three months and there was additional evidence that some patients were chronic, in that, in 1978 14.6% of admissions accounted for 62% of patient days. Further, there was some evidence of recycling in that 22% of cases had been admitted on 3 or more occasions.

The causes of recurrent admissions may be summarised as follows:

1. Inadequate assessment and inappropriate treatment.
2. Inadequate maintenance medication.³⁵
3. Impaired social readjustment and failure to reintegrate into the family.

The sample also showed evidence of impaired social adjustment in that only 55 of the 173 cases (32%) were known to be married (69

cases were single, 29 separated, widowed or divorced, 20 status not recorded); the proportions were similar in males and females. Among the males 59 out of 120 (49%) were unemployed, as compared with 44 out of 53 females (83%). There was at least anecdotal evidence that many patients with no fixed abode eked out an existence either at a bus stop or the railway station.

When a patient returns to a family the degree of disruption caused depends on:-

1. The type of family. Conjugal families withstand the stress better than parental families, and extended families may even do better, accounting for the comparatively few patients admitted from rural areas (36.5%).
2. Emotional relationships within the family. When a key relative expresses criticism or hostility towards the patient, this is termed an emotionally expressive or "EE" family.³⁶ High EE families have been shown to produce relapse more often than low EE families.^{37 38}
3. The number of crises or life events occurring in the family.³⁹ In this context it should be noted that 81 cases (47%) in the survey presented with violent or aggressive behaviour.
4. A diagnosis of schizophrenia in the patients. Schizophrenics tend to show poor social readjustment^{40 41} and intensive social work with them (major role therapy) is of only marginal benefit.^{42 43 44}

Discharged schizophrenics who cause serious or prolonged stress within a family tend to be readmitted following a social crisis rather than an exacerbation of their symptoms.⁴⁵

Factors tending to reduce the relapse rate of schizophrenics in high EE families include: phenothiazine medication, reduction of the amount of face to face contact and the availability of outside help. The extended family may function in terms of these latter two factors.

With the foregoing considerations in mind it was decided to open a half-way house or rehabilitation unit (Tariro Centre) with the following objectives:

1. Adequate observation and treatment of patients requiring long-term care (longer than three months).
2. Reintegration of the patient into the family

through the following measures:-

- (a) Instruction of the patients in socially acceptable and useful behaviour.
- (b) Gradual re-introduction of the patient into the family.
- (c) Social work with the family with the following objectives:-
 - (i) combating negative expectations
 - (ii) maintaining an emotionally supportive environment
 - (iii) education in the importance of maintenance medication
 - (iv) supporting the family in terms of stress.

The 20 bed centre was opened in December 1980 and the progress of the 24 patients admitted during the first 6 months has been reported elsewhere.⁴⁶ Suffice it to say that the results have been encouraging both in human terms and cost effectiveness, although the numbers treated so far are small.

In summary the factors which appeared to act against social readjustment were found to be:-

1. The patient is an immigrant from another country.
2. A diagnosis of subnormality.
3. Patient from a rural area.
4. An illness of more than 3 years duration.

Surprisingly a diagnosis of schizophrenia was not found to be a factor and relatives were not usually rejecting unless there had been repeated readmissions (more than 5).

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