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EDITORIAL

It is inevitable that discharging a large number of patients into community care leads to particular problems when people do not realize that living in the community may still necessitate some form of continuing treatment and supervision. In their cases behaviour disturbances can become so offensive and, at times, dangerous to others and themselves, that ordinary care is insufficient to prevent severe trouble.

Continuing treatment, whether medication or regular therapy by psychiatrists or psychologists, can help, but unless these measures are maintained, there may be serious consequences for the patients' welfare and for the public. Several highly publicized incidents in recent times have shown that adherence to the requirement for continuing treatment is often neglected. This has now resulted in legislative proposals for tightening the conditions of psychiatric patients who live in the community.

The proposed new power of supervised discharge concerns so far only mentally ill persons. It is quite possible that a small proportion of people, formerly classified as mentally handicapped, might also need stricter supervision and treatment on similar lines and this problem will have to be considered later. Its nature and size can be assessed by perusal of more than a thousand papers published during the years 1970 to 1985¹ on the behavioural problems of people with a mental handicap. It is estimated that up to 25% of this population presents behaviour problems to a significant degree. Although we would expect that the change to community living will result in some alleviation of the severity of the disorders and that many difficulties can be managed by knowledgeable care and attention, there will still be severely disturbed people whose behaviour must be kept under control to prevent them inflicting serious damage to themselves and others. The proposals concerning psychiatric patients are therefore of great interest to those who work with discharged people formerly referred to as mentally handicapped.

The government proposes to make community care for mentally ill people more effective by introducing a ten-point plan of precautionary measures. While the

government insists that it "will continue to sustain the effective development of community care" the next sentence of the announcement² adds that the government "will continue to refuse permission for any mental hospital to be closed unless and until it can be shown that better alternative facilities are available in the community." This is a very ominous pronouncement since it is a way out for local authorities. Obviously, if there is no immediate urgency for providing this kind of community service because closure of the local mental hospitals is not imminent, other urgent problems will take priority.

Most of the ten points deal with "paperwork" such as: publication of the review of the 1983 Mental Health Act; of an improved Code of Practice; of fresh guidance; of a review of standards of care; of an agreed work programme for the Mental Health Task Force and also encouraging better information systems "including special supervision registers of patients who may be most at risk and need most support". All, admittedly, useful knowledge, but scarcely able to help social workers making recalcitrant or careless ex-patients take their tablets regularly or maintaining a much needed close contact with a few uncooperative people while also trying to attend to an increasing workload.

The potentially most promising approach to the problem of elusive patients at risk is, however, the proposed extension of power of supervised discharge from six months to one year during which period patients can be recalled to hospital. To make the most effective use of this trial period "patients would be subject to conditions, including a treatment plan negotiated with them and their carers, and a requirement to attend for treatment. A named key worker would be immediately responsible for that patient's care. He or she must ensure that the procedures agreed in advance are followed, and that decisive action is taken if the patient does not cooperate".

The brunt of the correct and effective execution of a treatment programme and continued adherence to it is placed on the "named key worker" for whom the ten point plan proposes "better training . . . in their duties under the care programme approach. This will cover the new Code of Practice and guidance, and will take account of the lessons from the cases which have gone wrong, and from the Royal College of Psychiatrists' confidential inquiry into homicide and suicides by mentally ill people."

This all-important requirement that a named key-worker **must** be allocated to a patient to ensure the maintaining of an agreed individually tailored programme of health and social care represents an essential first step towards tackling a situation that, if unresolved, could sour the still very tenuous beginnings of community acceptance of patients who do not seem to be "cured". One must, however, ask the question whether this labour-intensive programme can be implemented generally and reliably if need be? There is no doubt that the demands made by this requirement will put much additional work on the comparatively small number of competent, experienced and qualified social workers and is likely to overstretch the existing

resources in many authorities. There is no mentioning of extra resources for increasing the number of people who will shoulder additional supervisory duties. The simple remark that the plan will ensure that "the health authority and GP fund-holder purchasing plans cover the essential needs for mental health services" will scarcely strengthen confidence in the success of a new measure at a time of stringent financial economics by the National Health Service. Unless this very sensible and, hopefully, often successful intensive supervision of treatment by one conscientious and experienced key-worker can be realized wherever there is need, many people will have to be returned to hospital units for more effective supervision. This could prove an easy way out for disposing of people who do not respond positively and quickly to community arrangements or for whom there are simply no adequate provisions in the community.

Most people will by now be aware that residential hospital provisions are still required for extremely difficult people with behaviour problems, but everything must be done to avoid that the existence of such provisions will gradually be used as an exit from the community that has lost interest in maintaining community care that, as practised now, has proved unexpectedly less effective and more expensive than had been anticipated.

- 1 **K. Day, J. Hamilton and P. Smith (1988).** Behaviour Problems in Mental Handicap: an annotated bibliography 1970-1985. London: Gaskell.
- 2 **Department of Health (1993).** Legislation planned to provide for supervised discharge of psychiatric patients. Press Release M93/908.