

Deinstitutionalisation — from Hospital Closure to Service Development

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The necessary components of a comprehensive service of local non-institutional forms of care for the seriously mentally ill have been researched separately in pilot trials, but not within integrated programmes for defined populations. Reported outcomes are at least as favourable as for traditional long-term hospital care, but alternative provisions are no less costly. A case manager system may allow co-ordinated formal and informal services to meet the individual needs of chronically ill patients. Poorly integrated programmes will expose discharged patients to disadvantages.

The recent history of the treatment of those with severe and chronic mental illness must be one of the most significant social changes of our time. It has hardly gone unremarked, but it is typically an area in which informed opinion has had scant effect on the underlying policies or on their implementation. This seems tragic in view of the major impact that the change has had on the lives of tens of thousands of people, both patients and their relatives who are increasingly faced with the burden of care. In this paper, we chart the current rush from hospital towards community care and the work that has attempted to evaluate the process. Although the processes of deinstitutionalisation and of the development of alternative community services vary between countries (Mangen, 1988), there are common themes which we shall try to identify in this paper. In doing this we have drawn mainly on the extensive British, American and Italian literature.

Definitions

Deinstitutionalisation has been succinctly defined by Bachrach (1976) as the contraction of traditional institutional settings, with the concurrent expansion of community-based services. We will use this distinction to describe the components of these processes, which may be related more in hope than practice. Brown (1975), the then Director of the National Institute of Mental Health, identified a further essential component of deinstitutionalisation: the prevention of inappropriate mental hospital admissions. Another important distinction is that between asylums as institutions and asylum as a function: the provision of a place of safety or haven is not necessarily related to institutional size (Wasow, 1986; Rosenblatt, 1984; Wing & Furlong, 1986; Goldman *et al*, 1983c). Finally, the term 'community care' requires careful specification. The concept

ambiguously implies both care in and by the community, and so has united supporters of the former (libertarian radicals) and the latter (fiscal radicals). It may imply merely a change in the locus of care, or, more thoroughly, in the methods and financing of care delivery (Goldman *et al*, 1983b).

Methodological issues

The evaluation of outcome for psychiatric patients after discharge from hospital has been reviewed by Avison & Speechley (1987). They report that six forms of outcome criteria are used in such studies: the hospital readmission rate, the interval before readmission, social role performance, social adjustment, symptom levels and combined global ratings. They found that studies rarely employ a full range of social, clinical, economic and service usage outcome measures, and characteristically use small and heterogeneous samples, with imprecise, poorly validated and inconsistent measures (Hall, 1979, 1980; Schulberg & Bromet, 1981; Goldman *et al*, 1986).

Outcome studies of alternatives to long-term hospitalisation were reviewed more specifically by Braun *et al* (1981) and Kiesler (1982). These reviews included the relatively few studies which at least partially fulfilled the following criteria of methodological adequacy: randomised control design (Newcombe, 1988), clear sociodemographic description, adequate accounts of both the experimental and the control programmes, the use of validated instruments for outcome, and a sufficient number of cases and length of follow-up.

The limits of model programmes

The absence of clearly defined and evaluated programmes of care services for the chronic mentally

ill has led to the establishment of demonstration centres of good practice. Bachrach (1980) has provided a valuable corrective to the over-interpretation of findings from these schemes. She defines a model programme as a "planned demonstration effort that tests the application of distinctive, often innovative, programmatic strategies to the care of chronic mental patients". Successful models target chronic patients, link with other resources, and provide a range of individually tailored treatments. There are, however, limits to their general application and replicability, because they employ special start-up funds, enjoy the non-specific 'Hawthorne effects' of being part of an experiment, and benefit from the contributions of charismatic individuals. They may only treat a selected sub-population of patients, and may not be able to sustain their initial enthusiastic momentum. For these reasons, the results from each pilot programme must be interpreted with caution.

The process of hospital closure

Trends in services since 1954 in Britain

In Britain, the numbers of in-patients peaked at 148 100 in 1954 (Tooth & Brooke, 1961). On 19 February 1954 Mr Kenneth Robinson introduced a Private Members' Bill to the House of Commons, "That this House . . . expresses its concern at the serious overcrowding of mental hospitals . . ." (Jones, 1972). A reduction in numbers was seen as the only humane option. In the following year Houston (1955) wrote in the *Lancet*, "By incarceration we were aggravating the natural process of the disease. At last a new era is dawning and the doors of despair are being unlocked."

The decline in numbers of psychiatric in-patients has continued at an even rate since 1954 (Thornicroft, 1988). The average number of psychiatric beds occupied each day in 1985 in England and Wales was 64 800 (Audit Commission, 1986). This represents a return to the occupancy level last seen in 1895 (Scull, 1984).

Service trends in the United States

The trend of rising numbers of psychiatric in-patients until the mid-point of the twentieth century has been thoroughly documented (Jones, 1972; Rothman, 1971; Scull, 1979; Levine, 1981; Morrissy & Goldman, 1984; Busfield, 1986). In the United States, for example, there were 8500 psychiatric in-patients in 1860, compared with 535 500 a century later (Castel *et al*, 1982; Scull, 1984). Since then

this process of deinstitutionalisation in Britain has been paralleled in the United States. From a maximum in-patient population of 558 900 in 1955, numbers had fallen to 132 164 by 1980 (Scull, 1984). At the peak of this process during the 1970s, the institutional population was diminishing by as much as 6% each year (Mechanic, 1986).

Rationalising hospital closure

The recognition of institutionalism

The justifications for this transfer of long-stay patients from the larger psychiatric hospitals are many and varied, being associated with sociological, financial, pharmacological, administrative and legal changes (Jones, 1972; Hawks, 1975; Scull, 1984; Solomon *et al*, 1986). Both within and without the psychiatric profession a view criticising the ill-effects of prolonged stay within the large institutions emerged with increasing force during the 1950s (Miller, 1985). Barton (1959) described 'institutional neurosis' as "a disease in its own right . . . characterised by apathy, lack of initiative, loss of interest". He confidently asserted that hospital "rehabilitation solves these problems".

Extending this, Goffman (1961) formulated the concept of the 'total institution', central to which was "the handling of many human needs by the bureaucratic organisation of whole blocks of people", so that those admitted are "shaped and coded" into the roles of psychiatric patients. Wing & Brown (1970) reinforced this view with their description of the 'institutionalism' of chronic patients. From their study of long-stay patients in three British hospitals, they accepted "the hypothesis that the social conditions under which a patient lives (particularly poverty of the social environment) are actually responsible for part of the symptomatology (particularly the negative symptoms)", although they stressed that institutionalised practices were not confined to large facilities.

Financial incentives and constraints

Financial considerations have been especially important in the United States in fostering this transfer of care. Since the 1960s federal mental health funding was provided through two mechanisms: categorical programmes and reimbursement. The former consisted of grants-in-aid to state, district, and local organisations for targeted programmes, while the latter were the insurance provisions of Medicaid and Medicare. These forms of reimbursement introduced a perverse bias towards accommodating

former in-patients in nursing homes, even when a lesser degree of supervision might be required (Brown, 1985). These programmes did provide, together with Supplemental Security Income (Goldman *et al*, 1981), a safety net of provisions, but they have underwritten a transfer of responsibility from the state to local care providers: the public sector has accepted the main responsibility for the long-term mentally ill, while the private sector offers acute services (Levine, 1981; Sharfstein, 1978; Scull, 1984; Mechanic, 1986).

In Britain, general public expenditure has declined since the early 1970s. Moreover, although psychiatric services were designated as a priority area (Jones, 1988), the share of total NHS spending allocated to them during the last decade has fallen (Bosanquet, 1986). In addition, despite attempts to promote joint financing, only 5% of joint funds have been used for the mental health services (Knapp *et al*, 1987). Recent proposals for local authority social service departments to become the 'lead agencies' in providing community services for the mentally ill (Griffiths, 1988) were made in the context of a total current NHS expenditure on mental health services of approximately £1 billion, compared with £42 million by local authorities (Mahoney, 1988; Marks, 1988). The funding of the psychiatric services generally has reflected wider trends in public sector spending within the last decade: resource control through cash and manpower limits, cost containment through efficiency savings and self-funding, and the centralisation of decision-making (Carrier & Kendall, 1986). It is within this economic climate that cost-benefit analyses have been used increasingly in the evaluation of psychiatric services (Glass & Goldberg, 1977).

Treatment developments

Treatment patterns have also shown rapid change. Within three years of the formulation of chlorpromazine in 1952, its use as an antipsychotic agent was widespread (Jones, 1972). This was paralleled by innovations in patient management. Industrial therapy organisations were set up (Early, 1978; Wing, 1960), therapeutic communities were developed (Jones, 1968; Clark, 1974), day hospitals appeared, hostels and halfway houses were established (Golomb & Kocsis, 1988), and in both Britain and the United States community mental health centres were founded (Levine, 1981; Brough *et al*, 1983).

Legal influences

The legal provisions relating to the mentally ill in Britain were unified in the Mental Health Act 1959. This established Mental Health Review

Tribunals, dissolved the Board of Control, and delineated the responsibilities of central and local government (Jones, 1972). In the United States there were also significant legal changes during this period. President Kennedy heralded the 1963 Community Mental Health Centers Act as a "bold new approach" (Levine, 1981). Designated catchment areas serving populations of no more than 200 000 were to be served by Mental Health Centers. The central assumption was clearly revealed in the 1975 Amendment to the Act: "community mental health care is the most effective and humane form of care for a majority of mentally ill individuals".

Hospital inquiries

A series of inquiries into malpractice in British hospitals for the mentally ill provided further critical evaluation of psychiatric institutions. Martin (1984) has documented 14 investigations and inquiries in Britain from 1969 (Ely) to 1980 (Rampton). He set out the recurring themes associated with established cases of ill-treatment: isolation of the institutions, lack of staff support, poor reporting procedures, a failure of leadership, ineffective administration, inadequate financial resources, the divided loyalties of trade unions, poor staff training, and occasional negligent individuals. These influences combined to allow the substitution of secondary aims, such as the establishment of ward routines, for the primary aim of delivering care to patients. The effect of such inquiries was to reinforce the developing view that the large institutions were self-evidently harmful.

Current Government policies in the United Kingdom

British Government policy, as set out in the White Paper *Better Services for the Mentally Ill* (DHSS, 1975), has established a target of 47 900 in-patient psychiatric beds after the completion of the current programme of closure of psychiatric hospitals. On these estimates, 84% of the planned reduction in long-stay psychiatric beds towards this goal from the high point in 1954 has already happened, and only the final sixth of long-stay patients remain to be relocated. Alongside this attrition, there has been a corresponding increase in the annual number of admissions: from 78 586 in 1955 to 185 514 in 1981 (Social Services Committee, 1985; Wilkinson & Freeman, 1986).

Current policies in the United States

Present United States Government policy is embodied in the National Plan for the Chronically

Mentally ill, which codifies the results of the President's Commission on Mental Health (Goldman *et al*, 1981). The chronic mentally ill population is defined by diagnosis, by level of disability and by duration of hospital stay. In practice the disability criterion is most usually taken as met by those patients who are registered as disabled persons and so are eligible for Medical Assistance funds. The numbers of such patients can be estimated from those receiving Social Security Disability Insurance and Supplemental Security Income at state and small area levels (Ashbaugh & Manderscheid, 1985). Of an estimated 1.7–2.4 million chronically mentally ill persons in the United States (Goldman *et al*, 1983a), only 116 000 remained within state mental hospitals by 1983 (Bachrach, 1986a). A Government review of policy (General Accounting Office, 1977) demonstrated that community-based facilities have been implemented "in the absence of a planned, well-managed and systematic approach". In response to this criticism, NIMH Community Support Programs were established in 1977. Fifteen sites provided demonstration projects of services for chronic mentally ill patients (Scull, 1985). In reviewing the outcome of these initiatives, Tessler & Goldman (1982) saw this programme as "an incomplete reform". They found that the political trend towards shifting responsibility and costs for the chronic mentally ill from federal to state level threatened to undermine the benefit of these federal programmes.

Service developments in Italy

Far-reaching policy changes have been introduced more rapidly in Italy than in Britain and the United States (Mollica, 1985), and allow limited comparisons to be made. Data of the Central Institute of Statistics in Rome show that the number of psychiatric in-patients in Italian hospitals has declined annually since 1963 (Bennett, 1978; Tansella *et al*, 1987; Maj, 1985). Law 180, enacted in 1978, formalised and accelerated this pre-existing trend in the care of the mentally ill (Tansella *et al*, 1987). In the north-western region of Piedmont, for example, there was a fall from 5544 to 2396 psychiatric beds between 1977 and 1981 (Becker, 1985). In contradistinction to the policies in the United States and Britain, the major provisions laid out that no new patients be admitted to the large state hospitals, nor should there be any readmissions after 1 January 1982. No new psychiatric wards or hospitals were to be built. Psychiatric wards in general hospitals were not to exceed 15 beds and must be affiliated to community mental health centres. Community-based facilities would be responsible for a specified

geographical area, staffed by existing mental health personnel (Mosher, 1983).

In essence, the legislative reforms have reversed the previous order of priorities accorded to hospital and community forms of service provision (Perris & Kemali, 1985; Tansella, 1986). A number of evaluative studies have appeared in recent years (Rawnsley, 1986). Bollini *et al* (1986) performed a case-control descriptive study of patients in community mental health centres, psychiatric wards in general hospitals, private community facilities, and those remaining in large psychiatric hospitals. The patients remaining in the large institutions had more illiteracy, history of prolonged illness, organic diagnoses, and previous custodial treatment, and had lower expectations of their own social functioning.

At the national level, Tansella *et al* (1987) have reviewed the effects of the reforms on the structure and function of the Italian psychiatric services. As a result of the closure of hospitals since 1978, there had been a progressive decline in the number of public mental hospital beds, to a level of 0.76 per thousand of population by 1983. Secondly, the number of private psychiatric hospital beds had declined by 7% and the total number of patients by 12% in the three years following 1978. In the first two years after enactment, expenditure on community services increased by only 28%, to bring it up to 30% of the total psychiatric budget.

Finally, suicide rates have been examined as one index of psychiatric morbidity before and after 1978. Williams *et al* (1986) compared the trends in suicide rates attributable to mental illness between the periods 1973–77 and 1979–83. The rate was found to have increased consistently over the whole time period, with no clear increase in the proportion of suicides attributable to the legal changes.

The Italian reforms suggest that moving the centre of gravity of psychiatric services from hospitals to community services has been implemented rather slowly and inconsistently. Clear indications have not yet emerged on the adequacy of local services for the younger patients who would have otherwise constituted the 'new long-stay' patients (Mann & Cree, 1976; Becker, 1985).

Target levels for psychiatric services

There is considerable debate about the numbers of psychiatric beds that are necessary (Wing, 1971; Hailey 1971). The 1975 British White Paper suggested targets of 50 District General Hospital beds per 100 000 of the population, together with 35 for the elderly severely mentally infirm and 17 for the 'new' long-stay patients. More recently, the House of

TABLE I
Effects of deinstitutionalisation on the manifest functions of psychiatric hospitals

<i>Function</i>	<i>Effect of transferring function to community services</i>
Active treatment for short- to intermediate-stay patients	Function maintained or improved: but data from model programmes may not be generally applicable
Custody for long-stay patients	Function maintained in residential homes: quality of care variable
Physical assessment and treatment	Function may be better transferred to GP
Protection of patients from exploitation	Function markedly impaired: increased physical, sexual and financial vulnerability
Respite for family	Function equivocal: locus of treatment at home, offset by potential for increased professional support to family
Haven/asylum for patient	Function maintained in crisis/foster homes, or impaired in home treatment
Research and training centre	Function partially decentralised: greater co-ordination and flexibility required
Provision of day and out-patient services	Functions decentralised and may be impaired if successor services not established: renegotiation of responsibilities of health and social services for day care. Opportunities to work from health centres
Secure provision for involuntary and assaultative patients	Function vulnerable: clear commitment needed to provide well-staffed units
Occupation and vocational rehabilitation	Function at risk if industrial and occupational therapy not transferred
Shelter, nutrition, basic income and clothing	Functions decentralised and at risk without continuity of care

TABLE II
Effects of deinstitutionalisation on the latent functions of psychiatric hospitals

<i>Function</i>	<i>Effect of transferring function to community services</i>
Job security to professional ancillary staff	Function less secure: staff roles, numbers, location, and pay may change
Segregation from society of deviant or dangerous members	Function impaired: behavioural deviance more visible in urban areas
Economies of scale from block treatment	Function vulnerable: dependent upon size of residential settings and staff: patient ratios
Local tax base, and consumer of local goods and services	Function lost: redevelopment of hospital site may offset loss
Segregation within psychiatry of less attractive patients	Function impaired: but two-tier community services may develop
Structured roles and identities for staff and patients	Function eroded: risks of role blurring and patient anonymity
Providing the illusion of comprehensive care	Function reduced: consequences of inadequate care more publicly visible

Commons Social Services Committee report on Community Care (1985) noted that "a smaller number of in-patients beds is now thought necessary for general psychiatric services", and a Royal College of Psychiatrists working party has specified this as 44 acute beds for a population of 100 000 (Hirsch, 1988).

The process of service development

The manifest and latent functions of the psychiatric hospital

A clear understanding of what would constitute an adequate replacement of hospital care for the chronic

mentally ill must be based upon a knowledge of the functions served by such hospitals. Bachrach (1976) distinguished between the manifest and latent functions of institutions. The former are those that are intended and recognised by the participants, while the latter are unintended, unanticipated and often unrecognised consequences (Mirabi *et al*, 1985). These manifest and latent functions and the extent to which they can be maintained by community-based services are summarised in Tables I and II.

Analysed in this way it becomes clear that current policies focus almost entirely on the manifest hospital functions. Inadequate attention to the latent functions can provide barriers to the success of the whole programme.

Transitional issues: discharge planning

The selection of patients for rehabilitation has often proceeded in an unsystematic and *ad hoc* manner (Bachrach, 1976; Watts & Lavender, 1987; Falloon & Marshall, 1983). Discharge planning follows such patient selection, and has been shown to be highly variable between psychiatric units (Caton *et al.*, 1984b). Using a Discharge Planning Schedule, the authors found that drug treatment and psychiatric after-care were the best arranged provisions on discharge for a group of 119 chronic schizophrenic patients, while living arrangements were least satisfactorily planned. Adequate discharge planning was related to improved treatment compliance at three-month follow-up and to a reduced rate of early readmission. The timing and degree of consultation with patients and relatives may also improve outcome (Bachrach, 1976; Shugar *et al.*, 1986). Furthermore, in assessing the suitability of in-patients for discharge, both clinical and social disability need to be considered, as these may not be correlated (Wykes *et al.*, 1985; Sturt & Wykes, 1987; Brewin *et al.*, 1987).

To examine the effect of discharge planning, Linn *et al.* (1977) randomly allocated 420 chronic patients from five Veterans Administration hospitals to foster care preparation or continued hospitalisation and followed them up for four months. The experimental group, which excluded severely disturbed patients, showed improved social functioning and adjustment, and 88% had been discharged from hospital.

Principles guiding service development

The Royal College of Psychiatrists (1987), in collaboration with organisations representing psychiatric patients and their families, has set out the principles which should guide the establishment of a programme of local mental health services. They should be comprehensive in meeting the whole range of psychiatric disturbances, accessible geographically and culturally, and acceptable to clients, their families and their neighbours. The interventions should be of proven effectiveness, and must be efficient in cost-benefit terms.

Direct services

Models of residential services

The success of community-based services is crucially related to the nature and availability of accommodation. Within the British context, Wing & Furlong (1986) have described a ten-fold typology of sheltered housing for people with severe psychiatric

disorders. The level of least supervision is that of unsupervised housing, in which the individual lives alone or with family or friends. Contact with psychiatric services is through non-residential staff. A variation of this arrangement is to afford a degree of administrative protection, for example from eviction for incurring arrears in rent. At the next level, supervised housing provides regular domiciliary supervision by a mental health practitioner to sustain standards of hygiene, nutrition, and household maintenance (Anstee, 1985). In group homes, which may be arranged in clusters, several residents with psychiatric disorders share the same house, which may be supervised by a residential landlord or landlady, with support from visiting staff.

In supervised hostels, residents may each have a bedroom and share communal facilities, with residential staff offering close daily supervision (Goldberg *et al.*, 1985). A higher level of supervision is required for residents more disabled by psychiatric or physical conditions: the hostel model can be supplemented with night nursing staff, the provision of meals, and the supervision of budgeting (Wing, 1982). For those with severe behavioural disturbance, an intensive supervision hostel (or hostel-ward) may be needed, characterised by high staffing levels, a structured regime, a perimeter area, and the rapid availability of extra staff (Garety & Morris, 1984). Finally, a form of basic nursing unit will be necessary for people who are incontinent, immobile or disorientated.

In the United States, these gradations of care have been provided in a range of different settings. A level of support similar to supervised housing is provided in sheltered lodging, or board-and-care homes (Linn *et al.*, 1977). These are often privately owned homes or hotels that provide lodgings, meals, and medication management for an unlimited period (Blaustein & Viek, 1987). In 1977 approximately 20% of the two million chronic mentally ill people in the United States were living in such homes (Goldman, 1981). A further variation of this form of hostel is required for residents with severe physical disabilities, and in the United States nursing homes are the most frequently used provision for the elderly chronic mentally ill (Linn *et al.*, 1985).

It is argued, both by professionals (Lamb, 1982) and by the users of these forms of accommodation (Casteneda & Sommer, 1986), that a comprehensive psychiatric service must include a flexible range of accommodation, with many levels of professional support varying with the changing needs of each resident.

The facilities described in this section provide primarily for chronic psychotic patients in periods

of full or partial remission. Community-based alternatives and methods of crisis intervention are also being developed for the periods of relapse that have traditionally been managed in hospital (Brandon, 1970; Fenton *et al*, 1982; Hoult & Reynolds, 1984; Weisman, 1985) and have received critical attention elsewhere (Braun *et al*, 1981; Tantam, 1985; Marks *et al*, 1988).

The evaluation of residential services

Before turning to the question of how adequately residential services provide for long-term patients after discharge, it is necessary first to ask where the patients are (Johnstone *et al*, 1984). Leavitt (1984) made estimates for the 55 000 patients who would have been in state hospital beds, had deinstitutionalisation not occurred in California. He estimated that 45% were in board-and-care residential homes, 22% were independent or with their families, 7% were in locked facilities, 7% in halfway houses, and 9% were in-patients. The remaining 9% were untreated and mostly homeless. In Britain, Jones (1985) followed up 34 long-stay patients in York for one to two years after discharge. They had been in-patients continuously for more than 12 months before discharge, and 68% had a diagnosis of functional psychosis. She showed that 44% lived largely independently in their own homes, flats or lodgings, and as many lived in sheltered homes or hostels.

Evaluations of differing residential settings have been largely unsatisfactory, either because they were uncontrolled or inappropriately matched, or because residential provisions were only one among many variables in a 'package of care' delivered to discharged patients.

The quality of life of patients discharged to new residential facilities has been reviewed by Lehman (1983). In an uncontrolled study, Lehman *et al* (1982) administered the Quality of Life Interview to 278 randomly selected residents of board-and-care homes in Los Angeles. The respondents were most consistently dissatisfied with unemployment, poverty, housing, and their relationships with friends and family. In an extension of this project, Lehman *et al* (1986) compared quality of life between long-term hospital patients and residents in board-and-care homes. Regardless of their length of stay, the community residents perceived their living conditions more favourably, had more financial resources and were less likely to have been assaulted in the last year.

These findings are supported by a five- to nine-year follow-up study of 120 Feighner-criteria chronic schizophrenic patients discharged from Shenley

Hospital in North London (Johnstone *et al*, 1981). In the 66 cases where social information was available, 35% lived with a spouse, 39% with other family members, usually parents, 11% lived alone and 15% in residential accommodation. Although severe emotional, social, and financial problems were commonplace, not one patient in this study sought readmission to hospital, and few relatives favoured this course.

These studies plainly demonstrate the great variation in location at follow-up, with the majority needing continuing supported accommodation. This work also emphasises the need for effective monitoring and tracing systems for relocated patients.

That institutionalism may be independent of the size of the facility has been shown in a West German study of 961 chronic patients in nursing homes, group homes and a state hospital. Kunze (1985) demonstrated that the nursing homes manifested the most impoverished social environment, housed the most chronic and severely disabled schizophrenic patients, and were at least as likely to foster the features of institutionalism as the state hospital (Wing & Brown, 1970).

A considerable concern is that discharged patients will rapidly lose contact with services, in spite of remaining symptomatic or socially disabled. An uncontrolled interview study in Los Angeles of 101 residents of board-and-care homes who had been recently discharged from hospital found that initially over half had contact with community occupational rehabilitation services, but in only a quarter of cases was this maintained (Lamb, 1979). Among the whole group, over half had no goals to change any aspect of their lives (Lamb, 1977). At six-month follow-up a third of the patients had changed their accommodation at least once (Lamb, 1980).

The issue of residential mobility in the North American context was studied by Caton & Goldstein (1984a) in Manhattan. One year after discharge, half of the study group of 119 chronic schizophrenics had changed their living arrangements at least once. Typically, different housing placements were arranged after each readmission.

Models of occupational services

The significance of daily occupation is illustrated by the finding of Wing & Brown (1970) in the Three Hospital Study that the amount of time patients spent doing nothing was directly related to their levels of primary symptoms. Occupation may usefully be seen as either work (a purposeful activity requiring effort and discrimination that has a social

significance) or employment (an economic exchange relationship where effort is rendered for payment) (Hartley, 1980). Occupation may confer a sense of mastery, through the performance of social roles. It may also bring social status and social contacts. Finally, it can be a criterion of recovery (Shepherd, 1984). Many long-term psychiatric in-patients are involved with occupational therapy, but very few indeed maintain competitive employment (Ford *et al.*, 1987).

To respond to this need for occupational rehabilitation, a 'club-house' model of day-centre care has been developed, based upon Fountain House in New York (Beard, 1978). The chronic mentally ill become members of a club that offers a centre where they can drop in for social activities or refreshment. There are also concurrent programmes of vocational training which actively encourage members to participate in the planning and running of the club.

As an extension of the club-house approach, Transitional Employment Programs, also originating at Fountain House (Beard, 1982), are gaining in popularity in the United States. Each Program is an agency that negotiates positions for unskilled labour with local employers, and guarantees that there will be no employee absences. If a Program employee does not attend work, the vacancy is filled immediately from the pool of other workers, or by one of the Program staff (Beard, 1978).

Day hospitals were begun in Britain in 1946 after their establishment in the Soviet Union a decade earlier. They provide a service that can compare favourably with standard in-patient treatment for those in acute relapse (Hirsch *et al.*, 1979; Dick *et al.*, 1985). Unless, however, day hospitals are specially orientated to the needs of the chronic mentally ill (Archarya *et al.*, 1982), such patients are more likely to attend social service day centres, which are less well staffed, and more orientated towards support than treatment.

The evaluation of occupational services

Anthony has reviewed the literature on the specific effects of occupational rehabilitation programmes upon performance outside hospital (Anthony, 1972; Anthony *et al.*, 1978). Overall, the proportion of patients who are readmitted increases as the period of follow-up lengthens (Pryor & Distefano, 1986). Five to ten years after discharge, only 25–30% of the patients had avoided readmission. Several treatment variables were indicators of outcome. Day centre attendance was associated with lower readmission rates (Kruzich & Berg, 1985; Dickey

et al., 1986), as were medication compliance, and contact with psychiatric supervision. Contact with occupational centres is also highly associated with their geographical accessibility (Lamb, 1979).

The continuing need for in-patient facilities

Several authors have described groups of patients whose needs are not and will not be met by acute and community-based services alone (Rachlin, 1976; Bennett, 1979; Bowen, 1979; Talbott, 1984; Harris *et al.*, 1986b). These are the elderly demented and behaviourally disturbed, the mentally impaired and psychotic, the brain damaged and assaultive, the psychotic and assaultive, and those chronic schizophrenic patients who are vulnerable to neglect and exploitation. Gudeman & Shore (1984) have estimated that there are at least 15 patients per 100 000 population in these categories who cannot be adequately cared for in community facilities. Such patients will continue to require the provision of asylum, whether or not this is provided within asylums (Bachrach, 1986b).

The indirect provision of psychiatric services

The influence of patients' and public attitudes

Do long-stay in-patients wish to leave hospital? There is a notable lack of information about this (Weinstein, 1979). Abrahamson's survey (1982) showed that patients with more than ten years of hospitalisation are more likely to wish to remain in hospital, and usually gave realistic reasons. Conversely, patients' attitudes towards hospitalisation may strongly predict their length of hospital stay, and their likelihood of readmission (Drake & Wallach, 1988; Kalman, 1983).

Ambivalent or adverse public attitudes towards the discharged mentally ill may further attenuate the security of former patients (Goffman, 1968; Appelbaum, 1987). The seminal work of Nunnally (1961) on public attitudes towards the mentally ill demonstrated that they were regarded with fear, distrust and dislike by the general public. Their behaviour was seen to be characteristically unpredictable (Cumming & Cumming, 1957). Psychotics were held in lower esteem than neurotics. There was a much narrower range of attitudes than of knowledge. More recent work has suggested that public attitudes may be favourably influenced by educational programmes (Peterson, 1986) or by direct personal contact with former patients (Trute & Loewen, 1978; Schwartz *et al.*, 1974). The provision of services may have developed in

advance of the public education necessary for these services to function effectively.

The needs of care-givers for support and information

The paramount need for consistent, carefully organised support is a recurrent theme in the literature on deinstitutionalisation (Mollica, 1983; Brown, 1985; Mechanic & Aiken, 1987). For the public, such support means education to deal with disproportionate fears. For patients' relatives, support translates into psycho-educational intervention, and counselling about the range of financial, vocational, domestic, and mutual-help services available (Falloon *et al*, 1985; Grunebaum, 1986; Creer & Wing, 1974; Marks *et al*, 1988). The employees and proprietors of public and private residential facilities in turn face the risk of isolation unless they receive professional consultation and statutory monitoring of their quality of care (Blaustein & Viek, 1987; Scull, 1985). The needs and views of staff during the transition from hospital must be dealt with directly (Bachrach, 1976; COHSE, 1984; Towell & McAusland, 1984) if misunderstanding and resistance are to be avoided (Talbot, 1978; Greenblatt & Budson, 1976). Finally, administrative support must be rendered to institutions in decline to maintain morale, adequate staffing levels and treatment standards, and to avoid staff 'burnout' (Mendal, 1979; Lamb, 1982).

Psychiatric services provided at the primary care level

General practitioners provide the overwhelming bulk of all care for psychiatric problems (Goldberg & Huxley, 1980), and about 8% of patients seen in primary care suffer from a chronic mental disorder (Wilkinson, 1988; Wilkinson *et al*, 1985). The redeployment of psychiatric staff outside the psychiatric hospital has generated new forms of collaboration between the primary and secondary care services. Over one-fifth of British psychiatrists now see patients in primary care centres (Strathdee & Williams, 1984). This may include a greater emphasis upon home visits, holding out-patient clinics in general practitioner surgeries, seeing selected patients at the request of family doctors, acting as a consultant to the primary care team, or seeing patients jointly with their general practice colleagues (Mitchell, 1985; Monk-Jorgensen, 1986).

The implications of transferring the locus of care from hospital

Homelessness and the failure of residential provision

Homelessness has rightly become a predominant issue in the North American literature concerning the chronic mentally ill (Bassuk & Gerson, 1978; Fischer & Breakey, 1986; Appelbaum, 1987; Farr, 1986). The National Coalition for the Homeless estimated that, in 1983, 2.5 million people were without accommodation in the USA (Bassuk, 1984). NIMH studies suggest that at least 30% of these suffer from serious and persistent mental illness (Morrisey & Levine, 1987). These recent surveys conducted in the period 1983–1986 in ten NIMH-funded centres were consistent in finding that the homeless mentally ill had multiple needs, tended to be long-term residents in their local areas, and had frequent police contact (Lamb, 1982).

Many of these 'new rootless' use emergency night shelters on a routine basis. Surveys at such shelters across the United States agree in indicating mental illness rates in the range 41–93%, alcohol dependency in over 60%, and chronic medical and dental problems in over 40% of this group (Bassuk *et al*, 1984; Fischer & Breakey, 1986; Kroll *et al*, 1986). These individuals characteristically had very restricted social support networks, little contact with psychiatric services, lower readmission rates than their domiciled counterparts, and little likelihood of referral to long-term care facilities (Appleby & Desai, 1985). Local psychiatric facilities clearly do not serve these homeless mentally ill at all adequately (Lamb, 1984).

The relatively scant British psychiatric research literature on the homeless mentally ill has focused on people living in lodging houses (Priest, 1976), reception centres (Leach & Wing, 1978), and those in prison or hospital who are of no fixed abode (Berry & Orwin, 1966; Herzberg, 1987). As in the North American studies, variations in the methods of case identification and the heterogeneity of the samples selected have produced a very wide range of values for the prevalence of such disorders. No clear findings have yet emerged. There is concern, however, from a series of small surveys of shelter users, that a large (36%) and rising proportion have a mental disorder, and that this may reflect the consequences of discharging psychiatric patients without adequate, or indeed any, follow-up (Weller *et al*, 1987).

What lessons emerge that may allow the prevention of homelessness among the chronic mentally

ill? Drawing together the implications of this failure of public policy, the American Psychiatric Association Task Force on the Homeless Mentally Ill reported that homelessness was not a consequence of deinstitutionalisation *per se*, but of the way in which it had been carried out. It recommended the establishment of a wide range of local supervised housing options, and a greater provision of general medical care, peripatetic psychiatric services and crisis intervention, together with a secure and simplified source of income. It further recommended that the mental health services should become more integrated, based upon the case manager model, and that asylum should be provided for the small proportion of patients who continued to need sanctuary (Lamb & Talbott, 1986).

The integration of clinical responsibility

For psychiatric teams working with the chronic mentally ill, the concept of the 'case manager' is increasingly influential (Intagliata, 1982; Harris & Bergman, 1988). A particular staff member is given the primary responsibility for named patients. The case manager will act as advocate and as broker between the various service agencies concerned with each case, maintain the central therapeutic relationship, monitor the patient's well-being and progress, and plan social and occupational goals. The case manager model is increasingly used within the context of the multidisciplinary team (Mechanic, 1986) to ensure the maintenance of continuity of care, without which a high proportion of patients are lost to follow-up (Torrey, 1986; Bachrach, 1976; Tantam & Klerman, 1979). As yet, however, there is a paucity of evaluative research on the costs and effectiveness of case management (Franklin, 1988).

The administrative integration of services

The administrative integration of services has also been advocated within Britain through the allocation of development funds, competed for and administered by district-based Joint Mental Health Development Committees. In the National Health Service, current revenue expenditure on joint finance and per capita transfer payments amounts to about £100 million a year from a total expenditure of £3 billion for the mentally ill. The capital assets released by the closing of institutions may exceed £500 million (Audit Commission, 1986). The Griffiths Report (1988) proposed that local government social service departments accept responsibility for being the 'lead agency' in managing community services for the mentally ill, although the Department of Health is likely to recommend that District Health Authorities take on this 'lead agency' role.

There is a striking consensus in the literature on deinstitutionalisation that the variety of individual service components must be integrated into a programme of care (Stein & Test, 1980; Test & Stein, 1980; Mollica, 1983; Murphy, 1988). Such a programme should be based on clear public policy and priorities for the chronic mentally ill (Pepper, 1987; Murphy, 1987). Responsibility at each level needs to be clearly established. Measurable objectives for each element of the service must be defined and regularly reviewed, and this implies a regional or national inspectorate to monitor quality of care (Griffiths, 1988).

Financing deinstitutionalisation

How cost-effective are community-based forms of psychiatric care? In general, the more sophisticated the evaluation, the less apparent the cost advantage of home-based care. Weisbrod *et al* (1980) performed a cost-benefit analysis on an experimental home-based care programme in Madison, Wisconsin. They found additional annual costs for each person in the experimental group of \$800, but this was outweighed by additional benefits totalling \$1200, largely accruing from a doubling of patients' earnings. They were, however, unable to quantify 'hidden costs' (Bachrach, 1976; Scharfstein, 1978) such as the burdens upon neighbours, illegal activities, and the costs of occupation. Fenton *et al* (1982) compared home and hospital treatment for severely mentally ill patients. They found that manpower and operating charges formed the greater part of the total costs and were higher in the hospital group, but the group treated at home incurred greater costs for transport and medication. Although the relatives of the home-treated group had insignificant loss of work time, they commonly experienced symptoms of depression.

A less complete evaluation of the range of costs incurred by a community care programme in Chicago demonstrated that a psychosocial programme could produce savings of between \$2000 and \$5000 annually for each patient (Bond, 1984). Using a randomised controlled design, Linn *et al* (1985) followed up 403 male chronic psychiatric patients allocated to community nursing homes, to hospital care and to two intermediate groups. Annual costs per patient in the nursing homes, at \$20 000, was \$11 000 less than for the hospitalised cases. The important point, however, is that the patients allocated to the nursing home showed significantly worse outcome in terms of self-care, behavioural deterioration, mental confusion, depression and satisfaction with care. A further randomised

control design at the Quarterway House in Boston (Dickey *et al*, 1986), but using only 22 patients "who had no potential for community placement", compared traditional long-term hospital care with an experimental programme that provided an intermediate level of 24-hour care. There was no difference in clinical or social function at two-year follow-up but for the experimental group there was a total annual saving of \$7000 per patient.

There is evidence that the transfer of patients from state hospitals in the USA has produced both a considerable cost saving and cost shifting. An analysis in the ten San Francisco Bay Area counties (Leavitt, 1984) estimated that this policy had produced a net annual saving of \$400 million to each county and that when extrapolated to the State of California, this amounted to a saving of \$1.3 billion, most of which had been diverted away from the chronic mentally ill. The introduction of Medicaid in the mid-1960s enabled both a transfer of obligation to be made from state to federal budgets (Mechanic, 1986) and a more rapid transfer of patients to nursing homes (Scull, 1985).

In sum, these studies tend to follow-up selected groups of patients over inadequate periods of time. They vary considerably in the completeness of estimating community-care costs. The more comprehensive community programmes tend to show less short-term cost saving and to require forms of bridging finance. Conversely, the least expensive successor services have been shown to offer an equivalent or worse standard of care than the asylum. The balance of current evidence is that adequate community care is no cheaper than inadequate hospital care.

Conclusion

How much progress has been made towards the British policy targets since the publication of the 1975 White Paper? The 67 000 remaining psychiatric in-patients in 1984 represented 45% of the total target reduction over the decade. The 6800 residential places were 41% of the proposed target increase, and the 17 000 day hospital places were only 17% of the target figure. The 9000 places available in day centres showed an increase of only 16% towards the stated target of 28 200. From these figures alone it is clear that the rate of hospital rundown has far outstripped the development of successor services (Audit Commission, 1986). On this evidence deinstitutionalisation is succeeding; new provision is not.

The dangers of deinstitutionalisation imperfectly implemented are clear. Those discharged face the

prospect of isolated, segregated, impoverished, and under-stimulated lives. They have a high likelihood of homelessness and recurrent admission (Goldstein & Caton, 1983; Craig *et al*, 1984; Pepper *et al*, 1981; Bachrach, 1984*b*; Linn *et al*, 1985; Harris *et al*, 1986). In short, such discharged patients are at risk of multiple disadvantage and neglect (Bachrach, 1976). Seen in the longer historical perspective of cycles of care for the chronically mentally ill (Morrissey & Goldman, 1984), deinstitutionalisation has passed through a phase of the idealisation of community care (Banton *et al*, 1985; Minkoff, 1987). It may yet decay into the disillusionment of reinstitutionalisation (Elpers, 1987).

More positively, the following points emerge clearly from the literature. Community care, properly provided, can indeed improve the quality of life of the seriously mentally ill, but there will, however, be a continuing need to provide asylum for the most disabled patients. Adequate community provision is no cheaper than institutional care and will be more expensive in the bridging period, when elements of both services are provided. Finally, the full potential of community-based psychiatric services will only be realised where the administrative and financial structures exist to integrate local services into a co-ordinated programme of care.

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