From the asylum to community care: learning from experience

Helen Killaspy*

Department of Mental Health Sciences, Royal Free and University College London Medical School, London NW3 2PF, UK

Introduction: A review of research and policy on community care was carried out.

Methods: The methods used included the following: (i) Medline search using terms: ‘mental health’ and ‘community care and long-term conditions’ and ‘community care’; (ii) Searches of the Department of Health and the Royal College of Psychiatrists’ websites using the term ‘community care’ and (iii) hand search of historical texts on the development of community care.

Results: Medline searches returned 349 titles in total. Inclusion criteria were quality and relevance to other specialties. Policy material was included to illustrate the socio-political context of the development of community services. Community care was consistently associated with greater patient satisfaction and quality of life across specialties. It was not a cheaper alternative to hospital care. Disadvantages included the exodus of experienced inpatient staff to community settings and the development of alternative institutions in the non-statutory sector.

Conclusions: Those planning community-based care for physical health problems should learn from the experience of mental health services.

Keywords: community care/mental health/physical care

Introduction

In this review, the process of deinstitutionalization of psychiatric services to community-based care over the last 50 years is used as an example from which other specialties could draw as they attempt to respond to current directives on the provision of increased community care for longer term physical illnesses.
Methods

A search of Medline from 1950 onwards using the search terms ‘community care’ and ‘mental health’ and community care and ‘long-term conditions’ was carried out. Searches of the Department of Health (DH) and Royal College of Psychiatrists’ websites were carried out using the search term community care in each website’s own search engine to identify relevant policy and guidance documents. In order to provide an overview of the historical perspective of the development of community care in relation to psychiatry, hand searches of historical accounts of the asylums and their closure were carried out at the libraries of University College London (Hampstead Campus) and the Institute of Psychiatry.

Results

The Medline search for community care and mental health identified 287 titles. When mental health was substituted for long-term conditions, no titles were returned. The term ‘physical’ was therefore substituted for long-term conditions and identified 62 titles. Research papers were included on the basis of the quality of the paper or research and the relevance of the content for a broad audience. Policy, legislation and guidance documents were included to illustrate the social and political context supporting the development of community care in the UK. International policies were not included. Although there are a number of books and records detailing the history of the asylums, the historical materials included in this article were selected for their inclusion of relevant information about the development of community services prior to the closure of the asylums.

The history of psychiatric services

The origins of psychiatric services in England date back to 1247 when a monastic priory was founded in the city of London on the site where Liverpool Street station now stands. This priory provided shelter for the sick and infirm and from 1330 onwards was referred to as a hospital, The Bethlem Hospital (the name being derived from Bethlehem). In 1403, King Henry IV ordered a Royal Commission to investigate allegations of scandals, malpractice and embezzlement of funds at the Bethlem Hospital. The report of the Royal Commission provides the earliest evidence that the Bethlem Hospital was treating men suffering from insanity as well as from physical illnesses.1
In 1676, the city of London commissioned a new building for the Bethlem Hospital to be built at Moorfields. This was the first hospital for the insane in the UK. This building became something of a tourist attraction and the patients considered most appropriate for admission were described in Stow’s Survey of London (1720) as:

‘those that are raving and furious and capable of Cure; or, if not, yet are likely to do mischief to themselves or others; and are Poor and cannot be otherwise provided for’.\(^1\)

Concern for the well being of those suffering from mental illness gradually increased and was particularly embraced in the charitable social and political policy of the Victorians. County asylums were the recommendation of a House of Commons select committee, which had been set up in 1807 to ‘enquire into the state of lunatics’. Legislation in support of the establishment of asylums followed, including Wynn’s Act of 1808 ‘for the better care and maintenance of lunatics, being paupers or criminals’ and the Shaftesbury Acts of 1845 ‘for the regulation of the care and treatment of lunatics’.\(^2\)

Most asylums were built on the outskirts of major cities, in order to provide a rural retreat for patients. Most operated as self-sufficient communities with their own water supplies, farms, laundries and factories. They were therefore isolated from the local community and psychiatrists working with them were isolated from their colleagues in other medical specialties. The Lunacy Act of 1890 set the parameters for admission, providing a legal system in which a patient had to be certified as insane in order to be admitted to the asylum. Under the Act, asylums became ‘a last resort for the insane rather than a means to their recovery’.\(^3\) No psychiatric opinion was sought prior to admission. The parish doctor declared patients insane and they were then placed on a compulsory reception order by a local magistrate and taken to the asylum.\(^2\) As Henry Rollin describes in his autobiography:

‘Medical officers in mental hospitals had no control over the selection of the patients they were called upon to treat, nor was there any opportunity to follow them up once they had been discharged into the community’.\(^4\)

There was no legislative provision for patients to be treated voluntarily in the asylum, but the situation was different for registered hospitals such as the Bethlem where admissions could take place free from certification. The Bethlem stopped admitting parish patients in 1857 and, from the late nineteenth century, prided itself on being one of the pioneers of uncertified cases. By 1900, only 3% of patients were certified
when compared with 97% of the asylum population. Admission policy at the Bethlem during this period specified that no patient could be admitted if they had been unwell within the previous 12 months and the length of stay should not exceed 12 months.

These differences in admission criteria contributed to an exponential rise in the asylum population. Colney Hatch Asylum, the largest in Europe, was originally built to accommodate 1250 patients but was enlarged within 10 years to take 2000 and in 1937 (when it was renamed Friern Hospital), there were 2700 patients. The rising population was due to a number of factors including the admission of many severely disabled patients who could never be discharged and the expanding Middlesex population. There were also a large number of poorly understood and untreatable conditions presenting with psychiatric symptoms such as metabolic disorders, lead poisoning, syphilis and intracranial tumours. Once admitted to the asylum, medical officers’ duties included classifying patients as ‘curable’ or ‘incurable’ according to the duration of their illness and the presence of complications such as epilepsy and paralysis.

In order to address the ever increasing asylum population, the Mental Treatment Act of 1930 extended the voluntary admission procedure to asylums, which encouraged them to establish outpatient departments ‘for the examination of applicants as to their fitness for reception as voluntary patients into asylums’. In 1925, there were 25 psychiatric outpatient departments in the UK and by 1935, this figure had increased to 162. These were the origins of community psychiatric services.

The closure of the asylums

The establishment of the National Health Service in 1948, the introduction of phenothiazine drugs in the 1950s and the social and political climate around this time were all factors that influenced the gradual closure of the large Victorian institutions. This led to the increasing awareness that to keep patients in hospital when they had recovered from the acute stage of their illness was an infringement of their human rights. The 1957 Royal Commission on the Law Relating to Mental Illness and Mental Deficiency recommended that ‘no patient should be retained as a hospital inpatient when he has reached the stage at which he could go home’.

The 1959 Mental Health Act was the first mental health legislation to clarify the reasons why an individual might need to be admitted to hospital and treated against their will, and the distinction between voluntary and involuntary treatments became clearer. The work of
Goffman and Wing and Brown on institutionalization of psychiatric patients and the poor standards of care and quality of life fuelled a political and social movement to close down the Victorian asylums. In 1961, Enoch Powell gave his renowned ‘water tower’ speech in support of the dissolution of the asylums, and in 1962, the Hospital Plan for England and Wales predicted the closure of half of all mental health beds by 1975.

Community mental health service provision

There followed a dramatic change in the location of psychiatric service provision. In 1971, a Government paper on ‘Hospital Services for the Mentally Ill’ proposed the complete abolition of the mental hospital system with all services being delivered by district general hospitals with close liaison with general practitioners and social services. The model adopted by the district general hospitals for the organization of psychiatric services was the same as for other hospital disciplines, namely, inpatient and outpatient facilities within the hospital building. Outpatient clinics, therefore, became an integral part of psychiatric service provision and moved from having a triage function to becoming a resource for both assessment and follow-up.

Alongside these developments, there was a shift towards the provision of other community-based services for people with mental illnesses, such as supported housing, day services and community-based mental health nurses and social workers. This was colloquially referred to as community care and was supported by government policies such as ‘Better Services for the Mentally Ill’, ‘Care in the Community’ and ‘Community Care with Special Reference to Mentally Ill and Mentally Handicapped people’.

Reported inadequacies in community service provision for those individuals who had previously lived in asylums have provoked a great deal of debate over the last 40–50 years. However, the tenor of this dialogue has altered. Early critics often cited that there were increased numbers of people with mental health problems who had become homeless secondary to the closure of the asylums and cited this as evidence that community care had ‘failed’. However, longer term studies of the outcomes for people who had spent many years living in the asylums have shown that the majority of people, even those with the most complex problems, have increased their social networks, gained independent living skills, improved their quality of life and have not required re-admission.

Events in the 1990s turned societal attention from charitable concern for this group’s welfare to an increasing fear of them. The high profile
case of Christopher Clunis, a man with a diagnosis of schizophrenia, who murdered Jonathan Zito in an unprovoked attack at Finsbury Park station in London,\textsuperscript{18} highlighted the potential for community patients living a transitory lifestyle to lose contact with mental health services. The implementation of the Care Programme Approach (CPA),\textsuperscript{19,20} which is still a fundamental framework within which mental health services operate, attempted to improve continuity of care for people with mental health problems. All patients considered appropriate for the CPA have an identified professional who co-ordinates their community care package and who arranges regular reviews of their care with other professionals including their consultant psychiatrist. Handover of this responsibility has to take place through a formal process if the patient moves to another geographical area to minimize the chances of them becoming disengaged from services.

In addition, the National Service Framework for Mental Health\textsuperscript{21} detailed the development of a number of new community mental health services that were designed to interface with existing community mental health teams but to focus on certain groups. Two of the three new models, early intervention services and crisis resolution teams, have both been shown to reduce the likelihood of admission when compared with community mental health team care and to lead to improved patient satisfaction with services.\textsuperscript{22,23} However, assertive outreach teams have not been found to be able to reduce admissions in the UK\textsuperscript{24,25} despite good evidence for their efficacy in this regard in the USA and Australia.\textsuperscript{26} This model, developed in the USA, specifically focuses on people with severe and enduring mental health problems who have difficulties engaging with services and who are high users of inpatient care. It has been suggested that the reason for the lack of efficacy of assertive outreach in the UK may be due to replication of certain critical components of the model by the services with which it has been compared (community mental health teams), specifically integration of health and social care management and greater use of home visiting than the comparison services in the USA.\textsuperscript{27} In other words, in contexts where there are well-developed community mental health systems, it is harder for assertive outreach teams to reduce inpatient use. However, even in the UK, it does appear to be more successful at engaging this group than community mental health teams and patient satisfaction is also greater.\textsuperscript{24,26}

One unforeseen and negative consequence of the National Service Framework’s investment in community care has been the exodus of experienced staff from inpatient to community settings. A report by the Sainsbury Centre for Mental Health\textsuperscript{28} stated that 25% of inpatient staff had left their jobs to work in the new community teams. In addition, mental health wards have become increasingly difficult places
to work and, for patients, difficult places to recover from mental illness as they now concentrate on those who are most unwell and cannot be treated in the community. The poor conditions exacerbate staff retention problems leading to disproportionate numbers of inexperienced or temporary staff.

Some service developments from the National Service Framework may have been, at least in part, a response to public concerns about the risk that mental health service users living in the community pose to others. However, evidence from a large study in Victoria, Australia showed that in the 25 years since deinstitutionalization, the proportion of people with a mental health problem charged with an offence rose at the same rate as a control group drawn from the general population. In England and Wales, the national survey of homicide and suicide among people with mental illness found that the majority of those with a mental illness who commit homicide do not have a severe mental illness and have never been in contact with mental health services. In addition, only one-quarter of people who commit suicide have had contact with mental health services in the previous year and one-quarter of these were inpatients at the time. These data do not support assertions that community care (in terms of secondary mental health care) has failed. However, it is well established that the identification of mental health problems in people presenting to primary care services is difficult and few are referred to secondary mental health services.

Supported accommodation and the virtual asylum

With the closure of the asylums came an expansion in provision of specialized housing for people with mental health problems by health and social services, voluntary organizations and housing associations. Legislation such as the 1990 National Health Service and Community Care Act as well as the Supporting People initiative has facilitated non-statutory agencies to develop and provide specialized housing. These include independent tenancies with community workers providing outreach support, supported tenancies with staff on site and staffed hostels, group homes, residential care homes and nursing homes. There have been no trials investigating the efficacy of different types of specialized housing to date, which reflects the inherent feasibility issues in carrying out this type of research, but certain models appear to be developing secondary to patient preferences, with increasing investment in supported flats rather than group settings because the majority of services users prefer their own independent living space.

Although this emphasis on the promotion of independence is encouraging, there remains a group of patients whose needs are such that they
continue to require inpatient care. This group, most of whom are detained under the Mental Health Act, has arisen since the closure of the asylums. They have been called the ‘new long stay’ \(^{37}\) and their existence has undermined the previously held view that the social impairment associated with certain mental illnesses was due to institutionalization. In response to this, the reduction in psychiatric inpatient beds since the 1950s has been more or less equalled by an increase in the provision in the private sector for this group, the so called ‘virtual asylum’. \(^{38}\) In addition, many health and social service localities find it impossible to provide sufficient residential and nursing home places for those leaving hospital and outsource to facilities away from the local area. Concerns about the quality and continuity of care for people placed in these ‘out of area treatments’ (OATs) and the associated social dislocation have been identified. \(^{39}\) There is also concern that those commissioning these services have inadequate information about the clients they place there, the facilities provided and lack systems for review of placements. \(^{40}\) Overall, the cost of the whole virtual asylum to the NHS alone has been estimated at £222 millions per year. \(^{41}\) This process of ‘reinstitutionalization’ appears to be taking place elsewhere in Europe too. \(^{42}\)

**Costs of community care**

As inpatient bed use is the most expensive component of health care, community alternatives can appear attractive and potentially cheaper. However, Macpherson et al.’s \(^{43}\) review of supported accommodation for people with severe mental illness included reference to an investigation of the costs associated with hospital-based and community-based mental health care. This concluded that appropriate community care is not a cheaper alternative to hospital care and that the costs associated with caring for those with high levels of need in the community may be greater than hospital care. In line with this, McCrone et al. \(^{44}\) compared two geographical areas, one of which had more intensive community mental health services than the other area, and found that services provided to clients in the intensive area cost more than those in the standard area and that older age and higher levels of disability were associated with higher costs.

**Socio-cultural factors**

A study that compared inpatient mental health care in two areas where deinstitutionalization was well established (Verona, Italy and Victoria, Australia) and one area where most care was still hospital-based
(Groningen, The Netherlands) found that the length of stay was shorter where community services were well developed.\textsuperscript{45} However, the likelihood of admission was greater in Italy than Australia. There was no clear explanation for this, which suggests that socio-cultural factors and admission thresholds play an important part in how minimal inpatient service use can become.

In keeping with this, the ‘AdHOC’ study\textsuperscript{46} compared models of community care for 4500 older adults in 11 European countries and found that recipients of community care in France and Italy had high physical and cognitive needs, whereas those in Northern Europe had much less impairment of their activities of daily living. The highest levels of formal care were received by participants in the UK and the lowest levels were in Italy. In addition, it has been found that a higher proportion of patients in Italy live with relatives than in the USA,\textsuperscript{47} which supports the importance of the role of socio-cultural factors in determining the amount and type of community care delivered.

\textit{Social inclusion}

The degree to which society is willing to accept people with mental health problems has an obvious impact on their quality of life and the success of community-based care. Recent governmental support for the promotion of more socially inclusive practices for the mentally ill has come from the Social Exclusion Unit of the Office of the Deputy Prime Minister’s report on mental health.\textsuperscript{48} It identifies the needs for improved access to mainstream work, education and leisure facilities, with a resulting reduced dependence on specialist institutions such as day centres. It also includes public campaigns to reduce stigma and discrimination against people with mental health problems and the promotion of existing legislation around equality. This agenda has been strongly influenced by the success of the civil rights movement and organizations such as the Disability Rights Commission in their campaigns to gain equality in many aspects of life for people with physical disabilities. It might, therefore, be expected that society will be more familiar with these issues and supportive of community care for people with physical health needs than has been the case for people with mental health problems.

\textit{Community care for other conditions}

The Government’s white paper, ‘Our Health, Our Care, Our Say’\textsuperscript{49} details the increased expectation that services will focus more on community care and less on hospital care for long-term physical conditions.
Together with National Service Frameworks for Coronary Heart Disease, Diabetes, Renal Services, Long Term (Neurological) Conditions and Mental Health, there is a clear governmental steer to increase home-based services to people whose health problems place them at risk of recurrent hospital admissions. These initiatives are driven by a desire to improve integration between health and social care provision for people with multiple and complex health needs, with the aim of improving the patient experience and reducing the risk of relapse and hospital admission. The White Paper also identifies a shift in resources into prevention of illness and the development of ‘community hospitals’ to provide dermatology, ear, nose and throat, medicine, general surgery, orthopaedics, urology and gynaecology services. In addition, community matrons will support these new ways of working. These are highly skilled community practitioners whose role will include co-ordination of health and social care services for people with complex physical health needs as well as carrying out investigations and administering treatments.50

It remains to be seen whether these approaches will reduce admissions. A systematic review of home care programmes for patients with cancer found that quality of life and satisfaction with services were greater for those treated at home, but there were equivocal findings regarding the impact of the programmes on inpatient bed use.51 A recent systematic review of nurse-led community management for patients with chronic obstructive pulmonary disease did not find an advantage over treatment as usual, but this may have been in part due to the paucity of high quality trials (such as well-conducted randomized controlled trials) that have investigated it.52 However, there is growing support for self-care programmes based on ‘expert patient’ initiatives, which are considered suitable for 70–80% of people with long-term conditions and are reported to empower patients and to reduce demands on resources.53

Discussion

The evidence from this review suggests that a number of areas should be given attention when services shift from hospital-based to community-based models of care. Perhaps, the most important message is that community services cannot completely replace hospital care. Some patients, particularly those with higher levels of need, may remain supported at home for longer with the input of more intensive forms of home treatment but still require admissions from time to time. Among mental health service users, being unemployed or single increases the chance of inpatient bed use 2-fold and those with more severe and complex problems such as psychosis and personality disorders are more likely to
It may be the case that people with other forms of long-term health needs who are socially isolated and on lower incomes are also at higher risk of admission. In fact, Thornicroft and Tansella’s review of community mental health service provision clarifies that a balanced service includes inpatient beds, although the number of beds inversely reflects the quantity and quality of community resources available. They conclude that to enable a balanced system to work, resources from reductions in inpatient services should be invested into community services. In other words, community services are not cheaper alternatives to hospital-based services, but should be seen as part of a whole system. Therefore, the focus on inpatient bed use as a measure of efficacy needs to be considered in the context of its integral role within this system, accepting that it is the most expensive element of care.

The evidence presented highlights some benefits of community-based care, which are consistent across specialties such as greater patient satisfaction and quality of life. However, for those people with high levels of need, the experience from mental health services suggests that awareness of the potential for inpatient beds to be gradually replaced by other forms of institutional care in the non-statutory sector is needed. A further problem is that new community services may draw staff away from inpatient settings which become increasingly focused on the most severely unwell, which, in turn, makes the ward environment an increasingly difficult place to work, leading to further staff retention issues and poorer quality of care for those who require hospital admission.

This article has attempted to review the major research, legislation and policy relating to 50 years of community mental health care and to draw out themes relevant to service planners and providers responding to the current political and social drives to expand community care for other specialties. Currently, there is a need for further research in this field, particularly for randomized controlled trials of different models of community care for people with long-term physical health needs. Since the era of community care has arrived, the experience and evidence base of mental health services should inform other specialties. It seems unlikely that the critics of community mental health care will have the same unfounded allegations of ‘failure’ for the community care of those with physical health problems, so this era should provide a source for health services research with a patient centred and therapeutically optimistic focus.

With this in mind and to conclude, a study that investigated the characteristics of good community care for people with severe mental illnesses from the perspectives of clients, families, professionals, policy makers and other citizens in five European countries found that the most important characteristic was a trusting and stimulating relationship between clients and professionals. Good care was defined as effective treatment...
tailored to individual needs and accessibility of services was also highly rated. These factors are clearly relevant to all patients, irrespective of their health needs and the location of their treatment.

References

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