possibility would be to offer practices a nursing capitation fee in return for appointing a nurse partner. The income from this fee would cover the costs of all nursing services and include an element of profit to pay the nurse partner. Family health services authorities would determine the range and quality of nursing services to be provided, but the practice would decide how to meet those needs. This model is a logical extension of the payment structure for general practitioner partnerships, and would provide a flexible service at lower cost by eliminating several tiers of nursing administration.

The current discussions demonstrate that the present inconsistent pattern of nursing in the community should not continue. Doctors and nurses either have to propose structures that will put the primary health care team on a more sound managerial footing, or face an increasing division between themselves and a separately managed community nursing team. It is important that those actually working in primary care involve themselves in the discussions, so that decisions are not made only by those who have a vested interest in continuing a service managed from the centre. The reward could be a more integrated primary health care service offering better, more cost effective care through genuine teamwork.

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# Care for patients discharged from psychiatric hospital

THE mental hospital closure programme is now well advanced. Approximately 30 hospitals have been closed and 100 000 longstay patients have been discharged.[1] About 4000 patients have found homes in various types of local authority or voluntary association accommodation, but little is known about the whereabouts of the rest. Some are with families, some are living independently or in lodging houses, some are on the streets, some in prison, some have died and some have returned to asylum care.

The psychiatric problems of this group vary. They include personality disorders, manic depressive psychosis, chronic depression, early dementia, mental handicap and alcohol psychosis. But by far the commonest diagnosis is that of schizophrenia, in various stages of activity and severity. It has been stated that about 25% of all schizophrenics will make a good recovery, 10% will not respond to treatment and will remain severely ill, and the rest will respond to a degree but will remain vulnerable and in need of long-term support and medication (Leff J, personal communication).

The social problems of schizophrenics are usually considerable and have been well documented; but these people also have a need for care from medical staff. It has been said that psychiatric patients are more likely than the general population to be harbouring physical disease,[2] and Brugha found that 41% of long-term psychiatric service users had serious medical problems.[3] Although accurate figures are scarce, there is fairly general agreement that 'the relative risk of death in schizophrenia is increased twofold'.[4] Certainly the impression is that these patients are prone to self-neglect, live in poor housing and poverty, and tend to smoke and drink too much. Suicide and accidents are the commonest causes of death in this group of patients.[3] Schizophrenics may not register with general practitioners and in a survey carried out in south Camden 25% of schizophrenics were thought to be out of touch with all medical services (unpublished results).

However, general practitioners are now taking on the care of longstay mental hospital patients living in local authority hostels and this is likely to affect their workload considerably. I visited three newly established hostels regularly for a year and collected information from the medical records about the health needs of the residents and about their contacts with doctors.[5] I also questioned the general practitioners providing care to the residents and the psychiatrists who were in contact with the hostels.

Twenty six people lived in the hostels and their age range was 24–77 years. The majority were chronic schizophrenics recently discharged from asylum care of between five and 60 years' duration. As well as their psychological disabilities, they had many other problems. Four suffered from diabetes, four suffered from epilepsy and several had behavioural problems including mutism and incontinence. During the year there were cardiovascular, diabetic and abdominal emergencies as well as several emergencies owing to falls and accidents. Three residents were readmitted to permanent asylum care and three needed short-term admission.

The hostels were staffed by trained psychiatric nurses and care assistants on a 24-hour rota system. A total of 24 staff cared for the 26 residents, the high ratio being necessary because of the nature of the work, staff absences and changes, and the need for constant cover. The residents were all registered with local general practitioners, although initial reluctance to accept these patients had had to be overcome.

Three patterns of care were found in the three hostels. In one, a general practitioner from a three-doctor practice shared the provision of care with a community psychiatrist, the one dealing with 'physical' problems, the other mainly with 'psychological' problems, although there was inevitably overlap. In the second hostel, nine general practitioners from four practices were involved but, in reality, care was provided by a hospital consultant psychiatrist who dealt with physical as well as psychological problems. In the third hostel, two practices were involved and the residents, a somewhat younger and less disabled group, were able to consult as ordinary National Health Service patients. A community psychiatrist made regular contact with the third hostel.

Thus, three models of medical care were demonstrated in the hostels. The first, shared care, worked well but there were problems in communication and in defining areas of responsibility, and this produced difficulties for the staff. In the second pat-

tern, most of the care was provided by the psychiatrist, and the model seemed more akin to that of an institution than to that of community care, although it had the advantage of simplicity for the staff. The third model approximated most closely to the pattern of NHS primary care, but even so there were problems in communication and in defining areas of responsibility. In all three models there was a considerable commitment of time from a psychiatrist and it is perhaps questionable whether this is necessary or justified when general practitioners are available, when the problems that these doctors will be asked to deal with are similar to those presenting everyday in their practices, and when there is such a high level of support by trained hostel staff, who in fact deal with most of the problems by themselves.

A fourth model might be that of a general practitioner medical officer for each hostel. This would provide continuity, accessibility, familiarity and total cover. The general practitioner would need to have an interest in psychiatric problems and, as well as caring for the residents, be prepared to give time to support the staff, an important part of the work. This model may provide a more efficient use of medical manpower, avoiding duplication of roles. It moves away from an institutional pattern of care towards a community based one. But extra remuneration might have to be considered for the general practitioners involved.

Consultation rates with general practitioners in two of the hostels were above average — 7.8 and 7.5 consultations per resident per year. In the hostel where care was provided by the consultant psychiatrist, the rate was 1.5 consultations per resident per year. McKinlay found a rate of 5.5 in a similar hostel to the three described here, plus a high level of correspondence and telephoning.[6] However, because of the hostel setting, there were no social problems to deal with, few emergencies, few difficult medical problems, and out-of-hours work was minimal. The first year in such a hostel would be a time of special stress for residents and staff alike, and it is probable that the consultation rate is now much lower. Both at the beginning of the year and at the end the 12 general practitioners providing care in the three hostels were unanimous in saying that the work had not been excessive or difficult. Only three had any regrets about taking on the work, and several made comments about its interest and value. Only four of the general practitioners reported a special interest in psychiatry.

The residents in these three hostels were living lives of dignity and comfort, looked after by dedicated and well-trained staff. But in spite of optimal care, all remained severely disturbed and were unlikely to be able to make the move to a more independent life, although there had been some improvement in their health and capabilities. Curson came to the same conclusions after studying a group of people with chronic schizophrenia who had been in institutional care.[7]

My investigation answered questions about workload, and allowed an opinion to be formed about the best way of providing medical care. But it raised more general questions. Have these very sick individuals simply been moved from one type of asylum to another? Is the small hostel concept making the best use of scarce resources? Would larger purpose-built community units provide more flexibility and variety of accommodation, while also giving supervision and care when necessary? Would this option be more economical and would it reduce the need for such a high staff to patient ratio? Would it also be more challenging for the residents?

General practitioners are already looking after many people with mental illness who are living independent lives in the community but should they also take responsibility for those in residential care? If so, should extra remuneration be provided? Should general practitioners be able to arrange short term crisis admissions to community beds, so that hospitalization can be avoided?

There are a multitude of organizations concerned with the mentally ill, including statutory bodies and charitable and voluntary groups. Many different professional groups as well as untrained carers are involved in the care of these patients. How well are they working together? Could their efforts be better synchronized so that duplication is avoided and optimum use is made of their resources?

The inadequacy of present arrangements is in no doubt, and better systems need to be developed in order to reduce the unacceptable number of people who are 'falling through the net'.

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