environment has been well established as creating positive benefits in the quality of life of both patients and carers. What has not been shown before is our finding of being able to effect such immediate improvements in long-stay elderly patients with severe degrees of impairment and dependency.

We hope that further study of such initiatives may help formulate the type of care needed in the management of long-stay psychogeriatric patients.

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Audit in practice

Developing a community orientated mental health service

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This paper describes the development of a community orientated mental health service including the introduction of a community-based admission unit. The catchment area is a compact conurbation with a population of 56,000 in a deprived part of North Tyneside. Most people come from social classes IV and V and less than 1% are from ethnic minorities. The male unemployment rate varies from 16–24% and the area is ranked 58th (out of 192) on the Jarman deprivation indices. The primary health care services suffer from many of the problems of inner-city general practices, with the Family Practitioners Committee being the highest prescriber in the country.

In 1988, the Newcastle Mental Health Unit took over the provision of mental health care for this population, while the local authority services continued to be provided by North Tyneside. Initial staffing was one community psychiatric nurse, one half-time junior doctor, and a consultant/senior lecturer in psychiatry. Other resources included places at a day unit in Newcastle, and seven acute in-patient beds and access to long-stay beds at the hospital. We negotiated access to two local authority developments: a day centre and a sheltered workshop and in addition MIND also operates a young peoples' housing project providing accommodation for eight individuals. A hospital hostel was being planned.

Given the lack of available resources we set limited objectives for the first year of the service:

(a) to identify and assertively treat those individuals with severe and long-term mental illnesses

(b) crisis intervention for other individuals, ie although appropriate care would be provided for the acute problem we would aim for early discharge back to the general practitioners

(c) the focus of our work with the primary health care team would be liaison-consultation input. We aimed to educate general practitioners about the service and support them in their management of cases

(d) our focus with social services departments was to set up inter-agency linkage aiming for clear communication and to open discussions on joint planning.

We then began planning the future service. We wanted to make our service accessible, acceptable, comprehensive, co-ordinated, continuous and multidisciplinary. Wilkinson (1985) outlined two models of increasing accessibility in the community: the 'attachment' model (liaison-consultation work linked to the primary health care team) and the 'alternatives' model (community mental health teams based in centres offering direct access to clients in the community).

We focused on providing a community mental health team which offered home assessment and treatment for all clients referred and also assertive outreach to the long term and severely mentally ill. We aimed to provide by day services in the locality and appropriate in-patient care for those requiring admission.

Pattern of service usage

During the first year, 202 clients were seen. Ten per cent received only one appointment while 50% had long-standing mental health problems. Forty-five clients required admission, of whom two were placed in the Special Care Unit. The number of individuals assessed was much less than the predicted level of morbidity in the catchment area (Reiger *et al*, 1984). However, the ratio of admissions to patients seen was less than that recorded by catchment areas of similar size, and hospitalisation rates were significantly lower than predicted (Tantam, 1985). Thirty clients were referred to the Day Unit. Most of them had neurotic or personality disorders but a third were referred because of acute crises (n = 6) or for acute psychotic illnesses (n = 4).

During the second year, a much expanded multidisciplinary community team (n = 7) operated. Four hundred and eighty-nine referrals were seen, of whom 230 presented with acute mental health problems. A third of the cases were clients referred during the first year of service operation. Again the admission rate was low (n = 62), and the number of involuntary admissions fell.

Over the two years we identified the current case mix as 25% with schizophrenia, 15% affective disorders, 40% neuroses while 20% were referred with acute crises or adjustment reactions. About 25% had severe mental illnesses and would require long-term contact with the service.

The case mix seen is similar to that of other early intervention projects based in inner-city areas. At present we can only speculate on whether targeting the long-term and severely mentally ill and offering partial hospitalisation to some of them helped to significantly reduce our admission rates. Previous studies certainly suggest that early intervention and assertive intensive after-care can be effective (Thornicroft & Bebbington, 1989). A further factor in reducing admission rates may be that hospital admission is less likely to occur in those assessed at home (Dean & Gadd, 1989).

Implications of service use for service planning

During the first two years of operation the mean bed usage was four places. However, the nature of our catchment area suggested access to beds would always be needed. Those admitted predominantly suffered from major mental illnesses and frequently showed a combination of psychosis and social isolation. As well as life-threatening situations, the in-patient facility offered asylum for those in need of respite and an alternative treatment setting for individuals whose families were no longer able to cope with the burden of care. Tantam (1985) suggested that even with intensive community treatment 20–30% of the long-term or severely mentally ill will need access to a hospital bed at some time. In addition, given the low staff/client ratio, case management for the long-term mentally ill would at times be rendered ineffective and precipitate some admissions. Lastly, published research suggests that shifting to community-based services may increase referrals by about 30%.

Careful analysis of the cases seen over the first two years of operation suggested that while a safe structured patient environment was required it should not automatically be assumed that the only alternative improved provision was in a District General Hospital unit. Evidence from the United States suggests that non-hospital acute psychiatric in-patient care may be less alienating and disorganising for the individual client, can enhance independent functioning and possibly reduce readmission rates. We therefore designed a unit that offers seven full and eight partial hospitalisation places. The smaller unit allows the permanent staff to engage in more therapeutic and less custodial care and use of a domestic environment hopefully enhances 'normalisation'. The stand-alone admission unit is situated within the catchment area which should ease the transition between home and hospital.

Partial hospitalisation seems to be under-used both in America and Britain. The programme we run fulfills two of the three roles identified by Klar *et al* (1982). An intensive programme is provided for those with acute problems who require flexible access to input but refuse in-patient care and cannot be admitted involuntarily. Additional places are available for those patients with long-term mental health problems who require continuing support and would benefit from open access to staff who are willing to listen and are skilled in offering practical psychosocial rehabilitation.

The Community Mental Health Centre functions as a base for the community mental health team. The team has a dual role in acting as 'gatekeeper' to the stand-alone unit and offering outreach home assessment and treatment. Both individual and group therapy are carried out at the centre.

Preliminary conclusions

To meet the diverse mental health needs of the community, services must cover a broad spectrum and be offered in a flexible range of settings. The multifunctional role of the institution can be replaced by community services but these must be carefully coordinated and some individuals will need additional help in making contact with them. This service is in its infancy and at this stage only clinical impressions of its development can be reported. Assertive outreach to the long-term mentally ill may have reduced admissions, or at least increased the time between readmissions. In addition, early intervention has meant that those who need admission are less disturbed and can be catered for in a more domestic environment. Support for our clinical impressions is provided by previous research in this area. The treatment settings available should prevent the service from selectively attending to the needs of one group of clients to the detriment of others. The stand-alone unit may also provide an effective alternative admission facility to a District General Hospital in the future, but only when we know more clearly which patients the unit can and cannot treat. A longitudinal research evaluation programme is currently underway to determine the benefits and problems of the service outlined.

Note

A more detailed version of this paper is available from the first author.

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