The Mental Health Act Commission and detained patients

DEAR SIRS

The leaflet designed by Dr Philip Sugarman and Ms Angela Long (*Psychiatric Bulletin*, 1992, **16**, 549) for the needs of informal patients is to be warmly welcomed.

Unfortunately it contains a fundamental error in relation to their description of the role of the Mental Health Act Commission. The Commission is a Special Health Authority and its primary statutory function is to keep under review the operation of the Mental Health Act in respect of patients detained under the Act. Its statutory remit is therefore essentially confined to detained patients.

As far as patients' complaints are concerned the Commission's jurisdiction is complex but can be summarised as follows.

(a) The Commission can investigate any complaint made by a person in respect of a matter that occurred while he or she was detained under the Act and which the complainant considers "has not been satisfactorily dealt with by the Managers of that Hospital or Mental Nursing Home";
and

(b) the Commission can investigate any other complaint "as to the exercise of the powers of the discharge of the duties conferred or imposed by [the] Act in respect of a person who is or has been detained".

If informal patients have a complaint about something that occurred while they were detained in hospital under the Act then the Mental Health Commission has the power to deal with this. What the Commission cannot do is deal with any complaint they may have which arises during the time that they were informal patients in hospital.

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Lessons from community care of mentally handicapped ex-patients

DEAR SIRS

It is ten years since the policy of care in the community for long-stay hospital mentally handicapped in-patients was introduced. Ex-patients have now been living in the community long enough for problems to begin coming home to roost. In Leeds, from 1982 to 1992, 190 mentally handicapped people moved from hospital into group homes, private residential accommodation and establishments run by housing association and voluntary or charitable agencies. A range of issues can be recognised – many emerge gradually after an initial honeymoon period.

Incompatibility. Staff and residents in the confined space of community houses face more intensive and intimate personal relationships than in large hospital wards. Tensions can arise among residents and between staff and residents. Before discharge residents may have been matched for compatibility and lived together, but this is no guarantee that harmony will be sustained. Some residents have an itch to move, feeling that the grass on the other side is greener.

Accidents and Injuries to ex-patients inevitably occur. After serious fractures, mentally handicapped people may need prolonged physiotherapy and rehabilitation to restore their mobility when it may not be practical for them to live in their community setting. Some return to a mental handicap hospital for a time to receive this treatment.

Recurrence of mental illness. Some community facilities are staffed by people who have no specialist training in mental illness who can have difficulty coping with psychiatric symptoms. Untrained staff may be fearful of such residents. Some care workers have idiosyncratic views on how such patients should be treated, so that teaching, counselling and ready support of care staff are essential. Furthermore, staff may not be able to administer medication with the flexibility and urgency applicable in hospital.

Resurgence of challenging behaviour in a community residence can have a knock-on effect. It disturbs other residents and staff and can become intolerable.

Increasing dependency with ageing and physical and mental deterioration can occur; dementia is increasingly diagnosed in mentally handicapped people. Staff may not be able to treat residents with developing dependency who may need care in a nursing home or mental handicap hospital.

Community supervision. When people have been diffused into the community overall supervision of change is not possible. Subtle changes may not be recognised by untrained staff with a frequent turn-over. Problems patients had in hospital do not disappear in the community, despite the less regimented, more private and domestic environments, but regular visiting by experienced professionals who know the patients can lessen the risk of breakdown.

Study of the issues arising in the community care of discharged hospital patients should help clarify the planning, preparation and support services for those in-patients who will be resettled into the community in the future.

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Discharge delays

DEAR SIRS

We report a recently completed study which examined discharge delays from the acute admission wards of a psychiatric hospital once the psychiatric condition for which the patient was admitted had been dealt with. In addition to the waste of resources implied, it raises questions on the ways in which this could affect the cost, quality of service, and patients' satisfaction about their care.

We conducted a questionnaire survey on four acute admission wards for the under 65s and three acute admission wards for the over 65s, over three months.

Sixty-six patients (30 under 65s and 36 over 65s) were identified to have spent extra time in hospital for non clinical reasons and the extra time spent by them was 3,727 days with an average of 49.7 days for under 65s and 62.1 days for the over 65s. During the 91 day study period, of the total 15,117 bed occupancy positions on the seven wards, 2,768 (18%) were occupied by patients awaiting discharge, despite being ready to leave hospital.

Of the various reasons for delays in discharge, accommodation problems ranked highest, with 73% (22/30) of under 65s falling in this group. Among the psychogeriatric patients, the accommodation problem was the sole cause of delay in only 11% (4/36); however, when those awaiting Part 111 accommodation (12/36) were also included, the figure rose to 44% (16/36). The second important factor was internal transfer to continuing care wards in the case of over 65 s (25%) and to rehabilitation wards for the under 65s. Although the proportion of patients in this category was less than those awaiting accommodation, the average length of extra time spent per person was substantially higher (122.2 days v. 36.8 days).

Legal problem (section 37/41) was causing delay in discharge in one patient (under 65) who had already spent an extra 108 days at the close of the study. Other reasons included awaiting transfer to other facilities (e.g. medical wards, reprovision programme) within and outside the health authority and those awaiting input from social services.

Our findings confirm the considerable problem posed for treatment teams by discharge delays, leading to occupancy of facilities in acute admission wards which are then unavailable for other patients who may require them. In the present climate of thinly spread resources, this limits the availability of acute beds which are already insufficient to meet the demands of the respective catchment areas. The implications of this waste of limited clinical resources are serious. The reasons for delayed discharge seem to point to major accommodation problems in the community and it emerges that there is a need to increase these resources. It may also be worthwhile to consider the provision of a 'Resettlement Officer' to liaise with the community and co-ordinate the effective use of available facilities. More detailed analysis should be undertaken in future, attempting to find out whether diagnostic categories have any influence in delays, staff attitudes in hospital and in other agencies, especially for patients with prolonged or multiple admissions. Findings of the present audit will be distributed to Social Services, Housing Agencies and Unit General Management, to help improve deficiencies in the existing services. The authors wish to repeat this audit on a regular basis to monitor any change in trends. A more systematic study may be required to focus on the exact nature of the difficulties in the context of available local resources. This will help plan future mental health services in the area.

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Out of hours admission

DEAR SIRS

We read with interest Gardner's study of out of hours admissions to a general psychiatric hospital (*Psychiatric Bulletin*, 1992, **16**, 357–358). The nature and volume of such admissions have important implications for staffing levels and service planning. When assessing their volume it is important to take into account the timing of the preceding referral.

Not all patients admitted out of hours have been referred out of hours. We wonder whether the author has data on the proportion of out of hours admissions in which the decision to admit was made during routine hours. Due to differences in working hours, duty rota and shift systems of medical and nursing staff, the time of referral is likely to be of greater importance to doctors, and the time of admission more important to nursing staff. Out of hours, medical staffing levels are reduced to a skeleton on-call team, and it is this team that is called upon to make the decision whether or not to admit a