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Working together for the chronically mentally disabled

A long-term case management system for schizophrenics has been initiated in the city of Salford, England, with a view to improving the coordination of services and involving patients and their families in the assessment of needs and the formulation and implementation of care plans.

Health care systems the world over need comprehensive services for chronically disabled patients who do not live in institutions. The more affluent nations have begun to acknowledge the drawbacks of long-term institutional care; the less wealthy cannot afford it. Whereas many rich and poor countries have organized care for the acutely ill and have built public health infrastructures, systems ensuring comprehensive long-term care for patients who live outside hospitals and other institutions remain scarce.

In the United Kingdom, general practitioners carry overall responsibility for their patients’ health care and in theory form a pivot for specialized services. However, in many chronic cases the requirements for specialist and/or general medical or nursing care vary in intensity with the passage of time, and as the social consequences of chronic illnesses are considerable there is a basic need to develop mechanisms that facilitate the coordination of social, informal and health care services. In other countries, long-term involvement with a single health professional such as a general practitioner is not usual, and there is thus an even greater need for long-term care management systems.

Need for coordination and user involvement

The present project was conducted in the city of Salford in northern England in response to a government initiative whereby

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three health authorities were invited to devise long-term case management systems in order to remedy a lack of coordination of services and poor access for patients and their families to information on mental illness and sources of help. Salford Health Authority serves an urban area with a population of 230,000 affected by many social problems, high unemployment and much chronic sickness. It was decided to restrict the study to schizophrenic patients because their situation reflected the problems outlined above.

Schizophrenia is a long-term disabling mental illness of uncertain etiology in which social functioning and the ability to cope with everyday life become greatly impaired; relatives or other supporters shoulder much of the burden of care. The multidimensional nature of disabilities in this group of patients demands more than purely biomedical skills. In addition to psychiatrists, it is likely that psychologists, occupational therapists, community psychiatric nurses, social workers and other professionals will be involved in the care of patients, because of the influence of family dynamics, the need to maintain and improve daily-living skills, and the requirement for social and family support within a sophisticated health and welfare system. It is also probable that each professional category will have varying degrees of involvement as time passes.

In Salford the members of the various professional groups were applying diverse concepts of care and were operating under different administrative structures, with the result that the coordination of their work presented considerable difficulties. A single multidisciplinary team of mental health professionals did not exist. Research had shown that the long-term involvement of psychiatric nurses was generally limited to the administration of depot-neuroleptic medication and that social workers were generally restricted to giving intensive support during crises (1). It had also been demonstrated that some 80% of the families of newly referred schizophrenic patients had high levels of expressed emotion, yet were receiving little therapeutic help (2).

The aims of the project were therefore:

— to encourage professionals to work as a team;
— to ensure that all patients and their supporters were involved in detailed assessments of needs;
— to ensure that written care plans were formulated and implemented with the involvement of patients and their families;
— to ensure that assessments and care plans were available to all members of the professional team;
— to implement a system whereby assessments and care plans for each patient were regularly and systematically reviewed.

It was decided that the professional team should be built round a core group representing psychiatrists, psychologists, occupational therapists, general social workers, mental health social workers, community psychiatric nurses, and general practitioners, and that additional members should be coopted if appropriate to particular patients.

The project was funded for two years and was directed by a steering committee consisting of representatives of health and...
social services, together with three representatives (a professional, a relative and a patient) from a voluntary agency. A full-time project coordinator with part-time secretarial assistance was given sole responsibility for devising and implementing a system to meet the project’s aims.

Management system

The first task was to define a catchment area. Psychologists, mental health social workers, occupational therapists and psychiatrists worked from hospital bases, community psychiatric nurses were attached to primary care teams, and social workers with mixed caseloads worked from small local teams. None of their catchment areas coincided exactly with one another although there was some overlapping. The patients selected were being treated by a particular consultant psychiatrist. Newly referred patients were drawn into a rolling programme and existing patients were referred by team members. A full list of patients who fulfilled the criteria laid down was obtained from the psychiatric register.

It was decided that the professional team should be built round a core group representing psychiatrists, psychologists, occupational therapists, general social workers, mental health social workers, community psychiatric nurses and general practitioners, and that additional members should be coopted if appropriate to particular patients. Patients and their relatives were invited to attend review meetings. An information pack had already been developed by the two psychologists attached to the team. The case management system is depicted in the figure.

Because the team professionals already had well-established methods of working and carried full caseloads, only a limited amount of time could be devoted to assessment and review. Meetings were held monthly and lasted not more than two hours. General practitioners rarely attended. Reviews and care plans were completed for 25 patients in a year.

Separate medical and social assessment schedules were used. The psychiatrist completed the medical assessment, and any other team member, usually the one who knew the patient best, completed the social assessment. The coordinator planned the first review, at which two team members were designated to make both assessments. A date was set for the first review meeting on each patient, usually so as to allow approximately a month for the review schedules to be completed.

The intention was to see and review each patient immediately before the first care plan was drawn up. This was not always achieved, as a third of the patients resisted attending outpatient consultations at which the psychiatrists conducted the medical reviews, and only two patients attended their review meetings. The social assessments were generally made following home visits, ensuring that almost all social reviews were completed, although this did not always happen within the specified time.
As part of the care plan for each patient a key worker was appointed, whose role was to:

- contact the patient at appropriate intervals and keep informed of the patient's circumstances and welfare;
- act as a contact in case of concern by or about the patient and mobilize extra services if needed;
- monitor the effectiveness of the services received by the patient and if necessary initiate referrals or undertake advocacy;
- inform and consult the patient and his or her relatives/care-givers about the services received.

The completed care plans were circulated to patients, relatives and general practitioners, and copies were inserted in hospital case notes so that if admission became necessary or any emergency occurred the plans would be available to ward staff.

Information on reviews and care plans was stored on a microcomputer, so that it was...
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easy to produce details of meeting schedules and to perform systematic analyses of documentation on patients’ needs and characteristics. Before the data base was set up, reviews and care plans were stored using a word-processing package.

Overcoming the constraints

Although the staff involved in the project were prepared to attempt to work as a team, it quickly became apparent that there had been little collaboration between them in the past. Except for their work on the project, they continued to function as they had always done, and their extra commitments consequently represented a considerable burden. In the opinion of the steering group, this indicated that arrangements for delivering care were inadequate. The project confirmed previous evidence (3) of a large expansion in the proportion of neurotic patients in the care of community psychiatric nurses transferred from psychiatric teams to primary care teams, together with an expansion in the boundaries of the psychiatric services. Yet the care of the most severely disabled patients was seriously inadequate, calling into question the organization and management of the services.

Although it was recognized that the non-medical professional groups each had a distinct contribution to make to the assessment of patients’ needs, only one of them completed the non-medical assessment. The low completion rate for medical assessments threw doubt on the arrangements for medical review at outpatient clinics, and the possibility of doing them in patients’ homes is now under discussion. The mental health social worker in the team probably undertook the largest additional burden, as she became more involved than the other members in welfare issues and consultation and negotiation with relatives. This underlined the deficiencies in the training of health staff in communication skills and the need for a considerable input in terms of finance, housing, and so on. The perceived need for a general practitioner and a general social worker on the team was not always achieved.

It became clear that systematic working was unlikely to continue in the absence of a team coordinator. Previously, it had been considered that any member of the team would be able to fill this role. However, the skills required for coordination differ from those needed for direct patient care, the staff responsible for which almost always place the needs of individual patients above administrative considerations. Unless staffing levels are such that care-givers have no difficulty in meeting their clients’ needs, administrative tasks tend to be neglected.

Despite its shortcomings the project was successful in several ways. The more systematic medical and social assessments revealed previously unrecognized needs that could be met. An increased involvement of patients and relatives in the construction of care plans and in the assessment process was achieved. The wide circulation of care plans ensured that professionals did not embark on plans of their own which conflicted with those already put into effect. The writing down of assessments and care plans assisted
staff to keep their overall objectives and strategies more clearly in mind. Managers became convinced that services and resources were inadequate and consequently took steps to improve them.

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The sophistication of the health and social care setting in which the system was developed presents problems of coordination and collaboration. However, even if an array of professionals were not involved, the part played by non-professional care-givers would have to be recognized. Data were stored on a microcomputer, which certainly facilitated analyses, but the assessment and care plan documents could equally well have been handwritten and copied for circulation. Thus the principles that directed the system should be applicable in any setting. Of course, they are not confined to mental health problems. In all chronic illness, social as well as physical deficiencies need to be addressed. Informal care-givers carry considerable burdens and require support. Patients' requirements for physical and social care vary in intensity over long periods, yet there is a tendency for their needs to be seen as static and for care to be limited to maintenance simply because systematic re-assessment is not done. Ironically, the more successful the health care systems become, the larger are the numbers of chronically disabled patients who survive. The continuing and growing need for systems that facilitate long-term care should be recognized and acted on.

Acknowledgements

The authors wish to thank all who took part in the pilot project for their ideas and support. In particular they express their gratitude to Professor Hugh Freeman, whose involvement from the beginning has been invaluable.

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