Readmissions from registered care homes

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Registered care homes have been developed in Newham, a deprived inner city borough of about 220 000 population, by a number of different housing associations. Some of these provide the care component themselves while others purchase it from separate agencies. The formats of the homes also vary. Features common to all the provision include prolonged preparation of future residents in rehabilitation houses on the Goodmayes Hospital campus prior to taking up residence, particular attention to their compatibility and social networks, and regular individual reviews by a community rehabilitation team which also provides training and support to care staff.

Extent of provision

The homes provide 76 places which have been occupied by 82 residents (57% male; 43% female) for a total of 266 resident/years. Four residents have died of natural causes, one remains in a general hospital after a cerebrovascular accident, and one returned to her home country. Half the places are in single or coupled houses and half in two flat clusters designed to provide space and opportunities for both privacy and social contacts.

The first of the homes opened in July 1987 and the most recent in March 1993; half of their places have been occupied for more than four years.

Two further registered care homes are due to open by early 1995 and it is likely that the then total of 97 places, with a small amount of nursing home and specialist provision, will be sufficient to cater for the remaining long-stay ward population, and to meet the future needs of the district for this type of accommodation. Additional development will concentrate on less intensively staffed provision based on the '209' model described elsewhere (Abrahamson, 1993). Some of this may cater for existing home residents if they wish to move on but there will be no pressure for them to do so.

Resident characteristics

The residents have been predominantly long-stay patients from Goodmayes Hospital. Sixty-three per cent had been in hospital continuously for more than ten years, 37% for more than 20 years and 4% for more than 50 years. However, 21% had lengths of stay less than five years ('new' long-stay) three of whom came direct from newly opened acute wards at East Ham Memorial Hospital.

Twenty-eight per cent of the total had only a single previous admission, 41% had two to five, and 31% from six to 23.

Thirty-nine per cent are aged over 65; 52% 40–65, and 9% under 40 years. The diagnosis is schizophrenia in 76% with 11% affective, 11% organic and 2% other disorders.

REHAB Scale (Baker & Hall, 1984) scores were available for 56 of the patients, in some cases after improvement had already occurred during the pre-discharge rehabilitation programme. The range of scores on the Total General Behaviour (TGB) sub-scale was from 11–110 (mean 49): 39% of scores fell into each of the potential for discharge and moderate handicap categories and 21% into the severe handicap category.

The flat clusters have tended to cater for the more disabled or challenging patients. In the first of these 42% of the residents were in the moderate and 32% in the severe handicap TGB scale categories and in the second 43% of the residents were 'new' long-stay with clinically volatile illnesses.

Readmissions

Eight patients (10%) have been readmitted on 15 occasions – one readmission per 17.7 patient/years in the homes.

Twelve readmissions were to acute wards for from two days to 8.5 months (75% less than one month). They comprised three each for a young man whose unusually severe schizophrenic illness responded to a combination of

https://doi.org/10.1192/pb.19.12.734 Published online by Cambridge University Press

atypical antipsychotics following transfer to a specialist unit, a patient with an unstable bipolar affective disorder who had been accepted for shared care with the ward concerned and a third who was admitted after an overdose, shortly afterwards because of increased depression with suicidal thoughts, and finally for what proved to be a confusional state caused by a urinary tract infection; two – with a very brief interim – related to changes in medication for a schizoaffective disorder during the preparation period; and one readmission for an unexplained schizophrenic relapse.

The remaining three, long-term schizophrenic patients, were readmitted to Goodmayes Hospital rehabilitation houses or continuing care wards: one because of disturbed behaviour which eventually spilled out into the neighbourhood; another because of deterioration following prolonged refusal of medication, and the third because of a need to live nearer to a close friend. The first of these patients returned to the care home after almost a year in hospital, the second is undergoing further preparation in a hospital house and is now accepting medication, and the third is awaiting a suitably located community placement.

The reasons for readmission were thus very disparate and no clear pattern emerges from these small numbers other than the prominence of affective conditions in the acute ward group.

Comment

The level of readmissions has been low both in terms of their impact on the projects – more than half of which have experienced no readmissions – and in comparison to similar accommodation elsewhere.

The Team for Assessment of Psychiatric Services (TAPS) (Dayson, 1994) reported that 33 of 119 (28%) former Friern and Claybury Hospital long-stay patients resettled in community provision for five years were readmitted on 78 occasions – one readmission per eight patient/years. Ten of these patients and no Newham patient remained in hospital for more than one year.

Shepherd (1993) found that 12 of 34 (35%) ex-Friern long-stay patients from one health authority were readmitted from hostels to acute services on 18 occasions over four years – one readmission per 7.5 patient/years. Fifteen per cent of the overall TAPS cohort were readmitted in their first year after discharge (Leff, 1984) compared to six per cent of the Newham patients.

Clearly, there may be differences between the patient cohorts relevant to readmissions which would require detailed analyses to establish. However, the differences in rates are large, and efforts have been made in Newham to avoid the practice of 'creaming off' the better patients (Carson *et al*, 1991) which appear to have been successful in avoiding the creation of a 'remnant' group of difficult to place patients (Ford, 1987). Recent assessments of the less than 40 Newham patients who will remain in continuing care wards or preparation houses in Goodmayes after the two further housing projects open indicate that not more than five will need specialist provision for challenging behaviour, about half the remainder will be catered for by the existing pattern of care homes and half will need nursing home settings.

Possible reasons for the findings, which may merit consideration in planning other resettlement programmes, include the preparation provided, which among other effects promotes social networks, and the individual and communal space available in the larger projects, as described more fully elsewhere in relation to a wider spectrum of housing provision (Abrahamson, 1993) as well as the coordinated backup which has been developed by the multidisciplinary rehabilitation team. This comprises a half-time consultant psychiatrist with two part-time clinical assistants, a psychologist, two occupational therapists, a speech and language therapist and 3.5 whole-time equivalent community psychiatric nurses. In addition to the home residents the team also deals with approximately 150 community long-term patients.

The final point is that despite the small number of readmissions it has been essential for the morale of the team and of both staff and residents of the projects that hospital beds were readily available when needed.

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A study of facial dysmorphophobia

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The psychopathology of 20 subjects who presented to psychiatrists with facial dysmorphophobia was examined. Seven had body dysmorphic disorder and 13 had dysmorphophobic symptoms secondary to an underlying psychiatric disorder (usually depression). The body dysmorphic group had a younger age of onset and overvalued ideas about their appearance. In both groups there was a high proportion of associated personality disorder, usually of the anxious (avoidant) type.

In dysmorphophobia or body dysmorphic disorder, the patient has a subjective feeling of ugliness or physical defect which he or she believes is noticeable to others although appearance is within normal limits (Hay, 1970*a*). It has been considered to be a rare psychiatric syndrome.

There has been controversy as to whether this disorder is just a symptom of an underlying disease or a separate disease entity (Andreasen & Bardach, 1977; Thomas, 1984). The condition did not feature in ICD–9 (World Health Organization, 1978) but in ICD–10 (WHO, 1992) it is classified under hypochondriacal disorder and in DSM–III–R (American Psychiatric Association, 1987) under body dysmorphic disorder. In the ICD–10 definition, the dissatisfaction with appearance must be present for longer than six months, cause persistent distress or social disability and not be of delusional intensity.

This investigation aimed to identify any associated psychiatric disorder; classify the nature of the belief; and determine the premorbid personality of patients with dysmorphophobia.

The study

A letter requesting referral of any patients who had dysmorphophobia or perceived facial disfigurement was sent to 221 consultant psychiatrists in the North Western Region of England three times over three and a half years (1986/89).

A full clinical history and a standardised assessment of the mental state using the Present State Examination was performed. Psychiatric diagnoses were made using the DSM–III–R and the Diagnostic Criteria for Research (DCR) of the ICD–10 classifications.

The nature of the dysmorphophobic belief was determined by following Jaspers' classification of abnormal beliefs (Jaspers, 1946). The premorbid personality of the dysmorphophobic subjects was ascertained by interviewing a relative or another informant using the Standardised Assessment of Personality (Mann *et al*, 1981).

Findings

Twenty-five patients were referred over three years by 23 different psychiatrists (of whom two referred two patients). Most patients were

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