

## *The Effect of Community Care on Long-Stay Patients at Knowle Hospital*

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It was in 1961 at the Annual Conference of MIND that Enoch Powell first announced that the traditional mental hospitals were to be run down. Since then it has been government policy to emphasise the value of a transfer of care from hospital to the community. Concern was soon being widely expressed at the growing gap between statements of proposed government policy and their realisation.<sup>1</sup> It has long been the intention to close Knowle Hospital, which originally served the city of Southampton, and over the last ten years there has been a gradual transfer of some of the services away from the main hospital site. A major problem in successfully implementing the closure of any mental hospital is the appropriate relocation of the long-stay population. The problems this involves have been much debated recently.<sup>2</sup>

At Knowle we have been successfully reducing the number of long-stay patients on the hospital site. This has occurred as a result of many factors, including tighter controls on admission to the long-stay wards and discharges to a wide range of facilities. We have also developed hospital hostels (HHs) for some of the old long-stay. The two HHs so far established are substantial residential properties in community settings, remote from the hospital. They are owned and staffed by the NHS, 24 hours per day. The HH residents are still classed as in-patients and if appropriate return to the hospital for occupational or industrial therapy. It has been hoped that the patients transferred to the HHs will have a superior quality of life, greater involvement in the community and as a consequence will show further improvement in their social and psychiatric well-being.

Despite the development of the HHs a considerable number of long-stay patients remain which, in view of the planned closure of the hospital in the early 1990s, presents a worrying problem. A survey of the long-stay population had been performed in 1983. We decided to re-survey the long-stay patients, currently in either the hospital or HHs, since making assessments at two points in time would overcome some of the drawbacks of a single cross-sectional study. It was hoped that the information would enable us to make a reasonable assessment of the likely future requirements for the orderly run-down of the hospital and to see whether the transfer of patients into the HHs had produced the beneficial effects intended by this policy.

### **The study**

The first survey was conducted in 1983 and the second between December 1985 and February 1986. During the

1985/86 period there were 140 designated long-stay patients resident in the hospital or HHs. This is from a catchment population of approximately 500,000. The survey specifically excluded those patients who were under the care of the psychogeriatric service. A questionnaire was completed on all of the long-stay patients. Since the 1983 survey, 15 hospital patients had been moved into a new hospital hostel (HH2). The questionnaire consisted of five sections, which are summarised below:

*Part One.* This included information such as the patient's age, sex, psychiatric diagnosis, using the ICD-9 classification.

*Part Two.* This was concerned with the patient's outside social contacts.

*Part Three.* This was concerned with the patient's self-care skills.

*Part Four.* This is a modified form of the MRC Social Behaviour Schedule.<sup>3</sup> Four questions have been dropped: reason for being in setting; most difficult problem; other handicaps (not psychiatric); and work: quality and attitudes. One question on destructive behaviour was expanded to three in order to obtain more detailed information.

*Part Five.* This examines the patient's social habits and particular problem areas.

The information to complete part one was taken from the patient's notes. Parts two to five were completed by interviewing a member of the nursing staff who, where possible, had been on the same ward of HH as the patient for at least three months.

One hundred and thirty patients consented to being interviewed: this was desirable in completing certain items of the questionnaire. The interviews in the current study were performed by HD and in the previous study by ST. Interviews were conducted jointly between HD and ST prior to starting and during the current study to ensure a satisfactory level of inter-rater reliability.

The results are presented for each section of the questionnaire.

*Part One.* Of the 140 patients, 67.9% were male and 32.1% were female: 108 patients were living in one of the five hospital wards and 32 patients were in the two HHs. The majority were single (75%), with 3.6% still being married; 15% divorced; 2.9% widowed and 3.6% legally separated.

The mean length of time in continuous care was 19.3 years: 28 patients had been in continuous hospital or HH care for five years. The ages ranged from 26–79 years with a mean age of 58 years. 65% of the patients were found to be suffering from one of the schizophrenic psychoses (295.0–295.6); 12% from an affective psychosis (296.0–296.9); and 6% from personality disorder (301.0–301.9). The remainder of the patients suffered from a wide range of diagnoses including presenile dementia (290.1); obsessive-compulsive disorders (300.3); and infantile autism (299.0).

*Part Two.* Of the patients, 60% were regularly in contact with their relatives. In over half of these cases, the relatives visited the hospital or HH. When comparing ward to HH patients, it was found that those patients living in the ward had significantly less contact with relatives than those in the HHs [54.6% compared to 78.1%  $P=0.03$ ; Student's *t*-test (two-tailed)]. However, when these results were compared with those of the 1983 study, it transpired that similar differences between the patients' contact with their relatives were evident at that time: those patients who had moved to a HH from the hospital had not increased their contact. The patients had very little contact with people apart from the relatives. Only 8.6% of the patients regularly saw or heard from anyone else. There were no significant differences found in this type of contact between the hospital and HH patients.

*Part Three.* The mean number of problems identified from this part of the questionnaire is shown in Table I.

TABLE I  
Mean number of problems identified

	No. of patients	Mean	Range
Ward 1	20	5.7	1–9
Ward 2	21	5.6	0–9
Ward 3	24	5.5	2–9
Ward 4	17	4.7	1–9
Ward 5	26	4.4	0–9
Ward Mean		5.2	
HH1	15	1.8	0–4
HH2	17	2.4	0–5
HH mean		2.1	

It can be seen that the patients in the hospital showed, on average, more problems than those in the HHs. The differences that were in favour of the patients in the HHs (using Chi square) were at the 5% level of significance: dressing, and at the 1% level: washing clothes, travel, control of money and shopping. Comparing these results with those of the 1983 survey, it was found that the patients who had moved to an HH had improved in their ability to wash clothing and shop ( $P=0.05$  and  $P=0.05$  respectively). Those remaining in hospital had become worse at travelling ( $P<0.05$ ). Overall it was found that 27 of the patients in hospital and four patients in the HHs were incontinent of

urine on occasions: similarly, 11 of the patients in hospital and one patient in the HHs were incontinent of faeces on occasions.

*Parts Four and Five.* Results from these parts of the questionnaire are shown in Table II.

TABLE II  
Percentage of patients with a problem

	Wards	HH
Initiating conversation	38.9	9.4
Inappropriate social mixing	39.9	28.1
Posturing mannerisms	24.1	12.5
Inappropriate sexual behaviour	13.9	3.1
Verbal hostility	33.3	28.1
Physical hostility to people	12.3	0
Fire risk	28.7	28.1

The mean number of problems for the patients on the ward was 6.9 and for the patients in the HHs it was 4.6. Patients in the HHs were found to be significantly better than those in the hospitals (at the 5% level) for ability to occupy their daytime leisure activities and (at the 1% level) for initiating conversation, concentration and the need to restrict activities. Comparisons of the results of this survey, with the one in 1983, are shown in Table III.

TABLE III  
Comparison of results

<i>Remaining in a HH</i>	
Less underactivity now	$P<0.05$
<i>Moving to a HH</i>	
Better at initiating conversation	$P<0.05$
Fewer unspecified behavioural problems	$P<0.05$
<i>Remaining in hospital</i>	
More restricted	$P<0.05$
Better at initiating conversation	$P<0.05$
Less bizarre conversation	$P<0.05$
Less acting out bizarre ideas	$P<0.05$
Less abnormal posturing/mannerisms	$P<0.01$

#### Comments

The survey excluded patients under the care of the psycho-geriatricians, but nevertheless 30% of the population was over 65 years of age. The high average age we found is in agreement with the findings in Leicestershire.<sup>2</sup> However, it cannot be hoped that the long-stay population will simply dwindle as the population ages, since we found that 28 patients had been admitted to the long-stay beds in the last five years. At Knowle Hospital admission to these beds is only arranged after an extensive and formal consultation process. Also the number of admissions found is likely to be an underestimate, since we know of several patients who

have been in hospital beds for more than one year but have not yet been referred or accepted for long-stay.

The finding that the patients in the HHs had more contact with their relatives than those in the hospital was in accordance with our expectation. It was, however, very disappointing to discover that the differences could be best accounted for by these changes being present before the patients were transferred to the HHs, and that the transfer to the community setting had not led to further improved contact either with relatives or friends. Similar findings were evident in parts three to five of the questionnaire. Again, the hostel patients were generally superior to the hospital patients but the majority of these differences were evident before the patient left the hospital. The percentage of patients showing verbal or physical hostility, inappropriate sexual behaviour, or who were thought to present a fire risk, is of note when considering discharge to less supervised accommodation.

We feel that part four of the questionnaire is sufficiently similar to the standard Social Behaviour Schedule (SBS) to make comparisons with it valid. Wykes & Sturt<sup>3</sup> used the standard SBS on 66 patients at Netherne Hospital. Three main groups of patients were studied: those living in a high expectation villa or own accommodation; those living in a medium expectation 'villa'; and those living in a traditional hospital ward. They found that the median number of problems for groups one to three were 2.7, 3.4 and 4.9 respectively. Our HHs and hospital group probably most closely resembled Wykes & Sturt's groups two and three, and we found the mean number of problems for the patients to be 3.9 and 5.9 respectively. These results seem to be similar to the Netherne study and highlight the large differences between those who could cope in a high expectation villa or own accommodation at Netherne, and our residual hospital long-stay population.

By analysing the score of all the patients on the complete questionnaire, we attempted to predict the most appropriate distribution of patients within our existing resources. The findings suggested that 17 of the hospital patients could be managed within a HH, and that eight of the HH patients could be moved into less supervised accommodation. However, these predictions are probably naive and optimistic, since four of the patients that were assessed by us as being potentially able to be transferred to a HH had already been tried and had failed.

The House of Commons Second Report from the Social Services Committee on Community Care<sup>4</sup> looked at the

results of various approaches to community care both in this country and abroad, and came up with clear recommendations: "genuine community care policies are achievable only in the context of some real increase . . . in expenditure on the services for . . . mentally ill people"; "the simple facts are that there is little prospect of major change for the better for many mentally disabled people"; "we must face the fact that some people need asylum"; "the pace of removal of hospital facilities for mental illness has far outrun the provision of services in the community to replace them."

Our findings underline the severe degree of psychiatric morbidity evident in the long-stay patients remaining in hospital. They show the continuing failure of substantial numbers of patients to recover from their illnesses and attest to the lack of recovery in many patients even when they have been able to experience the good community care provided at the HHs. At Knowle we wish to approach the closure of the hospital in a positive manner. In order to discharge satisfactorily the remaining long-stay patients, it will be necessary to provide a wide range of provisions. Discharge to unsupervised lodgings without daytime occupation is not an option open to us for the vast majority of the remaining patients. The findings make it quite clear that many of those still in hospital will need an environment at least as sheltered as our HHs if they are going to be humanely discharged. It is to be hoped that political and economic factors will not force us into becoming unwilling accomplices to a shabby deal.

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