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Mental handicap and the new long stay

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For almost 20 years planning for the mentally ill and mentally handicapped has focused on a shift of care from hospital to community, the advantages and difficulties of this process generating much discussion and interest. The hospital population of the mentally handicapped is currently at the forefront of this change, planning impetus now being propelled by alterations in funding with budgets being transferred from NHS to local and social services. One consequence is the closure, or planned closure, of large mental handicap hospitals situated at the periphery of urban centres, with residents being moved to small group homes and hostels within the towns and cities the hospitals once served. The change should prove beneficial for a majority of residents although the process continues to generate debate.

Community care is probably not as cheap an option as was initially believed. Glennerster (1990) calculating the costs following closure of Darenth Park, found both NHS hostels and group homes more expensive to run than comparative hospital care. If Darenth Park is representative of other similar hospitals it would seem that, unless there is central commitment to increase the budget assigned to the mentally handicapped, community care may become impossible to implement fully. In addition, there is evidence that the resettlement which has already taken place has involved the less disabled, with the possibility that full resettlement might become more expensive still (Farmer *et al*, 1990).

There are other considerations. During the period of transition from hospital to community, residents who continue as in-patients may become progressively more deprived both in real and comparative terms as budgets are diverted from institutions to the community. Possible consequences include overcrowding and loss of services. There now seems to be a recognition of this occurring, although little hope for any solution. Also, in spite of planned closure, admissions continue to arrive at the hospitals, often staying for prolonged periods of time. The implication is of a service provision unmet elsewhere. Adult psychiatry is unlikely to provide comprehensive alternatives, and may not be able to offer all the facilities and expertise these admissions require. Supra-district services have not been developed, and in the current financial climate are unlikely to be forthcoming.

In view of the important bearing these admissions have for future planning, we designed a study to try to discover their recent extent, to examine if among these a new long-stay group could be identified, and if so, what factors which might help predict this outcome.

The study

Leavesden is a large mental handicap hospital serving the London boroughs of Hillingdon, Hammersmith, Harrow, Hounslow, Ealing, and Brent. The catchment population is approximately one and a quarter million. Total hospital population has fallen from 2000 in 1961 to 810 in 1990, beds being lost through reduced admission lengths and deaths. In this study, data on residents admitted between 1983 and 1987 were examined, holiday and respite procedures being ignored. A new long stay (NLS), group was defined (continuously in hospital for more than 12 months) and compared to a control group (discharged within 12 months). Information collected included age, sex, consultant in charge, family history of mental illness or mental handicap, (parents and siblings only), presence or absence of epilepsy, parents (alive or dead), where admitted from, where discharged to, previous admissions, consultant's diagnosis, based on DSM–III–R criteria, and level of handicap (DSM–III–R criteria, and rated from nursing and medical assessments in addition to IQ).

A diagnosis of psychosis was given if criteria A and C for schizophrenia were present, or if the disorder was of a delusional, schizophreniform, or schizoaffective type. Behavioural disorder cannot be quantified using DSM–III–R, and was almost universal among the group examined. It clearly represents an important variable; however its presence or absence alone would not have helped distinguish between the controls and NLS.

A comparison was made between the NLS and controls. Marital status was not included as only two of the controls were married, and none of the NLS.

Findings

There were 116 admissions between 1983 and 1987. Case-notes of 104 were found; 57 (55%) became

NLS, 47 (45%) controls. The average length of stay for the controls was $6\frac{1}{2}$ weeks, in excess of two years for the NLS. The sex ratios were similar with 25 male and 22 female controls and 31 male and 26 female NLS. The average age of the controls was 33, and for the NLS 39. The average number of previous admissions was 1.4 for controls and 2.7 for the NLS ($P<0.01$).

There was no excess of epilepsy in either group, a level of 32% being found in both, and the level of handicap was similar between the two groups. Of the six NLS with borderline handicap, five were male.

There was an increase in family history of psychiatric illness among the NLS (13/57 NLS, 1/47 controls, $P<0.01$) although no difference in family history of mental handicap. An excess of NLS with deceased parents was found (22/57 NLS, 9/47 controls, $P<0.01$). There was a non-significant trend towards the presence of psychosis and dementia in the NLS with an excess of adjustment disorder in the controls (0/57 NLS, 6/47 controls, $P<0.05$). Less common diagnoses were autism, organic mood disturbance, personality disorder, conduct disorder, and Asperger's syndrome.

Of 42 controls admitted from home, group homes, or hostels, 39 were discharged to the same place; 20/21 controls admitted from home returned (the other to a different hospital). This compares to 1/28 for the NLS. Of the others, one died, 16 continued in hospital, and 10 were found hostel placements. Thus 0/21 controls admitted from home were discharged to hostels, the proportion being 10/11 for the NLS admitted from home and achieving discharge during the study period ($P<0.001$).

Comment

Between 1983 and 1987 a significant number of admissions were made to Leavesden Hospital. Of these, more than half stayed for longer than 12 months. Slightly under half came from hostels and group homes, illustrating the need for continued community back-up, and of these half became NLS.

Significant factors predicting NLS status were excess of previous admissions, a family history of psychiatric illness, deceased parents, and being discharged to a hostel following admission from home. The single significant factor predicting control status was a DSM–III–R diagnosis of adjustment disorder. There was also a trend towards the NLS being older, male with borderline handicap, and a diagnosis of psychosis or dementia.

Within the constraints of this study, NLS status seems to be dictated by two factors: psychiatric (characterised by increased previous admissions, family history of psychiatric illness and a diagnosis of psychosis and dementia) and social (indicated by deceased parents, and an inability to be discharged back to the place of admission, particularly if admitted from home).

These factors are not dissimilar to those found among the NLS in the general psychiatric population (Jakubaschk & Hunziker, 1987) although the role parents play in ensuring continued community placement is probably more significant in the handicapped group. Many parents care for their children at home, and those who cannot are often successful in competing for scarce community resources on their childrens' behalf. It would also seem that transfer from one community placement to another takes time (particularly the move from home to hostel), and it is tempting to assume this reflects the inability of the hospital, local authority, or social services to find suitable alternatives. Although a contributing factor it should be stressed that the breakdown of a placement, where the original carer is unwilling or unable to take back care responsibility, is often precipitated by severe behavioural problems, a proportion of which will be the result of mental illness. Long-term behaviour modification, psychiatric intervention, and other treatments, may be necessary before community care becomes a viable option again.

Admission policies have no doubt changed since this group were in hospital, and community services are probably more able to deal with some of the problems previously beyond their scope. It seems unlikely such change has been comprehensive, and admission facilities will continue to be required for a minority of mentally handicapped people. The results of this study suggest about half of admissions will be long-term, and that there are recognisable risk factors predicting this outcome. Local district psychiatric services may meet some of the need but it seems unlikely this provision will be comprehensive. As yet there are few alternative specialist services with properly equipped and supported facilities.

In the meantime, pressure to admit will remain with the large Victorian mental handicap hospitals which with adequate funding can offer the expertise these admissions require. Active planning should already be in hand to decide on their replacement, since it seems unlikely the demands of the NLS will disappear with their closure.

References

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