The first twelve months of a community support bed unit

Philip Thomas, Mike Greenwood, Gabrielle Kearney and Ian Murray

The characteristics of clients admitted to a community support bed unit (SBU) serving an isolated, rural community were compared with those of clients from the same sector, admitted to a district general hospital (DGH) unit over the same period. There were few differences in the nature of the problems presenting to the two units, although there were more readmissions to the SBU, and more women tended to be admitted there. These results suggest that although the need for in-patient care remains for some patients, many who are currently admitted to such units can be managed in less institutional settings in the community. A support bed unit may play an important part in offering service users more choice about where and when they received help.

There is abundant evidence that many people suffering from acute and severe mental health problems can be managed successfully at home or in a day hospital (Stein & Test, 1980; Hoult & Reynolds, 1984; Creed *et al*, 1990; Dean & Gadd, 1990; Muijen *et al*, 1992), although in-patient care remains an important service component for the most severely ill. Stein & Test (1980) found that people managed at home in intensive community programmes spent up to a third less time as in-patients without spending more time in prison. Recent work by Marks *et al* (1994) has confirmed the effectiveness of home care (the Daily Living Program; DLP) compared with in-patient care. At 20 months follow-up DLP patients' symptom status, social adjustment and satisfaction with services received, were superior to those who had received in-patient care.

It is difficult to relate these results to the reality facing most psychiatrists in their daily work. With the exception of Dean & Gadd (1990) and Creed *et al* (1990), most of these studies were of specially funded 'demonstration projects'. These are usually better staffed and have more resources than the services in which most of us work. Staff morale tends to be higher. Indeed, at 45 months follow-up (Audini *et al*, 1994), most of the early advantages of DLP care over in-patient care were lost. The authors believe this was due to the attenuation of the quality of DLP care, with low morale and staff shortages. This suggests that the intensive use of staff resources in experimental services might account for improved outcome. Another problem is that most of these studies took place in urban or suburban settings. Those of us who have worked both in urban and rural areas feel that there are considerable differences between the two as far as social networks, family supports and expectations of services are concerned. This makes it difficult to generalise results from urban services to rural ones. In this paper we describe the first 12 months of a community support bed unit (SBU) serving a sparsely populated rural area. The unit was established not as a demonstration project for research purposes, but as part of a naturalistic service development.

The service

Gwynedd Community Unit NHS Trust provides mental health services for the bilingual population of Gwynedd, North Wales. The service is broken down into five sectors served by community mental health teams (CMHT). The population of 243 327 (1991 census) is served by a district general hospital (DGH) unit of 54 beds in Ysbyty Gwynedd, Bangor. The Meirionnydd sector, population 33 100, is both remote from the DGH unit, and sparsely populated. Its most southerly town is Aberdyfi, 80 miles from the DGH unit. The economy is rural. Hill farming and tourism predominate. Traditional industries such as slate quarrying are in decline. There are areas of very high unemployment.

The support bed unit

Dryll-y-Car, originally a private dwelling in the seaside town of Barmouth, was purchased by the Health Authority and converted to an eight place SBU which opened in July 1993. Four months later it was operating at full capacity. It provides a local alternative to DGH admission for people with acute mental health problems, as well as offering planned admissions, rehabilitation and respite care for people with chronic mental health problems. Because the unit is isolated potential residents are screened for risk factors prior to

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admission. For this reason referrals must be known to the sector CMHT or the DGH unit. No referrals are taken directly from GPs. People meeting the following criteria are accepted for admission:

(1) Not on section of Mental Health Act (except for subsequent rehabilitation).
(2) No risk of harm to self or others.
(3) No serious physical health problems.
(4) No primary problem of learning disability or substance misuse.

The unit is staffed by a nurse manager, five whole-time equivalent staff nurses and five whole-time equivalent health care assistants, offering 24 hour cover. Medical input is provided by the consultant psychiatrist (PT) or senior registrar (GK) who spend one session a week at the unit. Junior staff cover is provided by a registrar in psychiatry (one session) and clinical assistant in psychiatry (five sessions). Emergency cover is provided by the local GPs on a sessional basis. The unit is led by the nursing staff who undertake initial assessments and formulate individual care plans jointly with residents. We use a care model which engages people with mental health problems as partners in the process of care.

We examined all admissions to the unit over the 12 months after it became fully operational, using admissions to the DGH unit from the same sector over the same 12 month period as a comparison. Non-parametric tests (Mann–Whitney *U* test or chi-squared) were used to compare the two groups.

Findings

In the 12 months before the SBU opened there were 116 admissions from the sector to the DGH unit. In the 12 months after the SBU opened fully (from 1/12/93 to 30/11/94) there were 110 sector admissions in total, 54 to the SBU and 56 to the DGH unit. This indicates that the SBU was able to reduce admissions to the DGH unit by 50% compared with the previous year's figure. More women were admitted to the SBU (65%) compared with the DGH unit (51%). This difference is not statistically significant (chi-squared=1.92, d.f.=2, on cell frequencies). There was no difference in the age distribution of the two samples ($Z=-2.67$), but Fig. 1 shows that a higher proportion of people in the age range 36–55 years were admitted to the SBU, and people below the age of 25 or over the age of 65 were more likely to be admitted to the DGH unit (chi-squared=5.35, d.f.=2; $0.1>P>0.05$). The distribution of length of stay and numbers of admissions in the two sites are remarkably similar and any differences were not statistically significant. The mean length of stay in the DGH unit was 2.8 weeks (median=2.0, range 1.0–10.0), compared with 5.1 weeks in the SBU (median=2.0,

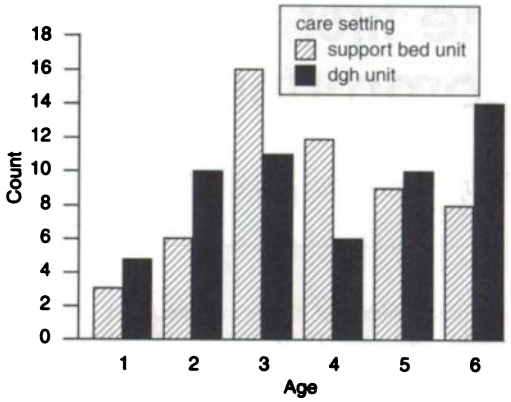

Figure 1. Age by site of care. 1=16–25 yrs; 2=26–35 yrs; 3=36–45 yrs; 4=46–55 yrs; 5=56–65 yrs; 6=65+

range 1.0–47.0). The mean number of admissions to the DGH unit was 1.7 (median=1.0, range 1.0–4.0) compared with 1.6 in the SBU (median=1.0, range=1.0–6.0).

We used a simple system based on hospital ICD–9 (World Health Organization, 1978), diagnoses for coding the main presenting problem. Figure 2 shows that there are few differences in the nature of the problems presented by people in the two care settings. In both sites the greatest proportion of admissions is accounted for by people suffering from schizophrenia or affective disorders. More people with primary depression and interpersonal relationship problems tend to be admitted to the SBU, whereas the reverse holds for primary anxiety and 'other' problems. This category largely consists of people admitted to the DGH unit for withdrawal from alcohol. People in the SBU tended to have more re-admissions than the DGH unit, but this was only a small difference. In the SBU the majority of people admitted with psychotic illnesses were planned admissions. Two out of nine people admitted to the SBU with schizophrenia and three out of 11 with affective disorders were acute admissions.

We compared the proportion of people suffering from psychotic disorders admitted to the DGH in the year before the SBU opened, with the proportion admitted to the DGH and SBU in the year after the SBU opened: 10.4% of all DGH admissions in the previous year had organic psychoses, in the following year 8.9% went to the DGH unit and 5.4% to the SBU. For schizophrenia the equivalent figures were 16.4% (DGH the year before), 21% (DGH unit) and 20.4% (SBU). For affective disorders the figures were 26.7% (DGH the year before) 30.4% (DGH unit) and 25.9% (SBU). Overall there were only small differences in the proportions of patients

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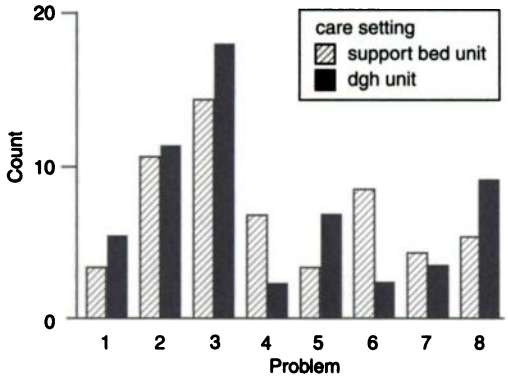

*Figure 2. Problem by site of care. *Codes: 1. dementia or organic brain syndrome (ICD 290 and 294); 2. schizophrenia and paranoid states (ICD 295 and 297); 3. affective disorders (ICD 296); 4. depression (ICD 300.4, 309.0, 309.1, 311.0); 5. anxiety disorders (ICD 300.0, 300.2 and 300.3); 6. interpersonal problems (ICD 301.1); 7. abusive relationship problems (these include people whose problems are primarily attributable to the effects of past or present abuse in relationships); 8. other (includes alcohol misuse)*

with psychotic disorders admitted before and after the SBU opened, and in the proportions subsequently admitted to the DGH unit and SBU.

During the first 12 months, only two patients had to be transferred from SBU to DGH unit. One person with a mood disorder became irritable and dysphoric. The other person had abusive relationship problems and required more intensive care in the DGH unit for a short period, after cutting herself in the SBU. Ten people were transferred from the DGH to the SBU. Their diagnoses were functional psychosis (n=4), affective disorder (n=3), interpersonal problems (n=2) and depression (n=1). The purpose of all these transfers was to facilitate the return of the individuals concerned back into the community.

Comments

Perhaps the most important point to emerge from this study is that traditional in-patient care is not essential for everybody. We found that a small, isolated facility, over 50 miles from the DGH unit, can play an important role in offering a range of services for people suffering from serious mental health problems, many of whom would otherwise require DGH care. The success of the SBU in this area is dependent upon close working relationships between members of the sector CMHT, the DGH unit staff and SBU staff. The main benefit of such cooperation is to extend the choice available to people experiencing mental health problems.

There is anxiety that the move to community care will neglect the needs of those suffering from the most serious and disabling forms of mental illness (Bachrach, 1980, Sayce *et al*, 1991; Audit Commission, 1994). In this study there were no differences in the nature of the problems managed in the SBU. People suffering from schizophrenia or affective disorders accounted for 46% of admissions to the SBU, and 52% of admissions to the DGH unit. Although these conditions constitute the most severe forms of mental health problems, other conditions, such as long-standing interpersonal conflict and the sequelae of abusive relationships, cause just as much personal suffering and pressure on resources. In our service we found the SBU especially valuable in helping people with such problems. Although many people suffering from acute psychosis required initial assessment in the DGH, many were transferred to the SBU for continuing care and placement back in the community (seven out of ten transfers from DGH to SBU suffered from functional psychoses).

There were two main differences between the sites. It is worrying to see that more women tended to be admitted to the SBU. The reason for this is not clear. Perhaps more men were admitted to the DGH unit because they were perceived to be at greater risk of self or other harm. CMHT and SBU staff may assume that women are more likely to benefit from SBU care. It is not possible to explore this with these data. More people had multiple readmissions to the SBU. If keeping people out of hospital is regarded as a positive outcome this suggests that SBU care is less effective. But this is not the case here. Care in the SBU is tailored for individuals, and planned readmissions form an important aspect of long-term support for those with the most serious problems. This offers families and carers respite, as well as providing an opportunity for brief intensive periods of work with the individual. The benefit of this approach is not measured by re-admission rates over 12 months, but by long-term service use, clinical and social outcome and burden on families, as well as consumer satisfaction. We intend to study this in the next stage of our work.

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