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Eastenders on the South Coast

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In spite of the moves over the last 20 years towards community care, there remain substantial numbers of elderly people with both physical and mental illness who require residential, nursing home and hospital care. There is evidence to suggest that health service provision of long term care for the mentally ill has been, and continues to be, reduced. In addition there has been reduction in beds for long term care by geriatric physicians and while the nursing home and residential care sectors have expanded, this expansion has been entirely within the 'independent' private and voluntary sector, with considerable contraction of local authority provision. Representations have been made about this to the Old Age Section of the Royal College of Psychiatrists and they have reported on this (Benbow & Jolley, 1992). Concern has not been confined to the profession. Over the last year, there has been considerable media publicity about the long term care of elderly people in institutions. Some of this has been very critical [Panorama, 20.1.92] and has provoked debate on the pages of the national papers.

There are particular problems in inner city areas where there are few private and voluntary homes. This is the case in Tower Hamlets where our local facilities have been reduced by at least 200 places in the last five years. Tower Hamlets is a deprived area of inner London with high Jarman Indices (Jarman, 1981). The plight of elderly Eastenders in the community was well described by Dr David Widgery (1991).

Tower Hamlets has a population of 160,000 in a small densely populated area, of whom 23,050 are over 65 years of age. There is a large immigrant population, particularly represented among the young. Old age psychiatry up until the period studied had 48 medium and long stay beds. Since 1990, 17 of these beds have been used increasingly for short term and respite care and assessment. There has been no change to the functional beds. Geriatric services are concentrated at Mile End Hospital where there are 121 acute and 46 long stay beds. Within the borough there is one private nursing home, one 40 bedded EMI (elderly mentally infirm) unit and approximately 190 part III beds.

In these constrained times, health and social services in areas such as our own have had no option but to look outside the district for alternative residential care of all types. This has not evolved as coherent strategy but has been driven by need. We therefore decided to look at the consequences of this increased use of private and voluntary homes outside our borough. Although we did not formally assess the quality of the homes used, they were all approved by social services and visited by one or another member of the multidisciplinary team and by family or carers where possible. They were all found to be satisfactory at the time of placement. Other workers have found the quality of the environment in private homes reasonably good (Perkins *et al*, 1989).

The study

We examined the characteristics of all patients placed in long term care of some sort directly from the acute/assessment functional psychogeriatric and dementia beds in Tower Hamlets from October 1989 to September 1991 and made enquiries to determine how satisfactory the placement had proved using brief standardised questionnaires. (Nursing staff, professional carers, relatives and lay carers were approached). In addition, general practitioners and hospital units were contacted to determine use made of their services by these patients in the follow-up period.

Findings

A total of 34 patients were placed from hospital into a new long term residential placement. Thirteen patients were placed in year one from October 1989 to September 1990 and 21 in year two from October 1990 to September 1991. This represents 5.8% and 7.4% of all discharges from psychogeriatric wards for these periods. There were 12 men and 22 women and the average age of the whole group was 76 (range 66–92 years). There were more women in the in and out of borough groups although numbers were similar in the long stay group (6 male and 7 female). The long stay group was also marginally but not significantly older (mean age 78). The duration of admissions prior to placement varied from two weeks to three and a half years but was not significantly different for the three groups.

Duration of follow-up

The patients in borough had all been placed prior to June 1990. Out of borough placements occurred after June 1990, and the average follow-up was 22.2 months and 9.6 months respectively.

The diagnoses were taken from the medical notes. Seven of the patients had functional psychiatric illness and 27 had organic brain disease. All the patients had had a Folstein MMT score and those with a score of less than 23/30 were included in the organic group.

The seven patients with functional illness were placed as follows: two long stay ward, two in borough, and three out of borough.

The two patients with functional illness who were placed in continuing care beds had such severe behavioural problems that they could not be cared for anywhere else.

Seven patients died during follow-up of whom three were on the long stay wards, three initially placed in borough and one out of borough. One in borough patient was transferred out of borough by social services and another was admitted to long stay psychogeriatric care. Two patients were admitted to long stay psychiatric wards in Tower Hamlets and another to an in borough home during follow-up.

The homes

The reports received from placements out of borough rated all but three placements as satisfactory. Two of these were in the same home where initial standards of care were not maintained. One was admitted to our long stay ward and the other to a part 3 home locally. The third patient was so aggressive she too returned to a long stay ward and could not have been cared for elsewhere. The in borough placements were reported as satisfactory by the homes.

The nurses on our long stay wards felt they had managed to settle all the placements on the ward although the single difference between these patients and those placed outside hospital was in the increased rate of behavioural disturbance. Eight of the 21 patients placed out of hospital had some behavioural disturbance (38%) and 8/13 placed in hospital (62%). Two of the out of borough placements eventually came to long stay psychiatric care. This bears out Hilton *et al's* (1989) findings.

Carers

As many as possible of the carers and relatives were contacted. Two patients had no next of kin and were placed out of borough. They were single men who were living in Tower Hamlets when they became ill but were not Eastenders. All the other carers and relatives were included, however distant. From the out of borough homes, there were two complaints from relatives about the placement and both patients moved back to Tower Hamlets. Otherwise there was no dissatisfaction with the homes and the care was felt to be good. Two patients had been moved nearer their relatives who were pleased. However distant the relationship, there was distress at the distances involved in visiting and many said they had not realised how much this would affect them. One could not afford the journey. Two were too frail. One said she was very sad her aunt might die and she would not have seen her. At the time of placement all these people had been consulted and they continued to understand the reasons for distant placements. It may be we underestimated the importance of even tenuous links within families. Several of the relatives said they felt guilty. One carer who was not a relative said "It didn't seem fair – he's lived all his life in Poplar and paid his stamp; why did he have to go away when he was ill?"

There were no complaints from relatives and carers of in borough placements except one about under staffing in one of the local homes. Some of the families of in-patients were initially distressed at the long stay wards but have all accepted it now and are happy with hospital care. They are also able to attend carers groups. The relatives of patients who moved from residential to long stay care were all

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pleased with hospital care and felt it superior to the residential care.

Use of medical resources

Long stay wards. This group maintained their physical health and had little call on other medical services apart from two patients who were transferred to medical wards and subsequently died.

In borough. All seven had acute general hospital admissions ranging from two weeks to four months. (It should be noted this group had the longest period of follow-up). Two died in hospital, one is now in long stay geriatric care, and one placement is still viable but she has attended psychiatric day hospital continuously since discharge.

Out of borough. These patients have made considerable demands on local medical and psychiatric services. Two were admitted to long stay wards in Tower Hamlets, two required in-patient psychiatric care, both for more than ten weeks and one of these attends a psychiatric day hospital, two required brief medical admissions of ten days and seven days, and two died without hospital care (one of whom was transferred by social services out of borough).

Summary of status at follow-up in December 1991

Of the seven placed in borough, three were still in their original residence (three had died and one had been transferred to a long stay geriatric bed). Ten of the 14 original out of borough placements were still in their original placement (one had died but three had been transferred back into the borough). The long stay group was least changed with ten still in their original placement (three had died).

Comment

The placements represent a small proportion of patients having contact with the service and placed in residential care. In spite of the care we thought we had taken in arranging satisfactory placements, some relatives and carers were dissatisfied when patients had been placed out of borough. Most of these placements have, however, been adequate and the patients themselves settled. We continue to feel a great deal of disquiet about out of borough placements and we feel that our patients, who are almost all native Eastenders, deserve to be cared for in old age where they were born and have lived their lives. They have made considerable demands on other districts' NHS services and are likely to continue to do so as their placement continues. We are aware of the limitations of a retrospective study and are planning to study all patients referred to our service. This preliminary work has highlighted three important points.

(a) That the need for residential care has persisted in spite of health and social service efforts to establish care in people's homes.
(b) There is still a need for long stay old age psychiatry beds for a number of patients who have behavioural problems.
(c) Exporting patients with some serious mental and physical health results in considerable demands on medical services which have not been negotiated with the new providers.

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