Criteria for long-stay care

David Jolley, Susan Jolley and Susan Benbow

Most old age psychiatrists see long-stay care in good quality community hospitals as an essential component of a comprehensive service for older people suffering from mental illnesses (Jolley & Arie, 1992). Yet in recent years some Health Authorities have sought to reduce or close their long-stay beds and this has caused a great deal of controversy (Alzheimer's Disease Society, 1993; Benbow *et al*, 1994).

New guidance from the Department of Health makes it very clear that the NHS has a responsibility to provide a reasonable number of long-stay beds for this patient group. Authorities are required to agree and to publish criteria for admission to such facilities and a mechanism is envisaged which will allow investigation of appeals (Department of Health, 1995).

How common is it for Authorities to have written criteria available now? What are the criteria identified, are they likely to meet the requirements of the new guidance and can they be useful to others who are only now addressing this exercise?

The study

In preparation for a consensus meeting on the topic, from which it was intended to offer advice through the College, a request for information on current practice was circulated to 139 old age psychiatrists, distributed through the 15 Regions of England and Wales.

Findings

Eighty-eight replies were received. Twenty-seven (31%) services are already using written criteria, usually agreed with social service departments and others. Fourteen different statements of criteria were provided by respondents, there being two 'standard' lists in use by services in Wessex, and some respondents declared they were using written criteria but did not make them available. The context in which work is done and criteria will have to be applied covers a considerable range: seven of the 88 services have no access to long-stay beds. The average provision is 1.7 beds/1000 over 65 years, with respite beds included; the most generous Authority provides 4.5 beds/1000. All but 15% of long-stay beds are provided directly by the NHS as are 81% of respite beds.

It was not possible to define a relationship between the criteria in written statements of eligibility and the level of NHS provision as only a proportion of services had such statements and made them available, but it must be the case that *de facto* criteria differ widely. Analysis of those written criteria which have been made available reveals a number of common themes (Table 1). Most include a requirement for clinical judgement from a consultant within a multidisciplinary team. None make use of numerical scales and all emphasise the presence of multiple, complex, changeable needs among the patients to be offered long-term care. Inclusion criteria couched

Table 1. Criteria for admission to long-stay psychogeriatric beds

	n*
Difficult behaviour	11
Diagnosis of dementia	11
Other serious psychiatric disorder	10
Decision by consultant-led team	9
Need for frequent review of management	9
Aggression: physical or verbal	9
Need for skilled care	8
Disinhibition, sexual activity, stripping	8
Interference with others	8
Extreme noisiness	7
Combined mental and physical problems	7
Restlessness, falls, absconding	7
Resistance to care	6
Incontinence not manageable by usual means	6
Variable mood and behaviour	5
Security requirements: MHA, Home Office	4
Age 65+, younger with similar problems	3
Failure to cope elsewhere	3
Terminal stages of dementia	2
Family insistence or preference	2
Help with feeding	2
Help with mobility	2
Sensory impairment	2
Patients who deteriorate elsewhere	1
Rapid deterioration	1
Mobile	1
Not physically ill	1
Severity of cognitive impairment not sufficient	1
Severity of impaired self-care not sufficient	1

*Numbers refer to the frequency with which individual criteria were mentioned in 14 written returns

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in wider terms were found in most statements (criteria 1–7) with mention of specific behaviours or characteristics being less common and sometimes idiosyncratic. Very few exclusion criteria were identified and exclusion for one might be a specific inclusion for another, e.g. 22/26.

Comment

Most Authorities will need to establish written criteria for the first time to comply with the new guidance. While those with established criteria will be reassured that most share a common set of basic requirements, this must conceal wide differences in practice or interpretation because of the range of provision which exists. It is doubtful if any of these extant statements will stand up to the rigours of an appeal procedure addressed to discontent in individual cases but they do offer a glimpse of the sort of characteristics of patients likely to be included in long-term care and could form the basis from which a national framework of criteria can emerge.

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*David Jolley, *Consultant Old Age Psychiatrist, South Manchester NHS Trust and Wolverhampton NHS Trust*; Susan Jolley, *Consultant Old Age Psychiatrist, South Manchester NHS Trust; and* Susan Benbow, *Consultant Old Age Psychiatrist, Central Manchester NHS Trust*

*Correspondence: Dr D. Jolley, Psychogeriatric Unit, Withington Hospital, Nell Lane, West Didsbury, Manchester M20 8LR

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