

A SURVEY OF ADULT PATIENTS IN FOUR HOSPITALS FOR THE MENTAL HANDICAPPED

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Introduction

This survey of adult patients at present resident in a group of four mental handicap hospitals, follows exactly the same approach as adopted in a previous study (Browne *et al.*, 1971) when only one *quarter* of the patient population of those hospitals was sampled. Apart from this difference, the consultants out of five involved in the present study had not participated previously.

In the eight years following the first survey much change has taken place in the mental handicap field and many of the more able patients have moved into the community. One would therefore expect — on the assumption that the previous sampling of one quarter of the population was representative — that the results of this present survey would show a higher population of people requiring hospital care than on the previous occasion.

The purpose of this investigation was simply to establish the proportion of the hospital population which does not need hospital provisions as such, e.g. psychiatric, nursing, etc., even though this population may require some very supportive help which exceeds what is generally available in the community now. The emphasis was, therefore, on “who does not need hospital care” rather than “who can be looked after in the community with present facilities.”

The results of this survey are based on clinical opinions, rather than objective facts. It can be expected that different people might have different opinions on individual cases and results might have varied to some extent if other consultants had given their opinion. However, the sample is large enough so that such factors have less influence and this makes it possible to observe differences between the two surveys.

Method

Following the procedure used in the previous survey, the five consultants were asked to indicate on a record card for each patient the major problem which required attention and also any associated problems. The question they asked themselves was as previously: “What problems of care, supervision and treatment could be anticipated if a particular patient of a subnormality hospital were to be discharged at the time of the survey?” The same checklist of “problems” was used as previously (see Browne, 1971, Appendix 1) which makes it possible to compare the results of the two surveys.

In the previous survey it was found that the major “problems” could be put into four groups A,B,C,D, which indicated the type of care required.

Group A = people with low capability who require conscientious but not necessarily skilled nursing attention. Here were the care problems, which were defined as those patients who have difficulties in feeding, dressing and toileting. They require basic nursing skills that could be given by any untrained but reasonably careful person. The group also includes people who are quite unable to manage even a sheltered work situation and old people who need help on account of age.

Group B = people with limited work ability who require primarily sheltered work conditions. These are people whose work ability is too limited to be remunerated normally but who do not present special behaviour problems.

Group C = people who need medical or nursing attention of some kind.

Group D = people who are social misfits and behaviour problems.

Groups A and B are made up of people who need obviously care and much attention but not of the specialised skilled nature as required for Groups C and D. They are people who do not need primarily the services of a mental handicap hospital, even though, many of the associated problems may need advice from a specialist.

Groups C and D are made up of people whose major problem requires the psychiatric/nursing skilled attention available at a mental handicap hospital.

This report concentrates on Groups A and B because they contain those people who, according to the consultant's clinical judgement, do not need the full services in the residential accommodation of a hospital.

Results

The population sampled by this survey comprised 923 patients, (Table I). Of these 49% were classified in Group A, 9% in Group B, 27% in Group C and 15% in Group D (Tables II-V). This sample contained all patients resident in the four hospitals except for some 20 patients at Hospital B, who could not be assessed in time for the survey. The previous investigation was based on a quarter of 1335 patients and it appears, therefore, that some 400 patients had left the hospitals since 1971.

The comparison of the results of the two surveys is shown in Table VI. The 1970 survey suggested that over half of the hospital population at that time did not require specialised hospital service. The 1978 figures indicate that this is still true. It appears that, as far as these four hospitals are concerned, every second "patient" need not be a patient in the National Health Service but could be provided for in less specialised conditions.

The 537 patients in Groups A and B representing "Care and Habilitation problems" which do not require the full resources of a mental handicap hospital, do nevertheless need some careful attention. Further analysis of the records indicates that practically all the people in this group require sheltered home life which provides regular assistance. Probably every second member of this group makes special demands on occupying him in some way. They tend to be people who are left out of the current limited OT and IT provisions because they make scarcely any contribution. Even when they participate they will need much attention. However, only one quarter of this group requires medication to function reasonably well.

There are, of course, many behavioural and physical difficulties and these were mentioned specifically, for example in 115 cases out of 219 male patients in Hospital A. These include blindness and deafness, vomiting, wheelchairs, etc., but all the same, they are not of a degree to require hospital care. Serious behaviour difficulties, such as aggression occur in approximately 10% of this group but only 13 patients needed geriatric care as such. The majority of patients with psychotic behaviour are not included in this population but there are a few people with odd behaviours of a mild kind, probably amounting to no more than 5% in this type of group.

Discussion

Perhaps the most confusing finding is that between the two surveys the proportion of those not requiring the full services of a mental handicap hospital (Cat. A. and B) has changed little and in fact is somewhat larger in the later survey. It is generally assumed that most of those discharged from long term care are amongst the more able and least disturbed residents. This would be expected to lead to a diminished proportion of those in category A and B still in hospital.

There are a number of possible explanations. It could be that the above assumption is not correct and that there has been an approximately similar distribution of abilities and problems in both those discharged and those remaining in hospital. This observation is not in accord with the clinical impression, but a review of those discharged would be required to establish the true facts.

Another reason could be that only 2 consultants in the later study took part in the first and the individual consultant's views could have influenced the results. This is possible but the effect ought to be relatively small because the criteria used were identical in both surveys.

A third explanation could be that in the earlier study the random sample was not in fact representative. This is again unlikely because the numbers used were still large and the results were similar to those in other studies of a similar nature.

The explanation which is perhaps more likely is that the consultants' clinical judgement is inevitably influenced by the kind of alternative residential and support services available in the locality, the nature of the people currently being dealt with by these services, trends in community care at the time and perhaps a knowledge of experimental and research projects in the field. The evidence from all these areas is that the "community" can indeed cope with, and even improve the quality of care of mentally handicapped people with lower abilities and a greater range of problems than formerly thought possible. Perhaps therefore nowadays consultants can be confident in predicting that a much larger number of residents in mental handicap hospitals could return to the community provided appropriate facilities were available.

If the findings of this survey are applicable on national scale the financial, staffing, rebuilding and policy implications for Local Authorities are enormous.

A survey of this kind could and should result in a "waiting list" of people, at present in hospitals but not requiring their specialised services. But it must also be made clear that "transplanting" may not be necessarily in the best interest of those people. There are many humanitarian considerations, such as age, length of residence, infirmity, etc., which would have to be taken into account before a mass exodus is organised. On the other hand it is not justified to make a priory decision on those grounds and preventing thereby the unexpected development and growth in the mentally handicapped as the result of new environmental stimuli.

Whilst one can appreciate that a large number of mentally handicapped people of the type described above, cannot easily be absorbed in the kind of facilities at present available in the community — even if there were more of them — it is nevertheless important to stress once again that in their cases hospital provisions are not appropriate to their needs and that their continued presence in hospital will block the admission of those patients who really require hospital facilities. The community will have to develop more facilities for the mentally handicapped but they will have to be of a different type to cater for the population described above.

Reference

R. A. Browne *et al* (1971), The Needs of Patients in Subnormality Hospitals if Discharged to Community Care. *Brit. J. Ment. Subnorm.*, XVII, 32, pp.7-24.

TABLE I
Population according to sex.

Hospital	Male	Female	Total
A	219	176	395
B	98*	143	241
C	63	43	106
D	68	113	181
* incomplete figure.			923

TABLE II
Group A: People with low capability who require conscientious, but not necessarily skilled nursing attention.

Hospital	Male	Female	Total
A	196	77	273
B	20*	49	69
C	8	8	16
D	40	52	92
* incomplete figure.			450 = 48.7%

TABLE III
Group B: People with limited work ability ranging from low to poor average - who require primarily sheltered work conditions.

Hospital	Male	Female	Total
A	0	27	27
B	7*	7	14
C	25	14	39
D	6	1	7
* provisional figure.			87 = 9.4%

TABLE IV

Group C: Medical or nursing attention of some kind is required.

Hospital	Male	Female	Total
A	22	56	78
B	33*	76	109
C	7	8	15
D	11	37	48
* incomplete figure.			250

= 27.1%

TABLE V

Group D: People who are social misfits - behaviour disorders.

Hospital	Male	Female	Total
A	1	16	17
B	38*	11	49
C	23	13	36
D	11	23	34
* incomplete figure.			136

= 14.7%

TABLE VI

Comparison between the 1970 and 1978* surveys.

	1970		1978	
	N	%	N	%
Group A	127	40%	450	49%
Group B	40	13%	87	9%
Group C	102	32%	250	27%
Group D	48	15%	136	15%
	317	100%	923	100%

* incomplete figure.