

## DISCHARGE PROSPECTS OF A MENTAL HANDICAP HOSPITAL POPULATION: A survey of nursing perceptions

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### INTRODUCTION

National policies in mental handicap envisage a gradual but irreversible shift of the focus of residential care from hospitals to community settings. Thus hospitals will need to appraise their residents' abilities and disabilities not just to enact improvements in their quality of life in general but now with the demands of community based lives specifically in mind. This shift will inevitably include residents who have never before been considered candidates for life outside hospital. There is little doubt that many hospitals still have a patchy overall picture of their residents' prospects for discharge and of the factors determining them. Few surveys aimed at obtaining this kind of overview have been published though a survey of over 3,000 residents in Minnesota State hospitals showed that 12.5% were dischargeable in the sense that they met the admission criteria for a range of state community residential facilities (Bock and Joiner, 1982).

Nursing staff spend many hours of each working day in close contact with the residents and seem in a sound position to make personal judgements about their overall prospects for discharge and of the day to day difficulties thrown into relief in each case by such objectives. This study, which covered the entire population of a long stay hospital, sought to collate the nursing opinions passed about each resident in respect of possible future discharge and to see how these judgements interacted with other variables within the resident or his environment, some already known (e.g. sensory disability or use of long term medication) and some identified in this survey (e.g. behavioural problems).

### METHOD

#### Setting and respondents

The hospital in question, situated in a suburban setting on the fringes of London, had 134 residents at the time of the survey. 3 had been admitted too recently for inclusion and there were thus 131 in the survey. This hospital has always been almost exclusively a long stay institution, the current average stay being 26 years (range  $\frac{1}{2}$  - 72 years).

The respondents were the nursing staff of all grades working at the hospital. There were 102 nurses on the staff.

#### Procedure

All 102 nurses were written to individually. Each was asked to answer the following question about each resident on the ward on which her or she worked (and, if they chose, about residents they remembered from previous placements on other wards). Senior nurses, not based on a single ward, were asked to reply for those residents they knew well enough to assess.

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— In your personal opinion could he/she ever be discharged from hospital and live in a community facility of some kind?

If "no", please say what disabilities would make this move so highly unlikely.

If "yes", please say what disabilities would have to be tackled before discharge.

The covering letter stressed that it was personal judgements that were being sought rather than agreed answers made after staff discussion. It also noted that we had to assume that expansion of community facilities would in fact continue so that residents considered dischargeable might have somewhere to go.

The replies were collated for each resident. Firstly, aggregating the "yes" and "no" votes allowed the majority verdict about their dischargeability to be expressed as a percentage of the total number of replies returned for each resident. E.g. 10 "yes's" and 4 "no's" meant a  $10/14 = 71\%$  "yes" vote for discharge.

The disabilities specified as impeding discharge (or making it impossible) were also collated and analysed in terms of other factors e.g. communication/sensory problems, obtained from a previous survey, and, in particular, the use of medication obtained from the computerised records kept by the Pharmacy Department.

## RESULTS

### Definitive sample

51 nurses replied (50% response) with similar proportions in each grade as in the full nursing complement. Each resident had on average 12 nurses pass an opinion about his/her dischargeability (range 4-21).

### Agreement between nurses

The table below shows the distribution of the 115 (88%) of the hospital population who received a fairly clear-cut majority either favouring discharge ("yes" votes) or opposing it ("no" votes).

|       | 100%<br>agreement | 80-99%<br>agreement | 67-79%<br>agreement | Totals    |
|-------|-------------------|---------------------|---------------------|-----------|
| "Yes" | 2                 | 6                   | 11                  | 19 (15%)  |
| "No"  | 34                | 36                  | 26                  | 96 (73%)  |
|       | 36                | 42                  | 37                  | 115 (88%) |

From the table it can be seen that there was 100% agreement about the dischargeability (whether for or against) of 36 residents (27% of the total), at least 80% agreement on 78 (59%) and at least 67% agreement on 115 (88%). This represents a considerable measure of agreement between nurses. Nearly twice as many residents with an overall "no" secured an 80% majority compared to those with an overall "yes" i.e. there was a much "tighter" consensus around "no" votes than "yes".

Taken overall there was no significant difference between assessments by trained compared to untrained staff.

### **Residents considered dischargeable**

It can be seen that 2 residents secured 100% agreement that they were potentially dischargeable i.e. 100% "yes" votes. A further 6 secured at least an 80% "yes" vote. The average stay for this group was 28 years, slightly (but not significantly) longer than the hospital average. Self help/domestic/social skills problems were generally nominated here as the principle obstacles to successful placement in the community. Behaviour problems or physical difficulties were scarcely identified.

A further 11 residents were considered potentially dischargeable by at least a 67% majority of nurses. The average stay for this group was 27 years. Though still affecting only a minority of residents, there was more mention here of behaviour problems as an issue affecting the possibility of discharge.

### **Residents not considered dischargeable**

96 residents (73% of the total population) were not considered dischargeable by at least two-thirds of the nurses replying for each of them. The burden of care for this large group not expected to change did not fall evenly between the wards, two of which had all their residents in this group. Replies on these residents tended to stress their overall dependence on hospital-based care rather than nominate specific disabilities as was requested by the survey; the helplessness of this group was often perceived to arise from multiple handicaps acting in tandem so that it was not easy (nor perhaps relevant) to decide which of them were the main barriers to discharge. When specific disabilities were mentioned, they were mostly locomotor problems and bad behaviour.

### **Residents subject to divided opinions**

There were a further 16 residents (12% of total) not represented in the table above. This was a "low agreement" group where the number of nurses who saw them as potentially dischargeable was fairly evenly balanced by the number who did not. The nurses who viewed them as dischargeable tended to nominate self help and domestic skills as being the major obstacle to overcome, as was the case with the residents who received a clear-cut "yes". In contrast, the disabilities mentioned in the "no" votes were evenly spread, without particular preponderances. Behaviour problems — in various guises — were considered to be a factor impeding discharge in 8 of the 16 and were clearly a major issue in 4.

Old age/institutionalization, physical or communication disabilities did not seem to be important determinants of dischargeability in these residents, nor indeed in the 19 who were considered dischargeable by a majority of nurses.

### **Old age/institutionalization**

There was a small group of residents for whom only old age or institutionalisation (with unwillingness to leave, in particular) were identified as all that impeded discharge. For these residents staff tended towards the view that they should be left where they were.

### **Epilepsy**

Pharmacy records showed that there were 44 residents (34%) of hospital population taking anticonvulsants. In 27 of these cases epilepsy was identified (by 1 nurse or more) as a factor affecting dischargeability. In fact none of these 27 received a majority vote for discharge, even those who rarely had a fit.

Other specific medical conditions (e.g. diabetes mellitus or Hepatitis 'B' Ag. positivity, were also reported as factors affecting or barring discharge.

#### **Epilepsy and behaviour**

25% of those residents whose epilepsy was judged to bar discharge were also recorded (by 2 nurses or more) as having behaviour problems. This figure rose to 50% if observations made by a single nurse were also counted. But looking at it the other way round, the 59 residents, discussed below, identified as having behaviour problems affecting discharge were no more likely to have epilepsy cited as an additional factor than the rest of the hospital.

#### **Behaviour problems**

59 residents (45% of the total) were identified (by 1 nurse or more) as having difficult or antisocial behaviour such as to affect their prospects of discharge. Their average length of stay in the hospital was 22 years. 27 residents (average stay 20 years) were so identified by 3 or more nurses and 16 (average stay 18 years) by 5 or more nurses. This last group of 16 thus appears to represent the most behaviourally difficult in the hospital. Only 7 of the 59 were viewed as potentially dischargeable.

Other types of behaviour or personality style e.g. solitariness or unassertiveness, were only infrequently identified as factors bearing upon discharge.

#### **Speech/sight/hearing difficulties and behaviour**

A previous survey on nurses' assessments showed that 57 (45%) of the hospital population had poor or no speech skills (Bradley, 1986). In the 'difficult behaviour' group of 59 identified above, there were 29 (49% of this group) with poor speech skills and thus there is no particular correlation between poor speech and difficult behaviour. This still holds true for the sub-group of 16 very difficult/aggressive residents identified above.

21 (15%) of the hospital population were shown in the same survey to have significant hearing loss. No correlation between marked hearing loss and behavioural problems was identified: only 2 of the 59 were definitely deaf.

The 10 residents previously shown to have significantly reduced vision were also not significantly represented in the "difficult behaviour" group.

#### **Behaviour problems and medication**

Pharmacy records showed that 30 residents (23% of the total) were currently taking major tranquillisers (neurolepts) and almost all had been doing so for years. In fact this figure underestimates the history of prescribing since there were others who had also taken neurolepts for many years though were not doing so currently.

Of this 30 no fewer than 26 residents were amongst the 59 in the "difficult behaviour" group. A further 11 in this group had previously been on neurolepts (usually for years, though not at present). 37 residents then, out of the 59 (i.e. 63%) in the "difficult behaviour" group have had prolonged exposure to neurolepts, a much increased proportion compared to the rest of the hospital.

Of the 59 there were 20 (34%) who were or had been on regular benzodiazepines, 13 (22%) were or had been on antidepressants.

If we look at the 16 residents identified above as the most behaviourally difficult in the hospital, the picture is even more striking. 11 were currently on neurolepts (almost all for years) and 3 others had previously been so (for years) — 88% in all. In addition 6 (38%) were or had been on benzodiazepines and 5 (31%) on antidepressants.

## DISCUSSION

19 residents (15% of total) were considered to have good prospects of discharge, 8 of whom were judged so by 4 out of 5 nurses. This is a similar figure to that quoted by Bock and Joiner, as mentioned in the introduction. On average this group had been in hospital for over 27 years and arguably discharge would have been viable years ago. In fact 5 have moved into the community in the 18 months since this survey was completed.

In residents considered dischargeable it was self help/social skills which were most commonly nominated as the *problem area*. *Behaviour or other personality* difficulties and physical or communication problems all seemed to be fairly minor determinants of discharge. It seems that once residents were perceived as relatively free of major difficulties — of whatever kind — it was their self help or social skills which were thrown into relief as the last hurdle before successful placement in the community. Clearly these areas need to be the focus of well organised and on-going rehabilitation programmes aiming for discharge. 96 residents (73% of total) were not considered dischargeable by the majority of nurses. Many of these were seen to have multiple handicaps acting together.

Respondents identified a small group of residents who were not considered to have any disabilities preventing life in the community except institutionalisation and, usually, advancing age. Most staff would view these residents as having been inappropriately placed in hospital years ago but there was a trend towards the view that discharge should not be pursued at this stage.

Of the 34% of the hospital population who were taking anticonvulsants none were considered dischargeable. Clearly this reflects the increased likelihood of epilepsy in the more severe forms of mental handicap. However there were also varying attitudes about the extent to which the mere existence of epilepsy, regardless of how well controlled it was or was not, should be judged an impediment to life in the community. This also seemed true of some other medical conditions like diabetes mellitus or Hepatitis 'B' Ag. positivity.

Though epileptics were not infrequently identified as having problematic behaviour as well, most residents showing difficult or antisocial behaviour sufficient to imperil discharge did not have epilepsy. 59 residents (45% of total) were identified (by 1 nurse or more) as having difficult behaviour and only 7 were considered to have some prospect of discharge. Thus bad behaviour, identified by nursing staff, was a strong predictor of their overall judgement that discharge was not viable.

There was a significant fall in the average length of stay in hospital in those residents most clearly identified as having particularly difficult or aggressive behaviours. The 16 residents about whom there was maximal consensus that their behaviour impeded discharge had been in hospital 18 years on average, 8 years (i.e. one third) less than the hospital average of 26 years. One can speculate that since in recent years the existence of mental handicap alone has been less likely

to lead to hospitalisation, perhaps for this group behavioural problems were a significant determinant of the original decision to admit.

Almost all the behaviour reported, perhaps not surprisingly, was of the anti-social kind likely to have an immediate adverse effect on others nearby. Other types of behaviour or personality style, e.g. solitariness or unassertiveness, were only occasionally reported as being factors affecting discharge prospects though of course we know that such traits can also make successful integration into community settings more problematic.

Speech, sight and hearing difficulties were almost always identified in the context of residents not considered dischargeable. There was no particular association found between these difficulties and bad behaviour.

23% of the hospital population were currently taking major tranquillisers (neurolepts) mostly for years past. This is fairly low compared to the figure of 40-50% found in a survey of the literature (Aman and Singh, 1983). In very few cases was there a well documented history of psychosis and it is likely that medication had almost always been aimed at behaviour; no fewer than 87% of these residents were identified in the survey as having behaviour problems. A similar association was noted in a recent paper, also using nursing perceptions: anti-social or aggressive behaviour was by far the most likely reason for initiating or continuing drug treatment (Aman, Singh and White, 1987). It is very striking that nurses' identification of residents with behaviour sufficiently difficult to impede discharge should so unerringly pick out those with a history of years on neurolept medication. One might surmise that this illuminates a traditionally close relationship: for example, the starting point of prescribing is often the point at which nursing staff call for help or extra treatment for difficult behaviour – over the years little or no treatment other than medication has been consistently available. One might also query the efficacy of long term medication aimed at behaviour when in almost all cases these behavioural problems are still judged as unmanageable outside hospital.

In the 59 residents identified as behaviourally difficult, there also appeared to be increased likelihood of the use of antidepressants and of minor tranquillisers (benzodiazepines) currently or in the past. These associations were even more striking in the sub group of 16 residents who were considered the most behaviourally difficult in the hospital. 88% were or had been on neurolepts, almost all for years, nearly 40% had had courses of benzodiazepines and 31% antidepressants.

This was also an enquiry, indirectly, into nursing attitudes and philosophies. Firstly, there was a substantial measure of agreement between nurses over nearly 90% of the residents, as already noted. That said, there was "tighter" consensus around residents who were not considered dischargeable than around those who were. In other words it was easier to agree about who needed to stay in hospital than about those who did not. Clearly this will reflect the extent and nature of the handicaps carried by residents but perhaps also says something about the way a hospital's perspectives on its residents crystallise when, after all, the average stay is a quarter of a century. There were divided opinions about the prospects for discharge of just 12% of the hospital population. Behaviour problems were identified in half of these and it is possible that varying personal attitudes and responses to difficult behaviour may well play a part in producing a mixed picture of the problems they posed. There was a broadly consistent pattern of replies between trained and untrained staff – the latter are of course rather more numerous. This may suggest that untrained staff can provide as good witness as anybody

else. We do not know for sure whether, for example, trained staff are better informed about national policies or even whether being better informed necessarily leads to greater optimism about the chances of placing long stay residents in the community, either directly or after rehabilitation. Nonetheless it is worth noting that just over 25% of all residents generated at least some support, albeit variable, about their capacity to live elsewhere. This does not suggest that staff were steeped in institutional conservatism or pessimism.

Attitudes were also shaped at times by wider issues. For example, some expressed feelings about the chance that politicians would in the end opt out of a proper funding of the proposed expansion of community places; these views could obviously colour individual responses to this survey. Indeed it became clear during the conduct of the survey that the climate created by the present handling of the N.H.S. at governmental level was exacerbating the already shaky morale amongst mental handicap nurses. In part this emerged in the shape of the resistance first encountered when the questionnaire was circulated. There was both apathy and paranoia, the latter leading to Union involvement because some nurses feared that this was a covert management exercise designed to facilitate the emptying of the hospital and thereafter jettison nursing jobs. These difficulties were eventually overcome after informal discussion on the wards in which the aims of the survey were emphasised. Issues of morale also reflect the sense of isolation many nurses feel on wards which may be thinly staffed and where doctors often seem remote and only intermittently accessible figures. The paucity of in-service training and updating is surely a factor here. And hospital nursing itself is likely to become more demanding since the gradual discharge of the more able will leave a population of the most highly dependent and difficult. (Spencer 1977).

## CONCLUSIONS

The core findings are the identification of about 1 in 7 of the hospital population who could probably manage in the community, short only of extra training in social and domestic skills; a similar number whose prospects of discharge, whilst not negligible, hinge on more substantial difficulties, including bad behaviour; three quarters of all the residents are considered to have a poor chance of managing outside the hospital; the strong inverse relationship between identification of bad behaviour and perceived prospects for discharge; the strong association between bad behaviour and long term use of neurolept (and other) medication; the relative infrequency of sensory disabilities, epilepsy or other medical conditions in residents judged dischargeable.

This and other data, distilled from nurses' observations and judgements, helps to give a useful overview of the situation within hospitals whose task is the return of as many residents as possible to the community. The perceptions of nursing staff working at the "coal face" of mental handicap care must be part of the continuing debate about the viability of alternative modes of care. These perceptions have not been sought often enough in the systematic way attempted here.

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