

FIRST 99 RESIDENTS OF A "NEW" MENTAL HANDICAP HOSPITAL: A 10 YEAR FOLLOW-UP STUDY

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Introduction

In Britain the care of mentally handicapped people has undergone a radical change since the publication of the document "Better services for the mentally handicapped" (DHSS 1971). As recommended in that white paper large institutions which previously provided the bulk of residential care for mentally handicapped people have been considerably reduced in their size and some of them have been completely run down. Most of the ex-residents of these institutions have been resettled in small residential units in the community. In recent years the pace of this change has gained momentum following the publication of the document "Care in the Community" (DOH 1989).

The studies which have looked into aspects of resettlement including the profile of residents and effects of the move into the community on their adaptive and maladaptive behaviours have drawn differing conclusions (Cohen *et al.*, 1977, Race and Race, 1979, Locker *et al.*, 1984, Flemming and Kroese, 1990). However, these studies have described people with mental handicap who were long term residents of large institutions. There are very few studies that have looked into the characteristics of residents admitted to relatively new hospitals built during the last few decades (Keene and James, 1986).

In the 1970's there was an increasing awareness of the importance of locally based services for people with mental handicap in contrast to the

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practice of sending people with mental handicap to far flung large institutions. This awareness was highlighted in the Jay report (1979), and was the driving force behind the development of Ridgehill Hospital in Dudley which is the subject of this study. The main aim of the study was to describe the group characteristics of those who were not resettled in the community and thereby make an attempt to describe the true extent of difficulties involved in the process of resettling the "difficult to resettle" residents.

Ridgehill Hospital, Stourbridge

During the decades 1960 and 70, Dudley Health Authority in the West Midlands concentrated its efforts in providing a community based local service to people with mental handicap within its catchment area. Also, steps were taken to bring back people with mental handicap who were in various hospitals in the region and other parts of the country but whose families were in Dudley. The result was the development of a "Swiss Village", which later became Ridgehill Hospital, to provide localized services which were community based and community orientated.

Ridgehill Hospital (RH) in Stourbridge, West Midlands was opened in 1977. It consisted of seven bungalows, a special school, a nurses' home and an office block - spread out on a large site of land adjacent to the local district general hospital. A number of residents admitted

to RH were eventually resettled in the community residential facilities. At present it has a population of about 80 residents for a catchment area population of 340,000. This study selected the residents who were admitted during the initial 3 years and compares the group characteristics of those who were resettled in the community (community group) with those who were still resident in the hospital (hospital group) at the time of the study.

Method

The admission register of the hospital was scrutinized during the month of January, 1990. All those admitted during the first three years (from 1977 to 1980) were selected. Individual demographic details and residential status before admission to the hospital were noted. For those who were alive at the time of follow-up, additional information (Appendix A) such as current residential status, details related to abilities, disabilities, behavioural problems, medical information and day care were collected from the local Special Needs Register (SNR). The description of this register, which is similar to that of the Birmingham Special Needs Register can be found in an article by Clarke *et al.* (1990). The uses of the SNR (Dudley) and the method of collection of information for the register are described in detail in an article by Dagnan and Kroese (1992). Disability details were re-categorized into three levels of dependence. Items in the behavioural profile were re-rated to give six degrees of severity. Collected data was compared

after dividing the surviving population into community and hospital groups.

In addition, the group of patients who were originally admitted to RH from other mental handicap hospitals of the region were further studied. This group was called "from other hospitals group" and the group was further subdivided into those who were eventually discharged into the community (community sub-group), and those who could not be resettled (hospital sub-group).

Results

The first residents were admitted to RH in 1977. During the next 3 years a total of 99 residents were admitted to the hospital. Of these 28 were from the community and 71 from other hospitals.

At follow-up 15 (15.1%) patients had died. Of the 84 alive, 43 were in RH, 2 were in other hospitals and 39 were in the community. In order to make the hospital and the community groups comparable, those who stayed for less than a year in the hospital were excluded.

These included the patients admitted either for respite care or for the management of an acute psychiatric illness. A further seven patients unknown to the S.N.R. were not included in the follow-up. The resulting 75 patients consisted of 38 (50.6%) males and 37 (49.3%) females (TABLE I). None were married and 74 (98.6%) belonged to the caucasian ethnic group.

Comparison of Hospital and Community Groups (N = 75)

There were no significant differences in sex ratio or in age ranges between the two groups. Degree of mental handicap did not differentiate between the two groups and lack of precise information about the residents' I.Q. precluded further grouping and comparison based on this item. A third (36%) of those in the hospital did not have any day care activity compared to 27% in the community group. A high proportion of those (88%) in the hospital were on medication as compared to 64% of those in the community (TABLE II).

TABLE I
Follow-up Details (N = 99)

1977-1980 Admitted from	Follow-up in 1990			
	Community	R.H.	Other Hospitals	Dead
Community Group (N = 28)	18	5	1	4
Hospitals Group (N = 71)	21	38	1	11
Not Traced/Studied	6	1	2	15
Total Studied (N = 75)	33	42	-	-

TABLE II
Demographic Details (N = 75)

	Community Group	Hospital Group	X ² -test P-values
	(N = 33) %	(N = 42) %	
SEX			NS
1. MALE	51.5	50	
2. FEMALE	48.5	50	
AGE RANGE			NS
16 TO 20 YRS.	03	04.8	
21 TO 30 YRS.	36	33	
31 TO 40 YRS.	24	17	
41 TO 50 YRS.	15	09.5	
51 TO 60 YRS.	09.1	07.1	
61 TO 70 YRS.	09.1	12	
71 TO 80 YRS.	03	14	
81 TO 90 YRS.	-	02.4	
DAY ACTIVITY			*
1. NO DAY TIME ACTIVITY	18	36	
2. TRAINING CENTRES	73	60	
3. SCHOOL/COLLEGE	-	-	
4. WORK TRAINING	9.1	0	
DEGREE OF HANDICAP			NS
0. NOT KNOWN	42	26	
1. MILD/BORDERLINE	3	2.4	
2. MODERATE	18	19	
3. SEVERE	36	52	
MEDICATION			*
1. YES	64	88	
2. NO	36	12	
EPILEPSY			(*)
1. YES	22	44	
2. NO	78	56	
Note:	NS = not significant		
	* = < 0.05		
	(*) = 0.05		

Source of admission

Those who were transferred from other hospitals constituted 72% of the total population while others were admitted from family homes (22.6%) and group homes or hostels (5.3%). Of the 33 people resettled in the community 18 (54.5%) were in private accommodation. Further breakup of figures according to source of admission and residence at follow-up are in TABLE III.

care (eating, drinking) and house work. The group in the community had better community skills with higher scores in skills such as survival cookery, road sense and time awareness (TABLE IV).

Behavioural problems

Aggressive behaviour ($p = 0.054$) was more common in the hospital group. There were no differences between the two groups in behaviours such as

TABLE III
Comparison of Community and Hospital Groups (N = 75)

CURRENT RESIDENCE	SOURCE OF ADMISSION						TOTAL	
	HOME		HOSTEL GROUP HOME		HOSPITAL		N = 75	
	N = 17	%	N = 4	%	N = 54	%	N = 75	%
1. FAMILY	2	11.7	-	-	5	09.2	7	9.3
2. HEALTH/HOME	3	17.6	-	-	-	-	3	4.0
3. SOCIAL/HOME	2	11.7	2	50	-	-	4	5.3
4. VOLUNTARY	-	-	-	-	1	01.8	1	1.3
5. PRIVATE	6	35.2	1	25	11	20.3	18	24.0
6. RIDGEHILL	4	23.5	1	25	37	68.5	42	56.0

Disabilities/Skills

Most of the people in the community group (88%) were mobile. They also had less sensory impairments and better communication skills when compared to those in the hospital group. Those in the community were better at communicating their needs to others with a statistically significant difference ($p = .004$) between the two groups. The community group was also significantly more competent in abilities such as hearing and adaptive skills (reading, writing), self

attention seeking, temper tantrums and abnormal eating pattern. (TABLE V).

Transferred from other hospitals group (N = 54)

Of the 54 people who were admitted from other hospitals 10 years ago 17 (31.5%) were in the community (community sub-group), and 37 (68.5%) remained in the hospital. The formation of these sub-groups is illustrated in Figure 1). There was no difference in the degree of

TABLE IV
Demographic Details (N = 75)

	Community Group	Hospital Group	X ² -test P-values
	(N = 33) %	(N = 42) %	
HEARING			*
1. NOT	0	04.8	
2. PARTIAL	6.1	31	
3. ABLE	94	64	
COMMUNICATION/SPEECH			*
1. NOT	0	07.1	
2. PARTIAL	36	57	
3. ABLE	64	36	
NEEDS UNDERSTOOD BY OTHERS			**
1. NOT	0	24	
2. PARTIAL	45	48	
3. ABLE	55	29	
READING			*
1. NOT	55	79	
2. PARTIAL	39	21	
3. ABLE	6.1	0	
EATING/DRINKING			(*)
1. NOT	0	14	
2. PARTIAL	15	19	
3. ABLE	85	67	
HOUSEWORK			*
1. NOT	15.2	45	
2. PARTIAL	55	29	
3. ABLE	30	26	
SURVIVAL COOKERY			**
1. NOT	45	81	
2. PARTIAL	33	19	
3. ABLE	21	0	
ROAD SENSE			*
1. NOT	30	47.4	
2. PARTIAL	45	50	
3. ABLE	24	2.4	
<p>Note: No significant difference between the two groups in the following abilities; mobility, continence, vision, writing, dressing, bathing and time awareness.</p> <p>(*) = 0.05 * = <0.05 ** = <0.005</p>			

TABLE V
Behavioural Problems (N = 75)

	Community Group (N = 33) %	Hospital Group (N = 42) %	X ² -test P-values
AGGRESSION TO OTHERS			(*)
0. NOT KNOWN/ NO PROBLEM	45	33	
1. OCCASIONALLY, MILD	12	36	
2. FREQUENTLY, MILD PROBLEM	9.1	7.1	
3. OCCASIONALLY, SEVERE PROBLEM	33	17	
4. FREQUENTLY, SEVERE PROBLEM	-	7.1	
5. SEVERE PROBLEM MOST OF THE TIME	-	-	
<p>Note: No significant difference between the two groups in the following behaviours:- verbal abuse/aggression, attention seeking, temper tantrums, destructive to property, self injurious behaviour, obsessional/stereotype behaviour, abnormal eating behaviour, excessive activity, excessive noise, restlessness, being withdrawn, unco-operative/laziness, socially unacceptable behaviour, sexually inappropriate behaviour, wandering off, relating to strangers, group activity, stealing and being untruthful.</p> <p>(*) = 0.054</p>			

mental handicap in both the sub-groups. These sub-groups were further compared for differences in respect of their characteristics. Comparison of age ranges suggested that there were more elderly people with mental handicap in the hospital group ($p = 0.005$, TABLE VI).

A significantly higher proportion (88%) of those in the community sub-group had day care ($p = 0.056$) and were significantly less likely to be on medication ($p = 0.055$). Nearly all those in the community sub-group had better self help skills such as eating food by themselves ($p = 0.05$), were able to do

house work ($p = 0.052$) and were good at survival cooking ($p = 0.004$). They also had better community living skills such as road and time sense ($p = 0.012$).

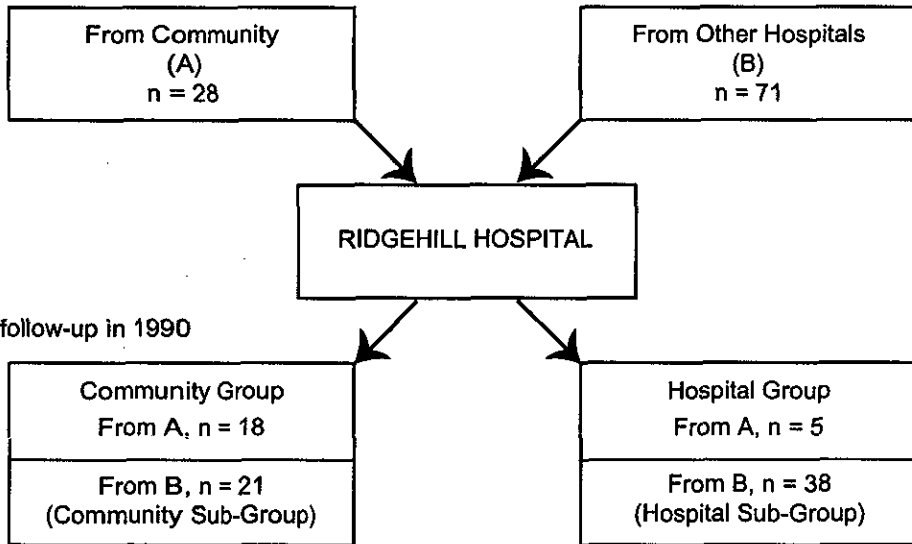
Although both the sub-groups had similar profiles of behavioural problems and had comparable levels of severity (3 to 5 as in Appendix A) in most behaviours, in only some of the behaviours statistically significant differences could be found. Being untruthful ($p = 0.044$) and stealing ($p = 0.040$) were more common in the community sub-group. Other behavioural problems such as attention seeking, aggressive, destructive and

TABLE VI
Admitted from other hospitals, demographic details

	Current Residence		X ² -test P-value
	Community Sub-group	Hospital Sub-group	
	(N = 17) %	(N = 37) %	
SEX			
MALE	47	54	NS
FEMALE	53	46	
AGE RANGE			0.005
16 TO 30 YRS.	12	35	
31 TO 60 YRS.	82	35	
61 TO 90 YRS.	5.9	30	
NS = Not significant			

FIGURE 1

Admitted during 1977-80



socially unacceptable behaviours were common in both the sub-groups.

Discussion

While this study demonstrates only a limited number of group differences between the two groups of people with mental handicap the limitations of data collected for the purpose of the SNR register should be taken into consideration in generalizing the results to other hospital and community groups. It is possible that the instrument used in the routine collection of SNR data was less sensitive to the degree of severity of behavioural problems especially in recording the quality and duration of disruption caused in relation to a sensitive community setting or a tolerant hospital setting. It was not possible to collect other details such as duration of stay in other places before admission to RH, details of medical conditions and pattern of medication on admission to RH.

A relatively small number of people under 20 years of age were in the study at follow-up which is in keeping with the current trend (Kiernan and Moss, 1990) as compared to figures given by Morris in 1969. This shows that in the late 1970's only very few children were admitted to RH. The preponderance of elderly people (over 60 years) in the hospital group suggests a selection bias towards younger residents for resettlement or that the community facilities were not adequate for resettling elderly people with mental handicap who may have special needs such as ground floor accommodation.

Medication

88% of the hospital group received medication as compared with 64% in the community group, which is similar to the overall trend found in another study conducted in the same health region (Clarke *et al.*, 1990). However, in their follow-up study (Thinn *et al.*, 1990) the same authors did not find any significant difference in the level of medication after a minimum follow-up period of 6 months. It is possible that after a period of 6 months a number of factors other than the effect of recent discharge into the community come into operation.

Disabilities/skills

The finding that those placed in the community had better communication skills and in particular were able to communicate their needs to others confirms the important role played by communicative competence in the overall management of people with developmental disabilities (Fraser and Rao, 1991). In a recent study of "new long stay" patients of a mental handicap hospital, inability to communicate with others effectively was a significant disability and this was considered to have a major role in the genesis of severe behavioural problems leading to prolonged stay in the hospital (Khan *et al.*, 1992). It has been reported by Locker *et al.* (1983) that in hostels which had proper supportive environments the residents showed improvement in areas of self help, communication, socialisation and occupational skills. Therefore it can be argued that

higher level of abilities in the community group is the result of successful resettlement. On the other hand it can also be argued that those with a higher potential self select themselves for resettlement in the community (Atkinson, 1988).

Behavioural problems

Recent research has shown that carers can identify people whose behaviours present serious management difficulties (Kiernan *et al.*, 1989). Moderate management difficulties, as assessed by carers, tend to be in the domain of social adaptation (Kiernan and Moss, 1990). The recording of behaviour problems by the S.N.R. team was in greater descriptive detail thus making it a simple instrument to record verities of behaviours. The similarity in the pattern of behavioural problems in both the groups, as observed in our study, is a significant finding. As there was no reliable recorded information available about behaviour problems *before* discharge into the community it was not possible to conclude whether those in the community had lower levels of behavioural problems at the time of their discharge from hospital. Crawford *et al.* (1981) have shown that persistence of behavioural problems can lead to readmission to the hospital. In our study, although the pattern of behavioural problems between the community and hospital groups were grossly similar, it is likely that the level of local resources (e.g. psychiatric services) or the operational policies of the day centres and residential homes in the community may have prevented the readmission.

Private Sector

The major contribution by the private sector (54.54%) in the process of resettlement is noteworthy. However, the figures given above, are limited to the first 99 admissions to the hospital and, therefore, may not reflect the pattern of resettlement during the decade. A separate analysis of individual characteristics of people in private and other residential accommodations in the community did not show any statistically significant differences in disability/skills or behaviour problem profiles. The role of the private sector in this regard can further be enhanced as suggested by Ferrity *et al.* (1986).

Admitted from Other Hospitals Groups

Adaptive behaviour rather than the presence of behavioural problems distinguished the two sub-groups (community sub-group and hospital sub-group) in that those with better self help skills were in the community sub-group. Also people in this sub-group had better skills related to domestic work, survival cookery and time awareness. Most of those in the community sub-group were in private accommodation and had better community living skills. Being untruthful and stealing was significantly more common in the community sub-group. Hemming (1982) did not find these behaviours a major management problem for the care staff in the community although it was recognised that such behaviours caused distress to the residents,

and these behaviours may have emerged as a result of recent acquisition of possessions by newly discharged residents from large institutions. However, in the extended follow-up study of the same residents (Hemming *et al.*, 1986) the findings were mixed but rebellious and untrustworthy behaviours, as defined in Adaptive Behaviour Scale (Nihira *et al.*, 1974), emerged along with whether or not the resident was on anti-psychotic medication before discharge from the hospital, as best predictors of return to the hospital.

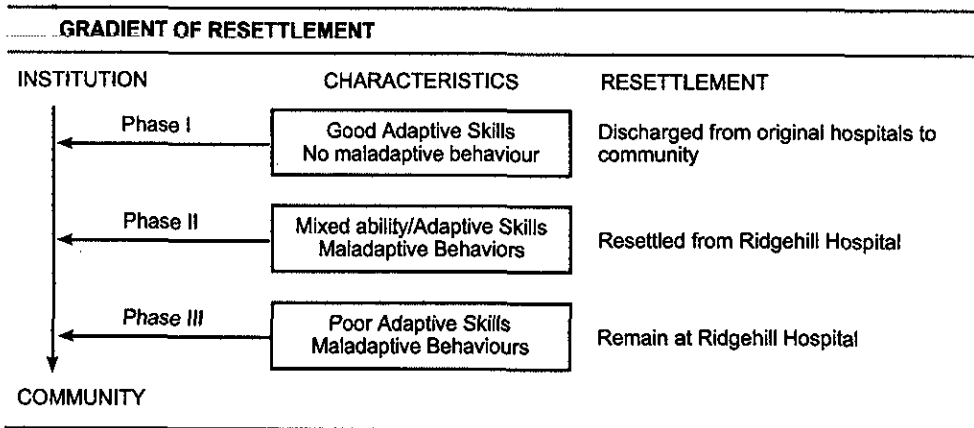
Conclusion

This study confirms the generally held view that people who are resettled first, as a group, have higher levels of skills and that without the provision of proper community resources less able and more dependent people are left behind in the hospital (Farmer *et al.*, 1990) The pattern of resettlement from Ridgehill hospital is outlined in Figure 2

and this illustrates the trend mentioned above. 1990). The major role of the private residential services indicates the share of care provided by these services and reflects the current policy in community care.

In retrospect, it is possible to conclude that the residents who remained in RH for a period of 10 years after their admission fulfilled the criteria required for hospital care during the late 1970's as set out in the DHSS (1971) document. However, with renewed emphasis on community care (DOH 1989) for this group further assessment of the needs of the "new" and "old" long stay residents may have to be undertaken, keeping in mind the realistic implications for capital and revenue costs as discussed by Felce (1981). If the long stay residents in the hospital tend to outlast the plans for their resettlement by being resident in the hospital for another decade, due consideration should be given to their special needs and quality of life in hospital.

FIGURE 2



Withdrawn, Uncooperative, Lazy/Unresponsive
Socially unacceptable,
Sexually inappropriate behaviour
Wandering off, Relating to others, Group activity
Stealing, Untruthful

Degrees of severity

0. Does not occur, never a problem
1. Occasionally, mild problem
2. Frequently, mild problem
3. Occasionally, severe problem
4. Frequently, severe problem
5. Severe problem, most of the time

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