

## **SPECIALIZED TREATMENT OF MILDLY MENTALLY RETARDED ADULTS WITH PSYCHIATRIC AND/OR BEHAVIOURAL DISORDERS: INPATIENT OR OUTREACH TREATMENT?**

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### **Introduction**

It is generally held that the same psychiatric disorders occur in mildly mentally retarded persons as in persons who are not retarded (Benson, 1985; Eaton and Menolascino, 1982; Philips and Williams, 1975; Singh *et al.*, 1991). Diagnosis, assessment and psychiatric treatment of persons diagnosed as mentally retarded, however, is associated with some specific problems. First, there are some limiting factors in the use of DSM-III-R criteria (Sovner, 1986) and general assessments methods (Sturmey *et al.*, 1991) with this population. Furthermore, interventions by direct-care staff members or by parents of patients often fail to produce lasting changes in behaviour. This failure may be attributed to lack of skill and knowledge of treatment procedures (Emerson & Emerson, 1987; Slater & Bunyard, 1983). Therefore, specialized treatment approaches are required. To

address the needs of these patients, several clinics are specialized in the treatment of mildly mentally retarded persons with psychiatric disorders or severe behavioural problems. These clinics treat patients as inpatients, which requires a temporary relocation, thereby removing the patient from familiar surroundings. Disruption in the patient's social life (O'Connor, 1983; Reiss, 1985), or in more serious cases a relocation syndrome (Cochran *et al.*, 1977; Cohen *et al.*, 1977; Heller, 1982), can result from the relocation. Furthermore, an inpatient treatment approach makes it difficult to address environmental factors that may cause or maintain problems. The result may be that behaviour changes do not generalize to other settings, such as the original living situation of the patient (Cullari and Ferguson, 1981). The disadvantages of inpatient treatment described

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here, led one of the clinics in the Netherlands to set up an outreach treatment programme for mildly mentally retarded adults with psychiatric and/or severe behavioural disorders. In the outreach treatment programme patients are treated in their own home environment with their parents, in other institutions, group homes or shelter homes. The outreach treatment programme does not only focus on the patient, but also on significant others in the patient's daily life. For a detailed description of the outreach treatment programme, we refer to a previous report (Minnen van *et al.*, 1993). Several previous articles report on community mental health - and outpatient services (e.g., Reiss, 1982). The main difference between outpatient services and the outreach treatment programme is the location of treatment. In outpatient services, patients come to the outpatient clinics; whereas with outreach services an outreach team goes to the patients in their living setting. Maguire and Piersel (1992) report on so-called mobile intensive treatment teams, a treatment programme comparable with the outreach treatment approach. The mobile intensive treatment for behaviour problems of persons with mental retardation was reported to be as effective as and even more efficient than inpatient treatment. For psychiatric patients without retardation, research demonstrates that outpatient treatment and home care is at least as effective as or even more effective than inpatient psychiatric treatment (Fenton *et al.*, 1979; Kiesler, 1982; Langsley *et al.*, 1971; Polak and Kirby, 1976; Stein *et al.*, 1975; Stein and Test, 1980).

Given the disadvantages of inpatient treatment, and the effectiveness of out-patient or outreach services, it is important to develop criteria to identify those patients for whom relocation can be prevented and treatment can be offered in their own living situation. Because the outreach treatment approach is relatively new, no explicit criteria are yet available to make that decision. Therefore, the primary research question the current paper addresses is: what factors are important in the decision to treat mentally retarded adults with psychiatric and/or behavioural disorders in an inpatient setting versus by an outreach team? In a review of the literature, no studies were found addressing this question. However, research has been done on the determinants of the decision for hospitalization of psychiatric patients without mental retardation. In the following, these determinants are summarized. Patients between 20 and 40 years of age are reported to be most likely to be admitted to a hospital (Mishler and Waxler, 1963). In one study, diagnosis was not significantly related to hospitalization (Mendel and Rapport, 1969), whereas in other studies patients with psychotic (Baxter *et al.*, 1968; Giel, 1973; Tischler, 1966) or suicidal behaviour (Baxter *et al.*, 1968; Giel, 1973; Goldstein and Horgan, 1988) were more likely to be hospitalized than patients with another diagnosis. Furthermore, longer duration of illness and poor physical appearance were related to the choice of hospitalization (Baxter *et al.*, 1968). History of previous psychiatric hospitalizations was found to be a predictor of future

hospitalization (Goldstein and Horgan, 1988; Mendel and Rapport, 1969; Mishler and Waxler, 1963).

In addition to patient characteristics, environmental factors have also been found to be associated with the decision making process. Decisions to hospitalize a patient are significantly influenced by the number of support resources available to the patient (Mendel and Rapport, 1969) and degree of pressure put on the decisionmakers by the patient's family (Tischler, 1966). Furthermore, factors other than those related to patients' needs may influence the decision to hospitalize a patient. Education of the referrer (Giel, 1973; Mishler and Waxler, 1963) and the decision-makers (Mendel and Rapport, 1969) play a role: social workers hospitalize fewer patients than psychologists and psychiatrists. Additionally, the less experienced the decision maker, the more he or she tended to hospitalize patients (Baxter *et al.*, 1968; Mendel and Rapport, 1969). Time of day or week also appear important: the percentage of hospital admissions is doubled during weekends and evenings (Mendel and Rapport, 1969).

The question addressed in this study is whether the above mentioned factors also influence hospitalization decisions of inpatient treatment of psychiatric patients with mental retardation.

## Materials and Methods

Subjects were 109 mildly mentally retarded adults, referred to the Clinic for Psychiatric and Behavioural Disorders in the Mentally Retarded between July, 1990

and September, 1991. Follow-up patients from earlier years were excluded. Characteristics of the patients are presented in the results section. All of the clients were referred to the clinic because of a serious psychiatric or behavioural problem. The referrals came from social community services (40%), institutions (29%), shelter homes (20%) and medical centres (9%). Referrals were made by means of filling in a standard form. An intake team of the clinic, consisting of two social workers, a social psychiatric nurse and a psychiatrist, decided, based upon the information in the standard forms, whether the patient concerned could best be treated in an inpatient setting or by an outreach treatment programme. To make this decision, no objective and explicit criteria were used. Of the 109 patients, 81 were referred to the outreach treatment programme and 28 to the inpatient treatment.

Data were retrospectively obtained from the standard forms and included the following demographic variables: age, sex, level of intelligence and living situation; psychiatric variables: diagnosis, number of symptoms and medication; and treatment history variables: age of first placement in institution, number of previous psychiatric hospitalizations and legal history.

### Data Analysis

The data were analyzed using the SPSS-X package (SPSS, 1990). Two-tailed t-tests for independent samples were used to test differences between groups; Chi-square was computed for categorical variables.

## Results

### *Demographic variables:*

Demographic variables of the two samples including age, sex, level of intelligence and living situation are presented in TABLE I.

There were no significant differences between the two groups on demographic variables. There was a tendency that of patients who were referred for inpatient treatment, more were living independently, but this finding did not reach statistical significance.

### *Psychiatric variables:*

The diagnosis of both groups, based on DSM-III-R categories, and number of symptoms are shown in TABLE II.

There were no significant differences between the two groups on diagnosis based on the DSM-III-R criteria. There was a significant difference, however, on the number of diverse symptoms mentioned by the referral; patients indicated for inpatient treatment had significantly more symptoms than patients indicated for outreach treatment ( $T(107) = 2.85$ ,  $p < .05$ ). The majority of referred patients were on medication (89.4%), primarily antipsychotics or sedatives. There were no significant differences between the two groups on medication.

### *Treatment history variables:*

The majority of the patients were placed in an institution or shelter home before they were 20 years old (63.3%).

**TABLE I**  
**Demographic Variables**

	Inpatients (n = 28)	Outreach Team Patients (n = 81)
Age (years)		
Mean	28.4	30.6
Sex (%)		
Males	71.4	65.4
Females	28.6	34.6
Level of Intelligence (IQ)		
Mean	70.3	68.6
Living Situation (%)		
Institution	28.6	32.1
Shelter home	28.6	30.9
Parents	21.4	25.9
Independent	21.4	8.6
Unknown	0.0	2.5

**TABLE II**  
**Psychiatric Variables**

	Inpatients (n = 28)	Outreach Team Patients (n = 81)
Diagnosis (%)		
Psychosis	25	21
Adjustment Disorders	4	0
Personality Disorders	50	53
Affective Disorders	7	12
Psychosexual Disorders	4	1
Anxiety Disorders	7	11
Other	3	2
Number of symptoms		
Mean	3.6	2.7*
* significant at p<0.05		

**TABLE III**  
**Treatment History Variables**

	Inpatients (n = 28)	Outreach Team Patients (n = 81)
Previous psychiatric hospitalizations (%)		
None	43	60*
1 or more	57	30*
Unknown	0	10
Legal History (%)	25	7*
* significant at p<0.05		

There were no significant differences between the groups. TABLE III shows the number of previous psychiatric hospitalizations and legal history for both groups.

Patients indicated for inpatient treatment had significantly more often one or more previous hospitalizations than patients indicated for the outreach treatment programme ( $\chi^2 (4, n = 109) = 10.04, p < .05$ ). Lastly, patients with a legal history, concerning robbery, firesetting,

rape, use of drugs and aggression, were significantly more likely to be admitted ( $\chi^2 (1, n = 109) = 9.23, p < .05$ ).

## Discussion

When the number of symptoms was considered as an indication of the severity of problems, it was found that patients with more severe disorders were more likely to be indicated for inpatient

treatment. This finding remains questionable, however, for several reasons. First, one specific symptom can be more severe than several superficial symptoms. Further, less information was found in the reports of patients indicated for the outreach treatment programme, than for those assigned to inpatient treatment, possibly indicative of a referral bias. It may be that when a referrer wants the patient to be treated as an inpatient, he or she gives as much information as possible, even if it's not relevant to the present disorder. More information may seem more severe to the intake team, and can indeed lead to an inpatient treatment decision. When there is little information about a patient, the intake team may consider the problems as less severe and be more willing to first try an outreach treatment approach.

Findings that psychiatric patients referred to inpatient treatment have more often a history of previous psychiatric hospitalizations than patients referred to the outreach treatment approach was confirmed in the present study. Further, patients with a legal history were more often indicated for inpatient than outreach treatment. It is not clear, however, whether patients with a psychiatric or legal history actually were in need of a repeated inpatient treatment. It may be that the intake team was influenced by the idea that previous hospitalization is an indication for more severe disorders and thus automatically recommended another admission: the so-called self-perpetuation of hospitalization of mental patients (Kiesler, 1982). Former research shows, however, that previous

hospitalization is not related to severity of symptoms and that indeed variables other than those related to the needs of the patient, like personal attitudes and professional background, influence the decision about hospitalization (Mendel and Rapport, 1969).

In the available information on patients, no information about their social situation could be found, a considerable limitation of this retrospective study. The possibility that the decision-makers made their decision independently of the social situation of the patient seems rather unlikely, given the results of previous research indicating that environmental factors are related to the decision-making process. In the study of Mendel and Rapport (1969), the decision-makers reported that 84% of the patients would not have been indicated for inpatient treatment if their social situation would have been different. Sherman (1988) states that individuals with mental retardation cannot be judged in isolation from the social context in which they live. There appears to be an interaction between the social psychological factors of the environment and patient characteristics when a decision about inpatient treatment is concerned.

Further research on identifying those variables that influence the decision for inpatient versus outreach treatment is important. Investigations should, however, be accompanied by research evaluating the effectiveness of the chosen decision, so that a distinction can be made between factors that influence the decision-making process and factors that are predictive of successful indications.

Given the disadvantages of inpatient treatment, emphasis in future research should be on identifying predictive factors on the need for inpatient treatment (Kobe, Rojahn and Schroeder, 1991) and for whom and under which treatment and environmental conditions outreach treatment is possible and effective (Goldstein and Horgan, 1988).

## Summary

Treatment of mildly mentally retarded persons with psychiatric and/or behavioural disorders often requires specialized help. Instead of transferring the person involved to a specialized treatment clinic, another treatment option has been introduced: an outreach team treating persons in their own living situation. In this article the differences between patients indicated for inpatient versus outreach treatment are examined. Number of symptoms, previous psychiatric hospitalizations and legal history were found to be related to the indications made.

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