

DISABILITY ASSESSMENT IN A POPULATION WITH LEARNING DISABILITIES IN THE COMMUNITY: A FOLLOW-UP STUDY

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Introduction

With the philosophy of community care and implementation of resettlement programmes the large mental handicap hospitals have discharged the majority of their patients into the local communities. Cell Barnes Hospital in St. Albans, Herts. is one of these hospitals where active resettlement programmes are going on at present, and some of its long stay patients have been in the community for some time now.

Methodology

This is a longitudinal follow-up study of all the patients assessed in the Cell Barnes Hospital (CBH) in 1992 and

resettled into North-West Herts region between 1992 and 1994.

The Disability Assessment Schedule (DAS) (Holmes *et al.*, 1982) has been used to compare the present community results with the previous hospital outcomes.

The DAS has been used to assess the total hospital population of CBH between 1.11.1991 - 1.5.1992 (Fernando *et al.*, 1995). This data formed part of the Cell Barnes Hospital Psychiatric Database, which has been valuable for psychiatric, medical, management and research purposes.

In the CBH patients were living in large spacious wards. Each ward on average had about twenty patients, most wards had either male or female patients and there were only very few mixed

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wards. The ward had a large sitting area, and a dining area shared by all ward patients. Most wards had a large dormitory where all the patients slept, very few wards had private bedrooms. Almost all the patients attended the occupation therapy department in the hospital for day care, while few attended activities outside the hospital.

The DAS has been designed to elicit information on patterns of abilities, disabilities and behaviour problems exhibited by adults with learning disabilities. It is a 44 item screening device with high test re-test and inter-rater reliability. Each item has a series of ratings from 3 - 8 points. The 44 items are listed under 10 headings: mobility, continence, self-help, vision hearing communication, skills, behaviour problems, quality of social interaction, stereotyped behaviour, echolalia repetitive speech and symbolic activities. For all the items, the greater the score the higher the level of development and lower the level of disability.

A group of patients (n = 22) was resettled in the North-West Herts region from CBH from 1992-1994. Four were resettled in a nursing home. Eighteen were resettled in small staffed group homes which are ordinary houses in the residential areas of North-West Herts. In each house were about four to six residents. The sitting area, dining area and kitchen were shared by all residents (about 4-6). Almost everyone had their individual bedroom.

Most of them used outside facilities for day care activities, such as adult training centres, day care centres in the community, college, various clubs, arts and craft centres and leisure activities such as swimming, horse riding, gymnasium and used other community

facilities like hairdresser and shops regularly. Those who were most able used public transport. Some of them took an active part in domestic work.

Those resettled patients (n = 22) have been reassessed in the community between 20.10.94 - 20.1.95 using DAS. The changes in their DAS score were compared with their previous results, demographical variables and diagnoses.

Results

Of the 22 resettled people 45% (n = 10) are males and 55% (n = 12) are females; 82% (n = 18) are over 50 years of age and 18% (n = 4) are under 50 years of age. The level of handicap assessed according to ICD-10 criteria: 86% (n = 19) have mild to moderate learning disability, 14% (n = 3) have severe to profound learning disability. They all had lived in the hospital for more than 10 years. 32% (n = 7) had behaviour problems, 32% (n = 7) had mental illness, 13% (n = 3) had cerebral palsy, 23% (n = 5) had physical handicap, 4% (n = 1) had autism, 13% (n = 3) had physical illness and 10% (n = 2) had epilepsy.

Four patients have been diagnosed as suffering from senile dementia since the previous study in 1992. These four are resettled in a nursing home while the others are resettled in small group homes in the community (see TABLE I).

45% (n = 10) have been in the community from 6 months - 1 year, 32% (n = 7) for more than 1 year and 23% (n = 5) for more than 2 years.

The comparison of % mean score in the DAS between 1992 in the hospital and 1995 in the community shows that in the community there is an

TABLE I
Demographic Variables of the Resettled Population (n = 22)

SEX	(n)		%	
Males	10		45	
Females	12		55	
AGE				
>50 Years	18		82	
<50 Years	4		18	
LEVEL OF HANDICAP				
Mild/Moderate	19		86	
Severe/Profound	3		14	
LENGTH OF STAY IN HOSPITAL				
>10 Years	22		100	
<10 Years	0		0	
DIAGNOSES				
Behaviour Disorder	7		32	
Mental illness	7		32	
Dementia (1995)	4		19	
Cerebral Palsy	3		13	
Physical Handicap	5		23	
Autism	1		4	
Physical Illness	3		13	
Epilepsy	2		10	
LENGTH OF STAY IN COMMUNITY				
6 months - 1 Year	10		45	
>1 Year	7		32	
>2 years	5		23	
MEDICATION	1992	1995	1992	1995
Antiepileptics	2	2	10	10
Neuroleptics	10	9	45	41
Carbamazepine as a mood stabiliser	0	2	0	0
Antidepressants	2	2	10	10
Lithium	0	0	0	0
Antiparkinsonian	2	2	10	10
Benzodiazepines	2	2	10	10

improvement in self-help, communication, skills, social interaction, stereotyped behaviour and symbolic activities. But there has been a deterioration in the items of mobility and continence. There has not been a change in the % mean score in behaviour problems (see TABLE II).

The specific changes in DAS are shown in TABLE III.

The following items show improved scores in the community: 4% (n = 1) showed an improvement in continence, 41% (n = 9) in self-help skills, 55% (n = 12) in communication, 67% (n = 15) in literacy, numeracy, occupational and domestic skills. 41% (n = 9) have improved in their behaviour, 50% (n = 11) in social interaction, 45 (n = 10) in stereotyped behaviour, 13% (n = 3) in speech

TABLE II
DAS % Mean Score of Resettled Population

DAS	1992 Hospital %	1995 Community %
Mobility	94	90
Continence	93	91
Self Help	85	88
Vision/Hearing/Communication	90	95
Skills	47	54
No Behaviour Problems	95	95
Social Interaction	75	85
No Stereotyped Behaviour	86	92
Speech/No Echolalia	89	90
Symbolic Activities	70	97

TABLE III
Changes in DAS of the Resettled Population in the Community (n = 22)

DAS	Improvement (n)	Unchanged (n)	Deterioration (n)
Mobility	0	19	3
Continence	1	17	4
Self Help	9	8	5
Vision/Hearing/Communication	12	9	1
Skills	15	2	5
No Behaviour Problems	9	5	8
Social Interaction	11	7	4
No Stereotyped Behaviour	10	10	2
Speech/No Echolalia	3	17	2
Symbolic Activities	13	9	0

and 59% (n = 13) in symbolic activities.

The following items of DAS have not changed in the community: 87% (n = 19) show no change in mobility, 77% (n = 17) in continence, 36% (n = 8) in self help skills, 41% (n = 9) in vision, hearing and communication, 10% (n = 2) in literacy, numeracy, occupational and domestic skills, 23% (n = 5) in behaviour, 32% (n = 7) in social interaction, 45% (n = 10) in stereotyped behaviour, 77% (n = 17) in speech and 41% (n = 9) in symbolic activities.

The following have deteriorated in the community: 13% (n = 3) mobility, 19% (n = 4) continence, 23% (n = 5) self-

help skills, 4% (n = 1) vision, hearing and communications, 23% (n = 5) literacy, numeracy, occupational and domestic skills, 36% (n = 8) in behaviour, 18% (n = 4) in social interaction, 10% (n = 2) in stereotyped behaviour, 10% (n = 2) in speech, but no one showed any deterioration in symbolic activities such as imaginative play, interest in TV, radio, current events and other people etc.

Even though there has not been a change in % mean score in behaviour problems, there is an improvement in behaviour in 41% (n = 9). There is a deterioration in behaviour of 7 points in one patient who has a history of mental

illness. This deterioration is probably related to the relapse of the mental illness which is also reflected by the increase in the antipsychotic medication dosage.

Discussion

This study shows that there is an overall improvement in DAS scores in most areas in this resettled group in the community. Marked improvement is detected in communication, skills, social interaction, stereotyped behaviour and symbolic activities. Where there is a deterioration in this resettled group, it is mainly related to mental disorders such as onset of dementia and exacerbation of already existing mental illness.

One of the reasons for improvement in the DAS in the community may be the higher staff/resident ratio in the community. This results in more staff/resident interaction and gives more opportunity for staff to engage in constructive activities with residents. These will directly contribute to the improvement of communication and possibly lead to the reduction of behaviour problems. In the community, there has been less boredom and wider choice in the residents' activities and they have a more 'normalised life' as compared to that in the institutions, all of which add up to increased quality of life.

The majority in this group belong to the older group who were more sociable, with few behaviour problems (Fernando *et al.*, 1995) and who have been classified mild/moderately handicapped. They are from the initial phase of hospital resettlement which included easy to resettle people with less psychiatric, behavioural, medical and physical problems,

and less disabilities than the rest of the inpatient population. It will be useful to have further follow-up studies on the rest of the hospital population with severe/profound handicap, severe behavioural and major psychiatric problems, uncontrolled epilepsy, and to assess the changes in DAS after their resettlement into the community.

Summary

The current study describes the comparison of DAS results of the resettled group in the community with their previous hospital outcomes.

There is an overall improvement in DAS scores in most areas in this group in the community. Marked improvement is detected in communication, skills, social interaction, stereotyped behaviour and symbolic activities. Where there is a deterioration it is mainly related to mental disorders.

The improvement in the DAS scores in the community may be related to higher staff/resident ratio in the community which gives more opportunity for staff to engage in constructive activities with the residents. There has been less boredom and wider choice in activities in the community than in institutions, which add up to increased quality of life.

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