believed the educational seminars to be most helpful, a previous study (Tarrier et al, 1988) found education alone had no effect on relapse rates.

In conclusion, if professionals working in everyday NHS facilities wish to embark on family intervention, they should probably offer such help to relatives living with patients who have recently been readmitted to hospital.

Acknowledgements

We thank the patients and their relatives for their co-operation, Dr J. G. Greene for statistical advice, and Mrs M. McCormick for secretarial assistance.

References


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Replacing the Mental Hospital

Community Provision for a District's Chronically Psychiatrically Disabled in Domestic Environments?

DAVID KINGDON, DOUGLAS TURKINGTON, KATY MALCOLM, KRYSTYNA SZULECKA and EMMETT LARKIN

Eighteen long-stay patients from an old county asylum moved into hospital hostels. After 12–24 months, there were significant reductions in overall symptoms, as rated by the CPRS and the Krawiecka scale, as well as in deviant but not general behaviour, rated by the REHAB scale. Six later moved to live in supported accommodation. All relatives and patients who expressed an opinion to an independent assessor were satisfied with their present accommodation or wished to move to more independent living. British Journal of Psychiatry (1991), 158, 113–117

As the run down and closure of the mental hospitals proceeds, the need to provide the chronically psychiatrically disabled in hospital and in the
community with continuing support and asylum has become increasingly apparent. The vast majority continue to require support from hospital services and only a very small proportion live in their own home or their family's. Both Italian (Jones & Poletti, 1985) and American (Brown, 1985) experiences confirm the need for those with chronic psychiatric disabilities to be provided with suitable accommodation with adequate levels of support staffing. Curson et al (1988) have shown that almost half of their long-stay schizophrenic patients have active symptoms and a “sizeable proportion exhibited behaviour which could set them apart in a community setting.” They conclude that “inpatient facilities, albeit at a local level, will be required to offer genuine asylum for those patients who are most severely ill.” The alternative of slowing down or even stopping the closure programme leaves a sizeable proportion of patients in hospital who, when they have been asked, have expressed the wish to leave hospital (Abrahamsen et al, 1989).

A range of accommodation options is described in standard handbooks of rehabilitation practice (Wing & Morris, 1981), but descriptions of such ranges of facilities in operation are relatively few, and diverse in the types of facilities they describe. This range has been supplemented recently by newer developments such as hospital hostels for new long-stay patients (e.g. Gibbons, 1986), which are increasingly seen as suitable environments for providing asylum and support for this group of patients. An extension of this concept is the ‘haven community’ for the severely disabled described by Wing & Furlong (1987) “within the context of a comprehensive psychiatric community service”. Development of such provision is likely to become more widespread in the future and would seem to be desirable in providing care within patients’ own communities. The characteristics of a service which has developed an integrated and comprehensive range of residential care for the chronically psychiatrically disabled in a district which does not contain a mental hospital is described.

Description of the service
The initial establishment of the mental health services in Bassetlaw has been described by Kingdon & Szulecka (1986). Policy decisions were made to accept all new and old long-stay patients from Saxondale Hospital (the ‘county asylum’, which closed in 1988) who originated from and wished to return to the district. Domestic as opposed to ward provision for continuing and rehabilitation care was developed.

Hospital hostels sited on the edge of the site of the district general hospital were opened in June 1988 and October 1987 with the transfer of 18 patients from Saxondale and one new long-stay patient from the acute ward of the district general hospital. These are staffed 24 hours a day by nurses. All patients are registered with general practitioners and are regularly seen as out-patients by psychiatric staff, except in emergencies or where patients are unfit to attend a clinic, when they are seen in the hostels. Regular multidisciplinary reviews of individual patients also take place. Token-economy or similar reward systems are not used. The rehabilitation system is based on social rewarding with structured objectives.

Other supported accommodation comprised the following. Local-authority residential homes for the elderly have provided accommodation for long-stay patients discharged from hospital, including those under 65 years old who are frail, as specialised social-services accommodation for this group is not provided within the district. An adult placement scheme is being developed.

Private residential accommodation includes nursing homes for the elderly, with a home specifically for those with organic brain disease, an eight-place psychiatric rest home run by nursing staff previously employed in the district service, and supported lodgings, which accept clients with long-term disabilities and whose landlords/ladies are supported by the multidisciplinary team in so doing. Supervised flatlets (10 places) were established in two houses bought by Nottingham Community Housing Association and run by the Turning Point organisation which provides staff for daily supervision and night cover. Warden-assisted accommodation is made available to patients where appropriate. Support in these and patients’ own homes is given by a general psychiatry community team who were ‘generalists’, with one community psychiatric nurse specialising in rehabilitation. An application for funding to the housing department for a scheme to provide single housing with a ‘roving’ warden specifically for those with psychiatric disabilities has been made by a local housing association.

Two group homes were in existence before the establishment of the service. Both were initially run by a voluntary organisation (MIND). One was handed over to the housing department of the local authority with the resident’s agreement, and so ceased to be a group home. Clustering together of a small number of day-centre attenders for the purpose of mutual support into one small block of flats has been arranged by the local council as flats have become vacant.

Financial costs of the development
No special funding was available for the development from the Department of Health (DoH), etc. Trent Region’s Strategic Reserve provided finance for the hospital hostels, which were established in two houses, one of which had been staff accommodation. The cost of buying the second and conversion of the two was £163 000, with £34 000 for furnishings and equipment. Running costs are less than £12 500 per patient per annum. This figure has been lower than planned because of difficulties in recruiting paramedical staff. Equivalent costs of a patient in a mental hospital are at least £13 200 per annum. The nursing and
Diagnoses of patients transferred from asylum to more domestic settings

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Transfer group (n = 18)</th>
<th>New hospital patients (n = 9)</th>
<th>Others in supported accommodation (n = 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>7</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Manic-depressive psychosis</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Depressive neurosis</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Alcohol dependence</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Organic syndromes</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Personality disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Histrionic/asthenic</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Antisocial</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Obsessional</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Conversion</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hysteria</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bulimia nervosa</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Mental sub-normality (borderline)</td>
<td></td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

1. According to ICD-9 criteria (World Health Organization, 1978). Note that some patients qualified for more than one diagnosis.

fest-home accommodation attracts the standard rates set by the Department of Social Security (DSS). The Turning Point flats were bought and converted from a grant of £175 000 from the housing corporation (of the Department of the Environment) and £5000 for furnishings. Running costs are provided by the DSS (rest-home rates) with top-up funding of £20 000 per annum from the health and local authorities. The group homes were donated out of local council housing stock and rent is paid by the DSS. Clustering of flats together required minimal administrative costs. Allocation of places in warden-controlled and Part-III local-authority accommodation was dependent on local government finance. No specialist social-work staff were employed for the project. Domiciliary services were used for four months for two residents who lived together and to support one resident who lives with his mother in warden-controlled accommodation.

Method

The study population comprised, firstly, all new and old long-stay patients who were moved from Saxondale Hospital to the hospital hostels in Bassetlaw. They were interviewed by DK, KS, KM or DT at least one year before, and between one and two years after, transfer to the district. Secondly, all those patients with chronic psychiatric disabilities aged 18–65, living in supported accommodation in the district, were interviewed by KM or DT. They were assessed using the Comprehensive Psychopathological Rating Scale (CPRS), which covers the total range of psychopathology and is sensitive to change (Asberg et al., 1978), and the Krawiecka scale (Krawiecka et al., 1979) which provides a measure of those symptoms most prominent in chronic psychiatric disorders. Evaluation of rehabilitation was undertaken using the REHAB schedules of Hall & Baker (1983) completed by trained nursing staff in the hostels and by care staff, with the assistance of KM and DT in other settings. The Patient Attitude Questionnaire, developed by the Team for the Assessment of Psychiatric Services at Friern Hospital (North East Thames Regional Health Authority, 1990) was used to assess the opinions of the patients on the changes, and modified for use with relatives who were in contact with them. It was administered independently by EL.

Results

Sixteen new and old long-stay patients resident in Saxondale Hospital were transferred into the district out of a total of 19 who had originated from it (two had not wished to return to their district of origin and one patient died of complications of diabetes before the move). Two patients transferred who were not from the district. The group was predominantly elderly (average age 66.7 years), unmarried, and with a variety of diagnoses (Table 1). They had marked disability and distress (Table 2). Use was made of acute psychiatric facilities after exacerbation of psychotic illnesses. All patients however returned there after amelioration of symptoms. At the end of the study period, nine remained in the hostel, of whom two had been accepted for local-authority (Part-III) accommodation but were awaiting places. One had died, six had moved to less intensively staffed provision. There were significant reductions in scores on the CPRS (global: t = 3.096; d.f. 16; 0.01 > P > 0.001; total: Wilcoxon’s rank sum test, P < 0.01) and the Krawiecka scale (r = 0.419; d.f. 16; P < 0.001). Overall REHAB scores showed little change but scores for deviant behaviour improved significantly (t = 3.88; d.f. 16; 0.01 > P > 0.001).

The assessor was able to obtain meaningful responses from 13 patients using the Patient Attitude Questionnaire: nine were pleased with their new accommodation, preferred...
it to hospital, and were happy to remain there; four were not particularly happy where they were and would have preferred to be in their own homes rather than live in their present accommodation indefinitely. None expressed a desire to return to hospital. Of these relatives who retained contact with patients (eight) and who had visited them and therefore felt able to comment (six), none expressed dissatisfaction with the change of accommodation.

At the end of the study period, there were significant differences in REHAB general scores \((t=3.93; \text{d.f.} \, 40; \, P<0.001)\) between those remaining in the hospital hostels and those in other accommodation (14 men, 3 women, average age 40.3 years), but no such differences were found in Krawiecka or CPRS ratings.

A study of those admitted to forensic facilities, including the local prison, regional secure unit and special hospitals, coinciding with the period October 1984 to October 1986 (Kingdon & Bakewell, 1988), detected one patient with mental illness who was resident in secure accommodation. One person from the district with no history of psychiatric contact was admitted from the courts to a special hospital in 1987. No request for transfer of Bassetlaw patients from any of these institutions has been received to date. Since the completion of that study one transfer to the regional secure unit has taken place.

Discussion

Ward accommodation has not proved necessary for the care of chronically psychiatrically disabled patients, apart from brief support from an acute psychiatric ward to treat exacerbations of underlying psychiatric illnesses. In those patients transferred from the traditional mental hospital, deviant behaviour and symptoms improved in the hospital hostels, such that six patients moved to less intensively supported ‘resting places’ specially developed for them and those community patients requiring care, in the manner described by Wing & Furlong (1987). The only comparable description in the literature is of the Massachusetts service (Zanditon & Hellman, 1981), which provides for most, but not all, its chronically disabled patients in a range of domiciliary settings. They also have followed the progress of patients returning to their district of origin from Boston State Hospital over four years (Dickey et al, 1981) and found that all but two of their 27 patients preferred their current life to that at the state hospital. Our British study supports those findings.

The health authority is one of the smallest in England and is co-terminous with local-authority boundaries; this has undoubtedly enhanced planning and liaison, although recruitment of staff has at times proved difficult and the economies of scale of larger districts are not available. The demographic details of the district suggest that the population is unexceptionable. It may be that this type of provision would not be suitable for other districts with markedly higher levels of morbidity unless supplemented by intensive-care facilities. Some of the patients described however had displayed severe behavioural disturbance, including fire-setting and violence to person and property, and one had previously been resident in a special hospital.

The major advantage of domestic care is that the rehabilitation setting approximates far better to a normal home. Parry-Jones (1988) comments that, in the 19th century, “the emulation of a domestic family model was undertaken in all types of institution”, though with few examples of success. The aim then also was to provide more comfortable and individual settings for patients who can move up and down the ‘staircase’ of care, eventually settling at a resting place which they can cope and be relatively contented (Wing & Furlong, 1987).

Care in the community should provide a wider choice of facilities and support for patients and their relatives. Although houses and nursing homes can become understaffed and neglected by senior staff, they are less likely to become so than easily identified, large and inevitably impersonal hospitals which are restricted in the range of ‘resting places’ that they can provide. The costs involved are not extortionate, but detailed planning and negotiation with the local community is essential.

Acknowledgements

The support of Trent Regional and Bassetlaw Health Authorities, and Bassetlaw District and Nottinghamshire County Councils in the development of the service, and TAPS for the use of their questionnaire, is gratefully acknowledged as is the contribution of Eddie Bakewell, Tony Edwards, and all the other members of staff and patients involved.

References


Bipolar Affective Disorder Following Head Injury

J. S. BAMRAH and J. JOHNSON

A patient developed distinct episodes of major depressive illness, schizophreniaform psychoses and mania as well as focal epilepsy following head injury. Head injury may be directly causative in the development of affective psychoses, in this case secondary bipolar (mixed) disorder.


Head injuries resulting from road traffic accidents are a major cause of cerebral damage, particularly in young adults. One estimate suggests an annual attendance rate for head injuries of about 2000 per 100,000 referrals to casualty departments, with about 250 requiring admission to general surgical wards (Jennett & MacMillan, 1981). The most common presentation is of closed head injuries; in open head injuries the intradural contents communicate with the outside through skull and scalp wounds usually as a result of a sharp and circumscribed impact. In the closed head injury, the effects of external trauma are enhanced by the undulating internal surface of the cranium, damaged protective coverings of the brain, cutting action of blood vessels, and shearing and rotation of the brain, thus producing widespread neuronal injury and multiple areas of focal damage (Crockard, 1983).

Not surprisingly perhaps, a number of psychiatric conditions have been reported following closed head injury, with or without any demonstrable neurological sequelae. The relationship is, however, not straightforward and has fuelled several debates, particularly in the development of psychosis. Some (e.g. Davison & Bagley, 1969) favour a direct aetiological role, while others prefer a constitutional predisposition as the main contributing factor (e.g. Lishman, 1973). Depressive psychoses occur most frequently, although schizophrenia, and less commonly mania, are also reported (Achte et al, 1969).

An unusual case with no psychotic vulnerability is reported here.

Case report

The patient was involved in a car accident at the age of 27 years and sustained multiple fractures, including closed head injury involving fractures of the right skull bones. He was unconscious for over 12 hours, and had retrograde and anterograde amnesias upon recovery. Before the accident, he had worked as a busy salesman and was described by his wife as being a ‘very able’ man. He had no previous history of psychiatric illness, alcoholism or any illness suggestive of cerebral disorder, and no psychiatric illness or epilepsy are reported in the family.

Following the accident, he developed an amnestic syndrome, headaches, anxiety, tearfulness, and was unable to work. In fact, he never regained employment, and although according to his wife he remained fairly well between relapses while on medication, he lived a restricted life, in the extremely caring atmosphere of his family. His symptoms gradually worsened, and two years after the head
Replacing the mental hospital. Community provision for a district's chronically psychiatrically disabled in domestic environments?

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Access the most recent version at DOI: 10.1192/bjp.158.1.113