Assessing Needs in the Community

How long is a piece of string?

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We were asked to do some research into the needs of people with long-term mental health problems who were living in the community. The main questions which sprang to mind were WHO, WHAT, and HOW to approach this.

WHO was most easily answered as it became clear that information was required about people living in boarding houses. Clacton is a typical seaside town—pier, amusement arcades, buckets and spades and a falling tourist trade. With the boarding houses no longer catering for holiday makers, the market has been for those groups of people unable to live independently—the elderly, mentally ill, or mentally handicapped.

Over the years there has been local public concern expressed about large numbers of patients being discharged from psychiatric hospitals without adequate day care facilities being provided. Add to that political concern about the conditions existing in boarding houses and sensitivities because of the implementation of the Registered Homes Act 1984 and it can be seen that the time chosen for the research was a potentially explosive one!

WHAT to assess came from our three aims:

(1) to assess the quality of life of psychiatric and ex-psychiatric patients with long standing mental health problems in boarding houses;
(2) to assess the present range of day care services;
(3) to assess the 'need' for day care facilities.

HOW to do this was the biggest question. We looked at 'quality of life' in several ways: features of the environment, e.g. facilities available in the boarding house, management practices, rules and people's likes and dislikes; the extent community facilities were used, e.g. shops, transport, clubs, pubs; how people spent their time, the range of activities, e.g. leisure and work; the extent of individual social networks and supports, e.g. family and friends.

We did this using an hour's structured interview with individual residents. Our two research assistants found people very willing to talk: out of 147 people only five did not want to take part.

Assessing the range of day services offered was relatively simple as it was so limited. We looked at individual contact with professionals, both health and social services; day hospitals or day centre.

The 'need' for day care was assessed in two separate ways:

(1) We looked at people's levels of functioning using the REHAB Scales.[1] Staff rated residents from their observations on their abilities, e.g. self-care skills, daily living, social and community skills, as well as any behavioural difficulties they had.
(2) We examined the 'expressed needs' of residents and carers in social, economic, medical, occupational, therapeutic, leisure and residential areas. Views from staff and residents about deficiencies in the current services and what they would like to see in future ones were also sought.

The structure of the survey is outlined below and shows the source of information, what information was given and how it was collected.

(1) *Boarding house proprietors* were interviewed individually to elicit their views of the current service, problems or deficiencies encountered and what they would like to see provided. They also gave information on the rules, philosophy and management of their house. In addition they made observations on the skills of their residents and any existing behavioural difficulties.
(2) *Individual residents* were interviewed on a wide range of aspects of their life, covering medical, therapeutic, economic, accommodation, occupational, leisure and social topics. Their views on their living situation, the services they received and what additional facilities they would like to use were collected.
(3) *Community support staff* were approached and these included community psychiatric nurses, general practitioners, social workers and voluntary staff. They were interviewed on their amount of contact with this client group, the services and facilities currently provided and required in the future.
(4) *Attenders at a day centre* run by a voluntary group were also interviewed individually. Who attended, their views on the activities provided and the changes they would like to see were collected.

WHEN was met with a straightforward "now and the joint finance grant is for a year"!

The result was, as can be imagined, an enormous amount of information. One lesson we learnt was that for a year's research assistant time to collect, code and input data, almost another year is needed to analyse and organise its presentation.[1]

Who were these people and what were their problems?

The residents were mainly middle-aged, predominantly single, with slightly more men than women: 50% had been to the local psychiatric hospital; the remainder had at some time moved to the area from another part of the country. This is in common with the experience of other seaside towns nationally.

Many people's daily living skills were rated as 'normal' for community living, although there were 14% who would typically require the kind of supervision available only in hospital. Even though the level of problems was generally lower than those shown by people living in hospital the pattern was strikingly similar. The top five in both hospital and boarding house were: difficulties in mixing socially, use of spare time, using community facilities, handling money and level of activity. In other words, the same problems in different places.

What was life like living in a boarding house?

Many common myths and rumours abounded for which there was no evidence. The most striking fact about the houses was their variety, making generalisations about "all boarding houses" impossible.

Fifty per cent were satisfied with where they were living and did not want to move, 33% ideally wanted to live in their own home or with their family, and only 3% preferred to be in hospital. The most commonly liked feature of the boarding houses was the food; secondly, the accommodation itself, e.g. warmth, cleanliness, privacy; thirdly, the freedom or lack of rules. Most existing rules were to do with safety, e.g. no smoking in bedrooms or the kind most families have; to be on time for meals, to let people know if they are going to be out late, and no fighting.

A small proportion of people did their own washing or room cleaning; 31% had set bath times, 50% could make a drink when they wanted but none could make snacks. Although they could come and go as they pleased, few had a front door key and a particular problem was the lack of lockable facilities for personal possessions in their own rooms.

The most widespread management practices involving staff supervision or control concerned money management and the administration of medication. This 'block treatment' is commonly found in institutions where all residents are treated in the same way regardless of individual ability. It makes administration easier and reduces risks. But it tends to reduce residents' skills, minimise personal responsibility and increase dependence on staff. With increased guidance, training and support from a clinical team this could be changed to some extent.

From these findings, boarding houses seem an appropriate setting for many people who are unable to live independently and would otherwise be living unnecessarily on a long-stay ward.

What do people do with their time after they have left hospital?

Many people said they never felt at a 'loose end'; about 37% passed the time by walking on the seafront or around the shops. We looked at which community facilities people used. The most common was shops, but after that, in order, were pubs, library, amusement arcades, betting office and the cinema. Lack of money did limit people's use of facilities. Half went to some form of club or church regularly; a few went to adult education classes.

Thirty-three per cent were actively pursuing a hobby, although many more mentioned having a specific interest or hobby. These varied greatly, e.g. crafts, photography, electronics, nature study and sports. Only 50% attended some form of day care either at the hospital or in the local voluntary day centre. This local centre was attended by 20% of the residents; they enjoyed meeting people and joining in communal activities like singing or dancing as well as following their individual hobbies or going to the education classes.

No-one was in open employment, which is unsurprising with a local unemployment rate of 20%. The main benefits of employment–financial, social contact and having something to do–were equally missed. Twenty-eight per cent were in sheltered employment for a few weekly sessions; this left a lot of time to fill and we know that a lack of activity and stimulation can lead to deterioration with this particular client group.

To overcome this problem, the development of a variety of small work schemes to re-use old skills as well as to learn new ones has been suggested. Some schemes based on manufacturing small, simple items for sale through a public outlet would provide the opportunity to use a wide range of skills. 'Community service' projects which offered assistance to others, e.g. garden maintenance, luncheon or coffee clubs, were also suggested. This would allow people to offer something *to* the community and help others for a change.

Who were these residents in touch with?

The importance of social contact in mental health has been shown in at least two ways: having people to turn to and confide in acts as a protective factor; difficulties in forming friendships can contribute significantly to incidents of mental illness.

The majority were in touch with their family—33% monthly or more—but half wanted more contact. Not surprisingly the most frequent social contact was with other boarding house residents. The proprietor was turned to most frequently when there was a problem, then family or professionals and lastly friends. Many people felt their needs for a confidant were being met, but 20% wanted someone with whom they could talk over their problems.

Fourteen per cent found it was hard to get along with others and some wanted professional help. This could be met individually or within a group. It was apparent that a place to meet people outside the boarding houses was needed and possibly also a befriending scheme for just under half who had no particular friends.

When we asked about contact with support services we found that, even though 87% were on some psychotropic medication, only 50% were seeing a psychiatrist on a fairly

regular basis, and half of these wished for more contact. Thirty-three per cent were seeing their GP monthly or more but most were less than twice a year. The need for an improved system of reviewing medication has been recommended and a local service proposed. Ways of educating more proprietors and residents on the purpose and effects of medication are being investigated. The most common request was for an increase in service from social workers; only one in five had any contact. This highlights the importance of non-medical problems in this group. Community psychiatric nurses were seen by only 14% and few wanted increased contact. Other services that were used included dentist (4%), optician (1%), chiropodist (6%). In view of the ageing nature of these people, the level of contact seems very low. Encouragement to have regular check-ups would be worthwhile to maintain a good level of health.

What are the conclusions and the results of this work?

For many people a boarding house is equivalent to a staffed hostel, and is what they need. More selective matching of people's skills to particular houses and finding ways to increase or maintain their independence were suggested. Proprietors have had to handle difficult situations, often with very little support. The need for better organised and closer support for the boarding houses is proposed. Already link social workers and a community psychiatric nurse with special responsibility for this client group have been established. The beginnings of a specialist team are being funded over the next few years. Information and training opportunities are being started for proprietors and the first course, currently running, appears to be going well.

The need for day-care facilities—occupational, leisure and social—were highlighted and two jointly financed project development posts are being advertised. They will develop, with the other agencies, the variety of work and leisure schemes required. One very real benefit from the survey has been the improved understanding and communication between statutory, voluntary and private sectors.

An unexpected aspect of the project has been the number of presentations of the results we have done for different groups, and the amount of interest shown. As one proprietor said, "We were rather sceptical about the research in the beginning, we have had promises before, but this time we're impressed." This is an exciting period for developing services in our area. We want to show that 'care in the community' means just that for people in our district.

ACKNOWLEDGEMENTS

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REFERENCE

[1]HALL, J. & BAKER, R. (1983) *Rehabilitation Evaluation*. Aberdeen: Vine.

This is the third of a series of four papers to be published in the *Bulletin* on rehabilitation developments at Severalls Hospital.

The European Association of Geriatric Psychiatry

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