Closing psychiatric hospitals. Evidence from the English experience

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INTRODUCTION

Most of the large psychiatric hospitals in England were built in the Victorian era. The number of psychiatric beds rose throughout the nineteenth century and the first half of the twentieth century, reaching a peak in 1954 of 148,000. Thereafter they fell steadily with the result that most psychiatric hospitals were reduced to one third of their peak size by the early 1980s. Since then a quarter of psychiatric hospitals have closed completely, and it is government policy to close most of the remainder by the year 2000.

While there have been a few studies of the outcome for samples of patients discharged from psychiatric hospitals (O'Driscoll, 1993) there has previously been no comprehensive study of the closure of an entire psychiatric hospital. An opportunity to initiate a study of this kind arose when one of the London Regional Health Authorities (NETRHA) announced its decision in 1983 to close two large psychiatric hospitals, Friern and Claybury, over a ten year period. In 1985 the Team for the Assessment of Psychiatric Services (TAPS) was established to conduct this research. TAPS set up a series of studies of the different patient groups whom the two hospitals served. Collaboration was established with a team of health economists from the University of Kent to compare costs of care in the community and care in the hospital for each group of patients. In 1983 there were about 850 patients in each of the two hospitals. These could be classified into long-stay non-demented patients, patients with Alzheimer's disease, and short-stay patients using the admission wards. We will consider the findings for each of these groups in turn.

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LONG-STAY NON-DEMENTED PATIENTS

Long-stay was defined as more than one year's continuous stay in the psychiatric hospital. Long-stay patients who, if aged over 65, were not demented formed the study sample. There were 770 of these in the two hospitals when TAPS began the study in 1985. However, this number increased to 1168 over the course of the study as some patients entering the admission wards remained in hospital for over a year. These patients are sometimes referred to as the 'new long-stay' (Thornicroft *et al.*, 1992a).

Each patient in this sample who was discharged was matched as closely as possible with another patient who was likely to remain in hospital for at least a year. The matching variables were age, sex, hospital, duration of stay in hospital, total score on the mental state examination, and total score on problems of social behaviour. Leavers and their matches were assessed at baseline in hospital with a batch of eight interview schedules which covered a broad range of clinical and social variables, including the patients' opinion of the care received, and their social networks (O'Driscoll & Leff, 1993). Leavers were followed up one year after their discharge into the community, while matches were reassessed in hospital at the same follow-up time.

So far follow-up data have been analysed for 494 leavers and 279 matches. There are fewer matches for two reasons; firstly it became increasingly difficult to find close matches as the pool of remaining patients got smaller; secondly some of the matches

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left hospital before the end of the follow-up period. The data were analysed to detect changes over time affecting leavers which were not shown by their matches. In the event there were relatively few of these. There were no differential changes in the patients' psychiatric state or social behaviour problems (Anderson *et al.*, 1993). The stability of these features probably reflects the long duration of the patients' illnesses, their average length of hospital stay being 15 years. There were far fewer restrictions in the community homes compared with the hospital wards, and the leavers appreciated the increased freedom of their living environment. They greatly preferred their life in the community, over 80% wishing to stay in their current homes. The social networks of the leavers did not increase in size, but were enriched by a greater number of friends. They also made social contact with ordinary people in the community, some of whom became their friends.

The death rate among leavers was no greater than among the matches, and there was one suicide in each group. The leavers committed a small number of offences, one person was sent to prison briefly before being transferred back to a psychiatric hospital, and only one individual was imprisoned for any length of time. This was a young man with a dependent personality who was convicted of attempted rape the day he was discharged from hospital and spent the whole of the follow-up year in prison. The follow-up failed to trace only six patients, who are presumed to have become homeless. Three of these were vagrants before becoming long-stay. The other three were discharged to bed and breakfast accommodation, which suggests that they needed more closely supervised aftercare.

The findings so far indicate significant improvements in the patients' quality of life as a result of their move into the community, and no serious disadvantages. The majority of leavers were placed in ordinary houses in ordinary streets. The houses were converted to provide single bedrooms for the residents, and for the most disabled people, staff were on duty 24 hours a day. This may sound an expensive option, but the economic analysis showed that it was no more costly than hospital care. The success of this programme of community placement is attributable partly to the provision of substantial capital and revenue funds by the Regional Health Authority and partly to careful planning by the local community teams. However there are two cautions that need to be mentioned. Firstly, there has been a «creaming off» process whereby the least disabled patients were selected for discharge first (Jones, 1993). TAPS has still to follow-up the most disabled patients who were discharged towards the end of the reprovision programme. Secondly, when Friern Hospital closed in March 1993, there were 72 long-stay patients who were considered to be too problematic to be placed in the community. The main problems preventing community placement were aggressive behaviour and sexually disinhibited behaviour. It is interesting that these form the public stereotype of the mentally ill person. These 'difficult to place' patients have been transferred to special wards, mostly on other hospital sites, and are the subjects of a special TAPS study. It is probable that every psychiatric hospital contains a group of such patients, for whom special facilities will need to be provided when hospitals are closed.

PSYCHOGERIATRIC PATIENTS

Most of these suffer from Alzheimer's disease, but elderly long-stay schizophrenic patients often share the same wards. As patients with dementia make poor informants, the main focus of this study was on relatives' views of the different care settings and on detailed observations of staff-patient interactions. These were carried out on a group of patients in psychogeriatric wards in the hospitals and on an overlapping, but not identical, group in community settings. These varied from converted houses to buildings which more resembled hospitals.

The observations showed that the elderly patients interacted more with staff and with relatives in the community homes than in hospital. Additionally, they spent more time drinking. This may seem trivial, but it was confirmed by relatives, who approved of the fact that it was easier to make drinks for the residents in the community homes. The relatives also preferred the community homes because of encouragement to bring in residents' furniture and personal possessions, and to take residents out for walks. These findings indicate that the community homes offered an improved quality of life for the elderly patients compared with the psychiatric hospitals, and were subject to no disadvantages.

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PATIENTS USING THE ACUTE SERVICES

The admission wards at Friern Hospital were replaced by psychiatric wards in general hospitals situated in local catchment areas from which the patients came. This process resulted in a reduction in the total number of admission beds. Since patients stay only a few weeks on average on an admission ward, it was not possible to follow a sample of patients through the changing service. Instead groups of patients and nurses in the service were asked their views at two points in time before and after the Friern admission wards were closed. Following the closure there was a considerably increased demand on the admission beds. It was not possible to ascribe this entirely to the reduced number of beds, since a similar pressure was experienced in other hospitals in London which had not altered the number of admission beds.

The service responded to the increased pressure in several ways. The length of patients' stay on the admission wards decreased, there was an increased use of beds in private hospitals and hospitals outside the catchment area, a larger number of patients who needed admission were not admitted, and there was an increased throughput in a local day hospital. In the view of the nurses, the service suffered as a result of these changes. They considered that they were providing a worse service than before, they were dissatisfied with the short stay of patients on the wards, and they reported a significant drop in their morale. The patients themselves had few complaints, but those who had experienced acute care in the psychiatric hospital missed the extensive grounds.

CONCLUSIONS

The short term outcome for long-stay patients with functional psychoses and for elderly patients with dementia appears to favour community care over hospital care. It is likely that similar results would be found with any psychiatric hospital serving an urban catchment area. It is possible that the outcome would be even better for patients resettled from rural psychiatric hospitals since there is a strong association between social deprivation in the catchment area and the size of the 'new long-stay' population (Thornicroft *et al.*, 1992a). The 'new long-stay' are significantly more often readmitted after community placement than the 'old long-stay' (Thornicroft *et al.*, 1992b). However, it is an essential component of success that reprovision programmes are well funded and carefully planned. The old psychiatric hospitals represent a large investment of capital and revenue which the Friern and Claybury programme proves can be mobilised to provide a good quality community service. However there is a major problem with the acute services, which cannot benefit from the investment in the old psychiatric hospitals, and which appear to be coming under increasing pressure in English cities. It is essential to find ways of solving this problem if we are to achieve the aim of providing a truly comprehensive psychiatric service.

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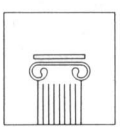

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