FEATURE

DECANTING A PSYCHIATRIC HOSPITAL: DEVELOPMENT OF A PATIENT ASSESSMENT METHODOLOGY[1]

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Introduction

In the past it was often felt that mental disorders were much less frequent in developing countries than in developed ones. Consequently, in developing countries attention was given, and resources were allocated, to those suffering from physical illness. This belief, now challenged, is gradually being discarded. WHO, which has assisted this process, states that "Epidemiologic studies in several parts of the world have shown no fundamental difference, either in the range of mental disorders that occur or in the prevalence of seriously debilitating illness. These studies indicate that such seriously debilitating mental disorders are likely to affect at least 1% of any population at any one time and at least 10% at some time in their life" *(1)*.

Two central questions then arise, these being (1) What is to be done for individuals presenting with mental disorders? and (2) What alternative forms of care should be offered to those already institutionalized, often for extended periods?

Historically, fear of mental illness led to the emergence of private madhouses and then the creation of public asylums. With the advent of mood-controlling drugs, community care, representing what some say is the first big policy change in psychiatry since the early nineteenth century, has been instituted—often with poor results due to low levels of funding and poor preparation.

[1] This piece will also be published in Spanish in the *Boletín de la Oficina Sanitaria Panamericana*. Portions of this work have previously been presented in a 1986 PAHO report entitled "Psychiatric Services in Barbados: Prefeasibility Study" that cited work funded by the Government of Barbados and the Inter-American Development Bank (Project ATC/SF—2521—BA).

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In the United Kingdom, for example, the 1959 Mental Health Act resulted in the "decanting" of thousands of mental hospital patients without providing sufficient services to care for them *(2)*; and in the United States the term "bag lady" is now common parlance, denoting an explicit social phenomenon. (The term describes transient women, many discharged from mental hospitals, who are without homes or contact with relatives and who wander aimlessly, carrying their life's possessions in a bag.)

PAHO's member states, subscribing to the concept of "Health For All By The Year 2000" in 1982, agreed that "The integration of mental health, alcohol abuse, and drug abuse activities in Primary Health Care Services is considered a key activity for the development of a Plan of Action. Primary Health Care workers can be trained in simple techniques of crisis intervention, management of emergencies, detection and follow-up of cases, and the formation of self-help groups, which will prepare them to handle a high proportion of affected persons and diminish the number of institutionalized cases" *(3)*.

It is the last part of this statement (relating to diminution of hospital cases) that is of particular concern, especially when an explicit policy of mental hospital decanting is involved. In particular, the assumption that all will be well if primary health care workers and programs are in place is clearly wrong. Among other things, many inpatients, especially in moderately developed countries, have found their hospital experience to be long and debilitating. Hence, their ability to carry out the normal activities of daily living is questionable, and their need for alternate forms of *supervised* community and residential care is critical.

Assessments Needed

When assessing psychiatric inpatients for possible discharge to alternate forms of care, it is especially important to assess the quality of their social and mental behavior—partly because their acceptance by family or friends often depends upon it. In addition, however, many inpatients have been hospital residents for some years, and so assessment of their ability to carry out activities of daily living (ADL) is essential.

Much of the literature to date has focused on the development of "disability indices" for use in research dealing with chronic diseases and rehabilitation *(4–8)*. These usually consist of inventories of the ADL. In recent years the construction of such indices has been the subject of some theoretical and methodologic debate, but this has mainly concerned the process of combining the component items *(9–11)*.

The emphasis of the work reported here is not directed at testing the validity of particular procedures but rather at constructing a tool that would help to measure the incidence of patient disability—physical, social, and mental—for planning purposes, thereby providing information on the *current* demand for different types of care.

It should be emphasized that the approach used was developed for *group* planning purposes alone, and that decisions regarding any *individual* would require a detailed clinical review.

The Patient Assessment Form

Many countries possessing substantial institutionalized psychiatric populations confront a need to make planning decisions about the future of this patient group with scant information. In this regard, as of the start of the work described here, Barbados was no exception. To deal with that situation, following extensive discussions at the hospital level, an approach was adopted based upon two assumptions. These assumptions were (1) that the eligibility criteria for admission to alternate forms of care could be stated in behavioral terms; and (2) that a patient's ability to carry out the tasks of daily living, in combination with his social behavior, could provide a useful planning indicator of requirements for particular types of alternate care (as defined in Assumption 1).

Within this context the team performing the work listed six alternate, hypothetical types of care that were felt suitable for Barbados in the future (clearly, other countries might develop a different list). The types of care were as follows:

1 Institutional care (a mix of chronic and acute care including care for the mentally retarded).
2 Halfway housing[3] (for those who have homes to go to).
3 Halfway housing (for those who have no homes to go to and who can be expected to subsequently require a workers' group home, foster care, or rooms).
4 Group home care.[4]
5 Foster care.
6 Care at home.

[3] A halfway house is defined as a care facility with no more than 10 residents that is therapeutic in character and enjoys psychiatric and social work support services. Residents needing reintegration into normal community life function with some independence.

[4] A group home is defined as a care facility with no more than 10 residents where the residents function with a high degree of independence without medical or resident nursing supervision. A resident supervisor normally administers the home.

The patient assessment form developed by the study team—a form that proved easy to administer—is shown in Annex 1. Most of the medical questions on this form were included because many of the patients were elderly, the form was also used in a parallel geriatric services study, and certain data on morbidity among the institutionalized group were needed.

Nurses from each ward in the hospital who would be conducting patient assessments were given a half-day theoretical and practical training session (in retrospect, the second part of this session could have been longer). Written instructions provided to these nurse-assessors to help them complete the patient assessment forms appear in Annex 2. Following this preparation, these nurses administered the forms to all 544 patients at a 570-bed institution over a two-week period. A further two weeks were required to complete the forms in cases where omissions had occurred.

Decision Algorithms

The study team set out combinations of behavioral criteria that patients would have to meet in order to be eligible for each of the six forms of care. This was done by indicating ratings for the individual elements of the patient assessment form in Annex 1. However, because of the complexity of these behavioral combinations and the large number of patients being assessed, an IBM PC XT microcomputer with a dBase III package[5] was employed to scan the data base using the following algorithms:

A *General instructions*
- i Ignore vision, hearing.[6]
- ii Score "most impaired" through "not impaired" 05 through 01.

B *Institutional care eligibility.* Scan total data set and include patients who score:
- i 5 on any item in Section D.
- ii 4 or 5 on Section C (iii).
- iii "Poor" on Section E (comprehension), except when patient does not score in (i) above, and scores "no problem" or "some problem" in Section F.
- iv "Poor" on Section E (memory).
- v "Poor" on Section E (reality orientation), except when patient does not score in (i) above, and scores "no problem" or "some problem" in Section F, and/or
- vi Any item "intolerable" in Section F.
- vii Cut those eligible for institutional care away from the total group.

[5] Acquired in March 1986 by the PAHO/WHO Office of Caribbean Program Coordination. A copy of the program developed is available on request but would only be of use if the same care alternatives were being considered.

[6] It was decided retrospectively that the vision and hearing items were of little importance.

C *Halfway house care eligibility.* Scan data set of remaining persons and include patients who score across all items in the following combination:

i Section C (iii) Understanding—2,1
ii Section D (i) Ambulation—4,3,2,1
" D (ii) Transfer—1
" D (iii) Bathing—1
" D (iv) Dressing—2,1
" D (v) Grooming—2,1
" D (vi) Eating—3,2,1
" D (vii) Bladder—1
" D (viii) Bowel—1
iii Section G: "Yes," works "with no supervision," works "with some supervision."
iv Section J (ii)—"Very much" or "yes."
v Section J (iv)—If "yes," then cut away from group and allocate to halfway house (with home to go to). If "no," then cut away from group and allocate to halfway house (later requiring a workers' group home, foster care, or rooms).

D *Group home eligibility.* Scan data set of remaining persons and include patients who score across all items in the following combination:

i Section D (v)—3,2,1
" D (vi)—3,2,1
" D (vii)—3,2,1
" D (viii)—3,2,1
ii Section E Comprehension—Fair/good
" E Reality orientation—Fair/good
iii Section F All items—"No problem," except "Bizarre mannerisms/speech": "Some problem" or "No problem."

E *Home care, relative care, or foster care eligibility.* Scan data set of remaining persons and interrogate as follows:

i Section J (ii)—If "No" (does not want to leave hospital), then allocate to group home care.

Scan remaining persons:

ii Section J (iii)—"Own home" or "Family home"
iii Section J (iv)—If "Yes" (there is a home), then allocate to home/relative care. If "No," then allocate to foster care.

Given the all-encompassing nature of the algorithms, no patients will be left outside the predetermined groups.

The last item on the patient assessment form (the assessor's recommendation) was included in order to test, albeit in a crude way, the congruency between the results of the algorithm allocation and individual "clinical" decision-making. Some problems were encountered in completing this item because of unclear training instructions; that is, assessors either tried to out-guess the scored items or left the item blank because they felt unable to do so. Where answers were given (for 54% of the patients) the correlation was R = 0.74.

Finally, many questions were raised as to why diagnoses were not noted. The study team had specifically precluded mentioning diagnoses for several reasons. First, it was felt that doing so would be apt to overtly influence completion of the assessment form by reinforcing stereotypes of expected behavior. Also, with patients who had been hospitalized, many for long periods, present behavior was felt more important in anticipating future care requirements. Finally, if diagnoses were not cited, the nurse-assessors would not require sophisticated degrees of training to use the form.

Results

The results obtained by processing the assessment form data in the described manner are shown in Table 1. It should be noted that the "Institutional care" category included 75 mentally retarded patients, leaving 252 patients requiring a chronic/acute setting (principally the latter). The international standard for provision of acute psychiatric beds is one bed per thousand population; the findings reported here are in accord with that figure.

Concluding Remarks

The method presented here appears satisfactory, but only up to a point. Essentially, it deals with an existing population and assumes that if no changes in the mental health delivery system are made then the proportions of patients requiring certain types of care will not vary over time. It should be regarded, therefore, as a gross planning tool that gives preliminary indications of the size of the problem confronting policymakers, resource allocators, and clinicians. It should not be viewed as providing data that will remain valid after changes have been implemented.

TABLE 1. Allocation indicated by the algorithm of the 544 patients studied to the various types of care listed.

	Patients	
Type of care	No.	(%)
Institutional care (chronic/acute mix), including mentally retarded patients	327	(60.1)
Halfway house (with home to go to)	37	(6.8)
Halfway house (with no home to go to—later requiring workers' group home, foster care, or rooms)	40	(7.4)
Group home	53	(9.7)
Home	58	(10.7)
Foster care	29	(5.3)
Total	544	(100)

However, given the method's ease and low cost of administration, as well as its beneficial side-effect of sensitizing nursing personnel to patients' capacities, it appears to provide a useful trigger for the planning process involved in preparing to decant a psychiatric hospital.

Acknowledgments

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ANNEX 1. The patient assessment form devised by the study team that was administered to the patients at a 570-bed institution in Barbados.

RECORD NO. [ ][ ][ ]

PATIENT ASSESSMENT STUDY

A. DEMOGRAPHIC

1. HOSPITAL CODE [ ][ ] 2 AGE [ ][ ][ ] 3. SEX: MALE [ ] FEMALE [ ]

ASSESSOR'S NAME: _____

WARD OF PATIENT: _____

NAME OF PATIENT:
SURNAME: _____
FIRST NAME: _____

4. MARITAL STATUS

[ ] SINGLE [ ] VISITING [ ] COMMON LAW [ ] MARRIED [ ] DIVORCED
[ ] SEPARATED [ ] WIDOWED

5 YEAR OF FIRST ADMISSION [ ][ ][ ][ ]

6. YEAR OF CURRENT ADMISSION [ ][ ][ ][ ]

7. NUMBER OF PREVIOUS ADMISSIONS [ ][ ]

B. MEDICAL

(MARK IF CONDITION IS PRESENT)

[ ] LIMB AMPUTATION
[ ] EPILEPSY: CONTROLLED
[ ] CHRONIC LEG ULCERS
[ ] HYPERTENSION: CONTROLLED
[ ] PARALYSIS: UPPER LIMB—LEFT
[ ] PARALYSIS: LOWER LIMB—LEFT
[ ] MILD DIABETES
[ ] EPILEPSY: UNCONTROLLED
[ ] CHRONIC RESPIRATORY CONDITION
[ ] HYPERTENSION: UNCONTROLLED
[ ] PARALYSIS: UPPER LIMB—RIGHT
[ ] PARALYSIS: LOWER LIMB—RIGHT
[ ] INSULIN DEPENDENT DIABETES
[ ] DISABLING ARTHRITIS
[ ] ADVANCED MALIGNANT DISEASE
[ ] SUICIDAL

C. COMMUNICATION [ ] WEARS GLASSES [ ] USES HEARING AID

(i) VISION [ ] UNIMPAIRED [ ] ADEQUATE FOR PERSONAL SAFETY [ ] DISTINGUISHES ONLY LIGHT OR DARK
[ ] BLIND—SAFE IN FAMILIAR LOCALE [ ] BLIND—REQUIRES ASSISTANCE

(ii) HEARING [ ] UNIMPAIRED [ ] MILD IMPAIRMENT [ ] MODERATE IMPAIRMENT BUT ADEQUATE FOR SAFETY [ ] IMPAIRED—INADEQUATE FOR SAFETY [ ] TOTALLY DEAF

(iii) UNDERSTANDING [ ] UNIMPAIRED [ ] UNDERSTANDS SIMPLE PHRASES ONLY [ ] UNDERSTANDS KEY WORDS ONLY [ ] UNDERSTANDING UNKNOWN
[ ] NOT RESPONSIVE

D. ACTIVITIES OF DAILY LIVING [ ] USES CANE [ ] USES WALKER [ ] USES CRUTCHES [ ] USES WHEELCHAIR
[ ] OTHER PROSTHESIS OR AID

(i) AMBULATION [ ] INDEPENDENT IN ENVIRONMENT [ ] INDEPENDENT ONLY IN EXISTING ENVIRONMENT [ ] REQUIRES SUPERVISION [ ] REQUIRES OCCASIONAL OR MINOR ASSISTANCE
[ ] REQUIRES SIGNIFICANT OR CONTINUED ASSISTANCE

(ii) TRANSFER [ ] INDEPENDENT [ ] SUPERVISION FOR: [ ] BED [ ] CHAIR [ ] TOILET [ ] INTERMITTENT ASSIST. [ ] BED [ ] CHAIR [ ] TOILET [ ] CONTINUED ASSIST. [ ] BED [ ] CHAIR [ ] TOILET [ ] COMPLETELY DEPENDENT FOR ALL MOVEMENT

ANNEX 1. (continued)

(iii) BATHING	[ ] INDEPENDENT IN BATH OR SHOWER	[ ] INDEPENDENT WITH MECHANICAL AIDS	[ ] REQUIRES MINOR ASSISTANCE OR SUPERVISION	[ ] REQUIRES CONTINUED ASSISTANCE	[ ] RESISTS
(iv) DRESSING	[ ] INDEPENDENT	[ ] SUPERVISION AND/ OR CHOOSING OF CLOTHING	[ ] PERIODIC OR DAILY PARTIAL HELP	[ ] MUST BE DRESSED	[ ] RESISTS
(v) GROOMING/HYGIENE	[ ] INDEPENDENT	[ ] REQUIRES REMINDER MOTIVATION AND/OR DIRECTION	[ ] REQUIRES ASSIST WITH SOME ITEMS	[ ] REQUIRES TOTAL ASSISTANCE	[ ] RESISTS
(vi) EATING	[ ] INDEPENDENT	[ ] INDEPENDENT WITH SPECIAL PROVISION FOR DISABILITY	[ ] REQUIRES INTERMITTENT HELP	[ ] MUST BE FED	[ ] RESISTS
(vii) BLADDER CONTROL	[ ] TOTALLY CONTINENT	[ ] ROUTINE TOILETING OR REMINDER	[ ] INCONTINENCE DUE TO IDENTIFIABLE FACTORS	[ ] INCONTINENT LESS THAN ONCE PER DAY	[ ] INCONTINENT MORE THAN ONCE PER DAY
(viii) BOWEL CONTROL	[ ] TOTALLY CONTINENT	[ ] ROUTINE TOILETING OR REMINDER	[ ] INCONTINENCE DUE TO IDENTIFIABLE FACTORS	[ ] INCONTINENT LESS THAN ONCE PER DAY	[ ] INCONTINENT MORE THAN ONCE PER DAY

E. MENTAL HEALTH

COMPREHENSION

[ ] GOOD [ ] FAIR [ ] POOR

MEMORY

[ ] GOOD [ ] FAIR [ ] POOR

REALITY ORIENTATION

[ ] GOOD [ ] FAIR [ ] POOR

F. SOCIAL BEHAVIOR

	NO PROBLEM	SOME PROBLEM	INTOLERABLE
(i) PHYSICALLY ASSAULTIVE (people and things)	[ ]	[ ]	[ ]
(ii) VERBALLY SCREAMING/THREATENING	[ ]	[ ]	[ ]
(iii) INAPPROPRIATE UNDRESSING/EXPOSURE	[ ]	[ ]	[ ]
(iv) OVERACTIVITY (manic)	[ ]	[ ]	[ ]
(v) UNDERACTIVITY/SOCIAL WITHDRAWAL	[ ]	[ ]	[ ]
(vii) BIZARRE MANNERISMS/SPEECH	[ ]	[ ]	[ ]

G. WORK PERFORMANCE

DOES THE PATIENT WORK? ANY? [ ] YES [ ] NO

[ ] WITH NO SUPERVISION
[ ] WITH SOME SUPERVISION
[ ] TOTALLY SUPERVISED

BECAUSE? [ ] THEY CANNOT
[ ] THEY WILL NOT
[ ] NO WORK AVAILABLE

H. SOCIAL ACTIVITIES

	NEVER	OCCASIONAL	REGULAR
(i) RECREATION/SPORTS	[ ]	[ ]	[ ]
(ii) CULTURAL	[ ]	[ ]	[ ]
(iii) CHURCH	[ ]	[ ]	[ ]

ANNEX 1. (continued)

J. MISCELLANEOUS

(i) DOES PATIENT HAVE REGULAR VISITORS? (at least weekly) [ ] NO [ ] RELATIVES [ ] FRIEND(S)

(ii) DOES PATIENT WANT TO LEAVE HOSPITAL? [ ] VERY MUCH [ ] YES [ ] NO (go to J(iv))

(iii) LOCATION DESIRED? [ ] OWN HOME [ ] FAMILY HOME [ ] PRIVATE NURSING HOME [ ] HOME FOR THE ELDERLY

(iv) IS THERE A DOMESTIC HOME TO WHICH THE PATIENT CAN GO? [ ] YES [ ] NO

ASSESSOR'S RECOMMENDATION (ONE CHOICE ONLY)

PATIENT IS ELIGIBLE FOR

[ ] RETURN TO OWN HOME

[ ] RETURN TO HOME OF FAMILY

[ ] NURSING HOME CARE

[ ] HALFWAY HOUSE

[ ] GROUP HOME CARE

ANNEX 2. Instructions provided to assessors for completing the form shown in Annex 1.

INSTRUCTIONS TO ASSESSORS

RECORD NO.: Each form has been precoded. Do not change code.

ASSESSOR AND PATIENT DETAILS: Fill in accurately in order that if there are queries a check can be made.

A. DEMOGRAPHIC

ITEM 1: HOSPITAL CODE

Code appropriately as follows:

01 Psychiatric Hospital
07 Evalina Smith Ward
08 St. Andrew's Hostel

ITEM 2: AGE

Right justify as follows:

e.g., for age 85 years

0	8	5

ITEM 3: MARITAL STATUS

Be as accurate as possible. Whilst the inpatient population would not have responded to the census, think of the options presented in this way.

ITEM 4: YEAR OF FIRST ADMISSION

ITEM 5: YEAR OF CURRENT ADMISSION

ITEM 6: NUMBER OF PREVIOUS ADMISSIONS

These data should be ascertained from ward records, not directly from the patient.

ANNEX 2. (continued)

B. MEDICAL

Ascertain this information from the nurse-in-charge of the ward, and check, where necessary, with the record.

C. COMMUNICATION

D. ACTIVITIES OF DAILY LIVING

E. MENTAL HEALTH

F. SOCIAL BEHAVIOR

These will form the principal subjects of the training session but:

Please beware of automatically classifying patient function at its worst just because the individual is in a hospital.

G. WORK PERFORMANCE

Note here the branch line of responses for "YES" and "NO." A subsequent question is asked in each case.

H. SOCIAL ACTIVITIES

"Cultural" can be separated from "Recreation" by defining it as involving art, reading, etc. as opposed to dancing, bingo, etc.

"Church" is a loose expression, but is meant to indicate the patient's involvement in religious practices at any place.

I. MISCELLANEOUS

(i) Note, visitors must come at least weekly and either "no," or "relatives," or "friend(s)," or "relatives" and "friends" can be answered.

Ward staff should assist with this question.

(ii) (iii) Please ensure it is the patient, *without influence*, who answers these questions.

(iv) Answer, in consultation with ward staff.

ASSESSOR'S RECOMMENDATION (ONE CHOICE ONLY)

This recommendation must *assume* the existence of a variety of options even though they do not occur in Barbados at the moment.

Consult with ward staff before making a final determination.
