

Changing the Institution—Research in Action

ANDREW QUARRY and ROSEMARY RAYNER, Principal Clinical Psychologists (Rehabilitation and Resettlement)
Severalls Hospital, Colchester

Large psychiatric hospitals are notoriously resistant to change. Their size and organisational complexity inevitably hinder their capacity to keep pace with trends. The serious consequences of a system that has ceased to adapt have been documented many times. Stereotyped routines and practices combine with rigid and bureaucratic management structures to produce the phenomenon of staff 'burn out', the "I've seen it all before and it doesn't work" syndrome.

The effects on the patients themselves can be equally damaging. The work of Wing & Brown¹ and others has convincingly demonstrated how badly long-stay patients can be affected by the understimulating social environments found in moribund institutions. It is easy and tempting to over-dramatise. Often a lot of good work is accomplished despite poor conditions and, in most cases, the worst that happens is simply a passive acceptance of the status quo. Occasionally, however, the balance shifts and real abuses occur.

The problem of how to prevent the insidious social paralysis to which institutions are prone has never been easily solved. In the past, a major role was played by certain charismatic individuals who possessed great drive and a positive vision which they were able to communicate to others. These people, generally psychiatrists, operated from a position of formal authority within the institution. The history of psychiatry provides several examples of personalities such as Maxwell Jones, Russell Barton and David Clark who pioneered new concepts and forms of treatment and who were able to effect substantial changes in the establishments within which they worked. Nowadays, it is unrealistic to rely on 'hero-innovators'² of this kind. The emphasis on multi-disciplinary teamwork and the need to view the hospital as only part of a larger community-oriented mental health service means that no one person is likely to be able to fulfil this role any longer.

What, then, are the alternatives? One popular solution is to try to abolish the problems altogether by replacing the large hospitals with smaller, less institutional kinds of accommodation and services. However, it may only be a matter of time before these problems re-emerge, albeit in a different form. For instance, there is the acknowledged risk of creating 'mini-institutions' in the community³ as well as the additional difficulty of preserving service continuity and comprehensiveness when units are physically dispersed.

A better approach may be to consider why *any* system of long-term care, whether hospital or community based, tends to lose momentum and ceases to cater for the needs of clients. There are clearly a number of important factors.

These would include the chronic nature of client disability which makes persistent and often exhausting demands on the creativity and energy of staff. There is also the presence or absence of external pressure to change in the form of service review bodies, consumer groups, media reports, etc.

At Severalls Hospital, *information* has a key role to play in establishing a system of care which can respond flexibly and appropriately to the changing needs of clients. To operate effectively, any system needs some kind of feedback mechanism which conveys information about the extent to which it is achieving its goals.

Mental health care systems do generate large amounts of information but this is often fragmentary or of dubious reliability and validity. It may be difficult to access due to the use of unstandardised recording procedures. It may be presented in a form which is largely incomprehensible to those who need to use it, e.g. in complex statistical tables. Finally, collection or processing methods may be so bureaucratic and time-consuming that it may not be readily available at the time when it is most needed.

To be really useful, the right information has to be available in the right form at the right time. In particular, it should be directly relevant to the goals of the system. In long-term care, these goals could relate either to the *structure* of the system, e.g. ward characteristics; *process*, e.g. frequency of reviews; or *outcome*, e.g. amelioration of disability. A method which has the virtue of generating information relevant to all three aspects is that of a well-designed hospital survey.

Of what does such a survey consist? In its most basic form it can be rather like a census. In other words, a simple tally of individuals on a given date with a few personal details thrown in for good measure. Such information, however, is of limited usefulness. A better survey is one which gathers a broader range of information about hospital residents and accurately reflects their pattern of ability and disability.

In July 1984, the rehabilitation psychologists and senior nurses at Severalls organised a survey of all patients who had been in hospital for six months or over. It was an ambitious undertaking involving 17 wards, 34 ward staff and 287 residents. The aim was to obtain a kind of 'snapshot' of the resident population with a view to planning rehabilitation and other services within the hospital. We needed to gather the maximum amount of information without sacrificing ease and speed of administration. For this purpose we chose a combination of a behaviour rating scale and a 14-item supplementary information questionnaire.

The choice of scale was important. A prerequisite was that it should not make too many demands on nurses' time; it had to be short, easy to understand and to complete. It also needed to be reliable (i.e. different staff rating the same person would achieve similar scores) and to measure those aspects of a patient's behaviour which are relevant to rehabilitation. In particular, it had to be able to distinguish between patients of different levels of skill and to be sensitive to changes in behaviour. The most satisfactory in these respects appeared to be the REHAB rating scale⁴. This assesses the extent to which an individual carries out a number of basic skills related to independent functioning. These include a representative range of social, self-care, communication and community skills. The scores on these factors are added together to provide a 'Total General Behaviour' score. This overall score can be used to estimate the type and degree of supervision that might be needed. The scale also measures the frequency of common types of anti-social behaviour such as violence, verbal aggression, etc.

The supplementary information scale which we devised recorded personal details and additional characteristics which were not otherwise covered. These included basic data, such as age, sex, diagnosis etc, but also important factors such as mobility, physical illness, type of daily activity, frequency of review and contact outside hospital. It concluded with an item which asked nursing staff to make a judgement about the best possible placement which each patient might be able to attain.

Having selected the measures, the next step was to inform the staff about the survey aims and methods. Training sessions which offered instruction in the use and interpretation of the rating scale were also organised. Guiding principles were to try to keep staff as well informed as possible, to encourage their involvement and to provide feedback to them about the results. The latter was particularly important. There is nothing worse than having to fill in forms for 'research purposes' only to hear little about the outcome.

On each ward, two raters were given the task of observing a selected number of patients for a period of a week and, at the end of that time, completing an independent rating of his or her behaviour. This meant that the amount of agreement between raters could be easily worked out and any undue bias identified. Since some of the wards were quite large, i.e. over 30 patients, and no more than eight patients were rated in any one week, it took approximately four weeks for all the data to be recorded and collected. An additional two months was needed for processing and analysis.

In terms of basic demographic characteristics, the surveyed population was fairly typical of a long-stay hospital. There were 128 males and 159 females (a ratio of 1:1.2). The mean age was 62.5 years and mean length of stay was 18.9 years. Schizophrenia was the predominant diagnostic group comprising 56% of the population. The next most frequent diagnoses were depression, dementia and mental handicap, each of which groups represented about 10% of the population.

What were the main conclusions? We found that 22% of patients had scores which suggested that they might have some 'resettlement potential', i.e. they were living fairly independently in hospital and, with appropriate support, might be good candidates for community-oriented rehabilitation programmes. However, these patients were found to be scattered throughout a number of wards rather than grouped together. Because they were on 'mixed dependency' wards, they often did not receive the kind of attention they needed to prepare them for resettlement. Inevitably the staff on these wards had to spend more time with the less independent patients who required a greater degree of supervision.

Another important result was that nearly half the total population fell within the 'high skills deficit' category. In other words, they lacked a wide range of social and self-care skills and, in consequence, needed a level of staff support which is usually only found in hospital. Similar proportions of patients were over 65 years old or had no structured activity during the day. Any proposed resettlement programme would therefore have to take account of the fact that a large proportion might never be expected to be able to live independently and would continue to require intensive support, whether in a hospital or community setting.

A factor which was of some cause for concern was that a sizeable minority of patients (33%) was seen for consultant review less than every six months. The fact that each consultant had beds dispersed over a number of long-stay wards appeared to make a system of regular review difficult to organise. When as many as three consultants had patients on one ward, the difficulties a charge nurse had in co-ordinating communications and treatment can be imagined.

With the support of the Unit Management Team, plans were made to create a system of 'functional wards', linked with only one consultant each. The survey results were used to make a provisional estimate as to the kind of ward to which each patient might be best suited. In addition, those who had scores indicating 'resettlement potential' were given a structured interview designed to elicit their own views about their future and other relevant information, e.g. degree of involvement of relatives, friendship networks.

On the basis of this data, each ward was given a specific function, i.e. 'resettlement', 'continuing care', 'behaviour disturbance', 'physical dependency'. Patients were then assigned to the ward that was judged to be the most appropriate for their needs.

Specialised teams were created on the resettlement wards with the intention of extending the idea to others, particularly the 'disturbed behaviour' wards, as resources permitted. An independent multi-disciplinary assessment procedure was also set up to advise on the placement of all new patients thought to require long-term care and to monitor movement between wards.

The re-organisation of the long-stay area was only one of the uses of the survey data. Individual ward teams have used the information to plan and evaluate treatment programmes. Others have used it to make a case successfully for

more or better resources. Planning groups have used the data to estimate the type and size of a disturbed behaviour unit and to outline future community housing needs.

Finally, it is worth noting that, although prior to the survey many people throughout the hospital had been informally aware of many of the facts which were demonstrated, no significant change in practices or organisation of the wards had occurred. The presentation of relatively objective information in the form of simple graphs allowed these points to be grasped and accepted in a way which may have been impossible on the basis of personal opinion alone. The survey had, in a sense, held up a mirror to the institution and, in doing so, had helped to begin a process of change which is still continuing.

Since 1984, the survey has been repeated annually on a specific date, allowing the additional advantages of the identification of longitudinal trends and the comparison of individuals or groups over time. As well as initiating change, it is evident that survey information still has a significant role to play in providing feedback on the results of

planning decisions and in ensuring that the system continues, as far as possible, to meet the needs of those whom it is designed to serve.

REFERENCES

- ¹WING, J. J. & BROWN, G. W. (1970) *Institutionalism and Schizophrenia*. Cambridge: Cambridge University Press.
- ²GEORGIADES, N. J. & PHILLIMORE, L. (1975) The myth of the hero-innovator and alternative strategies for organisational change. In *Behaviour Modification with the Severely Retarded* (eds. C. C. Kiernan and F. D. Woodford). Amsterdam: Associated Scientific.
- ³RYAN, P. (1979) Residential care for the mentally disabled. In *Community Care for the Mentally Disabled* (eds. J. K. Wing and R. Olsen). Oxford: Oxford University Press.
- ⁴BAKER, R. & HALL, J. N. (1983) *Users Manual for REHAB*. Aberdeen: Vine.

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

Fund for Memorial to Dr Michael York-Moore

In tribute to Michael York-Moore's commitment to the welfare of people with mental handicap and their families and of his association with and contribution to the British Institute of Mental Handicap, the Institute wishes to establish a memorial fund in his name. Michael York-Moore had wide interests in the field of mental handicap which extended beyond his own particular specialism in medicine. He was aware of the diverse, important contributions which different service disciplines, families, the public and people with mental handicap themselves could make to changing the position of people with mental handicap in our society. He had a particular empathy for the needs of families and children with mental handicap living at home.

The proceeds of this appeal will be held in trust by BIMH and the interest used to fund an initiative which would benefit Families and Children with Mental Handicap. This initiative, to be determined by appointed Trustees, would take any of the following forms. It could:

- (1) fund travel by a parent or professional to learn about effective ways for working with families;
- (2) fund an invited presentation by a person with international repute for his or her work with families;
- (3) fund acquisition to the BIMH Information and Resource Service of resource materials designed for families or professionals working with families;
- (4) support the organisation of a conference or other forms of information exchange designed for parents.

BIMH will establish the Trust and the Trustees following legal advice to implement the remit set out above. The purpose of the Trust has the full support of Rosemary York-Moore.

Please send donations to establish this fund in memory of Michael York-Moore to: Administrator, British Institute of Mental Handicap, Wolverhampton Road, Kidderminster, Worcs. DY10 3PP.

Cheques should be made payable to BIMH.