

Locked ward patients 25 years on

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Aims and method A retrospective case note study of 43 patients who were residents of a locked ward in 1970, augmented by a cross-section of the ward's current residents was undertaken.

Results The study established a profile of the 43 patients in 1970 and determined their outcomes. A brief comparison of the use of medication then and now was also undertaken.

Clinical implications This view of the past aimed to provide a perspective on why and how the field has changed, and to facilitate planning for the future.

Goodmayes Hospital was opened almost 100 years ago, and in its heyday accommodated more than 500 long-stay patients. Many of these have been resettled in the past 25 years and only 66 now remain. I was surprised to find that the 25-bed admission ward on which I was working had in 1970 accommodated 43 patients, as the hospital's male locked ward, despite being only two-thirds of its current size. The increase in size since then was achieved by the addition of a verandah. The ward was 'unlocked' in the late 1970s.

The aim of this study was to establish a profile of the 43 patients and determine their outcomes. A brief comparison of the use of medication then and now was also undertaken.

The study

All 43 in-patients were identified from a report by the ward consultant dated 6 October 1970. Some details were contained in the report, the remainder were drawn from the patients' case notes. Complete case notes were recovered for 30 patients, partial notes were available for the remaining 13.

Findings

Age

Patients ranged in age from 17–61: the average was 35, and 74% were under 45 years.

Legal status

Ten patients were detained under the 1959 Mental Health Act. The reasons given for detention were risk to others (5), 'irresponsibility' (2)

and one each wandering and self-neglect. In the remaining patient no reason was given.

That the remaining 33 patients were 'informal' although on a locked ward illustrates the different legal climate at the time. The view was that they voluntarily accepted this arrangement, as indicated by not attempting to discharge themselves from hospital and returning when allowed to leave the ward.

Diagnosis and length of stay

Thirty-two patients were classified as having schizophrenia, either alone or in combination with another diagnosis. Three had manic-depressive psychosis, and three were drug/alcohol dependants with depression. Other diagnoses were one each of pre-senile dementia, 'inadequate psychopathic personality', temporal lobe epilepsy, taboparesis and 'mental subnormality'.

The average duration of admission was 15 years with a range of three months to 49 years. Unsurprisingly, separating the patients into diagnostic categories revealed that patients with schizophrenia stayed the longest. The average stay for schizophrenia was 18 years (range 3 months to 49 years), while that for all other diagnoses was 5 years (range 5 months to 19 years).

Medication

Adequate records for medication used were traced for only 34 of the 43 patients. Chlorpromazine was the most widely prescribed (18 patients, 53%); also commonly used were haloperidol (6, 18%), trifluoperazine (6, 18%) and thioridazine (3, 9%). Modecate was the only depot used (5, 15%). The average daily dose was 378 chlorpromazine equivalents (range 50–750). Of non-neuroleptic medication, sodium amyltal was used quite widely (13, 38%), as were benzodiazepines (6, 18%).

In the 17 who remained from the same cohort, 25 years later, a move away from chlorpromazine (7, 21%) towards zuclopenthixol (10, 29%) was seen. Haloperidol (2, 6%), trifluoperazine (2, 6%) and thioridazine (1, 3%) were still used. The number of modecate prescriptions was the same (5, 15%). A striking rise in the dosage to 607 chlorpromazine equivalents was seen (range 33–2700). Sodium amyltal was prescribed to only one patient who had become dependent on it to the extent of severe disturbance whenever

it was reduced. Three (9%) were prescribed benzodiazepines.

The current population of the ward was also surveyed for medication used. For the 22 patients prescribed neuroleptics, the average daily dose was 426 chlorpromazine equivalents (range 10–1300). A wider range of neuroleptics was used: risperidone (4, 18%), trifluoperazine (4, 18%), chlorpromazine (3, 14%), thioridazine (3, 14%), droperidol (3, 14%). Other neuroleptics were less popular. Three patients (14%) were prescribed diazepam; no other benzodiazepines were used.

Outcome

Of the original 43 patients, 19 (44%) had died by 1996, 7 (16%) were living in community placements under the hospital's supervision, 3 (7%) were in independent accommodation and 4 (9%) were still in-patients. Two (5%) were discharged with no follow-up, 2 (5%) were repatriated outside the UK and 3 (7%) did not comply with follow-up. The outcome for the remaining 3 (7%) could not be traced.

Of the 19 who are known to have died, 17 were in-patients at the time of death and the other two still being registered as out-patients. Causes of death were ischaemic heart disease (5), obstructive airways disease (3), lung cancer (2) and oesophageal cancer (1). Two died by suicide (both in-patients on leave). One died of idiopathic vomiting and one of food aspiration. The causes of the remaining three deaths were not recorded in the case notes.

Comment

This study offers a brief historical perspective of 43 patients treated under locked conditions. Three points are discussed here: medication, deaths and quality of life.

The diminishing use of sodium amytal and benzodiazepines followed greater awareness of their dangers. A decline in the use of chlorpromazine is also seen, in favour of a wider range of neuroleptics. An increase in chlorpromazine equivalents is seen both in the study group and in the present population of the ward. That the latter increase is relatively small (from 378 to 426 chlorpromazine equivalents) is perhaps surprising in the light of recent concern about the perceived use of high-dose antipsychotic medication (Thompson, 1994). There are two confounding factors. The ward is no longer locked and might therefore be expected to cater for a less disturbed patient group who should need less sedation. However, many of the patients on the locked ward were in effect long-stay patients and no longer receiving acute treatment.

Nineteen deaths (44% of the cohort) over 25 years is a high figure. Previous studies (Casade-

baig & Quemada, 1989; Zilber *et al.*, 1989) have found mortality ratios two to three times higher than the general population in psychiatric in-patients and out-patients.

Most of the deaths (11 out of 19) can be linked with smoking. Two known suicides in this group (5%) is roughly to be expected (Barracough *et al.*, 1974), but three deaths were of an unknown cause. Further, a proportion of the surviving population may yet choose to take their lives.

The average duration of admission (15 years) is the most striking finding. The growth of community placements with graded amounts of supervision has largely put an end to such long admissions. Only three of the 43 are known to be living independently currently.

Reviewing case notes of medium- and long-stay patients from the 1970s makes grim reading, with records of violent outbursts, restraint, little independence and symptoms of institutionalisation.

Nevertheless, almost all the patients either maintained a broadly similar level or improved as time went on, and managed also to maintain individual personalities.

My impression of housing projects in the Goodmayes' catchment area, which accommodate mainly former long-stay patients including a number who had been in the locked ward described, is of much improved qualities of life despite continuing impairment. The recent official proposal to develop community placements with 24-hour nursed care (NHS Executive, 1996) offers the prospect of extending such benefits widely. It may be useful for planning to be reminded of lessons from the past.

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