

Characteristics of State Hospital Patients Who Are Hard to Place

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As a result of deinstitutionalization, acute care beds in state hospitals have become blocked by patients who lack access to appropriate community placements but who have derived maximum benefit from hospital care. To help plan community services for these patients, this study identified and described patients at an Oregon state hospital who were hospitalized longer than therapeutically necessary because no community facility could treat them. A total of 146 patients were identified during a three-month period, and 81 were described; 65 percent were men, 70 percent were schizophrenic, and 90 percent presented a risk to themselves or others. The patients exhibited few strengths, and one-third had a substance abuse problem, at least one counter-

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therapeutic attitude, or a need for medical monitoring. The authors describe how new community residential facilities can meet the needs of these difficult patients.

Over 30 years have passed since more than a half million Americans resided in state mental hospitals. Many hospitals of that era were oversized and overcrowded and provided seriously inadequate treatment. In *Death of the Asylum*, Talbott (1) reported that state hospitals suffered from neglect, mismanagement, and much higher expectations of success than could ever have been realized. During the 1950s and 1960s, awareness of these conditions combined with an awakening interest in civil liberties to provide much of the impetus for deinstitutionalization.

Between 1955 and 1982, state hospital populations dropped from more than 500,000 to about 120,000 (2). Expectations were high that with proper treatment and support, many previously institutionalized patients—and subsequent generations of people with similar illnesses—would live in the community. Indeed, many model programs successfully placed disabled chronic mentally ill patients into structured support networks in the community (3,4). Unfortunately these model programs have not been widely implemented (5).

While community programs were failing to adequately house some chronic mentally ill patients, the old state hospitals, which had provided long-term care, were being converted into acute care facilities (6) that met new mandates for

higher staff-to-patient ratios. Yet despite the increased intensity of care, some state hospital patients stayed in the hospital much longer than is necessary for acute care per se. The acute care state hospital is increasingly under pressure to be the residence of last resort because it is the only facility with the capacity to maintain and tolerate these patients.

Consequently acute care beds are blocked, acute care resources are used inefficiently, and community service enhancements are preempted. This situation has become a major crisis in the administration of mental health services and a source of severe frustration for both hospital- and community-based clinicians.

Of course it is the mentally ill themselves who absorb the losses when hospital and community services fall short (7). Because neither the hospital nor community services have succeeded in providing them a home, chronic mentally ill young adults with nowhere to go are now overrepresented among the homeless (8,9). Appleby and Desai (10) reported a rise of from 1 to 5 percent from 1971 through 1980 in the percentage of patients admitted to Illinois state hospitals who reported being homeless.

Kroll and associates (11) found that 41 percent of residents in eight Minnesota shelters reported having had contact with the mental health system. Mentally ill homeless people are frequently exploited, physically abused, and exposed to drug abuse and criminal influences.

In short, the quality of life of

many mentally ill patients living in proprietary nursing homes (12) or on the streets (13) continues to be as bad as or worse than that of patients institutionalized during the 1950s. Some people have suggested that deinstitutionalization has failed and that the state hospital should return to its emphasis on long-term care (14).

Regardless of the method chosen to house our most difficult patients, the first step in planning appropriate services for them is to better understand their needs and characteristics. This study collected information about patients at an Oregon state hospital for whom community placements could not be found. It was hoped that this information would help in the planning of residential services that could retain these patients in community residences.

Matching patients and places: the literature

What are adequate residential services? Lamb (15) demonstrated the value of a personalized treatment milieu, of structure, and of organized treatment goals in his study of a locked 95-bed skilled nursing facility for chronic mentally ill patients. The patients had histories of violence, major psychopathology, frequent state hospitalizations, and unmanageability in prior community placements. Lamb found the facility to be an effective alternative to state hospitals and institutions for the criminally insane.

A number of attempts have been made to match profiles of patient characteristics with residential services. Gudeman and Shore (16) described criteria for planning community services for five classes of patients who are still likely to be receiving long-term care in a hospital. They recommended reserving three beds per 100,000 population for elderly patients and demented persons who require containment and support, three beds for mentally retarded and psychotic patients, one and a half beds for brain-damaged and assaul-

tive patients, and two and a half beds for flagrantly psychotic patients needing physical security, maintenance, and long-term care. They suggested allocating five beds for providing a structured milieu and long-term care for chronic schizophrenic patients who are disruptive and dangerous.

Studies conducted in Oregon and elsewhere have demonstrated the effectiveness of intensive community services in reducing the use of institutions.

Randolph and others (17) compiled data on the residential needs of 1,714 patients in Hawaii based on a survey of practitioners and programs. They found that 23 percent of the population studied needed residential services as an alternative to state hospitalization. A full 43 percent of the sample, most of them young adult males, had a history of acting out with which existing programs were not prepared to deal.

The state of New York developed a level-of-care inventory that it uses to predict the degree of care that state hospital patients require to live in the community (18). The inventory assesses physical illnesses; activities of daily living; presence of confusion, disruptiveness, psychotic symptoms, and activity appearing dangerous to self or others; and use of alcohol or drugs. Johnson (19), in Washington State, and Shern and associates (20), in Colorado, have used similar methods to match patients with services, in Washington through face-to-face interviews and in Colorado through a clinician survey.

Based on survey data, the Coulton group (21) in Ohio identified clusters of characteristics found in community residences and patients and studied the relationship be-

tween types of homes and types of patients. They found that a placement was more likely to be successful when a good match occurred between the patient's need for and the residence's provision of supportiveness, structure, and privacy.

In summary, the literature suggests that detailed measures of patient characteristics may help planners to develop the sophisticated, intensive, and relatively expensive residential care that some of today's candidates for community placement appear to need if hospital overcrowding is to be controlled.

Background for the study

The number of occupied beds in Oregon's three state mental hospitals dropped from a peak of 294 per 100,000 of general population in 1958 to 39 per 100,000 between 1983 and 1985. Studies conducted in Oregon and elsewhere have demonstrated the effectiveness of intensive community services in reducing the use of institutions (22-26).

Nonetheless, utilization of state hospitals has been 10 percent greater than was anticipated. A sizable proportion of acute state hospital beds have appeared to be occupied by patients who have reached maximum benefit from hospitalization but who have been very difficult to place in community services. Many of these patients are assaultive and difficult to control.

A brief review of these cases and a survey of community providers indicated that existing residential facilities have not been sufficiently staffed to manage the assaultive, problematic patients increasingly referred for placement (27). The analysis also revealed that residential staff have lacked knowledge, skill, and experience and that community-based case management and related support services have not been available to back up residential services.

We attempted to determine the

characteristics, severity, and frequency of specific problems experienced by hard-to-place patients at Dammasch State Hospital in Oregon, a 330-bed facility serving Portland and most of the state's rural western counties. We were concerned specifically about identifying problems that the community residential services should plan to address. We also sought to note patients' strengths on which the residential services should plan to build in order to retain patients in the community. After collecting this information, we compared the patients' needs with the capabilities of existing residential resources to fill them.

Methodology

Social workers and nurses at the hospital were asked to identify hard-to-place patients on two occasions between April and June 1985. Criteria for selection were being hospitalized at the time of selection; having no need for or receiving no benefit from continued acute inpatient care; and lacking access to appropriate or acceptable community placements.

Patients identified in this manner were assessed using a predischarge nursing summary (PNS), developed at the hospital by one of the authors (PM). The PNS was used to compile and integrate information about the patients from a self-care assessment completed by nursing staff, from clinical records, and from staff interviews.

The PNS provided complete and organized documentation of the patient's characteristics that had proven to have implications for his care and treatment, including history of compliance with treatment and social and daily living skills. The PNS also featured a risk profile, which assessed the degree to which the patient presented nine major risks, such as risk of committing assault. A high degree of congruity was found in the predischarge nursing summaries for two patients completed by the developer of the summary

and a nursing colleague trained in its use.

The information in the PNS was summarized in a PNS profile through a protocol developed by another author (LJM). Two authors (PM and LJM) reviewed each case to identify and reconcile differences between the PNS and the PNS profile, which resulted in more dependable ratings.

Results

A total of 146 hard-to-place patients were identified in the three-month period. During the next six months 81 patients were assessed using the PNS and the PNS profile. The other 65 patients left the hospital before they could be evaluated. One year later, 70 percent of the evaluated patients remained in the hospital.

Of the patients who were assessed, 53, or 65 percent, were men. Nearly all of the men ranged in age from their 20s to their 50s, and they were distributed fairly evenly across the decades. Almost half of the women were in their 30s. The mean age for men was 33.98 years and for women was 37.93 years.

Half of the patients had some form of cognitive deficit. A total of 56, or 70 percent, had a primary diagnosis of schizophrenia. Only three had a bipolar disorder, and the rest had a variety of dementias or organic personality syndromes.

The risks the patients' behavior

presented to their own and others' welfare seemed to constitute a major barrier to their placement in community residential settings and posed a significant problem in planning services for them (Table 1). Assaultiveness was the most common risk presented by the patients, but all of the risks assessed by the PNS were present to some degree. Only 10 percent of the patients presented no major risks, while 60 percent evidenced a combination of two or more risks.

Problem behaviors, such as loud outbursts that would be likely to frighten and alienate nearby residents and passersby, occurred frequently (Table 2). These behaviors are more troublesome in community care facilities than they are in state hospitals, which are more isolated from the public and less vulnerable to rejection by the surrounding community.

About a third of the mostly schizophrenic sample presented a risk of substance abuse or had some attitude problem that impeded treatment. Of the problem attitudes, denial of illness was demonstrated by 38 percent, non-compliance in the community by 33 percent, poor response to medication by 20 percent, refusal of placement by 16 percent, non-compliance in the hospital by 14 percent, inappropriate response to structure by 12 percent, and negative response to structure by 3

Table 1
Behaviors presenting major risks to the patient or others observed among 81 state hospital patients

Behavior	Type of risk, by N of patients			Total patients	
	Low	Medium	High	N	%
Assault	28	21	1	50	62
Injury				14	17
Self-harm	11	6	1	18	22
Suicide	9	4	0	13	16
Fire starting	19	3	4	26	32
Substance abuse in hospital	8	0	3	11	14
Substance abuse in community	7	11	12	30	37
Escape	14	5	3	22	27
Wandering	12	5	4	21	26

Table 2
Problem behaviors of 81 state hospital patients

Behavior	Patients	
	N	%
Up at night and disturbing	12	15
Up at night but not disturbing	5	6
Loud outbursts	50	62
Isolated	43	53
Ritualistic behavior	27	33
Disrobing	3	4
Threatening	13	16
Inappropriate sexual behavior	17	21
Stealing	4	5
Racial delusions	4	5
Excessive fluid intake	13	16
Impaired mobility	8	10
Impaired communication	21	26
Incontinent at night	18	22

percent. Both drug abuse and attitudinal problems severely exacerbate the care and management of residents of community facilities.

The patients' medical needs would further increase the burden of caring for them in the community—33 percent required medical monitoring, 10 percent required basic medical care, and 6 percent required skilled medical care.

Unfortunately we were not able to identify personal strengths of a

Table 3
Personal strengths of 81 state hospital patients

Strength	Patients	
	N	%
Leisure-related skills		
None	34	42
Few	36	44
Some	11	14
Social-interpersonal skills		
None	38	47
Few	35	43
Some	8	10
Daily living skills		
None	52	64
Few	18	22
Some	11	14

significant degree in two-thirds of the patients (Table 3). Strengths were present only very minimally in the remaining third. On the contrary, most patients were markedly dependent. Self-care deficits were found in 65 patients, or 80 percent, poor social skills in 79 patients, or 98 percent, and vulnerability in 40 patients, or 49 percent. A mental health service must keep patients busy and interested, but it would have difficulty doing so if the patients had no strengths and interests on which it could build.

Discussion

We have provided a profile of hard-to-place patients at a state hospital. The typical hard-to-place patient identified in this study is a schizophrenic male in his 30s with either a medical or a drug abuse problem. He has lost most social and self-care skills, is assaultive, behaves unacceptably, and is not cooperative with treatment. Indeed, he represents what appears to be a growing pool of patients for whom advanced community support treatment, especially that provided in existing residential services, has not been adequate.

The characteristics of many of these patients, such as showing poor compliance with structure (shared by 12 percent), being assaultive (62 percent), starting fires (32 percent), and having little or no self-care skills (80 percent) make them highly undesirable for placement in existing community facilities, which are poorly funded.

Many residential facilities have closed (28), and those that remain often develop screening criteria that rule out many patients referred for discharge from the state hospital. These hard-to-place patients present a serious problem to already inadequate and understaffed facilities, which have no shortage of referrals of patients who are easier to manage.

It is clear that we need to develop some form of structured facility that will protect patients

from themselves and from each other and that will provide support to all of its residents and training to those who can learn. Such a facility will need to have the capacity to hold people who are belligerent or who are confused and prone to wander. The activities and training provided at the facilities will have to be geared to the young male and emphasize developing social, leisure, and daily living skills.

New community residential facilities should also provide the following services:

- More intensive supervision and control to meet the needs of difficult patients.

- Ability to compensate for patients' limited strengths by stimulating the patients to become motivated and providing considerable training in activities of daily living and recreation.

- Close monitoring and capacity to intervene frequently and effectively to address the high level of alienating and dangerous behaviors among this population, which are compounded by the lack of good response to treatment.

- Intensive staffing and significant psychiatric input several times a week to address patients' high risk of assaultiveness and medical, cognitive, and compliance problems.

We feel that stays at these facilities should be lengthy, measured in years, to give patients ample time to grow in a protected environment. A facility that meets all these criteria may be more expensive to operate than is the current state hospital. In fact, planners considering establishing this type of facility should not view it as a means of avoiding expensive hospitalization but as a way to provide an equally good or superior alternative to existing hospitals.

Conclusions

A new generation of chronic patients seems to be emerging despite good community care. These patients appear much worse than

difficult patients described in another study (3), who appeared to go through various developmental and adaptational stages but who eventually adjusted to the community.

As Talbott and Glick (6) pointed out, "When the patient's behavior cannot be controlled, or antisocial and incompetent behavior endangers the patient or others, long term inpatient care may be warranted." Clearly such treatment is necessary for some of the patients described here, who currently receive little more than protection and containment. A number will require treatment in a new, more structured and secure hospital or community facility. Others may need the services of a long-term rehabilitation-oriented community facility or state hospital similar to those found in Europe (29) or eastern Oregon (4).

Perhaps in the 1990s it will be possible to build a state hospital better than the one originally conceived in the 1840s. We have actually learned quite a bit about "therapeutic communities" since that time. It may be time for the pendulum to begin to swing in the direction of providing asylum and protection for young adult chronic patients while they are in their 20s, when they have so much difficulty adapting to their illnesses.

During such a crucial stage of their lives, this very sensitive group of patients will need a spectrum of care that should include a new or modified version of the long-term rehabilitation-oriented hospital and a broader range of community facilities that can provide structure, support, and carefully timed rehabilitation.

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