attendance at a day hospital, Joan was critical of some authoritarian attitudes she had experienced. She added that the hospital routine combined with the rapid patient turnover prevented meaningful relationships from being developed. Prior to becoming a member of START Joan had numerous admissions to the day hospital. She blames her repeated relapses on having no friends and lack of purpose to her life. While not being free of symptoms since she became a member of START, Joan feels that her quality of life has greatly improved and she has not required further admissions to the day hospital.

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Measuring levels of behavioural disturbance in long stay patients

DOMINIC BEER, Senior Registrar, Training Rotation, Medway Hospital, Gillingham, Kent ME7 5NY

Large mental hospitals are gradually being emptied. Patients return to the community. But often their prospective carers have little idea of what to expect when they arrive. Hospital staff often cannot give information regarding how disturbed patients might be.

To some extent this ignorance is a calculated part of the process whereby ex-patients become 'clients' and members of the local community, that is 'normalisation'. Community carers initially may not wish to identify problem behaviour, but when such behaviour subsequently occurs, there is unease.

In order to help bridge this communication gap and to investigate simple methods of determining disturbed behaviour, 45 in-patients were studied at a mental hospital (Bexley Hospital, Kent). Patients had previously been allocated probable community placements pending discharge. Preparations for discharge were already under way at the time of the study. The study therefore provided an opportunity to assess a survey tool which could be used easily where staff and facilities for research may be sparse, and to see if ward team's judgement regarding patients' placement was associated with patients' level of disturbance.

Survey

Levels of behavioural disturbance were observed for four weeks. Criteria for inclusion were: patients had been in hospital for more than one year; they were under 65; they were from one Health District (Lewisham and North Southwark); and, patients were not suffering from senile dementia or alcohol-related brain damage.

The survey was based on one used at Springfield Hospital. When compared with other surveys, it differed in its particular focus on behavioural disturbance. The WHO/DAS (WHO, 1988) is a Disability Assessment Schedule. Similarly REHAB – Rehabilitation Evaluation Hall and Baker – (Baker & Hall, 1983) covers more general measures of function. The Nurses' Observation Scale for Inpatient Evaluation (NOSIE) (Honigfeld & Klett, 1965) rates 80 items of general behaviour.

In this study, nurses were given a verbal introduction to the survey plus the following instructions:

> "We are trying to assess the degree of difficulty which these patients pose in terms of nursing management.
>
> The enclosed scale was devised to assess difficult or inappropriate behaviour. To complete this scale, the patient has to be observed for a period of four weeks. It is important to familiarise yourself with the behaviour items included in the scale, so that you know what to look out for. The scale has to be completed at the end of each week. Simply enter the numbers in the rating column as indicated.
>
> At least two members of staff should complete the scale for each week, so that it does not reflect just one person's perception of the patient. It would increase accuracy if the nursing staff could complete the scale during 'handover'."

The nurses were asked to score the patients on each of 17 types of behaviour. These behaviours had been previously identified as 'difficult' by 26 nurses from Springfield Hospital and had been put in rank order of difficulty. The individual score is the mean rank given by the Springfield nurses to the 17 behaviour types. These were: physical violence to staff (15.5); physical violence to patients (14.9); self harm (13.6); constant daily intimidation (11.6); sexually abusive behaviour (9.9); deliberate damage to property (9.5); swearing at other patients (8.6); refusing to take part in programmes (8.5); refusing medication (8.3); inappropriate masturbation (8.0); smearing faeces (7.9); swearing at staff (7.8); inappropriate urination (7.7); absconding (7.5); faecal incontinence (5.4); talking to self (4.2); urinary incontinence (4.0).

Out of the four weeks observation and scoring, the most disturbed week's score for each patient was selected. This had the advantage of providing both current and potential future carers with an accurate idea of what to expect in a short time span.

The total score denoted the aggregate of the individual scores for the week's 17 behaviours. Thus for each of the 17, if that behaviour did not occur at all the score was zero; if it occurred once then the single score for that behaviour was calculated. If the behaviour occurred twice (or more) then the score multiplied by two was scored; and so on, for each of the 17 behaviours.

There were three categories of patients: new long stay under 50 years of age (resident in the hospital for more than one year but less than five); new long stay over 50; and old long stay (in hospital for more than five years).

The rationale for differentiating new and old long stay was that the former reflect an important aspect of current psychiatric practice returning patients to the community. The old long stay by contrast sometimes reflect older practices whereby patients stayed in hospital, which may have rendered them more liable to institutionalised behaviour (Wing & Brown, 1970). The reason for separating by age was that the functionally ill new long stay can roughly be divided into the young male schizophrenic patients and the middle-aged, often female, affectively ill patients (Clifford *et al*, 1991).

Findings

The new long stay (over 50) group were the least disturbed with an average of 7.9 – the equivalent of one episode of shouting or swearing at staff per week.

The old long stay group had a much higher level of disturbance which was very evenly spread through the range. The mean score was 55.4, but of those who scored under 40 only one scored at all in the 'top four' threatening behaviours.

The new long stay (under 50) group also interestingly fell into two categories, with seven scoring over 80 and nine under 40 (with none in between). Those in the higher category scored heavily on the threatening behaviours.

Results according to future placement. Patients were looked at according to their possible future placement. Each patient had been assigned to one of the four placements some months before the survey was conducted. The plans had been decided upon by consultant psychiatrist, nurses, junior doctor, and social worker.

(a) Own home: four patients who in the worst week had mean scores of 16.2 for all behaviours and 3.7 for the top four.
(b) Group home with minimal staffing: 11 patients scored 46.1 and 9.8 respectively.
(c) 24-hour staffed hostel: 16 patients scored 42.1 and 13.1 respectively.
(d) Hard to place – no suitable placement as yet in the community: 14 patients scored 90.0 and 36.3.

Comment

With regard to the aim of finding a simple way to determine behavioural disturbance, it can be inferred from the results that using just four behaviours is as accurate as using all 17. Thus nearly all patients who scored highly using the scale of all behaviours scored comparably in the 'top four' (physical violence to staff or patients, self-harm and constant intimidation). More importantly, if a patient scored at all in the top four, then it is very likely that he would score very heavily here. This should be of considerable value in setting up surveys of patients in large mental hospitals prior to discharge. Those receiving them under their care in the community should have a rough guide of what to expect.

The new long stay (under 50) fell into two groups: the very disturbed who are hard to place; and another group who scored low and are easier to place.

Regarding the second aim: the ward team's judgement on the placement of the patients was associated

with their level of disturbance. The hard to place group scored very highly, while the own home group scored lowly. In between these two were those assigned to the 24-hour staffed hostel and to group homes. The former were more disturbed (on the top four scale) than the latter.

The objection that can be raised is that this association could be spurious, because the ward team decided placement *and* rated the behaviour. However, it should be remembered that the placements were determined some months before the behaviours were rated. The other related factor is that the placements were discussed by a consultant psychiatrist, junior doctor, social worker and nurses. The behaviour rating was performed by nurses alone. Further, because of the time lag, the nursing staff had changed to some extent. Moreover, they performed these ratings 'blind' to the placement decisions made earlier.

Conclusion

The subculture of community carers differs from that of ward nurses. Sometimes the ideology of the former is such that they do not wish to identify problem behaviour. There is need of a simple medium whereby one group can communicate with the other about patients who will become residents. This very simple survey tool, estimating the level of behavioural disturbance, provides this means of communication.

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Hostages returned from the Gulf

Recent reports show that continuing problems are being experienced by the returned hostages and their families. The Department of Health advised at the time of the hostages return that, apart from those who needed immediate emergency treatment, the initial point of referral ought to be the persons general practitioner. General practitioners in many cases now employ their own staff who are able to offer support and counselling. In some cases the general practitioner may, however, decide that the most appropriate response is referral to the psychiatric service. All local psychiatric services should be able to respond to the needs of people suffering continuing stress as a result of traumatic experience.

There is a further resource available within the system in the form of a list of psychiatrists with special expertise and experience in this field. The list was circulated to Regional Medical Officers in January, 1991 and those listed are available to offer tertiary level opinions and guidance if necessary. Any psychiatrist who wishes to have a copy of this list should contact the Secretary, Mrs V. Cameron.

Professor ANN GATH
Registrar

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