Psychiatric Bulletin (1989), **13**, 415–417

The Day House

A specialised community service for people with mental handicap

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There is increasing recognition that people with a mental handicap who also suffer from psychiatric disorder will need specialised services. Those with major psychiatric disorders may need periods of hospital in-patient care but treatment as out-patients or day-patients may be more appropriate for those with neurotic disorders, behaviour or conduct disorders, problems of adjustment or personality problems. Many such psychiatric difficulties are amenable to treatment by therapies commonly used in general psychiatry. However, the treatment process can be prolonged and may need modifying so that there is always a 'concrete' or 'practice' base for handicapped persons who may have limited or no ability to conceptualise abstract ideas, although able to gain insight and modify their behaviour when taught appropriate skills and strategies.

Description of the service

The Day House was set up in 1983 in a three-bedroomed, semi-detached house in a residential area about five minutes walk from the hospital. It aims to provide a normal physical environment with normal daily living activities for a small group of people (4–6) offering specific training, counselling and other treatments.

Patients attend for one day a week and are carefully grouped so that activities can be programmed to suit their needs. The peer group is balanced as far as possible, taking into account age, ability, problems, background and therapeutic need. At present 26 people attend each week. The work of the unit has been described in detail by French (1988) who, as Senior Occupational Therapist, was responsible for day-to-day running of the unit. A registrar on rotational training gives psychiatric oversight. Assessment and treatment is available for individuals, who may be referred to clinical psychologist, speech therapist or physiotherapist based at the hospital.

Those referred are all seen by me to decide whether the Day House facilities are an appropriate treatment resource, and then a preliminary assessment is undertaken by visiting the home and family of the referred persons and any day centre or hostel attended by them.

Survey of patients

For this paper, all those cases (41) who had attended the Day House up until September 1987 were reviewed; at that time 23 were attending and 18 had been discharged, 17 women and 24 men. The age at referral ranged from 18–58 years but half were aged between 16 and 24. The largest single group were ten men aged between 16 and 19. Twenty-four were living at home with their families, six in hostels, eight living independently and three in lodgings or staffed houses. Family relationships were considered to be problematic in 16; three times more commonly for the men than the women. Families were interested and supportive in 22 cases and three had no family. Only six had no other occupation or activity outside the home when referred; most attended adult training centres or sheltered workshops, but a few had part-time employment.

There were no records of formal assessment of IQ, mental age or scholastic achievement in four cases; however, two were considered to be mildly retarded and two moderately retarded. Of the remainder, three had IQs between 80–90 and three had IQs between 70–80. Fourteen men and four women were mildly retarded (IQ 50–70) and six men and six women were moderately retarded (IQ 35–49). One man with Down's syndrome, living in a group home, who has a major speech and language deficit, had a recorded IQ 34, in the severely retarded range under the International Classification of Diseases (1978).

Most had more than one reason for referral; commonest reasons were assessment (34), training in daily living skills (25), counselling (11) and behaviour problems (8).

An aetiological diagnosis was assigned for 30 (73%) and 33 (80%) had associated medical conditions leading to additional handicaps including hearing defects (5), visual defects (6), cerebral palsy (7), epilepsy (5) and diabetes mellitus (2). Other conditions included peptic ulcer, stroke,

hypothyroidism, chronic renal failure and a variety of skeletal anomalies.

Psychiatric diagnoses

Thirty-four (83%) were considered to have symptoms and problems which merited a psychiatric diagnosis in addition to their mental handicap. Nineteen had a conduct disorder; five were delinquent (of whom two were also aggressive) – five had disorders of sexual behaviour and nine had other conduct disorders, mostly aggression. Ten were considered to have neurotic conditions, mostly anxiety based. There were two with schizophrenia, both of whom have had periods of in-patient treatment. Three had a personality disorder as defined in the International Classification of Diseases (1978) (including one with schizoid personality) but there were many (22) who showed problems which suggested that their personality development was restricted. This group had serious difficulties in relationships and problems of adjustment which were related to their own personal crises in understanding and accepting the limitations mental handicap imposed upon their lives and the concurrent problems for other family members.

Treatment

Training and learning in daily living skills has been experiential for all attenders. Specific treatments were usually incorporated into the daily programme but at times other agencies contributed, for example to evening courses on sex education and counselling. Many attenders were helped to find suitable further education, evening classes or leisure activities. Training and counselling in social skills was given to all patients with emphasis on inter-personal relationships at home, at work and during leisure activities, sometimes using role-play or projective techniques. Training in budgeting and money management was important for 25, in basic educational skills for 15 and in self-care and personal hygiene for 28. Relaxation techniques were used in 12 cases. Three couples received specific marital counselling, all have now been discharged, one couple having successfully set up home together. Length of attendance varied from one month (three cases) to four years (two cases whose skills are being maintained by attendance enabling them to live independently).

Outcome measures

Patients were thought to have derived benefit from attendance if their life-style had changed towards more independence, either in activities or in their residence; if they had gained employment or successfully attended educational courses; if their behaviour or family relationships had improved; if they had developed more self-confidence or an improved self-image; if life expectations or plans became realistic and in keeping with their abilities and opportunities; or if the skills in daily living which were acquired at the Day House were transferred and maintained in other settings. Excluding those whose attendance was for assessment only, approximately half of those who have been discharged gained benefit from attendance and three-quarters of those still attending have benefited. The latter group have usually attended the Day House for a longer period.

Comment

The Day House has been able to provide treatment and help to a group of younger and more able people who may fall between the services offered in general adult psychiatry and those offered in mental handicap hospitals. The move towards the community has led many workers in this field to deny or ignore the existence of psychiatric or emotional problems which cause intractable difficulties in the everyday lives of some of our patients. Psychiatric diagnosis in people with a mental handicap is fraught with difficulty but only seven attenders were not assigned any psychiatric diagnosis, which was only reached in most cases after observation and interviews held during their period of attendance. Assessment of personality disorders in mildly and moderately mentally retarded adults resident in a hospital has recently been reported by Reid and Ballinger (1987) who found 56% showed features of abnormal personality, a figure not dissimilar from 61% among the Day House attenders. As the latter have a preponderance of young males, investigations at an older age may well show improvement but it is clear that detailed longitudinal studies of cohorts of people with defined mental handicap and abnormal personality traits or other psychiatric disorders are necessary.

The frequency of associated medical conditions in people with a mental handicap is well recognised and the number and range of such conditions is similar to that reported by Rubin (1987) for institutional residents.

The therapy provided from the Day House depends largely on the availability of skills and experience of the staff but the service is relatively economic in terms of professional time and capital involvement. It has prevented hospital admission for some and fostered the independence of many so that future demands for costly residential services will be lessened. This service can also be considered as preventive of secondary or tertiary handicaps. The move to community care has focused attention on the management of challenging behaviour within community residences, sometimes at great cost. More

effort should be directed at preventing behaviours becoming intractable or over-learned, which may mean providing much more skilled intervention from psychiatric and multi-disciplinary teams earlier in childhood.

Acknowledgement

I would like to thank the staff of the Day House for their help and co-operation.

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Psychiatric Bulletin (1989), **13**, 417–419

Relative support group of long-stay psychiatric patients

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It is now widely recognised that families represent a hidden and largely unacknowledged resource to the NHS in the day to day management of long-term disabilities, particularly severe mental problems like schizophrenia. It is most likely that 50–60% of first admission schizophrenic patients will return to some type of family environment and a significant number will remain with the family for a considerable time. The current trend towards community management of mental illness, hampered by the lack of community provision, almost inevitably means discharge to families and is likely to continue and increase further.

Many families face difficult behavioural and emotional problems associated with persisting symptoms and the impairments which the illness can bring (Gibbons *et al*, 1984). These serve to challenge the coping resources of the family and place stress on the family unit

Despite the efforts of groups, such as the National Schizophrenia Fellowship, which have been increasingly vocal concerning the needs of families, until recently the needs of families have often been regarded with scepticism by mental health professionals. Families have been held at arm's length by mental health professionals and this has influenced the general lack of responsiveness to their needs, particularly in giving basic information about the illness, treatment and advice concerning home management (e.g. Carstairs *et al*, 1985). More recently, as a direct result of the renewed interest in the family environment arising from the Expressed Emotion Studies (e.g. Leff & Vaughn, 1986), attention has been directed towards families, and earlier findings concerning their needs appear to have been rediscovered. This change in attitude is reflected in the recent report by the Select Committee on Community Services to the Mentally Ill which specifically identifies the need and importance for family support in the transfer of emphasis and resources to the community. Consequently, in recent years we have had an increasing number of initiatives which have attempted to address families' needs. These have ranged from intensive family interventions (e.g. Leff *et al*, 1982; Falloon *et al*, 1982), dedicated family services (Smith & Birchwood, 1987) and increasing provision of relative support groups. Although family interventions have been quite systematically evaluated (Falloon and others, 1985) there has been little systematic evaluation of relative support groups in terms of meeting families' needs. The aim of the present study was therefore to identify the families caring for a relative attending Hahnemann and to assess the value of a relative support group in meeting these needs.

Background to the present study

Hahnemann House was set up in 1983 as a unit for the rehabilitation of long-stay psychiatric in-patients. There has always been a policy to involve the relatives in discussions concerning rehabilitation plans for a given individual. Many relatives commented on how