Prosecution should cease to have effect when fresh proceedings are taken, e.g. on arrival of the accused in court. The recently adopted policy on reprosecution, together with legislative change, would ensure that the effect of a finding of unfitness to plead would not necessarily be permanent. Psychiatric disorders run a fluctuating course and the capacity of a person to stand trial may similarly alter over time. Court procedure and criminal legislation should reflect these clinical facts.

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References

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Trends in recruitment of new long-stay male schizophrenics

Norman A. Todd, Consultant Psychiatrist; Ernest H. Bennie, Consultant Psychiatrist; A. F. Cooper, Consultant Psychiatrist; Joseph P. McKane, Consultant Psychiatrist; and Linda J. Watt, Consultant Psychiatrist, Leverndale Hospital, Glasgow G53 7TU

In 1973 a survey was carried out of male schizophrenic patients who had become long-stay residents in Leverndale Hospital, Glasgow, 'long-stay' being defined as having been continuously in hospital for more than three years (Todd et al, 1976). The patients were recruited from a four year cohort of admissions in the years 1967 to 1970 inclusive. In the following years there have been many changes in the provision of facilities and in clinical practice. In some countries, such as Italy, the USA and England, there has been a strong drive to reduce long-stay populations along with the closure of some mental hospitals. In Scotland the process has been much more gradual, possibly reflecting the differences in pre-existing provisions and patterns of care.

Since 1973 there have, nevertheless, been major developments in Glasgow. The community nursing service, group homes, day hospitals and out-patient clinics at health centres have all added to the network of community support, although hostel accommodation has not yet played a significant part. Programmes of rehabilitation have been developed in the hospital and linked to the other facilities. The main treatment advance during these years has been the increasing use of depot neuroleptic therapy. In view of these changes, a further survey was carried out in 1987.

Male patients were identified on 12 April 1987 from an annual hospital census as having been admitted with a diagnosis of schizophrenia (ICD-9) for the four years April 1980 to April 1984, and not discharged. They were assessed in respect of age, duration of illness, number of previous admissions, marital status, place of origin, occupation in hospital, and any special characteristics.

It has to be explained that during the period between 1973 and 1987 there were changes in the catchment area of Leverndale Hospital which is now shared with a neighbouring district general hospital psychiatric unit. This unit, however, has always been able to refer patients to Leverndale Hospital if long-term care is required. The inner-city population has
Trends in recruitment of new long-stay male schizophrenics

fallen and the catchment area has been extended, but
the net result is that the population from which long-
term patients are drawn is only minimally smaller, at

Findings

In December 1973, 39 long-stay patients were ident-
ified by personal survey of each ward, i.e. an intake of
about ten for each of the four years of intake 1967 to
1970. In 1987 the corresponding total was only 12, an
average of three per year from April 1980 to April
1984.

Figures for new long-stay male schizophrenic
patients, i.e. over three years’ stay, are not available
for most of the years between the surveys, but in 1978
a count was made of such patients admitted in the
years 1972 to 1975 inclusive, the number being 30.

There has been a decrease in the number of male
schizophrenic patients admitted. In 1967 to 1970
there was a total of 471 admissions (215 individuals),
of whom 45 were first admissions, while the figures
for April 1980 to April 1984 were 209 admissions
(184 individuals), including 36 first admissions.

The 1973 cohort was not in fact assessed in detail
until 1975, when the numbers had been reduced by
six (three discharges, three deaths), so that the total
available for comparison with the 1987 group is 33.
There was a comparable attrition of numbers in the
two years following the 1987 census (see ‘Subsequent
changes’).

Age

There was no appreciable difference in mean age,
which was 45.4 in 1973, and 46 in 1987.

Duration of illness

In 1973 the average duration was 15 years, with a
range from 5 to 40 years. In 1987 it was 20 years,
ranging between 4 and 28 years.

Number of previous admissions

In 1973 the average was 3.3, and in 1987 it was 4.6.
Three of the 1987 cases had been previously treated
in the adjacent general hospital psychiatric unit.

Marital status

In 1973 seven men (21.2%) had been married,
although only three retained any contact with their
wives. Only one of the 1987 group, however, had ever
been married, and indeed re-married during his stay.

Place of origin

The 1973 cohort had contained only two immigrants.
All the patients in the 1987 cohort originated in
the Glasgow area and came from the indigenous
population, none being immigrants. Five had their
original address in the Leverndale catchment area,
six from the area of the adjacent general hospital
psychiatric unit, and one from outside both areas.

Occupation in hospital

In 1973 two patients held outside employment, and
15 worked within the hospital, 13 of these at the
industrial therapy unit. Eleven were incapable of any
regular occupation and the remaining five attended
occupational therapy or did ward work.

In 1987 one patient had a job outside hospital, one
worked in the Industrial Therapy Unit, one
employed himself inefficiently in a hospital paper
round, two attended occupational therapy, two did
ward work, and the remaining five were incapable of
any occupation.

Special characteristics

In 1973 five patients were noted to be aggressive, a
further four both aggressive and suicidal. One elderly
patient was in poor physical health.

In 1987 one patient showed recent serious
agression but no other special behavioural features
were noted. Two patients had physical impairment,
one having ankylosing spondylitis causing consider-
able disability, the other had bronchial carcinoma.

One patient had brain damage resulting from a
suicide attempt, one was considered to have congeni-
tal brain disorder possibly due to birth injury. Four
patients suffered from borderline or mild but definite
mental subnormality, one of those having epilepsy as
well.

Subsequent changes

Since the date of census in April 1987 there has been
some reduction of numbers, four patients having been
discharged and one, mentioned above, having died
from bronchial carcinoma. The patient with ankylos-
ing spondylitis was discharged to specialised sheltered
accommodation, one was transferred to another men-
tal hospital with his mental state unchanged, and two
were discharged to relatives but are considered pre-
cariously placed there; one of these has married a
female schizophrenic patient and they were dis-
charged together. It appears, therefore, that a stay of
over three years for male schizophrenic patients does
not necessarily imply permanent residence in all cases.

Comment

The most striking finding is the drop in recruitment of
new long-stay male schizophrenic patients from 39 in
1973 to 12 in 1987, a reduction of 69%. The fact that
the new long-stay recruits had fallen to 30 in
1978 suggests that the reduction may be a trend rather
than a chance variation. This has to be seen
against the background of the figures for admissions of male schizophrenic patients, all of which have fallen but to varying degrees. Thus, all admissions and readmissions for male schizophrenic patients have fallen by 56%, and first admissions by 20%, but the number of individuals admitted has fallen only by 14%. These surveys, therefore, appear to have marked a period of major change.

Demographic factors have to be considered. The new part of the catchment area consists of industrial towns which came within Greater Glasgow on the reorganisation of boundaries, with relatively little private housing and with pockets of high unemployment. Unemployment greatly increased in the region between the two surveys, being 5.2% in 1973 and 19.1% in 1987 (Strathclyde Regional Council, 1987). Such social factors seem unlikely to be reflected in reduced incidence or improved prognosis of schizophrenia. Examination of the catchment populations and their age distribution reveals only minor changes not statistically relevant in view of the age bands of the patients found (Bryden, 1989).

Changes in diagnostic practice seem unlikely to have played a significant part in these reductions, especially in the long-stay recruits, who all suffered from well-established chronic illnesses. Eagles, Hunter & McCance (1988) considered this factor probably did not account for the fall in schizophrenic first-admissions and contacts observed in their own and other studies. A fall in the incidence of schizophrenia has to be considered in accounting for the results, but no definite conclusions can be drawn, since there were no data on total contacts for the 1967 to 1970 period, i.e. it is possible that more schizophrenic patients were treated in the community in 1981 to 1984 without ever being admitted to hospital.

The difference between the fall of total admissions (56%) and the number of individuals admitted (14%) shows that the revolving door is revolving more slowly, presumably in relation to the development of community facilities. There has been a reduction in the number of relapses leading to readmission, which might indicate less chronic disability, but it may be that minor relapses can now be dealt with more effectively in the community. Once admitted patients are also less likely to become long-stay residents. This is probably due to the increased emphasis on and facilities for rehabilitation, reflecting a change of expectations from those prevalent a generation ago, when long-term hospital care was the usual outcome anticipated for the type of patient considered here.

The nature of the patients becoming long-stay also appears to have changed, although the small numbers make conclusions tentative. Five of the 1987 patients had physical, including neurological, handicaps, and a further three borderline or mild mental subnormality without such handicaps, leaving only four (33%) with uncomplicated schizophrenia, albeit in severe form and with incomplete response to treatment. Only one (8.3%) was ever married, compared with 21.2% in 1973. There has been a large drop in the number of in-patients capable of sustained work, as has been found, for example, by Ford et al (1987) who comment “if patients are capable of industrial training or sheltered work, then, with rare exceptions, they are living in the community”.

The question arises as to whether the new long-stay schizophrenic patients of 1987 can be cared for elsewhere than in a psychiatric hospital. There is a small group with severe and treatment-resistant psychoses who, in our opinion, can only be dealt with in a psychiatric setting for the foreseeable future; and it is important that this provision be retained. A greater number, however, have additional disabilities and merit further consideration. They require a degree of support and supervision which is, at present, not attainable outside the psychiatric hospital, and when assessed for or tried in other settings, have been found unsuitable or unable to cope. If supervised accommodation of some other kind were to become available, this might meet the needs of some of them; they could at least be said to be living in the community and might have a better quality of life than in a long-stay ward (Gibbons & Butler, 1987). There is, at least in this particular hospital, some overlapping with the needs of the mentally subnormal, and this would need to be taken into account in devising suitable programmes of rehabilitation and after-care.

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References


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