

## Original Article

# Long-stay Psychiatric Patients in Kuwait: Assessment of Their Needs

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**ABSTRACT**

**Objective:** Over the recent times, proclaimed cost-effectiveness and favorable response from patients' perspective has resulted in a major shift from hospital to community care, especially for long-stay psychiatric patients. Our study was aimed at defining all the long-stay psychiatric patients in Kuwait and assessing their dependency needs so as to make tentative suggestions for their rehabilitation.

**Methods:** Information was obtained from case-notes and interviews with the patients and the charge-nurses. Two scales devised for the purpose of the study were used to estimate both the medical and the daily living needs of the patients.

**Results:** Out of a total of 150, more than half had been in hospital for more than five years and just under 4/5<sup>ths</sup> of

them were schizophrenic. Just under 2/3<sup>rds</sup> of the patients retained the abilities to wash, dress and undress, and control bowels; and about 3/4<sup>ths</sup> had not required any medical consultation during the previous month.

**Conclusions:** About 2/3<sup>rds</sup> of the patients can be discharged into the community. This would require ten community homes, each accommodating eight to ten patients. The possible number of patients requiring rehabilitation, however, may be much higher. It is estimated that for every long-stay patient in the hospital there are five similar patients in the community, living with and being cared for by their families. In order to accommodate long-stay patients living with and being cared for by their families, another 130 hospital beds and 180 places in the community would be needed.

KEYWORDS: chronic patients, community care, long-stay patients, psychiatric

**INTRODUCTION**

Serious and persistent mental illnesses can result in considerable functional impairment requiring long-term hospitalization of patients. Most patients requiring institutional care of extended duration have limited functional capacity in relation to a number of primary aspects of daily life, including personal hygiene and self-care, self-direction, interpersonal relationships, social transactions, learning, and recreation<sup>[1]</sup>. The deleterious influence of the traditional custodial care on the long-stay population of the mental hospitals has been well-documented<sup>[2]</sup>. The last two decades have witnessed a major shift in the provision of psychiatric services to the acutely disturbed patients in general and the chronically disabled group of patients, in particular. Increasingly, they are living in the community and the number of mental hospital beds has correspondingly decreased. In the U.K, for instance, 38 (29%) of the 130 hospitals with more than 100 beds have been closed in recent years<sup>[3]</sup> while in U.S., 65 (20%) of the 321 state hospitals were closed between 1972 and 1993<sup>[4]</sup>. Whereas 'too rapid' a shift from hospital-based to community-

based care has proved counterproductive in some cases<sup>[5]</sup>, most workers have found the latter to encompass greater potential for stabilization and even improvement in the condition of the long-term psychiatric patients<sup>[6]</sup>. In addition; the community-based care has been shown to be cost-effective. In a 3-year follow-up study of 321 discharged state hospital patients, the cost of community care was found to be less than half of the estimated cost of state hospitalization<sup>[7]</sup>. Similar findings have been reported by other workers<sup>[8,9]</sup>.

Estimates vary as to how many of the long-stay psychiatric patients could possibly be discharged into the community. Obviously, it depends on the nature of their illnesses and the degree of functional deficits of the patients as well as the availability of suitable accommodations and activity programs in the community. In a national sample survey of 15 mental hospitals in England and Wales, it was found that about 1/3<sup>rd</sup> needed further hospital care, 1/3<sup>rd</sup> were suitable for discharge into the community, and the remaining 1/3<sup>rd</sup>, because of their multiple handicaps including physical disability and mental retardation, were in hospital simply because no other agency would accept them<sup>[10]</sup>.

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Kuwait has a population of 1.8 million and, being a rich oil producing country, attracts a large number of expatriate work-force who comprise 59% of its population<sup>[11]</sup>. The population is divided into five regions (Governorates) and the population of each, ranges between 252,157 (Al-Jahra) to 498,584 (Farwaniya). Each region has a general hospital. In addition, Sabah Medical Center comprising specialty hospitals, provides tertiary health care services like ophthalmology, neurosurgery, transplant surgery, etc. The 394-bed Psychiatric Hospital, established in 1958, is the only facility of its kind in Kuwait and provides psychiatric facilities for the entire population<sup>[12]</sup>. We decided to define the total long-stay population in Kuwait and, based on their dependency needs, attempted to set out tentative guidelines for their rehabilitation.

### AIMS AND OBJECTIVES

The aims of the study were to (a) describe all the long-stay patients in Kuwait, (b) assess their dependency needs and, based on our findings, (c) make tentative suggestions for their rehabilitation.

### METHODS

#### Sampling:

The sample consisted of all the 150 patients admitted into the four long-stay wards of the hospital. The study was carried out from February to April, 1997.

#### Instruments:

The dependency needs of the patients were identified to encompass (a) the lack of daily living skills and (b) the frequency of medical (psychiatric or physical) consultations required during the past one month. The two scales used for this purpose were:

1. Daily living abilities scale. Six related items, measuring the patient's competence in daily living skills, were selected. These included ability to wash, dress and undress, control bowels, feed themselves, engage in meaningful conversation (regarding their day-to-day needs, inquiries about family visits, asking for medication or complaining about side-effects etc.), and ability to contribute in the ward activities (changing bed-sheets, helping in the kitchen, escorting fellow-patients, etc.). A minimum score of 0 meant an absence of all six abilities and a maximum score of six suggested the retention of all the skills. Internal reliability of the scale was tested using Cronbach's Alpha<sup>[13]</sup>, which yielded reliability co-efficients, based on 6-items,  $\alpha = .8267$  and standardized item alpha value of 0.8239. "Cronbach's Alpha is one of the most commonly

**Table 1**  
Psychiatric diagnoses

	Number	Percentage	Cumulative percentage
Schizophrenia	109	72.7	72.7
Epilepsy	19	12.7	85.4
*Mental subnormality	9	6.0	91.4
Dementia	8	5.3	96.7
Affective disorder	3	2.0	98.7
Personality disorder	2	1.3	100
<b>Total</b>	<b>150</b>	<b>100</b>	<b>100</b>

\* Total number was 28; 11 also had schizophrenia, and 8 epilepsy

**Table 2**  
Characteristics of patients

*Nationality	Kuwaiti	117	78%
	Non-Kuwaiti	31	20.7%
	<b>Total</b>	<b>148</b>	<b>98.7%</b>
Sex	Males	90	60%
	Females	60	40%
	<b>Total</b>	<b>150</b>	<b>100%</b>
**Marital status	Single	103	69.1
	Married	24	16.1
	Divorced	20	13.4
	Widowed	2	1.3
	<b>Total</b>	<b>149</b>	<b>99.9</b>

\* Information about nationality was missing in 2 patients

\*\* Information about marital status was missing in one patient

**Table 3**  
Abilities retained by patients

Abilities	Frequency	Percentage
Feed	127	84.7
Control bowels	108	72.0
Wash	107	71.3
Dress	87	58.0
Converse	40	26.7
Contribute	36	24.0

used reliability measure. Based on the "internal consistency" of a test, its value is derived from the average correlation of items within a test, if the items are standardized to a standard deviation of 1, or on the average covariance among items on a scale, if the items are not standardized. Cronbach's Alpha can be viewed as the correlation between our scale and all other possible identically-numbered scales measuring the same entity<sup>[13]</sup>.

2. Medical consultation scale. Depending on the number of consultations, psychiatric or physical; the dependency was rated 0 = no consultation, 1 = one consultation and 2 = two or more consultations. The scores were summated and the reliability of the scale tested using

**Table 4**

Medical consultations during the past month

No. of Consultations	Frequency	%	Cumulative %
0	106	70.7	70.7
1	14	9.3	80.0
2	14	9.3	89.3
3	7	4.7	94.0
4	4	2.7	96.7
5	3	2.0	98.7
6 or more	2	1.3	100
Total	150	100	100

**Table 5**

\* Summary of guidelines for rehabilitation services in Kuwait

Facility	Beds		Day places	
	Beds for each region	Total Number in Kuwait	Places for each region	Total number in Kuwait
<b>Hospital Services</b>				
Acute psychiatric hospital beds	92	460	112	560
Accommodation for the elderly severely mental infirm	56	280	56	280
<b>Community Services</b>				
Hostels	9-10	46		
Long-stay accommodation	28	140		
Day centres			112	560

\* Based on end-year 1997 estimated population [12].

Cronbach's Alpha<sup>[13]</sup>; which yielded reliability co-efficients, based on 2-items, alpha = .8401 and standardized item alpha of .8439.

**Procedures:**

Case notes of all the patients were examined and information obtained regarding age, sex, marital status, nationality, and duration of stay in the hospital. Psychiatric illnesses, diagnosed according to ICD-10<sup>[14]</sup> (the system adopted in hospital clinical practice) and as assigned by the treating clinicians, as well as the chronic physical illnesses as documented in the case notes were recorded. Each patient was interviewed and physically examined by the psychiatrist (MAR). Based on the clinical findings by the psychiatrist and the nursing observations by the charge-nurse, the dependency needs were jointly rated by the psychiatrist and the charge-nurse. The data was analyzed on SPSS.

**RESULTS**

The total number of long-stay patients was 150. Accumulating over the last four decades, they were confined to the four different wards within the premises of the psychiatric hospital. The minimum duration of stay was one year. More than half (n = 88) had been hospitalized for more than five years

and the remaining 41.3% (n = 62) for 1-5 years. About 1/3<sup>rd</sup> of the patients (n = 51) had remained in the hospital for more than 10 years. The patients had been assigned multiple diagnoses: schizophrenia 72.9% (109), followed by epilepsy 12.7% (19), and dementia 5.3% (8), being the most common amongst them (Table 1).

A total of 28 (18.7%) of our patients suffered from learning disability. Out of them, 11 also had schizophrenia, eight had epilepsy, and the remaining nine needed residential care directly attributable to their learning disability. A total of 83 (55.3%) patients did not suffer from any associated physical illness while 42 (28%) were known to suffer from one concomitant physical illness and 25 (16.7%) from two or more.

**Demographic characteristics:**

The age of the patients ranged from 17-99 years, (mean 51.26; SD=14.97); 90 (60%) were males and 60 (40%) were females (Table 2). About 4/5<sup>ths</sup> (n = 117) of our patients were Kuwaitis as against 31 (20%) non-Kuwaitis. The nationality of two patients was not traceable. About 2/3<sup>rds</sup> were single, 24 (16%) were married and 20 (13.3%) were divorced/widowed.

**Potential impairments requiring rehabilitation:**

The functional abilities reportedly retained by the patients are shown in Table 3. Information regarding ability to wash and control bowels was missing in one patient each (Table 3). Thirty-three (22%) of the patients retained all six abilities against eleven (7.3%) lacking them all. The mean number of abilities retained was 3.38 (SD=1.9306). Out of six daily living abilities selected for the purpose of this study, just under 2/3<sup>rds</sup> of the patients were able to wash, dress and undress, and control bowels (Table 4).

The mean number of all medical consultations needed was 0.7 (SD = 1.3). Just under 3/4<sup>ths</sup> of them did not require any medical, psychiatric or physical consultation during the past one month (Table 4), while 14 (9.3%) needed only one.

**DISCUSSION****Characteristics of patients:**

The majority of our patients were single, middle-aged, males with schizophrenia as the most common psychiatric disorder. These findings are more or less similar to those reported in earlier studies<sup>[15,16]</sup>. The number of long-stay patients known to suffer from one or more concomitant physical illnesses has been reported to be 30%<sup>[8]</sup> to 50%<sup>[17]</sup>; while 44.7% of our patients suffered from one or more physical illnesses. Ridgely et al.,<sup>[18]</sup> and Fattrel et al.,<sup>[19]</sup> found excess of females while Leff et

al.,<sup>[15]</sup> and Fairley et al.,<sup>[17]</sup> found excess of males in their groups of long-stay patients. Relatively higher excess of males in our patients can be accounted for by social attitudes. The under-representation of females in mental hospitals in the Arab communities is well-known<sup>[20, 21]</sup>. Firstly, the psychiatric illness in older females does not interfere with the running of the extended family where other females compensate for the role of the sick. Secondly, the males, with greater responsibility outside the family home, call for more urgent and specialized attention when they become psychiatrically ill and are, therefore, more likely to be referred to psychiatric services<sup>[21]</sup>.

One interesting finding was the under-representation of expatriates in our sample. The expatriates, outnumbering Kuwaitis 1.5:1, constituted only 1/5<sup>th</sup> of our long-stay population. This may be partly explained by the age-related demographic trend reflected in the make-up of population of the country. Most of the imported manpower comes from younger age-groups, from age 20 onwards their number begins to rise, peaks at 25-50 (reaching up to four times the Kuwaitis); declines steadily thereafter so that, around the age 65, the number is reduced to just over a half of Kuwaitis<sup>[11]</sup>. The number of Kuwaitis in the vulnerable age-group, in terms of long-term psychiatric morbidity, is much higher than the expatriates. Moreover, possible repatriation of immigrants afflicted with chronic psychiatric illnesses requiring long-term institutional care is another likely explanation.

#### **Implications for rehabilitation of the patients:**

The recent trends towards deinstitutionalisation aimed at enhancing the quality of life of patients, permitting their entry into community, and preventing their relapses and rehospitalizations, corresponded with setting up of alternative community care facilities. Community homes (hostels) replacing the hospital beds; and day centers, staffed with multidisciplinary professionals including doctors, psychologists, nurses, occupational therapists, dietitians, art therapists, etc, have been set up to cater for the needs of the chronically disabled and the mentally infirmed<sup>[22, 23]</sup>. It is clear from our findings that, while 1/3<sup>rd</sup> of our patients, because of their medical and nursing dependency needs, would continue to need hospital care; 2/3<sup>rd</sup>s (n = 100) can be considered for discharge into the community. The authors, however, believe that the total number of patients requiring rehabilitation and possible community care in the country may be, in fact, much higher than it sounds. The United Kingdom D.H.S.S. census in 1971<sup>[24]</sup> estimated that 50/100,000

of the population had been in hospital for psychiatric illnesses for 1-5 years. By the same token, in a population of 1.8 million, the estimated number of long-stay patients would be around 900. This means, for every long-stay patient in the hospital, there are about five similar patients in the community; living with and being cared for by their families. These families, therefore, act as the main social agency, assuring the patients' continued welfare in the country. Development of community care and rehabilitation programs, therefore, must address the needs of not only the hospitalized group of patients, but also those being taken care of by their families currently .

#### **Estimated requirements for rehabilitation services in the country:**

In estimating service needs for Kuwait, we followed guidelines set forth in the Government White Paper "Better services for the mentally ill", produced by the Department of Health and Social Security U.K.<sup>[25]</sup>. The White Paper recommended 50 beds and 65 day places per 100,000 population for acute disorders or exacerbation of chronic disorders; and 30-40 beds and 25-40 day places per 100,000 population for the elderly mental infirm (Table 5).

Consistent with the demographic trends, reflected in the composition of our long-stay patients, we estimated the service needs for the indigenous population and added another quarter to cater for the needs of the expatriates. The estimated figures for Kuwait, according to these estimates, would be 92 beds and 112 day places for acute and exacerbated chronic disorders; and 56 beds and 56 day places for the elderly mentally infirm, in each of the five health regions (Table 5). Similarly, the community services suggested in the White Paper included 4-6 hostel beds, 15-24 long-stay accommodation beds and 60 day places per 100,000 population. This would translate into 9-10 hostel beds, 28 long-stay accommodation beds and 112 day places for each of the five health regions in Kuwait. Facilities like day centers, community homes, and hostels, the essential ingredients of community care, will be a novel development and simultaneous provision to the extent of estimated needs may not be feasible. Phased implementation of our recommendations is, therefore, suggested.

Two points must be added here. Firstly, the daily living skills and the medical consultation scales used in the study were not the standardized and some of the patients' behavior studied, like 'holding meaningful conversation', may have been subject to assessor-bias. However, the internal reliability co-efficients of our scales were well within acceptable range. This epidemiological

survey was intended to define the basic medical and/or nursing needs of the long-stay patients rather than make comparisons with the previous studies. Secondly, the ethnic composition of our hospitalized long-stay patients does not necessarily reflect their overall number outside the hospital. Expatriates, being a transit population in terms of their long-term psychiatric morbidity, would continuously vary in numbers. For this reason, we estimated the service needs for the host population and, for want of any other suitable measure, used proportion of expatriates in our sample, to calculate the overall estimated needs.

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