Hostel placement of mentally handicapped patients in Northern Ireland

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SUMMARY

All patients discharged to hostels from an 800 bed hospital for the mentally handicapped were studied over a 12 year period. Those whose placement was successful were compared with those who returned to the hospital. Youth and early institutional upbringing were associated with failure of placement. Twelve specific problems were identified by hostel staff and of these aggression, psychosis, absconding and interpersonal difficulties were associated with failure. A worrying trend was that the more modern hostels had a lower success rate and a higher proportion of problems than those which were older and more established.

INTRODUCTION

The policy of discharging increasing numbers of mentally handicapped residents from hospital to hostels within the community has been the subject of controversy (Social Services Select Committee,¹ Kinnell²). Particularly worrying are the numbers of patients whose placement in a hostel proves unsuccessful and who must return to the hospital from whence they came. The object of this study is to examine some of the factors associated with these failures of placement.

During the past twelve years, in this part of Northern Ireland, many patients have been discharged into the community from Muckamore Abbey Hospital, which is a large hospital for the mentally handicapped. Patients are given a pre-discharge course lasting for several months, designed to help them cope with life in the community. Some are discharged directly home, to lodgings, to private houses with staff support or staffed group homes, but the vast majority are discharged to hostels. These are seen as stepping stones to future integration within the community. Fourteen hostels were involved: Elliscourt, 505 Antrim Road, Hillhall, Ward House, Glenwood, Lynnwood, Balligan, Greystone, Myrtlefield, Hanna Street, Colinbrook, Breda Park, Redhall and Colgrennan. These hostels had been in use for one to twenty-five years and were scattered over two Area Boards, with a catchment population of one million. Four of the hostels are staffed by Social Services personnel with the rest being staffed by nurses trained in Muckamore Abbey Hospital. All hostels provide individual rooms for their residents.

Ames and Levy³ point out that hostels vary in the degree of handicap catered for, tolerance level of staff, rate of turnover of residents, size and site. Hostel environments change over the time as the static residents grow older. These

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authors have also grouped patients into four categories: those ready for hostel placement; those who could be prepared in a short time; those who need extensive preparation and those who do not require hostel placement. Important factors identified in the selection of candidates are social maturity, vocational adjustment, capacity for independent action and institutionalization.

Patient variables which influence the success of placement have also been examined by Wing, Kushlick, McDonald and Challis and Shepherd. The large array of assessment tools used to determine the suitability of patients for hostel placement includes — McDonald's Initiative Scale, the Adaptive Behaviour Scale of the American Association of Mental Deficiency and the Handicaps, Behavioural and Skills Interview. Some of these have proved useful in identifying patients who would be unable to cope with hostel living, but little attention has been paid to the assessment of the other side of the equation, hostel environment and the interaction between the resident and this environment. The importance of this is obvious, since the patient may prove unsuitable for one hostel and yet succeed in another.

Shanks, in the Northern Ireland context, examined a group of eleven individuals who had returned to hospital following unsuccessful hostel placement and compared these to a group who had been successfully placed in hostels and had remained there for two years. The two groups were similar in terms of intelligence. The group whose placement was successful tended to be older, contained more females and had more active mental illness, though these results did not reach statistical significance. When the Adaptive Behaviour Scale scores of the two groups were compared they were found to be remarkably similar on all parameters except for anti-social and untrustworthy behaviour. These were associated with failure, indicating the possible importance of subjective factors influencing the success of placement. The present study seeks to enlarge these findings by studying a larger sample and by examining the problem from the perspective of the hospital staff.

**METHODS**

The sample population included all patients discharged to hostels from Muckamore Abbey Hospital (an 800 bed hospital for the mentally handicapped in County Antrim) between 1972 and 1984.

One hostel was selected at random and each resident was discussed with the member of staff in charge. Twelve problems were identified as causing concern to the hostel staff. These became the basis for a hostel problem check list. The problems identified and included on the check list were: inadequate community skills; inadequate self-care skills; inadequate communication skills; physical disability (including epilepsy); psychoneurosis; deliberate self-injury; absconding; drug or alcohol abuse; aggressive behaviour (physical or verbal); dishonesty (lying or theft); heterosexual promiscuity; homosexual promiscuity; and interpersonal difficulties. This last category of problems was defined as problems with the interaction between the resident's personality and that of other residents and staff irrespective of objective behaviour problems or illness. The check list also included an extra category in which other problems could be recorded.

Each of the 14 hostels was visited in turn and the member of staff in charge was interviewed by the same researcher. This was necessary to ensure that the problems on the check list were clearly understood, while it also provided a
valuable first-hand insight into the attitude of hostel staff towards the hospital discharge policy.

All the residents who had ever been discharged to that hostel from Muckamore Abbey Hospital were discussed in turn. The criterion for unsuccessful placement was that the patient was forced to return to Muckamore Abbey Hospital within one year of discharge. A problem check list was completed on each resident on the basis of information from hostel staff, who were also asked to identify the major reason for return to hospital in those cases where placement failed. The reliability in a study like this is adversely affected by inconsistencies in staffing and the fallibility of the human memory. We attempted to minimise this by interviewing the longest serving staff member, and in most cases we were able to find someone who had been working in the hostel since it opened. In a retrospective study it must be remembered that most observations are coloured by hindsight. The 0·05 level of probability was taken as the level of statistical significance.

RESULTS

There were 185 patients who had been discharged from Muckamore Abbey Hospital to a hostel during the 12 year period. There were 73 males and 112 females. The mean age at sampling was 40 years (SD 12·5). The mean IQ was 62 (SD 8·3). Comparing males to females there was no significant difference in IQ, the females (mean age 41·4) were older than the males (mean age 38·4 p > 0·03).

The total population was then divided into 142 whose placement was successful and 43 who failed using the one year criterion, a 77 per cent success rate overall. The mean age of the successful group (41 years) was significantly older than the failed group (36 years). No difference between the two groups was found in the sex ratio, IQ or number of years spent in hospital, but significantly more of the group whose placement failed had spent time in institutional care before the age of nine (Table I).

| TABLE I |

Differences between successful and failed residents in terms of subject variables

|        | No. | %    | Mean IQ | Mean age years | Percent female | Mean years in hospital | In care before age of 9 years |
|--------|-----|------|---------|----------------|----------------|------------------------|-------------------------------|
| Successes | 142 | 61%  | 56·4    | 41·5          | 59%           | 7·2                    | 21·1%                         |
| Failures  | 43  | 23%  | 56·2    | 36·0          | 65%           | 6·3                    | 41·8%                         |

NS p < 0·01 NS NS p < 0·01

Data fulfilled the criterion for parametric testing and analysis was by Chi squared and students T tests.

Despite the low failure rate problems were common. The mean number of problems per resident was 1·6. The problem check list proved fairly exhaustive in identifying problems as perceived by hostel staff. Of the 290 individual problems identified only three fell outside the 12 specific categories of the check list. The problems fell into three main groups: objective behavioural problems; objective illness and the subjective category of interpersonal difficulties. Some of the hostel
staff felt that this latter category merely reflected a summation of the other problems experienced with that resident, and that difficult behaviour might lead to a negative attitude towards the resident. The 68 patients with interpersonal difficulties were examined as a group. No significant difference was found in the number of objective problems identified in this group compared to the overall sample, which supports the view that interpersonal difficulties is a separate issue not related to illness or behaviour problems. It is an umbrella term covering many different problems each of multifactorial aetiology and in this paper it is not treated as a unitary problem, but used to give some indication of the importance of subjective attitudes.

The presence of problems was significantly associated with failure. At least one problem was identified in only 73 per cent of the successful group compared to 100 per cent of the failed group \((p > 0.001)\). There was no significant correlation between the number of problems and the percentage of failure \((r = 0.3445)\). Thus no evidence was found to support the view that the problems identified interact in a cumulative way to influence failure of placement.

Individual problems were identified to determine which of these were associated with failure. Some problems had very low frequencies (drug/alcohol abuse or neurosis) making the results difficult to interpret. Aggression, absconding, psychosis and interpersonal difficulties were significantly associated with failure of placement (Table II).

**TABLE II**

*Failure rates for the specific problems identified*

| Problems                      | No. | Failure rate | This problem stated cause of failure |
|-------------------------------|-----|--------------|-------------------------------------|
| **(1) Behaviour**             |     |              |                                     |
| Inadequate skills             | 50  | 18 NS        | 33                                  |
| Community skills              | 18  | 22 NS        | 25                                  |
| Self-care skills              | 25  | 12 NS        | 33                                  |
| Communication                 | 22  | 14 NS        | 33                                  |
| Self-injury                   | 16  | 31 NS        | 22                                  |
| Absconding                    | 24  | 50 \((p < 0.001)\) | 25                                  |
| Drugs/alcohol                 | 11  | 45 NS        | 60                                  |
| Aggression                    | 45  | 40 \((p < 0.001)\) | 44                                  |
| Dishonesty                    | 40  | 22 NS        | 22                                  |
| Heterosexual promiscuity      | 25  | 36 NS        | 11                                  |
| Homosexual promiscuity        | 15  | 7 NS         | 100                                 |
| **(2) Illness**               |     |              |                                     |
| Physical                      | 34  | 21 NS        | 100                                 |
| Psychosis                     | 16  | 68 \((p < 0.001)\) | 81                                  |
| Neurosis                      | 6   | 50 NS        | 33                                  |
| **(3) Subjective**            |     |              |                                     |
| Interpersonal                 | 68  | 32 \((p < 0.05)\) | 51                                  |
The problems most frequently identified as causing the patient's return to hospital were homosexual promiscuity, drug/alcohol abuse, physical disability and psychosis. The three problems not identified by the check list were single cases of arson, clothes-ripping and anorexia, and only in the case of arson was this the identified cause of failure of placement.

In the original design of the study the date of discharge from hospital was not recorded, but it became apparent through visiting hostels that patients who were discharged from hospital in recent years were much less likely to succeed in the hostel environment. It was thought that this might be due to the increasing difficulty in finding suitable hostel candidates as efforts are made to reduce numbers in the hospital. If this were the case then recruiting candidates from a decreasingly able hospital population would lead to an exponential increase in failure rates with time. The percentage of failures in each hostel was plotted against the logarithm of the number of years that the hostel had been open which produced a significant negative correlation ($r = 0.54$, $p < 0.05$) (Fig). There was a greater negative correlation between the mean number of problems encountered and the logarithm of the age of the hostel ($r = 0.67$, $p < 0.01$).

![Graphs showing correlations](image)

**DISCUSSION**

The demographic results agreed largely with those of the previous survey, the overall failure rate being 23%. Subject variables found to be significantly associated with failure of placement were youth and early institutional upbringing. Surprisingly there was no significant correlation with the number of years spent in hospital. Many years spent in an institutional environment might have been expected to prejudice chances of successful hostel placement, but the results did not support this theory.

Where a patient was forced to return to hospital, in every case the hostel staff were able to identify a problem which led to failure of placement. Twelve common problems were identified as causing concern to the hostel staff. The subjective nature of some of these problems made them difficult to quantify, but the

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presence or absence was recorded for each patient. These twelve problems are comparable to those identified by Challis and Shepherd,7 which were physical condition, social isolation, behaviour disorder and sexual behaviour.

Of the problems identified by the check list, those significantly associated with failure were found to be aggression, absconding, psychosis and interpersonal difficulties. Only in the case of psychosis was the problem frequently identified by staff as the cause of failure. Other commonly identified causes were drug/alcohol abuse, physical disability and homosexual promiscuity. These problems were not significantly associated with failure yet were often identified by hostel staff as the reason for the patient's return to hospital. It may be that these objective and easily observed behaviours are conveniently used to explain failure in patients with multiple problems. Alternatively these problems may all be potential causes of failure which can only be tolerated under certain circumstances, depending on the attitudes of staff and other residents, and the neighbourhood.

More direct evidence of the importance of subjective attitudes can be found in interpersonal difficulties. Understandably this is the commonest problem. Such difficulties are endemic in any form of communal residence. Although this problem was found to be significantly associated with failure, it was very rarely the identified cause. Perhaps the presence of interpersonal difficulties determined the level of tolerance for the other more objective problems identified. It must be emphasised that these are all problems which have arisen in patients who have already been selected as suitable for hostel accommodation. Possibly the process of transfer to the hostel has precipitated the problems, but an alternative explanation is that the problems were already present in hospital, in which case the present selection process has failed to identify them.10

The placement of a mentally handicapped person in a hostel is more analogous to an arranged marriage than to an assessment of capabilities and potential. The interaction between the resident, staff, other residents and neighbourhood is multifactorial and it is difficult to assess objectively. The trial and error approach has the advantage of allowing a mentally handicapped person eventually to settle into a niche which is suitable for him. There are problems however, and the turmoil of changing the environment may precipitate behavioural problems. Repeated failure may demoralise the patient, prejudice staff and lead to resentment of hospital discharge policies by hostel staff. The best method of selection available at present appears to be clinical impression based on a knowledge of both the handicapped person and the range of hostel environments available. This must be based on a careful assessment including individual programme plans, discussion with the patient, the family and the hostel staff.

It has proved more difficult to discharge the established long-stay population than was originally envisaged.4,11 One possible reason is that decreasing levels of problem tolerance in the newer hostels has led to more failed placements. The results of this study would not support this view, but suggests that patients discharged in recent years are posing more problems than those placed in hostels ten years ago. Another possible reason is that the older hostels have become miniature hospitals within the community with a stable population of ageing residents. This would be consistent with the lower failure rates seen in these hostels and with the fact that the successful population had a higher mean age at the time of sampling. These chronic hostel residents, with their higher age and lower failure rate, might be the cause of the higher success rate seen in older hostels.

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A third possible reason for the exponentially increasing rate of problems seen in the newer hostels is that it may be proving increasingly difficult to find suitable hostel candidates from a decreasingly able hospital population. Future study is necessary to elucidate this by studying the problem rates for each hostel one year after opening and the failure rates for each resident in relation to their date of discharge from hospital. Further research is also required into the other factors of the multifactorial equation influencing the success of placement, including size and location of hostel, staffing levels, staff training and day care facilities.

The higher failure rate found in newer hostels is a cause for concern. The methods used at present in the selection of hostel candidates are not always capable of identifying those whose placement will fail. Perhaps the problems which hostel staff identify as causing failure of placement only become obvious in the hostel environment.

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