THE PROBLEM OF COMMUNITY REINTEGRATION OF SUBNORMAL PATIENTS DISCHARGED FROM HOSPITAL

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INTRODUCTION
THE AIM of the Special Care Service in Northern Ireland is to help the mentally subnormal to help themselves to lead useful and contented lives in the community. Scally and MacKay (1964b) found that about one in three patients who were registered as requiring special care were under residential care. At present, approximately the same proportion of over 6,000 patients are in hospitals or institutions. Their rehabilitation poses many problems. One is the establishment of good prognostic indicators which will help hospital personnel to predict the degree of success a discharged patient will enjoy in the community. For a small number of patients, such indices are not required: some severely physically and mentally handicapped patients whose parents cannot or will not look after them at home have a nil probability of release and, therefore, the question of reintegration into society does not arise.

But for many, discharge from hospital is an important event. In subnormality, as in mental illness, there are two related dangers involved in institutionalisation. The first is that of premature discharge when there is the danger that a patient might soon be on the waiting list for re-admission. The second is the fact that prolonged institutionalisation may have deleterious effects on overall intellectual level (Crissay, 1937; Strauss and Kephart, 1939; Lyle, 1959, 1960), on personality (Barton, 1959; Goffman, 1961) and on social competence (Schiphorst, 1968; Elliott, 1969). It would appear, therefore, that there is an optimum length of stay in hospital: if discharge takes place before or after this interval, it might be expected that adjustment to community life would be made more difficult.

Several common-sense assumptions are often made about other factors which might be related to the degree of success or failure in community adjustment (Windle, 1962). These can be briefly stated as follows:

(i) Young people are more flexible and adaptable than older people. Therefore, the young subnormal discharged from hospital is at an advantage.

(ii) The brighter patient has a better chance of success than the comparatively dull person.

(iii) Females discharged from hospital to the community may have fewer stresses to withstand (Harbison, McKay and Weir, 1967) and the probability of their requiring re-admission may be consequently less than that of the male.

(iv) A patient who goes out to employment immediately following discharge is better off than the patient who returns home and then has to search for a job.
(v) A patient who has had a foretaste of community life in terms of "trial leave" has a better idea of the problems facing him and can, therefore, plan more effectively than the patient who is discharged without such leave.

This report describes the post-hospital histories of patients discharged from Muckamore Abbey in 1962 and investigates the relationship between the factors outlined above and community adjustment.

**SUBJECTS, METHOD AND CRITERIA OF SUCCESS**

Nelson (1964) analysed a cohort of 137 subnormal patients discharged from Muckamore Abbey in 1962. He found that the turnover rate for that year was 19 per cent. As this is considerably in excess of the 5.6 per cent estimated by Windle (1962) for United States institutions, we suspected at the outset that there was a danger that the hospital might have employed a "revolving door" policy of discharge in that year. Nelson divided the discharges into four main groups: (i) Hospital planned e.g., improved behaviour (Group HP); (ii) Others e.g., specific request for discharge by parents against medical advice (Group O); (iii) Temporary admissions (Group T) and (iv) Deaths.

Our five year follow-up of this cohort was made possible largely by the structure and policies of the Special Care Service. The administrative, medical and other provisions for the ascertained mentally handicapped (special care patients) in Northern Ireland are very well suited to this type of study. Responsibility for them, irrespective of their age, is vested in the one body and is not divided as in England and Wales. Social workers and doctors are in frequent contact with their patients both in hospital and in the community. Records on patients are extensive and easily available and progress reports on discharged patients are frequently made. For the purposes of this paper, three further terms related to the informal grading of patients should be defined: "low grade" refers to patients with IQ's of less than 20, "medium grade" to those with IQ's 20-49 and "high grade" to those with IQ's over 50. (The latest grading system of the International Classification of Diseases is now used). For more details see Scally and MacKay (1964a) and Nelson (1964).

All the records of discharged patients were examined and social workers were, in certain instances, asked to supply up-to-date information or details over and above routine reports.

Because of the heterogeneity of our cohort (which included patients of all three grades and of ages at discharge ranging from under nine to over fifty), the main problem was how to assess their success or failure in society. The simplest, most objective and most often used definition of success was adopted and defined as "the amount of time spent in the community, out of mental hospitals, special care institutions or prison in the five or so years since discharge". In addition, other factors such as employment, attendance at day centres, reasons for readmission, etc., were examined.

**RESULTS**

A simple five point code was drawn up to relate each patient's success or failure in terms of the amount of time spent in the community in months out of
possible maximum of 64. Of the 127 patients discharged alive in 1962, it was possible in 1968 to obtain records on 124 and full records on 122. In the following tables N's may vary by one or two in release totals because certain types of information were unreliable or because low grade cases have been omitted.

## TABLE I

**Overall success/failure rates of the hospital planned and other discharges, together and separately, according to months in the community.**

| Time (months) in community | H.P. and | H.P.² | O² |
|---------------------------|----------|-------|----|
| Code (1962–67)            |          |       |    |
| I            60–64     | Very successful | 61% (53) | 80% | 58% |
| II           50–59     | Successful       | 10% (9)  | 10% | 20% |
| III          15–49     | Unsuccessful     | 14% (12) | 10% | 22% |
| IV           5–14      | Failures         | 6% (5)   | 10% | 22% |
| V            0–4       |               | 9% (8)   |     |    |

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1Actual numbers in brackets
2Difference between H.P. and O., \( \chi^2 = 4.98, 0.1 > P > 0.05 \).

Table I shows the code and the numbers of patients in the HP and O groups and in both groups combined. (Temporary patients will be discussed later). It will be seen from the second and third columns that we designated those patients who had remained in the community for 60 or more months as 'very successful'; those in the community for 50-59 months as 'successful'; those in the community for fewer than 14 months as 'unsuccessful' and those who had spent fewer than four months as 'failures'. According to these criteria, 71 per cent of both groups were either successful or very successful. Fifteen per cent were either unsuccessful or outright failures. Surprisingly, the difference between the two groups in terms of outcome is not significant although the HP group tended to fare better. Because of this insignificant difference the HP and O groups will now be combined.

We next examined the common sense assumptions about the relationships between the factors mentioned earlier in this paper (age, grade, etc.) and outcome. Table II gives a summary of the results.

It will be seen that age, sex, or grade of patient was not related to outcome. Patients who went out to residential or daily employment and lived in the community fared significantly better than others. The employment officers of the service carry out an intensive follow-up programme with patients newly placed in jobs (J. Erwin, personal communication, 1970). Further, those who had a foretaste of community life in the form of trial leave also did well. Length of hospitalisation was also related to outcome, but in a most peculiar way. Patients in codes I and II
TABLE II

Summary of the relationship between possible prognostic indicators and outcome.

| Variables                             | 
|---------------------------------------|
| Grade                                 | N.S. |
| Sex                                   | N.S. |
| Age                                   | N.S. |
| Length of hospitalisation             | P<0.001 |
| Trial leave                           | P<0.2>0.1 |
| Discharge reasons specific            | P.<0.01 |

(successful) and in codes IV and V (unsuccessful) had been hospitalised, on the average, for very nearly the same lengths of time (24 months), while those in codes III had a mean hospitalisation period of approximately nine months. Few of the discharged patients were assured of employment immediately after leaving hospital. But many were found jobs by the employment officers of the Special Care Service, or found jobs for themselves, at some time during the five year period. We were interested in how the members of the cohort were occupied in this period. Thirty-eight in the HP and O groups were gainfully employed and 47 attended day centres, or spent their time in other ways. Forty-five per cent of the patients were gainfully employed at some time during the five years. The number of jobs held by individuals ranged from one to eleven, with a median of 2.5 in the H.P. group and a median of 1.5 in the O group.

Of greater interest than the mere number of jobs held is the length of time spent continuously in one form or other of employment. Fifteen were so employed for less than one year and 22, or 60 per cent, held their longest job for a year or more.

The next obvious step was to determine whether success or failure in terms of the five point code was related to employment. Table III shows the number of patients in each of the five categories who were employed. The difference between those in codes I and II and the rest is significant (p<0.02).

TABLE III

Numbers of patients employed in success/failure categories.

| Success/Failure | Total | Employed |
|-----------------|-------|----------|
| I               | 53    | 28\(^1\) |
| II              | 9     | 4\(\) |
| III             | 12    | 3        |
| IV              | 5     | 1        |
| V               | 8     | 1        |

\(^1\)Codes I and II employed versus the rest, \(\chi^2=6.05, P<0.02.\)
The types of jobs held by these patients were quite varied. Over two-thirds (71 per cent) held by the male patients in both the HP and O groups involved outdoor work and of these the commonest was labouring. All the female patients in both groups had indoor jobs, factory work and domestic employment being the commonest. Of the fully documented cases relating to the cessation of employment, it was found that half of the jobs were terminated for reasons connected with the patients' demeanour, standard of work, etc., and half for reasons unconnected with the patients' ability or behaviour (e.g., redundancy, seasonal work).

The third large group within the cohort comprised patients who had been in the hospital on a purely temporary basis. Nearly half had been admitted in order to enable their parents to have a holiday. The rest were admitted for miscellaneous reasons such as dental treatment, relief in times of crisis in the home and so on. During the following five year period many were re-admitted for the same kinds of reason. But, at the end of the five years, it was noted with some concern that 43 per cent of these temporary admissions were now under permanent residential care.

The finality implicit in the concept of permanent residential care is worth examining. In this context, and in the case of individuals, it is defined as a nil or negligible probability of release except by death. So large was the number of temporary cases who changed to permanent residents over the five year period that we attempted to determine how many patients in the HP, O and T groups now required, or presented overwhelming evidence for shortly requiring, permanent hospitalisation.

| Success/Failure Code | Patients now requiring permanent hospital care |
|----------------------|-----------------------------------------------|
| I                    | 4                                             |
| II                   | 5                                             |
| III                  | 11                                            |
| IV                   | 8                                             |
| V                    | 8                                             |

It will be seen from Table IV that 36 patients from all groups fall into this category. This represents 29 per cent of the total cohort discharged over five years ago. It will also be seen from the Table that those individuals who now require, or will shortly require, permanent residential care do not necessarily come from the unsuccessful codes IV and V although there are proportionately more in these categories than in I and II.
DISCUSSION

The findings of this survey can be briefly recapitulated. Nearly three-quarters of the patients discharged in the HP and O groups from Muckamore Abbey over five years ago have been successful in that they have managed to stay out of any type of statutory residential units (mental or special care hospital, prison, etc.) for at least 75 per cent of the time since release. Fifteen per cent have been adjudged unsuccessful in that they have experienced considerable periods of rehospitalisation or imprisonment. The possibility (mentioned in the introduction) that this hospital was operating a revolving door policy for all patients, is not upheld by the evidence. Neither the grade nor the sex nor the age of the patient at discharge was related to outcome. But the factors of length of hospitalisation, trial leave and specific reasons for discharge were related to outcome. Nearly half of all the patients were gainfully employed at some time during the period since discharge and, of these, 60 per cent held their longest job for a year or more. Further, those who experienced employment were more likely to be successful than those who did not. Perhaps the most disturbing finding was that 29 per cent of the cohort now require, or will shortly require, permanent residential care.

This discussion will take as its starting point the fact that, in terms of the original criterion of success/failure, 71 per cent of the discharged patients in the HP and O groups have been adjudged as successful. As was mentioned earlier, this evidence does not support the view that the hospital allowed for premature discharges. And yet it is paradoxical that, despite this overall success, twenty nine per cent of all patients in all three groups now require, or will shortly need, permanent hospital care.

As far as patients in the T group are concerned, the commonest reason for permanent re-admission is not difficult to find. The patients become too awkward behaviourally, or too awkward as nursing problems, for ageing parents to cope with and the only resort is hospitalisation. If a similar situation holds for the HP and O groups, then a rather interesting point emerges: it is highly likely that we have not so much established the success or failure of a few of the patients themselves but have instead indirectly estimated the abilities of the parents and relatives to keep them in the community.

If the success of a few of the younger patients in the community depends to some extent on the parents’ or relatives’ ability to supervise them, then it follows that an unknown number of the current cohort who are still in society may at some future date require permanent institutionalisation. In some cases this will mean permanent residential care at one of the three special care hospitals in Northern Ireland. It is highly likely in other cases the two hostels at present acting as “half-way houses” between hospital and community will cater for those patients who can still hold down a job but require the minimum of supervision hitherto provided by the parents. But a serious situation may arise for both hospital personnel and the patients themselves if the pattern of events we have described repeats itself for all discharge cohorts. That is to say, if approximately one third or more of all patients discharged annually from hospital eventually require permanent hostel or hospital care, then the present waiting lists for admission to these units will
increase alarmingly. It is, therefore, essential that the patients in the present three groups of discharges be followed up over the next few years to determine
(a) how many eventually find their way into residential units,
(b) how many survive in the community when the family "props" have fallen away,
(c) how many will continue to work in the community but live in hostels.
In this way it will be possible to gauge more accurately the likely re-admission rate of discharged patients. The future provision of special care "family" homes will, of course, affect hospital accommodation demands.

Allowing for this fact of eventual and permanent institutionalisation, it is clear nevertheless that many patients get on well in the community and that some survive even when their parents die and family supervision ceases. The popular view that subnormals cannot be employed or, at best, that they are shiftless and move from one job to another is not substantiated by the evidence of this survey. Although the largest number of jobs held by any individual in the HP and O groups was eleven, the number of jobs held by most patients fluctuated between one and four. In fact, this job record is remarkable in view of the high unemployment rates in the province.

Thus far, the patients in the groups have been treated as numbers. It would be of interest to give three examples of the type of patient in our sample: one "successful" patient (code I) from the HP group, one from the T group, one "unsuccessful" patient (code IV).

_A successful patient_: A male, epileptic, high grade, born April, 1950, the third in a family of five. Referred to the Special Care Service at the age of 16, the main reason, apart from suspected subnormality of intelligence, being his uncontrollable temper. At the time of his ascertainment, both parents had been attacked with various implements, including a knife and they were anxious to have him institutionalised immediately. Following declaration he was admitted to a Special Care Hospital where he remained for exactly one year. While on leave to his home in May, 1958, he obtained employment as a labourer in an abattoir and refused to return to residential care. The parents reported that he behaved well and that "he had changed completely". Three months later he was declared redundant and commenced stool-making at home. However, his behaviour deteriorated and his family were again subjected to physical abuse. He was admitted to Muckamore Abbey in 1959 where, apart from one unsuccessful attempt to reintegrate into community life, he remained until 1962. He was finally discharged from hospital early in 1962 and has never had to be re-admitted. His behaviour over the follow-up period has fluctuated but has never reached previous lengths. He has been employed in several jobs and his behaviour appears to be at its best when he is fully occupied.

_A "temporary" patient_: A female, high grade, spastic diplegia, born 1945, declared a person requiring special care at the age of 16. She was difficult to control at home because of marked emotional immaturity. A year later (1962) she was admitted to Muckamore Abbey on a temporary basis in order to allow her parents to have a holiday. Five months later she was re-admitted to hospital because of her increasingly bad behaviour at home and she has stayed there ever since with only occasional weekend leave. She is never likely to return to the community on a permanent basis.

_An "unsuccessful" patient_: A male, epileptic, high grade, born August, 1936, the only child in the family. Referred to the Service by his practitioner. He is slightly deaf and had spent some time in an institution for the deaf and dumb where he had learned simple crafts. At the time of his referral he was described as a well-mannered, clean boy and the
main problem concerned his future training. However, a year later, while living with relatives, he became obstreperous and his employment record deteriorated to the point where he lasted only a few days in any job. In 1953 he was admitted to Tower Hill Special Care Hospital in Armagh and this marked the beginning of constant moves between hospital, prison and the community. He can be violent at times and, when at home, often terrorises his relatives. He has absconded from hospital several times and on more than one occasion has had to be escorted back from England. He has also been imprisoned, usually on charges of larceny. His record of misdemeanours is too long to give in detail. It is highly unlikely that he will ever experience an appreciably lengthy and unbroken period of community life.

A further follow-up study is planned with the same cohort and attempts will be made to determine whether differences in community reintegration are reflected by differences in personality factors. Such surveys are essential for the establishment of prognostic indicators in the rehabilitation programmes for the mentally abnormal.

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REFERENCES

BARTON, R. (1959). Institutional Neuroses. Bristol: Wright.

CRISSEY, O. L. (1937). Child Develpm., 8, 217.

ELLIOTT, M. E. R. (1969). An investigation of the social competence of normal and subnormal children living under different types of residential care. Unpublished B. A. Thesis, The Queen's University of Belfast.

GOFFMAN, E. (1961). Asylums. Essays on the Social Situations of Mental Patients and Other Inmates. London: Pelican Books.

HARBISON, J. J. M., MACKAY, D. N. and WEIR, T. W. H. (1967). Irish J. med. Sci., 501, 421.

LYLE, J. G. (1959) J.ment.Defic.Res., 3, 122.

LYLE, J. G. (1960). J.ment.Defic.Res., 4, 1.

NELSON, W. McC. (1964). Acta psychiat.Scand., 40, 50.

SCALLY, B. G. and MACKAY, D. N. (1964a). Irish J. med.Sci., 6, 267

SCALLY, B. G. and MACKAY, D. N. (1964b). Acta psychiat.Scand., 40, 203.

SCHIPSHORST, B. (1968). Spec.Educ., 57, 26.

STRAUSS, A. A. and KEPHART, N. C. (1939). Amer.Assoc.ment.Def., 44, 137.

WINDLE, C. (1962). Amer.J.Ment.Defic., 66, Monogr. Supp., Whole No. 5.