

II. MENTALLY HANDICAPPED ADULTS RETURNED TO LARGE INSTITUTIONS AFTER TRANSFERS TO NEW SMALL UNITS

HEATHER HEMMING
University College of Swansea (South Wales)¹

INTRODUCTION

In Britain, recommendations for change in social policy concerning mentally handicapped people have included reduction in institution size. The White Paper 'Better Services for the Mentally Handicapped' (1971) recommended halving the number of hospital places for mentally handicapped people by increasing local authority residential places. The Jay report (1979) recommended that mentally handicapped adults should have residential provision in or near the social and geographical communities in which they had spent their childhood or early adult years. Recently, the Green Paper 'Care in the Community' (1981) suggested that hospitals for mentally handicapped people should be run down and community services built up. The feasibility of each district providing for all its mentally handicapped adults in small facilities without a large established hospital has not been empirically tested. The Jay report recognises that special problems may occur in small local facilities and suggests that:—

"... Certain mentally handicapped people have a temporary or permanent need for specialised skills because of the nature of their handicap."

Jay, 1979, p. 97, para. 258

At present, specialised skills for containing or ameliorating maladaptive behaviour are concentrated in traditional mental handicap institutions. Transferring these skills to specialised units in the community may be harmful to residents in so far as it prevents easy transfer to a less restrictive environment.

This paper is primarily concerned with mentally handicapped adults who were transferred from large institutions to new small units and were subsequently returned to their large institution. Two aspects are examined:— 1) whether the return could have been predicted before and 2) why the returnees were returned and what happened to them.

A number of studies suggest that return to a large institution after transfer to new small facilities is associated with behaviour problems (Windle, Stewart & Brown, 1967). In general, return is associated with behaviour problems similar to those characteristic of institutionalised mentally handicapped adults within the same ability range. Eymann & Call (1977) found that the most frequent problem among severely handicapped adults in large institutions was 'Stereotyped Behaviour' but other common problems included physical violence to others, property damage, rebellious behaviour, self-violence and hyperactivity. Older, more moderately handicapped institutionalised adults were more likely to use profane language, be rebellious and untrustworthy as well as indulging in physical violence.

Cohen, Conroy, Frazer, Snelbecker & Sprent (1977) found that transfer of institutionalised mentally handicapped adults from large institutions to small facilities increased behaviour problems and decreased adaptive behaviour. It could thus be argued that studies comparing behaviour of residents returned from small facilities to

¹ Present Address:—Paisley College of Technology, High Street, Paisley PA1 2BE, Renfrewshire, Scotland.

their large parent institutions with residents remaining in the small facility after their return, are measuring the effects of transfer and return. However, Cohen et al's results were based on short time periods of 1 to 2 weeks and 6 to 8 weeks after transfer to the small facility. The present study is concerned with a considerably longer time period on the new small units before the majority of the returnees were returned to their parent institution. It also considers behaviour in the large parent institution after return.

Research reviewed indicates that small facilities have had to return some mentally handicapped adults to their parent institutions. This suggests that certain types of small facility may be inappropriate for some mentally handicapped adults. Furthermore, transfer and subsequent return may have adverse effects on the people concerned.

This study investigates the hypotheses that:— 1) return of mentally handicapped adults from new small units after transfer from a large institution can be predicted before transfer, 2) disturbing and aggressive incidents recorded on the units are associated with return, and 3) returnees are adversely affected by transfer and subsequent return compared with remainers and matched controls not transferred.

METHOD

Design

The study falls into two sections:—

- 1) Predictors of return
Returnees and remainers compared on measures taken before transfer.
- 2) History of behaviour
 - a) Disturbance on the units from returnees and remainers. Reasons for return.
 - b) Changes in behaviour
 - i) Returnees compared with remainers
 - ii) Returnees compared with matched controls not transferred from their institutions.
 - iii) Case histories of returnees.
 - iv) Case histories of remainers with high disturbance scores on the units in the returnee range.

Subjects

This study was part of a wider project evaluating new small units for mentally handicapped adults in the Swansea area. The total sample consisted of the first 51 mentally handicapped adults transferred from large institutions in the South Wales

TABLE 1
Demographic data for returnees and remainers

	Returnees		Remainers		
	Male	Female	Male	Female	
Sex	10	1	27	10	Chi-squared=1.5 NS
Age	Mean	35	41.4		
	SD	12.8	14.9		t=1.28 NS
Number of institutional years.					
	Mean	20.0	20.9		
	SD	11.4	10.5		t=.25 NS
IQ Untestable		5		13	
Off WAIS		3		5	
On WAIS		3		19	Chi-squared=2.13 NS

area to new small units near Swansea. Before transfer, the sample was individually matched with controls remaining in the large institution. There was a deliberate policy to transfer as representative a sample of institutionalized mentally handicapped adults as possible. Selection was based on proximity of next of kin's residence to the units. The majority of the total sample were classified as severely subnormal with a range of dependency as wide as the total institutionalised population of mentally handicapped adults in South Wales. Residents were transferred at different times with the majority being transferred within the first year after the units opened. During the course of the research project, 11 of these residents were returned permanently to the large institution (three were excluded from the sample since they were returned to the large institution on a temporary basis.) Time spent in the bungalows varied from 2 weeks to over a year for permanent returnees. Returnees and remainers did not differ significantly for sex, age, number of institutional years or IQ. (Table 1)

Institutions

The sample was transferred from 7 institutions for mentally handicapped adults run on traditional nursing lines. The majority (41) were from one large institution (566 beds) set in extensive grounds well away from main residential areas. 10 of the 11 returnees were returned to this hospital. Two other large institutions (524 and 492 beds) each transferred 2 residents. Two smaller institutions (97 and 64 beds) transferred 2 residents each. While two other similar institutions (27 and 60 beds) transferred one resident. The four largest institutions were divided into wards ranging from 17 to 51 patients. Other institutions consisted of one living unit. Nursing staff were provided with an office separate from the wards but allowing supervision and monitoring of access.

There were two new units, each built in hospital grounds with no independent street frontage. One hospital was a small General Hospital and the other a traditional hospital for mentally handicapped women. One resident was transferred from the latter hospital to a bungalow in its grounds. All other residents were transferred from hospitals in different districts. One unit had 4 bungalows and the other unit had 3 bungalows. Each bungalow was built for 8 residents. Sex, age and ability level were mixed and the aim was to achieve as homelike accommodation as possible. The bungalows were designed to be like the type of building currently erected by the better housing authorities in the United Kingdom but suitable for non-ambulant people in wheelchairs. The only provision for staff was a small toilet/cloakroom in each bungalow. Each unit had a separate building for occupational therapy and recreation. Units were managed by a co-ordinator and two deputy co-ordinators with nurse training. Direct care staff were "care assistants" without nurse training who were to act as substitute parents. Each shift had one care assistant per bungalow and the shift overlap was from 1.30 to 3.30 p.m. Night cover was provided by medically trained nurses.

Measures and Procedure

1) Predictors of return

- a) Ward staff's prediction of return and possible behaviour problems obtained from interviews before transfer.
- b) The AAMD's Adaptive Behaviour Scale (ABS) (1974) revision with British amendments and direct testing recommended and standardised by Thomas (1974) was used to assess behaviour. This scale was considered the most comprehensive standardised scale available and had been used in comparable previous studies. This scale evaluates both adaptive and maladaptive behaviour. Part I measures 10 personal functioning domains while Part II measures 13 categories of personal and social maladaptation. Scoring on ABS Part II was modified to increase reliability. One or more statements checked in any one item were scored as 1. Item scores were then summed to give category scores.

- c) The ABS medication scale was too gross to assess differences in prescription of the same drug type. Medication was noted on the ABS form from current prescription. Analysis was confined to psychoactive drugs.

The ABS was completed before transfer and at intervals of 4 months, 9 months, one year and 2 years after transfer for unit residents and their matched controls remaining in large institutions as part of the main study. ABS's were also completed for returnees 4 months after return and for returnees and their matched controls one year after return.

2) History of behaviour

- a) Disturbance on the bungalows was assessed from number of problem incidents recorded by care staff in the day report book for residents transferred within the first year (n=45). Three sub-categories of aggressive incidents were noted:— aggression towards objects, aggression against staff and aggression against other residents.
- b) The ABS was used to assess changes in behaviour over time for:—
- i) Returnees and remainers
 - ii) Returnees and their matched controls remaining in the large institution.
- c) Individual case studies of returnees were obtained from interviews with staff and researcher's observations before transfer, while on the units and at least one year after their return to large institutions.
- d) Individual case studies of high disturbance remainers were obtained from interviews with staff and researcher's observations before transfer and on the units.

RESULTS

1) Prediction of return

- a) Charge nurse/ward sisters' assessment of suitability for the units. Returnees and remainers were classified into three categories:— suitable, doubtful and unsuitable. Table 2 lists the frequencies for returnees and remainers in each category.

The 2 returnees classified as suitable were David and John (Table 4) David was classified as suitable from the charge nurse's answer of:— "Very well, I think". Problems were said to be a little aggression towards people and objects. John was classified as suitable by one of the male charge nurses in his original institution, before he had started to display behaviour problems which resulted in his transfer to large institution, prior to unit transfer.

The one resident classified as unsuitable but who remained on the unit was Alun (Table 5). Behaviour problems were reported, but they could be contained.

The charge nurse/ward sister's prediction of suitability/unsuitability was significant at the .01 level provided a doubtful category was allowed.

TABLE 2
Returnees and remainers according to staff prediction of suitability

	Returnees	Remainers
Suitable	2	24
Doubtful	6	7
Unsuitable	3	1

Chi-squared=12.41 p<.01

- b) ABS assessment before transfer.

There were no significant differences between returnees and remainers for total ABS Part I scores. The mean total ABS score for all 51 transferred

residents was used to classify them into higher and lower ability groups. There were 3 higher ability and 8 lower ability returnees. The higher ability group were thus too small to make meaningful statistical comparisons. Lower ability returnees displayed significantly more "Rebellious Behaviour" ($p < .01$) "Untrustworthy Behaviour" ($p .05$) and total maladaptive behaviour ($p < .05$) than remainers.

c) Medication.

Psycho-active drugs were classified into four types:— Anti-psychotic, anti-anxiety, anti-convulsant and anti-depressant. Significantly more returnees were taking anti-psychotic drugs before transfer than remainers. ($p < .01$) There was also a non-significant trend for fewer returnees to be taking anti-anxiety drugs than remainers ($p < .1$).

d) A combined prediction index of return.

Ward staff prediction and anti-psychotic drug prescription were combined by assigning values to each type of prediction and summing them. Staff opinions were given the following values:— Suitable=0, Doubtful=1, Unsuitable=2. Anti-psychotic drug prescription was given the value 1 and no anti-psychotic drug prescription the value 0. This gave an 83.7% prediction for the whole sample ($p < .001$).

The best predictor of returning or remaining on the units after transfer is the combined index of ward staff's prediction and prescription of anti-psychotic drugs. Ward staff prediction alone omits about a third of the sample, while use of high "Rebellious Behaviour" scores is confined to lower ability residents. Lower ability high scoring on ABS "Rebellious Behaviour" did not increase prediction, since all high scoring, lower ability returnees were considered unsuitable and were prescribed anti-psychotic drugs.

2) History of behaviour

a) Disturbance on the units from returnees and remainers.

Disturbance was quantified by counting the number of disturbing incidents recorded in the day report books kept on each bungalow during the first year, or for the duration of resident's stay if this was less than one year. The measure used was average weekly disturbance score. A higher disturbance score is associated with a significantly greater likelihood of return. The analysis of ability level shows that within each ability group high disturbance scores are associated with return. However, higher ability residents have a considerably lower disturbance score than lower ability residents (Table 3).

TABLE 3

Average weekly disturbance scores in returnees and remainers

	<i>Returnees</i>		<i>Remainers</i>		U.	p. (2 tailed)
	Mean	SD	Mean	SD		
Total sample (n-11, 32)	3.83	2.03	.38	.96	28	.001
Higher ability (n-3, 18)	1.78	.88	.35	.32	3	.02
Lower ability (n-8, 14)	4.60	1.80	1.15	1.37	7	.001

Disturbing incidents involving aggression were classified into: Aggression towards objects, aggression towards staff and aggression towards other residents. All sub-categories of aggression differentiated returnees from remainers significantly and aggression towards staff ($p < .001$) and aggression towards other residents ($p < .001$) were both significantly better discriminators than aggression towards objects.

($p < .002$) Results by ability level suggest a trend for higher ability returnees to have more aggression towards staff than higher ability remainers. However, there were only 3 higher ability returnees and one of these had a sufficiently high level of aggression towards staff to account for this trend. Lower ability returnees differed significantly from lower ability remainers on aggression towards other residents ($p < .002$) and aggression towards staff ($p < .05$). Disturbance data were examined for evidence of any consistent pattern prior to return. This analysis was confined to 7 returnees, 2 returnees did not remain long enough in the unit to allow comparisons over any time period. 2 returnees stayed for more than one year on the units. Disturbance measures were confined to the first year on the units, hence the latter 2 returnees had no pre-return disturbance measures. Average weekly disturbance was compared for the first 3 weeks after transfer to the units, 3 weeks before the first assessment and 3 weeks before return. A similar analysis was performed for the different subcategories of aggression and total aggressive incidents. There was a non-significant trend for disturbance to decline after the first 3 weeks and a significant increase ($p < .02$) in disturbance 3 weeks before return compared with a standard time period. Means for aggressive incidents only suggests a similar non-significant trend for aggression to increase before return.

Remainers had no significant changes in disturbing incidents between the first 3 weeks and 3 weeks before the first assessment or between the first 3 weeks and 3 weeks before the one year assessment.

b) Changes in behaviour.

(i) Returnees compared with remainers.

The ABS was used to compare changes in adaptive and maladaptive behaviour between transfer and 4 months after transfer for the 9 returnees who stayed a minimum of 4 months in the bungalows and remainers. ABS Part I was totalled excluding "Vocational Activity" since this scale depended on facilities available at the time. ABS Part II item scores were totalled to give an overall maladaptive behaviour score.

Remainers had a significant ($p < .02$) increase in adaptive behaviour while returnees had a non-significant trend to increase. When changes in returnees were compared with changes in remainers, the difference was not significant. Maladaptive behaviour had a non-significant trend to increase in remainers but maintained its high level in returnees. Changes in maladaptive behaviour did not differ significantly in returnees and remainers.

(ii) Returnees compared with matched controls not transferred from their institutions.

The duration of time spent on the units varied from 2 weeks to over one year for returnees. The longer duration returnees had more time to benefit from the new environment than the shorter term returnees. To control for this variation in length of stay, the ABS assessment taken immediately prior to return was compared with the pre-transfer assessment for returnees and their controls. The comparison sample was confined to the 9 returnees who had stayed more than 4 months in the unit.

There was a non-significant trend for returnees to increase adaptive behaviour between transfer and return, while the same trend in controls reached significance. Changes in returnees and controls did not differ significantly. There were no significant changes in maladaptive behaviour of returnees or controls.

Returnees and controls were followed up after their return to the large institutions. 9 returnees were rated on the ABS 4 months after return, while the total 11 returnees and their controls were rated on the ABS one year after return. The effect of transfer and subsequent return was evaluated by comparing the ABS assessments 4 months and one year after return with the pre-transfer assessment. Changes in returnees

between transfer and one year after return were compared with changes in their controls over the equivalent time interval to evaluate the effect of the moves. There were no differences in adaptive behaviour before transfer to the units and after return to their large institutions. However, there was a non-significant trend for increases in adaptive behaviour on the units to decline 4 months after return. One year after return adaptive behaviour had increased significantly compared with the pre-transfer assessment. Controls displayed a similar gain which did not quite reach significance. There were no differences between returnees and controls over this same period. Maladaptive behaviour did not change significantly but there was a non-significant trend for a decline between transfer and one year after return. This change did not differ significantly from changes in controls. However, one maladaptive behaviour category, 'Withdrawal' did have a non-significant trend to decrease during this time interval ($t=2.9$, $p<.1$). When this change was compared with changes in controls, the difference in decreasing 'Withdrawal' reached significance ($t=2.52$, $p<.05$).

(iii) Case histories of returnees.

Returnees' case histories are summarised in Table 4. They were obtained from three sources:—

a) Pre-transfer interviews with residents and their charge nurses/ward sisters, b) interviews and meetings with bungalow staff and consultants, together with records from day report books and c) a follow up interview with hospital staff responsible for returnees at least one year after return. This was supplemented by returnees' report cards. Hospital wards did not keep day books in the same manner as the bungalows, so disturbance scores could not be directly compared between hospitals and bungalows. However, hospitals did record extreme incidents of disturbance.

The case histories do suggest that in at least 7 cases (Blodwen, Hefin, Dai, Myryon, Colin, David and Barry), transfer and subsequent return were associated with substantial deterioration in behaviour. This deterioration was mitigated to some degree a year or more after return to the parent hospital. At the time of final interviewing, at least three cases (Blodwen, Wyn and Barry) seemed to be considerably worse than they were before transfer. Five cases (Hefin, Dai, David, Myryon and Colin) had required extensive work by hospital staff to produce a tolerable level of behaviour. Three of these cases (Hefin, David and Myryon) appeared to have behaviour problems, emerging either after transfer or after return, which had not declined to their reported pre-transfer level at the time of final interview. In sum, these case histories indicate possible harmful effects of transferring an unsuitable mentally handicapped adult from a large institution to a new small unit and back to the large institution.

(iv) Case histories of remainers with disturbance scores in the returnees' range for higher (.56 to 2.58) and lower (2.61 to 8.0) ability residents are summarized in Table 5. They were obtained from:—

(a) Pre-transfer interviews with residents and their charge nurses/ward sisters and (b) interviews and meetings with bungalow staff and consultants, together with records from day report books. High disturbance remainers were equally distributed between the two units, one higher ability and two lower ability remainers in each unit.

These case histories of high disturbance remainers indicate some of the problems that the new small units could manage. Behaviour problems of higher ability residents could be regarded as a function of the smaller bungalow environment compared with large hospital wards and their surroundings. Incessant chatter from Martin was dispersed between more staff and patients in the large hospital than in the bungalows and hence regarded as less of a problem in the large hospital. Gill's relationship with a female care assistant followed a similar pattern previously reported in the large hospital. However, the large hospital had not moved her or the female staff members involved from the ward. Her victimization in the bungalows had no parallel in the large

hospital. This may have been prevented in the large hospital by her particular friendship with a resident similar to herself. In the bungalows, she had little choice of friendship and no particular resident friend. Behaviour problems with lower ability residents all included aggression, either towards staff, others or objects. In general, these residents could be regarded as displaying more activity, both adaptive and maladaptive, in the bungalows than in their large hospital wards. Adaptive behaviour tended to improve when staff followed consistent behaviour modification programmes but declined when these programmes were abandoned. Behaviour problems required continuous staff attention for their control, withdrawal of this attention resulted in almost immediate regression to previous levels. In sum, a small number of highly disturbing residents could be contained in each unit. Neither higher ability residents appeared to benefit from transfer. Behaviour problems of lower ability residents seemed to be more prevalent after transfer but the intermittent improvements in adaptive behaviour suggest that these residents could derive some benefit from transfer.

DISCUSSION

(a) Predictors of return

The best predictor of subsequent return after transfer from a large institution to new small units was the combined index of charge nurse/ward sister's opinion of suitability and prescription of anti-psychotic drugs. This index was superior to any of the standardized measures obtained from the ABS. As indicated by Eyman & Call (1977), type of behaviour problem differed with ability level. The sample of three higher ability returnees was too small to allow any statistical inferences to be drawn. ABS, Part II administered before transfer, discriminated lower ability returnees from lower ability remainers on "Rebellious Behaviour", "Untrustworthy Behaviour" and total ABS Part II scores. "Rebellious Behaviour" consists mainly of items which indicate that staff have difficulty in controlling the resident. Hence, residents who were management problems in large institutions were less likely to be managed on the units than those who presented few or no management problems in the large institutions. "Untrustworthy Behaviour", while apparent in large institutions, was less of a problem there than in the units. In the large institutions, few residents had any private property. Those residents who did have a few possessions, carried them around in pockets or bags and defended them from other residents. In contrast, the units actively encouraged residents to keep private property, have individualized clothing and manage their own money. This situation meant that much more distress was caused in residents who, for the first time in many years, had been given personal belongings and money and then lost them through pilfering from other residents.

Total ABS Part II item scores did discriminate lower ability returnees from remainers. This suggests that it is the overall pattern of problem behaviour, rather than number of problems within any category, which is important for assessing a resident's return from the units. This notion is substantiated by the accuracy of the charge nurse/ward sister's prediction. This prediction is able to take the total personality pattern into account, together with possible reactions to a new environment. The ABS measurement of individual problem categories fails to consider interactions between type of problem and environment.

Prediction based on current prescription of anti-psychotic drugs can also be regarded as an overall assessment of problem behaviour. These drugs seem to be prescribed for any behaviour problem which staff find difficult to control by other means. It is possible, that by trial and error, over many institutional years, a manageable balance between drugs and behaviour within the large institution had been achieved but when the resident was transferred to a new environment, this balance was upset and previously controlled behaviour problems re-emerged at too high a level to be contained within the units.

(b) Disturbing and aggressive incidents on the units

Analysis of disturbance scores on the units confirmed that residents involved in most disturbance (i.e. incidents considered serious enough to report) were those most likely to be returned. Like, Eyman & Call, who found a relationship between severity of handicap and presence of a behaviour problem, there were more disturbing incidents reported for lower ability residents. Within ability levels, return was associated with a greater number of disturbing incidents. Aggressive incidents also discriminated returnees from remainers but this measure was not as significant as disturbing incidents. Comparison of disturbance and aggression in the first 3 weeks, a 3 week period after residents had had a chance to settle down and 3 weeks before return, indicated a non-significant trend for disturbance to decline after the initial 3 weeks and to increase significantly in the 3 weeks prior to return. Aggressive incidents had a similar but non-significant trend. This indicates that behaviour problems increased to a high level immediately prior to return and may have precipitated return.

(c) Effect of transfer and subsequent return

ABS scales did not indicate that returnees were adversely affected by transfer from large institutions to new small units compared with either remainers or matched controls not transferred. However, there was a trend suggesting an adverse effect on adaptive behaviour 4 months after return to their large institutions. One year after return this effect was no longer apparent. Unlike Cohen et al's study, ABS Part II scores had little change between transfer and return and 4 months after return. One year after return there were indications that maladaptive behaviour had declined, in particular "Withdrawal" declined significantly compared with controls over the same time period. Case histories of returnees do indicate that return to the large institution was associated with substantial deterioration in behaviour compared with pre-transfer behaviour. However, return to the large institution alone need not have been responsible for behaviour problems displayed, since disturbance scores were significantly higher 3 weeks prior to return than in a standard 3 week period on the units. One must thus conclude that it was the combination of becoming uncontrollable on the units, followed by return to the large institution, rather than return alone, which was associated with deterioration in behaviour between transfer and 4 months after return.

(d) Recommendations

It is clear from the results that it is vitally important to consult charge nurses/ward sister before residents are transferred and that the ABS is unnecessary provided anti-psychotic drug prescription is taken into account. The deterioration in returnees' behaviour prior to and after return indicates that it is more humane to have a policy of selectivity before transfer. Selectivity inevitably leads to a system of creaming off better residents from large institutions unless "specialised homes" are set up in the community. Both institutions catering only for the most disturbed and "specialised homes" would tend to be unnecessarily restrictive. Only 2 of the 11 returnees were returned to a locked ward designed for close supervision and intensive treatment of behaviour problems. This could be regarded as equivalent to a "specialised home". One returnee required permanent care on this ward, while the other was soon transferred to an ordinary ward. All other returnees went back to ordinary wards with freedom to use institutional leisure resources. Hence, running down institutions for mentally handicapped people and building up community services, as recommended by DHSS (1981), would tend to be detrimental to the most disturbed mentally handicapped residents.

Number of disturbing incidents did discriminate returnees from remainers but a few remainers had disturbance scores within the returnee range for their ability level.

TABLE 4
Summary of Returnees' Case Histories
Behaviour

<i>Behaviour</i>	
<i>Before Transfer</i>	<i>On Units</i>
<p><i>Description</i></p> <p>Gwil Age=50 No. I.=20 I.Q.=54 T.U.=5 weeks</p>	<p><i>After Return</i></p> <p>Refused to work, preferring to go to bed. Complained of stomach pain. Became withdrawn but later began to help around the ward.</p>
<p>Dai Age=28 No. I.=17 I.Q.<41 T.U.=8 months</p>	<p>Put on a locked ward at first but soon transferred to a high dependency ward. There he was physically aggressive towards himself and female staff. Later transferred to a low dependency ward and displayed less aggression but pestered female staff.</p>
<p>Barry Age=29 No. I.=7 I.Q.=45 T.U.=1 year</p>	<p>Stable periods, interspersed with running away from work. Absconded 4 times during first year after return. Suspected of setting a barn on fire. Petty pilfering and smoking in bed continued.</p>
<p>David Age=25 No. I.=14 I.Q.<40 T.U.=3 weeks</p>	<p>Obstreperous and unco-operative. Aggressive towards other patients. Bad temper tantrums. Would only be fed by Charge nurse. Mother did not interfere on ward since visitors were encouraged to see patients off the wards.</p>
<p>Unco-operative, verbally aggressive towards others. Returned at own request.</p>	<p>Hyperactive. Physically aggressive towards staff and objects.</p>
<p>Hyperactive. Violent when frustrated.</p>	<p>Few problems reported in first 9 months, except petty pilfering and smoking in bed. This behaviour increased with unco-operativeness. Discovery of his hoard of transistor radios led him to abscond.</p>
<p>Normally affable. Periodic, severe epileptic fits. Stole compulsively and absconded.</p>	<p>Main difficulty was feeding. Refused to take food from strangers. Mother insisted on coming to feed him. Other problems were self-injurious behaviours and violence towards others. Parents solved this by talking him home.</p>

<p>Myryon Age=19 No. I.=1 Verbal I.Q.=61 T.U.=5 months</p>	<p>Originally ESN but subsequently received head injuries. Deteriorated while in hospital being fairly withdrawn in a wheelchair. With physiotherapy he could just stand between parallel bars.</p>	<p>An initial high level of verbal aggression towards staff. This increased with shouting and unco-operative behaviour. Staff thought he defaecated deliberately. Control was attempted by withholding cigarettes but his family subverted this. His family were insulting to staff and complained about staff.</p>	<p>Very demanding, asking for cigarettes all the time. Temper tantrums and violence were reported. 5 months later he would not converse and was doubly incontinent. He could not stand and did not receive physiotherapy. He shouted and swore at staff when frustrated. Parents took him off the ward when they visited.</p>
<p>Wyn Age=36 No. I.=28 I.Q.<41 T.U.=6 months</p>	<p>Untidy and fidgeted continually. Hyperactive with tendency to break windows. Masturbated in public.</p>	<p>Initially popular with improvements in adaptive behaviour. Later shouting and unco-operativeness increased. He broke windows when frustrated and was aggressive towards others.</p>	<p>He tried to be helpful. Masturbated in public. Later he started O.T. and was only returned once for bad behaviour. It was thought that he was stagnating on a high dependency ward.</p>
<p>Willy Age=26 No. I.=11 I.Q.<40 T.U.=6 months/ 1 week</p>	<p>Autistic and impossible to test. Spoke repetitively.</p>	<p>Hyperactive. Pestered others with repetitive questioning. He ate and drank anything. Returned temporarily. Tried again 4 months later. Behaviour was unchanged so he was returned permanently.</p>	<p>He settle quickly into his old routine. Repetitive speech and hyperactivity continued but the effect on staff was diluted by space and number of other patients.</p>
<p>John Age=51 No. I.=39 I.Q.<40 T.U.=7 months</p>	<p>Down's syndrome man who preferred to communicate by gesture rather than speech and to crawl rather than walk. Behaviour problems emerged with female staff resulting in his transfer to a larger hospital. Here numerous behaviour problems were reported including compulsive stealing.</p>	<p>Unco-operative with increasing aggression towards staff and thieving. Particularly unco-operative with night staff. He was doubly incontinent on some days.</p>	<p>Initially on a low dependency ward he happily greeted old friends. He wouldn't walk so was transferred to a high dependency ward. Here he would sometimes refuse to walk. He played up at night, particularly with female staff. He stole compulsively. Later he began to go to O.T. and would occasionally talk.</p>

TABLE 4 (continued)

<i>Description</i>	<i>Before Transfer</i>	<i>On Units</i>	<i>After Return</i>
Colin Age=24 No. I.=14 I.Q.<40 T.U.=10 months	Down's syndrome man whose main vocabulary was swear words. Violent outbursts had given him a bad reputation and large male staff were required to control him physically. Periods of violence were interspersed with periods of relative calm.	He was generally disruptive with continual attempts to take food. He followed staff around or interfered with other residents' belongings. He stripped off his clothes and blocked the toilet by stuffing things down it. His disruptive behaviour increased steadily.	He was placed on a locked ward designed for close supervision and intensive treatment of behaviour problems. Here he was 'crazy', doubly incontinent and stripped off his clothes. He had frequent outbursts of violence for no reason, preferring to attack females, 6 months later these outbursts declined in frequency. Aggression was contained by seclusion and injections. He was also toilet trained.
Blodwen Age=56 No. I.=38 I.Q.=52 T.U.=1 year	An overweight woman who rarely left her high dependency ward. She would be easily upset by strangers and screamed if they insisted on talking to her.	The main problem was screaming which reached a peak between 4 and 9 months after transfer. She also stripped off her clothes and moved around continuously. This behaviour declined between 9 months and 1 year but a later increase in screaming caused neighbours to complain.	Her initial high level of screaming declined but was still more than before her transfer. She had lost her previous interests and developed the habits of removing her knickers inappropriately. She was only prevented from going to bed in the day by locked doors.

<p>Hefin Age=42 No. I.=16 I.Q.<40 T.U.=1 year</p>	<p>An untidy loner who had to be forcibly removed from places. He pestered everyone for cigarettes. He had little speech and did no work. He exposed himself.</p>	<p>He progressed well even going to work for a short period. He shouted and pestered staff for cigarettes. He masturbated in public and tried to do the same for Wendy. He made sexual advances to staff. Staff encouraged him to masturbate in the bedroom and he was prescribed Androcur. Night staff threatened to walk out if he was not returned.</p>	<p>Initially on a low dependency ward, he annoyed other patients by pestering for cigarettes. Patients hit him badly and he could not defend himself. He annoyed night staff by continuous pestering. A charge nurse from a high dependency ward had him transferred to his ward. Here, masturbating in front of women was an initial problem but this was discouraged. New staff were pestered for cigarettes.</p>
--	---	--	---

Key. No. I.=Number of Institutional years.
T.U.=Time on units.

TABLE 5
Summary of Remainers' case histories with disturbance scores in the returnee range

<i>Description</i>	<i>Before Transfer</i>	<i>On Units</i>
Martin Age=63 No. I.=44 I.Q.=55	A lively, friendly man who talked incessantly. Speech was difficult to understand but he was always eager to please.	Main problem was excessive talking as he followed staff around. Relief was obtained for staff because his sister took him home for long periods.
Gill Age=22 No. I.=11 I.Q.=52	A quiet, tidy Down's syndrome lady. Helpful around the ward with simple domestic tasks. Had one particular friend. Previously, had had a special relationship with a female staff member.	Main problem was fighting with another female resident. She was usually the victim. Could be unco-operative with staff. She was moved to another bungalow but formed a strong attachment to a female care assistant. She was moved again which caused her distress.
Jane Age=28 No. I.=15 I.Q.<40	A large, overweight, non-verbal lady. Would sit all day if left alone. Previously, had done puzzles and embroidery. Would take food and masturbate. Could be stubborn.	Main problem was taking food. Would wander around continuously and sometimes attacked staff physically. Took things from others and could be unco-operative with tantrums. She showed improvement initially with some understanding of gestures. This improvement was not sustained and she started to withdraw.
Wendy Age=27 No. I.=19 I.Q.<40	An obese, slow moving lady with a deformed left arm and leg. She was incontinent and sat alone most of the day. Would bite herself and others. Could be stubborn. Would masturbate.	At first, the main problem was self-injurious behaviour and masturbation. She did not object to Hefin's sexual advances. She physically attacked others, stripped, had tantrums and was unco-operative. Frequency of masturbation declined but self-injurious behaviour continued. After the first year behaviour fluctuated from distressing others by masturbating while menstruating during meals to behaving appropriately in a public house.

Penny
Age=30
No. I.=22
I.Q.<40

A small Down's syndrome lady who communicated by gesture. Incontinent if not supervised. She had been known to be aggressive a long time ago but was a favourite patient on her high-dependency ward.

Displayed a number of behavioural problems. Stripped and was unco-operative. Broke furniture and stripped wallpaper. Problems increased with self-induced vomiting, defaecating and smearing faeces over the walls. Staff wanted her returned but the consultant persuaded staff to keep her and worked out special behaviour modification programmes. Behaviour improved with programmes but lack of staff disrupted programmes with a consequent regression.

Alun
Age=25
No. I.=11
I.Q.<40

A small wiry young man with partial paralysis of his left arm. He communicated in grunts and gestures. Spent all day pacing up and down the ward. Had temper tantrums and would rip off clothes.

Unco-operative, stripped frequently and had temper tantrums. Attacked others. Initially on same bungalow as David and Colin so was moved to distribute problem residents between bungalows. Temper tantrums declined but he still stripped and was over active. He formed a good relationship with a male care assistant and many aspects of behaviour improved. This care assistant left and problems re-emerged but were reduced to some extent with firm handling.

This suggests that environmental factors interact with personality factors to affect return. It is notable that the high disturbance remainers were all on different bungalows. It thus appears possible to contain one of these residents within a group of eight, when the others do not display excessive maladaptive behaviour. The fact that time on the units for returnees showed substantial variation, from 2 weeks to over a year in three cases, suggests that fluctuations in staff morale may affect return. Once staff morale begins to deteriorate it is easy to scapegoat the most disturbed resident. Comparison of disturbance in the first 3 weeks, a 3 week period after residents had had a chance to settle down and 3 weeks before return, indicated a trend for disturbance to decline after the initial 3 weeks and to increase significantly in the 3 weeks prior to return. Poor staff morale and scapegoating could account for the adverse reaction of the most vulnerable resident and precipitate return.

Penny was an exception in that behaviour which would normally have precipitated return, was contained by adequate behaviour modification and staff support from the consultant. It is possible that other returns could have been prevented by this type of intervention. Alternatively, occupational therapy and programmes specially designed for each individual's particular maladaptive behaviours could prevent deterioration of staff morale. Staff should have a pre-planned technique for coping with residents when extreme disturbance is displayed. Fast intervention could prevent the situation reaching a crisis. In cases where maladaptive behaviour is persistently irritating to staff (e.g. Willy) return may be prevented by short term care in 'specialized units' as recommended by Jay. Providing short term care was on a regular basis and there was no question of permanent return, this would allow staff regular respite before morale deteriorated.

Some returns may have been preventable by allowing co-ordinators, care staff, resident's families and residents themselves to participate in the transfer decision. Co-ordinators could ensure that their units were not overloaded with behaviour problems and could take the group mix on each bungalow into account before accepting the residents. Care staff approval of residents would help motivate them to manage problems on the bungalows rather than returning them. Consultation with family could gain their co-operation in working with care assistants and avoid the type of antagonism created in the cases of David and Myron. Higher ability residents should also be well prepared for the move with a visit before transfer and a trial period. An adequate explanation and trial period for Gwil might have prevented his deterioration on return.

References

- Cohen, E., Conroy, J. W., Frazer, D. W., Snelbecker, G. E. and Sprent, S. (1977) "Behavioural effects of interinstitutional relocation of mentally retarded residents". *American Journal of Mental Deficiency*, 82, 12-18.
- Department of Health and Social Security and Welsh Office (1971). "Better Services for the Mentally Handicapped," Cmnd. 4683. London, HMSO.
- Department of Health and Social Security (1981). "Care in the Community".
- Eyman, R. K. and Call, T. (1977). "Maladaptive behavior and community placement of mentally retarded persons". *American Journal of Mental Deficiency*, 82, 137-143.
- Jay, P. (1979). "Report of the Committee of Enquiry into Mental Handicap Nursing and Care." Cmnd. 7468. London, HMSO.
- Nihira, D., Foster, R., Schellhaas, M. and Leland, H. (1974). "AAMD Adaptive Behaviour Scale. Manual, 1974. Revision," Washington.
- Thomas, D. and Webster, R. (1974). "The application of the adaptive behavior scales in the United Kingdom". *Paper presented at the meeting of the American Association on Mental Deficiency*, Toronto.
- Windle, C. D., Stewart, E. and Brown, S. J. (1961). "Reasons for community failure of released patients". *American Journal of Mental Deficiency*, 66, 213-317.