the findings of Citron and Scadding (1957) in sarcoidosis, where 50% of the patients who were insensitive to tuberculin alone gave a positive reaction with tuberculin plus cortisone. This suggests that the mechanism of suppression of the tuberculin reaction in sarcoidosis is different from that in the reticuloses. The implications of these results are discussed.

In a patient who is insensitive to tuberculin the development of sensitivity when cortisone is added suggests, but is not diagnostic of, sarcoidosis rather than one of the reticuloses.

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A TRIAL OF DISCHARGE AND AFTERCARE OF LONG-STAY MENTAL HOSPITAL PATIENTS

BY

J. C. N. TIBBITS, M.B., Ch.B., D.P.M.

*Consultant Psychiatrist and Deputy Medical Superintendent,
Hollymoor Hospital, Birmingham; lately Assistant
Psychiatrist, All Saints' Hospital, Birmingham*

AND

W. B. HARBERT

*Psychiatric Social Worker, City of Birmingham
Public Health Department*

Even if it should be possible in the future to avoid entirely the accumulation of chronic patients in mental hospitals, there remains the immediate task of discharging into the community, and if possible into regular employment, those patients who do not present any marked behaviour problems due to their illness, but are still in hospital for social or other reasons.

The Investigation

This paper reports on a review of 223 long-stay male patients from one hospital made to assess those who could be discharged immediately and to overcome, with the help of a psychiatric social worker, the difficulties in the way of their discharge. The hospital is one of those in which investigations by Garratt *et al.* (1957, 1958) have shown that about 12% of such patients exist,

and similar findings have been made by Cross *et al.* (1957) in the same hospital. Not included in our review were patients in the sick ward, in the "refractory ward," or from the two annexes of the hospital in other parts of the city. Female patients were excluded for administrative reasons only, though it is clear that the chronic female population is of greater practical importance. The review itself took from January, 1957, to September, 1958, but this paper covers the period from January, 1957, to January, 1960, in order to include the follow-up results.

The hospital is old and overcrowded and stands in a densely populated industrial area. Modernization schemes have improved the accommodation and facilities for the patients. The catchment area includes the city centre with its doss-houses, prison, lock-up, reception centre, and busy casualty departments. The patients in the five long-stay male wards which we have investigated have all been treated by drugs, and other physical methods over recent years. Lately, individual and group treatment along social and occupational lines has been increasingly applied.

In 1955 about 40% of the male patients were not working and 38% were occupied with ward work only (Cross *et al.*, 1957). At the time of our review 20% of the patients were unemployed in the hospital, and 18% were occupied with ward work only.

Because of severe overcrowding, arrangements were made, towards the end of 1956, for a psychiatric social worker of the City of Birmingham Public Health Department to assist the hospital staff in the discharge and aftercare of patients. The intention was to make a detailed investigation of long-stay patients, to select those considered fit for discharge, and to provide aftercare for them. Tables I and II set out data about the 38 patients discharged.

Each patient was interviewed and assessed individually. The doctor usually began the interview and led up to the special point at issue in the case. The interview was then continued by the social worker. We were careful to tell the patient why he was being seen and to seek his views about our suggestions. All decisions were taken with the patient's knowledge and consent. This procedure proved time-consuming, and as a rule we interviewed six to eight patients in a two-hour session.

We found that 45 patients (20%) were neither having leave nor being visited. After 15 relatives had been approached by the social worker five families began visiting.

Where relatives were already visiting regularly, the question of day or week-end leaves was discussed. Seventeen relatives were approached, and this led to regular leaves for 10 patients.

In other cases, where regular leaves had led to no difficulties, relatives were encouraged to have the patients to live at home. Seven patients were discharged and attended the hospital daily for periods of from three days to three years. Their families appreciated this arrangement, because the patients were supervised and occupied during the day and, if necessary, kept under treatment. The scheme also helped patients who, though they seemed fit, could not immediately find suitable employment.

In this area, and probably in other industrial cities, employability is an important factor when considering

a patient's discharge (Cross *et al.*, 1957). The families have often changed greatly during the absence of long-stay patients and there is little willingness to accept one who is now a stranger and unable to support himself. In doubtful cases, we were fortunate to have the advice of a clinical psychologist, especially experienced in vocational guidance, in deciding whether the patient was suitable for referral to an industrial rehabilitation unit. He saw 27 patients, of whom 17 later attended the local I.R.U. while still living in the hospital. This

proved a useful stage in overcoming institutionalization and in the assessment and development of patients' ability to work. We arranged for two other patients to travel daily to work from the hospital.

When discharge seemed probable the social worker helped the patient to plan for the future. Sometimes the offer of practical help was all that was needed, but, when encouraged to talk about their feelings, most patients expressed considerable anxiety and clearly felt somewhat inadequate to face the outside world. They needed much reassurance and asked for the continued support of doctor and social worker. Nevertheless, as much responsibility as possible was placed on the patients to make their own decisions and arrangements. In the ensuing months several patients came, of their own initiative, to the social worker with personal problems, and the therapeutic value of the relationship established while the patient was still in hospital was obvious.

When visited by the social worker most relatives showed some ambivalence towards the patient, and those who agreed to have him home welcomed the offer to keep in touch and be available in case of difficulties. Reassurance and advice were as much sought by relatives and landlords as by the patients.

We encouraged those patients who had no home available, but could work, to move into lodgings. Great efforts were made to find landlords who would accept former mental hospital patients, but with little success. Fortunately, one lodging-house keeper took, in all, 11 patients for varying periods. Altogether 16 patients were found lodgings; two found their own accommodation in Salvation Army hostels.

Despite their dependent attitude before and during the first two or three weeks after discharge, we noted the independence and initiative shown by some patients once they had settled in their new surroundings—for example, the social worker was able to find a job for only one patient, but the others found work by themselves or through the Labour Exchange.

Most patients who left hospital continued to receive medication, and some of them were followed up at the out-patient clinic for a few months. The social worker also kept in touch with the majority.

Three Case Summaries

Case A.—This patient, an unmarried labourer, had developed a florid paranoid schizophrenia at the age of 20, and was admitted to hospital in 1933. He remained in hospital continuously until 1957. Under treatment with chlorpromazine his psychosis became controlled and after a period at the I.R.U. he was discharged and went to live with his aged and ailing mother. He had early difficulties in adjustment and was unable to find work. However, after five months he found employment, and at the end of our survey had been working 27 months. During that time he showed increasing interest, redecorated the house, bought new floor coverings, and in general greatly improved his own and his mother's living conditions. Her health deteriorated and she needed the help of the home nursing services. Her son's presence helped to avoid her admission to hospital. Drug treatment and rehabilitation led to a partial recovery, and resettlement at home has continued the process.

Case B.—This patient, a cycle-frame builder, developed a catatonic schizophrenia at the age of 19, in 1947. Treatment included a full course of E.C.T. in 1947, with little improvement, and in 1957 a course of intensive reserpine therapy.

TABLE I.—Discharged Patients who Remained Out of Hospital on January 31, 1960

Case	Age on Discharge (Av. 43)	Length of Stay in Years (Av. 11½)	I.R.U.	Period of Discharge under Review in Months	Work Record (Months)	Living Accommodation
1	51	24	Yes	31	26	Home
2	29	10		26	Nil	"
3	44	24	"	32	32	Lodgings
4	52	18		33	14	"
5	24	1	"	34	34	"
6	53	1		30	Not known	Home
7	37	21		32	Nil	"
8	50	13		31	20	Lodgings
9	45	8	"	24	24	Home
10	59	29		27	24	"
11	45	6		36	Nil	"
12	29	5		24	(day patient) Not known	Home to Ireland
13	31	8		21	" "	Home to B.W.I.
14	50	9		21	21	Home
15	45	10		16	Nil	Lodgings
16	49	17		24	"	"
17	50	3 times in a year		16	13	"
18	37	6		19	16	Home
19	47	20		21	3	Lodgings
20	54	3	Yes	15	Nil	Home
21	43	22	"	4	4	"
22	38	10	"	6	6	"
23	52	21	"	12*	4	Lodgings
24	40	6	"	35*	31	Lodgings and home
25	23	6 times in 4 years	"	18†	Not known	Home
26	42	17 and previously 2 and twice previously	"	28‡	2	Lodgings
27	47	4	"	32§	14	"
28	39	4		6./Died	2	"

* Includes further admission of three months. † Includes further admission of six months. ‡ Includes two further admissions of three and four months. § Includes further admission of two months.

TABLE II.—Discharged Patients who were Later Readmitted and Remained in Hospital on January 31, 1960

Case	Age on Discharge (Av. 38)	Length of Hospital Stay (Av. 3 yrs)	I.R.U.	Period of Discharge	Work Record	Living Accom.	Reason for Readmission
29	32	6 mths	Yes	5 mths	Nil	Home	Schizophrenic episode
30	42	1 year		3 days	Day patient	"	Anxiety symptoms
31	56	3 years		10 "	Nil	"	Schizophrenic episode
32	28	3 "		1 mth	"	Lodgings	Death of father, depression
33	38	5 times in 4 years	"	4 mths	"	"	Schizophrenic episode
34	47	6 mths		2 wks	"	"	Confusional state
35	24	1 year		6 mths	6 mths	"	Court order after petty larceny
36	32	6 times in 8 years	"	10 "	Day patient	Home	Family complained of behaviour
37	45	11 yrs	"	4 "	"	"	Attempted suicide
38	32	10 "	"	1 mth	Nil	Lodgings	Schizophrenic breakdown

peak dosage 13 mg. daily. Though his behaviour became quieter and more co-operative, he remained solitary and mute. His mother was most anxious to have him home. After four week-end leaves he left the hospital and has been at home for 26 months. He is still generally mute, though he does speak occasionally. His mother is delighted with the arrangement, as she has difficulty in walking and he runs errands for her. Drug treatment led to moderate amelioration of symptoms only, and the problem appeared to be one of custodial care. His mother values his company and his help, and provides the care needed in a much more normal environment.

Discussions are being held with the Ministry of Labour about the possibility of his attending a course of industrial rehabilitation.

Case C.—This patient was a single man, a labourer, who developed florid paranoid schizophrenia in 1933 at the age of 27. He stayed in hospital continuously until 1957. Treatment with chlorpromazine led to considerable all-round improvement, and he was able to attend the I.R.U. from the hospital. He was helped to find lodgings and within a week of discharge was working. He has remained at this job since that time, and after 22 months changed his lodgings of his own initiative. This man shows the apparent ease with which some long-stay patients can settle in the community when drugs have improved psychotic symptoms. Since his discharge he has not required help from any social agency.

Discussion

The widespread use of drugs has led to a great improvement in the behaviour of long-stay patients, and this in turn has made possible an open-door policy with a growing programme of rehabilitation. The effects of these methods have shown not only in an overall improvement in the life of patients but also in the larger number of them able to be discharged. The increase in discharges is definite, though the numbers remain small, and appeared to be lessening again when this work was started. Table III gives the number of long-stay patients discharged in the years 1953–8.

TABLE III.—Yearly Number of Long-stay Male Patients Discharged

Year No.	1953	1954	1955	1956	1957	1958
	8	8	17	17	17	19

The increase in discharges from 1955 onwards can be attributed to the long-term benefit of drug treatment and the consequent renewed interest in the long-stay wards.

Thus, despite these improvements, together with the work described, no great number of discharges has resulted, nor at present could this be conscientiously predicted. We have tried to assess why only 28 patients (12%) could be discharged to remain out of hospital, and have grouped those patients who were still in hospital at the end of our inquiry under three headings, as follows:

Group 1.—Patients whose mental condition made resettlement in the community impossible: 165 (85%).

Group 2.—Patients capable of living outside hospital but considered unfit for work and without relatives willing to have them because of residual symptoms or lack of accommodation: 14 (7%).

Group 3.—Patients who might easily become employable and could benefit from living under supervision in sheltered

hostel accommodation. These patients could not cope with life in the type of lodgings obtainable: 16 (8%).

These groupings are approximate, but to us it seems true that the vast majority of patients were unable to leave hospital because of their mental state rather than for social reasons. In their study of four Birmingham mental hospitals, Garratt *et al.* (1957, 1958) found that 13% of the male patients did not require hospital facilities—a finding which is comparable with our groups 2 and 3. They also estimated that 119 (8.8%) required only the support of an organized community (cf. group 3).

What is here described as a specially arranged investigation should be part of the routine work of psychiatrist and social worker. By joint initiative, regular meetings now take place between hospital staff and social workers of the local authority. It is only an apparent paradox that aftercare should begin before patients leave hospital. A social worker should see the patient before discharge, so as to offer practical help and encouragement. If the patient leaves hospital knowing the kind of difficulties that lie ahead, yet also knowing that at least one person in his new community understands his needs, he is likely to have more confidence and his chances of making a satisfactory adjustment will be increased.

Of the 15 readmissions during the three-year period, 10 occurred within one year of discharge. Brown *et al.* (1958) found that of the relapses during six years after discharge, 74% in schizophrenics and 58% in non-schizophrenics occurred within the first year. The higher relapse rate during the first few months after discharge confirms the need for adequate psychiatric aftercare, and also points to a need for hostel accommodation, which would make possible a gradual reintroduction of patients into the community and closer supervision than is otherwise possible.

Summary

During an inquiry into the individual needs of 223 male patients in the chronic wards of a mental hospital in an industrial city it was found possible to discharge 38 patients. Fifteen were readmitted within the period of the survey (though five were again discharged). The work was jointly undertaken by a hospital psychiatrist and a psychiatric social worker from the local health authority.

The inquiry illustrates the necessity for the social worker who is to provide aftercare to make an initial contact with the patient before he leaves hospital; it also suggests a need for hostels to help patients in the transition from a long stay in hospital to a normal life outside.

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