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The Netherne Resettlement Unit: Results of Ten Years

By M. Y. EKDAWI

The Netherne Resettlement Unit, established in 1957, has been described in detailed publications including those by Bennett *et al.* (1) and Folkard (15, 16). These authors stressed the Unit's dual function of assessment and preparation of disabled patients for resettlement, and described results of its first two years in terms of discharge, readmission and employment. The basic Unit aims of resettlement in optimum employment and accommodation have remained unchanged since that time. The programme has been geared towards minimizing the patients' handicaps by improving their coping abilities (24) so that they can manage in less protected situations, by utilizing the pooled experience of a multidisciplinary rehabilitation team (18) and by mobilizing community resources (36). Hospital living and working conditions are repeatedly scrutinized so that factors which might provoke, increase or reactivate the patients' symptoms (10) are reduced. The Unit's policies, therefore, remain dependent on the forward-looking hospital administration which has encouraged democratization, effective communication and clear definition of function (33).

This paper is a follow-up study spanning eight years (1959–1967), and some comparisons are also made with the results of the following two years (1967–1969). An attempt is made to evaluate some of the rehabilitation procedures practised, and to consider whether certain aspects may have useful implications for the future care of the psychiatrically disabled.

The Rehabilitation Process

The Unit aims are preparing the patient for employment through graduated work settings and at the same time increasing his social independence (19). When the patient is discharged a follow-up system of continuous reassessment and support comes into operation so that readmission is avoided.

1. *Assessment*

During his stay in the Unit, the patient's progress is monitored by repeated clinical, occupational and social assessments presented at weekly staff meetings and at the resettlement conferences (2), where rehabilitation plans are formulated. Conference summaries are circulated to the patient's general practitioner, the Disablement Resettlement Officer (D.R.O.) and other community agencies involved. These assessments often reveal widespread areas of social malfunction affecting relationships with family and workmates; they set out the patient's financial difficulties, and attempt some measure of his confidence and persistence. They explain some of the reasons for poor employability and show up the areas in which help is most needed.

2. *Placement in work*

A patient's employment record after discharge is an important measure of the success or otherwise of his rehabilitation programme (8, 9). Whether the patient works steadily after discharge depends to some extent on his past work record (26), but mostly on proper preparation for work during his hospital stay (41). This was clearly demonstrated by Freudenberg (19), who showed that Netherne Rehabilitation Unit patients had a much more stable work record after discharge than that of patients discharged from other wards in the same hospital. Preparation takes place in the hospital industrial or maintenance departments (12), followed in some cases by training courses. Work pressures are graduated and good working habits are fostered. When the patient's working performance stabilizes at an acceptable level an outside job is found for him by the D.R.O. or by the Unit P.S.W. Invariably, the patient starts working outside while still residing in the Unit, and he is only discharged after he has worked steadily for some months. The working patient needs considerable support, particularly

during the settling down period, and much of this is given at special workers' meetings where problems and future plans are discussed with members of the rehabilitation team and with other patients. Some discharged patients continue attending these meetings, thus maintaining their contact with the Unit; their presence also favourably influences other patients' attitudes by helping to relieve their anxieties over life out of hospital.

3. *Placement in accommodation*

As in work resettlement, the process of transfer from hospital to community living is graduated (14). The Unit accommodation approximates that of a hostel for both sexes, and emphasis is laid on increasing the patient's competence in looking after his person, his clothes and his living place, to budget his money sensibly and to mix socially with others. He is encouraged to occupy his leisure hours outside the hospital rather than in. When he is ready, one of several flexible methods is chosen to help him over the process of leaving hospital: he may spend alternative weeks in and out of the Unit for a period; he may go out on increasingly longer leaves. A useful manoeuvre for some who have left is to spend their week-ends in the Unit. In any case, efforts are made to link the patient with community clubs, voluntary organizations or evening classes.

Successful resettlement often depends as much on the relatives' cooperation as on the patient's. For this reason, regular meetings take place between the rehabilitation team and the relatives. Initially, these relatives' meetings were started to advise families on the management of problems presented by the patient at home, thus filling a gap in the service which Brown *et al* had criticized (6). They were modelled on parent-teachers' meetings; there is a mutual exchange of information on progress and on any changes in the patient's condition, and relatives' grievances and anxieties are ventilated and dealt with. Relatives have derived support from each other, and their relationship with the staff has been strengthened. Many relatives' interest in the rehabilitation programme has been revived and their expectations have become more hopeful (15, 31).

4. *Follow-up*

Wing has commented on the inadequacy of many of the follow-up services for patients who need long-term attention since their symptoms tend to fluctuate in response to environmental changes (3, 39). Of the London area outpatient clinics, 90 per cent were found by Parkes *et al.* (29) to function during working hours; consequently, working patients could not keep their appointments and only half took their medication as ordered (32). During the patient's stay in the Unit, medical examinations and interviews are mainly held outside working hours, and, similarly, most follow-up work takes place in the evenings. The Unit operates two concurrent methods of follow-up: 'routine' regular appointments (either individually or at workers' meetings) and emergency visits. Members of the rehabilitation team are involved in both types, whether the follow-up is predominantly hospital-based or community-based, depending on the patient's needs and convenience. This ensures continuity and enables the patient or relatives to contact at least one member if a crisis threatens. No time limit is put on the follow-up period.

Criteria for selection

Any patient aged between 16 and 55 who has had prolonged social or work problems is eligible for admission to the Unit, provided his disabilities are not severe. Until 1964, and following Brown's definition of chronicity (5), only patients with a continuous hospital stay of two years or longer were admitted. In 1963, Catterson *et al.* (11) found that of the Netherne long-term population only 13 per cent were anywhere near a point at which discharge could be contemplated, and at that time there was concern among some of the Unit staff that the best rehabilitees had been 'creamed off', leaving patients who were too difficult to resettle. Similar anxieties from St. Wulstan's Hospital were voiced by Morgan *et al.* (27). However, with the changing patterns of hospital admissions in the last decade, it became clear that a patient may suffer long-term illness and disability even though his cumulative hospital stay may be less than two years. It was therefore agreed to admit patients whose period of illness

exceeded two years, regardless of the length of their stay in hospital.

Patients admitted to the unit (1959–1967)

A total of 367 (163 men and 204 women) were admitted. Their mean cumulative hospital stay was 9 years and 4 months (range 34 years—8 months—1 month). Their average length of stay in the unit was 2·09 years. Omitting those who died and those for whom insufficient data are available, the distribution was as follows:

TABLE I
Duration of hospital stay

Over 10 years	13·8%
5–10 years	25·9%
2–5 years	29·8%
Under 2 years	30·5%

DIAGNOSES

Although the majority of patients admitted were diagnosed as suffering from schizophrenia, most other diagnostic groups were represented. On admission, the diagnosis is re-evaluated, and following the publication of Wing's classification of chronic schizophrenia (37) schizophrenic patients have also been rated on the scales. This classification has proved very useful in evaluating certain steps of the rehabilitation process and as a prognostic guide.

TABLE II(a)
Diagnostic categories

Diagnosis	P	A	S
1959–1967	13 (8·9%)	17 (11·6%)	146 (79·5%)
1967–1969	20 (20·4%)	13 (13·3%)	65 (66·3%)

P = Personality disorder and neuroses.
A = Affective psychoses.
S = Schizophrenia.

The table shows a significant difference in the proportion of the three diagnostic categories in the two periods, the most likely reason being the much higher number of schizophrenic patients in 1959–1967. There has also been an increasing proportion of patients suffering from personality disorders, a trend noted by Price *et al.* (30) in another rehabilitation service, and it confirms the view that those patients are increasingly presenting a major problem (35).

Although more severely disabled schizophrenic patients were admitted in the second period, the difference in proportions of the Wing sub-groups is not highly significant.

TABLE II(b)
Diagnostic categories

Wing's classification	1-A	1-B	1-C	2
1959–1967	25	53	26	6
1967–1969	15	24	12	14

Of the schizophrenic patients admitted five had had a leucotomy, and while there were no marked differences between those patients and the remainder the impression gained from medical and nursing records was that they presented more difficult resettlement problems, as has been described by Nicholas (28).

Patients transferred from the unit

In the first series (1) 28 per cent of the Unit patients were transferred to other wards. During the following eight years 46·4 per cent were transferred, the majority to other rehabilitation wards, and some of these were later resettled. Emergencies leading to transfer were either physical or psychiatric, the latter being acute psychotic illness or suicidal behaviour. There was a reasonable suspicion that most patients constituting this group of emergencies had avoided taking their medication regularly. Other reasons for transfer included a firmly entrenched negative attitude towards resettlement, usually related to long residence in hospital, and repeated socially unacceptable behaviour (13).

Patients whose length of hospital stay was less than two years

Those patients, who constituted 30·5 per cent of the Unit admissions, are of particular interest as they are more representative of the contemporary disabled population. The proportions of diagnostic categories here followed that of the 1967–1969 pattern; 63 per cent were schizophrenic, and the distribution of their level of

disability was also similar, with a slight increase in the Wing 2 sub-group. The rehabilitation methods applied to this group were identical with those used for the rest of the patients.

Results

Patients discharged

Between 1959 and 1967, a total of 151 patients were discharged, and the picture at the end of that period was as follows:

Total admissions	..	367
Discharges	..	151
Patients transferred to other wards	..	128
Patients remaining in the Unit	..	88 (41 working out of the hospital)

The proportion of discharged patients in the three periods under consideration was 27 per cent (1957–1959), 41 per cent (1959–1967) and 34·7 per cent (1967–1969).

Patients readmitted

In their original paper, Bennett *et al.* (1) stated that resettlement was more than just discharge, and more even than prevention of readmission; in a more recent paper (35) Watson, Bennett and Isaacs make the point that readmission may reflect either efficiency or inefficiency. Despite these reservations, readmission rates are one of the 'hard' data in measuring morbidity. Wing *et al.* (43) found that 43 per cent of 113 patients who left London psychiatric hospitals in 1959 were readmitted within two years. In a paper by Brown *et al.* (9) the figures rose from 50 per cent to 64 per cent in three years. Taking readmission within two years as an index of resettlement failure, Waters and Northover (34) found that out of 42 patients discharged from another rehabilitation service, 29 per cent were readmitted.

The Unit readmission figures, in comparison, have been consistently lower. In the first six months (1) the rate was 5 per cent (compared with 10 per cent in the series of Waters and Northover). Taking two years as minimum and eight years as maximum follow-up period, only 9 per cent (12 patients) of the Unit patients were readmitted.

Although there was no relationship between broad diagnostic categories and readmission, schizophrenic sub-groups 1-A and 1-B had a significantly higher chance of remaining out of hospital.

Table III(a)
Diagnosis and readmission

Diagnosis	P + A	S
Readmitted ..	1	11
Remained out ..	29	105

Table III(b)
Diagnosis and readmission

Wing's sub-classification	1-A	1-B	1-C	2
Readmitted	·0	2	5	4
Remained out	25	51	21	2

For patients whose length of stay was less than two years, readmission rates were even lower (7 per cent).

Brown *et al.* (7) found that the most important factors in the social experience of discharged patients were whether the patient worked and with whom he lived. Some of the Unit results are therefore presented here in terms of employment and living accommodation.

1. Employment

There have been several follow-up studies on the employment of discharged patients. Miller and Dawson (25) found that of 1,082 such patients only 20 per cent were in employment after a year from discharge. In their five-years follow-up, Brown *et al.* (6) found that 55 per cent of the men were out of work. Only 12 Unit patients (10·17 per cent) were unemployed in the follow-up period of two to eight years. The outcome for patients whose stay was less than two years was fairly similar (12 per cent).

(a) *Type of work*

Patients admitted to the Unit have almost invariably had a poor previous record of job difficulties, frequent job changes and long periods of unemployment. Their work dis-

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abilities are often aggravated by lack of confidence and feelings of stigma (21, 25). These factors may contribute to the limited variety of jobs open for them in the employment market. The greatest proportion (100 patients) have been resettled in mainly unskilled factory, labouring and domestic work. This is at variance with the follow-up figures of Renton *et al.* (32) which showed only 23 per cent of their patients engaged in manual work.

In the first two years of the Unit 18 patients were found sheltered work. Such places became progressively more scarce, and only 11 were placed in sheltered work in the following eight years. Out of those eleven only one was re-admitted, when another sharing her flat became ill. She showed no clinical deterioration, continued to work from hospital and was later discharged.

For many patients sheltered placement ensures more stability in work.

TABLE IV
Type of employment

	Open	Sheltered
Readmitted ..	11	1
Remained out ..	98	11

TABLE V
Employment and job changes

	Open	Sheltered
One job	59	11
Two or more jobs..	49	0

TABLE VI(a)
Diagnosis and employment

Diagnosis	P	A	S
Still working ..	8	12	98
Unemployed ..	1	—	11

(b) *Diagnosis and employment*

Brown *et al.* (7) have demonstrated that the presence of symptoms is not necessarily a serious obstacle to employment; in this study it was also evident that the broad diagnostic category was not relevant to the state of employment on follow-up.

But among schizophrenic patients the Wing sub-groups 1-A and 1-B were more successful in holding down jobs.

TABLE VI(b)

	Diagnosis and employment			
Wing sub-group	1-A	1-B	1-C	2
Still working	22	47	17	5
Unemployed	0	5	5	1

In general, schizophrenic patients have had fewer job changes than other diagnostic groups.

TABLE VII
Diagnosis and job changes

Number of jobs	0–1	2–3	4+
S	64	24	8
P + A	5	13	3

(c) *Rehabilitation courses and employment*

In 1959, Wing and Giddens (42) made the case that Industrial Rehabilitation Unit (I.R.U.) courses could benefit psychiatric patients by demonstrating their work abilities to staff and employers in a realistic setting, inculcating work habits and minimizing hospital atmosphere. These arguments were reinforced by Wing when he showed that I.R.U. courses could increase the patient's confidence in his own powers of adjustment. However, for the 15 patients who attended I.R.U. in the study by Brown *et al.*, the courses did not seem to have affected subsequent employment history. These authors concluded that the patients might not have been carefully selected or that they might not have been prepared well enough. Disappointment in these facilities has been expressed by Leyberg (22) and by Gittleson (20).

In the early days of the Unit (1) 52 patients completed the I.R.U. course, and from this experience it was shown that adequate preparation prior to the course was essential to success (41). The numbers submitted to the course in

the following years (1959–1967) markedly diminished, partly because of the long waiting period for admission to I.R.U., and, probably, partly due to longer experience in selecting patients who might benefit. The influence of the courses on subsequent work record of Unit patients seems at first sight to be equivocal.

TABLE VIII
Rehabilitation courses and employment

	Attended course	Others
Still working ..	38	80
Unemployed ..	3	10

There was also no significant difference in readmission rates between patients who had attended I.R.U. and those who had not.

TABLE IX
Rehabilitation courses and readmissions

	Attended course	Others
Readmitted ..	4	8
Remained out ..	39	74

All Unit patients who attended the I.R.U. courses were prepared in the same way. However, there were certain diagnostic differences: patients who benefited most were schizophrenic and the majority fell in the Wing 1-B and 1-C sub-groups.

2. Living Accommodation

Brown *et al.* (4) studied the experience of 240 male long-stay patients and found that successful resettlement was associated with the type of living group to which they went; patients living with siblings and in lodgings fared better than those staying with parents, wives or in large hostels. In a later study (8) involving 128 patients, deterioration was greatest in those who returned to relatives who showed a high degree of emotional involvement. Partly because of the influence of such studies, few patients were discharged from the Unit to parental homes (8 out of 44) in the first two years. In the following ten years, with the increasing contact between the Unit team and the relatives, more patients were discharged to parental homes.

TABLE X
Type of accommodation

	Parents	Others
1959–1967 ..	54	85
1967–1969 ..	5	30

(a) *Accommodation and employment*

Freeman and Simmons (17) found a strong relationship between the family setting and work performance levels; patients living in conjugal homes did better than those living in parental homes. Somewhat similar findings had already been described by Mandelbrote and Folkard (23). In eight years, the relationship between employment and accommodation type in Unit patients was a follows:

TABLE XI
Accommodation type and employment

	Parents or siblings	Spouse	Hostel	Lodgings	Living-in jobs
Still working	35	18	27	30	10
Unemployed	11	0	1	1	1

Because of the small numbers of unemployed patients, each group was compared against the total, and the conclusion was that accommodation type had a very significant relationship to employment status on follow-up.

TABLE XII
Type of accommodation and readmission

	Parents, siblings or spouse	Hostel, lodgings or living-in-job
Readmitted ..	5	7
Remaining out ..	67	57

(b) *Accommodation and readmission*

Various authors (4, 6, 23) have indicated that patients living with relatives, especially parents, were at a higher risk of readmission to hospital.

In this study, no significant relationship was found between accommodation type and readmission.

Discussion and Conclusions

In their original paper, Bennett *et al.* suggested that further work was needed to evaluate the principles which operated in the Unit. They also predicted that more patients could benefit from the Unit. The principles of frequent assessment and gradual exposure of the patient to working and living conditions in the community, and of involving relatives and other community members with the Unit's work, have resulted in a record of very low readmission and unemployment rates after discharge. Most diagnostic groups can benefit from the Unit, but for all patients a better outcome is associated with a shorter hospital stay. Although most of the schizophrenic patients admitted were moderately disabled, those whose disabilities were rather more severe benefited most from I.R.U. courses; but they also had more difficulty in holding down jobs, except those placed in sheltered work, who did best of all. Patients who were unemployed on follow-up had similar disability levels. It could therefore be argued that had there been more sheltered places available the results may have been even better. It would follow that about 20 per cent of the jobs available to moderately disabled patients should be sheltered. Taking the population figures served by the hospital, and the number of moderately disabled schizophrenic patients admitted to the Unit into account, it is recommended that there should be a minimum of eight sheltered places for hospital patients per 100,000 population. It was hoped that if relatives, particularly parents, were frequently contacted and adequately supported patients could be more successfully resettled with their families. However, although readmission rates in this study were not associated with the type of living accommodation, the results confirmed earlier findings that the highest unemployment rates were found in patients living in parental homes. This may explain the tendency shown in the last two years of this study to place more patients in other types of accommodation (repeating the pattern of the first two years).

It has also been shown that shorter term patients (about one third of the total) have benefited from the rehabilitation methods practised in the Unit. As the trends towards shorter hospitalization continues, it is suggested that the need for such a system of rehabilitation will continue, as was earlier predicted, and that it should be built-in in the developing community services of the future.

Statistics

Chi-square tests have been used in this paper. The criterion of statistical significance is the ·05 level.

It will be noted that in some of the tables the numbers do not add up to the total; this is because of incomplete information on a few of the items.

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