A Hostel Ward for New Long-Stay Psychiatric Patients

The careers of the first 10 years' residents

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On 21 September 1977, the first British 'hostel ward' was opened. In this paper we review the thinking behind such a concept and evaluate its successes and failures. This is not simply of value as an introspective exercise since it is also crucial that service planners and providers who are moving towards the closure of mental hospitals should consider the value for their district of such a service.

The residents

111 Denmark Hill, the Maudsley Hospital Hostel Ward, was set up to serve the newly accumulating population of new long-stay patients under 65 years who needed a service as a result of the gradual incorporation of district responsibility into the Maudsley's functions. The background to this, and the initial evaluation of the unit, is described in full in Wykes (1982).[1]

Briefly, in 1977 about 30 patients were eligible for admission from a total population of about 150,000. These people had been continuously in hospital for at least one year, and generally not more than five years. It was not thought that any accommodation outside the hospital was suitable for them: they had become 'new long-stay' patients despite the efforts of staff to find an alternative to hospital care. Over the past 10 years that number has remained remarkably stable; initially, 14 people were catered for in 111 Denmark Hill and a further 10 to 15 could be found on the Waiting list, living in wards of the hospital. Opening a new house in 1981, administratively but not geographically attached to the unit, did serve to cut the waiting list by its number of places, seven. Thus we now have, for our total population, a hostel ward of 14 places, an attached house for seven and a waiting list of about eight. In Table I data are presented showing characteristics of the total sample of 33 residents who have over the past 10 years been admitted to the hostel. Fourteen are now resident in the hostel; two of these are re-admissions, and thus 21 have at some point been discharged or died.

The philosophy of the Unit

At the time 111 Denmark Hill opened, a clear philosophy and operational policy were elaborated. The unit was to be a house, a place for people to live, but one where a high level of staffing, facilities and supports normally only available in a conventional hospital ward, would also be present. Wherever possible all those who could not be discharged from the acute wards would be offered a place, regardless of severity of disability, psychiatric condition or behavioural disturbance. The majority of those eligible were referred and only one referral was initially turned down although he too was later admitted. Those who came would be offered permanence: a place to live, not a place from which they would either be forced or indeed *fail* to move forward, as had typically been their recent and often frequently repeated experience. Indeed in 1977 it was thought that few would leave, and that 30 hostel ward places were required.

While residents were not expected to leave, certain goals were laid down. It was acknowledged that permanent living environments in hospitals, the 'back wards' could be not

TABLE I
Characteristics of all admitted to hostel ward

		Age at 1st psychiatric consultation		*Age at admission*		*Length immediately preceding admission*			DIAGNOSIS		
Sex	*N*	$\bar{X}$	S.D.	$\bar{X}$	S.D.	$\bar{X}$	S.D.	*Schizophrenia*	*Affective Disorder*	*Organic Psychosis*	*Personality Disorder*
Male	16	24·7	8·7	38	4·3	3y 9m	2y 10m	11	2	2	1
Female	17	27·0	10·1	43·3	12·1	3y 5m	11m	12	3	0	2
Total	33	25·8	9·5	40·8	12·1	3y 6m	1y 11m	23	5	2	3

https://doi.org/10.1192/S0140078900019970 Published online by Cambridge University Press

TABLE II
Total discharges

	Discharged N	*Length of stay in hostel ward (months)* $\bar{X}$	S.D.	*Died at 111 (nat. causes)* N	*Length of stay (months)* $\bar{X}$	S.D.
Male	12	46	19	0	0–	
Female	7	22	17	2	14·5	0·5
Total	19	37	22	2	14·5	0·5

	Readmitted after < 1yr or other poor outcome N	Length of stay $\bar{X}$	S.D.	Readmitted after > 1yr N	Length of stay $\bar{X}$	S.D.
Male	2	50·5	2·5	3	46	25
Female	2	13	3	1	46	0
Total	4	32	22	4	46	20.5

	All readmitted or poor outcome N	Length of stay $\bar{X}$	S.D.	No further readmission N	Length of stay $\bar{X}$	S.D.
Male	5	47·8	18	7	45·1	22
Female	3	24	14	4	21·2	11
Total	8	38·9	21	11	36·5	23·4

simply impoverished socially and physically, but as environments were actively debilitating. The findings of social social psychiatry and the attempts to operationalise the social environmental views of the anti-institutional movement[3] were incorporated into the ethos of 111 Denmark Hill.[4] So too were behavioural approaches, derived from operant psychology, and practices in the late 1960s and 1970s in token economies, but here modified to emphasise individual assessment and planning and the need to take account of cognitive and emotional factors as well as the importance of staff-resident relationships.

Early evaluations

Early-evaluations of the effectiveness of 111 Denmark Hill found broadly in its favour.[1,4] It was shown that 'new' long-stay patients under the age of 65 could be accommodated in a domestic setting at no greater cost than on the wards of a district general hospital. Residents' functioning improved, albeit not dramatically, and staff-resident interactions were frequent and of high quality. Staff attitudes tended to be positive and client-centred, as were the management practices of the house. A recent study[5] with a more detailed analysis of costs, has shown that a second hostel ward, Douglas House in Manchester, provides care superior in terms of clinical state, skills and activity level, to the care of a district general hospital ward, at a lower cost.

Changes in expectations

It gradually became apparent, moreover, that the initial goals of the unit were somewhat conservative. Within the first three years a number of residents improved to such an extent that the level of staffing and support in the unit was more than this sub-group required.[6] It was not the case, however, that they were thought to be capable of managing independently. Indeed no locally available hostel or other residential facility was thought capable of adequately supporting these extremely vulnerable individuals. Consequently in 1981 a charity was formed and, in partnership

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TABLE III
Place of discharge

Place of discharge	*Total discharged*	*Readmission < 1yr or other poor outcome*	*Readmission > 1yr or other poor outcome*	*No further admissions*
Attached shared house	11	1	3	7
Family	2		1*	1
Friends	1	1*		
Own accommodation	1			1
Reception centre	1	1*		
Hostel/Old peoples home	2			2
Death (natural causes)	2	2		
Special hospital (direct transfer)	1	1		
Total	21	6	4	11

*Unplanned discharge

with a local housing association, a shared house for seven residents was established. It was unstaffed, and two miles from the hospital. The staff from the unit visited frequently, initially daily, and the residents also visited the unit for medication, practical help with budgeting, shopping, and counselling from individual staff.

The progress of discharged residents

In the following six years some have remained in this shared house and others have returned to hospital. A small number have been discharged from the hostel ward to other settings, with varying degrees of success.

In all 21 people have left the ward. Tables II and III show the community tenure of all those discharged.

It should be noted that of those who have left the hostel, only one has been transferred directly from it to another hospital setting. This was a woman with a long forensic history who set three (minor) fires in the house. Eventually she was charged with arson and transferred to a special hospital.

Table IV shows the community tenure of those discharged, by diagnosis.

Comments

A number of issues can be drawn from this picture. Of the total number of discharges (excluding death by natural causes) i.e. 19, three were re-admitted rapidly to hospital (one of these was the direct transfer described above), one committed suicide, and a further four have been re-admitted subsequently. Three of these 'failures' were unplanned discharges. However 11 people have left 111 Denmark Hill and managed successfully over a number of years to live outside hospital, despite their past history of repeated and long in-patient admissions. Therefore nearly 60% of those who left have re-settled out of hospital; 69% of those whose discharge was planned have achieved this. Nonetheless the others, excluding those who died, and one who has disappeared, have all returned to hospital to live, and continue to require long-term care. No other unit of the hospital has managed successfully to discharge any of this group: all

TABLE IV
Diagnosis and discharge

Outcome after Discharge		DIAGNOSIS *Schizophrenia*	*Affective Disorder*	*Personality Disorder*	*Organic Psychosis*
Readmitted < 1 year or other poor outcome	6	6	—	—	—
Readmitted > 1 year	4	4	—	—	—
No readmissions	11	7	3	2	—
Total	21	17	3	2	—

https://doi.org/10.1192/S0140078900019970 Published online by Cambridge University Press

have returned to the hostel ward waiting list, and two are now re-admitted. Another of this group was recently offered a hostel ward place and has refused it, since he sees it as the cause of his problems. He remains inappropriately placed on an acute ward.

On the basis of these data three points can be highlighted. Firstly, the hostel ward has functioned well in catering for the new long-stay district patients and providing a permanent living environment which replaces a back ward. The unit has not been highly selective in its admission policy: it has taken people not for any supposed 'rehabilitation potential', but simply because they could not be placed elsewhere. Only once has it proved necessary permanently to transfer a patient to another hospital setting. (A small number of residents have over the years had brief admissions to more secure wards when acutely and seriously disturbed). Furthermore only three residents discharged themselves in an unplanned fashion in the course of ten years. None of these fared well.

Secondly, almost 60% of all those discharged and 70% of the planned discharges have managed to achieve long-term community tenure, albeit nearly all in highly supported living accommodation and with full day care. The average length of stay in the hostel for those who achieved this was three years (range 6 months to 6½ years) which was not substantially different from the length of stay of those who did not survive out of hospital (average stay 3 years 3 months). Thus length of stay does not predict community tenure, and some individuals will achieve a successful move from hospital only after a very lengthy period of stable residential care and preparation for moving.

Thirdly, some who left did not survive, despite considerable staff efforts at supporting them. About two-thirds of each diagnostic group, excluding organic psychosis, were discharged. It is worthy of note that those with a diagnosis of schizophrenia proved more difficult to support out of hospital, this diagnosis accounting for all of the 'poor outcome' group. These fell victim once again to the optimism of staff and again experienced failure and return to hospital. All remain there, proof that despite their improvements while in the hospital, a small number clearly require long-term hospital care. In addition, a small number of 'new long stay' patients have not been referred to the hostel ward. For some, this was because an alternative, less supported setting was planned. For others a more medical environment was needed, to cater for multiple physical and mental disabilities. For a very small number it seems that the referring team believed that the open door policy of the unit would not be satisfactory, and yet a Regional Interim Secure Unit or a locked hospital ward were also not deemed suitable. Provision must be made for these people.

To sum up, the first decade's experience of the hostel ward has been largely positive: the experiment of replacing a back ward has resulted in the hostel ward becoming a recognised element in a number of district services. Despite the past history of residents admitted to the unit, some improved substantially in this setting and are managing a more independent life in the community. This is alas not true for all; some remain in the hostel for many years (two for the whole ten years), becoming, in effect, 'old long-stay' and others return to hospital after discharge. While the numbers being catered for have not substantially changed, expectations have changed over the ten years and the balance between hospital and non-hospital accommodation has had to be adjusted in the light of experience. The experience of the Maudsley Hospital hostel will not be identical to that of the others now operating or soon to be established; however, the need to monitor the use of such a service, and to plan for some proportion of long-term hospital care places will, we suggest, be universally applicable.

ACKNOWLEDGEMENTS

The authors would like to acknowledge the contributions of Isobel Morris who collected much of the early data about the hostel ward and of Hugh Jones who assisted with the later data collection.

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