Resettlement and community care: 'The Mental Hospital as an Institution' revisited

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For almost four decades social policy has been directed at the closure of old mental hospitals and the resettlement in the community of large numbers of patients. Research into resettlement shows that, on the whole, individual needs are recognised, service responses are reasonably well planned, and that individual welfare has not deteriorated, at least in the short-term (Knapp *et al*, 1992; TAPS, 1993). Furthermore, those who receive services under the resettlement schemes are said to be better served than those who receive routine care on discharge from hospital (Allen *et al*, 1992).

Our research project was conducted in three sites and involved an initial assessment of 274 subjects. We investigated the extent to which patient welfare improved on resettlement, and reassessed this outcome every six months for two more years. The present paper is based upon findings from full data-sets on the first 35 patients. The main purposes of the longer period of outcome assessment are firstly to ensure that the initial gains are not a 'honeymoon' effect, and secondly to see whether there is a sharp or gradual decline (or increase) in their quality of life over time, or whether their welfare in the community is maintained. Both the questionnaire data and our visits to the community residential establishments provided evidence that without very careful planning it is possible for the environment to deteriorate, for the residents to become understimulated and withdrawn, and for opportunities for specific psychiatric treatment and rehabilitation experiences, or behaviourial interventions, to be missed.

If one looks back in the literature to descriptions of the features of institutionalisation, then a number of these features characterise the residents in these schemes. Of course, the features do not apply to everyone, but it is the case that, even in community residential schemes, institutional characteristics of the programme or home do tend to override individual characteristics, eventually. In 1973, George Brown wrote a seminal paper about the effects of institutionalisation entitled 'The Mental Hospital as an Institution'. Rereading this article provides a salutary lesson; Brown's observations about institutional care in the late 1960s constitute a pertinent, almost prophetic, commentary on the development of deinstitutionalisation services as we found them in our study in the early 1990s.

The first point which Brown makes is that there is no guarantee that small localised community based services will be able to avoid all the problems which beset large institutional care.

> "Even if 'community care' gets the kind of support it needs, there will still be psychiatric patients with severe long-term handicaps, a significant proportion of whom will doubtless require lengthy periods of care in some form of organizational setting . . . All will not necessarily be well when patients with long-term handicaps are treated in small local units . . ."

> "what reason have we to believe that the same processes will not evolve, on a smaller scale, in the hostels and longstay units of a locally based psychiatric system of care? In these settings personnel still need to be motivated; still need an appropriate belief system. The principles of preventing institutionalism will apply equally to a local authority home as a hospital".

We believe that, over the nearly three years of these projects that one can see evidence of problems developing in the application of the belief system which holds that community care is inevitably always superior to institutional care. In fact we think that there is evidence that, in eschewing the medical model altogether, and adopting entirely social models, some of the clinical needs of the client may be missed.

Brown's remarks that:

> "processes (may) be set in motion whereby only 'part' of the patient is dealt with. This does not arise from the falseness of the disease model itself – the idea that it is something inside the patient that is critically important. If it were there would be much less of a problem"

can equally be applied to exclusive use of a social model of care. The evidence that only part of client need is being met comes in the following descriptions in the report.

> In social settings, behaviours are sometimes inappropriate; clients may be disinhibited, withdrawn, or behave in a bizarre fashion. Often staff seem oblivious to these problems and tend to rate clients as having "normal" non-verbal communication skills and "normal" ability to hold conversations. These ratings were not borne out by the interviewer's experience of speaking to the clients.

Psychiatric 'relapses' (although not rehospitalisation) occur and are absorbed by the daily routine. The level of training in awareness of psychiatric disorder amongst the staff is low. One staff member pointed out that a client "sits around for days and days and I can't do anything with him –then he's running around all over the place". Without being aware of the psychiatric implications of this, the keyworker dealt with these mood variations by increasing or decreasing her level of practical help.

The dangers of exclusive use of one model are outlined by Brown. One of the most important is that an atmosphere of therapeutic pessimism can be engendered by the failure to live up to the ultimate goals implicit within the model. In the following passage we have inserted words representing the social model in use in the resettlement schemes into Brown's original observation upon the problems of the wholesale adoption of one model – in his original text the medical model.

> "Medical (social) aspirations are geared to ideas of cure (improvement) based on immediate intervention preferably of a physical (practical) kind. Anything that is much short of this can lead to pessimism and the idea that nothing (else) can be done ... In the long run the discrepancy between promise and fact is likely to be sensed and resented".

One can see that there may be a built-in tendency for disappointment and disillusionment where ultimate objectives such as 'cure' or 'independence' are held as the goal. Brown argues that staff will be adversely affected by their perceived failure to achieve these ultimate objectives and that their feelings about this affects their attitudes to clients. Their attitudes are communicated to the clients who may, in turn, be adversely affected. However, as he points out, breaking achievements down into smaller units can help to provide motivation and reward for the staff.

> "Once it is recognized how little can be done a worker can be greatly rewarded by quite slow progress. The level of aspiration and the kind of feedback and reward provided by the organisation is critical".
>
> "Practices will need to be tied to specific belief structures that can be seen to be relevant. Feedback and surveillance from work teams containing a variety of professional statuses are to be preferred to formal surveillance through a lengthy hierarchical system".

There is evidence from both our qualitative and quantitative data, that clients did indeed reach their limits in many respects, and that this did affect the care staff.

> The clients reach a plateau and progress in any skill or behaviourial area is imperceptible. Under these circumstances staff can become dispirited.

There was evidence in our study of conflicting expectations about the objectives of resettlement and little evidence of supervisory support which would assist the staff to handle this conflict (although to be fair this was not studied systematically). The following passages reveal something of the conflicting views which were held.

> Staff expectations of clients vary – some thought that clients would achieve independence – practical and psychological, after careful programmes and graduated removal of support. Others were prepared for long-term support – and prepared to accept some limitations in clients.
>
> Staff expectations of the purpose and outcome of resettlement vary. Some undoubtedly believe their clients have been "wronged" – deprived by society of the chance to lead a normal life, and they view themselves as repaying a debt. Others believe that with the right support – careful, graduated programmes, gradually withdrawn, that clients will achieve full independence. Others are more pragmatic and are prepared to provide long-term support, and do not find it difficult to accept clients' limitations and disabilities.

Difference in these views, and different interpretations of the normalisation philosophy, led to real dilemmas for staff. Although they argued that the clients' appearance had improved, this was in part because some staff took the responsibility for making sure the client's appearance was acceptable.

> The improvement in the general presentation of the clients is marked – though many required 'sorting out' before they could go outside because they were dishevelled or wearing dirty clothes.

However, not all the staff saw it as their responsibility to undertake such tasks, and this could lead to diametrically opposed choices.

> A lot of attention is paid to self-care skills. Within staff terms, these issues cause much discussion and the question of interference/choice arises. If it is A's choice not to wash "how far do we interfere?" Some staff see themselves as carers and advocates – "he doesn't know what he looks like" – and try to maintain standards. Others believe in freedom of choice – "I don't get up till 12 on my day off either –why should he conform to society's expectations and look neat and tidy" (this line of reasoning does not extend as far as the choice to remain in hospital).

As Brown pointed out, in many organisations conflicts which arise from different interpretations of the philosophy, or inherent conflicts within the philosophy/ideology remain latent.

> "Organisations can survive with considerable latent conflict in goals simply by-passing it (Cyert & March, 1963). They often attend to one goal at a time and avoid facing conflict between the goals themselves".

Now, if the care staff take the view that client choice is paramount then there is a danger that they will choose to do very little. We know from Brown's early work and subsequent studies of institutionalisation that inactivity produces, in some people, a real

risk of relapse, or the onset of negative symptoms. As he pointed out:

> "much of the morbidity stemmed from the hospital itself ... the critical factor appeared to be the amount of time the individual patient spent unoccupied ... (and) ... the amount of restrictiveness on the day to day behaviour of patients ... '
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> "Life can be hell without coordinating routines, but this does not mean that all of them are essential and desirable. Routinization can have unfortunate effects on both patients and staff ..."

There were clear indications that the level of activity became a difficulty over time, and that the regular routines which develop in most homes, while necessary in some respects also had adverse consequences on the staff. The following quotations illustrate this.

> Over time the level of activity becomes a problem. Most clients express satisfaction with their own levels of activity, and these tend to be the ones who don't want to do more. Financial constraints and the lack of opportunities prevent people from engaging in more meaningful activity. Consequently two men have continued with their predischarge work at the hospital. There does seem to be an awful lot of sitting around in front of the TV. Although routines are not imposed they nevertheless tend to develop a degree of rigidity (perhaps no more than 'normal', but there is very little spontaneity).
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> Many of the staff are dismayed by the tedium of their job – endless checking on personal hygiene, cleaning, cooking and shopping. They look forward to the social development of their clients to motivate themselves too. They are very closely involved with their clients, yet need a change of clientele to maintain their interest in their work.

The problem arises of the low level of intrinsic satisfaction which comes from dull routine. Moreover, the paradoxical possibility exists that even though care staff and clients might become very skilled in the tasks required to keep ordinary life going in the home and community, the very acquisition of high levels of skill produces something like job-dissatisfaction or even low morale. Brown quotes from Tomkins (1969) who said:

> "we cannot be aware, let alone deeply enjoy just those achievements in which we are most skilled, because these result from the compression of information into programmes which run off with minimal awareness and monitoring. Such a reduction in ideo-affective density has the function of reducing the load on the channel, freeing it for new learning. The price, however, may be quite severe because it results in the paradoxical consequence that we can be rewarded least by what should give us most satisfaction i.e. the achievement of our highest skill".

What is worse, Brown anticipates that the close specification of what is to be achieved by the staff and clients can result in this low level of reward, and the possibility of staff feeling demoralised. Most unfortunate, then, that social care training in the UK (both the National Vocational Qualification (NVQ) and social work diplomas (DipSW) and post-qualifying programmes) has been conceived in terms of closely specified worker 'competencies'. Demoralisation occurs, in part, because of the close specification of outcomes, and making outcomes more 'certain' or specific. The following passages from Brown contain the seeds of these ideas.

> "If (unrewarding, unpleasant) activities are tied to some overall goal which the person accepts as worthwhile, the actual nature of the task itself may not be of critical importance ... Nonetheless, routine tasks undoubtedly give less 'intrinsic' reward.
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> Quite specific goals are ideally required ... always remembering that such practices can easily deteriorate into empty routines without an appropriate emotional climate.
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> Skills can continue to prove rewarding if outcome is uncertain; indeed the difficulty of a job may be expected to increase intrinsic rewards so long as the person is not paralysed by low probability of success".

According to these ideas, a system of care based upon unrealistic objectives, with close specification of actions and outcomes to be achieved, even when high levels of skill and competence are displayed by care workers runs the near certain risk of producing unmotivated, unrewarded staff who are less, rather than more likely, to provide adequately for their clients emotional needs. One might add that the greater the rigidity (intolerance) within the model the more likely these consequences are, and the greater the risk that clients will suffer. A rigid social model is in this respect no better than an inflexible medical one.

Acknowledgements

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Social services response to psychiatric emergencies

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This paper reports the results of a nationwide survey of social services responses to psychiatric emergencies. The survey is a companion to that by Johnson & Thornicroft (1991) (J&T) who reviewed the emergency service options available in psychiatry, including the emergency clinic, general hospital services, the emergency ward, acute day hospital and crisis intervention and residential services, as well as considering the role of sectorised services, and community mental health centres (CMHCs). For the purposes of our respective surveys of health and social services in England and Wales, we have defined a psychiatric emergency as "occurring when someone (patient, friend, relative or professional) requests urgent intervention on behalf of someone in the community who is suffering from a mental disorder".

The study

The data for the present survey were obtained from a postal questionnaire which was sent to every social services department in England and Wales. The research committee of the Association of Directors of Social Services endorsed the study, and a letter indicating that this was the case was sent with the questionnaire.

Findings

Sample size. Eighty-two authorities replied (out of 117 authorities in England and Wales), an overall rate of 70%. The overall figure would be 77% but for the relatively lower return from London, in particular Inner London authorities.

Use of hospitals for emergency admissions. London boroughs and metro/cities are more likely than counties to be working with one district general hospital (DGH) or mental hospital only. Most social services departments (SSDs) have to respond to both mental hospital and DGH units, whereas only 22% of J&T's respondents provided both forms of care.

Accident and emergency units. It is unusual, in London and the metro/cities for a local authority to relate to more than one accident and emergency (A&E) department for psychiatric emergencies. Nearly 60% of counties have to relate to two or more A&E departments, and 10% of metro/cities and 18% of counties deal with four or more. The distribution is, however, not significantly different between London boroughs, counties and metro/cites.

Community mental health centres. CMHCs which provide psychiatric emergency services for local authorities are much more common (significantly so) in counties; 77% of counties receive this service, compared with about 40% of London boroughs and metro/cities.

Emergency help lines. These are, according to our respondents, absent from 68% of authorities. We believe respondents have interpreted this question narrowly and have therefore failed to include nationally distributed organisations such as Samaritans and, perhaps, more locally based 'lifeline' phone-in services.