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'A ward in a street'

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Attempts to deliver quality service outside the traditional mental hospital to those with chronic mental illness have resulted in several new models of care. We describe one such model of alternative care and asylum. Considerable improvements in quality of life, quality of care and clinical state occurred.

Carlton Hayes Hospital is a mental hospital in the village of Narborough on the outskirts of Leicester. It originally served as the county asylum. By the late 1970s the existing facilities for rehabilitation had been successful in discharging many patients but left a 'hard core' of long-stay patients who needed high levels of nursing and psychiatric care. To meet the needs of these patients we decided to extend the concept of the 'ward in a house' (hostel ward) (Wing & Wykes 1982), to a 'ward in a street'. We placed patients in upgraded staff houses, adjacent to the hospital and surplus to requirement, where full care could be offered in domestic accommodation. We hoped the enhanced facilities would improve quality of life and might lead to a breakthrough in rehabilitation. The new unit was called the New Rutland Unit (NRU).

Description

The unit was opened in June 1989. It is scattered in clusters over a quarter mile in a residential area, with a history of acceptance and tolerance of our patients. There are three components.

(a) Five pairs of semi-detached, self-contained houses. There are three patients to a house, each with a single bedroom. A telephone connects to the hospital switchboard.

(b) Langton House – a redundant nurses' home on the edge of the hospital campus, with eight single bedrooms and communal facilities. This was first used for patients for whom there was greatest uncertainty about their ability to cope and later as an assessment unit for new entrants.

(c) Two nursing stations, one in Langton House and the other in the farthest row of houses.

Planning

Six months before the opening a multidisciplinary planning team was formed. The chief task was to carry out multidisciplinary assessments of the 41 patients on the old (Rutland) ward, all of whom were potentially eligible for the new unit. These patients, most with schizophrenia, were the least disturbed and incompetent of the five graduate, non-dementia wards. We excluded five patients, one with intractable violent behaviour, two who could not climb stairs and two who refused to leave the main hospital. One was formally detained (Home Office Order). The unit was to be tested as a model of care for those whose quality of life might be improved even if discharge was unlikely. This was a major departure from the frequent practice of making the offer of improved living conditions contingent on progress towards discharge. The principle remains a benchmark for the unit. The administration found it necessary to insist on transfer of all 36 patients with their staff and closure of

Rutland ward, in a single day. We would be entering uncharted territory, experiencing new problems with observation, supervision and offering the support required for a self-care regime. The move was planned, aims clarified, management philosophy formulated, a nursing policy produced, and finances organised. Patient activities were arranged, beginning with the choice of decor and of housemates where possible.

Our principal aims were:

(a) to offer the full range of professional care and attention usually available in hospital wards, in an environment closer to that of a normal household than that of a hostel. This would approach optimal normalisation, without sacrificing continuing expert care and treatment.
(b) to monitor:
  (i) quality of care and quality of life
  (ii) rehabilitation and discharge potential.

Staff

There were 14 daytime nurses on Rutland ward with an average of three staff on each of two shifts. Prior to the move this complement was increased to 17 to include night cover, to enable rotational shifts and to implement a system of key workers. The unit became a training area for student nurses. There was no change in medical input from the part-time rehabilitation consultant and registrar. An occupational therapist, a social worker and a psychologist, all part-time, completed the team.

The move

This took place on a Monday, patients moving in four groups. Larders and refrigerators were filled over the weekend, even though few patients possessed cooking skills at the time. A robbery in one house on the Sunday did not help. Although some staff found themselves relatively isolated the first author was relieved to find everything calm and in order by the evening. No patient suffered any crisis or clinical disturbance.

Functioning of the unit

A budget is provided for food and household materials. Under supervision, residents look after their accommodation, clean, plan menus, shop and prepare meals. Staff assist with activities of daily living, making up any shortfall in skills. Emphasis is put on leisure and social activities. Residents are free to come and go and have increasingly made use of public amenities such as leisure centres and adult education. Individual and group work takes place in social skills, assertion training, road safety, 'time to move on', etc. New entrants come by referral to Langton House for a six week multidisciplinary assessment. We then hold a review and develop a care plan. At subsequent reviews this plan is refined and where appropriate discharge plans initiated with case managers. Residents attend all reviews and participate in discussions.

Monitoring

Thirty-six patients were transferred to the unit in June 1989. By the end of 1990 16 were discharged, of whom ten went to independent accommodation. None of these were previously considered likely to improve to this extent. By June 1993, 64 had been discharged. Seven had been readmitted, all for clinical relapse. Only one was refused admission, because of limited mobility. A controlled study was not possible but we monitored changes in mental state and in levels of function, required supervision, activity, social contact, patient satisfaction, relatives' satisfaction, quality of life, quality of the physical environment, staff satisfaction and changes in nursing practice. Measures of satisfaction, required supervision, activity and social contact showed the most dramatic changes but the other parameters also improved. Over the six months spanning the move the total unit consumption of psychotropic medication did not change significantly. Nursing practices changed with more time spent in direct work with patients. Work satisfaction increased dramatically but stress levels were higher, probably because the nurses were more thinly spread over a larger area and needed more support than it was possible to give.

Discussion

In the climate of hospital closure it is important to distinguish between developments which mainly serve the purpose of closure and those which genuinely benefit patients. Recent tragic cases highlight that the most enlightened plans can be fraught with unforeseen and damaging consequences. There is clearly a persisting need for care and asylum for some patients but alternatives to the traditional back ward must be devised.

The NRU is an attempt to offer asylum, with the level of psychiatric care available in a hospital, but delivered in a domestic and quasi 'community' setting. Compared with communal settings, such as hostel wards and hostels, this approaches nearer an optimal combination of 'normalisation' on the one hand, with a protective and therapeutic 'haven' on the other (Wing &

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Furlong, 1986; Wykes, 1982; Wing & Wykes, 1982).

The unit has fulfilled its aims at the minor expense of upgrading the houses and a few extra staff. Its limitations seem contingent on physical and staffing resources and are, in principle, remediable. Some patients who cannot cope alone, even after rehabilitation, are coping and enjoying life on NRU. A large number of the 'hard core' have been successfully discharged. The opinions of staff, patients and relatives point to satisfaction with the improvements in quality of life, care and physical environment. Relatives, ex-patients and neighbours continue to show interest and provide support. There has been overall improvement for some and stabilisation for others in mental state and level of function, decreased requirement for supervision, greater contact with relatives and use of community facilities. This is not surprising because the new facilities have enabled increased therapeutic activity. There has been little inclination to mix with people outside the hospital community and this agrees with other studies (Knapp *et al*, 1990). Mental state rather than competence was the main determinant of discharge, transfer back to the main hospital and readmission. If this is a general phenomenon it may be worth considering whether, when community care fails, it might be because competence rather than control of symptoms, has been the main criterion for placement.

Conclusions

The 'ward in a street' can substantially benefit some long-term mentally ill patients who need continuing professional care and asylum. Under these conditions there is a better quality of life and a greater possibility of clinical and social improvement than in a traditional hospital setting.

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