hostels for the mentally disordered

Elizabeth Durkin

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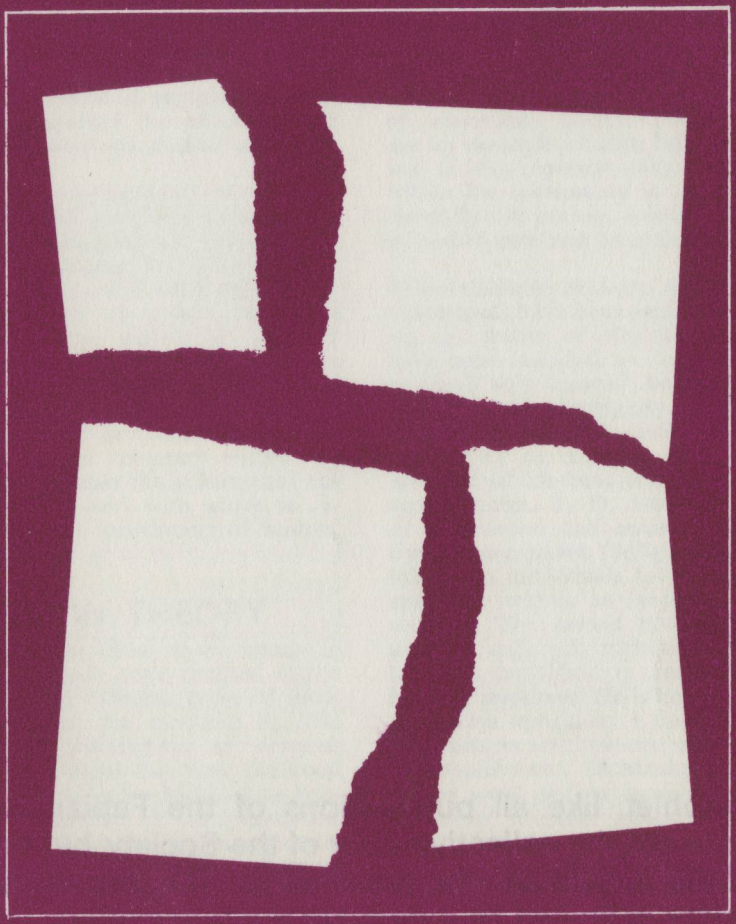

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hostels for the mentally disordered

Peter Mittler (*Mental health services in the community,* Fabian occasional paper 4) stated that "very little is known about the kind of hostels at present available, the way they are to be staffed and run and the kind of patients they propose to admit". This pamphlet aims to clarify the aims and functions of hostels, for the entire concept is at present confused. It can be said that hostels are institutions with varying numbers of residents, which lie on the spectrum of care for the mentally disordered, together with psychiatric and day hospitals, group homes, day centres, and boarding out schemes. Hostels developed, in particular, as a result of the recent growth of psychiatric knowledge which stressed the effects of the social environment on mental disorders.

However, the varying types of environment that would positively assist in the treatment of the different mental disorders are at present far from evident, and this confusion has been reflected in the establishment of hostels. Although there are many individual schemes throughout the country, there has been no unified policy concerning hostels and their organisation. This is also because of unco-ordinated development by local authorities, certain voluntary bodies and hospitals and because the government has no mandatory powers with which to rationalise the total functioning of hostels.

HOSTELS IN THEORY

There have been three main trends in social policy which have resulted in the establishment of different types of institutional care for the mentally ill. *The policy of the elimination of deviants from society*. Taking this view the good of society is seen to be achieved by protecting the majority of the population from deviants by isolating the mentally ill and subnormal in large institutions as was implemented in the nineteenth century. This policy was viewed as an economical method of caring for a dependant sections of the population. *The policy of rehabilitation*. According to this concept the good of society is promoted by encouraging the individual to conform to the values of the community. This concept led to the transition from care within large institutions to the establishment of facilities to provide care for the mentally disordered within the community. This policy emerged when the demand for unskilled, low paid labour was at its maximum and it was hoped that rehabilitated patients trained in such work would become employable within the community. *The maintenance of the deviant within the community*. This policy equates the good of society with the good of all the individuals within it, even if they are deviants. In an industrial society based on competition, some individuals will always fail to achieve the high standards of community norms. The mentally ill are an example of such failures. According to this concept they are accepted within the community in the role of the mentally ill person, without being expected to conform to community norms.

From available evidence it would appear that hostels have been established according to a policy of rehabilitation. Hostels have been intended as "stepping stones" or "half way houses" between the hospital and the community, aiming at the full integration of the individual into the community by assisting him in the adjustment of his behaviour to that of the accept norm. J. D. Edwards (*Conflict of expectation and achievement in residential care*. NAMH 1967), stated that hostels "help individuals to be independent and live within an accepted code of society". The period of training is on average only six months, after which time the individual is frequently left to his own resources. He is taught to assume the values upheld by a competitive society, such as self responsibility and regular employment. Olshansky (*The meaning of work and its implications for the ex-mental hospital patient,* Mental hygiene 1963, vol 47), stresses the importance of employment in resocialisation as a means of extending the individual's role and providing an opportunity for relationship formation. The Ministry of Health survey (*Survey of* 31 *hospitals,* HMSO, 1966) stressed that future residents were only to be admitted to hostels when in employment and R. Z. Apte (*The tran-*

sitional hostel for the mentally ill, theses unpublished at LSE library) showed that 80 per cent of local authority hostels and 67 per cent of the voluntary hostels held policies on employment as a criteria of selection. The emphasis on employability, apart from any economic motives the hostel may have of ensuring maximum payment by the resident, is consistent with the policy of rehabilitation.

The Richmond fellowship, a voluntary organisation establishing hostels, states that they select people who seem capable of considerable improvement in their adjustment to life. The persistence of this aim results in certain categories of the mentally ill being consistently excluded from hostels. In particular the so called personality disordered, phychopaths, epileptics and alcoholics, are considered to be least acceptable within a hostel. R. Z. Apte (*ibid*) showed that the voluntary societies in particular discriminate in this way. For the categories of mentally ill who are not capable of achieving complete integration into the community because the nature of their illness conflicts with community norms or because they no longer require continuous hospital treatment, and for those who will need continual social support, a different type of hostel is required. The compensatory hostel is a hostel which replaces the home environment, and provides long term protective care for the mentally ill within the community and compensates for their otherwise low position on the social scale. Such a hostel fulfils a third social policy whereby the mentally ill are accepted in that role within the community. In practice the distinction between rehabilitative and compensatory hostels is not recognised, with the result that neither function is fully achieved.

REHABILITATIVE HOSTELS IN PRACTICE

Although the mental after care association pioneered hostels for the mentally ill, the first government legislation was the National Health Service Act of 1948, section 28 of which gave the local authorities permissive powers to build hostels, but little occurred as a result of this act. Certain mental hospitals built hostels, some within hospital grounds, but further progress awaited the Mental Health Act 1959 which made compulsory the powers outlined in 1948. From this time the development of hostels was marked with uncertainty and in 1961 in the House of Commons, Kenneth Robinson asked why so few hostels had been built. The reply was that the local authorities had been fully occupied implementing other sections of the 1959 act. Without further enquiry into the causes of delay the hospital plan of 1962 advocated an increase in hostels before 1975, with the intention of reducing the numbers of beds in mental hospitals by 40 per cent, whilst replacing such care by hostels and other community care provisions. It is planned to have 259 hostels in 1976 caring for 4,966 residents. This compares with 1965 when there were 41 local authority hostels for the mentally ill with 813 residents. (The Williams report, *Caring for the people, the staffing of residential homes,* national institute for social work training, no 11, Allen and Unwin, 1967, p121).

One main reason for such extensive plans was the prevailing public opinion regarding the conditions of mental hospitals. They had been exposed as large neglected institutions where the mentally ill developed "institutional neurosis" as a result of the environment. This is a separate illness characterised by apathy, submissiveness and an inability to make dedisions. Barton claimed that it was caused by loss of contact with the outside world, loss of possessions, over sedation, authoritarian staff attitudes and enforced idleness, all of which he found in the large hospitals. Evidence had also been produced showing that large numbers of patients were in mental hospitals precisely because they had nowhere else to go, even though they were not in need of extensive nursing care. The hostel was seen as an alternative for such patients. Perhaps the most important influence leading to the proposed increase in hostels was the advance in biochemistry, which resulted in the more rapid treatment of mental illness, and enabled patients to be treated, for the most part, outside hospital. This development placed

a new emphasis on community care and led to the reduction in the proportion of patients requiring hospital care.

Despite the proposals for expansion, few hostels were built after 1962. R. Z. Apte (*op cit*) shows that of plans for hostel development up to 1975 submitted by 83 authorities, 42 per cent had, after a year, decreased the scope of their aims; 14 had given up their plans altogether, 11 had reduced the number of hostels they had proposed to open and 10 had reduced the size of the hostels. The delay is rather typical of provisions for the mentally ill; for they are an inarticulate section of society and tend to be given low financial priority.

lack of consistent policy

Rehin and Martin (*Psychiatric services in* 1975—Planning xxix no 468, 1963) showed, in a survey of a number of documents sent by local authorities to the Ministry of Health that "few claimed to have surveyed the probable demand and produced figures". Such hesitation by the local authorities is partly explained by the lack of public support for hostel development, several authorities meeting opposition from the local neighbourhoods. Yet it is important for local authorities to realise that the establishment of hostels can be a means of educating the public about mental disorders and of reducing the apprehension and prejudice that surrounds them. Hostels can provide an opportunity for public participation in the support of the mentally ill and subnormal within the community. Some local authorities saw the provision of hostels as the function of the regional hospital boards and as a result made no attempt to establish any. In general, however, many local authorities were overwhelmed with the increase in their responsibilities in the mental health field, particularly as they received little guidance from the government on community care priorities. There were also fears that hostels would become chronic wards in the community, so there was much stress on rehabilitation. When the rehabilitative aim was not always successful and patients returned to hospital, the hostel tended to be under-occupied, with the result that local authorities lost faith in the function of hostels.

There seems to have been little co-ordination between the hospitals and the local authorities. Temple-Phillips ("Hostels for the mentally disordered," *The Medical Officer,* 1966, vol 65, no 7) mentions the reticence of hospitals in making referrals and R. Z. Apte (*op cit*) found that only two out of 16 local authority hostels had based their hostel plans on probable demand from the hospital. This lack of co-ordination is mainly due to the lack of coherent policy formulation. Some hospitals, with the inevitable shortage of nursing staff, see the local authority hostel as primarily a means of reducing the numbers of patients in hospital beds and, most unsuitably, refer long institutionalised patients to rehabilitative hostels. The hospital should ideally have wards graded up to the social organisation of a local authority hostel, so that the patient can gradually adapt to the increase in stress. The hostel could then be a continuation of hospital treatment. Such a scheme would require close co-operation between the two institutions and one means of achieving this is by the appointment of social workers in joint user posts who can provide some means of liaison, along with conferences, and selection and discharge meetings. As a result of the general confusion in policy, it has been difficult for the administration to develop an efficient system. One major result of such indecision has been the under occupation of hostels, in itself a further reason for the delay in the progress of hostels.

under occupation

There is much evidence that some hostels have been grossly under occupied. Temple Philips (*ibid*) discovered less than 50 per cent occupancy in hostels for the mentally ill in county boroughs, and 43 per cent in county council hostels. Fletcher (*Mental health hostels, progress and problems,* Buckinghamshire department of health and welfare, 1970) and R. Z.

Apte, reported similarly. Apart from difficulties in the referral of cases from hospitals, under occupation can occur because the hostel is attempting to rehabilitate those unsuited to such a policy, e.g. Howe Hill Hostel, which was trying to provide short term care for the subnormal. (Tilbury, "Review of Howe Hill Rehabitation Centre, York," *The Medical Officer,* 1966, vol 115). Local authorities in the face of under occupation, and to justify the continued existence of the hostel, have taken unfortunate measures to ensure that they are fully occupied. Some have widened the entry requirement in hostels. G. H. Mountney said, "with a full staff and an empty hostel it was difficult to be over selective" (*British Journal of Psychiatric Social Work,* 1965, vol 8). Evidence from Dorset where boys and girls up to eleven years of age are mixed with adult women, and from Warrington where subnormal children and adults are mixed, suggests that these arrangements are unsatisfactory. Temple Phillips reports that in 20 out of the 68 hostels in the county boroughs, the mentally ill and subnormal are mixed with psychopaths and the senile, in order to ensure full occpation of the hostel. Such action results in the rehabilitation and long term functions of a hostel becoming confused, as the places in rehabilitative hostels become blocked with long stay residents.

Also it appears that hostels which had been open for a longer period of time had a greater proportion of long term residents. Fletcher (*op cit*) remarks on the consequences of such a situation, "to maintain a rehabilitative *milieu* is virtually impossible when the social pattern of the hostel is dominated by a stable group who regard the hostel as a permanent home, and who are reluctant to accept new tenants". That hostels with long term residents are less conducive to rehabilitation was illustrated by R. Z. Apte, who showed these hostels to be more restrictive in character, with little stress on self responsibility or the need for regular employment. It would appear particularly from Apte's survey and from other evidence that the categories of resident who remained long term were the females over the age of 60, the widows, the senile and subnormal, and those who had been long hospitalised. Such categories are unsuited to the nature of a rehabilitative hostel and thwart its proper functioning.

A further response to under occupation has been the recent development of the preventive role of hostels. When insufficient places are filled by referrals from hospitals, residents are admitted directly from the community. Although this action deviates from the idea of the hostel as a stepping stone between the hospital and the community, it is obviously a valuable function of hostels if hospital admission is thereby avoided. R. Z. Apte found that one third of the residents in his survey had been almitted directly from the community. Similar findings were made by A. C. Campbell, although both found that this policy is not always successful. Campbell found that for 9.5 per cent of patients the hostel was, in actual fact, becoming a stepping stone from the community into an institution! (*Medical Officer,* September 1968). One reason for this occurrence is because of a lack of intensive psychiatric care in hostels, care which a patient often requires in the first stages of the illness. Also many enter directly from home because of the breakdown of home care and therefore are more in need of a permanent replacement of the home and are consequently more suitable for a compensatory than a rehabilitative hostel. The rehabilitative hostel seems to be most successful when the individual has social contacts within the community which can provide some support when he leaves the hostel. Both major responses to under occupation, the widening of the categories of need admitted to the hostel, and the admitting of patients directly from the community, result in the confusion of the rehabilitative and compensatory functions.

the regime of hostels

R. Z. Apte (*Halfway houses,* Occasional papers in social administration, no 27) conducted a survey into the varying regimes of hostels. If rehabilitative and

compensatory hostels are to fulfil different functions they must contain different types of social organisation. At present he says "the social atmosphere of a hostel has a peculiarly indefinable quality; it is neither like a home nor a traditional mental institution". A rehabilitative hostel should be permissive in character, leaving the individual as much freedom and responsibility as possible in areas such as social relationships, dress, personal belongings and leisure activities. Wherever possible, residents should be encouraged to participate in the administration of the hostel by choosing their own menus, making their own rules and selecting new residents. Ideally a compensatory hostel would be similarly organised, but the residents would be less motivated than those in a rehabilitative hostel and would be in need of more cohesive social support and direction, therefore a greater amount of imposed organisation would be expected in compensatory hostels. Apte found that in practice rehabilitative hostels were more restrictive than is imagined. Many in their control over social relationships, placed restrictions on smoking, the drinking of alcohol and watching of television, and their refusal to allow residents any part in the administration of the hostel, bore more resemblance to a hospital ward than to life in the community.

One of the reasons for such restrictiveness is the staffing of hostels by trained hospital nurses, who tend to impose the organisation and discipline of a hospital within the hostel. It is questionable whether or not a psychiatrist should be specifically attached to a hostel. Such an arrangement would provide regular psychiatric advice for the residents, yet if the sick role is to be discouraged in a rehabilitative hostel perhaps the residents should receive medical treatment, in the same way as the average individual, from a general practitioner and by out patient appointments. Further research is necessary to provide a more detailed clarification of the most suitable types of social organisation within a hostel for different categories of resident, since the existing organisation of hostels is not related to the needs of the residents.

There is a severe staff shortage. Temple Phillips found that 50 per cent of the hostels in his survey had difficulties in staff recruitment. Fletcher reports of similar problems in Buckinghamshire, and Apte found that the ratio of staff to residents varied considerably, ranging from 1:4 to 1:33. The Williams report (*op cit*) points to certain factors, such as the extended education and the earlier age of marriage of women, as well as the growth of alternative employment for women, as having influenced the decline in the number of available staff. Yet the main reason for a shortage of staff would seem to be the conditions of employment.

staffing shortage

The work is of a residential nature and four-fifths of existing employees work full time, there is no agreed salary scale and the work is fully absorbing, with little time for leisure and a minimum of privacy. The existing staff shortage prevents the possibility of staff acting as replacements to allow for the current staff to have weekends and holidays free. Several changes are necessary if more staff are to be attracted. The Williams report recommended a 40 hour week for hostel staff with 1½ days full time and one long weekend leave in each month and it advocated the formation of a salary scale. In rehabititative hostels there has been an emphasis on residential staff. This has arisen from the concept of the hostel as a family unit with the warden and his wife representing the father and mother. This view inevitably includes the residents in the role of children. Such a role is possibly suited to the residents of a compensatory hostel which is to replace home care, but it would not seem essential to the functions of a rehabilitative hostel in which the aim is to encourage self responsibility and independence. That the idea has been advocated is evident from the fact that 34 per cent of wardens are married. Yet there is evidence that married couples are not altogether suitably for hostel management, this is partly because the family tends to maintain itself as a separate unit rather than achieving a total family atmosphere as was intended.

There is evidence that non-resident staff are suitable for hostels. In Oldham, according to Temple Phillips, one hostel has no residential staff at all, although it contains 31 residents, a supervisory part time warden is employed, and the remaining staff take turns at sleeping in. There must be a distinction made at this point between the hostel with non-residential or supervisory staff and the group home, which is a small house which a group of residents share without supervision. This is a further stage towards the complete independence of the individual and a resident from a rehabilitative hostel could graduate into such an environment if it were available. The effects of the policy of employing non-residential staff need to be more closely examined, but if it were more widely adopted it would relieve staff shortage.

support from social workers

There is a vast turnover of staff in hostels. One major problem in maintaining staff is the lack of support they receive. Fletcher remarks, "the position of warden reminds me of an expeditionary force sent into unchartered land, continually receiving a stream of instructions from a large number of commanding officers comfortably sitting behind the lines and rarely visiting the front, and the warden does not know what the war is about or whether it is being won or lost".

There is evidence from Wandsworth, according to Temple Phillips, that staff tend to remain if they receive assistance from a social worker. Unfortunately this is not always available, partly because of the shortage of mental health social workers, as was elaborated by Peter Mittler (*op cit*). When social workers are appointed to work with the hostel staff it is not an easy task because the respective roles of the social worker and warden are undefined. A. Julia (*New thinking about institutional care,* London ASW 1967) and B. Munday (*Case conference* 1968, vol 5, no 1) quote the social worker as coping with emotional problems, problems of relationships and group work, whilst the hostel staff deal with everyday problems. Yet the constant availability of the hostel staff frequently leads to the residents feeling better able to discuss their problems with them. In view of the likelihood of conflict, it is essential that social workers and hostel staff have conferences in order to clarify their mutual roles.

role definition for the staff

An analysis of the staff involved in the selection of hostel residents is useful to illustrate the confused role boundaries between those concerned with the hostel. A. Julia reports that in a local authority hostel the warden and social worker interview the patient at the hospital and the medical officer of health makes the final decision. J. D. Edwards (*op cit*) reports similarly, and in both cases the warden has some influence in the choice. In the hostels run by the Richmond fellowship the choice is made entirely by the hostel staff. Yet in the Ministry of Health survey (*Survey of* 31 *hostels,* 1966, HMSO) it is pointed out that the warden is unable to reject anyone whom he considers unsuitable and R. Z. Apte found that in 60 per cent of the hostels in his survey the medical officer of health, the psychiatric consultant and the mental welfare officer generally made the decision with little responsibility being given to the warden. There is a tendency for the warden to be omitted in decision making because his role is ill defined and consequently his status is not respected by the local government and hospital authorities. To quote the Williams report (*op cit*) "without having trained people in the position of warden and without more community services to help them, it is a question of what untrained staff could achieve to improve on the performance of a landlady". At present the only available training scheme is that of the Richmond fellowship, a primarily religious organisation which offers courses for hostel staff. This in itself is insufficient. Courses should be established by the government in an attempt to raise the status of hostel staff, to clarify the roles they are to play and to define their varying functions in different types of hostel organisation.

R. Z. Apte found that the majority of wardens saw their role as restrictive rather than permissive. This is demonstrated by the fact that, for instance, one third of the staff wore a uniform, few shared social activities with the residents, 60 per cent never watched television with the residents and 37 per cent had separate staff sitting rooms. One reason for such attitudes could be that the majority of wardens are over 60 years of age and tend to view the post as a semi-retirement occupation. Being of this age group they may tend to possess more disciplinarian attitudes. However, the main reason for such restrictiveness is that the majority of hostel staff seem to be ex-mental nurses who are familiar with a hospital environment and tend to transfer such values to the hostel. Such staff values although possibly more suited to a compensatory hostel are inimical to the rehabilitative aim. G. H. Mountney, chief mental health social worker in Salford, speaks of their recruitment as "foolish indeed to all concerned" (*op cit*). It is essential that the different functions of the rehabilitative and compensatory hostel should be quite distinct so that staff can be trained for each type of social organisation. When the roles of hostel staff are clearly defined according to the type of hostel in which they work, there is more likelihood of the needs of all the varying categories of patient being met.

THE COMPENSATORY HOSTEL

F. J. Esher ("Subnormality hostels—two different functions"—*Mental Health*, 1965, 24, no 3, p124), describes the hostel as a "modern replacement of institutional care". The compensatory hostel is exactly this. It provides a permanent home for certain categories of mentally ill who because of the nature of their illness could never be rehabilitated. Such a hostel compensates for the inability of the community in an industrial society to tolerate those unable to keep up with its demands. A compensatory hostel avoids the otherwise inevitable results of such illness, either social isolation within the community or non-identity within a large institution.

The hospital plan advocates a vast increase in hostels for the mentally subnormal from 2,346 residents in 122 premises in 1965 to 11,560 residents in 545 hostels by 1976. Much has been stated about the vast numbers in hospitals for the mentally subnormal who could be discharged to hostels. McKeown ("The medical and social needs of patients in hospitals for the mentally subnormal," *British Journal of Preventive and Social Medicine* 1967, vol 20 no 2), showed that in a Birmingham hospital for the subnormal in 1965, 66 per cent of the patients required no nursing care at all. The national society for mentally handicapped children recently suggested that 40 per cent of the 64,000 patients in hospitals for the mentally subnormal were not in need of hospital care and CARE, an organisation which is establishing villages for the subnormal, puts the figure at 60 per cent. S. Gilberdale recently studied female, high grade patients at Harperbury Hospital and found that 64 per cent of her sample could have been discharged, but she states that many subnormals suffer physical as well as mental illnesses; in particular, many are epileptic or incontinent and, therefore, the numbers who could be discharged from the total hospital population is in fact uncertain. She points out also that, of the 64 per cent high grade patients who could be discharged, the majority would require a long term protective environment and therefore the compensatory hostel would seem to be the most suitable for the subnormal.

One hostel of this type which appears to be functioning successfully is Torrington House in Coventry. However, there would appear to be a need for rehabilitative hostels for the borderline cases of subnormality, particularly for those with behavioural difficulties who potentially could become re-integrated into society. Stein and Susser ("Estimating hostel needs for backward citizens",*Lancet* 2, 1960) found that many educationally subnormal children had a prolonged period of adolescence during which time behavioural difficulties might arise in the home and a hostel might be necessary for a short time.

It is important that wherever such a hostel is built a training centre should be available, as many of the residents will not be fit for employment. Fletcher remarks that the residents should never be used as domestics in the hostel, which sometimes occurs, but that they should be occupied at a training centre. It may be asked what advantages are to be obtained from such long term care as compared with hospital care. The fact is that there are subnormal patients in hospital who no longer require nursing care but who will always require some supervision. In a hostel they have the opportunity of becoming part of the community. They can participate as fully as they are able in community activities and also they remain in close contact with relatives. It is important that the community within which the hostel is built should establish as much contact as possible with the hostel. This is bound to be difficult but hostels can be a means of reassuring the public about mental subnormality, which, in general, they tend to regard as less frightening than mental illness.

hostels for the psycho-geriatric

Temple Phillips and Apte both found the elderly mentally ill to be blocking places in rehabilitative hostels. In particular single and widowed women over the age of 60 and those who had been in hospital for a long time, tended to remain in the hostel as long term residents. Such evidence suggests that these categories are suitable for long term hostel care. A compensatory hostel can replace social contacts, a lack of which would seem to be a major reason for the inability of the elderly to cope within the community.

Connolly (*The Medical Officer,* 1962, vol 108, p95) examined the circumstances of admission of residents age 60 and over, to a Newcastle mental hospital, and found that the majority were only admitted when their home environment had broken down. At present the psycho-geriatric cases are primarily cared for in the mental hospitals and, as there are few beds available, the patient is frequently not admitted until he is extremely ill, which causes much distress to the relatives, the general practitioner and the patient. Ideally compensatory hostels would admit the elderly patient at an earlier stage and provide the support required, at the same time the patient would be more likely to remain in close proximity to his relatives. Living within the small group in the hostel there is less loss of self identity, which is frequently experienced on entrance into a geriatric ward in a hospital. Such hostels are particularly necessary in areas of high mobility where families are divided and less able to care for their aged relatives and where the elderly are more likely to live alone. Some compensatory hostels for the aged do already exist, but more are needed to relieve pressure on the hospitals.

hostels for the homeless and the chronic mentally ill

There is considerable evidence that a large number of the homeless, vagrant population are in fact chronically mentally ill, and the proportion would appear to be on the increase. Griffiths-Edwards in a study of residents in a Camberwell reception centre ("Census of a reception centre, *British Journal of Psychiatry,* vol 116, p1031-9) found that 26 per cent had been in a psychiatric hospital, and more recently Dr. Lodge Patch found a higher percentage in a study of Salvation Army hostels. The "revolving door" policy of 1962 stressed the values of rehabilitation and community care. Since then the mentally ill have been discharged into the community from hospital as no longer requiring hospital treatment. Yet there is a compete category of individuals who were protected within a psychiatric hospital which performed the function of an asylum from the community. Now those individuals who are unable to cope within society are denied this protection, they enter the community whose provisions are in the main focussed towards rehabilitation and they tend to swell the numbers of vagrants, unemployed and criminals. Rollin (*New Society,* 18 January 1970) showed an increasing number of criminals to have psychiatric histories. Berry and Orwin ("No fixed abode," *British Journal of Psychiatry,* October

1966) in an analysis of admissions to psychiatric hospitals showed a threefold increase between 1962 and 1964 in those admitted from no fixed abode.

If psychiatric hospitals are to perform a purely treatment function then hostels must be built to assume the role of protecting the mentally disordered from the pressures of the environment. Some hostels do already exist for the homeless but they are in the main large impersonal institutions providing a temporary place of shelter at low financial cost. Many homeless sleep rough each night in the cities and the need for more permanent shelter is apparent, to quote M. Shrewsbury (Shrewsbury, Kahle, Thompson "Homes for the homeless", *Prison Service Journal* 1968, vol VI) "present methods for dealing with social inadequates, or misfits, drunks or social nuisances are futile, we are more than ever convinced that there is only one possible answer to their needs, to provide a permanent home and care for them". Small hostels are needed to provide a permanent protective environment for those whose illness renders them "failures in a society which has become increasingly intolerant of failures" (L. Tuft, "Beyond the fringe", *Mental Health* 1965, vol 24).

hostels for alcoholics

Psychiatric hospitals and local authority mental health departments are constantly confronted with the problems of the chronic alcoholic. They are in general excluded from hostels because they are unlikely to be able to be rehabilitated. Alcoholics are also a category which is excluded from society because they contravene social norms. They are often unable to hold down employment, they tend to have criminal records and many are social isolates. The compensatory hostel is recommended by Griffiths-Edwards ("London's skid row", *The Lancet* 1966, vol 1, p249) "the basis of help must be to offer lifetime hostel care, dependancy on the hostel must be accepted". Rathcoole House in Clapham, is one of the few examples of a compensatory hostel for alcoholics. T. Cook (Cook, Morgan, Pollak "The Rathcoole experiment: first year at the hostel for vagrant alcoholics", *British Medical Journal* 1968, vol 1) describes the individual as socially isolated and apathetic, the majority had been on "skid row", they had no stable employment and were of a low socio-economic group, furthermore over half the men admitted during the first year had had 50 or more convictions for drunkenness. Many had previously wandered about the country staying at large hostels for brief periods. At Rathcoole House they were assured of a permanent home and could develop a sense of identity within it, and they gained mutual support in their renunciation of drink. The residents participate in the policy making of Rathcoole House and select new residents. A compensatory hostel not only protects the alcoholic but provides him with a positive role within the hostel setting which will enable him to regain self confidence.

hostels for drug addicts

It is widely held that there are very limited facilities available to assist the drug addict. In April 1969 the Ministry of Health issued a circular to local authorities recommending that hostels should be built for drug addicts to bridge the gap between the hospital and the community, thus stressing the rehabilitative function. Yet most drug addiction is a long term problem and although it may be temporarily alleviated by hostel care, addiction would be most likely to recur when the addict re-entered the community, particularly if he was to continue an existence void of social contacts or revert to the friendship of fellow addicts. Yet the country house idea discussed in *New Society* (2 July 1970) is not an answer. Such a home would provide a refuge for the addict but would not provide a long term opportunity for the individual to learn to live within the community. Long term hostels within the community are necessary, with opportunities for the addict to move into a less sheltered environment when he feels able to cope with its demands. In America the Synanon hostels offer permanent accom-

modation for addicts and they participate in hostel administration. In so far as Rathcoole House functions for alcoholics there is no reason why similar hostels for drug addicts should not function successfully in this country. Instead drug addicts, like alcoholics, at present gravitate towards the psychiatric hospitals which are not fully equipped to cope with this problem and once again they tend to engage in the treatment of the addict rather than provide him with a long term protective environment.

These hostels give a compensatory environment for those lacking social contacts and unable to establish relationships in the community. Yet apart from these categories the compensatory hostel could possibly be equally functional for the more general categories of mentally ill. With the limited amount of research available into the relationship of the social environment to mental illness or subnormality, it would be difficult to segregate those patients capable of rehabitation from those more suited to a compensatory hostel, other than by the subjective judgment of social workers and psychiatrists.

administrative implications

Hostels for the mentally ill are at present administered by three separate authorities, the hospitals, local authorities and voluntary organisations. Unless some attempt is made at co-ordination, hostels will develop as haphazardly as did the hospitals which emerged out of the poor law, monasteries and the voluntary movement. It is in the nature of a rehabilitative hostel that it is established within the locality in order that residents may retain and make social relationships, obtain employment and be prepared for eventual integration into the local environment, whilst maintaining a link with the hostel if necessary. The appropriate authority for their administration would therefore appear to be the local authority; ideally hostels would be administered by Seebohm type departments, which would also co-ordinate the work of the statutory and voluntary hostels.

Local authority housing departments should be alert to the need to allocate council houses as hostels and certainly more co-ordination is necessary between housing and health and welfare departments on this matter. In the case of compensatory hostels, as it is their policy to provide for more specialised and long term needs, it is likely that they would require a larger catchment area, also as the residents are less likely to be in employment, such hostels would be a financial burden on the local authority. Compensatory hostels would be more suitably organised at a regional level. This would also allow for organisation according to the needs of each area, as alcoholism, vagrancy, and schizophrenia appear to be concentrated in certain areas. This does not mean, however, that they should be isolated institutions, it is important that both types of hostel should be situated close to community facilities.

Crossman's green paper (*The future structure of the national health service*, HMSO, 1970) recommended that institutions should be administered by the local authorities wherever the "primary skill" is social care and support and by area health boards when the "primary skill" is of a medical nature. If this policy is enacted as the green paper suggests there would be a division between those hostels where residents require constant psychiatric supervision and those not requiring such care. In the case of the mentally subnormal, it is perhaps possible to make a distinction between the chronic subnormal case needing constant medical care and the adult borderline subnormal who does not need continuous medical care as long as medical advice is readily available. Yet is it possible to make such a distinction with regard to the mentally ill, the alcoholics and the other categories? In the case of schizophrenics it is likely that they will always require some medical care, yet the reasons for them living in a hostel could be primarily social. It would in practice be difficult to split the disciplines of medicine and social work in a way which, in effect, states that for the different categories of mentally ill in hostels one discipline is more relevant than the other. The ques-

tion is raised whether the administration of hostels should be on the basis of relevant professional skill or on the basis of area size and needs previously discussed.

THE FUTURE ROLE OF THE PSYCHIATRIC HOSPITAL

Recent policy has been almost entirely concerned with community care provisions, psychiatric hospitals receiving only gross criticism. The reduction of the numbers of patients in psychiatric hospitals as advocated by the hospital plan in 1962 is now unlikely to be realised. Because of a general shortage of community resources patients are not being discharged as rapidly as was planned; this is also due, in part, to the fact that fewer patients are able to be rehabilitated than was expected. Yet the hospitals are being denied additional resources on the basis that they will soon have fewer patients. A vicious circle has been set up and the hospitals are so lacking in resources that patients are being discharged haphazardly into a community without adequate community care facilities. To prevent the further deterioration of the hospitals their role should be clarified. There will always be the psychogeriatric and cases of organic mental disorder as well as the severely subnormal who require constant nursing care. Such cases account for the majority of patients at present in psychiatric hospitals. If hospitals are to be denied resources this group is bound to suffer. For those patients who do not require nursing care but who need a protective environment, compensatory hostels could replace hospital care. For those capable of rehabilitation hospital care is necessary during the acute phase of the illness and also wards organised towards rehabilitation can be provided, to initiate a process which can be continued afterwards in the community. In the immediate future resources should possibly be concentrated on rehabilitative facilities, yet if compensatory hostels are not to be provided then hospitals should be allocated greater resources in order to carry out their function in even the most minimal way. If rehabilitative hostels alone are to be provided at present, then hospitals should accept that they are the only available institution, apart from prisons, which can perform the function of protection rather than treatment and, until more facilities are available in the community, patients should not be thrust into the community purely because they do not respond to treatment. Hospitals can still perform a valuable function and the disadvantages of large isolated, archaic institutions can to some extent be overcome. The effects of institutionalisation can be avoided by the introduction of democratic organisation within the hospital, as at Severalls Hospital, Colchester.

The isolation of the hospitals from the community can be lessened by the provision of transport facilities by the local authorities to assist relatives in their visiting of patients. In spite of the onslaught on the hospitals, much can be said in favour of improving their functioning until such time as community care facilities can be increased in proportion to needs.

CONCLUSIONS

The need for two separate types of hostel has been discussed and it has been shown that there has been little thought as to the aims, functions and effectiveness of different types of social organisation in hostels catering for different needs. One reason why there has been so much stress on rehabilitation is that the values of the medical profession tend to place emphasis on the good prognostic categories. Fletcher remarks that the hostel has been run as a clinical treatment service. Far more team work is necessary in the administration of hostels and in policy making, betwen doctors, social workers and the hostel staff. Instead the hostel staff are frequently ignored and social workers deployed "in a self protective way to handle outsiders carefully, ward off difficult relatives, to dispose of unwanted patients, in general to lubricate the rough working surfaces of the machine" (Fletcher).

Hostels are but part of the spectrum of care for the mentally ill. If more hostels

are to be built, other facilities must be increased accordingly. In particular there must be group homes to receive residents from the rehabilitative hostels when they reach a stage whereby they can cope with an increase in stress. R. Fox mentions the need for such accommodation "after a hostel a lonely bedsitter can lead to social isolation, loneliness and relapse or even suicide" (*British Hospital Journal*, 19 June 1968). There should also be boarding out officers appointed in the mental health departments of local authorities who can find suitable lodgings for those reaching a further stage of independence and the number of mental health social workers should be increased to provide support for the individual as he progresses through the various stages.

There should be training centres in manual and non-manual trades for those desiring employment but unable to cope with the pressures in industry, and day centres for those unable to work or form social relationships. There should be improved out patient facilities instead of the inevitable six week wait before an interview can be obtained, and the channels of communication with the psychiatrist for all involved in community care must be improved. Until such facilities are increased the aim of the 1962 hospital plan for community care is a myth. In the meantime patients are entering the community before such services are available and what is in essence a viable policy could be reversed by public reaction. It is unreasonable to expect families, neighbours and general practitioners, often inexperienced in the treatment of psychiatric disorders, and not least the patient to struggle on in the community without adequate facilities for support.

As Kenneth Robinson pointed out, "unless community services are provided the community tolerance on which this policy depends will be severely strained". Yet before such facilities are increased haphazardly there must be research into their relative functions and effectiveness so that the original rehabilitative blueprint can be modified to ensure that the different categories of need are met.

young fabian group

The Young Fabian Group exists to give socialists not over 30 years of age an opportunity to carry out research, discussion and propaganda. It aims to help its members publish the results of their research, and so make a more effective contribution to the work of the Labour movement. It therefore welcomes all those who have a thoughtful and radical approach to political matters.

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Enquiries about membership should be sent to the Secretary, Young Fabian Group, 11 Dartmouth Street, London, SW1; telephone 01-930 3077.

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