Contemporary Themes

Bristol Industrial Therapy Housing Association: A Contribution to Domestic Resettlement

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Summary

A housing association for the rehabilitation of adults suffering from psychiatric illness now has six council houses, a former private hotel, and two large houses—providing a total of 100 places. The cost of full board and lodging is about £6.00 a week; the association shows a small profit; and virtually all the residents are in open or sheltered work.

Introduction

After negotiations with the Department of Employment (then the Ministry of Labour) in 1963 the Industrial Therapy Organization (Bristol) Limited (I.T.O.) established "sheltered groups" in open industry, composed of disabled persons unlikely individually to gain open employment but capable of working in groups in open factory conditions with a minimum of supervision. The initial agreement allowed groups of 10 or more persons to work under nursing supervision in local factories. Their work is paid for on an agreed basis to I.T.O., which turn guarantees to the workers a Remploy rate of pay as a minimum. Groups who earn more than this are paid what they earn.

Among the conditions agreed with the department was that persons chosen for such groups should have the prospect of discharge from hospital in the near future. At the time of the agreement the Bristol local authority proposed to establish one mixed rehabilitation hostel for adult psychiatric illness (10 men and 4 women), and had no further plans to provide living accommodation in the community for this category of patient. It was therefore decided to form a housing association to enable the agreement with the Department of Employment to be implemented. In June 1964 the Bristol Industrial Therapy Housing Association (B.I.T.H.A.) was formed by some of the directors of the Industrial Therapy Organisation, together with specialists from other fields—for example, an architect and an ex-housing manager.¹

As early as 1960 negotiations had taken place between Glenside Hospital and Bristol Corporation Housing Authority to build six standard council houses on the hospital estate, close to the hospital but separated from it by a main road. The local authority, the Hospital Management Committee, and the

Regional Board were in agreement, but opposition from Whitehall delayed the project. When this was overcome the local political situation had changed and negotiations had to be reopened. There were then geographical and climatic complications which beset the project and, finally, financial difficulties with the contractor delayed the provision of these houses until 1965.

The B.I.T.H.A. became the tenants, furnished the houses, staffed them and opened them in November 1965—more than five years after the original agreement of the local housing authority. One house is occupied by a manageress, and five discharged patients live in each of the others. Initially we allocated three houses to women and two to men but this was later changed to four houses for women and one for men—the present pattern. Our groups of men living on their own had failed to achieve an acceptable standard of living.

The Vale Hotel, a private hotel in a residential part of Bristol, was bought and renovated with a loan from the Transport and General Workers' Union, and in March 1965 21 patients moved in. In 1970 a large house which was previously a hostel and a preliminary training school for nurses of a local general hospital became vacant. Again there was interference from Whitehall and only the personal intervention of the then Secretary of State for Health and Social Security enabled the house to be let to B.I.T.H.A. "on a 10-year repairing lease" at a nominal rent. A manageress was appointed and the pattern successfully established in the Vale Hotel of two domestic workers and a part-time cook was followed. Belgrave House is a large Victorian house on five floors and accommodates 31 residents in uncrowded conditions. At present a further house is undergoing renovation and will start operation this year. It will provide a further 15-20 places so that when this house is occupied B.I.T.H.A. will have 100 places in Bristol. The cost of full board and lodging in these hotels and houses at present varies from £6 to £6.25 a week and the organization shows a small profit.¹

Medically, residents of B.I.T.H.A. houses and hotels are under the care of the general practitioner of their choice. The residents are all at work—open or sheltered—apart from one pensioner.

Review

From 1965 to 1970 103 residents have lived in the council houses (Blackberry Hill) and in the Vale Hotel. There are 21 places (11 female, 10 male) in the Vale and 25 (20 female, 5 male) in the Houses. Twenty-four residents (15 female, 9 male) in the Vale and 33 (17 female, 16 male) in the Houses have come and gone. There has been a higher turnover of women in the Vale, and of men in the Houses. The initial population of Belgrave House was 31 (13 female, 18 male).

Glenside Hospital, Stapleton, Bristol and Bristol Industrial Therapy Housing Association

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AGE DISTRIBUTION

The Vale Hotel has had 16% of its population under the age of 40, while the Houses have had 26%. The Vale (56%) and the Houses (60%) are roughly similar for the 40-60 age group. The Vale has, or has had, 29% of its guests over the age of 60 compared to a figure of 12% in this category for the Houses. Belgrave House shows the same proportion under 40 as the Vale Hotel (16%) but has a smaller proportion in the 40-60 age group (35%) and a much higher proportion (48%) in the over 60 age group. In all there have been only nine patients under the age of 30—less than 7%.

MARITAL STATUS

Altogether, 8.7% of Vale Hotel residents and 5.3% of the residents of the Houses have a living marital partner, and 13% of those in Belgrave House.

There is the same proportion of patients with paranoid schizophrenia and with schizophrenia in the Vale and in the Houses with a smaller number of patients with paranoid schizophrenia and a larger number with other forms of schizophrenia in Belgrave House (table I). Overall, the proportion with a diagnosis of schizophrenia does not differ greatly in the three locations (75%, 79%, 71%).

SOURCE OF REFERRAL

Most patients are from Glenside Hospital, 91% in the Vale Hotel, 99% in the Blackberry Hill Houses. In Belgrave House six (20%) of the initial residents came from sources other than Glenside Hospital.

CHEMOTHERAPY

In the Blackberry Hill Houses, where the level of supervision is least, the highest proportion of patients (81%) were currently receiving chemical treatment. In the Vale Hotel the comparable figure is 58% and in Belgrave House 71%.

LENGTH OF PREVIOUS STAY IN HOSPITAL

Slightly more than one-third of the population in the Houses and in the Vale Hotel had been in hospital one year or less. Twenty per cent. in the Vale and 33% in the Houses had been inpatients for two to five years. Forty per cent. in the Vale and 28% in the Houses had been in hospital five years or more. Overall, 19% had been in hospital for 10 years or more. One resident in the Vale and one in the Houses had never been in hospital. In the initial population in Belgrave House a smaller proportion have been in hospital one year or less than in either of the other establishments.

In the most recently opened house (Belgrave), and to a lesser extent in the Blackberry Hill Houses, there is a high proportion of patients who have had four or more admissions (table II).

About 20% of all residents were in open employment. Five residents derive their only income from State sources (N.H.S. + M.S.S.). All the rest were employed in one or other activity of I.T.O. except two who have private means (table III).

Forty-five patients were in residence in the Vale Hotel and in the Houses at the time of the survey. Of these 22 were original residents. Thirty patients returned to hospital and 25 went to accommodation listed in table IV, three residents died, two of them by their own hand.

TABLE I—Diagnostic Categories

	Vale Hotel (a)				Blackberry Hill Houses (b)				Total		Belgrave House (c)				Grand Total (a) + (b) + (c)
	M.	F.	Total	%	M.	F.	Total	%	(a) + (b)	%	M.	F.	Total	%	
Paranoid schizophrenia	5	9	14	31	4	14	18	31	32	31	2	1	3	9.7	35
Schizophrenia (other)	9	11	20	44	13	15	28	48	48	47	13	6	19	61	67
Affective disorder	3	1	4	8.9	2	4	6	10	10	9.7	1	3	4	13	14
Subnormality	0	5	5	11	—	—	—	—	5	—	1	2	3	9.7	8
Idiopathic epilepsy	—	—	—	—	2	0	2	—	2	—	0	1	1	—	3
Organic brain disease	2	0	2	—	—	—	—	—	2	—	—	—	—	—	2
Personality disorder	0	0	0	—	0	4	4	—	4	—	1	0	1	—	5

TABLE II—Number of Previous Admissions to Hospital

	Vale Hotel (a)				Blackberry Hill Houses (b)				Total		Belgrave House (c)				Grand Total (a) + (b) + (c)
	M.	F.	Total	%	M.	F.	Total	%	(a) + (b)	(%)	M.	F.	Total	%	
1	11	6	17	38	4	12	16	27	33	32	7	0	7	23	40
2-3	5	15	20	44	6	13	19	33	39	38	3	4	7	23	46
4+	3	5	8	18	11	12	23	40	31	30	8	6	14	45	55
Not applicable	—	—	—	—	—	—	—	—	—	—	0	3	3	—	3

TABLE III—Source of Income of Patients

	Vale Hotel (a)				Blackberry Hill Houses (b)				Total		Belgrave House (c)				Grand Total (a) + (b) + (c)
	M.	F.	Total	%	M.	F.	Total	%	(a) + (b)	%	M.	F.	Total	%	
N.H.S. + M.S.S.	—	—	—	—	—	4	4	7	4	4	0	1	1	—	5
I.T.O. + N.H.S. or M.S.S.	8	11	19	42	5	6	11	18	30	29	12	6	18	58	48
Sheltered workshop	0	3	3	7	2	17	19	32	22	21	2	2	4	13	26
Sheltered group	1	6	7	16	4	7	11	18	18	17	0	1	1	—	19
Car wash	4	0	4	9	3	0	3	5	7	7	—	—	—	—	7
Open industry	5	5	10	22	7	5	12	20	22	21	4	3	7	18	29
Private means	1	1	2	—	—	—	—	—	—	—	—	—	—	—	2

N.H.S. = National Health Service. M.S.S. = Ministry of Social Security. I.T.O. = Industrial Therapy Organisation.

TABLE IV—*Destination on Discharge*

	Vale Hotel			Blackberry Hill Houses		
	M.	F.	Total	M.	F.	Total
Hospital	4	9	13	8	9	17
Home	0	1	1	4	5	9
Flat	0	3	3	—	—	—
Welfare Accommodation	—	—	—	1	0	1
Lodgings	5	1	6	2	1	3
House (own)	—	—	—	1	1	2
Died	0	1	1	0	2	2
Original population still in residence	5	8	13	3	1	9

Discussion

The figure of 46,000 schizophrenics under the age of 65 in the mental hospitals of England and Wales² has probably been reduced by the passage of time, but the number must still be large. There are still 66,000 patients in these hospitals who have been inpatients for three years or longer, and Sir Keith Joseph³ has stated that even the first stage of establishing adequate new hospital and community facilities will extend into the 1980's and beyond. The need for community residential development and support is universally accepted and the failure of statutory authorities to provide community care has been a growing cause for concern among psychiatrists and other workers in the field of psychiatry.⁴

The Department of Health Annual Report⁵ gives no cause for hope, showing that only seven premises were opened by local authorities in 1970 providing 107 places for the mentally ill. Loan sanction was granted for six premises (85 places) during the year, so that the future looks no brighter. The total number of residents in Homes or Residential Training Centres owned by the local health authorities throughout England and Wales was 1,584 persons who were mentally ill or psychopathic, and in the same diagnostic categories were 1,161 persons resident in other Homes or private households. Even those authorities with more sophisticated schemes cater for small numbers at comparatively high capital and running costs. For example, the group home scheme of the Borough of Croydon⁶ has 42 beds available and admitted 19 persons during 1971; 77 persons were referred to their boarding-out scheme and 51 left. The cost of the group homes was £16,791 and of boarding-out £6,000. The Bristol Local Authority Hostel⁷ which has 10 male and four female places has admitted 104 persons (70 men, 34 women) and discharged 91 (63 men, 28 women) since it opened in 1965. The unit cost in 1971 was £13.43 a week. The Somerset boarding-out scheme⁸ found private accommodation for 275 mentally disordered patients in the 10 years 1960-69, of whom three-quarters were over the age of 60 with women outnumbering men in a ratio of 10 : 1. The cost to the local authority is greater than the average cost of lodgings in the area and the authority claims only that the cost may be less than hostel accommodation.

The statutory duty to provide for the after-care of patients suffering from psychiatric illness lies squarely on the shoulders of the local authority. There is little or no evidence that the necessary urgency attaches to the provision of these residential and other community services. The conflicting pressures on the newly formed social services departments indicate that community services for adult psychiatry will come after the aged, the subnormal, and the physically disabled (whose rights under the Chronic Sick and Disabled Persons Act have scarcely begun to be defined). It is difficult to foresee the massive development which will be required to allow the proposed run down of the psychiatric hospitals, and so to prevent disaster for the present "chronic" hospital patient and for his successor. The Tripartite Report⁹ points out that the Hospital Plan (1971) seems to have been devised on the assumption that first-rate social services already exist to support its proposals, whereas this is not so. Nor is it likely to be so in the near future.³

Apte¹⁰ surveyed 39 hostels (24 local authority, six hospital, nine voluntary) with a total of 1,192 beds and concluded that

none had been developed to their full potential. Durkin¹¹ pointed out that the rehabilitation hostels suffer from a lack of consistent policy and that they are always short of staff and under-occupied. She quotes Kenneth Robinson's view that unless community services are provided, the community tolerance on which the 1962 plan for hospital care depended will be severely strained. If more hostels are to be built, she believes that other facilities must be increased—group homes, boarding out, follow-up, together with improved training facilities and better outpatient and follow-up services. Jansen¹² insisted that half-way houses should not grow up in isolation but that hospital and community services must join forces and receive the requisite Government financial backing. Her own organization—the Richmond Fellowship,¹³ costing £18.50 per person per week sharing a double room—is less expensive than a hospital bed¹⁴ but is, nevertheless, out of reach of ordinary clients in the community.

The advisability of a voluntary organization becoming involved in the provision of accommodation for psychiatric patients may be questioned. The rules imposed on the Industrial Therapy Organisation by its agreement with the Department of Employment in the matter of sheltered groups in open industry and the failure of statutory authorities to provide accommodation left the organization no alternative but to do so. Housing associations such as the Bristol Industrial Therapy Housing Association show that the rapid provision of comparatively low-cost hotel, hostel, and housing accommodation need not be financially overwhelming, that the running costs can be reasonable, and that projects may be self-supporting. Purpose-built accommodation is not necessary.

If the local and hospital authorities can be persuaded to work in unison for the benefit of the patient there appears to be no reason why joint assessment of need cannot precede discharge to appropriate accommodation. This would necessitate the setting up within the hospital of a range of training and trial facilities—which might consist of small wards proceeding to self-supporting wards, flats, bed-sitting rooms, and houses, residential lodgings-type accommodation, and hostel-type accommodation, unsupervised and nurse-supervised.¹⁵ If the range of local authority facilities mirrored those in hospital, if the authority had confidence in the hospital's assessment, and if full use were made of existing facilities in the private and voluntary sectors, then patients could be given a choice and could be accommodated with greater confidence and with less fear of relapse.

Until a wide range of possibilities can be established and until some alternative other than return to hospital can be offered to a hostel resident, the question of "through-put" or turnover in hostels is of academic importance. When there is an incentive to do so, a patient will move on to more normal living conditions—ultimately, if possible, making his own living arrangements.

The run down of mental hospital beds, desirable in itself, is causing concern for patients among all grades of personnel. The Worcester Development project¹⁶ with its description of the future of patients in Powick Hospital is not reassuring. There are increasing doubts¹⁷⁻¹⁹ about the proposed ratio of beds for the treatment of psychiatric patients in district general hospitals. The figure is certainly unthinkable without extensive development of community services. The conditions criticized by the Committee of Enquiry at Whittingham Hospital²⁰ occurred in a region in which half of psychiatric patients were being treated in general hospitals²¹ but there was inadequate development of community services. If residential, rehabilitative, training, employment, and supportive services are not developed before, concurrently with, or shortly after district general hospital units, a two-tier system of hospital care will emerge and it is almost certain that the conditions of Whittingham will be reduplicated over and over again throughout Britain. Already the experience in Luton and Dunstable and in Watford General Hospitals has shown that district general hospital psychiatric units cannot be responsible for the admission of all patients in their areas requiring psychiatric treatment in hospital¹⁶ and that patients may

have to be transferred to the psychiatric hospital. To avoid catastrophe, capital must be spent on the declining mental hospital; this could not be better expended than on an inexpensive range of training and assessment facilities within the hospital which will help to cope with present and foreseeable future needs.

The failure to develop community services to support district general hospital inpatient units will result in the mental hospital continuing to be the only residential alternative, and we shall continue to provide those conditions which "in many instances constitute a pabulum for the disease it was intended to remove."²² Present and future patients will suffer as a result of our default.

My thanks are due to Mr. John Turley, Managing Director, and to the directors of the Bristol Industrial Therapy Housing Association, as well as to the manageresses of the hotels and the houses and to the hospital officers and doctors who help to sustain the residents.

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Any Questions?

We publish below a selection of questions and answers of general interest

Intercourse after Myocardial Infarction

A man aged 65 who had a myocardial infarction seven years ago walks up to two miles (3.21 km) daily and leads a normal, quiet life. Infrequent sexual intercourse, however, gives him chest pain of short duration, as do other stress situations. Should he be advised to abstain?

Certainly not: the pain should be managed in the same way as angina occurring in any other predictable situation. Trinitrin should be used prophylactically and to relieve such pain as occurs when prophylaxis fails. Angina on intercourse is common, and in mild angina many patients learn to avoid most situations which produce the pain save this one, though out of delicacy this is often concealed from the doctor unless a specific inquiry is made. Propranolol, which occasionally causes drowsiness, but is not associated with any variety of impotence, would be indicated in more severe angina, but in this instance trinitrin and the reassurance that to produce the pain neither damages the heart nor ever leads to further infarction should suffice.

Dangers of Herbicides to Water Supply

Is there any danger to water supplies when large areas of fell country is sprayed with the herbicide Asulox?

Asulam, the active ingredient of "Asulox," is a herbicide of low toxicity. The acute oral toxicity of the sodium salt of asulam to mammals is low, the LD₅₀ value being greater than 5,000 mg/kg in the rat, mouse, and dog and greater than 2,000 mg/kg in the rabbit. Acute dermal, subacute oral, and inhalation exposure tests also support its safety in use. It has a very low toxicity to birds, fish, and bees so that the hazards to wild life are negligible.¹

So far the Ministry of Agriculture has not made a definite statement about the conditions of application to catchment areas. Until it does precautions must be taken to avoid spraying standing or running water. The object of spraying the fells with asulam is to control bracken which is noteworthy not only for its mammalian toxicity but also for the naturally occurring carcinogen which it contains.^{2,3} Thus the clearance of bracken may be desirable on medical and veterinary grounds—apart from its agricultural value—and asulam is an effective herbicide for this purpose.⁴ However, the possibility of bracken becoming more palatable to livestock in the course of dying must be kept in mind though there is no evidence to date to suggest that this occurs.⁵

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Stopping Anti-hypertensive Treatment before Surgery

What advice should be given to patients about stopping anti-hypertensive agents before surgery?

The reason for stopping anti-hypertensives prior to surgery is to reduce the risk of hypotension occurring either during anaesthesia or in the post-anaesthetic period. However, the effect of drugs such as reserpine and guanethidine persists for many days after stopping therapy. Furthermore, there is no evidence that stopping reserpine several days prior to surgery reduces the risk of hypertension during anaesthesia.¹ In contrast, the effects of methyl dopa and bethanidine are comparatively short-lived and omitting more than a few doses may result in loss of control of blood pressure. It is usual to