

Psychiatric Halfway House

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PSYCHIATRIC HALFWAY HOUSEINTRODUCTION

This is an account of Winston House, a psychiatric halfway house in Cambridge, during its first eight years, 1958 to 1966. The thesis describes the House and its operation, gives details of the residents and a follow up of a group of them, then discusses some of the issues that arise.

I played a part in establishing the house; I was the consultant psychiatrist to it for most of the eight years and played an active part in the management throughout. In attempting to describe and discuss the work I face a difficulty common to all writers who have been actors in what they are describing, namely whether to use the first or the third person or one of the "elegant" devices traditional in medical writing such as calling myself "the present writer" or "the author". The first person singular seems out of place in a thesis, which aims at detachment. On the other hand a false "objectivity" is created when psychotherapy is discussed as if the therapist has no feeling. I have decided to use the first person plural where appropriate and, where it is necessary to refer to myself, to use my name alongside the other protagonists. Fortunately this is a thesis for limited circulation so I have been spared the necessity to erect an elaborate apparatus of pseudonyms.

Acknowledgements

Though this thesis, in the strict sense of the declaration,

is all my own work, a project of the size and complexity of Winston House, running for so many years, has involved many people, to whom I wish to express my thanks and gratitude.

I would particularly remember The Lady Adrian, D.B.E., who alas died in 1966. Hers was the original idea and it was her vision, her quiet determination and her magnificent gift of inducing cooperation from all, that launched and maintained the house. Her early death robbed mental health work both in Cambridge and in England generally of a great constructive force and many of us of a stalwart friend.

There have been many people associated in the work, as members of the Management Committee of the house, as officers of the two constituent voluntary bodies, The S.O.S. Society and the Cambridgeshire Mental Welfare Association, and as officers of statutory bodies, notably Cambridgeshire County Council. I should particularly like to record my gratitude to Mr E.A. Burrus, the general secretary of the S.O.S. Society, Dr P.A. Tyser, Medical Officer of Health for Cambridgeshire County Council, and the Chairman, Vice-Chairman and Secretary of the Committee of Management, Mr G.M. McFarlane Grieve, Mr W.A. Warren and Mrs Nora Smithies. To them I feel the gratitude and comradeship that comes from a worthwhile task pursued together over years. To the three wardens, Mr L.W. Cooper, Mr I. Cobain and Mr H. Morrison and their wives my debt will be manifest, especially to Mr Leonard Cooper the founder warden of the House.

To Dr Edmund G. Oram, Nuffield Research Fellow 1960-1964 and my deputy as psychiatrist to the House, I am most grateful,

particularly for his help with some of the follow up and analytic work. I should particularly wish to note our gratitude to the Nuffield Provincial Hospitals Trust for the liberal support of Dr Oram in this and other valuable research work in social psychiatry during those 4 years.

I am grateful, too, to the residents, who taught me most of all. Men and women battered by all manner of ill fortune -- unfortunate heredity, distorted upbringing, crippling mental (and sometimes physical) ill health and years in institutions -- they were still struggling for independence and human dignity where so many others had abandoned the struggle. During the years we talked together, I learned much from them of the harshness, bitterness and despair of the life of the ill favoured and unfortunate but also something of the gratifications that reward long courageous struggles.

Finally I would record my grateful thanks to my secretary, Mr G.F. Copeman, who has skilfully and tolerantly assisted this work through from untidy manuscript to final thesis.

SURVEY OF LITERATUREHistorical

The phrase "halfway house" is mentioned in the first article on the subject, the classic "Plea for Convalescent Homes in Connection with Asylums for the Insane Poor" (16) published in the 1871 Journal of Mental Science by the Rev. Henry Hawkins, Chaplain of Colney Hatch Asylum. After describing the convalescent homes he proposes, on page 110 he says, "they would thus be a kind of halfway house between the asylum and the world".

In this article, which is well worth reading in its entirety, he sets out arguments why such convalescent homes are needed; he points out the difficulty of emerging directly into the world, the problems of "recovered lunatics" who have no homes of their own, the difficulties in finding work, the need for understanding support to weather crises and setbacks -- all the arguments that have been repeated over the last century each time a project for halfway house has been floated. Finally Hawkins remarks "The suggestion that such institutions should be established in connection with asylums may be by no means new, but, as has been remarked 'a suggestion may be ever so old, but it is not exhausted until it is acted upon, or rejected upon sufficient reason'."

This remark is relevant to the history of the halfway house idea because it certainly lay long dormant. That Hawkins' plea came when it did is understandable; public asylums were widely provided in Britain after the 1845 and 1853 Asylums Acts. By 1871 the group of patients who were fairly capable but did not seem able

to leave the institution would be beginning to be obvious. As a result of his agitation the Mental After Care Association was formed in 1879 but most of their energies went into supporting small boarding houses for 3 or 4 patients run as money making concerns by former asylum staff (Apte 1 and Huseth 18), though they gradually began to develop houses of their own, especially after 1945.

About half a century later, between the Wars, a few halfway houses were started. The Ex-Services Mental Welfare Association (founded 1919) ran a home with an attached sheltered workshop. The S.O.S. Society (founded 1928) began to run small hostels for various groups, including the mentally ill. In the U.S.A. various convalescent camps and ranches started in the nineteen thirties.

It is not until the postwar period however that the idea began to appeal widely. Indeed in one of the earlier articles, Reik (41) in 1953 after describing Spring Lake Ranch, its value and successes, comments sadly "Those who conceived the idea ask themselves why, in the face of overcrowding in the mental hospitals, their halfway house has not been more widely duplicated elsewhere".

In the strict sense, there could not be halfway houses until there were large psychiatric institutions for them to be halfway from; few of these existed until the mid-nineteenth century. In the more general sense of "transitional facilities" however, there is a much longer history of arrangements to help people who had been acutely ill mentally, had made a degree of recovery, but were not fit for the full rigours of life. The most famous is the

colony at Gheel, Belgium, the origins of which go back before the earliest medieval records. It is based on the shrine of St Dympha, said to have been martyred in 698; the first written record is 1200. Mentally ill were brought to the shrine and many recovered; of those who did not, some were lodged with the local peasants and a tradition was established of having a lunatic living in the home. The system survived changes of government and sovereignty, the many wars which devastated the Low Countries, secularization and modern medicine, and still provides a model transitional facility (32).

Modern Publications

In the mid-1950s institutional psychiatrists in Britain and the United States were becoming increasingly interested in the rehabilitation of long term psychiatric patients and the use of social facilities for this. A number of "transitional facilities" -- Day Hospitals, Therapeutic Social Clubs, Ex-Patients Associations etc. were described, developed and discussed. Amongst these was the halfway house.

All interested in the history of the halfway house must here be grateful to Brete Huseeth and the Office of Vocational Rehabilitation of the U.S.A. who supported her in a survey of all discoverable halfway houses in the U.S.A. in 1958 (17) and in Britain in 1959 (18).

In the U.S.A. she found 7 halfway houses, Rutland Corner House, Boston (of which more later); Modesto State Hospital;

Portals (Los Angeles) Quarters (San Jose, California), the Foster Home Cottage at Brockton State Hospital (Massachusetts) and the rehabilitation houses in Montpelier and Burlington associated with Vermont State Hospital. She pointed out the advantages to the patients of these facilities and the freedom and opportunity, especially compared with the mental hospitals of that time. She discussed the problems of starting them, the needs of staff and the difficulties of selection of residents.

In Britain she found rather more halfway houses. In her report she described the development of the Mental After Care Association, the Ex-Services Mental Welfare Association and the S.O.S. Society. She described their hostels and also hospital-run halfway houses at Gloucester, Nottingham and York. She found the British halfway houses like the American in their way of operation, but different in their finances and she was clearly fascinated by the curious English compromise by which halfway houses were run by voluntary bodies, supported by local authority grants and filled from National Health Service Hospitals. She devoted one paper to these problems (20). In another article (19) she discusses "What is a Halfway House?" and says "It is a small group residence interim between hospital and community which provides some form of professional supervision and help while allowing more freedom and responsibility than the mental hospital". This is as good a definition as any offered.

Her survey covers the period when Winston House was starting and conveys the feeling of uncertainty, excitement and

experimentation of those days. She visited Winston House during its first year, and her paper on British Hostels comments on it as it was then.

Comparable Studies

A considerable number of articles on halfway houses have been traced, some of only limited value. Brown (3) and Kilczewski (24) for example, are merely discussions of the value of the idea, drawing most of their material from Huseth's articles; the latter even gets his facts wrong and blandly states (without quoting any authority) that "the halfway house was first conceived in Sixteenth Century England"!

A number are descriptions of individual halfway houses, mostly written within the first two years of operation and usually saying what a good idea halfway houses are, and how many patients have been rehabilitated. There is usually one striking instance of a person who had been many years in hospital. Some give enough facts and figures for comparisons.

Some are closely attached to hospitals; Paquette and Lafave (38) describe a converted ward at Medfield State Hospital, Massachusetts. Wayne (50, 52, 51) in several articles extolled Egremont House, a 36 bed house closely attached to a 53 bed private hospital in Los Angeles. Levine and Wolfe (31) describe the use of the medical superintendent's house at Boston State Hospital as a halfway house, and Walker (49) in a recent article speaks strongly in favour of his Gloucester Hostel which is closely attached to the hospital.

Most of the British studies describe local authority hostels rather separate from the hospitals. Harbert and Taylor (15) described a hostel for 12 men in Birmingham, Morgan (34) a hostel for 25 women in Newcastle, O'Donnell (36) one for 12 people at Worcester, Berrington and Green (2) a range of houses and hostels in Northern Ireland, Burkitt and Walker (4) a hostel for 12 men in Darlington, and May et al (32) a hostel for 43 in Croydon. The stories in all are fairly similar, though different stresses are laid -- the problem of finding a house, the staffing, the first residents, their getting out to work, details of how they have progressed and a final note of enthusiasm for the future.

Several studies (and some of the best) report halfway houses not so easily classified. Woodley House in Washington, D.C., was started by an enthusiastic occupational therapist with money loaned from private agencies and Government Trusts. It has been described in a lively recent book (42) and several earlier articles (43, 46). Rutland Corner House in Boston, Massachusetts which had been a shelter for homeless women since 1877 was turned over for psychiatric patients in 1954; it is fully discussed by Landy and Greenblatt (29) in a valuable and thought provoking book. The Boston workers have also contributed two other valuable studies, one of a halfway house that failed (28) because of bad planning, and one of an unusual house, Wellmet, which is run by University students and patients living together (23).

There have been a few reports of other transitional residences, such as patients living together without resident staff (30) and of

the Richmond Fellowship (5).

There have been a few review articles since Huseth. Wechsler (53) in 1961 reviewed 10 transitional residences which he had visited, differentiating halfway houses (mostly in towns where residents went out to work) from Work Camps (mostly out in the country where the work was provided by the organisations). The Ministry of Health carried out a survey in 1964 (33) of the 31 Local Authority Hostels which had been opened by the end of 1964. Walker (4) includes the results of postal questionnaire to 41 local authority hostels in 1965. Phillips (39) circulated all local authorities in England and Wales and reports on their hostels in August 1965. He notes 33 hostels solely for the mentally ill and 35 for a mixture of residents (as well as 47 for the adult mentally subnormal, 43 for subnormal children and 15 for the elderly mentally infirm). The Lancet has twice commented editorially on the development of halfway houses (26, 27) reviewing recent articles and summarizing the position.

There have been few follow up studies of any length. Landy and Greenblatt did a very detailed analysis of the 55 women who had entered Rutland Corner House in its first 4 years, but were only able to have follow up interviews with 33 of the 48 who had left. Rothwell and Doniger although they give many details of their residents deliberately refrain from any attempt to assess their stay in Woodley House as "successes" or "failures". Shaw (47) reports a summary of a master's thesis which showed the desire of 337 ex residents of 8 Californian halfway houses to keep in touch with the hostels but nothing of their personal status. Offman and

Friedman (37) discuss 189 persons who had been sent from a State Hospital to a halfway house between 1956 and 1961 but they give no details of the house or how it was run. They found that the 108 people who stayed in the house had done little better in the long run than the 81 who had been sent back to hospital, but their report is of small comparative value because of the lack of detail.

The earlier articles were all enthusiastic. In recent years a critical note has begun to emerge. Rehin and Martin (40) in a booklet entitled "Psychiatric Services in 1975" which discusses the inadequacies of the Plan of the Ministry of Health for Local Authority Services note the tendency for the turnover of residents in the M.A.C.A. hostels to slow down in the 1960s. Early and Magnus (13) in discussing population trends in Glenside Hospital Bristol comment that the Wiltshire halfway house had half its beds vacant in 1965. Walker (49) says that a number of Local Authority hostels were not full in 1966 and that one had had to close down for lack of clients. The Ministry of Health study revealed that the hostels were only 60% full overall in 1964, though they pointed out that some were not yet fully operational. Phillips (39) noted that though all the hostels for the subnormal were full, a number for the mentally ill were only partly occupied and he notes that the hostel at Chesterfield was closed in September 1965 because there were so few residents. Apte (1) in a critical discussion of 25 hostels noted uncertainties which affected function, especially doubts whether any particular hostel was transitional or permanently residential. He particularly examined the practices of the hostels and noted that those run by hospitals retained more

restrictive practices than those run by local authorities or by voluntary societies. Mountney (35) in a briskly outspoken article about difficulties with two hostels in Salford suggests that some of the trouble arises from the fact that Local Authorities have been called on to act as pioneers and that they find this difficult.

Official Publications

During the last fifteen years there have been three major pronouncements from authoritative bodies on what should be provided for psychiatric patients and it is interesting to see the increasing vigour with which they commend halfway houses.

The World Health Organisation in the 3rd Report of its Expert Committee on Mental Health (54) in 1953 said:

"It has also been found valuable to allow some patients to take employment before they are finally discharged from hospital, going out to work by day but returning to the hospital by night during the period when they are trying out their recovered capacity for social life in the community. In some cases, this provision has been extended to the provision of a night hostel, under the direction of the hospital but placed in the community, at which the discharged patient can stay during the period when he is convincing himself of his ability to live again effectively in society."

The British Royal Commission on the Laws Relating to Mental Illness and Mental Deficiency (44) said in 1957:

"613. Many witnesses suggested to us that local authorities should provide residential hostels for patients who need to be provided with a home and some help and advice but do not need psychiatric training or nursing care in hospital. Hostels or residential homes were suggested for young people leaving special schools for the educationally subnormal, adult feebleminded psychopaths who need fairly close supervision but do not need hospital training or who could be

discharged after a period of training if they had a suitable home in which to live, severely subnormal patients of any age whose relatives can no longer provide them with a home, elderly mentally ill or infirm patients, and patients recovering from mental illness or left with residual mental disability after such an illness.

614. Although we received conflicting evidence from the representatives of the local authorities themselves on the question whether they should provide residential homes we have no doubt that the local authorities should be responsible for providing residential as well as non-residential community care for patients handicapped by mental disability. Their responsibilities can be distinguished from those of the hospitals according to the general principles set out in paragraph 603. In deciding whether an individual patient should receive hospital or community care the consideration should be whether or not he requires in-patient treatment or training with individual psychiatric supervision or continual nursing attention.....

616. Residential homes provided by the local authorities themselves should not be large institutions. Twenty to thirty residents might be a usual size with a maximum not much over fifty. They should not be in isolated places but in or near enough to towns or villages for the residents to participate in the life of the general community as far as they are able. It would not be suitable for the local authorities to accommodate in one house all the different types of patients who might need residential care. For instance, young persons who have just left school and who are being helped to learn to hold their own in the world and to become self-supporting citizens should not be placed in the same home as severely subnormal children or adults. In some of the smaller local authority areas there might not be a sufficient number suitable to live together to make an economic unit. Various arrangements could be made to overcome this difficulty. One home might take residents from more than one local authority area. Or patients who are still hospital in-patients but who can suitably live in a hostel (see paragraph 612) might live in the same hostel or home as patients receiving residential community care from the local authority, with suitable financial arrangements. Some psychopathic patients whose intelligence is not seriously subnormal might live in the same home or hostel as patients of a similar age left with residual mental disability after an acute mental illness. Many older persons whose mental disability is only slight could suitably live in ordinary old people's homes. There is also room for experiment in the extent to which residential accommodation might be combined with occupation or training centres which would also be attended by patients living with their own families

618. Whatever form of accommodation is favoured in any particular locality, we are convinced that the aim should be a deliberate reorientation, away from institutional care in its present form and towards residential homes in the community. It will however be essential for the medical and other staff of the local authorities and hospitals to cooperate closely in determining the most suitable forms of care for each individual patient."

The American National Joint Commission on Mental Illness and Mental Health reporting in 1961 (21) said:

"The halfway house is one of the most recent of the specialized aftercare services.

Present halfway houses show considerable uniformity in aims, with some basic differences in practices and structure. In general, the halfway house is a transitional residence, based on the assumption that experience in a protected setting can significantly increase the ex-patient's chances of remaining out of the mental hospital, as well as prepare him for more independent living. These temporary residences for ex-patients are of three types:

1. The cooperative urban house - with residents limited to a small number of ex-patients of the same sex, with good enough remission to get along with minimum supervision, and potentially or immediately employable.
2. The rural work-orientated halfway house - often referred to as a farm, ranch, or homestead - and larger than the urban type. It accepts ex-patients of both sexes as well as persons never hospitalized for mental illness.
3. The treatment-orientated halfway facility - a residential treatment center standing halfway between the patient's home and the mental hospital. Residents are still patients and are not required to assume any larger degree of personal or domestic responsibility or to participate in community life.

The halfway house is the center of a mild controversy in the after care field. Critics point out that extensive planning and considerable capital outlay are needed before a halfway house can come into being. They argue that segregation of residents perpetuates separation from the community, and comment unfavourably on the tendency of former residents to return to the house for their social life. They fear the halfway house will become a static "little mental hospital ward" and maintain that foster family care can accommodate ex-patients in the community without these disadvantages.

Proponents point out that the halfway house offers more freedom and privacy than foster family care and that many ex-patients need this experience to become independent. Residents may feel it is their home in a way that a foster home can never be. Professionals operating halfway houses state that dependency, like other problems of the ex-patient, needs to be handled in any setting and that no properly managed setting need become a little mental hospital."

OPENING THE HALFWAY HOUSEThe Building

The house is a large 19th century dwelling house of the kind originally built for the prosperous middle classes. It stands in Brooklands Avenue approximately one mile to the south of the centre of Cambridge and half a mile from the railway station close to several 'bus routes. During the nineteenth century the grounds of Brooklands Farm were developed; large private houses were built and mostly occupied by the new class of married dons. Brooklands House and its grounds filled the southern side of the road (opposite Winston House) until World War II when the open area was filled with "temporary" one storey buildings to house Government departments evacuated from London; they still remain in 1966 and amongst other departments contain the Labour Exchange, most convenient for Winston House. Some of the houses in the road are still private houses, including both the next door houses, but many now house University and Government Departments. Amongst other buildings the road contains a large nursing home, a bowling club, some Victorian almshouses, the University Department of Oriental Languages and several boarding houses.

The house itself was built in 1869. It was last occupied as a private dwelling in 1927. Since that time it has had a variety of uses. For a time it was occupied by an order of Catholic Friars who converted much of the third floor into a high ceilinged room which they used as a chapel. During 1939-45 it was used by

the Cambridge Borough Council as a home for unmarried mothers. In 1945 it was purchased by the S.O.S. Society and was used as a hostel for youths on probation. It was then that the name "Winston House" was coined in the hopes that the erring lads would be heartened by the example of the great War Leader.

As a result of all this public ownership and varied use, by 1958 the interior of the house ~~had~~ had that rather battered, much altered look common to public institutions. The fabric was sound. There were a number of small rooms, suitable for bedrooms, a substantial kitchen, a large dining room, a sitting room, and an annexe with showers and urinals and wash basins suitable for youths.

The S.O.S. Society

This national philanthropic society was founded in 1928 by a group of active, altruistic wealthy individuals remembering exploits of the 1914-18 War, and desiring to help the increasing number of social derelicts created by the economic disasters of peace. The Society gave direct relief (by soup kitchens on the Embankment) and opened a number of hostels -- for ex-prisoners, elderly persons and others, mostly in London. The general secretary and his staff controlled the finances of the hostels, paid the staff and all accounts. A national executive committee controlled policy and developments but local committees, self elected, met regularly to have oversight over the affairs of each hostel. When the S.O.S. Society purchased 19, Brooklands Avenue in 1945 and ran it as a hostel for delinquent boys, the local

Committee consisted mostly of local Rotarians, ladies of the Inner Wheel and a few other nominated interested persons.

The Cambridgeshire Mental Welfare Association

The other organisation involved in the genesis and running of the psychiatric halfway house was the Cambridgeshire Mental Welfare Association (C.M.W.A.) and its leading member at that time, Mrs Hester Adrian (later The Lady Adrian, D.B.E.). The history of the C.M.W.A. has been fully recorded by Tyser (48). It is only relevant to note its long history (since 1906) and its dominant position within the British Mental Health movement. This was due partly to the energy and foresight of a series of high minded, energetic and philanthropic ladies of whom Mrs Adrian was the most recent and partly to a tradition that the Cambridgeshire Mental Welfare Association should start experimental mental health projects, and then, when the value of the project was established, hand them over to the statutory authorities and move on to new ones. In this way they carried out one of the first surveys of mental defectives (in 1906) in preparation for the 1913 M.D. Act; they organised one of the first psychiatric after care and domiciliary visiting schemes (1922) and one of the first occupation centres in Britain (1933). Immediately after the War they took an active interest in the establishment of a joint psychiatric service between Fulbourn (Mental) and Addenbrooke's (General) Hospitals and in 1948 they undertook the mental health responsibilities of Cambridgeshire County Council on a delegated basis employing

several social workers who worked with psychiatrists, general practitioners and others in serving mental health problems of Cambridge City and Cambridgeshire County.

Development of the Idea

Mrs Adrian had been active in psychiatric community services since her arrival in Cambridge in the early 1920s. In 1955 she became Chairman of C.M.W.A.; in 1951 she became Chairman of the Management Committee responsible for Fulbourn Hospital, the main public mental hospital for the Cambridge area since 1858; in 1954 she was appointed a member of the Royal Commission on the Laws Relating to Mental Illness and Mental Deficiency. She became aware of the need for "halfway houses" for people rehabilitated from psychiatric hospitals at both a local and a national level. During 1956 she formed a sub-committee of the C.M.W.A. to explore the local need. In July 1956 they submitted a report to the Cambridgeshire County Council with an attached memorandum of support from Fulbourn Hospital (see appendix A). The County Council endorsed the proposal but regretted they had no money to build and there, it seemed, the matter might have rested.

During 1957 however the Winston House Local Committee of the S.O.S. Society were becoming worried about the future of the House as it was running half empty; this was partly due to difficulties they had had over staff but also to an increase in alternative facilities for delinquent boys.

The Senior Probation Officer for Cambridge, Mr W.B. Gaskell,

was aware of both situations and brought the C.M.W.A. Committee and the S.O.S. Committee together. Through 1957 and 1958 there were a number of discussions to arrange plans, to estimate costs, and to balance differing interests. There was however general keenness to try the new plan. With great enthusiasm the ladies of the committee set about redecorating and altering the house. It was rearranged to give 1 two-bed, 1 three-bed, 2 four-bed and 1 seven-bed dormitories. A new sanitary annexe provided washing and toilet facilities for the women, while the men could use that provided for the boys. These arrangements meant that several of the smaller bedrooms could be switched to the use of either sex. There was also a small flat of 3 rooms for the warden and his wife and single rooms for the assistant warden and the cook. After a few months the warden made some rearrangements and freed another room for 3 beds so that the capacity of the house during the following 8 years was 23 residents.

October 1958

By the time the first residents were admitted on 10 October 1958 a system of management had been evolved which remained little changed for the next eight years.

The S.O.S. Society owned the house, paid the staff and managed the finances through its General Secretary. The Winston House Committee of Management was responsible for the running of the house; the members came equally from the Cambridgeshire Mental Welfare Association Committee and from the previous Winston House Committee.

The Warden, Mr L.W. Cooper had been selected by an appointments committee from a short list of candidates screened by the S.O.S. Central Officer.

The following notice was prepared and circulated to all whom it was felt might have possible candidates. A stock of copies were kept and were sent to enquirers.

WINSTON HOUSE

The S.O.S. Society are re-opening Winston House, Brooklands Avenue during October 1958 as a halfway hostel for men and women capable of rehabilitation but suffering from mental and emotional disturbances who are unsuitable for ordinary lodgings or who are unable to live at home. The affairs of the hostel are in charge of a Management Committee among whom are members of the Executive Committee of the Cambridgeshire Mental Welfare Association. A married resident warden has been appointed.

A Selection Committee to consider applications for residents has been appointed; consisting of Chairman and Vice-Chairman of Winston House Management Committee, Mr G.M. McFarlane-Grieve and Mr W.A. Warren; the Consultant Psychiatrist, Dr D.H. Clark; the Psychiatric Social Worker, Mrs J. Lawrence; and the Warden, Mr L.W. Cooper.

Residents will come mainly, but not exclusively, from the area covered by the Cambridgeshire Mental Welfare Association; the catchment area will be expanded, as necessary, to maintain a full hostel. There are 6 beds for women and 14 for men. The age range of residents will be from twenty-five to sixty-five years but it is expected that few over the age of fifty will be accepted. Mental Defectives will not be accepted unless capable of social rehabilitation. All applicants should be in employment, or capable of obtaining it almost immediately. It is expected that residents will stay from 3 - 6 months. It is not the purpose of the hostel to provide a permanent home; rather it should serve as a stepping-stone leading to complete integration within the community. The standard charge has been fixed at £4 per week, but this may be varied by the Selection Committee.

Names of persons for admission to the hostel should be referred to Dr D.H. Clark in the first instance.

Staff 1958-1966

The first warden was Mr L.W. Cooper. He was a large, impressive man - 6 ft. 1 in. 15 stone - with an ebullient confident manner, a full booming voice and an echoing laugh. He had had a varied career; he was originally an accountant but had become a Salvation Army missionary and had served for years in West Africa. In Cambridge he was soon on the panel of Methodist lay speakers and was offered many engagements. He was a vigorous man, skilled in home craft, kindly but firm, devoutly Christian and exuding a conviction of the worth and rectitude of his work. His wife, a quieter, subdued, figure who suffered much illness, was matron and they were supported by a series of cooks and assistant wardens. The latter were rather pallid and unsatisfactory young men, often seeking a vocation; their pay was poor and the prospects few. In Mr Cooper's absence they were in charge, but there was little constructive for them to do when he was there. They did not stay very long.

In September 1963 Mr Cooper was persuaded to take over the wardenship of Hill House, the S.O.S. Society's large psychiatric rehabilitation centre in London. A young couple, Mr and Mrs I. Cobain were appointed warden and matron, both psychiatric nurses. They did not settle and left for another post within six months.

Mr and Mrs H. Morrison were appointed in May 1964. They were older, in their middle fifties; he had been a divisional manager of a firm in Yorkshire. Childless and always interested in philanthropy -- boys clubs, works social clubs -- they had decided

to spend their later years helping others. After half a year as houseparents with Dr Barnardo's Homes they came to Winston House. Mr Morrison was a warm hearted concerned Yorkshireman whose kindness and desire to help were patent. Mrs Morrison was a more dominant figure, active, jovial, an excellent cook, always ready with a cheerful quip, and very much "mother" to all the residents. With the Morrisons, the cooks stayed longer and the assistant wardens were rather older but equally shadowy figures.

Dr D.H. Clark was the first psychiatrist to Winston House. As Medical Superintendent of Fulbourn Hospital since 1953, he had been much interested in rehabilitation of long stay patients and had helped to write the original proposals for the house in 1956. He chose the original residents from Fulbourn Hospital and sat on the Selection Committee throughout. When residents came from other hospitals he saw them as out patients at the nearby clinic.

In 1962/63 Dr Clark went to the United States for a year and Dr E.G. Oram, at that time a Research Fellow supported by the Nuffield Provincial Hospitals Trust to carry out a study of the fate of long stay patients discharged from Fulbourn Hospital, took over the work of psychiatrist to Winston House. After Dr Clark returned he shared the individual care of residents with Dr Oram. In 1963 reorganisation of consultant duties within Fulbourn Hospital meant that other consultants were sending patients to be residents at Winston House, but Dr Clark retained clinical care of a substantial proportion of the residents until the end of the study period.

The doctor to the hostel was a member of an active firm of

general practitioners in the City, Dr O.A. Sills, who had had considerable psychiatric experience. He or his partners were available to deal with physical emergencies though a few residents were registered with other Cambridge general practitioners.

Management 1958-1966

The Management Committee soon settled down and there were few changes during the years. The same Chairman, Vice-Chairman and Secretary held post throughout, though the Secretary was absent for one year during the eight; a few members retired. At times of change of warden there were selection meetings, caucuses and strong feelings, but most of the monthly meetings were quiet and uneventful. No major issues split the group during the eight years.

Originally Cambridgeshire County Council made a grant of £500 per year to the cost of the house. After the Mental Health Act 1959 local health authorities became more ready to make allowances in support of residents and in 1962 Cambridgeshire County Council also began paying toward the cost of individual residents.

During 1958-1966 local government in the area underwent a number of changes which caused some turmoil but this was prevented from affecting Winston House. In 1965 Cambridgeshire and the Isle of Ely were fused under one County Council. Throughout all this, however, the Medical Officer of Health for the old and the new Counties, Dr P.A. Tyser, remained a member of the Management Committee of Winston House and a valuable supporter.

The S.O.S. Society maintained the finances of the House. It

ran another psychiatric rehabilitation house, Hill House, Elstree, and opened several other homes during the eight years. The same general secretary remained in charge of its operations. The budget of the House gave some anxiety in earlier years but once the principle that local health authorities should make up the difference between what a resident paid for his lodgings and what it cost, the budget was maintained on a steady basis. The basic charge to the residents rose gradually from £4 in 1958 to £4. 15. in 1966. (There were always arrangements to allow rebates to low paid residents).

The Cambridgeshire Mental Welfare Association underwent changes during the eight years as it had done many times during the half century of its existence. The philosophy of the C.M.W.A. had always been to alter its work, its nature and its constitution as often as necessary to supply those emerging needs of the mentally ill and handicapped which were not being met by the statutory authorities at the time. In 1958 it supported two social workers doing adult psychiatric care. In 1960 it took over all the statutory mental health work for both the City of Cambridge and the County of Cambridgeshire (to prevent any disastrous splitting of the services during local government reorganisation). In 1964 it handed the services back to the local health authorities and became, once more, a voluntary society. In 1964 it opened a permanent halfway house for women, 7 Tenison Avenue; in 1967 another at 57 Hinton Avenue. These were different from Winston House; the residents all had private bed sitting rooms, there was no expectation that they would move on, and no staff lived in.

Selection of Residents

The Selection Committee remained unchanged throughout the eight years except that when Mrs Lawrence left Cambridge in 1960 she was not replaced. The Selection Committee reviewed all names put forward, decided priorities, and maintained a waiting list. Their policy varied over the years, depending on the number of residents and the pressure of the waiting list but they always gave priority to applications from Fulbourn Hospital. In their original prospectus much emphasis was laid on the value of an "emergency bed" which mentally disturbed people requiring shelter but not hospital admission could use. This was used about half a dozen times a year at first, but less in later years. This was probably due to changing public attitudes to hospital admission, and altering hospital policy. In 1958 Fulbourn Hospital was very overcrowded and had a waiting list for admissions; as numbers declined and overcrowding lessened, admission became easier and after the opening of the new admission unit, Kent House, in 1964, more acceptable.

During the first few months the numbers were built up slowly. After about half a year it became clear that Fulbourn Hospital could not keep the house full with local residents fulfilling the criteria of "being able to work and having a good chance of rehabilitation". During the second year, applications from other hospitals were welcomed and the numbers rose, especially after the publication of an article by Dr Clark and Mr Cooper in the Lancet in March 1960 (10). By 1961 there was a substantial waiting list

and unsuitable candidates were turned down. During this time the method by which local authorities should support the hostel was worked out, and from 1963 onward no one was accepted unless a local authority had agreed to support him. In general the fitness of applicants for Winston House was assessed by the Warden and the Consultant Psychiatrist by discussion of the information supplied. They were usually in agreement and the Selection Committee's function was mainly ratification and assessment of principles of priority. Whenever possible potential residents were encouraged to visit beforehand. All Fulbourn Hospital candidates were seen beforehand and any others who could travel to the House. This proved most valuable; a number of unsuitable persons were eliminated either by their own decision or the Warden's assessment.

Though the general policy remained constant during the years there were variations. These were partly reactions to the varying lengths of the waiting list, and the pressures put on the Warden, the psychiatrist and the Selection Committee. If one of the local social workers, mental welfare officers or probation officers begged the Warden to find a place quickly for someone in trouble he would usually comply. The criterion of being ultimately capable of rehabilitation remained. There were always a number of people, especially rather older men, in Fulbourn Hospital, working regularly, who were not allowed to come to Winston House because there was no foreseeable prospect of their moving on. During the high flood of applications from other areas the admission rate was high -- up to 63 in 60/61 -- more than one a week -- so that there were weeks when three or four new people arrived. As other

halfway hostels opened in the early sixties, the pressure of referrals slacked off.

There were several periods of experiment. In 1960, when the Alcoholics Anonymous were using the club house for their meetings, Mr Cooper wished to try to help some alcoholics. Several were admitted as residents; all did badly, causing trouble and disturbances and had to be asked to go. After that sad experience, alcoholics were seldom accepted.

During 1961 and 1962 Mr Cooper had some successes with unstable simple minded adolescent youths and for a time he looked for more of them, so then there was often a lively "younger element" of rowdy lads to be seen, or rather heard, in the house. In 1965 Mr Morrison had some unfortunate experiences with probation cases and after that was not willing to have more of them. For a time Mr Cooper experimented with using residents to work in the house, so that he accepted from Fulbourn Hospital several people well suited for this. The women for work in the kitchen were not a success, but a simple minded epileptic, Jack, made an excellent handyman; in 1966 he was still there after three and a half years.

However the following basic criteria were maintained.

1. All residents, had to be in work. Local candidates were not taken unless they were already in work. People from a distance had to find work in a month. Residents who fell out of work and could not find further employment had to leave and go back to their referring hospital.
2. The goal of ultimate rehabilitation was maintained (except for Jack, the handyman). In assessing applications, patients who

seemed likely to settle permanently were rejected. The residents were all told they must be prepared to move on ultimately. Most did. A few seemed to settle in, especially during the 1963/64 period of changing wardens, but in the end most of them moved on. Some of these "slow moving" residents broke down and returned to hospital; ultimately only one remained, a seclusive paranoid woman who had to be given formal notice to leave (after 2 years stay); she left and lodged herself with a relative.

3. The criterion that all residents had been mentally or nervously ill was maintained.

Relations with Fulbourn Hospital varied over the years. Winston House took many patients from Fulbourn Hospital, but at times rejected or returned some. Fulbourn Hospital admitted any resident of Winston House who became disturbed. From 1958 to 1962 while Dr Clark was both consultant psychiatrist to Winston House and Medical Superintendent of Fulbourn Hospital, irritations were quickly spotted and eliminated. During 1962/3 however, suppressed tensions emerged; the nurses at Fulbourn began to mutter that Winston House was importing difficult psychiatric problems into Cambridgeshire and then dumping them, as permanent troublesome residents, in Fulbourn Hospital at a time when they could not get their patients into the place. Dr Oram investigated this and found it arose from the problems of one difficult aggressive psychopath. He showed that hardly any Winston House residents from outside Cambridgeshire had become long stay patients in Fulbourn and the resentment diminished.

In 1963 the wards in Fulbourn Hospital were generally regrouped; a Rehabilitation Unit was formed (under Dr O. Hodgson) and they were the main suppliers of potential residents to Winston House. The Warden's links with them gradually became stronger and during the last two years of the study he regularly attended the monthly conferences of the Rehabilitation Unit and discussed candidates with the charge nurses and sisters of the wards. This improved relations generally and cut down the number of unsuitable referrals.

CHRONICLE OF WINSTON HOUSE

1956. June Cambridgeshire Mental Welfare Association presents case for a halfway house to Cambridgeshire County Council.
1958. March First meeting of Management Committee of Winston House; Warden appointed.
1958. 11th Oct. Four first residents admitted.
1959. March Report on first 6 months - 16 residents.
1959. October Report on first year. 17 residents. 41 admissions in 12 months. Decision to accept residents from outside area.
1960. January House full.
1960. March Lancet article by Dr Clark and Mr Cooper published.
1960. October Completion of second year. 58 admissions.
1961. October 3rd annual report. 64 admissions.
1962. August Dr Clark to U.S.A. Dr Oram acting as psychiatric consultant.
1962. October 4th report. 57 admissions.
1963. September Dr Clark returns. Mr Cooper leaves. Mr Cobain appointed Warden.
1963. October 5th year. Survey of 5 years by Dr Clark and Dr Oram with follow up report. 5th annual report, 45 admissions.
1964. July Mr Cobain leaves. Mr Morrison takes post as Warden.
1964. October 6th annual report; 37 admissions.
1964. December Dr Oram departs.
1965. October 7th annual report. 34 admissions.
1966. October 8th annual report. 23 admissions.

THE HOUSE IN OPERATIONGeneral

The physical state of the house, the mode of its setting up, the dominant personalities, the method of selection of the residents and the background chronicle have been set out. This chapter attempts to give some idea of how the house operated, what it was like to live in and some of the things that happened there during the eight years.

The disadvantage of any historical account is that it emphasizes the notable happenings - often the unusual ones. Yet the notable thing about Winston House was the ordinariness of much of the life. It was a boarding house where a number of working men and women lived. It was their home, from which they went out to work each day, to which they returned tired in the evening. They gave it heavy wear and a lot of work was needed by the staff both to keep it going - to keep residents fed, beds made and the weekly cleaning done - and to maintain and improve the fabric.

To a casual observer the residents would seem a normal group of heterogeneous people, men and women, all ages from adolescence to late middle age, some obviously labourers, mostly lower middle class in their dress. After a time the perceptive observer would notice their quietness and their loneliness. There was not so much clatter or chatter as would be heard in a group of normal people. The things they were doing - eating, reading, going up and down stairs, ironing clothes - were all normal activities but they were mostly doing them alone without much interaction. There

was little chaffing or bantering. After a time, too, some peculiarities might be noticed - a rather stiff wooden face, an obviously simple minded countenance, some physical disability - a hare lip, a hump back, a hemiplegic leg - or a person abstracted or perhaps muttering to himself. The psychiatric professional would recognise the high grade mental defective, the abstracted and possibly hallucinated schizophrenic, the phenothiazine-induced Parkinsonism, the stiff stalk of the paranoid - but nothing more remarkable than can be seen any day in London's Undergrounds.

The general physical condition of the house improved steadily through the years. The residents were not nearly so hard on it as the boys had been. Mr Cooper was a notable craftsman; he redecorated many of the rooms, and partitioned off a portion of the kitchen as an office for himself with the help of one of the residents. Some shabby outhouses were refitted as a clubroom and other shacks cleared away. The garden was gradually cleared and then was taken over in 1963 by Jack, the handyman who gradually got it into exemplary condition.

There was of course always plenty going on in the house. Arrivals and departures were frequent and the newcomers would tell all or part of their story. Often they were from Fulbourn Hospital and already knew some of the residents. Others came from a distance and had many queries about life in Cambridge. There were discussions about daily life - the television, the films on that week, the virtues of the various Cambridge pubs - more often than discussions of illnesses and doctors. There were usually one or two friendships developing, some of which proceeded to romances.

There were two weddings from the House in the eight years.

The Warden (or his deputy) was always in the little office at the foot of the stairs and much business was done there. Lodging charges were paid (and their intricacies discussed), calls were made to Labour Exchanges, employers, psychiatrists. Potential residents were seen and many visitors, from foreign professors to plumbers come to clear a drain. In the office the Warden had many long talks with residents about their problems and difficulties - advising the insecure about their work, helping the discharged to find new jobs, warning the antisocial or discharging the recalcitrant, persuading the suspicious to continue with the medication provided.

There were other centres of the life of the House. The kitchen was most important; there the Matron presided, helped by a staff whose numbers and quality varied a good deal and at times included residents. Though officially discouraged, many residents would come into the kitchen to talk to the Matron; the need to put in and take out laundry, to return dirty dishes, to collect lunch-time sandwiches created opportunities. The dining room was busy at mealtimes, empty at others except for a few people writing letters. The sitting room, dominated by the television, was always full in the evenings. The "quiet room" varied greatly in its use. At times there would be residents who used it a great deal -- to read, to write, to play classical gramophone records -- at other periods it was mostly vacant.

Apart from meal times there were few gatherings of the

residents. Mr Cooper started Sunday morning bible meetings. Attendance varied but was usually between a third and a half of the house. During 1959 he made an attempt to involve the residents in meetings to discuss the running of the house but these were poorly attended and were soon dropped.

The degrees of involvement of residents in the life of the House varied a great deal. Newcomers, especially those from other parts of the country, spent a lot of time with the Warden. Some residents continued to see him often. This was partly due to their basic personalities, their needs and anxieties, or to exacerbations of psychotic illnesses. Many residents, however, kept more to themselves. They went to their work, they took their pleasures alone, they conversed little. This was especially true of long term schizophrenics from Fulbourn Hospital who were well settled in jobs before coming to the House and being natives of Cambridge knew their way round the town well. Their eventual departure for lodgings might attract little notice. Other different personalities involved themselves with everyone; they offered regular greetings, arranged trips to the films, discussed their jobs, their homes, their mail. Any upset in their lives was soon known to all the House.

There were of course, stormy incidents through the years. They bulk dramatically large in the memories of the Wardens and the psychiatrists though they often did not upset the house very much at the time and there is little evidence of a continuing folklore about them. A few residents became more psychotic and had to be

admitted to Fulbourn Hospital; often this happened quietly but sometimes dramatically. One girl ran out of the house in her nightdress and went to the police station; one youth smashed a window in a rage and was taken to the local casualty department dripping blood; a recently arrived resident failed to return one evening, but walked into the police station at 3 a.m. with blood streaming from a self inflicted wound on his throat; a young woman took an overdose of aspirins and had to be taken to hospital; a man got drunk, made a row at night and had to be told to leave next day; two men had a fight and had to leave. Only once (during the first year) did a Mental Welfare Officer (Duly Authorised Officer, as he was in 1959) have to be called to remove a resident and only twice were the police called to the house — about average for 8 years of a working mens' boarding house! Several times the Warden took residents up to Fulbourn Hospital in his car for immediate admission and on a few other occasions nurses came down from the hospital and persuaded disturbed residents to go back.

Apart from the quiet daily tenor of life, there were a number of occasions in the life of the House. Some were regular. Once a week the Warden went up to London with his accounts. Once a week was the consultant's clinic held at the out patient department and a number of residents had to walk up there after supper. Once a month the Committee came to the House for their meeting, using the quiet room for several hours.

Christmas was always enthusiastically celebrated with a sit down Christmas dinner for the residents and the members of the

Committee of Management followed by party games, the presentation of gifts from the Christmas tree and carol singing (the Chairman of the Management Committee was an accomplished pianist). There were a number of special parties, outings, birthday parties, coming of age celebrations and two weddings from the house.

The outbuildings at the back, originally stables, were stripped and decorated by volunteers and organised as club rooms; a billiard table was at times used by the residents. For several years the social workers of Fulbourn Hospital held their Therapeutic Social Club meetings there on Tuesday afternoons, though the residents were little involved. During another winter the Alcoholics Anonymous group of Cambridge hired it for their meetings.

Other special occasions were less frequent but more exciting. Several Open Days were held for invited visitors. To one, all the professional social workers in the Cambridge area - about 60 people - were invited. For a Bring and Buy Sale a marquee was erected on the lawn. To a Coffee Morning for Fund Raising came many of those interested in mental welfare in Cambridgeshire.

To attempt to give some flavour of the life of the house, two accounts are appended.

The first was written by Dr Clark and Mr Cooper in 1959, and forms part of the Lancet article and describes the early days.

Life at the Hostel

The Warden has tried to run the house as a place in which the residents could adjust their way of life to a more normal pattern and could learn to appreciate that they are discharged from hospital and living in communal lodgings.

A "code of behaviour" rather than a "set of rules and regulations" has been set up and an effort has been made to create an atmosphere of homeliness and relaxation..... Attempts have been made to get the residents to help in running the hostel but meetings have been poorly attended. The staff join the residents for meals which are taken at separate small tables.....

All the staff have been asked to treat residents as normal people and to make no reference to the past. The atmosphere in the house has been reasonably good except for the first month or two. The first intake of residents included one or two who were unsuitable and who, by their difficult behaviour, caused some unrest and discontent. A few admissions from hospitals outside Cambridge brought a new outlook.

The staff found at first a background of mistrust, suspicion and indifference among the residents, but by the end of the first year there seemed to be more trust and confidence in the staff and the hostel as a way back to normal life.

The second is a note written by Dr Oram in 1964:

Reflections on the Atmosphere of Winston House

Approaching Winston House from Brooklands Avenue there is nothing immediately to set it apart from any other of the large, dull poker faced houses which line part of one side of the road. With the hum of traffic - the 50 mile an hour car, the 40 mile an hour lorry - one becomes aware of the inscrutability of the residences in this road. The activity is a coming-from or a going-to, not a staying-in. Walking up the driveway one would still not guess that inside one will find not an elderly retired Colonel and his lady, rooms full of the spoils and souvenirs of many a foreign land indiscriminately mixed with Victorian bric-a-brac, but a modern hostel designed for about thirty people. The entrance to the house is rather quaint; it would seem that one must pass through not a front door but a canopy or shelter to a wishing-well, modestly preserved by the National Trust. Having come thus far this indeterminate and inscrutable quality vanishes. Here indeed is the real world; here one remembers home when, suffering from the more or less genuine symptoms of a head cold, one stayed legitimately and with consent away from school. There is the drone of the vacuum cleaner, soporific on catarrhal ears, idling its time through the bedroom; there is the smell of Brasso and polish; there is the duster on the hall table forgotten after a chance opening of the door - another trip downstairs. Going farther, there are the faint smells of the kitchen, the bubble of pots and the random bump of their lids. And still like home, there are only the womenfolk and the Warden

trespasses on their ground. I remember one morning in such an atmosphere, the day when the curtains were being done, the sun streamed in the unclothed windows. Suddenly panic came; there was a photographer outside taking pictures of the house in all its nakedness. The bustle of activity continued until the curtains were resurrected, draped in their accustomed positions, modesty satisfied, and the photograph properly taken.

When the noise of traffic increases and the impatient hoot their horns, when the factory sirens have sounded, when the pushing and crushing on buses has begun, gradually life builds up in the house. The family have returned. Dirty feet on the step washed only that day; dirty feet on the clean carpet; umbrellas, bags, coats, hats, all of the paraphernalia of being outside laid down in some inappropriate place. Admonitions "Wipe your feet", "Hang it on the stand", "Put it upstairs" gradually settle to the relative peace of the family meal. After the meal some go to their own pursuits -- the cinema, the coffee shop, window-shopping, to others the peace of the quiet room -- short lived -- pop tunes from the record player; to others -- maybe most -- the conventional evening relaxation -- the infamous one-eyed Kelly in the lounge. A very heterogeneous family this, girls and boys all ages but not "steps and stairs", both sexes, fat, thin, plain, pretty; some who mix and some who don't; some resentful, some grateful; and from time to time family swells as some of the grown-up members return from their own now completely private lives often with a bundle of washing for the Matron to take care of. After supper to the last squabbles and confidences of the day, whilst in his room the Warden breathes a sigh of relief and looks forward to an hour or two catching up with the paperwork.

Management

There were few difficulties in the management of the house, and as far as could be told they had not a great deal of effect on the life of the house. Such difficulties and storms as occurred were more related to crises in the lives of the residents than changes in the management.

In the early years, Mr Cooper was the dominant individual. His big frame, his joviality, his conviction of personal righteousness dominated most exchanges. To many residents he was Winston

House. He aroused antagonism in some residents and quite a few professionals, especially those whom he felt were interfering in his rightful sphere, or even worse, giving residents wrong advice. Most residents however welcomed this firmness, sought advice and reassurance from him and kept in touch with him after they left the House.

The period in 1963 and 1964 after he left was a difficult one. The Cobains did not settle well in the house. When Mr Morrison came, the second new warden within a year, there was a good deal of uncertainty in the house. A number of residents, particularly women and particularly those paid to help in the kitchen, resented the new regime and made many difficulties. There were crises, floods of tears, visits to the psychiatrist. Gradually these residents left, some willingly, some stormily and the pattern of the house settled again.

Relations with other Bodies

These were important, if only to ensure a regular flow of residents from other hospitals.

During the first year there was, of course, considerable interest from local bodies and officials, many of whom visited or referred problem patients to see how the House worked.

At the end of the first year the House was not full, so details of the house were sent to all neighbouring hospitals. The Lancet paper aroused further interest. There were many requests for reprints. More important, there was a steady flow of referrals. Both Dr Clark and Mr Cooper were asked to address

various bodies and gatherings -- Cambridge Rotary (who donated money), a Conference on Halfway Houses organised by the National Association for Mental Health, the local Methodist Council, the Cambridgeshire Social Workers, the Staff Conference at Fulbourn Hospital. Both relished these engagements.

During the early years of the Mental Health Act 1959, many local authorities were thinking of starting halfway houses. Winston House was well known and many enquiries came in. More important, a number of psychiatrists and medical officers of health came to Cambridge to see Winston House and talk with the Warden. These visits were important in reassuring the staff of their importance -- and uniqueness -- of their work.

A Visitors' Book was kept and the entries show the interest the work aroused. The numbers of visitors each year from 1959 to 1965 were 38, 43, 88, 40, 51, 16, 46. The majority were British professionals, especially social workers from local authorities, but there were visitors from 15 countries in all six continents and the list included the Director of the Psychiatry Division of the Veterans Administration of the U.S.A. (1959) and a Minister of Health (Mr Enoch Powell 1963).

The Warden and the Psychiatrist

Discussions with staff of other halfway houses have revealed that the method of selection of residents and the removal of difficult ones is a major area of concern and that the responsibility for disturbed people is a major burden and worry to wardens. The critical articles about hostels, such as those of Walker,

Phillips, Mountney and Apte all mention difficulties with the consultants of the local mental hospitals as a reason for low numbers. Informed visitors have suggested that the relationship between the warden and the consultant psychiatrist was one of the unique features of Winston House, contributing to its successes. It is therefore necessary to discuss it further.

The wardens were Mr L.W. Cooper, October 1958 to September 1963; Mr Cobain, October 1963 to May 1964; Mr Morrison, May 1964 to end of study. The Consultant psychiatrists were Dr D.H. Clark October 1958 to August 1962; Dr E.G. Oram September 1962 to approximately August 1964, Dr D.H. Clark August 1964 to the end of the study in October 1966. Thus Mr Cooper worked with Dr Clark and Dr Oram, Mr Cobain with Dr Oram, Mr Morrison with Dr Oram and Dr Clark.

Dr Clark was Medical Superintendent of Fulbourn Hospital when the idea of a halfway house in Cambridge was first suggested. He drafted some of the earlier memoranda, was on the Committee of Management and the Selection Committee, and assisted in the selection of the Warden. He selected and knew personally all the founder residents as he had taken a leading part within Fulbourn Hospital in getting them out to work; he had been greatly identified with the rehabilitation programme in the hospital. Mr Cooper came to the House from a YMCA Hostel and previous years of experience as a Salvation Army missionary in West Africa. Mr Cooper knew nothing of psychiatry but a great deal about running hostels and managing people.

During the first winter 1958/9 Dr Clark came once a week to

the House. He saw residents individually in the quiet room, made notes on their progress, dispensed their drugs and then talked with Mr Cooper afterward. In their discussions they reviewed the progress of residents, discussed applications, forthcoming committee meetings and many other matters. In February 1959, Mr Cooper questioned the wisdom of this arrangement, pointing out that it made the residents feel that they were still in hospital, with the doctor "doing his round" and that it weakened his position as warden by suggesting that there was another authority in the House. After discussion Dr Clark saw the force of this and from March began seeing those residents who needed psychiatric help at the out patient department of Addenbrooke's Hospital, which was about half a mile from Winston House. All new residents from outside Cambridge were sent to see Dr Clark on arrival. Many continued in regular treatment. At any time about one third of the residents would be having active psychiatric treatment (psychotherapy and/or drugs), one third attending occasionally for review and one third not attending at all. Those that needed medication received prescription cards which they gave to Mr Cooper who obtained the drugs and handed them out twice daily. Dr Clark was always "on call" for the House. Mr Cooper, could, and did, phone him if any problem arose with one of the residents, and in a crisis he could always get in touch with Dr Clark or an appointed deputy.

By this time applications were coming in from other hospitals. Mr Cooper and Dr Clark would go through these in detail and decide their recommendations for the Selection Committee, where they were never questioned. In August 1959 Dr Clark moved his home from

Fulbourn Hospital to a street only a quarter of a mile from Winston House. At least once a week he would go into Winston House, usually in the morning when the residents were at work, to talk with Mr Cooper.

When Dr Clark went to the United States for the year September 1962 to August 1963 Dr Oram took over, seeing the out patients regularly, meeting weekly with Mr Cooper and attending Committee meetings; he continued this for another year after Dr Clark returned in September 1963, covering Mr Cobain's wardenship, and then in the summer of 1964, since Dr Oram was preparing to leave Cambridge, Dr Clark took over again and worked with Mr Morrison.

There are three aspects of this relationship - the selection process, the emergency arrangements and the mutual confidence.

Although formally the selection of residents was by the Selection Committee listed in the original notice, in effect the selection was by the Warden and Consultant. The P.S.W. of the C.M.W.A. soon dropped out; she stopped coming to the meetings and then left Cambridge and was not replaced. The lay members of the Committee accepted the recommendations of the Warden and the psychiatrist.

In their discussions Dr Clark insisted from the first that the Warden must have a major say in selection, and an absolute veto. The psychiatrist could assess the clinical record and guess who might do well and what might go wrong, but the Warden decided who was suitable. All the Fulbourn and Cambridge patients and most of the applicants from other hospitals visited the house at least once before being accepted; they met the Warden, were shown round

the house, and discussed whether it would help them. The only exceptions were people from far off hospitals - Scotland, Yorkshire, Lancashire, etc. Of course, this was only the first hurdle for the applicants; the social worker proposing them then had to get the promise of local authority support, and finally there was the waiting time, which could be as much as several months (though in some cases it was only a few days).

If the Warden thought someone was unsuitable then they were not accepted. Sometimes the Warden expressed a wish to try to help someone whom the psychiatrist, from a study of the records, felt was unlikely to succeed; if there was a vacancy the person was taken. Most of these did badly, but one or two surprisingly succeeded.

The emergency arrangements were most important. In the early days when Dr Clark knew all the residents and had usually seen them recently, Mr Cooper could ring him and Dr Clark could decide or take action. Quite often, particularly in the early days, Dr Clark would hurry to the house and see the upset resident. On several occasions he arranged immediate admission to Fulbourn Hospital, even in the middle of the night. On occasion Mr Cooper drove residents up to the hospital (2 miles away) by car for immediate admission, after Dr Clark had instructed the admission ward to take the individual in. This arrangement was particularly valuable when assistant wardens or holiday reliefs were in charge and faced by a crisis too difficult for them.

The arrangement was of course not without problems. Fulbourn Hospital was under pressure and at times had a waiting list for

admissions. Doctors and nurses might resent a patient being rushed in. When Dr Clark was on holiday there was once difficulty in finding a psychiatrist ready to act; when Dr Oram was in charge he had rather more difficulty than Dr Clark getting patients admitted to Fulbourn Hospital. Every time things went wrong like this there was full discussion with all concerned and the difficulties were in due course ironed out. Arrangements were gradually made by which the senior registrar on duty could always see residents at short notice at the out patient department at the general hospital. The hospital staff accepted that Winston House was helping many Fulbourn patients to independence (and helping to empty their overcrowded wards) and that their contribution must be to accept acutely disturbed residents and despite arguments the emergency system always worked. No acutely disturbed person with whom the hostel staff could not cope was ever left in Winston House for more than a few hours; never overnight. The knowledge of this support, which never failed, made the Wardens bolder in accepting residents of doubtful stability.

The personal relationship between the wardens and the consultants remained good. Dr Clark and Mr Cooper were both forceful men with radically different backgrounds, but each learned to respect the qualities of the other. Through the eight years similar mutual explorations between Dr Oram, Mr Cobain and Mr Morrison, were equally satisfying. There were of course episodes of disagreement and argument, and times of annoyance, disappointment, criticism and back-biting, but they were overcome by honest

confrontation over the hard realities of the difficulties of the residents. Had this trust not been established and maintained (by attention and hard reflection) it is unlikely that Winston House would have been so effective.

THE RESIDENTS

On 11th October 1958 the first residents, four men, moved in, two from Fulbourn Hospital and two from lodgings in Cambridge. Four came a week later and then another four making twelve founder residents (9 men and 3 women). During the following months about one resident a week came in; some began to leave so that by March 1959 although 21 had been admitted, there were 16 in residence. At the end of the first year 39 had come in but there were only 17 residents. By the end of 1959 the house was full, and apart from the inevitable casual vacancies between one resident leaving and another coming, it remained full for the rest of the eight years.

The first admissions from outside the Cambridge area were almost accidental. There were very few halfway houses in Britain at the time and a few people were desperately seeking places. A local general practitioner asked us to take a relative just being discharged from hospital; an enterprising psychopath heard from the social worker of his hospital that Cambridge had a hostel, so he discharged himself, came up to Cambridge from Surrey and knocked on the door. Other persons were referred by the National Association for Mental Health Enquiry Bureau to whom despairing enquiries came from all over the country. By the autumn of 1959 applications from social workers and psychiatrists in other areas were coming in. As it became clear that local sources would not fill the hostel outside applications were encouraged and often there was soon a steady flow. Most of them came from South East England; a few hospitals, notably Runwell Hospital, Essex,

Brookwood Hospital, Woking, and Stanley Royd Hospital, Wakefield, sent a number of residents. Some came from afar, the furthest limits being Southern Scotland (Crichton Royal Hospital, Dumfries) and the Channel Islands, though one resident came almost directly from the Argentine.

It is difficult to attempt to describe "the characteristics of the residents". There were 288 of them altogether and any generalization must in part be misleading.

Some of their common features arose from the conditions for admissions; the house was for "men and women capable of rehabilitation but suffering from mental and emotional disturbances who are unsuitable for ordinary lodgings or who are unable to live at home" they had to be "in employment, or capable of obtaining it almost immediately". Most of them were ex-mental hospital patients; many had been in hospital for a number of years; nearly half had been diagnosed schizophrenic. Most of them were alone in the world; this is generally true of long stay mental hospital patients but there had been a further selection for Winston House, because the residents were by definition people without homes to which they could return. On the other hand they were by no means so ill or crippled as a random sample of mental hospital patients; they all had a fair level of social capacity, since they were able to hold down a job of work.

The work they obtained covered a wide range but many held low grade jobs -- the men as labourers and kitchen porters, the women as cleaners and washers-up in restaurants. Many however held better jobs - bench hands at electronic works, assembly workmen in



small factories, clerical posts in Government offices. A few held good jobs - typist, saleswoman, research assistant, manager of a shop. Very few held positions of authority over other workers.

As the statistics show there was a wide age range. The majority were middle aged, but there were always a few adolescents and youthful adults. Apart from their common experience of mental illness, their backgrounds varied widely. There were University graduates, including one who had qualified in medicine, and public school boys; there were a number of residents with secondary education, though the majority had had only primary; there were a number of subnormal intelligence and illiterate. The majority were East Anglians but there were always a scattering of people from other areas, Scots, Irish, "Geordies", etc. Most of them were fairly accustomed to communal living though there were occasional difficulties about the degraded or offensive habits of some of the simpler members or the critical condescension of the well educated or grandiose.

A few examples are attached.

A.B. was a burly man of 45 when he came to Winston House as one of the founder members in October 1958. A local farm worker, he had been admitted to Fulbourn Hospital 13 years before in a hebephrenic state -- giggling fatuously and saying that he had ruined his brain by masturbation. In hospital he received insulin coma therapy, E.C.T. and Largactil and had made a degree of recovery but remained abstracted and frequently giggling. His sturdy strength soon won him a place on the hospital farm where he became a key worker, well liked by the paid staff. In 1957 he had been found a job with a building contractor.

When he first came to Winston House he was quiet and solitary. At the out patient clinic he confessed that for the last year he had been throwing away his Largactil, so the supply was stopped. Gradually he became more enterprising and active, talking more to the other residents, buying better clothes, going out to the pictures and then the pub. In May 1959 his employer offered him the use of a caravan on the building site and A.B. moved out of Winston House.

He is to be seen about Cambridge at times. He lives in his caravan, which his employer moves to each new building job so that A.B. has his own home, is on the job in the mornings, and acts as night watchman. He caters for himself and clearly prefers his solitary life. In conversation he remarked "Of course, I still have the ideas about having ruined my body, but then you've just got to ignore them things, haven't you?"..... "Of course, it's a business shopping for yourself, but you have your freedom don't you?"..... "The hospital was all right I suppose but they were a funny lot.....always pushing you around".

C.D. was an odd 20 year old young man, stolid, with a heavy ponderous speech and an earnest wooden face with owlsh spectacles when he came to Winston House in January 1960 from a hospital in Surrey. At the age of 11 he had suffered severe brain damage in a street accident. After months of neurosurgery and specialised treatment in teaching hospitals he was sent to a mental hospital at the age of 12 because of his ferocious temper tantrums at home. In hospital he gradually settled down and after years, had found work in the stores.

At first, in Winston House, he was a considerable problem, constantly seeking the Warden for long discussions about his problems -- himself and his future -- discussions

made even more tedious by his slow scanning speech. He found a job at a local sports manufacturers, varnishing tennis rackets. He smartened up his appearance and lost his institutional look. He began to play the Winston House piano. He attended the Warden's Sunday morning bible sessions regularly and became a member of a local Congregational Church. After ten months the warden suggested the possibility of lodgings and finally C.D. moved out in February 1961.

In 1967 he still lives in Cambridge, still at the same job. He is now heavier and fatter and his hairline is receding, but the same earnest stare peers through the same owlsh glasses as he spells out his self concern in his slow ponderous phrases. He lives in a bed-sitting room; every week he takes his laundry into Winston House; he attends his church and its youth club regularly and two evenings a week goes to his piano classes. About once a year he comes to the out patient clinic for an interview (by appointment, at his request) and reviews his situation. He has now over £400 in the Savings Bank; he feels that matrimony is now indicated but wonders how he can find a suitable "Christian young woman".

E.F. was a strapping woman of 38 when she came to Winston House in June 1962, with bland slightly puzzled face and a clear upper class accent. Her first admission to a mental hospital had been in 1944 when she broke down while an officer in one of the womens' services. She was the only daughter of an architect and she was at first treated in a famous private mental hospital. Her catatonic schizophrenic illness was violent and stormy, especially since she was a big strong girl; windows and nurses' ribs were broken. Despite insulin coma therapy and E.C.T. there was little change and in 1947 a leucotomy was performed -- one of the early "blind" leucotomies. Though there was some improvement she remained violent and out of touch and

she was incontinent and over weight as well. In 1951 her parents were told that there was little hope of further change and advised to transfer her to the nearest public mental hospital, which was Fulbourn. There E.F. soon became one of the most feared residents of the "disturbed ward" frequently violent, constantly incontinent. As the hospital began to change in the late nineteen fifties she began to emerge as one of those for whom there might be hope of rehabilitation. On one occasion she was Victrix Ludorum of the hospital sports. As the regime became less oppressive, she became less violent. During 1961 she obtained several jobs in Cambridge and finally was considered fit for Winston House.

In the House at first she was rather a problem. She was inconsiderate of others, eccentric, and at times overbearing, but she would listen to explanation and reason. Her incontinence returned briefly when she first came in, but this settled again. She improved her dressing and became more punctual at meals and at work. After April 1963 she moved out to carefully chosen lodgings in Cambridge.

Three years later she is still living in Cambridge, but has no formal contact with the psychiatric department. She keeps her job at a local electronics factory and lives in her bed-sittingroom. When one meets her casually she is still off hand and slightly perplexed, but is clearly well satisfied with her life. Her memories of Winston House are warm -- in marked contrast to her memories of the hospitals in which she spent 18 years of her life.

G.H. was a jovial stocky Irishman of 49 when he first came to Winston House in October 1962. He had been brought to Fulbourn Hospital 6 months previously from the Cambridge police station where he had been taken because of curious behaviour. On admission to hospital he was constantly and vividly hallucinated; the birds in the bushes were abusing

him vigorously. He soon settled down with chlorpromazine and a history emerged of numerous brief admissions to hospitals up and down Britain. Soon he found work and asked for admission to Winston House.

In Winston House he settled well; he was obviously well accustomed to the life of a working mens' hostel. He paid his rent regularly, did not drink to excess, made no trouble and was popular with the other residents. In May 1959 when the spring came round he announced he must be "off on the road" and departed but it was too soon and he turned up again one evening at the door of Fulbourn Hospital a month later because "the birds were talking to him again". He was readmitted, treated again with chlorpromazine and came back to Winston House in July 1959. This time he stayed for a month and then moved off again. Since that time there have been occasional enquiries from mental hospitals up and down Britain showing that his wandering life and periodic psychotic episodes continue.

K.L. came from a neighbouring county, aged 18, in December 1964. He was a simple minded youth, I.Q. 64 who had been backward in his rural school and had barely learned to read or write. For the previous 2 years he had been severely ill with nephritis (Nephrotic syndrome) and was still on regular penicillin. He had come to notice because he had assaulted his father in outbursts of rage at home. He had never done a job of work.

On arrival at Winston House he was small and youthful, with a large head and somewhat simple appearance. In conversation he was pleasant and docile. He was found a job in a local small manufacturers doing part of the process of glueing tennis rackets together. He obviously gave satisfaction, as he kept the job for the next three years earning up to £9 a week. In the House he was well

behaved and never had any outbursts of rage. He made friends with other youngsters in the house and went out to the pictures with them. He regularly visited an aunt who lived in Cambridge. At holidays and some weekends he went to see his parents 60 miles away and he became an ardent follower of a local football team going long trips on excursion trains to away matches.

In August 1966 after prodding from the Warden, he found himself digs and moved out of the House. It seems that Winston House has enabled this physically damaged simple minded adolescent who had never previously worked to make the transition to independent adult life.

STATISTICSAdmissions

During the 8 years, 11 October 1958 to 11 October 1966, there were 360 admissions, (203 men, 157 women) to Winston House. Of these admissions 72 (36 of each sex) were readmissions. The total number of people who lived in the House was therefore 288 (167 men, 121 women).

					M.	F.	T.
Total residents	...	...	...	...	167	121	288
Readmissions	...	...	...	...	36	36	72
Total admissions	...	...	...	...	203	157	360

The numbers of admissions varied in the different years. In the first two years most residents were well known patients from Fulbourn Hospital, carefully selected; the total number of admissions was not great. In the middle years there were many experimental admissions (especially from distant hospitals); a number of these were unsuccessful admissions, leaving soon after arrival, so that the total number of admissions in the year was higher. In the latter years with more experience, more careful selection and a slower turnover the number of admissions fell:

					M.	F.	T.
1st year	(1958-1959)	...	...	...	25	16	41
2nd "	(1959-1960)	...	...	...	33	25	58
3rd "	(1960-1961)	...	...	...	38	26	64
4th "	(1961-1962)	...	...	...	23	34	57
5th "	(1962-1963)	...	...	...	26	19	45
6th "	(1963-1964)	...	...	...	23	14	37
7th "	(1964-1965)	...	...	...	22	12	34
8th "	(1965-1966)	...	...	...	13	11	24
					<u>203</u>	<u>157</u>	<u>360</u>

The number of readmissions tended to rise over the years, though there was a sharp decline in the last year.

Readmissions

			M.	F.	T.	% of admissions for year.
Year 1	...	...	2	2	4	10%
" 2	...	...	2	4	6	10%
" 3	...	...	4	6	10	16%
" 4	...	...	7	8	15	26%
" 5	...	...	8	6	14	31%
" 6	...	...	4	6	10	27%
" 7	...	...	9	2	11	32%
" 8	...	...	0	2	2	8%
			<u>36</u>	<u>36</u>	<u>72</u>	

Most of the readmissions were second admissions (50) though 13 came in a third time. Only 5 people succeeded in gaining acceptance for a 4th time, three for the fifth and only one, an engaging hysterical psychopathic woman on a 6th occasion:

Readmissions

1st admission	...	288
2nd "	...	50
3rd "	...	13
4th "	...	5
5th "	...	3
6th "	...	<u>1</u>
		<u>360</u>

Origin of admissions

The largest group of admissions came from Fulbourn Hospital; about one quarter of these were readmissions of persons who were felt to merit a further chance in Winston House. A number of residents came from other sources in the Cambridge area. Some

were emergency admissions arranged by social workers; some were ex-residents in passing difficulties - landladies' holidays etc.; some were referred from the out patient clinics of the Cambridge Psychiatric Service; a few came in from their families by arrangement for a week or two for a holiday. One third of the admissions from "other Cambridge sources" were readmissions. A substantial group of admissions came from outside the area. The number of these referrals increased after 1960; at first they came mostly from mental hospitals, but latterly more came from psychiatric units of general hospitals. There were very few readmissions in this group; if a person had gone back unsuccessfully to their original hospital there was seldom any request for readmission.

	People	Readmissions	Total admissions
Fulbourn Hospital	120	37	157
Other Cambridge sources	73	28	101
Outside Cambridge area	95	7	102
	<u>288</u>	<u>72</u>	<u>360</u>

Referring Hospitals

	Admissions
Runwell Hospital, Essex	13
Brookwood Hospital, Surrey	8
Stanley Royd Hospital, Yorkshire	8
St. Audry's Hospital, Suffolk	6
Crichton Royal Hospital, Dumfries, Scotland ...	5
Hellesdon Hospital, Norfolk	4
Bethlem & Maudsley Hospital	4
Goodmayes Hospital, Essex	3
Claybury Hospital, Essex	3
Little Plumstead Hospital, Norfolk	2
Hellingly Hospital, Sussex	2
Penyval Hospital, Wales	2
Roundway Hospital, Wiltshire	2
Moorhaven Hospital, Devon	2
Severalls Hospital, Essex	2

One each from the following psychiatric hospitals:

Roffey Park Hospital, Holloway Sanatorium, St Bernard's Hospital, Warneford Hospital, Tooting Bec Hospital, Parkside Hospital, Fairmile Hospital, Saxondale Hospital, Netherne Hospital, Banstead Hospital, Bootham Park Hospital, St John's Hospital, Horton Hospital, Springfield Hospital, Powick Hospital, Napsbury Hospital, Rauceby Hospital, St Ebba's Hospital, Friern Hospital, Herrison Hospital, Hillend Hospital, The Retreat, Warley Hospital, Cheadle Royal Hospital, Grendon Underwood Prison.

One each from the following general hospitals:

Dulwich Hospital, Royal Berkshire Hospital, Queen's Park Hospital, Royal Free Hospital, Westminster Hospital, Prestwich Hospital, University College Hospital, St Swithin's Hospital, Bolton General Hospital, Rochford Hospital, St George's Hospital, Victoria Hospital Birmingham, Brook Hospital, Woolwich.

Length of Stay

There were 360 admissions but 22 residents were still in the hostel on 11th October 1966. There had therefore been 338 completed stays in Winston House.

Many residents left very soon - 47 in the first week, 80 in less than 1 month. Some of these stays were planned to be short, some were brief holiday reliefs, some were of undoubted benefit to the resident, but the majority of those leaving so soon were unsuccessful stays -- residents who did not like the house, found it other than they expected, would not conform to the rules or did not

find work. The proportion of these brief stays was highest in the middle years (1960 to 1963) when Mr Cooper was sending for many people from distant hospitals and trying experiments as the following table shows:

	Total Admissions	Stay less than 1 month	Proportion
1st year (1958-1959) ...	41	5	12%
2nd " (1959-1960) ...	58	16	27%
3rd " (1960-1961) ...	64	17	26%
4th " (1961-1962) ...	57	22	38%
5th " (1962-1963) ...	45	4	9%
6th " (1963-1964) ...	37	5	13%
7th " (1964-1965) ...	34	5	15%
8th " (1965-1966) ...	24	4	17%

All the stays are set out on the accompanying histogram (Figure 1). The mean length of stay was 4.3 months. As will be seen, most residents left within the year; 12 stayed for periods between 1 and 2 years, and two stayed for longer than 2 years (each for 30 months).

Personal Characteristics of Residents

Altogether 288 people (167 M, 121 F) passed through Winston House during the eight years.

Age

The age of the people on admission ranged from 16 to 64 with an average of 35.4 years. The proportions in different decades were:

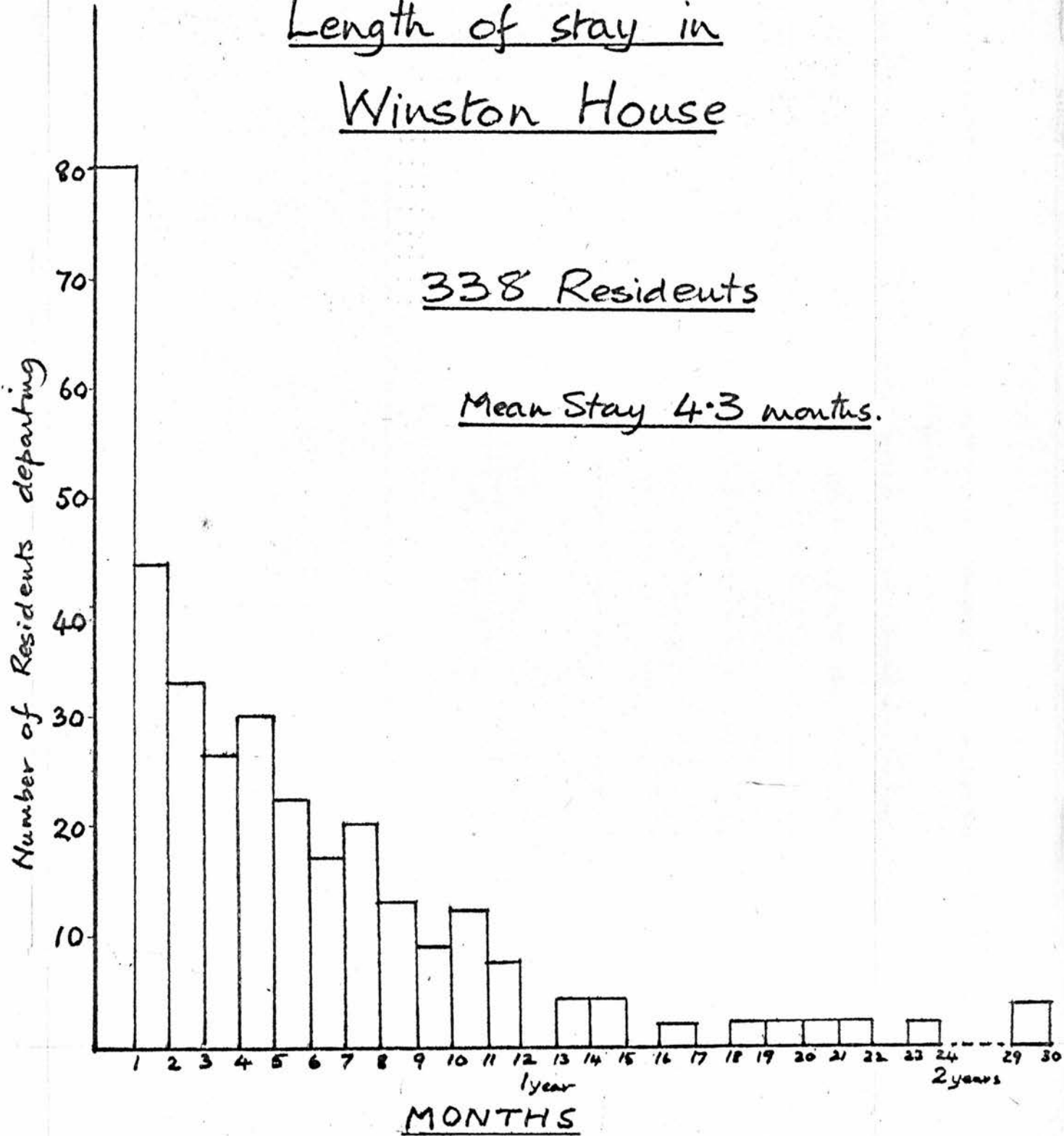
Under 20	...	...	...	...	41	14%
20 - 29	...	...	...	...	78	27%
30 - 39	...	...	...	...	67	23%
40 - 49	...	...	...	...	59	21%
Over 50	...	...	...	...	<u>43</u>	<u>15%</u>
					<u>288</u>	<u>100%</u>

Figure 1

Length of stay in
Winston House

338 Residents

Mean Stay 4.3 months.



There was not much variation in the proportions over the years but rather more adolescents were admitted between 1961 and 1963.

Diagnosis

Many of these 288 people had spent long years in mental hospitals and had been given a variety of diagnostic labels. Others fell into several categories such as a young man who had fits, was of limited intelligence and of unstable, unreliable behaviour. They could only be roughly categorised, but the following table indicates the main diagnostic groups.

	M.	F.	T.
Schizophrenia	81	69	150
Personality Disorder (including Alcoholism and Epilepsy)	51	31	82
Other psychiatric disorders (including Depression and Manic Depressive Psychosis)	22	20	42
Subnormality	<u>13</u>	<u>1</u>	<u>14</u>
	<u>167</u>	<u>121</u>	<u>288</u>

Immediate Destination

There were 360 admissions in the register; 22 remained, 338 had departed. The immediate destination of all were noted and analysed thus:

	Total Admissions	Departures	% of Departures
Community Address	233	246	73%
Other Hostel	13		
Fulbourn Hospital	56	76	22%
Other psychiatric hospital	20		
Physical hospital	6	16	5%
Prison	2		
Destination not known	8		
Still in Winston House	<u>22</u>	<u>-</u>	<u>-</u>
	<u>360</u>	<u>338</u>	<u>100</u>

The six departures to physical hospital concerned two people, a woman who went to hospital with cancer of the uterus and died there and a man with gastric ulcer who went to hospital five times, was operated on and finally was rehabilitated. The two departures to prison were two probation cases who did badly, offended and were reimprisoned. The eight unknown destinations were men who went off leaving no forwarding address, though we heard of most of them subsequently.

These figures are only of limited value and the more detailed follow up of a selected sample gives a more informative answer. However these figures are useful for comparison with those of other hostels. The striking fact is that only 22% of the departures went back to psychiatric hospitals.

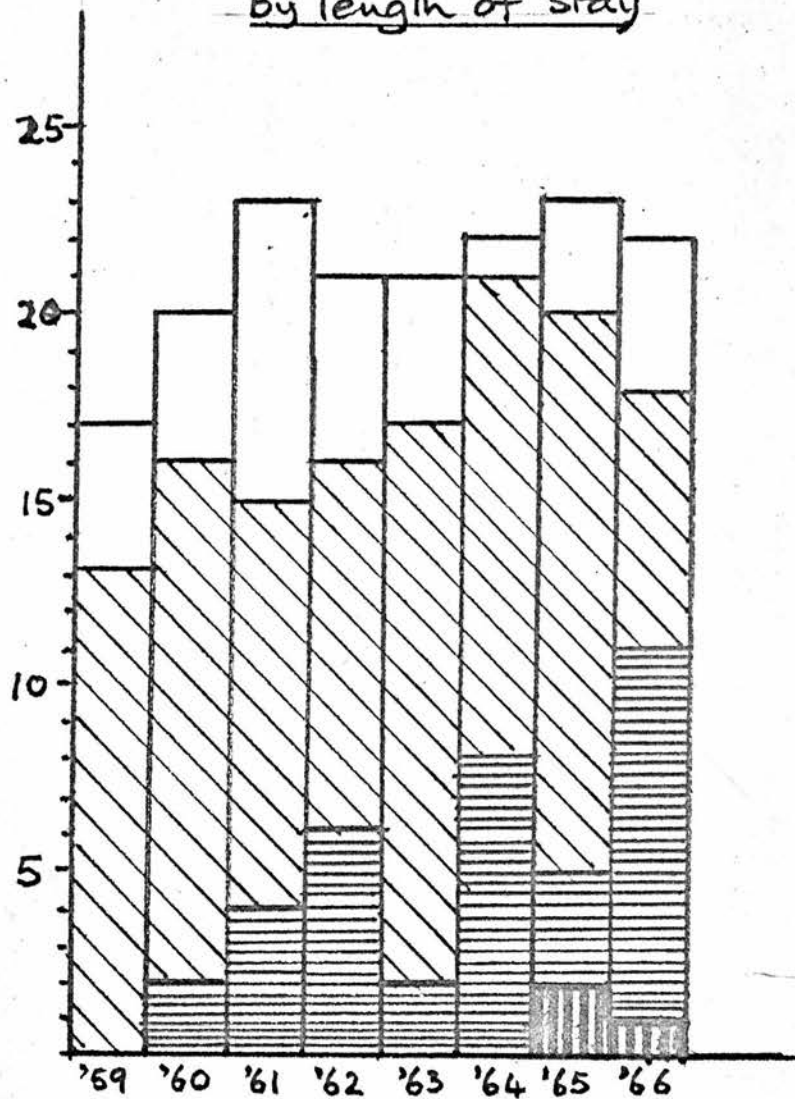
The attached histogram (Figure 2) shows an analysis of the census of Winston House on the first of October each year and illustrates a number of the trends mentioned elsewhere.

Figure⁶⁶ 2.

Census of Residents of Winston House

at anniversary date each year

by length of stay



Number of residents

11 October each year



Less than 1 month

1 to 12 months

1 to 2 years

more than 2 years.

Total numbers: After the first October, when the house was not quite full, the figure shows that it has always operated near capacity; in two years ('61 and '65) the house had its full complement of 23 residents at census time. At no count was the number less than 20.

Recent arrivals: The proportion who had been in the house less than a month varied a great deal, depending on recent departures and admissions.

Long Stay Residents: The number of people staying more than a year began to build up in 1960 and 1961. In his last year (1963) Mr Cooper moved a number of them on. During the interregnum year (1964) the number built up again and some even stayed more than 2 years. In 1965 Mr Morrison reviewed these very long stay residents. The Committee agreed that Jack the gardener should stay and he appears alone on the 1966 census.

The number of residents who had stayed more than a year remains fairly steady around a quarter of the total from 1962 to 1965 but in the 1966 census jumps to over half the total. It is not yet clear whether this will be a sustained trend.

Follow Up Study

The foregoing figures give a general idea of the people who came to Winston House, their numbers and origin. Other figures would show that many had spent years in mental hospitals; that some had been delinquent etc. Analysis would also show some variations in proportion over the years. The value of such

figures for an analysis of the work however would be of limited value because the total group included residents who had come for holidays, for temporary shelter from social stress, etc.

It is more valuable to select a group, to define them more carefully, and then to analyse their characteristics and their fate.

An opportunity presented to do this in the autumn of 1963, and the following study was carried out in early 1964. Dr Clark had returned from the United States, Dr E.G. Oram had research facilities, and Mr Cooper was still acting as Warden. A great deal of information about the residents was readily available.

This combination made it fairly easy to do a thorough study with limited resources, since each resident was known to at least two of the three, and their history after discharge was known or ascertainable. Not long after this date the trio dispersed and studies of later cohorts of residents would not have been possible without far greater resources than were available. Though there are some differences in the later population (fewer brief stays, slower turnover, more residents staying longer than a year) experience of a number of individuals indicates that the general pattern has not much changed.

By October 1963 there had been some 265 admissions of 212 people. Our interest was in those who had spent long enough in Winston House for the experience to have had an effect on them, and who had been out long enough for the effect to be measurable. Our primary interest in the study was to see whether residence in Winston House was effective in changing people, how often it was

effective, and in which groups of people.

It is always difficult to establish the effectiveness of any therapeutic measure, particularly when applied to a lengthy period of individual's lives. We therefore chose a relative simple hypothesis and plan of analysis.

All residents were sent to Winston House for rehabilitation. They could all work or were all supposed to be able to work, but they lacked a home to go to, or the ability to be independent. The aim of Winston House was to make them capable of independence. If they could be more independent on leaving Winston House than before they entered, their stay had been effective and successful. Their first placement after leaving Winston House might be directly controlled by the staff, but their state one year after leaving would be a more suitable measure.

We therefore decided to examine in detail all those residents who had spent at least one month in Winston House and who had been out of the House at least one year at the time of the study (i.e. had been discharged before October 1962).

These criteria eliminated a number of people. We discovered that three ex-residents had died during the 12 months after leaving Winston House (of natural causes — coronary thrombosis, cancer of lung, cancer of uterus) and we eliminated them.

We were left with a group of 199 people (68 M, 51 F) a number of whom had had several admissions. We took their last discharge from Winston House as the key discharge.

Characteristics of the follow up group

Year of admission:

	M.	F.	T.
1958 - 1959	20	13	33
1959 - 1960	21	15	36
1960 - 1961	21	11	32
1961 - 1962	6	12	18
	<u>68</u>	<u>51</u>	<u>119</u>

Length of stay
Weeks

	Number Departed	Number Remaining
4 - 8	36	83
8 - 12	8	75
12 - 16	15	60
16 - 20	8	52
20 - 24	4	48
24 - 26	4	44
26 - 28	5	39
28 - 32	8	31
32 - 36	6	25
36 - 40	6	19
40 - 44	6	13
44 - 48	3	10
48 - 52	5	5

5 residents stayed over 52 weeks but all were discharged before 18 months.

Immediate Destination

We noted where all the residents went on leaving Winston House:

	M.	F.	T.
Re-admitted to hospital or returned to former situation	14	14	28
To lodgings	29	18	47
To other hostel (Church Army, etc) ..	4	1	5
To relatives	7	7	14
Other (residential job, caravans, flats, etc.)	4	10	14
Left for unstated destination ...	<u>10</u>	<u>1</u>	<u>11</u>
	<u>68</u>	<u>51</u>	<u>119</u>

The last category are the people who gave no definite address on leaving. The subsequent follow up showed that many of them maintained their independence.

These figures show that of those who had spent at least a month in the house 23% had to go back to hospital or their former dependent position but that 67% moved off independently.

Follow Up

We aimed to determine where every person was, and what work he was doing, twelve months after leaving Winston House. Since all of them were social casualties and some had been vagrants we expected great difficulty. To our surprise we traced all but 3 of the 119, -- a follow up rate of 97.5%.

This follow up rate was gratifyingly high. Landy and Greenblatt with all their resources were only able to interview 33 of the 48 women who had left Rutland House in the first four years of its operation as a psychiatric halfway house. They console themselves (p. 7) with this follow up ratio of about 70% by quoting Freeman and Simmons that "in such studies a loss rate of over 50% is not unusual".

Many of the ex-residents were of course still living in Cambridge. Some were attending the out patient clinics. Those who had returned to hospital were readily traced. With the others, however, a major help in tracing them was the contact they had maintained with the House and the Warden. Many had sent Christmas cards or telephoned so that we knew what was required for the follow up, namely where they were (i.e. in or out of hospital)

whether they were working, and whether they were supporting themselves.

Our criterion of success or failure was determined thus:

If they were working, supporting themselves and living independently in the community, they were regarded as successes. If they were back in hospital or back in the dependent unoccupied position they occupied before coming to Winston House they were failures.

There were certain other residents in less clear circumstances; these were described as partial successes and partial failures. In calculating percentages the 12 men and 8 women in the more indeterminate categories have been included with straightforward successes and failures.

The final ratings are:

	Success	Partial success	Failure	Partial failure	Not traced	Total
Men	26	6	28	7	1	68
Women	22	3	17	7	2	51
Total	48	9	45	14	3	119
Combined		57		59		
Percentage		48%		49%	3%	100%

We analysed these success/failure ratios in various ways.

Length of Stay in Hospital

Residents were divided into those who had been a long time in hospital (more than 2 years) a short time (less than 2 years) or never in hospital:

	Success %	Failure %	Not known %	Total
Long stay	21 (55)	17 (45)	-	38
Short stay	32 (47)	34 (50)	3 (3)	69
Never admitted	4 (33)	8 (67)	-	12

Thus the long stay patients do rather better than the short stay but the differences are not marked. Further analysis showed that there were slightly higher success ratios for patients from our own catchment area (as opposed to those from further afield).

Age

Analysis by age showed a general tendency for the middle-aged residents to do better than the younger ones. A division at age 40 shows this and a division at age 25 makes it clear:

	Success %	Failure %	Not known %	Total
Under 39 years	35 (44)	42 (52)	3 (4)	80
40 and over	22 (56)	17 (44)	-	<u>39</u>
				<u>119</u>
Under 24 years	13 (41)	18 (56)	1 (3)	32
25 and over	44 (51)	41 (47)	2 (2)	<u>87</u>
				<u>119</u>

Sex

There was little difference in the success/failure ratios between the sexes.

Diagnosis

With the reservations noted earlier (multiple diagnoses etc.) each person was allotted to a diagnostic category:

	Success	Failure	Not known	Total
Schizophrenia	29	35	1	65
Manic-Depressive Psychosis	7	7	-	14
Epilepsy	1	5	-	6
Personality disorder and psychoneurosis ...	14	10	2	26
Subnormality	6	1	-	7
Organic	-	1	-	<u>1</u>
				<u>119</u>

Those schizophrenics who had spent at least two years in a mental hospital were picked out for further study. There were 26 (14 men and 12 women) and of them 14 (6 men and 8 women) were successful (54%).

Long Term Follow Up

Another way to look at the long term outcome of Winston House residents and Winston House policies was to examine the books of Fulbourn Hospital.

During the 8 years Winston House had taken 120 people from Fulbourn Hospital, some of them several times (157 admissions altogether). All, by definition, were people who had had difficulty in getting out of Fulbourn Hospital, and some of them had been there many years.

During the eight years 95 people had come to Winston House and to Cambridge from hospitals and agencies in other parts of Britain. If they broke down again acutely in Winston House they were admitted to Fulbourn Hospital. As we have noted, at one

period in early 1963 some staff at Fulbourn Hospital expressed the view that Winston House was importing difficult problems into Cambridge and dumping them in Fulbourn Hospital.

The rolls of Fulbourn Hospital were searched in November 1966 for any patients who had ever been in Winston House. 26 names were discovered. 2 (1 M. 1 F) were at that time day patients. Of the 24 in patients (12 M. 12 F) six (3 M. 3 F) had originally come from hospitals outside the Cambridgeshire area (Runwell 2, Brookwood 1, Parkside 1, Claybury 1, Maudsley 1) and 18 (9 M. 9F) were originally from Fulbourn Hospital.

These results were surprisingly good. Of all the 120 people from Fulbourn Hospital who had gone to Winston House, only 18 were now in patients in Fulbourn - 15%. Of course, many more were still receiving psychiatric help. Two, as noted, were day patients; many more attended the outpatient clinic or were being supported by local authority mental health services. Nevertheless it is a good outcome.

This small number should of course be related to the changes occurring in Fulbourn Hospital itself during the eight years of the study. During that time the rehabilitation activities of the hospital increased and diversified. There were sheltered workshops operating in the hospital, facilities for patients to go out to work, special rehabilitation wards and frequent and active rehabilitation conferences. Partly as a result of these activities, the average number of patients in the hospital fell from 932 in 1958 to 763 in 1966.

It is also interesting that only 6 people out of the 95 who had

come to Cambridge from other areas were in patients in Fulbourn. Of course, a number had returned to the original hospitals at the time of their failure and might well still be in patients. Nevertheless this figure shows that there was little tendency for Fulbourn Hospital to become overloaded with Winston House failures.

Discussion of Statistics

The figures speak mostly for themselves and the object in presenting them is to give a full picture of the work of Winston House. It is clear that the House has achieved remarkable success with these handicapped people. The follow up sample showed this most clearly. These people could not be independent when they came to Winston House; a year after leaving, half of them were still living independent social lives.

Even of the group who would seem to have the worst prognosis -- those diagnosed as Schizophrenic who had spent more than 2 years previously in continuous residence in a mental hospital -- 21 out of 38 had maintained independence for a year. It was clear that the House was succeeding, in its prime task of rehabilitating those badly crippled psychiatrically.

The analysis also brought out some other useful points. It confirmed that the person who did best was the middle aged, single, schizophrenic person who had been in hospital for some years but was able to work. The younger patients, and those who had not been long in hospital did not do so well.

The figures on epilepsy and subnormality are not too reliable, since these were highly selected patients. It seems however that

subnormal persons who could manage to get and hold a job in the open market did fairly well while epileptics did not do well in Winston House.

Comparison with other studies

An attempt was made to compare our figures with other studies. This proved difficult.

The American studies were not very comparable. Rothwell and Doniger in their account of Woodley House give very few figures and explicitly refuse to attempt to discuss success or failure. Landy and Greenblatt in their discussion of Rutland Corner House give many figures, but these relate only to a 70% follow up. Further this was a house for women only, all of them receiving regular and fairly intensive personal psychotherapy.

Of the British accounts which do give figures of outcome, most are accounts of what happened to the first groups of people who came through the hostel.

Burkitt and Walker reported the first 18 months of a hostel for 12 men in Newcastle on Tyne. There had been 36 admissions of 30 men. 26 had been discharged, 17 of them "successfully" — that is to independent life — give a "success rate" of 65%.

O'Donnell reported on the first 2½ years of a hostel for 21 persons in Worcester. There had been 37 admissions. Of 25 who "remained long enough to derive benefit from their stay" he claimed 12 "genuine successes" and 6 "partial successes", a success rate of 18 out of 25 (72%).

Morgan reported on the first year of a Newcastle hostel for

25 women. 46 women had 54 admissions; there were 38 discharges of whom 6 went back to hospital. They do not mention their criteria of a successful discharge. But 6 out of 38 is a failure rate of 16%.

Rehin and Martin's analysis of the statistics of the Mental After Care Association's halfway houses was done to illustrate administrative points, but they work out a "relapse rate" -- the number of residents departing directly to be readmitted to hospital from amongst those who had been in a hostel for less than a year. The rate was 25% both in 1955 and 1960.

It is difficult to be sure whether these hostels are directly comparable. Nevertheless these figures match with the Winston House finding that 22% of the immediate departures were back in hospital. This suggests that most psychiatric hospitals seem to find that about a quarter of their departures are sent back to hospital.

Landy and Greenblatt analysed the first four years 1954-1958 of Rutland House, a halfway house for 14 women in Boston. 48 women had left the house in that time; in March 1958, 13% were in hospital; 4% were attending the day hospital; 35% had been readmitted at some time but were living in the community at the time of the survey; 48% had never been readmitted to hospital.

These figures can be compared with our "long term follow up" which showed that of 120 Fulbourn Hospital patients who went to Winston House, 18 were back in hospital at the end of the eight years (15%) which is similar to their 13%.

One British study which attempts to assess long term outcome is Walker's, though he arranges his material in a different way.

He reported on a hostel for 16 men attached to the mental hospital at Gloucester. He followed up 26 discharged men for 2 years. Of those, 11 had been readmitted at least once, 1 was in jail, 2 were psychopaths, one had had a career but 11 were "known to be well". He thus claims long term success on 11 out of 26 (42%).

This seems comparable with the Winston House long term follow up figure of 48% successes.

The only study of outcome which is fairly directly comparable with ours is that of May et al who analysed the outcome of patients who had been in the Mental After Care Association's 43 bed hostel in Croydon.

They took their sample from patients admitted between January 1961 and April 1963. They excluded those who spent less than a week in the hostel (but do not say how many these were) and had thus a sample of 99 who were fairly similar to Winston House residents in age, diagnosis, previous length of stay in hospital etc. They assessed the position of these people in December 1963 at least a year after their admissions. They found that 24 were still in the hostel (20 after more than 2 years) that 28 had returned to hospital (most of them in the first year) and that 47 had gone into lodgings. Of 75 discharges therefore, 47 (63%) were successfully rehabilitated into lodgings, while 28 (37%) were back in hospital and could be regarded as failures.

These people are most comparable with the Winston House follow up sample, where those who had been in the hostel less than a month were excluded. The sample from 4 years was 119 people. Their position twelve months after leaving the house 57 (48%) successful, i.e. living at a better level before going to Winston House -- and 59 (49%) unsuccessful -- i.e. back at their former level, and many of them back in hospital.

This would suggest that May's group had done rather better. However, further examination of his figures shows that 24 (out of 99 admissions) were still in the hostel, 20 of them for more than 2 years. This is a substantial proportion of their total intake and suggests that some of their residents were becoming static in their hostel. To make the Winston House figures comparable, allowance would have to be made for the 21 persons remaining in the hostel. A direct comparison could then be made.

Allowing for these people it would seem that the Croydon experience is rather similar to Winston House, namely that of the people who settled in the house, about half achieved ultimate independence.

THE THERAPEUTIC EFFECT OF WINSTON HOUSE

As Winston House became established, and was manifestly not in danger of immediate collapse, questions constantly recurred - What does Winston House do for these people? How does it do it? How often does it succeed? Which people does it help best?

Some ideas emerged very quickly, as the following extract from the 1960 article by Dr Clark and Mr Cooper shows:

"It is difficult to answer the question "What did these people get from their stay in Winston House?" for this varied for different people. Many long-stay hospital patients said that it was a great pleasure to live again in a home. They enjoyed the privacy of the small rooms and the freedom to come and go. For others, the security of the house was important, and during their stay they were able to make progress in their psychotherapeutic treatment or personal development. Some of course resented the regime, but the tolerance with which criticism was accepted and the way in which it was met by pointing out the needs of the other residents was at times therapeutic and educative. The people who gained most were undoubtedly the long stay schizophrenics who had no home or interested relatives. Without Winston House they would have stayed forever in mental hospitals. With it some of them managed to achieve an independent life."

In the succeeding years we attempted to define this more clearly. This question was discussed with a number of people including the residents. There were, of course, those who felt that Winston House had done little for them, or who actively disliked the place. "I don't want to stay with that set of zombies" said one youth on probation, "After a few months I'd get like them". Such people left soon. Those who stayed expressed appreciation of the House and its atmosphere "It's like a home, it's quite different from hospital - it's not doctors and nurses all the time". When asked how (or if) it helped them, many could

not formulate this but some offered comments - "It gave me confidence - sort of. After all that time in hospital I was afraid to go out into town. Everything was different. Now after a few months in Winston House, I feel that I could manage on my own". "Well - it was going to the pubs and the pictures again. You felt like you was living once more". "Mr Cooper was a great help. It was like being in a home. He was strict, mind, but he was fair. When I was worried about things I could always go to him".

Discussion with nurses and doctors who had known residents before and after their time in Winston House stressed the increased spontaneity, individuality and reality sense of the residents. Their appearance had improved; they had bought better clothes and kept them neater; they walked more briskly; they had more spontaneous conversation; they carried their heads higher and had lost their beaten look; instead of vague unrealistic hopes for the future they had modest practical plans. These professionals commented that there was not much difference in the residents' "mental state" -- i.e. their degree of residual psychosis -- but that these had often been static for years. K.L. for instance, when retested after a year at work, showed an I.Q. of 66; to his family however he was quite a different lad, happy, busy and working where before he had been defeated, unemployable and violently irascible.

The clinical impression was that those persons who benefitted most from a period of residence in Winston House were middle aged individuals who had suffered a schizophrenic illness and had spent

a number of years in a mental hospital. These people came to Winston House, able to work but otherwise cowed and demoralised by their years of institutional life. They faced the adventure of leaving the place that had protected them for so long with great apprehension -- an apprehension that seemed a blend of comprehensible fear -- "I don't know if I'll manage the work" and near psychotic projection - "People make it very difficult for you if you've ever been put in one of those places". Some of them found it too much and retreated to hospital, either by a conscious choice "I want to go back!" or by showing a recrudescence of their symptoms. Those that stayed warmed to the atmosphere of the House, settled in their jobs (after perhaps a few changes) and began to build up a life. They found a favourite pub, or joined a church. Some took up fishing, or following the local football team; they got to know the cinemas and the cafes. A few developed a social life, visiting the homes of work mates. After some months, they began to talk of moving on, giving a variety of reasons, "I know I've got to move on sometime", "I've found a place that's cheaper than Winston House", "Mr Cooper has found me digs with a Methodist widow", "I want to be on my own; there's too many rules at Winston House".

There were different patterns of reaction to Winston House life. Older men and women liked the quiet and the comfort of the House after the mass living of hospital. Adolescents on the other hand, responded to others of their age. A group of lads would go out together, support one another, compare notes. If there were no other youths in the house, an adolescent soon became bored.

Residents with a history of personality inadequacy -- depressive episodes, suicidal attempts -- especially women, often became markedly dependent on the warden, seeking his help over many problems. Some of these people continued to visit and to write. C.D. was still bringing his laundry to Winston House every week five years after leaving. Individuals who had had paranoid illnesses used the house differently. They were usually courteous and distant with the Warden and with other residents. They found jobs, paid their dues regularly, took their pills without comment and would often announce their departure quite unexpectedly. They had not much more to say to the consultant; they would often indicate no particular desire to see him or take their pills (or sometimes reveal they had been throwing them away for months). Some even hinted that they saw a period in Winston House as part of the price that must be paid to "Them" (those who had put them into hospital, interfered with them, organised the "plot" and managed the world) before they could be allowed to go free.

Winston House residents bearing the diagnosis of "depression" were different from the large numbers of depressed patients entering psychiatric hospitals, most of whom soon go back to their families. "Depressive" patients who came to Winston House usually had a long history of hospital treatment; by definition, of course, they had no home; there were usually personal inadequacies or other disabilities (chronic bronchitis, simple mindedness, brain damage, epilepsy, etc). They were basically defeated people -- for whom life and all its difficulties had proved too much. Some of them found the challenges of Winston House too much also. Some stayed

many months and finally went back to hospital. But some of them did very well. Their months in Winston House seemed to give them confidence to face the world again.

During the years of thinking about Winston House and listening to the remarks, responses and attitudes of the residents certain ideas gradually crystallised about what the therapeutic mechanisms at work were.

The comment about the homelike atmosphere of the hostel is of interest. In fact, the living conditions were not much different from those in a better ward in a mental hospital (the sort of ward such working patients usually occupy). In some ways Winston House was more homely, in other ways no better. The residents saw the food cooked and the staff ate with them; they could get snacks in the evenings. On the other hand no resident in Winston House had a room to himself; most of them were in 3 or 8 bed dormitories; conditions were quite crowded. Over 2 dozen people sat down to meals. There were only three public rooms - dining room, TV room and "Quiet room". It was not therefore the physical surroundings they appreciated but the atmosphere, and in particular the absence of the constant control of hospital.

In general wards of general hospitals, in admission and infirmary wards of general hospitals nurses and doctors take a firm control of all aspects of the patients' lives; this is what the patients need, and often what they want. In rehabilitation wards of mental hospitals, especially in modern psychiatric hospitals adopting a therapeutic community approach, the doctors and nurses make a conscious effort to relax their total control of the

patients' lives. They probably do not realise however, how much they retain the control, even despite themselves. However permissive and benevolent they may feel the fact remains that nurses and doctors have little doubt of their fitness to order the details of other people's lives. Even though they may relax this control with selected people seen to be "improving" they and the patients know that if things go wrong the sedation can be increased, E.C.T. started again, the patient moved back to a more tightly organised ward.

The residents felt that Winston House was different in this way. There was authority there - but it was different. Some of the rules were quite strict; the door was locked at 11.00 at night and keys had to be requested. But these rules were based on the manifest needs of the others; some residents have to be off to work just after 7 and the breakfast cooking started at 6.30. The warden might tell a resident to leave or go back to hospital but he did not pretend to control the whole of a resident's life. Thus, though there was control, it was control based on the needs of all, and the basic contract between the resident and the institution was different from hospital.

Goffman (14) in his famous and thought provoking articles has made many comments on the bizarre life of "total institutions" places where an inmate's whole life -- his work, his play, his eating, his sleeping are under the control of the organisation. He discussed boarding schools, monasteries, battleships, but especially mental hospitals, pointing out how such institutions of necessity develop bizarre laws and rules -- stripping procedures,

debasement and depersonalizing rituals, etc. in their drive to control and to change the individual. A psychiatric hospital, however liberalised, remains a total institution. Winston House was not a total institution. The residents spent one third, if not half, the twenty four hours away from it, in their work situation and they found their recreation away from it. This difference was probably one of the major therapeutic mechanisms in helping them toward independence.

The contract between the psychiatric hospital and its patients is complex. Many patients are sent to hospital, some under legal compulsion (many of our residents had been certified at one time or another); only a proportion come entirely of their own free desire. Once in hospital their discharge waits until a doctor pronounces that they are "well". Attempts to leave before the doctor sees fit may be stopped. It may be profoundly difficult for a perplexed individual, plunged into a new, strange and puzzling world, to understand what criteria determine that he is "still ill" and cannot leave or is now "well again" and permitted to go. Laing (25) has spoken of the process of "mystification" that goes on between a schizophrenic person and his environment, and how this may be compounded in an institution run by psychiatric professionals who control the patient's life in detail and justify their control by reference to his "mental state".

At Winston House it was up to the resident to make what use he could of his stay. If he wished to leave or go back to hospital he could. He was encouraged to attend the out patient clinic but did not need to; at any one time at least one third of the

residents were not seeing a psychiatrist regularly. If his behaviour was unsatisfactory this was discussed with him in terms of the effects on others, not in psychiatric terms. Drunkenness or quarrelling or leaving the bath soiled attracted more concern or censure than seclusiveness or an indication of hallucinosis. The "rules of life" at Winston House were much clearer; they were related to real things -- what people said or did to one another. There was a much greater chance of learning a relevant social lesson. A few perceptive residents actually welcomed the fact that the wardens were not psychiatric professionals and did not know any more about their personal histories than they themselves had chosen to tell them. There was a constant process of Social Retraining going on, implicit and explicit. The warden explained the rules to the patients and checked lapses. Comment and reproof was given for uncouth table manners, offensive talk, untidy clothing. Some oddities perhaps tolerated in hospital drew comment in Winston House -- such as masturbating in the washrooms, or talking back loudly to hallucinations.

The first few months in Winston House forced some ex-hospital patients to learn a great deal about modern city life. They had to find their way to and from work, on and off buses. They had to learn to manage their money, to save for holidays, new suits, new dungarees and boots, or bicycles. They had to learn their way round the pubs and cinemas (instead of just going regularly to the hospital cinema show). They had to seek out a church of their own faith and make their way into its congregation. With some of them one could watch the process happening. When they just came to

Winston House they were quiet, shy and unworldly, dressed in crumpled clothes, timid and subservient. Gradually they reported adventures and excursions, a new suit, a new bicycle, a week at the seaside, a fishing rod and basket, trips to the swimming pool. Each of these require forethought, exploration, discussion with others, the chance of defeat as well as the rewards of success. The Cummings (11) have stressed the value of such Reality Testing in rehabilitation. In hospitals there are few chances for this; in Winston House they occurred more frequently.

One of the major functions of Winston House seemed to be a form of training in the appreciation of reality. At all stages of schizophrenic illnesses people are liable to have unrealistic self images; in florid form we see the classical grandiose paranoid delusions. Even during rehabilitation this may be present. Some feel they are above certain work. Others have not realised how much the world has changed since they first withdrew from it. Others cherish the occupation and social ambitions of their adolescence and have not yet realised that the world has far less to offer an unskilled person at 35 than at 15. Others have been more damaged than they realise by their illness and their time in hospital; after years of thought disorder they cannot manage skilled work - even though they may have been trained for it -- and they have to accept something different.

Often, in the mental hospital where they had lived, the opportunities for work and for reality testing are not great. There may not be much or varied work locally, sometimes there was no adequate rehabilitation organisation within the hospital and

they may have been living in a ward of patients devoted either unconsciously or even quite explicitly to maintaining their comfortable hospital existence. Once in Winston House the reality of work was constantly with them. The whole ethic of the house revolved round the necessity to work. The house emptied by day; there was nothing for the idle to do. Those who could not find work within a month had to leave. The residents had to go to the Labour Exchange and see the Disablement Resettlement Officer; they were expected to scan the local paper and visit employers; the Warden helped with all this but the initiative was up to them; in the discussions in the bedrooms and the lounges they heard of other jobs, rates of pay, hours of work. In all this atmosphere they learned a great deal. They found out what they could do and what they could not manage. With some, over the months, one could see clearly a process of learning going on, so that where at first their work aims were vague and unrealistic, by the end of several months they knew what sort of jobs they could do, how well they could do them, and whether they liked regular work!

There may be contemporary philosophers who would question these simple nineteenth century values; to the demoralised institutionalised empty schizophrenic they offer the only chance of a life free of constant supervision; most of them have no doubt of preferring this.

In psychodynamic terms something of what the residents received from Winston House emerges. They were in a mixed sex community which some had not experienced for some time. This was an opportunity to some, a challenge to others. There was a strong

benevolent paternal authority figure (the Warden) supported by a maternal food providing succouring figure (the Matron). This was more like a family structure than the one sex ward with charge nurses coming and going on shifts, and ruling a group of people of their own sex by formalised bonds of obedience.

It is interesting that there was never any tendency to develop a self governing organisation or a "therapeutic community" in the sense used by Maxwell Jones (22) particularly since Dr Clark was a known exponent of this method (9). Mr Cooper at one stage held meetings to discuss the running of the house; hardly anyone attended. One patient commented "Meetings? Oh, no! that would be just like the hospital!" It appeared that this group of people were too busy working out their own problems to wish to have to consider those of others. Further, they felt little desire to change, reform, or otherwise involve themselves in other residents. This is perhaps related to the particular nature of the population; they were mostly schizophrenics, little involved with others. For some years, at least, they had been quiet schizophrenics, affecting other people little. They had never acquired a spouse, or had lost what spouses or homes they had. They were thus highly selected for unsociableness.

One of the assumptions of some workers in "therapeutic communities" seems to be that this egalitarian, democratic, permissive way of living must be good for everybody. Experience suggests otherwise; the therapeutic community is a potent psychological tool but it is not a panacea. Some disabilities require other kinds of milieu. Most "therapeutic communities" select

carefully those who are felt to be most suitable; Henderson Hospital, Belmont, concentrated on personality disorders. Communities for other disabilities such as the homes for drug addicts, Synanon, have different social organisation (strict rules, authoritarian leader, catharsis sessions). Our experience at Winston House confirms that a place can be therapeutic and a community without being a "therapeutic community" and suggests that we probably require differing social organisations to produce beneficial change in different disabilities.

In summary, then it seems that Winston House is an effective milieu for rehabilitation because it is not a total institution, because it provides a homelike atmosphere, social retraining, reality testing and a continuing incentive toward independence.

THE PSYCHOTHERAPY OF REHABILITATION

The experience of spending several hours a week talking with Winston House residents over a period of eight years has prompted some reflections on the process of the psychotherapy of rehabilitation, a subject that has not been much discussed. Many doctors over the centuries have spent some of their time helping injured, demoralized or institutionalized people to recover their independence, freedom and belief in themselves, but not many have examined explicitly the process by which they did this. Of the doctors few were psychiatrists - the famous rehabilitators were physicians like Varrier Jones of Papworth and Guttman of Stoke Mandeville, or surgeons like McIndoe of East Grinstead. Many rehabilitators were non medical - Saints like St Vincent de Paul, humanitarians like Elizabeth Fry, or Florence Nightingale, educationalists like Homer Lane or Lyward. We can characterise these people from their writings and the memoirs of those who knew them as compassionate, warm hearted crusaders, flaming with indignation at the slights laid on their charges, battling for resources against indifferent authority and a public unwilling to hear of suffering. We realise that they were dominant charismatic individuals, often with a strong personal religious faith and sometimes a histrionic flair for publicity. We know however little of what they did when they talked to their charges and even less of what they thought they were doing. The patients who wrote or spoke described how they were given new hope and faith, how the doctor's warmth and sympathy and the devotion of the rest of the staff helped

them to accept themselves and their disability, how the example of others strengthened them to try again but we seldom hear what the doctor did, or thought he did. This is partly because of a medical tradition which prizes dispassionate, non-emotional, "scientific" language in which patients are "cases" and where the doctor's thoughts - or even more feelings and beliefs - are not mentioned, partly because these physicians had had no training or experience of self-examination and partly perhaps because the very personality traits which succeed best in rehabilitation - warmth, outgoingness, pugnacity and histrionic flair are found in people to whom introspective self-examination is most difficult if not repugnant.

Psychiatrists have of course been very involved with one of the groups of the disinherited - the institutionalised chronic psychotics of the great lunatic asylums - and many of them did much for them. This was particularly true of the great humanitarian reformers such as Pinel and Conolly; to read their accounts of how they took off the chains and restraints from individuals is to sense their compassion and identification with the despised, the hated, and the degraded. During the decline of hospital psychiatry during the latter part of the nineteenth century and the early decades of the twentieth the asylums and their inhabitants did not receive a great deal of attention and the rewards of society went mostly to those psychiatrists who served acute mental illnesses and nervous illnesses. The main skills of psychiatry therefore developed there. Methods of treatment of acute psychoses and psychoneuroses have developed greatly during the last fifty years. Most of psychiatric teaching is concerned with inculcating and

improving these methods and skills. The medical student is taught to recognise and diagnose the acute psychoses and the psychoneuroses. The psychiatrist acquires further skill in diagnostic interviewing, and often goes on to acquire skill in psychotherapy. Most systems of psychotherapy, particularly the system of psychoanalysis, were developed to help psychoneurotics, people who were functioning in normal society though with impaired efficiency and happiness, and helping them to examine, understand or adjust that impairment so that they could function better.

The process of becoming a doctor, a psychiatrist and a psychotherapist, has many facets. It covers a substantial period of a person's life - perhaps from 18 to 35. During this time the individual changes, matures (it is to be hoped), learns a vast number of facts - from the minutiae of anatomy to quotations from Freud (some of which he retains in immediate memory but most of which sink beyond easy recall) and meets and talks with a large number of sick people. One aspect of this process is role learning; he acquires a style of meeting those people defined as patients. This style has various components for different situations and different aspects - the physical actions, the deliberately adopted conversational practices, the unconscious tricks and the consciously planned approaches. The physical aspect includes ways of shaking hands (or not) with patients, ways of taking a pulse or pulling up a chair, ways of entering a house or a consulting room. The conversational repertoire is large; the brisk matter of fact manner for getting from the shocked survivors of an accident sufficient facts to start urgent first aid; the

slow, patient, receptiveness that coaxes details from a confused old man or a suspicious antisocial adolescent with sexual anxieties; the firm reassurance for the anxious; the deliberate building up of anxiety to bring out further material. There are of course many other attitudes which the doctor develops without realising it - the slightly solemn mien which encourages confidence, the firm, slow, pondered, way of speech comprehensible to the ignorant and frightened, the "professional air" and of course, the middle class identification in dress, manner, accent and choice of words that at once marks him as different from the bulk of mankind (who are not middle class) and particularly from the subjects of this study and their like - the failures, the rejects, the unfortunates of life - the "marginal men" as Daniels (12) has called them.

The attitude and actions develop and change, and each doctor adopts and uses those opportunities which best fit his personality, his intelligence, his training, his social background and his emotional needs. The moulding process is however a powerful one; many outside observers have noted with astonishment how a motley collection of untidy eighteen year olds turn in six brief years into a group of sober, dependable professional men.

When a doctor starts learning to be a psychiatrist a new process starts. He has of course to learn new skills and he has to learn how to talk and listen to much more emotionally disturbed people than he has met before. But that skill is fairly easily acquired. He soon acquires an effective interpersonal repertoire for eliciting signs and symptoms of mental and emotional illness, and for drawing out and sorting the life experiences which are told

to him into a tidy psychiatric work up - a personal history, family history, etc. Like most medical case taking it emphasises the pathological, the failures and the breakdowns of function rather than the successes and achievements.

Later comes the exposure to the psychotherapeutic situation. Here, for the first time, the doctor is required to think consciously about what he does and says. Until then only the patient's actions and feelings were legitimate areas of study; now he is called on by his instructors and his fellows to examine his own actions, remarks, counter transferences and feelings. This is an exciting and valuable revelation and leads to a reworking of his personal style. It has however one disadvantage; it implants in most psychiatrists a belief that the psychoanalytic style is the most desirable for a psychiatrist and that the nearer he approaches to this, the better psychiatrist he will be. He therefore strives to be detached, analytic, observant and permissive, accepting all the patient does and says without overt reaction, commenting helpfully and critically, pointing out the irrational behind the rational, refraining from reassurance or exhortation, leaving the choice in the hands of the patient.

This is an excellent professional apparatus for making a diagnosis of a freshly presenting psychiatric patient, or for helping a psychoneurotic understand the problems that perplex and hinder him.

Experience of talking with Winston House residents suggests that the skills and personal style acquired in psychiatric and

psychotherapeutic training are not very appropriate to the encounter with the institutionalised psychotic and perhaps even less helpful to the process of furthering his recovery of independent living and human dignity -- the psychotherapy of rehabilitation.

The residents of Winston House demanded a different approach from that usual in a psychiatrist seeing a patient. They had not come for a diagnostic interview; they had not come for psychotherapy. They had seen many psychiatrists and were often weary of them. In the long periods in mental hospitals they had been interviewed by many doctors (as the many different handwritings in their casenotes showed). They had been asked all the standard psychiatric questions many many times (Do you hear voices? Do you feel people are against you? Do you know the day, the date, the name of the Prime Minister?) Some of the more intelligent, cynical and sophisticated would recite serial sevens or explain why a rolling stone gathers no moss without prompting. Some of them had been in hospital long enough to have taken part in that bizarre verbal fencing match, the "Board of Control Interview", which was a feature of mental hospital life before the 1959 Act. In this duel a psychiatrist demonstrated his virtuosity by forcing the wary patient to disclose enough evidence of psychosis to warrant further detention under certificate. The Winston House residents had differing memories of the doctors they had met; often they had been disappointed and disillusioned though sometimes they had fond memories of a doctor who had given them hours of psychotherapy.

The residents came to the hospital outpatient department because the warden told them to; some came reluctantly, some

eagerly, most passively. Some of their expectations have been indicated. What was the purpose of the interview? What use could it be to them? What behaviour by the psychiatrist would help them most? Gradually a pattern was worked out.

The psychiatrist knew a certain amount about the resident before the first talk - he had seen letters of referral, he had had a brief report from the warden. He began by enquiring how the resident was getting on, how he liked Cambridge, how his work was going. This served to elicit attitudes. Some expressed dislike of the House, or doubted their ability to get work. The position was clarified. They could leave the House forthwith if they wished; if they wanted to stay they had to get work within a month; it was up to them. Some showed suspicion of the interview itself; they asked why they had to see a psychiatrist. They were told that this first interview was simply to make a contact. If they did not wish to see the psychiatrist they need not; if however they wanted psychiatric help it could be arranged. If they needed drugs, it was best for them to be seeing a psychiatrist.

These initial interchanges did much to change some expectations and establish others. Misunderstandings or paranoid misinterpretations that Winston House was just a part of another mental hospital were checked. A few residents made it quite clear that they hoped never to have to see a psychiatrist again; this fortitude was applauded and several of them passed on to independence without any further use of a psychiatrist. Some made it clear, explicitly or implicitly, that they did not like the House and wanted to go back to hospital. This was discussed and they

were exhorted to give it a fair try; if they insisted, or failed to get work, they went back.

After the initial exchanges, the present position and immediate past history was reviewed. The emphasis was on achievements and goals; they were asked what work they were doing, how long had they had it, what were they paid, what the workmates were like. New arrivals in Cambridge were questioned on their work skills and hopes, the local prospects and what the Disablement Resettlement Officer had said. Only later was the psychiatric situation touched on, mostly in relation to drug dosage, what they were having, how long had they been having it, whether they thought it was any use or wanted to carry on with it. For many it was clearly a new experience to talk with a psychiatrist who wanted to hear whether they thought the drugs were any good. A few confessed that for months they had been throwing away the drugs that they had been given. In general, detailed discussion about their long years of hospitalization was avoided unless they wanted to discuss it. After the initial interview the psychiatrist sent for the previous casenotes, read them and abstracted the essentials of the story (a most tedious task).

Subsequent interviews were arranged as often as seemed necessary. Some residents wanted interviews, some often. This was discussed, with the general attitude that the aim should be to do without them. Physical complaints were referred to the general practitioner to the house. Recurrences of psychiatric symptoms were discussed and assisted by understanding, exploration of precipitants and medication. If distress became severe admission

to Fulbourn Hospital was offered as a temporary measure.

The psychiatrist's attitude throughout was deliberately reassuring and exhortative. Questioning was directed to drawing out areas of social success - rises in pay, new clothes and bicycles, new ventures, plans for holiday and outings, steadily rising sums in the savings bank - and not ^{to} elicit symptoms of illness. These were only discussed if they were interfering with social function or if they were brought forward by the resident. If a resident constantly proffered reports of hallucinations or phobic anxieties, this practice was questioned. Why was he talking about this? What did this matter? Was it stopping him working? After all he had had these symptoms for years; all the other doctors had not got rid of them; it was unlikely that they could be cleared now; if they were that bad, then the only thing to do was to give up the job, leave Winston House, and return to hospital as a failure! Tales of success were warmly applauded; photos of seaside outings shyly shown were appreciatively studied. When stories of outings were told the psychiatrist would tell of his own pleasures in these beauty spots.

The element of reassurance was often considerable and deliberate. Residents doubted their ability to manage a job or take a promotion, or move on to a better paid one. The problem was discussed realistically; sometimes they were better to stay where they were and caution was wiser. But usually they were encouraged by reference to other successes in the House, and tales of people who had achieved success after even longer periods of invalidism, and exhorted firmly to have a try (being reassured that

if they failed they would be supported to try again).

There was no attempt to maintain the anonymity proper to analytic psychotherapy. The psychiatrist met Winston House residents as he cycled round Cambridge, shopped in the supermarkets and swam in the swimming pool. Those who had lived long in Fulbourn Hospital knew him and his family from the days when he had lived there and would often ask after them. The psychiatrists called the residents by their first names, as they were addressed in Winston House.

These attitudes were adopted partly because they suited the extroverted and optimistic attitudes of the two psychiatrists concerned, Dr Clark and Dr Oram. But both considered the matter considerably as this approach was different from that inculcated by their training. The success of the exhortative reassuring approach was however such that they steadily developed it. Discussion with other professionals working in the field of rehabilitation gradually strengthened the belief that this was the proper style for the psychotherapy of rehabilitation.

It is named psychotherapy because it was a deliberate, conscious attempt to change the residents' psychological functioning by psychological means - the interviews and the therapists' behaviour in the interviews.

Discussion with other rehabilitation workers brought out points in their attitudes in common with this approach. A workshop supervisor said "If they talk to me about their symptoms, I say, go tell that to your doctor. What I am interested in is your work". A halfway house warden said "I told her I wasn't interested in her

intra-psychic conflicts; what I wanted was the dishes washed!"

A psychiatrist remarked "John said he was hearing voices again; I asked if they interfered with his work; he said No. I told him to get on with his work and not to tell anybody about his voices - if he did they might think he was mad. I told him I wasn't much interested in hearing about his voices either".

Not many publications discuss this problem explicitly. Brooks in the account of the Vermont Rehabilitation programme (8) says:

"We see, then, that the atmosphere in which rehabilitation and therapeutic work with hard-to-reach patients can develop, requires a sense of trust and commitment, realistic goals and optimism, and a compassionate concern. It has struck us quite forcibly that these essentials are none other than our old friends, Faith, Hope and Charity."

In the Woodley House book the attitudes and behaviour of the staff, particularly Joan Doniger, toward the residents are vividly described. Though it is seldom discussed explicitly the book as a whole gives the flavour of this clearly. Two quotations will have to suffice:

Page 52. "Then she said "You know, I have another solution. When I have the urge to go to the bridge, you come with me". She said this with her eyes shining as if it were a wonderful idea. I replied "Alice, that's the most ghoulish idea you've ever had". She was very surprised by my reaction. People usually go along with her theatrical notions, but I said "Any time you want to jump off the bridge, go by yourself. I won't be party to that kind of wild and sick action". Then I repeated that her life was not worth anything in anybody else's hands."

Pages 91, 92. "Although the staff emphasis on the health and strength of residents has been described and illustrated elsewhere, the preceding diary entry about Anita demonstrates this attitude quite concretely. When the diary was written, Anita had just returned from a brief hospitalization during which she had been given a series of shock treatments. Joan Doniger took her on personal errands because Anita had been disorientated and confused. Yet the diary described

Anita's discernment of an overcharge and the praise she was given for it. It does not dwell much on her difficulties, and, even when some of these are described, they are in the present and future tense, rarely in the past. Furthermore, it is apparent that, although the staff discerned the depression and hallucinations which beset Anita, they talked about clothes and food rather than the pathology. Similarly, though the deep seated origins of Janet's anxiety about food might have been recognised, its manifestations were dealt with in a practical and expedient way, i.e. by writing her name on a sandwich."

The essential then, of the psychotherapy of rehabilitation, seems to be the following:

1. Consistently emphasize strength rather than weakness; achievement rather than failure; health rather than sickness. The basic aim is to rebuild or to assist a damaged ego by building up its areas of strength rather than analysing its areas of weakness.
2. Establish a matter of fact, open relationship, devoid of mystery or professional reticences, or any suggestion that the psychiatrist knows answers or will be able to "cure" the disability.
3. Place responsibility for all decisions clearly with the patient, only offering support, clarification or advice based on special knowledge. Dissociate the present therapist from all the previous doctors and nurses who made decisions for the resident during his patienthood and even enforced them on him. (There is no need to disapprove of what these doctors did; at that time, when he was acutely ill it was necessary, and proper, but now he is in rehabilitation, the contract is different).
4. Establish a trust and acceptance of the individual with all his weaknesses and previous failures, illnesses, and hospitalizations.

DISCUSSION

The setting up, and the operation of the halfway house have been described, the statistics analysed and some of the therapeutic principles propounded. It is now necessary to draw these together in discussion.

This appears to fall into three general areas, though there is of course a good deal of overlap.

The administrative implications are those reflections and lessons which appear to apply to those setting up or organising other halfway houses or transitional facilities.

The therapeutic implications are those lessons which appear to apply to the professional work of psychiatry. Finally there are a few comments on some theoretical principles which appear to be involved.

Administration

Winston House has remained in operation for eight years and 288 people have passed through. It has never had other than passing vacancies — unlike some hostels as mentioned by Early and Magnus, Walker, Phillips and the Ministry Survey. Of a sample of the people who stayed more than a month, half were independent a year after leaving the House. By simple operational criteria, therefore the House had been successful in its task.

Why did Winston House succeed where some other hostels had had less success? It started at a good time, when the need for such hostels was being felt throughout British psychiatry and when

there was a need for demonstration projects. It had good backing -- a sponsoring voluntary society with first class experience of running hostels (and hiring staff), substantial and experienced local support (especially Lady Adrian), a lively mental hospital in the full flood of rehabilitation. Governmental policies and actions -- the Royal Commission Report, the Mental Health Act, the Rehabilitation activities of the Ministry of Labour, the policies of the National Assistance Board -- all worked to help the House start and in maintaining its impetus. Full local employment meant there was little difficulty in getting jobs for residents, unlike Newcastle, where 24 out of Morgan's 38 residents could not get work. All these factors helped.

Successive wardens and psychiatrists of Winston House felt however that one thing that was unusual at Winston House and contributed greatly to its success were the professional relationships. We heard that in some hostels started by local authorities there was reluctance of the psychiatrists of the local mental hospital to use the hostel because of poor relations between the hospital and the authority. In other hostels we heard that the warden had no say in who came into the hostel; the residents were chosen by someone else, either a medical officer of health or a senior social worker. We heard that some wardens had been very worried because when a resident had become mentally disturbed they had not been able to get him moved for days, because the hospitals had refused to take him back. In their 1964 survey of 31 local authority hostels, the Ministry of Health sadly noted "At only a few hostels was there effective cooperation between hospital and

local authority resulting in careful selection of residents, team work and proper support for the warden".

We came to feel that much of our success was because we avoided these difficulties. The relationships between the psychiatric hospital and the local authority were excellent. Dr Tyser the Medical Officer of Health was on both the Medical Advisory Committee of the Hospital and the Hospital Management Committee. Dr Clark the Medical Superintendent was honorary adviser to the County Council. Both were on the Committee of Management of Winston House and were personal friends. Even more important was the relationship between the psychiatrist and the warden, and the warden's discretion regarding selection and discharge of residents.

When residents were being selected, both psychiatrists considered the warden's decision as the final one. They saw their task as advising on possibilities and lending their professional interpretation of the data. It was more often necessary to advise the warden of the dangers of taking a certain person than to persuade him to give someone a chance. Prompt psychiatric action with a disturbed resident if the warden requested it was always regarded as most important, including if necessary removal to hospital, even under compulsion. The last was only twice necessary and urgent admission only about 18 times in 8 years. But the fact that the aid was available and given fast was the important thing.

In adopting this policy the psychiatrists were acting quite deliberately, following the principles of mental health consultation enunciated by Caplan (6). The aim was to give the warden informed support to enable him to act independently and effectively, rather

than to take over his decisions. The aim was to enable him to operate more flexibly, confidently and therapeutically with the residents.

It is tempting to use this study of Winston House as a platform from which to add to the considerable number of authoritative statements there have been about what halfway houses should be, how many there should be, and how they should be run but this is better done as the result of a survey. It seems best therefore to underline what seems to be the lessons from Winston House and compare them with the conclusions of others.

The Winston House warden had a close, supportive relationship with the psychiatrist who was backed by a closely cooperating mental hospital and local authority. Other studies agree that this is most important.

Many dogmatic statements have been made about who are best to run halfway houses. Walker is sure that hospital run houses are best. Voluntary societies loudly proclaim their greater effectiveness. Mounthey wondered if local authorities were capable of taking on a pioneering activity and indicated that voluntary bodies might be more suitable.

Apte in his survey of 25 Hostels in 1963 found that the hostels run by voluntary societies showed far more flexibility and imagination in their management and in particular in their ability to switch their aims. The hostel which May and his colleagues described and showed to be so effective was run by the Mental After Care Association about whom both Apte and Huseth were rather critical.

The impression that arises from all the published articles and also from conversations with those running hostels is that at the present time, with full employment and a favourable climate, any halfway house will succeed in helping some recovering institutionalized people back to independence. There do not seem to be any grounds for asserting that any one kind of organisation is inevitably better at running halfway houses than another. What is most likely to damage its effectiveness are bad relations between the local mental hospital and hostel, or the local health authority and any situation where the warden is left without either a part in the selection or support in dealing with the (occasional) troublesome resident.

The number of hostels needed is still not clear. When Clark and Cooper said in the 1960 article "A mental hospital serving a catchment area of 360,000 population will probably only have about 16 patients at any one time suitable for and in need of a halfway hostel", it was a hesitant suggestion. The last eight years have tended to confirm this. Although there are always a number of people willing to settle down fairly permanently in a halfway house, if it is restricted to those capable of moving on, then the numbers in need of places is probably not great.

Nothing has been said in this thesis on the training of staff. The post of warden of a halfway house is a most exacting one, and it is the Warden's personality, his devotion, his integrity and his energy which tend to set the limits of what the hostel can achieve. Some have said that all wardens should be psychiatric nurses, others that none should be. Apte, in his survey, was inclined to think

that people who had worked for many years in custodial mental hospitals brought too many restrictive practices with them, and he may well be right. Winston House had three wardens, two with no psychiatric experience who did well, one with plenty who left after a few months. But the sample is far too small. The only tentative conclusion that Winston House experience would seem to suggest is that it is important that the Warden and his wife both have open outgoing personalities and a willingness to experiment and to learn from experience. If they have a good relationship with a supportive psychiatrist they can learn what they have to know about psychiatry.

There are many other administrative questions— such as desirable staff complements, the relative advantages of purpose built hostels and adapted premises, costs of maintenance etc. — which have not been discussed. To do this would again require a survey.

Therapy and Theory

One of the aims of this thesis was to explore the work of Winston House in the attempt to see what were the effective therapeutic mechanisms. The analysis showed that a number of people tried it, did not like it and left soon. The others stayed for an average of 4 - 6 months and as a result many of them became independent where they were not independent before. The younger residents did not do particularly well, nor did those with alcoholism, epilepsy and personality disorders. Amongst those who did well were a group who traditionally carried a very bad prognosis

-- middle aged schizophrenics who had been a long time in mental hospitals.

A few of the things that seemed to affect them are mentioned in the discussions of the therapeutic effects and the psychotherapy of rehabilitation. The following appeared important:

Social Retraining

Reality Testing

Supportive Human Relationships

These seemed to be the factors that were different in Winston House from the hospital rehabilitation wards they had recently left. In the hospital, with the best of good will, the professionals saw the sick part of them and the whole organisation was geared to this. At Winston House the whole emphasis was on the healthy part of their personalities. Psychotic behaviour was discouraged, sane behaviour encouraged and rewarded. The warden was interested in their work and how they did it, not in their psychological symptoms. The reality testing came from all the opportunities they had to try new ways of acting and working. The supportive relationships were with the warden and also with the psychiatrists. As indicated, the relationship at the outpatient clinic was unlike those that they have previously had with a hospital psychiatrist.

It is interesting that the other writers who have explored this area have given a similar emphasis; Rothwell and Doniger in describing Woodley House, lay frequent stress on how the staff refused to become involved in long discussions about feelings and psychotherapy but insisted on the demands of normal behaviour. In introducing their stories (case histories) they say:

"The stories show staff attempts to concentrate on residents' health rather than their pathology, and residents' awareness of these attempts. They present repeated examples of staff attention focussed on the practical and the present rather than the theoretical or historical."

Landy and Greenblatt (p. 10) discuss very fully what a transitional facility should provide to help people to change from patients to responsible independent individuals. They postulate first that rehabilitation should be seen as "a process in acculturation or cultural movement". After learning to adjust to the hospital milieu, the time comes when the patient begins to relinquish the sick role and move back to the well role. "As he learns something of the well role, he may be deemed ready for transfer to the House". Again a significant cultural movement occurs. "He must now adapt to the culture of the House. This segment of the rehabilitative process is divided into three major phases; exploration, operating with confidence and looking to the outside with many subphases". Later they say that the whole process can be structured "as one of socialization or resocialization - of learning and relearning ways of personal and interpersonal behaviour in a series of potentially therapeutic or traumatic situations in which the patient must learn to live with himself and with others at every step of the way".

Much later in the book (p. 126) they set out "four crucial dimensions of structure" for transitional facilities:

- "1. Provision of a more open system than that provided by the hospital, one more nearly resembling systems characteristic of normal life.

2. Emphasis on a lay as contrasted with a professional orientation, though without dispensing with the counsel and assistance of needed professionals.
3. Orientation away from dependent types of habitual behaviour and toward encouragement of independence.
4. Generally a tentative time perspective with a clear understanding that the facility represents a giant stride toward the community but not in itself a terminal point -- in other words, orientation of the former patient toward the shedding of in-patient role."

All these dimensions were seen at Winston House.

It seems therefore that the most helpful way to look at the change Winston House produced in the residents was as a social process ^{an} acculturation movement, a change in the personality brought about by the environment. It is a form of "milieu therapy".

Unfortunately the process of changing persons by use of the environment is one for which we have few reliable theoretical concepts. There are of course many traditional notions and practices, derived particularly from school, Service, hospital and penal practice. There are many passionate statements based on self evident reasoning, but there is little soundly based theory.

The social scientists have given us descriptions of social systems and their effects on individuals and it is partly because of the writings of Stanton and Schwartz, Goffman, Greenblatt and others that so many things have been changed in our mental hospitals. They showed us how much harm we were doing to the patients and indicated areas we might profitably study. They have not yet however given us a comprehensible body of theory from which to plan further action.

John and Elaine Cumming set out some of the principles in

milieu therapy and tried to construct a theoretical basis. Drawing on the theories of Hartmann, Erikson and Parsons and Lewin, they see the individual who requires milieu therapy as having impoverished ego function, with a paucity of "ego sets" (for dealing with situations), poor differentiation and blurring of ego boundaries (as in schizophrenia) and a failure of heirarchization of ego sets. They consider that a milieu, to be helpful, must offer at first a simplified environment, then a series of graded "crises" in a protected setting so that the patient may overcome them and by so doing strengthen his fragile ego function. They stress the need for simplified personal relationships, comprehensible reactions from the environment, realistic work situations, adequate and immediate rewards.

All these factors can be seen operating in Winston House. The personal relationships are simplified; there are the Warden, the Matron, the other residents. Hardly anyone else is involved, in contrast to the complex heirarchy of the hospital. The resident is offered a series of situations to overcome -- getting settled in work, getting new clothes, acquiring personal goods, organising a holiday, finding lodgings -- all within a protected environment, so that he gradually increases his range of social skills, his repertoire of ego sets. The work situation is entirely realistic -- it is the normal one. The rewards are immediate and meaningful. The reactions of the environment are comprehensible; reproofs come for manifest transgressions that affect the wellbeing of others.

Morris and Charlotte Schwartz (45) in their book "Social Approaches to Mental Patient Care" discuss similar concepts in

particular the idea that rehabilitation is a process of "Grading Stress" by which the damaged person faces successive hurdles, acquiring skill as he overcomes them. In discussing various transitional facilities and theories, they say "Whatever their differences, practitioners do agree on two general attributes. The setting should provide ex-patients with more exposure to community attitudes, values and social roles, and practice in assuming them, than is possible in the mental hospital. And, at the same time, their failures and inadequacies in the settings must not meet with the consequences that follow in the real world. In short a transitional facility must make real life demands while protecting the ex-patient from demands he is not yet ready to meet".

Here again we see that Winston House meets the basic requirements. The work situations and the financial challenges are entirely real. On the other hand, the penalties of the outside world do not fall with the usual inevitability. If they feel downhearted (or paranoid) they can talk to the warden, or to the psychiatrist. If they cannot pay the full rent, it will be abated. Help of all kinds is more readily available — counselling from the staff, medical or psychiatric consultation.

It seems then that Winston House fits in with the formulations of the leading theorists in the field.

We have demonstrated at Winston House, that a halfway house does work well in certain circumstances and in particular restores to independence some crippled people who would probably otherwise have remained indefinitely in hospital.

Like all studies, however, this one has opened more questions

than it has settled. There are many administrative questions unsettled about halfway houses -- how many are needed, how should they be organised, how are the staff to be selected and trained. There are a number of therapeutic questions -- what are the effective factors, how should residents be selected, are different kinds of halfway houses needed. Perhaps some "control series" would throw light on these. Finally, there are the underlying theoretical questions -- how are we to understand the process by which an institution produces change in the people resident in it?

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APPENDIX 'A'

A memorandum to the Cambridgeshire County Council by the
Cambridgeshire Mental Welfare Association, July, 1956.

CAMBRIDGESHIRE MENTAL WELFARE ASSOCIATION

ALEXANDRA HOUSE, ALEXANDRA STREET,

PETTY CURY, CAMBRIDGE.

The Cambridgeshire Mental Welfare Association wish to draw the attention of the Cambridgeshire County Council to the great need for a Hostel for the emotionally disturbed in need of temporary residential accommodation in a 'sheltered' home. There is an urgent need for such a hostel for people returning to life and work in the community after discharge from a mental hospital, and for people with incipient mental illness who may still be working while receiving out-patient treatment, but whose temporary eccentricities render them unacceptable in ordinary lodgings.

It is estimated that the usual period of rehabilitation will be from three to six months, and that at the end of this period the shelter of a hostel will no longer be needed.

The accompanying memoranda states the need for a hostel in its various aspects.

To meet this need, and extend and strengthen the work already being done by the Cambridgeshire Mental Welfare Association the following committee was appointed by them to make enquiries and suggestions.

C.M.W.A. Hostel Sub-committee

Chairman.

The Lady Adrian.

Dr French

Dr Clark

Mr Kester

Mrs Lawrence

Secretary

Mrs Briggs

The committee suggest that a hostel be established in Cambridge by the Cambridgeshire County Council in pursuance of its powers to provide community care under Section 28 of the N.H.S. Act. It is estimated that the cost to be borne by the County

Council will be as follows:

HOUSE.	Purchase price	£7,000
	Alterations and decorations	3,000
	Furnishings	<u>2,500</u>
		£12,500
RUNNING EXPENSES	Food per year	1,500
	Light, heat and fuel for cooking	200
	Rates and taxes	150
Insurance.		20
Staff salaries and insurance.		<u>1,300</u>
		3,170
If $5\frac{1}{2}\%$ on the capital outlay on the HOUSE is added to this		<u>687</u>
		3,857

The cost per resident per year is £193, or just under £4 per week.

It is expected that most of the residents will be working for a wage and would be able to pay the full amount. For those unable to pay but on National Assistance the cost presents no difficulties. Therefore it may be anticipated that the net annual deficit to the County Council will be negligible or very small.

The Association offer to act as agents for the County Council in consultation with their officers for the establishment of the Hostel, and afterwards to assist in the management of it as the County Council may direct.

Fulbourn Mental Hospital

Memorandum on proposal for Hostel.

The Proposal for a halfway house is welcomed at Fulbourn as it is becoming clear that there are a considerable number of patients who need just this help in rehabilitation to a full and useful life. The majority of short term patients come from jobs and families and return to them. With the long term patients - those who remain in hospital for more than a year - it is different. They lose their external contacts; spouses and families make other liaisons and arrangements, posts and positions are filled. These people too have usually suffered from severe mental illnesses and do not recover their original personalities unchanged. They may become very much better; the hallucinations cease, the delusions

are not expressed, there is no longer violence or over-activity; but they remain eccentric and difficult, and they may have become so used to the life of the institution that they do not fit easily into normal home life.

Yet some of these people are capable of holding down a job, earning a wage, and if helped, learning to live again in the community, after ten or even twenty years of mental illness.

The development of Social Therapy within Fulbourn at a time of full employment outside has made it possible to get a number of patients to work. This has developed especially on the male side of the hospital. On June 2nd, 1956, there were 13 men going out to work daily from Fulbourn. Some of these are recent patients for whom this is a passing service, but there are at least six who could, at this moment, be suitably transferred to such a halfway hostel. Details are given of these six.

	<u>Age</u>	<u>Years in hospital</u>	<u>Present job</u>	<u>Months in Present job</u>
A	33	8	Machine Op.	10
B	46	12	Aircraft F'tr.	3
C	60	21	Labourer	3
D	45	7	Labourer	3
E	26	12	Garage Attnt.	4
F	28	4	Labourer	4

There is little prospect of any relatives taking in these men. They are all schizophrenics except E who is a mental defective.

There is no question that there are a number of men for whom such work can be arranged. There are women too, and this side is being developed now. During 1955 one woman was placed in employment (factory cleaner) and worked satisfactorily for nine months until she was found a vacancy in Bene't Hostel.

A halfway hostel would fulfil an important need for Fulbourn and would be some contribution to the relief of our notorious overcrowding problem. We could place six men in such a hostel immediately and my estimate is that we could use approximately eight places for each sex at any one time.

(signed) D.H. Clark

6th June, 1956.

Medical Superintendent

Cambridgeshire Mental Welfare Association

Memorandum on proposal for Hostel.

I have now been working for the C.M.W.A. for eight years, and during the whole of that period the most pressing need has been a hostel where we could offer shelter to the people known to us, both those who have just been discharged from Fulbourn Mental Hospital and those who have perhaps never been in a hospital but who are in the early stages of a breakdown and need special care and a protective setting which cannot be given in lodgings.

With regard to those newly discharged from Fulbourn Hospital, we can say out of our experience that the problem of finding suitable lodgings in the city is insoluble. This is also true with regard to the "preventative" work among those who either have no home, or whose homes are unsatisfactory. There are in fact no lodgings obtainable where a person suffering from nervous or mental disability can receive adequate understanding or supervision. In some cases such a person has to go into Fulbourn Hospital because there is no one in the community experienced enough to take the responsibility for actually living with him and putting up with his eccentricities in an attempt to tide him over his difficulties. A Hostel such as the staff of the C.M.W.A. have often envisaged would be not just a roof over the head of someone having no home, but a special environment where that particular person would be understood and accepted with all his limitations and even anti-social habits. We often find that the strain of trying to hold down a job in competition with normal people is more than enough to bear, without the additional and frequently final strain of living under unsympathetic conditions.

There are very few hostels in Cambridge, and although we have always found the Wardens very sympathetic and helpful, these hostels are not designed for people with any form of mental disablement. We hesitate to push the claims of people known to us, firstly because an ordinary hostel is not the best setting for them, and secondly because it is not fair to the other residents to have to put up with eccentricities and often difficult behaviour. Added to this, it is often impossible, whether suitable or not, to get vacancies owing to the constant demands by every other authority in the city on the available hostel accommodation. The Church Army Hostel, in particular, has told us out of their own experience how necessary further hostel accommodation is for Cambridge.

At the present time we have 19 persons whom we should wish to place in such a hostel, and we can therefore most strongly support such a project. Our own work is hampered constantly by the lack of a hostel and its establishment would make it much more possible to do our work adequately and be of practical help to our patients.

(signed) Joan Lawrence

July, 1956

Psychiatric Social Worker