LEAVING THE HOSPITAL BEHIND?
AN ANTHROPOLOGICAL STUDY OF GROUP HOMES
IN TWO LONDON BOROUGHS

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ABSTRACT

The thesis examines the impact of leaving a psychiatric hospital, which is due to close, on a group of long-stay patients. Using anthropological method, the study provides a small scale, in-depth analysis of the transition processes involved. It aims to examine the differing perceptions produced from different positions within an institutional setting, focusing particularly on the residents' perspective, and to compare the experience of transition from the clients' viewpoints with the carers' knowledge and assumptions.

The first two chapters outline the context of the study, the historical and sociological background to community care policy and the methodological and theoretical approaches taken. Chapter three uses a 'life history' approach, which recounts the experiences of the residents of a particular group home project. These accounts are compared qualitatively with the official summaries of their case histories, suggesting that rehabilitation requires a different method of understanding the patients experiences, abilities, problems and needs. Chapters four and five outline the processes of selection and preparation for leaving the hospital. The experience of leaving hospital is analysed as a 'life crisis' and the professional handling of the move is examined.

In chapters six and seven, group home life is described in detail and compared to hospital life, bringing out key features of the environment, routines, and interactions within the home and beyond it. I focus on several areas of change and continuity in the lifestyles of the residents, their use of time and their relations to staff and others. The final section explores the conceptual models of the group home, as an aspect of community care philosophy. I focus particularly on the 'family model' of care, its bases and its implications for the quality of life of the residents, in terms of rehabilitation, social integration and the personal and social identities of the residents.

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CHAPTER 1

THE AIMS, METHODS AND CONCEPTUAL BASES OF THE STUDY

The aims and context of the study

My aim was to carry out a qualitative study of life in a group home for former long stay psychiatric hospital patients. This was linked to general policy questions about hospital closure, aiming particularly to compare life in hospital to life 'in the community' and to understand what the changes mean for those involved. More generally, the study aimed to throw light on the nature of certain social institutions, and the cultural assumptions they rest on, through looking at a period of critical change. In doing so, I wished particularly to bring forward the viewpoints of the patients who were affected by these important changes, to show what the experience was like for them.

Therefore, the study explored the move out of hospital, taking in the patterns of care throughout the process, the attitudes and working practices of the different carers involved, and the impact of these patterns on the residents and staff of the projects studied. It aimed to look at staff working methods and philosophies, to compare those of hospital and community based staff, and to compare staff attitudes to the perceptions of their clients. More importantly, to examine how everyday life in the group home compares with professional ideas of what it is, or should be like.

The study was carried out in North East London area, focused on the decision of the North East Thames Regional Health Authority (NETHRA), in 1983, to close two psychiatric hospitals over a time span of approximately 10 years. The philosophy behind this policy in the UK context [which will be discussed in chapter 2] is given to more than one interpretation at the general level. Furthermore, there was limited knowledge of what a community based mental health service would actually be like. Many doubts were raised, by hospital based staff in particular, as to whether long-stay patients could manage a move out of hospital, or

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as to whether this was what they wanted. Through this study, I have looked in depth at the sort of care and lifestyle which is provided by some of the early closure projects, and to find out from the patients themselves what the problems or advantages of the move out of hospital were.

Because of the research aims and the methodological approach arising out of these aims, I planned to undertake a small scale, in-depth study. I opted to study three group home projects, managed by one voluntary organisation, which was already established as a service provider in the districts involved. These projects were to be followed through from preparation stage to one year after the move, as closely as the time limits of the study and the timing of the projects would allow.

Although the study was not primarily a comparative one – hence the focus on a single organisation – there were two elements of comparison involved. Firstly, it showed the developments over time, at the strategic level, within the relevant planning authorities, and on a more day-to-day level within the organisation. Secondly, because the projects were set up in two boroughs, some significant differences in policy and practice between the two authorities emerged. Within the running of the group homes themselves, I compared planning and management of the group homes with everyday practice and examined how the effects of both policy and practice were experienced by the residents.

The study was deliberately limited in its scale, but very detailed and comprehensive in approach. Through this method I was enabled to explore a number of issues in depth, as they arose, and from a range of viewpoints. The thesis looks at what people say on a general level, what they say they are doing in practice, and what they actually do. It presents the view to some extent of an interested outsider, who has gradually acquired cultural knowledge through observation and participation; and the views of insiders, most significantly those of the residents themselves.

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The study method

The method of the study, participant observation, was derived from ethnography, and influenced by anthropological theory. Studies of this nature are both exploratory and complementary to larger scale surveys, which are unable to gain detailed insight into the experience of the people studied, and therefore have limited understanding of their needs. The method was chosen because it allows far more detailed knowledge and greater empathy with all those involved. It is also aimed at avoiding the reification which is part of the general process of becoming a psychiatric patient: the entry in to the social role and status of patient, involves a change of identity, where in the case of 'mental illness', the person is characterised in terms of his/her perceived symptoms. The patient's identity, therefore, can be defined and redefined, according to pathology, and objectified. This aspect of the experience of patienthood will be returned to throughout the thesis, in looking at the experience of living in hospital, of leaving it and of living in a group home. Additionally, it explores the self-identity of the patients, which is inevitably more personal, but can also be viewed as an attempt to maintain a coherent self consciousness which may be developed among marginalised groups.

The thesis shows, as far as possible in the words of an outsider, what the closure process has been like for some of the people it is aimed to help. Triangulation of data was achieved by comparison of observed, spoken and written forms of data. Likewise, data was taken from all sources as far as possible, among those involved. Thus it was necessary to seek information from direct care staff, professional and managerial staff, volunteers and clients. Observations and information given to me were cross checked for internal consistency, and with all available documentary evidence.

Although I had originally aimed also to elicit the views of the residents' relatives, the very limited degree of contact many residents had with relatives, or its tentative and stressful nature, led to my decision not to include this as an aspect of the study. It is also a

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reflection on the problems of 'community care' as an ideal, that I did not feel it appropriate to study the views of neighbours or local people about the hospital closure. Residents' contacts with 'the community' turned out to be so limited, that little meaningful information could have been obtained from neighbours in such a study. Furthermore, to interview local people who had no personal contact with group home residents, could have served to artificially reinforce any possible notion that these were outsiders who needed some sort of special permission to re-enter the locality.

In using this methodology my aim has been to develop hypotheses around those issues which are shown to be the concerns of the subjects, (those of the different caretakers and professionals and particularly those of the residents). This approach starts from the premise that the assumptions used within a cultural or institutional group - the nature of common sense or received wisdom - are often incorporated into the researcher's hypotheses, and therefore should in themselves be subject to analysis. The problem of how to comprehend the experience of long-term psychiatric patients, at different levels of communication, also had to be tackled. The aim of anthropological (or micro-sociological) method should not be to 'find' the structure of an institution or social group, as though it were an absolute and concrete entity, but to build up a picture of the way experience is structured. In doing so, the researcher pays particular attention to the shared understandings or assumptions, (as well as the misunderstandings and conflicts) through which a social institution operates and which are rarely investigated because they are taken as matters of fact. [Bourdieu 1972 p165]

In my research proposal I included the option of developing more structured interviews through the process of participant observation, but the experience has led me to the conclusion that, from the clients' point of view, formal interviews are often an inappropriate and inaccurate way of eliciting their experiences. Such interviews hold too many associations with the diagnostic or medical interview, in which the person feels s/he is being examined and tested. Similarly, a formal interview may reflect the mood of the subject on that particular

occasion without understanding the situation in which it takes place - a respondent may brush off a question or give inaccurate, closing, answers, because he resents the particular question asked, or suspects the interviewer is not revealing his real purposes. Alternatively, the respondent may try to please, and thus produce 'social desirability' responses to the questions asked: unless great care is taken in the interview design, respondents may choose answers which they believe are socially desirable, what the questioner would like to hear, and therefore having an implication of correctness. Furthermore, even the most careful structured questionnaire design will be setting the issues seen as important by the researcher, which may or may not reflect the main concerns of the subject.

A more structured approach, however, was taken with service providers, who had very little time in which to talk to me about their work. Semi-structured interviews were conducted with key professionals with roles on the closure programme linked to the group home projects.' The questions were developed towards the end of the study and were based around the main issues which were of concern to the group home residents, as well as seeking general background information on the roles of their departments in the development of 'community mental health services'. The responses to these interviews were found to be highly consistent with each other, and with the perceptions of group home residents.

An anthropological study, therefore, differs from the traditional social survey in significant ways: most importantly, a study of the social survey type was not likely to provide the type of information sought. Social surveys are able to give information on the broader patterns of service provision and its outcomes and therefore are important for generalisation. They are less well suited to explaining the more intricate patterns involved. For example, a survey might reveal how many patients move to a particular type of project, how many stay, and how many move on or return to the hospital; it would attempt to correlate this data to the main features of the service provided. An ethnographic study would look not only at these main features, but also at the way

they work out in detail and at the dynamics of a decision, such as that
to return a resident to hospital: the attitudes of the staff involved,
the events that preceded the decision, how it was arrived at, the impact
of the decision on the home, the role of the resident in the decision
and that resident's view of the events and how they have affected her.[2]

Such a study can be regarded as exploratory in several ways. Firstly,
anthropological method is grounded in an attempt to elucidate the 'world
view' of those involved. The issues to be studied should be set, as far
as possible, by the concerns and interests of the subjects. In this
case, I was concerned to do so in such a way that these issues can be
taken into account in the design of services and in examining their
underlying assumptions. Such approaches can also be used as groundwork
for larger scale studies that may be necessary. The findings, for
example, might be used to consider the design of interviews, or to
consider why certain types of response might emerge in data obtained in
a larger survey. They also have a role within teams which aim to conduct
comparative studies of institutions, or to undertake a large scale
study, which takes fully into account the considerations I have
outlined.[3]

The impact of doing research

It would be a mistake to imagine that the perfect research programme has
no effect on the situation it is studying. In this sense there is no
absolutely 'hard' data. Even in highly standardised tests or interviews
the results are mediated by the subjects' attitudes towards the test, or
the researcher. Therefore, explicitness about one's aims, plans for and
conduct of research are important. Many researchers, because they feel
they are being objective, do not aim to explain their research role or
to take account of it in their results. Rawlings [1980 ch1] argues that
the inevitable result of sociological method is that the descriptions it
produces will be constitutive of the world - through selection, notions
of relevance, assembling facts etc. Therefore, since all descriptions
are constitutive they cannot describe 'the world as it is' but rather

one version of it. The anthropologist's task is to take informants' descriptions, and the way they are arrived at, as a subject of enquiry.

Spending the large amount of time with the subjects, which participant observation requires, will make a difference to the situation: the time given is additional to that which staff have available and focused in a different way. Time spent on exploring past lives for example, may be rather different from the approaches to working with patients taken by staff. The presence of another person, who is neither an ordinary community contact, nor a member of staff may widen the residents' range of contacts, however slightly. The significance of the researcher's presence could, however, be overplayed. My approach was to try and fit in within the house, and not to intervene or attempt to alter the running in any way. My presence was in many ways comparable to the impact of having a volunteer attending on a part-time basis. Having informed the prospective residents of my research role, I did not attempt to make it directly comparable to that of a volunteer, but I felt that 'helping out' would make my presence less obtrusive and more productive from the residents' and workers' points of view. Its main purpose was to help me to understand better what it is like to be active within that situation.

The greater portion of time was spent with residents, both because of the focus of the study and because the need to allow time to enable people who may have become accustomed to institutional life and severely limited communication, to express themselves. The research was conducted over a period of 18 months, (the maximum time available) since time was also needed to gain familiarity with the people involved, and to follow changing patterns to any significant degree. In this process a balance has to be sought between the need to be competent to describe things, to some extent, as they appear to an insider, and the need to retain an analytical view, which is necessary to perceive patterns and interconnections within their context.

In the first half of the study, only one group home project was actually running. In this period, my time was divided between the offices of the

voluntary organisation, the group home and the day centre run by the organisation. All staff meetings concerned with the group homes were attended, and supervisory staff were accompanied on liason visits to the hospitals. Time in the day centre was spent participating in the activities (primarily packaging work) provided for the centre members, and talking to the members in the course of those activities. Time in the group home was spent sharing in everyday activities, in conversation with residents and occasionally going out with them. In the second period, more time was spent looking at the assessment and selection procedures for the later projects, and once the residents had moved in, in sharing activities with them as before. In this period it was not possible to spend such long periods of time with the residents. Furthermore, delays for some residents in moving in to the houses meant that I was unable to get to know all the residents equally well.[4]

In my view and I think in the residents' view, I was not there to report on them but to examine the type of situation they were in and to indirectly report their views, as well as to write about the way the services were being run. At times residents expressed surprise that anyone should be interested in their lives; some were very keen to talk about themselves while others were less interested. In my research/volunteer role I was able to offer things which the staff couldn't, such as plenty of time to sit and chat with residents if they wished to do this. Time constraints upon workers should not, however, create an environment where changes in practice cannot be envisaged. The way in which the workers allocate the limited time they have available reflect their concerns or priorities and the way the institution is managed. Arguably, there is a great potential for development by changing the forms of interaction and thus the use of time.

One of the objectives of the group homes is to effect just such a change in contrast to hospital practice, by working *with* rather than *for* residents on domestic tasks. Similarly, decreasing need to look after a person who has settled into a 'community' home and regained some personal skills and independence, could be viewed as an opportunity to devote more time to matters which have always been important, and become

even more poignant for the residents' experience as they leave the hospital. In a sense, it is a matter of not seeing rehabilitation as purely instrumental, but concerned with the integrity of the person and fostering any abilities s/he may have to make the most of changed circumstances; to reconsider the past and approach 'community life' again positively.

It was important, in adopting this role, that I did not belong to any professional group directly associated with carers and was not in a position of authority in the group homes. Nonetheless, some residents who wished me to put across their views, expressed concern that in my doing so, they might be laid open to criticism by people who were in a position of some authority towards them. Because of this I was careful to avoid pushing anyone to give me information. The names and minor details about residents and staff have changed in the writing up of this study in order to preserve the confidentiality of the people involved. I feel it is important to make clear to informants that they are helping you, and that all you are able to offer in return, apart from your company and appreciation of their help, is a more generalised contribution to attempts to improve services.

It is also necessary, in this approach, to avoid being directive in questioning or asking for information. The researcher should spend a large proportion of the time in listening, and in following the lines of interest which the subject wishes to pursue and should be willing to give information themselves. This could perhaps be described as 'active listening'. This is particularly important in a context where the subjects have felt powerless for a long time; who may have grown used to being questioned about their illness or problems by a variety of professionals, and who may consequently find it difficult to refuse people directly. This approach should not present problems in a study where the aim is to elucidate what the viewpoints and concerns of the subjects are.

In the workers' view, the regularity and long duration of my attendance in the homes prevented the study from being disruptive for them.

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However, staff who were involved in other group homes, became confused as to what my main role was. After such a long period, they began at times to see me as "one of the team" and inevitably tried to draw me in to the staff group, as they generally do with full time volunteers. This tendency was probably added to by my similarity in age, gender and class background (educational experience apart) to the residential workers as a whole. As a result I had to make clear to residents and staff that I was not there in a staff role in any way and did not share any obligations or authority with the staff group, but that due to my study, I had relatively free access to staff activities such as meetings.

My experience confirms the expectation that it will be difficult for a participant observer to avoid feeling involved in the setting in some way. Total detachment is neither possible nor desirable. Conflicts may arise for example over the need to give expression to problems experienced by residents, which may be felt as criticism by the service providers who have allowed the study to go ahead. It is also likely that the researcher will develop attachments to the project arising out of the length and closeness of the contacts involved. The researcher should make clear the way in which the study was carried out and whose perceptions are being presented at any point.

Anthropological perspectives in the study

In this study I have attempted to explore the relevance of anthropological method and theory, for understanding attitudes towards, and responses to, mental illness. Traditionally, anthropology has mainly been concerned with what are sometimes described as 'closed systems'. [Gluckman and Devons 1964 p185-188] This came about partly because of the historical and social context of its development (notably the colonial context and the issue of liberal intellectual concerns with the cultures brought into contact with the West by colonialism). It can also be related to the ethnographic research method, which emphasises the importance of intensive study and an in-depth knowledge of the culture of the area studied, leading to a preference for studying systems where

boundaries appear easily drawn, and sometimes for analysing the more static, apparently ahistorical aspects of a situation.

These features, however, are not inevitable limitations of anthropological method, as many works dealing with social conflict and social or cultural change have shown. They might more accurately be related to a tendency in functionalist analysis, to see the social system as a balanced whole, with normative social activity functioning to maintain its equilibrium. The work of Gluckman on witchcraft accusations and rituals of rebellion [Gluckman 1982 ch VI & VII] is an example of anthropological analysis which is functionalist but also attempts to analyse conflict within society. The accusations of witchcraft are not only disruptive in an immediate sense, but they relate to unresolved, perhaps unspoken, conflicts within the social group. He argues however, that the social response to these accusations, tends to bring about adjustments in relations which 'function' to restore the overall social order in an essentially unchanged form. Alternatively, where longer term change occurs, the responses tend to restore an idea of overall order, of equilibrium within which change is contained. [p279-283] In an anthropological study of admissions to a psychiatric hospital Perelberg [1985 ch.7] compares accusations of mental illness to accusations of witchcraft, similarly relating them to power relations within the family and to the ordering of social roles. In her case, however, she argues that accusations don't contribute to the maintenance of the existing order, (within the family at least) but are crises which express a process of change and problems encountered within it.

She also comments on how anthropological studies have also tended to follow a dichotomy between the *individual* and *society*, which is characteristic of much western social theory and of general cultural attitudes towards the relationship of the individual and the family with society. This pattern is reflected in the difficulties of some traditional anthropologists in dealing with psychological issues, such as Radcliffe Brown's attempted separation of socially prescribed relations and affective relations within social groups. [Radcliffe Brown

1975 p11] It has encouraged a tendency to leave study of the individual within sociological subjects to psychology and psychiatry and so to perpetuate a false dichotomy. Such attitudes are present within the assumption of more 'scientific' disciplines such as psychology and psychiatry (and also psycho-analysis), that individual states can and should be conceptualised as isolates, or perhaps adding some points about social influences (like sociological trimmings) which are not integrated with the basic argument. Furthermore, this perspective is inherent within the theoretical approaches of psychiatry and psychology, which view 'mental illness' as essentially a problem of individual pathology, requiring particular therapies to return the patient to a normal, functioning state.

I would argue that despite the problems some anthropologists have experienced in relating their work to psychological or individual issues, the general approach relies on an understanding of culture as constitutive of, and continually reconstituted by the individuals within it. It is essentially a dynamic concept, where the individual cannot be analytically isolated from culture and social group in this way: as individuality itself is socially constructed, individual behaviour cannot be reified and set apart from the culture in which it takes its form. In looking at the experience of ex-patients, of becoming defined as mentally ill, of living in hospital and leaving that hospital, somehow to "rejoin" society, we need to understand that they have a social role, albeit a *deviant* and therefore stigmatised one. Their experiences of childhood, family, religion, work, grief, illness and patienthood are formative. In a similar way, the nature of what we see as knowledge, the way in which a world view or scientific concept is arrived at, is embedded within such experience.

These patterns have changed in recent years, as anthropologists working in their own and other societies have focused on particular social issues rather than, or as well as, on particular communities. They have also increasingly explored the dynamics of social and cultural change at the micro-social level. [Basham 1978] The interest in psychiatry and community care as social and policy issues does not derive from some

idea that they are fringe issues, although it is true to say that the recipients of such services have suffered significantly from social and cultural isolation. Despite this marginalisation and the stigma of social attitudes, my argument is that these issues are central in a consideration of the nature of our social institutions.

Community studies, emphasising boundaries and continuities in social relationships and attitudes, which make it seem easier to encapsulate the community's structure, have often been perceived as ahistorical and marginal to society as a whole: the bounded community is at the same time idealised but thought not to exist. The crystallisation of 'community care' as an ideal for caring services has brought the issues of 'what is a community?' and 'what is care?' into the mainstream of social thought. [The related concepts of *community* and of *care* will be fully explored in the second part of this introduction.] Community studies such as Frankenberg's "Village On The Border" [1957] or Cohen's "Belonging" [1982] may easily be placed in a sociological category of fringe studies and therefore particularly appropriate for anthropology within western societies, but they are in fact dealing with the dynamics or contradictions of social continuity and change, where the so-called traditional community cannot be understood except as part of the wider system. Partly as a result of such compartmentalising, I feel that the implications of much anthropological work for the field of 'community care' have not been brought out.

Within British social anthropology, interest in health and social policy issues has continued a tradition of studying the forms and roles of ritual and healing in non-western societies. They have developed in the field of community studies in 'Western' societies and from anthropological studies of institutions, and have close links with certain areas of sociology (such as ethnomethodology, symbolic interactionism and phenomenology). A number of these studies, such as Goffman's 'Asylums' [1968] and Rapoport's 'Community As Doctor' [1960] have had a significant impact both on theory and the delivery of psychiatric services.

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Kleinman [1980] analyses medicine as a cultural system, in the sense in which Geertz [1973] describes a cultural system as:

"a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions" [p24]

The system as such isn't a concrete entity, but a conceptual model held by the researcher; (what Geertz describes as a "map") arising out of the process of reconstructing local health care systems through written accounts, and through coming to understand how actors in a particular social setting think about their health care, their beliefs about sickness, their response to it and the relationships between professionals and clients. In this approach, individual experiences and institutional responses are all interconnected, and the relations between patients and healers cannot be understood out of this context. Kleinman argues that clinical models of the health care system, in contrast, try to evade consideration of its cultural framework, by appealing to notions of universalistic and objective measures, based on the view that biological processes alone constitute the real world or on the assumption that science is culture free. [p25]

Kleinman sees the concepts of disease and illness as explanatory concepts, rather than as entities, although in practice they tend to be talked about and understood as entities. Disease refers to clinical reality, illness to social reality. He also stresses that symptoms (here he is referring to symptoms of illness of all types, studied cross-culturally) are socially constructed and shaped into the cultural form - illness. He also draws attention to the way in which language reflects such conceptual models: in British society metaphors of war are very common in discourse about illness, and mechanistic models of the body are commonly used. He contrasts these with Chinese metaphors of people being hit by ghosts;

"Explanatory models determine what is considered relevant clinical evidence and how that evidence is organised and interpreted to rationalise specific treatment approaches." [p110]

These approaches draw strongly on the anthropological principle of

'holistic' study, in which different areas of cultural and social life are shown to be interrelated in essential ways. Therefore, sociological theories about medicine, religion, politics and social organisation, have important structural as well as historical links. This realisation is particularly important when studying mental health beliefs or policy – the particular policies and institutional reforms studied in this thesis take their form in a much broader pattern of cultural attitudes and social relationships. In a sense, what are being questioned are the assumptions implicit in our ways of understanding the world, our ways of drawing boundaries and of defining normality and reasonableness.

If we analyse social institutions in this way, we can make understandable the perceptions of a cultural group, and their difficulty in accepting the perceptions of others, which may seem at first sight so strange as to be inexplicable, and therefore to be 'madness' itself. In a meeting between psychiatrist and patient, the attempt at communication requires a means of understanding what seems to be alien and other – the expressions of mental distress – which are interpreted as symptoms and aids to diagnosis. Although it may seem far apart, this argument echoes that of earlier anthropologists, such as Evans Pritchard [1937], in their attempts to explain the coherence of cultural belief systems which had previously been regarded as alien and inaccessible:

"In this web of belief, every strand depends on another strand, and a Zande cannot get out of its meshes because it is the only world he knows. The web is not an external structure in which he is enclosed. It is the texture of his thought and he cannot think that his thought is wrong" [p194]

In a sense, this provides a reflection on the inadequacy of the psychiatrist to achieve a dialogue with the patient's experience. [5] A holistic approach is vital to any understanding or empathy with beliefs or experiences which are not, to the observer, normative and therefore are perceived as bizarre and inexplicable.

Versions of reality: links between method and theory in social research

In debates about theory and policy in psychiatric services, the key division is usually centred on a distinction between two different approaches to psychiatry. The first, and dominant approach may be called the 'clinical' or 'somatic' model of mental illness and the second, (generally but not necessarily opposed to it) the 'social/psychological model'. This division reflects the main professional lines in the mental health services (that between psychiatrists and others, or that between health and local authorities who provide mental health services) and between different research disciplines (most simply between medical and social research and theory).

Such debates are particularly poignant in the area of community care, because of the nature of the reform it proposes. On a more philosophical level, it proposes a change in the nature and location of care, as something which can be achieved within an ordinary social and cultural setting. On a more pragmatic, policy oriented level, it proposes a change from hospital-based care to care provided in the patient's neighbourhood, and in a 'home-like' setting, preferably in ordinary housing. On this rather vague level it is possible to envisage a general consensus about the way in which mental health care should be carried out. However, when the detailed policies necessary to achieve community care are examined, we find that significant arguments about the nature of care persist.

In his address to the MIND conference of 1982 [MIND 1983] Norman Fowler, as Secretary of State for Social Services, described government policy as:

"designed to achieve care for mentally ill people as an integral part of society - not to leave them as a forgotten legion of outcasts, hidden away from the public gaze" [p5]

Such emotive, but insubstantial statements have in some ways served to mask the depth of the contradictions embodied in the community care policies as they are currently being enacted. They suggest that what is

being pursued is a fundamental transfer of care, which will remove the
isolation and stigma suffered by people who are categorised as mentally
ill and those who care for them. In contrast, evidence from this study
supports Ramon's argument [1985] that:

"despite official declarations, the British psychiatric system since the 50's has
continued principally in the mould of the clinical-somatic approach, yet calling it
community care when practised outside a hospital" [p318]

The two models can also be seen as having developed out of two major
paradigms of knowledge - those of positivist and of hermeneutic
knowledge. The positivist paradigm has been a dominant theory in Western
knowledge, growing out of its importance to the natural sciences, and to
the authoritative development of medical science. Much of social theory
is also positivist, in that it seeks to be scientific knowledge in the
manner of the natural sciences.[6] Even the psycho-analytic approach of
Freud, which is commonly seen as opposed to psychiatric theory, aimed to
provide a theory of the psyche which was universal and objective,
without recognising the significance of his own culture for himself or
his clients.

A positivist approach to social research assumes that direct cause and
effect relations can be found, on the model of 'operational effects' in
physics,[7] and that objective observation can be achieved, which is
experimentally replicable and testable. These assumptions tend to result
in a view that very complex social patterns can be fully explained by
reducing them to a set of operations. Ingleby [1981] describes the
impact of this approach on the psychiatric case history:

"The patient is pinned down to a few cut-and-dried epithets, with no hint of the
complex ambiguities of human conduct or the context in which the patient acts or is
observed." [p29]

He points out that, despite this approach, psychiatric descriptions are
themselves strongly rooted in common-sense cultural understanding,
rather than in neutral scientific terms.[8]

A key criticism of positivism, both in the social and natural sciences, is its failure to realise the cultural and subjective construction of normality. The basic definitions, proof of normality and abnormality, wellbeing and illness, are not objective or static in the way that positivist theory would require. Generally, a positivist approach is not able to account for the complexity of human actions and motivations, which are influenced not only by their biological nature, but by the cultural construction of perception, and the environment and experiences of the individual and of the social group.[9]

These problems have been particularly significant in the development of the psychiatric profession and its relation to concepts of mental illness. The traditional division in religious notions of the body and the mind, (as that between the natural and the spiritual) are reflected in the conventional divisions between 'physical' and 'mental' illness. Psychiatrists, historically, have sought to affirm their status as medical professionals by stressing that mental illness should be understood and investigated like any physical illness. Sedgewick's argument, [1982 ch. 1] that both mental and physical illness need to be understood as cultural phenomena - their definitions, nature and effects, requiring more than biological explanation - echoes the findings of many anthropologists working cross culturally. [Landy 1977] In his view, positivism in medical science postulates a radical separation of 'facts' from 'values' and suppresses the interactive relation between investigator and subject.

In a similar way, the mental health workers who are attempting to establish new models of care, have failed to confront their own concepts of normality, or even to consider the implications for their work of their concepts of appropriate behaviour and living conditions. In this context we have two different, but juxtaposed standards: firstly, for differentiation between a *normal* person and a *mentally ill* person, (which is very much dependent on the diagnostic definition of the patient once s/he has entered a 'sick role'); secondly, for the differentiation between normal and appropriate expectations and limitations upon life for a *normal* or *mentally ill* person. This study

will suggest that although the two appear logically related, they are in practice contradictory, because in the first standard the person is classified by his/her assumed incapability of meeting cultural definitions of normality, yet in the second standard, the *ill* person is expected to conform more consistently than the *normal* person to cultural rules, in order to achieve rehabilitation. This issue is touched upon repeatedly in my analysis of everyday life, reflecting the way it has repeatedly confronted service users and care staff in everyday life without any satisfactory resolution.

Ingleby [1981 ch. 1] draws a distinction between 'hard' and 'weak' positivism. In his view, weak positivism is typified in the eclectic approach of modern psychiatry[10] and in much of social science. It could be described as an attempt to reconcile interpretive approaches with positivism, or as an attempt to apply empirical science to the more awkward area of social interaction. An example of this would be an attempt to discover a simple environmental or social cause for mental illness - although undoubtedly certain interesting and informative social patterns may emerge, such a study may still assume that the definitions of normality are objective, universal and reliable, without further analysis. Ingleby's critique of Brown and Harris', 'Social Origins Of Depression' [1978] argues that they effectively dispense with their original (positivist) assumptions about diagnosis, when they show the symptoms of the depressed women to be warrantable in their situation. [p52/3] In effect the boundaries of normal and abnormal behaviour (diagnostic signs) have to be redrawn or to be understood as boundaries, rather than as objective fact.

When we look at anthropological research methods, it is clear that anthropological theory owes more to interpretive than to positivist social science. The researcher starts with the premise that the 'issues' or even the questions cannot clearly be defined, until s/he has analysed the basic beliefs and assumptions which the subjects are using. One possible problem in this approach, particularly if historical and cross-cultural influences on social life are ignored, can arise if the researcher adopts an extreme relativistic viewpoint. Just as, in a 'hard

science' approach, the complexity of social action, of learning, decision making and so on could not be accounted for, in a 'pure relativist' approach the common biological nature, and social experiences of different cultural groups would be ignored, and no bases for dialogue and social change would be conceivable. Ingleby stresses that there are means of detecting common ground in differing systems:

"If this were not so, there would be no sensible basis for choosing between different paradigms and each would occupy its own self contained, inpenetrable world." [p26]

Most anthropologists use relativism in a rather different sense, of demonstrating that different cultures have coherence and validity within their own terms and thus can be related and understood within others. An approach which teaches us to be sensitive, and to not assume universality of definitions is particularly valuable for the study of mental health.

This study has followed what is essentially an interpretive approach, particularly because it is concerned with the detailed implications of social attitudes, as they are enacted in social policy. It also follows a dialectical approach, in the sense that it explores the contradictions inherent in the system, and the way these contradictions are constituted and responded to by the different groups and individuals involved. The current ideal of 'community care' and the related policy of closing psychiatric hospitals, have only been explored in rather limited ways. There is no clear understanding of what this implies for the nature of mental health care, of the links between care and control.

The hospitals' closure is a symbol of de-institutionalisation, but we have to ask, what social institutions are replacing the asylum model? This is an important question, because the position of psychiatric inpatients should be analysed as part of society, despite the image of exclusion from it, which is built up by segregation. In moving 'to the community' they are not moving from outside to inside, in a simple way, so much as moving from one form of social institution or structure to another, which is ideally integrated rather than segregated. In order to understand the current status and experience of the residents of these

institutions, we also need to explore the background, in terms of the historical development of institutions and the life experience of the individuals. Finally, their everyday experience should be related to wider social patterns - of class relations, family patterns, of gender and ethnic discriminations and of dominant social attitudes towards normality and illness, adulthood and dependency.

Power and knowledge

The importance of positivism in our ways of thinking about social relationships and social change provides a reflection on the mutually reinforcing relationship of power and knowledge. The writing of Foucault [1979] is based on an argument that power is inherent in all relationships, and that it is productive as well as potentially destructive, a means of domination; and that power is intimately linked to knowledge:

> "we should admit rather that power produces knowledge, that power and knowledge directly imply one and another" [p27-28]

His concept of power, and the analysis of psychiatry which arises out of it, can also be related to Marxist ideas about power in social relationships - put very simply, economic power is reinforced through domination of ideas and knowledge. The forms of knowledge thus produced are mystifying and enable certain power structures to be developed and maintained. Turner [1987 ch1] argues that Marx, Engels and Weber all rejected any notion of the social order as a biological system, on the basis that social-Darwinism was an ideological distortion of social relations, giving expression to the competitive quality of capitalist society. He also notes a parallel of Foucault's work to Weber's historical sociology - seeing medicine as part of an extensive system of moral regulation.

Foucault [1973] looks at the way in which the development of psychiatry and its establishment of a dominant model of mental illness can be related to broader social and economic developments - the 'age of

reason' - bringing about a new, scientific, paradigm of knowledge. Cohen
[1989 ch.1] describes how in Italy, since the second world war,
critiques of psychiatry developed as part of a wider notion of change in
society, forming significant alliances with reforming political
movements which influenced Italian society after the demise of Fascism
and in opposition to it. In contrast to this broad political and social
movement, the critiques of psychiatry which developed in Britain and in
the US, in this period, despite their origins in sociological theory,
have remained relatively isolated in their implications for social
policy.[11]

The anti-psychiatry movements, typified by the work of Laing, Esterson
and Cooper, had an important impact on ideas about the origins, nature
and treatment of mental illness. However, they are powerfully criticised
for their almost exclusive focus on the individual and his/her family
and for trying to romanticise the pain of mental distress out of
existence, by redefining it both as social protest and as a higher level
of consciousness.[12] Much of the power of their critiques of psychiatry,
I believe, grew out of a body of earlier sociological work, which
analysed the roles of the psychiatric institutions and of *illness*
itself, in a detailed and critical way.

The concept of the 'sick role' outlined by Parsons, [1951 p428-479]
provided an important means of understanding how illness is defined and
responded to.[13] A person enters the sick role, when his or her problem
is perceived to be illness (rather than say moral fault). It is
therefore a normative social position, but one which creates abnormal
roles and obligations. The sick person is exempted from normal roles,
(such as work, nurture, sociability), but takes on a new set of
obligations, including the duty to co-operate with treatment and to
respond by seeking to get well. Parson's model, as an ideal-type, fits
most diagnosed states of illness, but is far more problematical in the
the case of mental illness. Under obligations to co-operate with the
healer, and to respond by getting well and returning rapidly to a
productive and normative social role, a person with mental illness is in
rather a contradictory position, since the state of being mentally ill

is itself defined in terms of the person's inability to maintain these social roles. The long-stay patients in the hospital which is to close, have become fixed in this role, and in the social exclusion which accompanies it - as chronic psychiatric patients they have no place.

In the 1950's, anthropologists such as Rapoport and Goffman, as well as dissenting psychiatrists such as Russell Barton and Maxwell Jones, analysed the institutionalisation of the sick role in psychiatry, by re-examining the structure and ethos of the asylum and re-assessing its therapeutic (or rather anti-therapeutic) effects. Barton [1976] suggested that much behaviour of long term patients, understood as manifestations of illness, could be more accurately understood as an outcome of their institutional experience. Goffman [1968] provided a detailed account of how such patterns develop in the context of asylum life. His characterisation of the asylum (among other institutions) as a "total institution" showed how the institutional experience of a psychiatric patient could come to influence his/her behaviour and to assume the person's whole personal and social identity - as an inmate s/he is stripped of her previous identity, and through mortification, comes to be seen, and to see herself, as a psychiatric patient, outside of society and degraded by it.

Goffman points out that whereas the basic social organisation of modern society is to work, sleep, play in different places, with different co-participants and under different authorities and without an overall plan, the central feature of a total institution is a breakdown of barriers ordinarily separating these spheres of life. [1968 p17] My study shows that this feature does not necessarily alter as a result of moving out of hospital. The group homes set up to care for former patients retain some of the key features of total institutions as described by Goffman in 1960. His second major point is about how the patient's identity is marked by entry into the life of the hospital:

"His self is systematically, if often unintentionally, mortified. He begins some radical shifts in his 'moral career', a career composed of the progressive changes that occur in the beliefs that he has concerning himself and significant others." [p24]

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We cannot assume therefore that transition is simple, a matter of changing places, when it ignores the history of the institution and of the patients' experience. If de-institutionalisation is sought, then we need to consider the way the user views him/herself, in terms of the continuing or changing power relations in the institution or the world outside.

The sociology of deviance has focused on the significance of the way a person is socially defined as mentally ill. Its exponents argue that the concept of mental illness itself is not based on an objective medical category, but on some form of deviance, socially conceived. [Scheff 1966] It rests on the view that mental illness, as currently defined, forms part of a broader category of definition and reaction to deviancy. Just as, in the workhouse, [see chapter 2] the ill, the indigent, the petty criminal or the socially outcast would be lumped together, people who are defined as mentally ill share their social marginality with people in other categories of deviancy. The importance of deviancy theory reflects, therefore, the historically and socially significant features of the way certain groups of people are treated, and the significance of rules of normal/deviant behaviour and the values through which diagnoses are made.

Within the deviancy approach, labelling theory was developed to analyse the way in which, once a diagnosis of mental illness or other deviancy such as mental retardation is made, the label (metaphorically) sticks, so that the person experiences great difficulty in returning to a normatively valued social role. Diagnosis, not only in clinical psychiatry, but broadly in any therapeutic intervention, has the capacity to redefine behaviour within its own terms. In this context, the relationship between power and knowledge is particularly significant. A professional, defined as someone who has access to expert knowledge, acquires the power to define the situation of a client and out of this 'knowledge power' comes the authority of the professional to regulate that situation.

A now classic 'experiment' on the authority of labelling was conducted by Rosenhan, [1973] using volunteers to present themselves to a psychiatric unit and complain of hearing voices. Once accepted within the unit, their illness was not questioned and although they had been instructed not to feign any further symptoms, they were responded to by staff as though they were exhibiting pathological symptoms. Although discharged, on average, within a few weeks, they were categorised as 'in remission': the diagnosis was not questioned absolutely. Leaving aside the ethics or merits of such covert research, (which had been agreed with the unit manager but obviously without the knowledge or consent of staff) it illustrated the general tendency of social institutions to treat people according to their defined social roles and not to question them, particularly when they rest on professional expertise. One student, who openly took notes on the ward, was said in case notes to 'engage in writing behaviour': an illustration of the way special use of language can contribute to and reaffirm labelling, but more importantly of the ease with which labels can be reinforced in an institutional context.

The approach has been particularly influential in studying the running of institutions and in analysing the ways in which social behaviour is defined and acted upon. This study, in its analysis of everyday practice and decision making confirms the importance of labelling processes in an institutional context. Such theories, because they focus on the process of definition, rather than looking further into the history of the patients' experience, have been inadequate to acknowledge and account for the distress of the individuals who came to be stuck with the label of mental illness and living in a psychiatric hospital. However, it is not necessary to imply, as Szasz does in 'The Myth Of Mental Illness', [1966] that the experiences which lead many people to the psychiatric unit have no reality. They imply that the reality of the person's experience, though often very distressing and disturbing, is oversimplified and distorted through the process of diagnosis.

In the chapters to follow, we can see that the ways in which staff define, or attempt to understand their clients, and to work out ways to

care for them, are very complex. They combine psychological, medical and moral ideas about normality and illness, and furthermore, their responses vary according to the situation and the threat it seems to pose to their concepts of care and rehabilitation: whether a person in difficulties is classed and responded to as ill, unhappy, or simply experiencing ordinary problems is influenced by the role of that person within the institution and its acceptability, or apparent deviancy within the terms of its regime. Care staff, situationally, may play down psychological problems or distress experienced by residents, yet may also fall back on punitive use of diagnostic labels, and the assumption of pathology, when a resident's behaviour in some way threatens the established order of life in the group home. The staff concepts attempt to define a regime which is conceived as *caring* rather than *controlling*, (set up in opposition to the idea of the mental hospital) yet where the use of control to maintain the ideal order is central. Thus, the inter-relations and contradictions between care and control as principles of the service are played out in everyday life.

Perelberg, in her study of admissions to a psychiatric hospital [1985 ch.3] noted that the beliefs of both professionals and relatives of patients were multi-levelled, incorporating in differing degrees organic, moral and social theories to describe and explain the onset of mental illness. In this way, they recall the key features of symbols as defined by Turner, [1964 p29] of polysemy, condensation and unification. i.e. they are able to express many levels of meaning, bringing complex associations together into one symbolic concept. The relatives expressed firm belief in the organic model of illness, yet in their interviews returned repeatedly to the moral questions the crisis had raised, such as the possibility that they had sinned. Conception of a child out of marriage, for example, was morally associated, in several accounts, with the 'punishment' of mental illness. The medical staff similarly followed a dominant organic model, but in practice relied strongly on judgements, which were often prejeudiced, about the class or ethnic group of patients and their families. Thus we might argue that the idea of madness brings together a number of related ideas about cause, moral fault and blame.

Freidson [1970] argues that:

"evaluation of what is normal, proper, or desirable is as inherent in the notion of illness as it is in notions of normality [p208] ... Thus biological deviance or disease is defined socially and is surrounded by social acts that condition it." [p209]

Similarly, we might argue that in the care of long-stay patients, who are characterised as *chronic* and *dependent*, the effects of labelling are still significant. The diagnostic labels are now both added to and obscured by the effects of institutional life on the individual. The term 'chronic' can be a comment on the person's mental state, but also on the state of an institutional regime and its effects on the inmate's identity and ways of coping with everyday life. Labelling theories have undoubtedly been significant in the support for community care policy, but their impact on policy should not be overestimated. In the ideal view of community mental health services such problems would not develop, but this cannot be assumed.

Gove [1982] concludes that beneficial changes have come out of deviance theory, but that it is now dated, as it has not taken these changes into account and fails to recognise that pathological phenomena exist. However, it is questionable how far the structure of psychiatric institutions have changed in response to such critiques: physical conditions may be improved for the benefit of patients and staff for example, without requiring any alteration in the forms of interaction and the types of activity found on the ward. The description of the hospital ward in chapter 6, shows that the material conditions, though far from ideal, are not the same as those described by Goffman and others. Older nurses will talk disparagingly about the old days, when patients had to carry their entire personal belongings around in a pocket or handbag. The hierarchy of the hospital has not substantially changed however, and patients may feel their conditions of existence have improved somewhat while still feeling powerless, insecure and resigned to, rather than satisfied by, life in hospital. In the group homes, substantial improvements in living environment facilitate an improved quality of life. However, continuities in the status of the

client and the power relationships within the care setting may persist in framing the residents' experience.

Gove's use of the term 'pathological phenomena', is similarly rather general. It seems he means in the broad sense, that deviancy theory cannot deal with the reality of the problems which have led patients to seek help or have it sought for them, for the sake of their own or others' well-being. The term carries the more precise connotations of disease, however, which many sociologists would argue is a misleading characterisation of an illness state which is not presently linked to any known disease process. The path to (and away from) the mental hospital is influenced profoundly by the economic and social circumstances and by the attitudes of those in the social network of the patient. [14]

Plans for community mental health services have to some extent been influenced by the ideas of 'normalisation', which have developed out of such sociological theories. [Wolfensberger 1972] In the broadest sense the principles of normalisation have permeated ideas of good practice in mental health services through provision of community based housing and other facilities. More specifically, the health and local authorities involved in planning for community care have in recent years adopted the language of normalisation, in their guidelines for new services. Normalisation is an approach to service provision, a principle rather than a theory per se, which has had its greatest impact on care for people with a mental handicap, encouraging de-institutionalisation and changing attitudes towards disability. Although it does not attempt to account for mental distress, it sets out guiding principles for rehabilitation as well as for service reform, by making it possible to see much behaviour as understandable in its context, and by aiming to enhance rather than deny the strengths and abilities of the user.

The philosophy of the organisation studied in this thesis, centred on rehabilitation, comes close to the principle of normalisation in certain ways, although no explicit connections to such ideas are drawn. It relies strongly on 'common-sense' judgement and on attempts to encourage

socially valued behaviour. In this way, it also rests very strongly on encouraging adherence to social norms which may be quite rigid in their application. Furthermore, it does not question the nature of its common-sense judgement, as opposed to the judgements made by residents about their own needs and desires. In a similar way the 'normalisation' approach doesn't explicitly address the concept of normality and its boundaries, although Wolfensberger stressed that the concept is intended to be morally neutral, using norms in the sense of typicality rather than conformity. [p28] The organisation's approach reflects a potential contradiction in the idea of normalisation, which, in certain cases, could be seen as an attempt to impose rigid social norms on users: it brings out the question of how far a person should be required to change to fit social norms, or whether social values can be made more flexible to accommodate many of those who are now seen as outside of them. Similarly it does not address the variations and flexibilities in norms which already exist, particularly between different class and cultural groups.

The concept of 'social role valorisation' developed by Wolfensberger, to resolve this problem, suggests that what should be sought for users are socially valued roles. This concept combines the idea of normalisation and one of its key corollaries - that of integration. It suggests that if 'deviant' groups can be given the assistance and opportunity to take up lifestyles which are more socially normative and less segregated, and to participate in roles which are socially valued, then the rigidity of segregation and of social attitudes towards the roles of 'deviant' groups can be further reduced. In this study I have looked at how far the group homes' lifestyle, and the range of activities encouraged among residents, enable them to find socially valued roles.

A key difference between the approach of the organisation studied and the principle of normalisation set out by Wolfensberger, and re-considered by Brandon [1987] and Ramon [1990] is in their theoretical and philosophical bases. Wolfensberger drew attention to the fact that the social definitions of the person (in the case of his work the individual who is mentally retarded) are part of a broader pattern of

defining and reacting to deviancy. [p14] The historical and current patterns of treatment of 'deviant groups' have common basic features: a personal quality is socially defined as deviancy if it is negatively value charged, although what is evaluated as deviant may vary in different cultures. [p13] Deviant groups are stigmatised and often segregated (for example in ghettoes, asylums, village communities, old people's homes) socially or physically. Different forms of deviancy may be explained in terms of each other. Wolfensberger notes that in the "eugenic alarm period" (circa 1890 to 1925) all manner of 'deviants' - not only the majority of disabled people, but the poor, the unemployed or the apparently immoral were categorised together as degenerate, and linked to mental retardation. Some sought to attribute this 'degeneracy' to tainting of the racial stock by foreigners, echoing the general symbolic theme of the 'other' - something which is both outside and strange, but within - in the idea of deviancy. Thus varying forms of discrimination - racism, attitudes of rejection towards disabled people and so on, can be seen as related at the level of a basic 'attitude complex'. [p14]

The voluntary organisation studied here does not follow a clear theoretical model, which could be said to be linked to 'normalisation', despite many similarities in ideas and their practical application. Its ethos is geared specifically towards containing mental illness, and towards providing relief to people who are disadvantaged by it. It tends to view the everyday problems of clients as located within the individual or family group, without drawing connections with societal issues affecting its client group. It does not draw comparisons with the social situation of other disadvantaged groups, except in terms of concern about poverty among disabled people, and in seeing a general link between mental illness and low class status. [15] The approach, on an explicit level takes 'common-sense' as a guiding principle in itself. Theoretical or professional training among direct carers is discouraged, not only for reasons of economy, and because personal qualities of the carer are given primary importance, but also in order to reduce the apparent social distance between carer and client. The approach, therefore, has more complex layers, which are implicit in its practical

implementation, and which rely strongly on traditional social attitudes about class and kin based social relationships.

It is not sufficient to argue therefore, within a philosophy for mental health care, that certain things are done purely because of the nature of mental illness, and that mental illness itself is the determinant of the nature of service institutions and the relationships within them. These institutions are an integral part of the wider culture in which our attitudes towards illness and towards care, are formed.

The concept of 'community care'

This is a phrase now in common use, yet its meaning is so ill defined as to be confusing. As a principle, it owes its attractiveness to the symbolic associations of the terms *community* and *care* which are brought together into a broad concept of the ideals for service provision. In practice, at the policy level it appears quite straightforward: it refers to the provision of health and social services at the local level, linked to the closure of the larger hospitals. However, in most peoples' minds it means more than this, just as the concept of community means more than that of locality. This policy is not just concerned with the locus of care, but with its form, and it is in this more complex idea that disagreements lie. The words care and community, are emotive and culturally loaded with strong positive overtones. Even pragmatic policy statements refer, implicitly or consciously, to the ideals these words express.

Sociological observers, such as Sedgewick [1982] have commented on the curious alliance which seems to have been formed, between right and left wing policy makers, around this concept. To understand this 'alliance' we have to look at the unifying, seemingly integrative nature of the concept of community itself. Banton and colleagues [1985 p167-170] focus on the idea of the *remembered community* as a sort of 'fetishized' version of social groups. The characteristics of the remembered community are: it is small in size and clearly bounded, so that it

appears coherent and manageable; there is an assumption of interpenetration and thereby mutual understanding; there is a notion of membership or belongingness - being bound to one another by shared responsibility; and underlying this, a possibility of participation in some common cause that unifies.

This idea of community, as discussed in the previous section, is both influenced by and formative of the writings of anthropologists, and has had a profound influence on their preferences for study. A version of the ideal community is clearly easier to maintain where boundaries can be drawn, where a greater degree of cultural cohesion can be described and where a sense of belonging is explicitly recognised by its members, so that the analyst's model fits comfortably with the existing model of community. Banton and colleagues comment that sociologists have typically tended to apply such a model to the working class, perhaps playing down the significance of conflict and power differentials in their lives:

"the working class community slipping nonchalantly into the idealised 'community' of the simple savage in everybody's anthropological imagination," [p 170]

In right wing political ideology, this concept is, however, a highly individualised one, resting on the view that the family, defined in a culturally narrow form, is the fundamental unit of the community. [16]

Many critical social theorists have tried to argue that community does not exist, except as an ideological fabrication. I would argue that this view arises out of seeing community in such idealised terms, that they cannot be usefully applied to most social settings, particularly in urban life. Yet still, common sense tells us that the community is 'a good thing'. Bulmer [1987] also argues that the ideal/romantic level of community should be rejected as unrealistic: "the political equivalent of love" [p15].

However, there is another level which it is reasonable to pursue: that of having some means of connection and integration, via networks or affiliations in the locality, or in a wider social grouping, described

by Willmot [1986 p83] as a 'community of interest'. This conception is able to articulate more closely the loosely defined sense of community characteristic of modern societies than a somewhat romantic search for the 'village type' community. The close-knit community described by sociologists such as Young and Willmot [1957] and Gans [1982] was regarded by Abrams [1989 p7] as arising in response to difficult social and economic conditions, which he argues we should not want to romanticise. In his view the strength of community in such a situation, was intimately linked to lack of geographical or social mobility, while social historians have shown us that the demands of labour have often led to very high rates of mobility in traditional social life.

Bulmer [1987 p103-106] outlines certain key theories of community: 'Community lost' assumes that attachment to primary groups breaks down in urban life. Bulmer draws attention to much sociological work showing that this is not an accurate view. 'Community saved' is based on notions such as that of the urban village (see above) with close knit networks and solidary ties. He points out that this is not characteristic of life for the majority of people in modern urbanised societies, and is often confined to particular social and economic conditions. 'Community liberated', he argues, describes the situation of the majority who tend to form loosely-knit, but often overlapping networks, which may be spatially dispersed and are "extending networks instead of being bound up within a single, densely-knit solidarity." [p105]

He also draws attention to the significant distinction in policy terms between care 'in' the community and care 'by' the community. [p15] The latter is centred on informal and voluntary care, and can be strongly criticised for its reliance on idealised versions of community and on assumptions about the willingness or ability of individuals to care. It is an essentially individualised approach, despite the terminology, because what is relied upon is the possibility of care provided by relatives, usually women. Abrams, [Bulmer 1986] in examining the differing relationships of kin, neighbours and friends, showed that whereas general support or crisis aid may be sought from friends and neighbours, long term and intimate care, is normatively restricted to

kin relationships. Care 'in' the community, however, says more about the
locus of care, with actual tending (if that is what the person needs)
being provided by paid workers, either in the statutory or voluntary
sector. Thus, a policy of care in the community should be collectively
funded and maintained, while ideally allowing the person in need of care
to remain within the neighbourhood and to retain social relationships
and activities within it. It should also take account of the users' own
ideas of 'community' and their consequent preferences for life outside
hospital.

The planned closure of the psychiatric hospitals studied relates to this
policy, but concerning the special case of those who were segregated
coming back to 'the community'. It was seen by some professional groups,
(mainly social workers, psychologists and community psychiatrists) to be
a direct response to the continuing problems of institutionalism in
psychiatric hospitals. The notion of the group home, as part of this
plan, relates particularly closely to community care ideals. Just as the
idea of community is generally rooted in that of the family, this study
shows that the philosophy of the group home, and its practical running,
are grounded in kinship oriented assumptions. The group home, as a
quasi-familial home, within the voluntary organisation, is ideally
visualised as the basis for a sort of alternative community. In fact,
the ethos of the voluntary organisation echoes the Victorian ideals of
the asylum as a social institution, as a sort of alternative community.
Like the asylum model, the idea of a psychiatric community, centred on
the group home, carries the problem of a stigmatised identity with it,
for, although it is no longer geographically isolated from the user's
neighbourhood, the voluntary organisation has not sought a means of re-
integrating it in this neighbourhood - the group home residents found
themselves isolated within the community.

A person's social identity is defined in various, cumulative ways - via
place in the nuclear family, in a wider kin group, in ties to local
institutions, via occupation and in friendships or neighbour relations.
The 'me' of social identity is related to the 'I' of personal identity
as object is to subject. Most individuals have a number of reference

groups by which to define themselves. The picture developed in the thesis is of the difficulty experienced by residents in trying to redevelop an identity which is not defined simply in terms of mental illness. The issue of the residents' needs to find a less stigmatised identity, in order to achieve some level of social integration which is satisfying for them, leads into a second general question, about the meaning of care.

The group home, with the support of properly paid and supported staff, is designed to provide care as a matter of communal responsibility, without assuming that it can be provided by relatives or friends. It recognises that the social networks of residents have been attenuated, even destroyed, by long periods of hospitalisation, if not by illness or other problems. The provision of such care avoids the imposition of unrealistic and ideologically distorted expectations of individual independence on a vulnerable person. However, the nature of care, as it is constituted in the group home, does not allow for mutual dependence (like reciprocity, an essential aspect of most social interaction) so much as a rather restrictive notion of dependency. My argument is that this pattern is carried over from the psychiatric hospital in an essentially unaltered form, because of the connotations of control contained within the idea of caring for a dependant and because of the continuing social control functions of psychiatric institutions. The thesis explores, in the accounts of staff practices and everyday life, how this conception of care profoundly influences the character of the group home. In the final chapter this is related to the ideas of kinship, (and the ambiguities of relying on closer, more 'benign' forms of authority, while still retaining an underlying notion of professional distance) in which the ethos of the group home is rooted.

The paradox of current British political policy is that it is advocating 'active citizenship' and informal care (which are perceived as essentially individualised), while actively undermining the means by which communal activities and supports for such activity can be developed and maintained. It is promoting an increasing atomisation of individuals and nuclear families within society that makes its policy of

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promoting community care virtually self defeating. Similarly, an individualised approach to understanding of mental illness, does not lend itself easily to a policy of communal responsibility. It would be mistaken, however, to simply adopt the 'community lost' theory, which perhaps feeds into the lack of interest among some voluntary sector carers in integrating the group home within the neighbourhood.

In one of the boroughs studied, Islington, the council policy of decentralisation is now being closely matched by local 'community and continuing service' teams within the health service. The authority aims to act as an facilitator for activity and support networks, which are loosely constituted, but based on locality and/or other ties of common interest. The outcome for mental health services in one part of the borough has been the development of a group home and sheltered flats project with participation from several local groups, including tenants groups and the neighbourhood forum, a local church and the council's neighbourhood office.[17]

Other models of participation are available to those planning community care projects - work co-operatives, (often employing equal numbers of 'disabled' and 'ordinary' workers) informal social clubs which do not require referral by mental health professionals for membership, befriending schemes, mixed housing schemes (i.e. incorporating ordinary and sheltered housing) educational, training and leisure facilities exist. However, considerable caution on the part of some carers discourages those residents who might hope, with some support and encouragement, to participate more fully in community life. In this situation the normative sanctions which might be experienced through social participation, are imposed as part of the regulative role of the care system itself, isolated from the wider community. This study has, therefore, attempted to explore the reasons why, despite the principle of living in "an ordinary house in an ordinary street", such possibilities for social participation, and for rebuilding a more ordinary social identity are not taken up.

The relevance and scope of the study

The issue of community care and the plans to close large psychiatric hospitals are currently matters of great concern. Much of recent research and writing has been at the broad policy level, notably the report by Griffiths in 1988, 'Community Care: An Agenda For Action', and submissions and responses to it.[18] My literature search confirmed the view that relatively little has been written about how such policies work through to the day-to-day lives of those whom they are intended to benefit.[19] Very little was also written, until recently, about the perceptions of the patients involved.[20]

The study can contribute in several ways to a number of disciplines, not least as an exercise in how to conduct social research in particular settings, and in order to focus on quality of life. It has also been an attempt at developing the principles and applications of anthropological theory and method, within the context of one's own culture and around social policy issues.

Evaluation of 'quality of life' is now a matter of considerable research interest in public services provision and is one of the central concerns of this thesis. Huxley [1986] argues that quality of life requires assessment on two levels, which cannot readily be evaluated in the same way. It can be divided in to the objective level, of environmental and material conditions of living, and the subjective level of quality of life experience. The former is clearly easier to evaluate via objective measures - basic standards can be outlined against which the person's conditions of life can be judged. These include adequacy and quality of housing, income, leisure opportunities, educational provisions and so on, which need to be set against some agreed criteria of what all citizens should expect for a reasonable quality of living. The level of subjective experience is vital to understanding of quality of life experienced by the individual and cannot be evaluated without reference to the subjects' own views of their life experiences. This study has taken in both aspects of quality of life, but has focused particularly on the more unexplored area of quality of life experience, which

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integrates evaluation of the objective conditions of living with their meanings for the group home residents.

At the broadest level, the outcome of the hospital closure process could be measured in terms of how many residents stay in the group home, how many move on, or how many return to hospital, either temporarily or permanently. However, such results are relatively meaningless unless we can understand the practices and policies which lay behind such decisions, and the attitudes and interactions which influence those policies and practices. The quality of life of ex-patients cannot simply be measured in terms of outcomes. [Shephard 1988] The fate of an ex-patient, whether to move-on or return to hospital, is often defined as *success* or *failure*, and understood in a functional manner, so that the person is seen as a failure unless s/he meets the ideal outcome of a policy. Moving-on, for example, might reflect a hoped-for move towards greater independence, or the inflexibility and insecurity of an institution which cannot allow its residents to change, or to grow old. Looking at quality of life, not only in terms of objective measures - quality of environment, security and adequacy of accommodation, income and support - but in more personal terms, will enable social policy to be guided more by the clients' perceptions of quality of life and to put different professional ideas of quality into perspective.

Patients in psychiatric institutions often lack the knowledge and opportunity to make choices, rather than the ability to do so. Rehabilitation, therefore, is not just about training in skills for living. It should also involve a process of empowerment through gaining knowledge. When Wing and Brown [1970] found a large proportion of long stay patients either wished to stay, or were uncertain about the idea of leaving hospital, their respondents had little knowledge on which to form a view of leaving hospital and few supported facilities available to assist them in making the transition. Dayson's study of patients leaving the hospitals undergoing closure [1989] found that of those who had left in the first two years, to live in sheltered accommodation, the great majority preferred their new homes in various ways and were happy to have left hospital. The residents in this study are no exception to

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this pattern. The thesis will show in detail their experience of the transition, the complexity of their attitudes towards moving and their perceptions of the quality of their lives. All, despite times of uncertainty and continuing frustrations in their lives, were glad to have left, but never quite sure of whether they had left the hospital behind.

NOTES TO CHAPTER ONE:

1. Interviews were conducted with eight key professionals, four from each district, and within each district two working in the health authority and two in social services.

2. A useful example of combined approaches in found in Bloor and colleagues, 'One Foot In Eden', 1988. They set up a team study of eight therapeutic communities, to enable them to explore both the detail of philosophy and practice in each institution and also to bring out their general and possibly definitive features.

3. In this respect the thesis can usefully be read alongside the epidemiological and clinical surverys being undertaken into the closure programme for these hospitals, by the Team for the Assessment of Psychiatric Services [TAPS], set up by the regional health authority to monitor the closure.

4. Due to time limits of the study and the problems in predicting progress of new projects it was not possible to follow all three projects to one year after becoming operational: this was done for the first project, while the second and third were followed through from the early stages of detailed selection and preparation to nine and six months after the main moving in day. Similarly, due to delays and problems in the selection process, several residents moved in well after the initial moving date. The timing limits of the study are reflected in the third chapter, which concentrates on the life histories of the original residents of the first project, the only residents whom I was able to follow through to more than a year past their move.

5. Littlewood and Lipsedge, in 'Aliens and Alienists', 1982, use these old fashioned terms as a title, to sum up both the problems in communication between psychiatrist and patient, and the common marginality of their social roles, looking particularly at the negative and discriminatory experience of black people within the mental health services.

6. The Darwinian theory of evolution has very basic links with 19th century social theory about the relations between individuals and social groups. The prevalence of mechanical metaphors for the body in medicine, sociology and in everyday speech is also significant.

7. In his critique of positivist approaches, Ingleby gives the example of the relation between mass and velocity in physics. Another example would be the relation between temperature and the properties of liquids.

8 See also the discussion of the attitudes of care staff in chapter 8.

9. Bourdieu's [1972] concept of 'habitus' and his discussion of the limits of objectivism are relevant to this point.

10. Exemplified by Clare's, 'Psychiatry In Dissent', 1980, and the social psychiatry of J.K. Wing.

11. Brown and Harris', 'Social origins of depression', 1978, and Hollingshead and Redlich's, 'Social class and mental illness', 1982, are examples of research with broad social policy implications which have never been fully acknowledged or taken up.

12. Such thinking can be seen to have some roots in existentialist philosophy. See particularly Laing, 'The divided self', 1965.

13. When I use the term mental illness, I am referring to the social role, as analysed by Parsons. The person who is called mentally ill, has been normatively defined as suffering from a disease, and has entered a sick role. I do not assume, therefore that the person is suffering from any objectively measurable disease.

14. As shown by Bott, 1976; Baruch and Treacher, 1978; Hollingshead and Redlich, 1982.

15. They have published several articles arguing that poverty is a major problem for ex-patients and join the disability alliance in campagning for improved benefit levels for disabled people.

16. e.g. Thatcher's statement, quoted in The Guardian 6.9.89: "there is no such thing as society, there are individual men and women and there are families".

17. This scheme is being studied by another researcher. It remains to be seen what impact this more practically *community* based development will have on the project and the experience of its future residents. Tomlinson, [1988c] outlines the development process for this scheme.

18. Most recently, the White Paper 'Caring for people', 1989.

19. Pritlove's, 'Group homes, an inside story', 1983, although apparently similar really fails to do this.

20. e.g. Early works written by ex-patients such as Beers, 'A Mind That Found Itself', 1948, and more recent works such as Barker and Peck, 'Power In Strange Places', 1987; Brackx and Grimshaw 'Mental Health Care In Crisis', 1989; Brandon 'Voices Of Experience: consumer perspectives of psychiatric treatment', 1981.

CHAPTER 2:
THE GROUP HOMES IN THE HOSPITAL CLOSURE PLANS
BACKGROUND AND CONTEXT

This chapter summarises the background to the hospital closure, both historically and sociologically. It argues that the historical process, through which social, economic and political changes have influenced the development of psychiatry, are reflected in the current patterns of service and of change. The history of psychiatry, as part of the history of our response to 'madness', is important to an understanding of how the idea of community care came to be such an ideologically significant yet practically neglected aspect of its development. That history itself is part of a wider history of ideas and social institutions in the UK and in the 'Western' world in general. However, my scope is more restricted and I have looked rather at several approaches to historical understanding, summarising their main arguments and their implications for a qualitative study of current practices and philosophies.

When considering the movements towards community care in the twentieth century in general, what is striking is not change so much as the lack of change. Repeated government papers have stated a case for community care and similarly have expressed disappointment at its apparent lack of progress. Ramon's work suggests that changes in ideas about care are not as coherent as they might seem and in fact that contradictions within such broad ideologies have mitigated against change in policy and practice. [Ramon 1985] Institutional care has been the dominant feature of mental health services. Understanding of the concepts of mental illness and its treatment, which have fed segregated models of care, is important, therefore, for understanding the current tensions between desire for and resistance to change.

The development of institutional care: two historical views

In my view, there are two key versions of the history of psychiatry, which have influenced perceptions of community care and of modern psychiatry in general. The progressive view of historical development, set out most clearly by Jones [1972] and found in the classic psychiatric texts, assumes progress from a past characterised by ignorance or superstition and lack of care, and culminating in medical understanding. Jones' history tends to assume a sort of historical logic in the development of models of madness. In one sense, it follows a linear and hierarchical path: from madness unseparated and undefined; through the madhouse, corrective and abusive; to the asylum, ideally reformed and curative. Community care, in Jones' schema, is an outcome of this development towards an increasingly refined medical and social understanding, where the medical treatment of madness is carried out within a specialised, modern and humane setting, while the caring or regulatory aspects of mental health services are returned to the social domain. In another sense however, a cyclical picture emerges – that of community care as returning to a principle of 'madness' as less differentiated' Similarly, one might see in 'community care' a return to the moral management principles of the eighteenth century, as I shall explain below.

In contrast to this rather neat view, the approaches of social histories such as Foucault's, 'Madness and Civilisation', Scull's 'Decarceration' and Busfield's 'Managing Madness' do not follow an assumption of development as progressive. They reveal change as characterised both by significant continuities and oppositional developments in ideas and practice. If we examine the history of mental health care, in relation to the recent policy developments for community care, it reveals that the process has been more complex and more open to conflict and misunderstanding than a model of simple historical progress would suggest. Instead, we see that certain patterns of service continue to be significant throughout periods of structural change, and that certain basic features of the approach to care (such as the association of care with control, or the symbolic associations of different therapeutic

forms) are present in differing historical periods and in different institutional settings.

Despite the rise of the public asylums from the 17th century, institutional treatment of deviants in general was only gradually separated out into special institutions for the 'insane' during the 18th century. The Poor Law distinguished in principle between the able and the helpless poor, but little effective difference in the conditions of paupers, whether the old, the destitute or the "mentally inadequate" existed. Jones views the establishment of asylums, and their legal framework, as a reformist response to growing public concern about neglect of such people, [Jones 1972 p60] and hence asks why the promise of early reform moves was not realised, so that asylums themselves became the eventual object of reform movements. In contrast, Foucault and Scull saw the rise of the asylums as a particular and important aspect of a wider history of exclusion of certain moral categories of people and stressed that they were concerned with concepts of order rather than of medicine, arising as one of the answers to broad economic change and crisis. It was in the context of the confinement of the socially 'useless' therefore, [Foucault 1967 p46-62; Scull 1979 ch.2] that the 18-19th century concept of madness emerged.

Although the asylum, as characterised by Foucault, instituted a notion of madness as non-being, a sort of social death, treatment within it responded to the fears of madness as non-reason. The first asylums were characterised by regimes of discipline and brutalisation rather than morality or cure. Therefore, while Jones saw brutalising treatment as an abuse of the asylum model, eventually to be corrected by reforms such as moral management and the development of medical treatment ideologies, Foucault saw the regime as being inherent in the development of the asylum.

Sedgewick, in his criticism of Foucault's "anti-history of psychiatry" [1982 ch.5], argues that Foucault concentrates too much on the ideas of the literate, so that the key sociological points are not brought out enough - that the patient tended to be put under another's domination,

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confined and prey to unfounded remedies or simply left to decline. He
argues that:

"what is surprising in history is the capacity to provide quite different
rationalisations for remarkably constant practice." [p 137]

Nineteenth century growth and reforms, moral management and psychiatry

During the nineteenth century the numbers and capacities of public
asylums grew to a massive scale. Friern Hospital, for example, was built
in 1851 as a model institution for 1,250 inmates, but within 10 years
had doubled its 'population'.[2] Ideas about community care were expressed
in the mid 19th century, in response to overcrowding, pressure to
restrain costs and the consequent decline in optimism about asylum care.
Jones [1972] notes that despite the work of key individual reformers to
improve the conditions of inmates, the main concern was with:

"protection of the sane from conditions which were considered suitable for the insane"
[p154]

Within the asylums themselves, the most significant reform movement was
concerned with ending the brutalising conditions of life and treatment,
by removal of physical methods of restraint. 'Moral management' was the
alternative model for the asylum regime. Jones [1972 ch.5] argued that
the approach was a straightforward answer to the abuses and failing of
the asylum regime in the nineteenth century, but that it did not fit the
prevailing mood of the time, with its concern for controlling costs of
institutions. The asylums were still essentially poor law institutions,
resting on ideas of deterrence. These historical problems of
responsibility, incorporating ideas of moral fault or blame, remain
relevant to the present day problems of transferring responsibility for
patients between the health and social service and voluntary or private
sectors.

In the moral management approach, the presence of fear was still
utilised, since the threat remained that if a calm or manageable state
was not maintained, restraint could be used. What had been the

therapeutics of the 18th century period, were now the punishments of the reformed institutions. [Foucault 1967 ch.9] At the same time, the idea of responsibility for madness was being increasingly seen as within the individual. The stress on moral responsibility also included stress on activity, confirming the wider moral notions of the value of work. A parallel can therefore be drawn between the moral management approach and an attitude to the role of the day centre in community care, where work is assumed to have a value for the psychiatric patient, almost regardless of its content, social value, financial rewards or or its meaning for the individual. [3]

Foucault also saw the moral management model as based on the inmates' moral and judicial minority, so that the asylum model became closed upon fictitious family values. [1967 p252] Skultans describes aspects of the regimes and writings of reformers which stress the need for order and supervision in the maintenance of control. [Skultans 1979 p58-59] She sees moral management as a rediscovery of the humaneness of the insane, [p61] yet the growing public asylums, fed by poverty and industrialisation, remained relatively untouched by such reforms.

The argument about the moral management approach is important for community care reform, because it is concerned with forms of care and control. On a broad level, moral management appeared as a straightforward and liberating reform - the replacement of cruel and brutalising forms of restraint with less violent forms, while it instituted more moral and socialised forms of control. Similarly, in community care developments, the control represented by the institutional regime is not removed, but altered and replaced by a new emphasis on normative behaviour and resocialisation. Care is provided within a structure, which aims to remove institutionalism, but which utilises both moral values and fear (e.g. of being returned to hospital or of being asked to move elsewhere) to maintain order. The vulnerability of the residents and the continued existence of legal and more physical forms of compulsion form a backdrop to the constitution of the group home as an alternative model of care.

It has been suggested that the impact of the moral managers was limited by the establishment of psychiatry in the nineteenth century as a branch of medicine. [Baruch and Treacher 1978 ch. 2; Foucault 1967 ch. 9] This role was not based on the existence of medical therapies so much as the wider influence of positivism and the general establishment of medicine as an increasingly effective response to certain types of illness. The mechanistic paradigm of the late 19th century, therefore, encouraged a move away from the moral management approach to a biologically and individually reductionist one. Perelberg [1985 ch. 2] saw the psychiatric institutions as emerging out of a struggle for control between the legal and medical professions. Scientific explanations for insanity were sought after insanity had been defined as a specific type of deviancy and psychiatry came to occupy a mediatory role between the public and private domains, creating institutional relationships between them.

The movement towards community care

Mangen [1985 p1-8] has pointed out that some very long standing models for community care, such as the Gheel settlement, exist. Concern about asylum abuses in the 19th century led to some attempts to set up care facilities outside the asylums.[4] Scull [1977 ch. 7] outlines a number of structural reasons why a 19th century decarceration movement did not come about in response to such criticisms. One factor was the emergence of the medical profession and its need to maintain an institutional base for psychiatry. Several economic factors were also important, grounded in the Poor Law's institutional basis for relief: the asylums protected relatives and communities from the burden of unproductive or difficult members, in the absence of any welfare state to support them. Furthermore, the asylums, many recently built, represented an enormous emotional, intellectual and material investment. Thirdly, there was the continued public fear of madness.

The origins of the community care reform are generally traced to the Royal Commission of 1924 and the resulting Mental Treatment Act of 1930. The Act introduced voluntary treatment, and the principles of outpatient

and aftercare for psychiatric patients. Although it created responsibilities for local authorities to provide alternative forms of care, these were not mandatory, and in a period of increasing unemployment and social distress, and in the continuing absence of a comprehensive welfare system, were unlikely to lead to much development. Although the perspectives of the key professional groups differed, the Act was hailed as a long overdue reform which would revolutionise the system. The emerging concept of patienthood was seen as beneficial, and with a classless image, rather than problematical.

In the 1940s, the impact of the second world war on social thought, the 1942 Beveridge Report on social inequality and the subsequent creation of state welfare and health systems, had profound effects on mental health provision. With the National Health Service, asylums were brought further into the hospital system, and the model of psychiatric units in general hospitals came to the fore. Clinical models of care began to extend to wider categories of disorder and more widely into National life. [Castel, Castel and Lovell 1982 p171-174] A division of services into hospital, local authority and GP services was instituted, forming a barrier to community service development, while the responsibilities of local authorities in the NHS Act 1946 remained voluntary, leading to great variation in practice. [Jones 1972 ch. 10]

The role of the voluntary organisations in mental health care was also developing in this period, outside the dominant hospital system. Several organisations amalgamated to form the National Association For Mental Health, now known as MIND and a number of new organisations concerned with mental health or illness emerged. The voluntary sector developed in the tradition of providing alternative, community based services and of campaigning for improvements in mainstream service provision.

The numbers of people resident in psychiatric hospitals peaked in the 1940's on a massive scale, leading Scull [1977 ch. 4] to argue that moves towards community based care had more to do with economic and practical pressures, than with reform. In the 1950s inpatient numbers decreased through an open door policy and decreasing lengths of stay. Both Ramon

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[1985 p150-162] and Scull [1977 ch. 5] argue that the common explanations for decline in hospital numbers, linking it particularly to the 'drug revolution' are misconceived in their focus and chronology. The decline in numbers began and gathered pace before the widespread introduction of psycho-active drugs and without any firm evidence on their effects. The 'open door' policies were encouraged by critiques of the asylum as a 'total' institution and by the ideas of the small but relatively influential numbers of 'therapeutic community' programmes set up within psychiatric hospitals. [5]

Early sociological studies, suggesting that the new drugs had few long-term therapeutic effects for patients, had very little impact on the professional response to drug treatment. [6] They found, however, that a new therapy could have a significant impact on the regime, encouraging the new open door policies, and creating a renewed sense of confidence in the effectiveness of treatment and the possibilities for earlier discharge. Despite the lack of precise knowledge about its effects, psycho-active drug treatment came to be seen as essential both to psychiatry and the possibility of care in the community. The faith in this and earlier treatments were bound up with the continuing need experienced by carers to provide an institutional order and a therapeutic rationale.

Community care and the background to hospital closure plans

From 1949 the hospital population began to decline (from its peak of 0.35% of the population in 1946), with shorter stays in hospital, but higher re-admission rates - what eventually came to be known as the 'revolving door'. Given that this period is seen as the one when open door policies gained ground and community care began to be implemented practically, it is important to ask why so little progress has been made in provision of community based services since then.

In Scull's view the impetus for change was not therapeutic or ideological but essentially economic: the arguments for community care

had not changed, but the context had. He argues that as the welfare state became established, the costs of institutional care became relatively high, and the calls for reform led unit costs of hospitals to increase, while changes in the benefits system made it easier for vulnerable people to remain in or return to life outside. [Scull 1977 ch.4 & 8] In my view, his suggestion that there is a single "real" explanation is an oversimplification of the issues — economic motivations cannot be separated from ideological motivations in this way.

A key problem in bringing about a commitment to resources and planning is the underlying incompatibility of the still dominant clinical/somatic model with the concept of community care. [Ramon 1985 p276] Scull asked why the community idea got so much response, despite running counter to the interests of the clinical professions, concluding that the answer must therefore be the dominance of economic motivation. However, the pattern of change shows that it was largely in line with the interests of the medical professions, focusing particularly on reintegration of psychiatry into the local/community health service, and transfer of the custodial and social care roles of the asylum to community homes of various types. Busfield [1986] argues that:

"in part, this was a reiteration of the old argument of ensuring that hospitals should be used for their proper therapeutic purposes and not end up merely providing a home for those with no suitable place to live." [p342]

The Royal Commission of 1954 was basically conservative, resulting in little change from the 1930 position. Although it recommended that implementation of community care by local authorities be mandatory, the subsequent Mental Health Act 1959 did not take on this aspect. The phrase 'community care' was often used but not worked out. There were ideas about hostels, day centres, domiciliary services and general hospital wards, but the ideas were unsystematic and did not lead to a plan for implementing such ideas. One influence, Ramon suggests, on the lack of input, was the hope that by controlling symptoms and minimising hospital stays, drugs would somehow do the job. [1985 p274] This sort of faith was reflected in the 1971 Government Memorandum, 'Hospital Services for the Mentally Ill':

"people go into hospital with mental disorders and they are cured and that is why we want to bring this branch of medicine into the scope of the 230 district general hospital units."

At the end of the day institutionalism continues to be viewed as a personal quality of vulnerable people [Ramon 1985 p293] and not of the contexts in which they live. This is an important point, because the approach to de-institutionalisation *has* had a profound influence on the detail of the current hospital closure plans, and perhaps on the increasingly negative media/public view of these changes. This study shows how changes in environmental regime can take place - dehospitalisation - without fundamental changes in the relationships involved, particularly in terms of relative power and responsibility, so that some of the key features of institutionalism are maintained. In this context, where professionals also have the power to define and redefine the situation and the motivations of the client, it is possible for the professional view to be reasserted that "it is the institutionalism of the residents which is creating an institutional environment in the home".[7]

Much of the impetus for community care, among medical staff, was placed in the development of district services such as units in general hospitals (DGH units). Baruch and Treacher [1978 ch.4] argue that they were seen as a way of combatting stigma, keeping the patients closer to their local community, and also as a way of bringing psychiatry closer to general medicine. The 1970 Conservative government anticipated complete abolition of mental hospitals within 15-20 years, with DGH units and outpatient clinics replacing them and the rest of need to be covered by community treatment. This general principle is still operating in the current closure plans - acute wards are to be relocated to general hospitals within the catchment areas the asylum serves, while the majority of long stay patients are gradually transferred to residential facilities, with any continuing treatment (normally medication) to be handled by the GP or the psychiatric outpatient clinic, supervised by the community psychiatrist.

The period has been one of expansion by psychiatry into increasing areas of life, increasingly defining social deviancy as mental illness [Conrad 1981]. Brown [1985 p158] notes an increased emphasis on control of symptoms, an emphasis which has carried over into non-medical community care facilities. This study suggests that such concerns may lead to a general orientation around the fear or possibility of workers losing this control, which has been perceived to make community care possible.

The 1975 White Paper, 'Better Services For The Mentally Ill', [DHSS 1975] which is still referred back to as a key policy statement, described psychiatry as "coming in out of the cold." It argued for the basic validity of community care policy, "a philosophy of integration rather than isolation" [p 17] but without specifying what its base should be, in terms of finance, detailed content or conceptual base. The main strategy was expansion of local authority personal social services, including residential, domiciliary, day care and social work support; these to be locally based, with good links between different aspects of the service and with a multi-professional approach to planning of care. It recognised that a local base doesn't automatically mean integration, but remained optimistic that "deep rooted" fears would be changed by "a steady increase in awareness that mental illnesses are illnesses" [p 18]

The paper, therefore, advocates a move into the social service sector, while retaining a view that the key to progress, in terms of positive attitudes, is the recognition of mental illness as fully within the sphere of medicine. It notes that much positive work is needed to help ex-patients in trying to become less isolated and preventing a continuation of life inside, and argues that volunteers should not be seen as a means of filling gaps and deficiencies in statutory services, but as having a distinct and complementary contribution. Despite setting out a structural framework for community services, little attention is paid to their content, and basic contradictions in its philosophical approach are not recognised. [8]

Since the White Paper envisaged community care policy as resting upon a publicly provided system of care facilities, it was also more cautious

in its projections than the 1971 paper, [Busfield 1986 p348] arguing that hospital closure plans were likely to be set back because of the piecemeal development of services so far, and by the prospect of increasing financial stringency. Ironically, Mangen and Rao [1985] show that the NHS reorganisation of 1974 transferred community health services *from* local authority to health service control, with the aim of a more unified system. This reform was then directly opposed to the aim of greater responsibility for community care on the part of local authorities.

The 1981 Consultative Document, 'Care In The Community' [DHSS 1981] exhorted health and social services to increase efforts to provide alternatives to psychiatric hospitals. Mangen and Rao argue this was pushed by the realisation that a number of the hospital buildings were near the end of their lives. It directed that one third should be closed over a ten year period. This new urgency came alongside a policy of central cutbacks and controls on social service and health spending.[9] Both the local authority/health districts covered in this study experienced rate capping and health spending constraints during the hospital closure period.

Busfield [1986 p351] also refers to the 1981 'Care In The Community' document's emphasis on private and voluntary care. She argues that, whereas in the mid-seventies economic forces limited policies of community care, which were quite widely agreed upon, since 1979 ideological changes have encouraged an economically motivated pursuit of such policies. Fowler, as Secretary of State for Social Services, agreed with the "general thrust" of the 1975 White paper, saying that it was now time to close those hospitals which are not well placed to provide a service reaching out into the community. [MIND 1983 p5-8] The hospitals' staff, capital and revenue were given as the source for developing a new pattern of services, aided by a revised joint finance scheme and permission for NHS districts to transfer money with patients on a lasting basis, to other facilities.[10] He stressed the role of voluntary activity in the new services, introducing the 'Opportunities For Volunteering' scheme as a means by which unemployed people could be

encouraged to provide voluntary care. He also made clear that no extra money would be available to facilitate change, or to fund public services in general:

"the problem of demand outstripping resources - which faces all health care systems, is going to remain. This problem means we have to be prepared to make choices - often difficult choices - and also to look very hard at the way we spend the money we do have." [p 7]

In 1986, the Audit Commission reported that money now put into institutional care, particularly hospital care for the elderly and mentally ill, was not being used to provide optimum care relative to costs. It argued that good quality services could be provided, on a wide range from domiciliary support to staffed homes with varying degrees of staff cover, on similar levels of finance to that required by hospital care. In response to this challenging report, a study was set up, culminating in the Griffiths Report [HMSO 1988]. It was to report on how, within the current levels of finance, community care should be organised. Griffith's proposals, echoing earlier ideas, included the arguments that the role of the NHS should be focused on treatment functions - on health care per se rather than wider social care - and that community provision of the latter should be managed by local authorities, using private and voluntary facilities, rather than concentrating on being sole, or even the main, providers. His study was undertaken during the course of this research and had clear implications for the future of the existing hospital closure programme, but government response was delayed until August 1989, finally announcing a guarded agreement to take up some of his recommendations. [DHSS 1989]

This outline account shows that a general and vague policy of community care has been advocated, by a succession of different governments and throughout periods of great social change, despite (or perhaps due to) being conceived in a 'woolly' fashion. It has been influenced over the period by critiques of institutional care, but an overall positive policy for alternative services, based on these critiques, has made little headway, when the weight of arguments and policy statements are considered. Two key problems appear to have arisen in the practical

realisation of the policy, which are effectively very closely interrelated: that of the ideology of community care and that of its funding.

The conceptual contradictions surrounding the provision of mental health services are reflected in the varying meanings which can be attached to the term community care. [Bulmer 1987 p13] The very term, mental health services, follows the underlying assumption, confirmed throughout this period, that optimum care can be achieved by full integration into the health service. Just as in the 1930's, the classless image of illness (despite the lessons of the public health movement) appealed to social thinkers, more recently the idea of 'mental illness' being accepted as illness, just like any other, has been seen as the key to improvements in public attitudes and public services while psychiatry has continued to command a proportionately smaller share of budgets than general medicine.

Within the policy of community care therefore, we can perceive three rather different movements: the psychiatric movement for integration, via more locally based health facilities, and concentrating on acute treatment; a political movement for redrawing the boundaries of public services into a more private sphere of care; and a critical social movement for the integration of care into a more socialised system of care and support, with medical treatment more limited in its field of influence. Successive governments have tried to pull together these movements, despite the contradictions between them, and particularly in recent years, despite the fundamental limitation on provision of health, public housing or social services by fiscal policy. [Korman and Glennerster 1985 p8]

Historical accounts show that a bias towards institutional care (confinement) is long standing and greatly resistant to change. Perelberg [1985 ch.6] suggests that the idea of moral fault is closely linked to the history of welfare institutions. This pattern can be traced through the Poor Law and the developments in the asylums, to the current system of welfare and the apparent difficulties in introducing a

non-institutional, or 'community based' structure for care. Welfare institutions are still characterised by attribution of *blame* to the victim, while moral inadequacies are seen as the root of most social problems.

The role of the voluntary sector in community mental health services

Much of the work on setting up innovative community based services, (in addition to their role in campaigning for community facilities and in promoting greater knowledge in the field of mental health) has been undertaken by voluntary organisations. Examples include Maca hostels, Richmond Fellowship's therapeutic communities and half-way houses, MIND's social clubs and group homes, and many small projects run by locally based organisations, including the group homes, day centres and restaurant clubs run by the voluntary organisation in this study. While structural and resource problems, as well as lack of motivation on the part of many local authorities have hampered the development of such facilities, voluntary organisations have become key providers of community based services, alongside, or even instead of, statutory authorities. The range of approaches within the voluntary sector is quite wide, so that no one organisation can be said to entirely characterise the whole sector. They are often viewed, or view themselves, as being more democratic, less bureaucratic and more representative (of the community or the clients) than statutory authorities. This study suggests that this is not necessarily the case – depending on the management structure, for example, power may rest with only a few key staff members.

Avebury [MIND 1983 p8-11] notes a contradiction between the belief that the voluntary sector should remain financially independent, resting largely on voluntary giving, and its role in provision of essential and permanent services. She points out that the voluntary sector is better in terms of speed of operation and flexibility or variety, with the advantages of ordinariness and reciprocity. In contrast, she notes the statutory sector is advantageous in terms of training and access to

records. Voluntary organisations, which for these sorts of reasons, are now providing long term residential services, linked to hospital closure and financed partly through closure funds, are being drawn increasingly into the statutory sphere of service provision and planning. In this context they are in a rather ambiguous role alongside health authorities or social services, where they may be seen as like junior partners, and are subject to the insecurity of short term renewable funding for long term projects. [11]

Heginbotham [MIND 1983: 57-60] argued that the NHS must provide the bread and butter, allowing the voluntary sector to remain innovatory and challenging, and to concentrate on those areas especially suited to volunteers, such as befriending schemes. He also stressed that voluntary organisations and volunteers aren't interchangeable - the former can't do their jobs without money. It is important to be aware that the majority of voluntary sector projects, providing basic services, have relied on paid staff and are increasingly characterised by paid staff rather than volunteers. As they are drawn further into community service provision, such organisations, particularly the larger ones which have been given a say in planning and policy, are increasingly similar to the statutory authorities in their structure, and increasingly distanced from 'the community' in any practical sense of continuing dialogue or interaction. [12] At the same time, recent developments in the statutory sector, such as decentralisation or 'going local' have allowed their 'community' schemes to move increasingly towards the structures and ideas used traditionally by voluntary organisations: a smaller local scale, avoidance of distant and complex bureaucracies, input from volunteers and neighbourhood groups and a less top-down approach to decision making.

Heginbotham argued that it is unfortunate that philosophies of community care and of monetarism should have become current at the same time. This pattern suggests that community care is envisaged as a more individual, privatised, rather than socialised care policy. This can be related to the continuing cultural tendency to see mental illness as an individual problem, divorced from social influences or conditions. He pointed out

that services have always been underfunded and remained so. His concern was not only with funding however, but with the forms of care and the structures through which they are to be provided:

"if a major role of the voluntary sector is to provide imaginative services which are then transferred to the statutory services, any reversal of the process negates the whole idea of a catalytic and innovative approach." [p 59]

The current hospital closure programme

The closure policy has been aimed particularly at the larger Victorian institutions. In London, these form a ring, which was originally quite remote from the metropolis, each serving several local authorities and health districts. This led to the relocation of people from London boroughs to a geographically and socially isolated setting. The group homes, hostels and other schemes for rehousing the current patients are attempting to reverse the direction of the physical and symbolic transition made in becoming a patient. The experience of those making the transition - the benefits and problems involved - needs to be understood within its context. Following on from the historical background set in this chapter, the remaining sections outline the local socio-economic and planning contexts in which the move took place.

The two hospitals chosen for closure were to test out the possibilities for developing an alternative service model. For this reason large scale and detailed research is being conducted, and the local situation should throw light on the debates about community care and the role of the asylums outlined above. Two key contextual points regarding the closure should be taken note of: firstly it is taking place in a situation of stringency and local cuts in health and social service finance; secondly, after years of rumour and discussion, followed in 1977 by the submission of a joint closure proposal by the relevant Community Health Councils, the Regional Health Authority made a clear decision to pursue a planned closure over a ten year period, asking each district to draw up and submit its own comprehensive plans for the new service pattern.[13]

In 1982, the Regional Health Authority published a consultative document considering a cost/benefit type analysis of the possibility of closing some (two out of six, in line with the proposals of the 1981 government paper) of its larger psychiatric hospitals. This shows that both finance and quality of provision were factors considered. [14] The two hospitals chosen were found to be relatively expensive in unit costs, to have a high land value and to require very expensive upgrading or repairs in the near future. In terms of service provision, (using the 'Yates Indices' of potential risk factors) both were ranked as low standard, but not as 'highly at risk'. It is likely also that the closure decision in respect of one hospital was encouraged by the bad press it had received on quality of care, administration and protection of rights, [Greenberg 1977] despite being the most 'expensive' hospital in the region. It appears therefore that where concerns about service quality combined with significant economic motivation, a closure plan was implemented.

The overall aims of the plan have been to replace hospital care with residential and day care for each long stay patient (long stay is marked at one year plus) and to replace the acute wards with more locally based wards, providing the same number of places. The group homes studied, therefore, are not isolated projects, but provide a particular facility which is now linked into a strategic plan for the closure in each district.

The local service plans

The process of drawing up the plans in each district is discussed in chapter four, reflecting how closely they depend on assessment of needs. The slowness of plans to emerge has been related to initial problems in securing broad agreements, [Korman and Glennerster 1985 p35-40] particularly between different professional groups, on which to move forward, [see chapter four] but was also affected by the prior lack of appropriate planning structures, and lack of any really adequate information on which plans could be based. Additionally, health

authorities and social services were now expected to work together in a new way and to plan jointly, on the basis of potentially quite divergent ideas, at a time when their respective management structures were already undergoing change.[15]

In Islington, the Health Authority formed a provisional plan by 1985, which was to be revised according to assessments of needs. To progress plans, they created development posts, including an officer to work within and provide a link with the local social service authority. In addition to existing planning teams, a 'Task Force' was set up, to advise, monitor and progress the closure, involving representation from hospital staff, health authority and social service managers, and from the more established voluntary organisations.[16] Within the strategy, accommodation was given the initial priority, with a plan drawn up for accommodation of the 'baseline population' in different facilities with varying levels of support.[17] At the end of 1985 Friern's Islington sector had approximately 293 beds as follows:

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Acute admission           -  28
Long stay/rehabilitation  - 134
Long stay/psychogeriatric - 104
Psychogeriatric assessment -  27  (shared with Bloomsbury)
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Within the borough a partial, basic community mental health service was already in place. The district general hospital provided three psychiatric wards for thirty people each, plus fifty day hospital places and a team of ten community psychiatric nurses. The local social services provided three psychiatric day centres, with a total of eighty places, nine part-time social clubs, six long term group home places and twenty short term hostel places. Three local voluntary organisations provided a social club, a group home and 25 sheltered flats. A specialised social work team at the psychiatric hospital provided support to in-patients and was already actively involved in rehabilitation work, and with local teams, in providing some follow up support to patients already leaving hospital. These figures show that a higher degree of community health and social services existed here than in many areas, but local providers have stressed the extremely high level of unmet need existing in the area. These facilities were for

people leaving hospital after a short stay, or for those already living 'in the community'. Only the local authority day centres were able to provide places for a limited number of long-stay patients who left early in the closure process.

The provisional plan for residential facilities was adjusted to take acount of assessed need at the hospital as follows:

1. Individual accommodation   - 30 places
   (20 of these for short term patients).
2. Group homes, with 24 hour staff cover   - 25 places
3. Group homes, 24 hour nursing cover   - 20 places
4. Adult care (fostering)   - 20 places
5. Group homes, day staff cover   - 15 places
6. Hostel ward (in DGH unit)   - 13 "
7. Low need for cluster, ordinary hostel and
   local authority elderly people's homes.

Facilities for 'psychogeriatric' patients (i.e. elderly people thought to be mainly suffering from Alzheimer's Disease) were to be divided into approximately 40 to 60 places in a new unit at the general hospital, while the remainder would move to highly staffed group homes run by the local authority. In the provisional plans, need for adult care and hostel ward places had been significantly over-planned for and individual accommodation had been significantly under-planned, while the remainder were close to assessed need. Monitoring of places was ongoing, as newer patients who stayed longer than one year became incorporated into the category of 'closure patient', so that the closure programme has to keep pace with the continuing mental health problems within the local community. [Margolius 1988]

Within this overall plan, the role of the voluntary organisations, by general agreement, has been primarily in setting up and managing group homes or sheltered flats with general care or support staff. Partly due to the initiative of the voluntary sector, and its greater speed in setting up such projects, they are now providing a large proportion of such residential places, while the remaining group homes and flats are managed by the local authority and the most intensively staffed, ostensibly more 'medical' facilities, are to be provided by the health

authority. Existing accommodation plans, including those in operation and those being built or converted, provide places for the majority of patients, while a small number of places are still under consideration, with the hope of being able to plan them in line with final assessments of need.

In Haringey, the plans for community based homes, have been slower to develop, but along a similar pattern. The process was complicated by the need to deal with both hospitals, and provide facilities for a larger number of patients in a geographically more extensive area. Detailed planning in the early years was also hampered by the lack of knowledge of how many patients they were responsible for or consequently what the needs of those patients would be. The main model employed in planning has been of the 'core and cluster'. This involves a small number of centres (core units) which incorporate intensive rehabilitation facilities, accommodation and day care, on a flexible time-limited basis. Linked to these cores, are a number of smaller, more dispersed housing projects, which are less intensively staffed. Residents in the 'cluster' homes have moved straight from hospital or via the core units, depending initially on the timing of project developments, although theoretically it was to be based on the differing needs of patients.

In both districts there has been a gradual and difficult process of health and local authorities working out shared strategies. [Tomlinson 1988a; Korman and Glennerster 1985 p77-84 & p128-9] Between the districts, a key difference is apparent in approach to use of one hospital site. Islington health and local authorities agreed to locate all facilities within the local area, without retaining use of the old hospital site. Haringey health authority, in contrast, is placing considerable resources in redevelopment of part of the site, to create a new, smaller and more specialised psychiatric hospital, with residential and sheltered work facilities. Considerable frustration and doubt was expressed by local authority staff, during the planning process, as to whether a coherent, community based service would be created.

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Plans for day care (in both boroughs) have followed a similar course to those for community based homes, but have lagged behind, reflecting the initial concern to find somewhere to live for all long term patients. As patients began to move into new homes, however, concern increased about the slowness of development and its effects on the quality of life, and choices open to these residents. [The implications of this pattern for the group homes are explored in chapter 7] As with accommodation, the range of day care envisaged has been broader than options available to patients in the hospital. Plans for 'work centres' have emerged out of local debates on the merits or disadvantages of the hospital-style industrial therapy units. Future clients will be able to attend industrial style workshops, or sheltered work co-ops offering more varied training and experience. The plans also include new social clubs on the model of existing voluntary sector facilities, and structured rehabilitation centres.

Within this general concern to provide adequate facilities, for something to do during the day, the issue of what type of activity has, therefore, been explored, but the question over the need for activity which will encourage integration in the locality appears to have been passed over. Furthermore, the question of what choices residents have between such centres is unclear - the residents in the study were presented with little choice, both due to the lack of a range of facilities locally and due to the approach of care staff. Within Islington's day care planning group, a small group of professionals looked at possible social facilities and suggested that social clubs should be sited, as far as possible, in existing community centres and should stay open out of office hours. Within the planning process, social clubs, despite being popular with clients and relatively cheap to run, have received relatively low priority.

General services in each district will be run from local 'community mental health centres'. These will become the point of referral to the mental health services and the working base for mental health professionals, who are expected to work together in a 'multidisciplinary approach'. These centres are also intended to co-ordinate and promote

the activities of local voluntary groups working with mental health problems.[17]

In theory, the staffing for community services is largely transferred from the hospital base. Plans for staff retraining, job protection policies, and interviews with all hospital based staff on their preferences, have only recently been instituted and very few nursing staff have been re-employed in community homes so far. Staffing in existing group homes (most of which are managed by voluntary organisations) tends to come from people with existing experience of community based services or people who are new to the field and interested primarily in social care.

Within the two districts the strategic roles of the voluntary sector have also followed different patterns of development. Larger voluntary organisations, several operating in both boroughs, have set up consortia to represent, co-ordinate and promote the role of voluntary organisations providing mental health services. In Islington this has involved a small number of organisations who are service providers, particularly those involved in the closure plans, and has been focused particularly on improving the voluntary voice in planning and the stability of its role in service provision. The organisations retain differing philosophies and service aims, and thus have not pursued joint projects. In Haringey, a wider range of voluntary organisations, including housing associations concerned with provision of supported residential projects, have set up a structure for joint provision of mental health services. Consequently, voluntary provision of closure projects is now initiated and managed via the 'consortium', with its own joint staff and relatively secure funding from statutory sources.

This more structured consortium appears to respond to some of the key philosophical and practical problems which have arisen for voluntary organisations in the course of the hospital closure: it allows organisations to be involved in service provision, without detracting from their other roles, such as campaigning on mental health or local issues and continuing to provide services to the wider community who are

not helped under the closure programme. Smaller organisations can more easily become involved, while retaining less bureaucratic or more community based management structures, where they are not required to assume full responsibility for managing essential services. In this structure, the larger scale funding can be more securely and centrally based, while allowing different organisations to retain their identities.[18]

The voluntary organisation: background and structure.

The voluntary organisation studied here, which I shall call 'Community Rehabilitation Trust' (CRT), began as a charitable trust in the 1950's. It grew out of an "action research project" in London, which led to the setting up of one of the earliest hostels in the London area for rehabilitation of psychiatric patients. CRT operated for many years with a small paid staff, plus a team of volunteers. In addition to several group homes with visiting staff cover, they ran weekly 'evening clubs' which were run by local volunteers and three 'day centres'. These were based in existing buildings, such as little used church halls and required a low level of support from statutory authorities.

CRT lays great stress on its long experience and early establishment in the field of community care. The letter-headed paper is updated annually to reflect its increasing years of work. A sense of continuity in the 'ethos' of the organisation is also carried by the small and stable management team, and passed on through staff selection, 'on the job' training and supervision. Until recently, CRT continued as a small scale organisation, in terms of personnel, management structure and scale of its housing projects, but was regarded in its areas of operation as one of the more established examples of 'community care'. Since 1983, when the closure policy was announced, the organisation has gone through a period of rapid growth, with new service demands and pressures on its way of working.

As the plans for hospital closure developed, the Director took an active role in Joint Planning and consultative bodies, and initiated plans for several residential and day care schemes. Three group home projects were planned in those boroughs where CRT was already involved in service provision in some way, but the hospital closure plans have made a greater impact on the organisation's work than may have been anticipated in these plans. The key difference for these new projects was that they would cater for people who, in theory at least, were only leaving hospital because of its closure. (It is likely that many would have left long ago if adequate alternatives had been available for them.) Therefore they were to have residential staff, providing all-day or, in one project, 24 hour care, to cater for the greater need for rehabilitation and support among the 'old long-stay' hospital population.

The closure programme led to a significant increase in the numbers of paid staff and the number of projects managed by the organisation. It does not operate on a committee structure (which is common to many voluntary organisations) but is managed by a small directorate, acting for a board of charitable trustees. Likewise the number of administrative staff is very low. The majority of employees work in the new group home projects. This structure, being less bureaucratic than those of much larger organisations, allows for fairly rapid and effective decision making, but offers surprisingly little linkage between the residential and managerial levels. In a small organisation, communication had been maintained by direct, formal and informal contact between the few workers and managers. As numbers grew, however, increasing levels of staff dissatisfaction developed, where residential workers felt they had no means of contributing to management on the basis of their daily experience and their knowledge of the residents. Similarly, they felt confused about the extent of their authority and responsibility and occasionally resentful at carrying through policies which were initiated at management level and which they felt were inappropriate or inflexible at the ground level.

In the course of the development of the closure projects, pressure on the structure of the voluntary organisations appeared to increase, with the increasing scale of work. Because of their effectiveness in planning and decision making, voluntary sector projects were operational very early in the closure process, at a point when statutory authorities were still trying to work out their principles and strategies for joint development work. This meant that voluntary organisations bore the brunt of the problems in developing a shared closure strategy.

The finance for the group homes, as with all closure projects, was provided partly by the health authorities, through hospital closure monies. Housing development finance was provided by the Housing Corporation and running costs were partly made up from residential fees, relying mainly on DHSS board and lodging payments. This cut down considerably the cost of each place to the health authority, but led to a number of problems for staff and residents in coping with the unreliability and means testing of such payments. In terms of the overall closure programme, the funding for the projects was also low because of their voluntary sector management and the type of clients they were to cater for, being classified as "of low or medium dependency".

Group homes in the planning process

The idea of the group home is very much an embodiment of the concept of community care for voluntary organisations. The ethos of CRT, (as this thesis will show) is essentially paternalistic, which although it sees the group home within a framework of communal (particularly financial) responsibility, models it on an ideal-type family structure. In this approach, it is not supposed to be seen as an 'institution'. Planning categories, however, do not reflect the philosophy of community homes as like ordinary housing: group homes which have more than four or five residents, or a high staff input, are not categorised as residential in the ordinary way, but instead as a separate 'hostel type' category. Such planning categories, one could argue, enshrine the idea that psychiatric

patients do not 'reside', like ordinary people, and do not share the same residence rights within the local community.

Two of the group home projects studied, in three small houses, did not require 'change of use' permission under current planning law, because of their small size and the retention of the original 'family home' layout. The third, which had seven residents and a higher staff ratio, was obliged to apply for change of use from residential to 'hostel type' despite the aim that it should provide a 'home for life' and the expectation that the majority of residents would not want, or be able, to move on to independent living. It seemed to be neither a 'home' in legal terms, nor a 'hostel' in terms of the common understanding of hostels as temporary and relatively impersonal accommodation. The voluntary organisation, quite justifiably I feel, took the view that people leaving psychiatric hospital should not have to ask their neighbours' permission to move home. However, this failed to acknowledge the contradictory reality that although pursuing community care ideals, the 'community homes' retained institutional characteristics which could be used to set them apart from ordinary housing.

Existing studies of community attitudes [Dear & Taylor 1982, Cumming E. & J. 1957, Segal & Aviram 1978 ch. 10] suggest that social attitudes are not rigid in the way we might assume, but that local people may be worried if they are given the impression that something presents a threat to the neighbourhood. The statutory authorities in Islington adopted a different policy of public information and education about their projects, designed not only as planning consultation, but to encourage local tolerance and support for the moves. In some localities churches, tenants associations and community centres are being involved, to offer contacts outside the psychiatric sphere. Dear and Taylor show that public responses vary in differing neighbourhoods, (as well as according to the characteristics of the facilities) and that areas which are neither very close knit and isolated, nor very deprived areas with unstable population, are generally relatively accepting of such facilities.

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If ex-patients are to have a chance of social integration, and not simply to be hidden away within community psychiatric facilities, these issues will need to be addressed further. The residents of the group homes studied remained fairly isolated people, although for some family contacts improved considerably. Although this study (for reasons given in chapter 1) has not investigated local attitudes, it does suggest that the planners of group homes need to reconsider their status in terms of ordinary housing and within the locality.

The residents of the group homes studied came out of hospital to a situation of partial and uncertain development of community mental health services. Although, in a sense, they represented the most positive support for returning to 'community living', the professional support for their move, among the earliest in the process, was relatively low. The chapters to follow will explore in depth the nature of the transition and the home environment to which they moved, describing the important improvements in lifestyle they achieved, as well as the difficulties they experienced in living in a group home. In making this exploration, (just as in the learning process of the rehabilitation workers) we need to understand who the residents were, and how their life experience will have influenced the course of this major life change which they have undertaken.

NOTES TO CHAPTER TWO:

1. Jones marks the 1845 Public Asylums Act as the beginning of a
    period in which 'mental abnormality is recognised as a specific
    condition requiring a specific course of action.' [p XI]

2. Source: Halpern S., 1977.

3. The ideas of the voluntary organisation studied here, about day
    care [see chapter 7] can be compared with Noble's ideas in the
    1850's, quoted in Skultans [1975 p9], about the role of occupation
    in preventing lapses into insanity.

4. The National Association for the Promotion of Social Science 1869,
    quoted in Busfield [1986 p339].

5. These programmes were directly influenced by the work of special
    units for the treatment and rehabilitation of ex-soldiers in the
    1940's.

6. Freeman and Simmons [1963 p82-85] found that drug therapy had no
    long-term impact on the ability of patients to manage out of
    hospital or the rate of re-admission. They refer to several studies
    with similar findings and to the effects on nursing morale of the
    belief that drug therapy had been introduced in a ward, encouraging
    a greater willingness to follow an open door policy. They
    concluded, therefore, that drug treatment was beneficial because it
    had a major social function for staff responses.

7. Remark made by one professional involved in the closure. Not
    recorded verbatim.

8. Hughes [1979] criticised the white paper as too narrow in its
    perspective, and for failing to explore the extent, nature of, or
    reasons for, lack of adequate community provision.

9. The fact that, at 6%, the UK proportion of the GNP spent on health
    [Mangen and Rao 1985] is the lowest in the EEC, suggests that
    priority has not been given to spending on public health.
    Additionally, the Resource Allocations Working Party (RAWP) set up
    in 1976 to redistribute resources more fairly throughout the NHS,
    has been hard on the Inner London boroughs covered in my study.
    [See also Korman and Glennerster 1985 p34] These have experienced
    population decline coupled with an increasing proportion of the
    population suffering social deprivation, with consequent pressures
    on both health and social services. Mangen and Rao also note that
    the 1976 Joint Finance Scheme which was to encourage joint planning
    between health and social services locally, by tapering funding
    over a limited number of years, created uncertainty about long term
    funding of community services.

10. Now generally called the Dowry system - patients relocated due to hospital closure are supposed to take out, by means of capital or revenue transfer to community projects, the average cost of a year's stay in the hospital.

11. These points emerged from a series of meetings to follow up Peaker and Tomlinson's study of the voluntary sector role in the closure. [TAPS 1987 Unpubl.]

12. These points may be relevant to the recent responses to the Griffiths Report with emphasis on a 'mixed economy' of care. The likely effects on voluntary organisations of moving even further into mainstream service provision have not been fully considered.

13. A strong parallel is apparent with the Darenth Park context, described by Korman and Glennerster [1985 p7-8].

14. Glennerster and Korman describe how financial pressures, added to the growing awareness of the negative impact of institutionalism, tipped the balance in favour of closing a large hospital for mentally handicapped people. [p7] They also note that ideally, community based services should have been developing anyway, and gradually, but in effect they only developed because the hospital was closing. [p130]

15. These points are necessarily only a basic outline of some of the significant planning issues, since the closure planning was the background to, rather than the focus of this study.

16. From 1986 it also included one representative from a voluntary organisation run by and for service users.

17. 1985 baseline census of the hospital's long stay population, carried out by the TAPS team.

18. Islington Health Authority Consultative Document

19. This consortium was only in the early development stages during this study, but has since taken on development of all remaining voluntary projects in the district plans.

CHAPTER THREE:

PATIENTS AS PEOPLE

In this chapter I introduce the residents of the group homes, who they are, and where they came from. They came directly from hospital, but all had lives before. My argument is that the life histories of long stay psychiatric patients have been forgotten by carers, thus devaluing the patients as people. In terms of the case record, the patient's life is her/his illness, previous experiences being relegated to anticipations or signs of that illness. Now that the hospital is closing, professional interest in the patients' histories has been reawakened. Knowledge of the patients' lives before hospital, their abilities, problems or interests are now seen as tools for assessment and rehabilitation. However, I shall argue that the case record has been unable to provide the quality of knowledge which is needed to prepare for life outside the hospital. In this way the history of institutional neglect is leading to a resource failure, not just of material resources but of a knowledge base and conceptual framework for community care.

On oral history and reminiscence

Anthropologists have traditionally used oral history as a key part of their cultural knowledge. This is not only a result of studying non-literate societies, but also because the quality of oral history was found to have significant cultural roles. Oral history was a vehicle for religious and cultural traditions, for learning, and for mapping out social structures. Although it has become less valued in literate cultures, for ordinary people it remains an important means of conveying experience. A history which is composed entirely of official records is unlikely to fully represent the range of experiences, particularly of less privileged members of society, in a particular period. [1]

History telling and reminiscence is also an important means for individuals to construct their own, personal histories, to place themselves within events and to give them meaning. Reminiscence is now used as therapy in many wards for geriatric and psycho-geriatric patients, for these sorts of reasons. It is also valued as a means of easing life changes, such as a transition from home to hospital for a frail elderly person. If that transition is also one to a stigmatised status (i.e. that of the psychiatric inpatient) then it is particularly important for people to be able to recall and re-examine their personal histories, in order to maintain a personal identity which is not simply a part of the 'illness history'.

In this study I have concentrated on viewing history in this way, but I have also used the official 'summaries' of patients' careers, which the patients take out with them, as a means of comparing the two accounts of the person's life. This comparison shows that official histories provide a very poor basis for rehabilitation work. Such work could be based on the fuller, and therefore less distorted, basis of personal history, as used in the 'Getting To Know You' models of rehabilitation [Thomas and Rose 1986] This history can then be used not only as a means for contextualising and interpreting the clinical history of the person, but also as a means for approaching the move out of hospital and the rebuilding of a life outside. While a hospital patient [see chapters 5 & 6] the person's previous social identity was withdrawn and a *liminal* identity found in its place, which is tied inevitably to the role of psychiatric in-patient. Although the residents were always conscious of their 'patienthood' their histories remained with them as an important part of their personal identity, their memories and a basis for their future.

Group homes residents as part of the hospital population

This study has been very small and exploratory in scale, and therefore it is limited in its comparability. Nonetheless, the outline demographic data below shows that the individuals involved were fairly typical of

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the long stay hospital population in measurable ways. The three group home projects studied were designed to house up to twenty people[2] The resident group was not designed as a representative sample of the hospital population, but was based on the selection of 20 residents for a particular group of housing projects. Chapter 4 will explore how this group was selected, but it will be useful at this point to look at how they relate to the general hospital population, and how they were categorised as hospital patients.

In most ways the residents were typical of the long-stay population of the hospitals. [TAPS 1988] There are, however, two main features which may be useful to distinguish them as a group. Since their move was early in the closure process, it can be argued that the residents were more self-selecting than patients moving out later on may be: they were willing to move out, even though closure plans had not progressed very far. Secondly, the projects were designed to care for people who are regarded as 'less dependent' than those who might be rehoused by the statutory authorities. Both arguments will need to be examined further to find how far the closure programme conforms to this pattern. [see chapter four] It is particularly notable from the data on the hospitals' population that, when asked, over 70% of patients did wish to move out, but when staff were asked little more than 30% thought that the patient's preference was realistic, suggesting that staff attitudes were far more negative than patients' attitudes to the moves. Wing and Brown's seminal study [1970] showed that willingness to leave generally decreases with number of years spent in hospital. It is important, therefore that a significant proportion of long stay patients did wish to leave.[3]

The psychiatric diagnosis of patients was not a major factor used in selection of residents for particular projects. Even though the voluntary organisation expressed a preference for housing people with a diagnosis of schizophrenia, the residents of the group homes studied broadly reflect the hospital population is terms of diagnosis. Twelve of the residents had a primary diagnosis of schizophrenia. Four residents

were diagnosed as suffering from depression, manic depression or neuroses. Four residents had an uncertain or doubtful diagnosis.

The cases of these four residents are interesting because they point to some of the problems of the diagnostic process in psychiatry. One resident had been brought to hospital for observation, with signs that she was suffering from myalgic encephalitis. For some reason she was not able to manage at home and was taken into the psychiatric hospital in the 70's, where she was given psycho-tropic drugs. She was never diagnosed as 'schizophrenic' yet was treated as such by the voluntary organisation and apparently by the hospital care staff. The second (also a woman) was thought to be suffering either from depression or a personality disorder. One man had an uncertain diagnosis of possible schizophrenia with low intelligence: consultants were unable to agree on whether he was suffering from schizophrenia or not; the other man had been in hospital for a very long period, after a 'psychotic episode' during service in the second world war. His assessor for the closure programme noted that there had been no evidence of any psychotic behaviour during his hospital stay.

With such a small resident group, it is not possible to make any general conclusions about the class or ethnic identity of patients leaving hospital to live in community based homes. Two of the residents were black⁴ and it should be noted that both these residents fell into the group with uncertain or doubtful psychiatric diagnosis. In both cases, the observation that any psychiatric basis for their status as in-patients was questionable was reflected in the views of some professionals involved in the selection process: In the words of one, "Unless there's something important that we don't know, he's had a bum deal."

The age range of the residents, on moving in, was from 30 to 78 years. However, the mean age of residents, at 61, reflects the fact that all but two come within a 50-80 age range. The length of stay recorded for residents ranges from 2 to 54 years. Again the mean length of stay, at 21 years reflects the fact that the majority of residents had been in

hospital for very long periods.[5] These figures compare closely with the statistics for the overall long-stay population of the hospitals concerned.[6]

We can see from this outline data that the residents of the group homes could not be distinguished from the overall hospital population demographically. The very long lengths of stay are above average, but reflect the pattern for many of the 'old long-stay' population. Their official diagnoses are characteristic of the general hospital population, but the assessed levels of dependency of the residents relates to the nature of each project and the selection process by which residents moved into each group home.

The case history

The type of information available to hospital workers in official records is centred on recording of behavioural and social problems and disabilities. Conversely little data is recorded on patients' abilities and past or current activities and interests. In the documents used to summarise the patient's 'career' [Goffman 1968 p139-151] there is remarkably little information on the person's pre-hospital life, or indeed on any aspect of the person which is not illness related. This is partly derived from the clinical purposes of hospital case notes and the ways in which they are recorded. It also reflects, however, the negligible interest in the non-hospital experiences of patients, or any characteristics of the person which are not perceived as illness-related. On the basis of hospital summaries, the picture presented of patients is discouragingly bleak. My argument is that they are unrepresentative of the people they describe, in such a way that they accentuate disability, by ignoring abilities and knowledge, which should form the basis for rehabilitation.

The hospital reports give only the most brief and succinct personal details, and these are typically selected as those which are thought to bear some direct relation to illness, or to be indicators of the future

psychiatric crisis. The dates and duration of admissions are given, the diagnoses made, and sometimes (though often these details are absent) the immediate circumstances of or reason for admission are noted. Family details are generally limited to naming next of kin and giving marital status. A brief account of the person's current mental state is given, taken from the assessments done for the closure and/or from the accounts of ward staff. Previous occupation and place of residence is noted.

In the case of Kathleen, the hospital account was rather different, giving a number of significant details about her family and past problems she had experienced. Her assessment included a report by a social worker who appears to have spent some time talking with her about her personal history. However, for the majority of residents in the Haringey projects, this sort of account was not provided to community based care staff. In the Islington project, the much greater involvement of social workers and specialised transitional workers enabled communication between the patient, the professionals and the group home carers to be improved.

A 'typical' summary of a case history[7] is outlined below, to show the type of information which prospective residents bring with them to the homes, and on which the community based carers are expected to build their knowledge of the person:

HOSPITAL REPORT - NAME, Date of Birth.
Done by CPN 1986

Admissions: First admission 1949. Discharged and readmitted in 1951. Continuous stay since then. Informal status.

Diagnosis: chronic schizophrenia

Treatment: Given ECT 1949, 1951, 1952. Psycho-active drugs since 1962.

Next of Kin: Sister in South London (name and address) Occasional contact by letter.

Religion: C of E

Previous occupation: Clerical.

Pre-admission address: (details given)

Marital status: Divorced. (maiden name given)

Psychiatric History: Admitted in confused and possibly depressed state, having neglected self and with deluded ideas. In recent years has been settled on ward. Transferred to 'rehab' ward in 1984.

Current Mental State: Last reported disturbed behaviour in 1971. Has some fixed delusions but functions well despite this. Tends to be a bit isolated on ward, but does go out on trips etc. and does a bit of personal shopping. Good self care, reasonably well dressed. Oriented in all spheres and with warm rapport. Some tremor of hands and abnormal mouth movements. Wanted to go and live with sister but now knows that is not a realistic option. Keen to leave hospital but will need intensive support.

What is most striking about the hospital reports is that they present, to the staff taking over caring responsibilities, the basic information about the resident's psychiatric history and little else. In one sense this has the advantage that it requires carers to get to know residents for themselves, to listen to them in their own words. This takes time however, and for some who are rather withdrawn or reserved, a great deal more time than workers have to give. Too often, the workers day is focused on benefit applications and housekeeping, rather than on the apparently more passive occupation of listening. Listening, however, in the ethnographer's sense (or the therapist's) is active rather than passive, because it is conversational and is aimed towards a dialogue, in which a person, who may have remained virtually silent for some time, can begin to talk about him/herself in a way which is satisfying and informative.

The life history

In the sections below I relate some of the accounts given to me by residents about their life histories. These accounts are in themselves incomplete, very much like snapshots taken from the person's memory. Oral history shows that we do not remember clearly all our experiences, but that our pattern of recollection reflects those things which have personal or social significance. My aim was to encourage interest in talking about life history, but beyond this to let each resident decide,

what, if anything, s/he wanted to tell. This differs strongly from either a structured interview, or from a psycho-analytical exploration of personal history. The result is likely to be more piecemeal, and with repetition of certain themes, particularly when a non-directive approach is taken, but it is also closer to what the subjects themselves wish to give expression to. Mostly the stories were given in short sessions over a long period. Some of these were initiated by myself, by explaining my interest to residents and asking them to describe aspects of their life to me, but increasingly they were initiated by those residents who enjoyed talking about their lives.[8]

I have chosen to limit the accounts to the first group home project, because the time span of the study meant that I had limited time with the residents of the other group homes. The residents of the first project, up until the closing months of the study were all women, and so this pattern is reflected in the accounts. In effect they give very much a women's view of the experience of life before hospital.

Unlike the case history, they show the subjects as more 'whole' rather than fractionalised people, involved in differing roles over their lifetimes and having insight into their own experiences. The theme of women's experience of life, the attachments and problems of family life, home and work, is particularly strong. The youth of these women was also profoundly affected by war, leading to grief, separation and fear. It also allowed new working and social experiences, which were not carried through into their post-war lives. They also show ways in which the residents try to make sense of their lives, looking for reasons for what has happened to them. There is an impression that, because so much of their lives has been taken away - the loss of home, family and ordinary identity - they needed to talk about other periods of life which were important to them. The desire to talk about ordinary life, rather than just about life in hospital, reflects an unmet need to get away from the 'psychiatric society'. Instead, the ordinary side of the self, as well as the losses and problems are revealed:

JANE

Jane was born in London in the 1920's. She recalls her life as being hard, emotionally and materially. She is a very articulate woman, and her many skills belie the poverty of her education and opportunities in life. She sees the past as being something that needs to be understood, and the future as a chance to achieve some of the things she was never able to before. She loves her family and wants to be a good grandparent, to fill the space that was left by her years in hospital and be part of something again. She feels frustrated by her situation as an ex-patient, but this is also part of her motivation to make a new life. She fills her days with creative activities and looks, with rather shaky confidence, for interest among her fellow residents and in the outside world.

My mother was an exceptional woman. For a long time she was alone with my brother, but she married again. She married partly because it was so hard for a woman to keep a family alone. We didn't suffer the conditions that some of them did, as working class children, because of her strength. She was a foundling, brought up by the nuns.

I had polio as an infant, though I didn't know it till late on. Do you think it could have had any effect on me? There couldn't have been any trauma, as I was only a baby. I don't think it affected my parents' relation to me. Mum was protective to me and Johnny alike. I sometimes wonder if it had a permanent effect on my brain! In hospital I remember being tested for a thyroid problem. I was disappointed when they said it was negative, because I hoped it might be something physical, that they could treat."

She didn't point to any other possible problem in her childhood, but said she couldn't understand how she became so severely depressed - she couldn't pin it down to anything. However, as time went on and she described more and more aspects of her life, it became clear to me that she was aware of many possible problems, which she was gradually beginning to put together.

"Education wasn't considered important for girls. I didn't get on very well at school, and didn't like going. My mum didn't worry about it too much because she assumed I'd get married. It would have been another story if attitudes were different, because mum was the type to be bothered with things. Some women could get on, if they were clever

or had the family backup. I think she would have supported me strongly if I'd been clever at school."

Jane, Hilda and I were talking and they were comparing memories about childhood. I asked Jane where she went to school:

"My first school was St Joseph's - Holy Jo's they called it. I hated it. Me and my brother were very clingy to my mother and she didn't really want us to go. Johnny didn't go until he was seven and got caught by the school board. When I first went, the nuns told her they didn't cane the children, but I was even caned for being late. When she found out she took me away, particularly because they had lied to her about it. I went instead to the convent a bit further away, where she had lived as a child.

I was happier here, but I didn't really like school. I did want to find out about things. I was bright as a child, but it just wasn't like that in school. I went to the local secondary, but didn't go very much, partly due to the outbreak of war. When my daughter started school I tried to make it different, talked to her about what she'd do and how she'd enjoy it. She went without any problem."

"I clung to my mother and my first school didn't help - the cruelty and deception. The second one was much better. My mother had wanted to send me to a boarding convent, hoping it would get me over the problems in settling, but we couldn't afford it. I think my literacy problems were inborn, I couldn't have taken courses because I just couldn't spell. I was brought up as a Catholic but I've lapsed now.

At the outbreak of war, my father lost his job by chance and because he was 65 had to go on a pension. My brother was called up. He was nineteen. The pension didn't account for dependants so we all had to live off a single old age pension, which was very difficult. My mum couldn't work because she was a very sick woman. I find it a bit funny sometimes when my daughter complains of poverty. It's all relative.

You wouldn't believe some of the things that happened to me during the war! My mum lost everything in the bombing and we had to start again - we weren't actually bombed, but as a side effect of it. She was a strong woman and we coped. We lived in Inner London. but after a landmine landed near our house we moved further out to get away from it all. I was 12 then and was evacuated to Somerset, so I effectively left school at 12. My mother came with me and we were taken in by a local family. The wife offered to take us in because she had 2 boys and her husband had always wanted a daughter. Their marriage was very shaky and possibly she hoped this would patch it up. I was to be the daughter he never had. At first he made a real fuss of me and was very affectionate. I was already physically matured and soon he started to want more than affection from me. Eventually he tried to rape me. I told my mum and she didn't call the Police because she didn't want to cause trouble for them, but we left. I was just glad I'd had my mother there. A lot of children were evacuated alone.

When we went back to London, I was a teenager and used to go out to the dances and everything. The US forces made a big impact on us. They were so different from the British men. Not only wealthier, but more interested in women themselves. The black US soldiers were the first black men many women had met and there was a lot of prejudice within the forces - white soldiers wouldn't dance with a woman who'd danced with a black soldier. I went out with some men in the forces. I couldn't understand a young woman not wanting to. When I was sixteen I got a job. Factory work, just for the money. We all did it, but only enjoyed it if the company was good. My mother died when I was sixteen. She had been ill for a long time."

On another occasion she returned to the subject of her youth, and its lost chances, leading eventually to a disappointing marriage:

"Women in my day were brought up to have ideals of marrying a dream man, but my husband certainly didn't live up to it. I probably didn't know him well enough when we were married - only six months when we got engaged and I usually only saw him one day a week because he worked in a pub. He was a very old fashioned man, who wouldn't lift a cup or cook. The type you'd have to stir the sugar for. He expected me to do everything for him. I really enjoy cooking now, because it isn't a routine thing I have to do everyday, like it was when I was married. I think lack of a career or alternative means of support did trap women in unhappy situations. I thought of divorce earlier on but I stayed on to keep my daughter. Once you've been in mental hospital, it's extremely difficult to get custody of a child if it is disputed - the hospital doctor told me this. My family also tried to persuade me to stay married at that time.

I think the literacy problems put a blight on my marriage right from the start. He wanted me to help with the business, but I was very nervous about my writing. I didn't tell him when we were courting and when he found out he tried to teach me, but we didn't make much progress. I even tried an adult literacy teacher, but didn't get very far with it. Karen [her daughter] was the same, even though she was bright and had quite a good education.

I first became depressed in my twenties. My GP was interested in helping and didn't like Friern, so he sent me to see a psychiatrist at UCH. He offered me a full psycho-analysis and explained it would mean seeing him for an hour, once a week for 5 years; he said I would have to lie down on the couch and would have to tell him if I thought his nose was a funny shape! He said if I committed myself to the full 5 years, he could cure me. At the time, it seemed like such a long time and I hadn't realised how serious the problems could become. I wish I'd gone through with it now, after everything. I wonder if I had done it, if things might have been different.

Ron was the manager of a pub and we lived over the premises for the first few years. He was a drinker, so I worked part time to pay the

bills. Then, after a stocktake showed a large discrepancy, he was sacked without notice. We had nowhere to go so we went back to live with my father, even though it was a tiny basement flat. He worked on and off, sometimes living in on the premises and we still had to live in those difficult conditions. I worked to keep us. At first we had nothing because he wasn't entitled to National Assistance, after being sacked and then when he got a job, his wages had to go to paying back the money which had gone. I was worried about my daughter, Karen, living in such a place and sent her for short term fostering. She was so distressed by the separation that I soon took her back again and she went to a childminder while I worked. A few years later, Ron got another publican's job, through my father, and we had somewhere to live again, but he was sacked after a few years for the same reason. We were sent off on holiday while they investigated and we couldn't even get back in to claim our furniture. We were forced to move back to my father's.

After this I became very stressed and depressed. I was sent by the GP to a rich man's hospital. It was lovely there, more like a hotel, so much so that you could get to like it too much. They had a time limit of one year. You could take children under 5 with you, but Karen was over 5 so she had to go into a home and this upset me. Unlike hospital, everyone had to help in the running – 3 people would cook the evening meal every night and everyone had to take their share of work, because it was part of the treatment, even if you were paying. I reckon it helped me to some extent, but when I came out I went back to the flat and didn't go out and saw no-one [else] for 4 years! I went back to him and tried to be the good little wife but it didn't work out. I'm frightened of the idea of living alone now because of the experience of being lonely all that time.

Since you've been a Housing Officer, could you explain why I never got a council flat? I had maximum medical points as well as points for the bad condition of the flat, but I didn't get an offer in 14 years! I can't understand it, especially as I used to meet people who seemed to have got flats fairly easily. The GP couldn't understand it either. I was suffering from depression, Ron had a bad heart and then my father had a stroke and lived for several years afterwards, with me caring for him. He could walk around a bit but he was incontinent. Ron used to go out drinking, but I couldn't get out, not even to work.

The GP told me I must get a job if I was to get over the depression and I found one in a school canteen, but then dad got worse, falling over. The doctor said he couldn't put him in hospital; then a few days later a woman doctor came and agreed to admit him so that I could keep my job. He died the next week. I felt guilty because he'd cursed me for having him put in hospital, even though I felt it was the only thing to do. I know he would have died anyway. He was 95 and very ill. I suppose my life was ended at that time in a way.

I can't believe how naive some professionals could be! Like the GP telling me to have another child, that this would make Ron be a better husband and make me feel less depressed, when we were desperate for somewhere decent and large enough to live.

Some time after this I learnt that a wealthy cousin had recently died and included me in his will. As I was desperate for somewhere decent to live I used it to buy a place and that was how we came to live in my flat. I lived there with Ron and Karen from that time until I went into hospital to stay."

I was looking at her cat painting and she commented that they could do with a cat, [in the group home] because they had mice. However, she didn't like the idea of getting another cat since what happened to Whisky:

"I got him for Karen. He was such a pet, but when Karen was older I was far more devoted to him - my only love. He got very neglected after I went into hospital because Ron didn't look after him properly. Karen took him, but it was a flat with no garden and when they had a baby they didn't want it. I was upset that she decided to have him put down, even though he was old and messing everywhere, because Whisky had been her pet."

"It was years later, when Karen was grown up, that I went in. The GP gave into circumstances and allowed me to go to Friern. I'd been on tranquillizers for 14 years. Before going into Friern I'd been carrying on with my life and managing pretty much as normal, still going out, doing the housework, part time work in factories. I was upset by Karen leaving home and worried about it, but there's nothing else I know of that sparked it off. It was just like this - one morning, I woke up shaking and unable to control it.

There was only one drug that I think helped me. I'd sort of managed the drugs myself for years, cutting down when I didn't feel so much need, but I could never do without just one. I had been prescribed all these drugs but at the time I was admitted, it was the trend for taking people off them. The consultant told me I was over-drugged and took me off medication completely. I went barmy and was very ill as a result. I can't understand why, after all that time, they'd made such a dramatic change. I think it's down to lack of agreement about psychiatry. I was in such a terrible state, they searched the medicine cabinet for something to give me!

I got into art, quite by accident, while I was in hospital. I'd never been taught how to draw or paint. I could have spent all day painting if they'd let me. I went to writing classes too, though I still can't spell. I need a secretary! I sometimes think I'd like to write about it all, but I can't even get my short stories printed."

On several occasions, she talked about her family and how abandoned she had felt in hospital. She never felt that she could get a full reason from them, even though they had talked about it, and remained worried that, whatever reasons they could give, they simply hadn't cared enough.

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"My husband and daughter stopped coming to see me. I don't know why but I wonder about it. He said that on the first visit I wouldn't see him, and on the second I wouldn't speak to him, then apparently he got upset by seeing me on a ward with people in such a terrible state and didn't like coming. I find this strange because he'd been a Friern patient himself for a short while. He was an alcoholic. The doctors tried to get me to agree to his admission, but having been in there a year before, I wouldn't do this and said he must decide. He was only supposed to be a voluntary patient, but even so they were ready to force him back in one night, when he went off drinking, if I would ask for them to send an ambulance. I refused - I reckoned he'd be OK because he just had a drink problem.

It doesn't have to be like it was for me - My father had been mentally ill, but he was never put in hospital. My mum had always stuck by him. He had support from my mother and managed to carry on a normal life. My solicitor said he couldn't understand why I'd been in hospital all this time. I can't understand myself why a lot of the patients were there for so long.

My husband has been to see me once in the house already. I think my ownership of the flat is what brought him, now I've left, because he's living there. Otherwise, why hadn't he been to see me in all that time? He used to go drinking in a pub near the hospital and he could have arranged to meet me there, since there weren't restrictions on me going out. Some patients used to go home for weekends. I was allowed, but they never came and I never saw my grandchildren. I suppose Karen was worried about taking them into that place. Then Ron came to see me in hospital again a couple of years ago, saying he wanted me to sell the flat and buy a family home out of London. Karen was unhappy and wanted to move out with the kids and was hoping I could buy somewhere big enough for all of us. They started to ask if I could come home for the weekend, after years of not bothering.

I didn't see my brother for years either, though he did write, He rarely came to London. It's taken me a long time to build up the courage to phone him. When I did, he said I should have done it [a divorce] years ago! He didn't talk much, but he's always been like that. His mate was very friendly and he rings me for a chat now, every so often.

After all those years in hospital, not seeing him for 8 years, Ron expected me to go back to him and be the good wife! Even when I said I was divorcing him, he didn't really give up. He isn't Catholic, but he tried to tell me this was a reason for not divorcing him! Only when I said I was leaving hospital and going to live somewhere else, not going back to him, did he accept the fact. I've sworn my affidavit now. I was surprised how little it came to, after all those years. It seemed to take very little to sum it all up, just a few paragraphs once the solicitor had condensed it.

I think a lot about my daughter. I've suddenly noticed that she's going grey and seems almost middle aged - that's the result of not

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seeing her for years. I felt outside of everything at first, not
seeing the kids grow up. I feel like I want to treat them, do things
for them, become part of my family again.

Leaving the hospital enabled Jane to renew her family contacts, and to change her lifestyle considerably. She quickly got to know her grandchildren, visiting regularly and inviting them for tea. The process was not without its pain however. It seemed as though her life had been one of repeated losses. Now, as well as her own divorce, (from a marriage which she felt had been irreparable long ago) she also supported her daughter through a decision to divorce her own husband, who was also alcoholic. She like the group home, but increasingly found its routine too rigid and began to look for ways of moving into accommodation which was more independent, without being isolated. She is still looking.

MARGERET

Margeret doesn't talk much about herself. She is a very quiet person who likes to spend time in her room. Although quite reserved, especially with strangers, she is very witty and affectionate towards people she knows well. Although at times she and Jane have quarrelled in the house, they also seem very close as fellow residents. She spends all her weekdays working at the hospital. At first she was glad to return there, and she and Hilda kept each other company on the daily bus journey, but more recently has begun to wish she could find something to do locally, work and maybe join a club of some sort. I saw much less of her in the house, because of her work and so I was unable to spend much time talking with her about her life. When attending meetings at the hospital, I often used to meet her in the corridor, where she walked because there was little to do at lunchtime, and she would tell me the news.

Margeret was born in Jamaica in 1937. She had a large family and several of her brothers and sisters live in England too. Her parents are living still in Jamaica. She talks about it as warm and beautiful - a place she

would like to return to, even if only for a holiday. After marrying, she said she lived in a nearby area, in a small family house, quite like this one. She talks a lot about her family, but rarely about her husband, although she did say that she would have liked to have gone back to live with him in her family home. Since they are separated her family life instead revolves around her children. Her grandchildren are a great pleasure to her and she always asks after my children too.

"I had four daughters. It was hard work bringing up four kids! I can remember the pregnancies because I was ill with all of them. They're all grown up now and working. Two are married with kids and they live quite near, I go to see them when I can. My youngest grandchild is nearly one and my daughter brings him here to see me sometimes. You should have seen him this weekend, walking round the furniture! He's into everything now and he'll be walking soon."

"I've been going home on Saturdays occasionally, to see my daughters. They always give me a bit of money when I'm broke! I'd like to be able to spend some on my family now I've got grandchildren. They come here to see me too from time to time.

I don't mind working up at the hospital. It's a bit of money and I know the people in the workshop, Betty and all. I like to take a day off sometimes, though, have a rest, a holiday."

Although Margeret looks happy – she smiles and laughs a lot – and was really enthusiastic about moving to the group home, she also seems rather lonely, as though something important is missing from her life here.

HILDA

Hilda was born in London in 1924. She has spent much of her life in London, although her family moved from time to time, and she travelled during the war. She talks very fondly of her childhood and her parents and loves to recall things that happened to her. Although the details are often confused, and real or imagined characters become mixed in her imagination, over time she has been able to put together an account of things which were significant to her, stories which she may tell over and over again. She also likes to listen to other peoples experiences

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and chip in with anecdotes and comparisons, sometimes serious but often to make you laugh. Jane tells me that in the evening, when I'm not there they may all talk for hours like this. "Hilda could tell you a few things about what happened to us in the war - like that one you were telling us last night, about the Americans during the war.." Hilda just smiled and nodded.

"I'm half Catholic, and half Jewish of Polish origin. My mother came from Ireland and was descended from Irish and Spanish nobility. I grew up in St. John's Wood and went to a Catholic school there. We lived in quite a grand house there, with famous people visiting all the time you know. Have you heard of 'so and so'? no? Well, he was in the theatre. Then there were my uncles; one was a doctor and another was a bank manager in Camden. I've still got my account at that bank. Do you think I'll have to change it now I'm here?

We lived in Scotland for 2 years when I was a baby. I don't remember it, but my parents told me how I used to run after my dad playing golf, saying "bunkem bunkem". My dad was a chef who used to work in hotels. Things could be very hard for people in those days, so much unemployment. My father was out of work for 2 years at one time and it was very difficult.

They were terribly strict at the Catholic schools. Mine was like Jane's school - we used to get it across the hands. I was very clingy to my mother, and me and my brother were reluctant to start school. Our mother was quite like that too - she didn't want to let go of us!

I used to skate. I learnt when I was 4½ and soon learnt to dance on them. I used to dance with a tall young man and said to him 'I want to marry you one day'. He thought it was so funny! When I was older I went to stage school and I used to do ballet.

My mother was a real lady. She won a hair beauty competition - two Italian girls who were lodging with us had their all done up for it, but mummy won without doing anything to hers. It used to be long, but my father persuaded her to have it cut short. I used to ride a bike like yours. It was when I was a teenager. I was in Gloucestershire for a while, during the evacuation. "

Once when Jane was talking about her husband and the problems in their marriage, Hilda said her husband wasn't like that and that he promised he would wait for her. I was rather confused by this because I thought she'd divorced quite early in their marriage, and asked her about this.

Oh, I don't mean him [her real husband], I mean Reggie. I worked with him in hospitals during the war. He was a surgeon and I'd taken the 'legion of honour' to do war work and was in the WAFs. We were going

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to marry - he said he would wait for me. I was in a reserved occupation, assistant matron in a boys' prep school, but I volunteered my services. I travelled round to several hospitals with him. At first I was a bit squeamish during operations and at the sight of so much blood. During the first operation I swooned and had to lean against the wall! Then in the 2nd, I was leaning right over the table with the surgeon! The man looked white as a ghost with pain as they were setting the bone; the radius. "Send for the carpenter", they said [she laughed]. I was asked to carry on nursing, but I didn't.

Afterwards I did GPO training. It was a very complicated system. After training I went onto the continental and international exchanges. They used analogical talk, as in T for Tripoli. I found it very interesting, but decided to leave because the headphones annoyed me - they were very different from the light and comfy ones you wear today, and you had to wear them all day. I went on to work in a different company with another woman operator who I'd been working with. Before the GPO I'd done a course - secretarial and book-keeping - which was very intensive. I stayed half the course, then went to the GPO. I completed the training there.

When I got married we had our honeymoon in Devon - went for a week and stayed for two, we loved it so much. We rented a cottage down there, which was owned by an army officer. Whereabouts do you go when you go down there? Oh, I've heard of it. Well this was in the South, near the sea, a beautiful place.

It's thirty years since I lived in this area. I lived up the hill, then in Woodland Road but it was so long ago. The flat in Woodland road was in that block by the traffic lights." "I know the one" "Then we moved to the next block. It was when I first married that I lived here. When I had a baby we moved to Camden, to flats owned by the railways. My husband worked for the railways board, you see. They became, (what is it called?) GLC flats eventually. My home in Camden was beautiful. My husband had it decorated for me, red roses and green on white, just as I liked it. I was very ill. I had a caesarian section having him! I'd been in hospital and when I came out it was all lovely for me. The baby used to sleep in his pram, in the carriage part which I could just take off and take inside. I used to feed him ostermilk. Mummy used to help me with him and show me what to do, because I was not well. "

She asked me what my husband did and when I said musician, she was very interested and told me about her own musical interests:

"I used to love music. I sang in a choral society, part amateur, part professional. We used to rehearse in Holborn and played at the Rudolf Steiner Hall, Covent Garden and other places. It was led by a famous composer and we used to go up to his house, a big house just off Highgate Hill".

On another occasion she returned to talking about her marriage and the difficulties she experienced after having a child. According to her, her problems in coping with life and her 'illness' began at this time:

After having my baby, James, I was very ill. I carried on trying to look after him for 2½ years, but then took him to my parents. I was on a lot of drugs at the time. I can't remember what they were called now, but they disagreed with me. They were very kind and helpful to look after him. And I used to worry about the influence of his father on him - he was swearing like a trooper. He shouldn't have talked like that in front of a little child. I took him somewhere when he was tiny and he'd pointed to all the men in the room and said "You're all boozing" [She imitated the way he'd said it, in an accusing tone.] So, I got divorced from him. When my father died, my mother asked me to go back and live there. I was trying to console her, and to do something about James' behaviour problems".

"I remember when he was two, wanting to take him for a walk in Hyde Park. I walked down with him in the pram and tried to cross Park Lane in the middle of the traffic. I got taken home in a police car. He thought it was very exciting to go in a police car like that."

I asked how old her son is now and she explained that she'd had him quite late in life and that he would be 27 now. She doesn't have any contact with him. She said that after she went into hospital, he lived with her mother, but as a teenager he started taking drugs and got into trouble. Her mum was old and couldn't cope with him anymore. She showed me a photo of him as a small boy, on holiday with her parents, and a recent photo of her mother, taken when she visited her shortly before her death, which she keeps with her in her bag.

She has a brother and sister in law, living in Essex, who have kept some contact by letter, and now she has left they visit regularly - Christmas, Easter, birthdays and so on. When I asked her if they were pleased with her moving to this house, she mistook what I was saying, and said she was happy enough, but really wanted to go and live with them.

"I like my brother very much. He told me I was very important to him. My sister in law is a good woman too and thoughtful. She works very hard, has a responsible job. I have cousins living in Essex who are also very nice people. I went to their house after mother died, a long time ago now."

Hilda is very content in the group home and settled there, despite her initial worry about how she would manage with the chores. She relies quite strongly on Jane and Margeret, both for company and for practical help with cooking. She described the staff who first worked with them as lovely people, not like nurses, but like a devoted son and daughter, and was very disappointed when they left. In this household, Hilda has the least frequent outside contacts, apart from going to work at the hospital, which she takes some pride in, but now finds too tiring to enjoy. However, she has one friend from the hospital, who now lives in another group home, and they go out shopping regularly together to the West End and have the occasional meal together. In the home, she enjoys the company of the other residents, and likes to chat with me, even though I never learnt to speak loudly enough for her failing hearing. She thinks and talks mostly about the people who have figured in her life, keeping them in her mind, since they are no longer a part of it.

KATHLEEN

Kathleen has always lived in the local area, apart from the time spent in hospital. Her parents still live locally. She had wanted to go back and live with them but they (and the hospital staff) felt this wasn't possible. Now she lives at the group home she is able to visit them frequently and stay overnight. Often when I visit she is "at home" and other times she will tell me what they did at the weekend, she and her mum - shopping, a shandy at the local, and so on. She is also a very quiet person, sometimes preferring to stay in her room, lying on her bed, but she is also very affectionate and friendly to everyone she knows well and will never argue. She often sits smoking in her favourite chair, thinking, looking rather sad, but if you talk to her she will listen and maybe talk with you.

"We lived round here for a long time, a couple of streets away. Mum and dad moved while I was in hospital. I didn't like it. I wanted everything to stay the same as the old house. I asked him to change things round and he did it, just like it used to be. He's very good at doing things in the house. Not bad for a man of eighty, was it, to do all that work.

*My dad was in the navy for long time, and drank a lot. He used to get
daft when he was drunk. Liked spirits, especially rum. Mum didn't like
it. She could always tell when he'd had one. When he visited me in
hospital and I said "you've had one" he said "you're just like your
mother, nagging". He didn't know what he was a'doing of. There was 17
in his family, including twins who died when they were babies. He was
the youngest and spoilt by his elder sisters and brothers. Maybe
that's why he was like he was. His father hadn't been a drinker."*

On her birthday, Kathleen had her hair done specially. After she had
opened her present from the staff and other residents, a bottle of
scent, we sat in the kitchen talking about families:

*"I wish I'd had sisters - who I could share with, go out with, have a
laugh or a cuddle. I had two brothers, bullies. They weren't friends
to me and the younger one used to hit me. My dad was bad as well. Mum,
I tried to get her to go dancing with me and things like that, but she
didn't. Mum was very unhappy. I remember going on picnics and having a
bottle of pop for special treats; that was lovely. I remember playing
netball as well, at school. I wish I'd had a sister.*

*When I was a little girl I didn't like being alone, especially in the
dark, and got nervous about places. I often felt there was someone
waiting behind a door, or coming up from behind to attack me, or stab
me in the back. [she made a dramatic pose to show her fear] We used to
have an outside toilet at the end of the yard and I used to rush
through the door to it, frightened that someone would be there to
attack me. Even in hospital I used to look under the bed." [She
laughed at herself]*

"Did you find it noisy in the ward or quiet? Did it bother you?"

*"It was usually very quiet. I've always liked quiet so I could hear
what was going on, or if there was any intruder. I like sharing the
bedroom with Jean. It's less lonely."*

One day, when Mary was telling Kathleen about her Welsh aunt and her
cousins Kathleen began to talk about her youth, and how things changed:

*"I can speak a little bit of Welsh. I was evacuated there during the
war. I was in a small village near Dyfed. I thought it was a lovely
place; friendly people and beautiful food, all fresh."*

*"I used to be a machinist. I was very good; [she demonstrated] quick.
I couldn't do it now. My hands shake and I don't know, I haven't got
the confidence. I didn't do OT in the hospital. I used to make all the
teas. I'm 56 years old and I was in there for seven years! I was
living with mum and dad before I went in there. I forgot how to cook
in there, but now I reckon you never completely forget. The workshop's*

all right I suppose. Fiddly stuff. I get such a backache sometimes,
right here.

I remember being in hospital when my son was born. I had to lie in bed
with a glucose drip in my arm. I was very upset because the baby was
taken off of me and I heard the nurse shouting at him when he cried.
It was very difficult to rest in there. He was a beautiful baby and I
couldn't bear for him to be shouted at. I felt better when I got home.
I called him Mark Thomas. I hoped that if I had another son I'd call
him Thomas. I thought of adopting another one you know. I don't know
where he is now. "

Kathleen talks from time to time about her son, but never about her
husband, who divorced her a long time ago. After the separation she
returned to live with her parents but this didn't work out very well. In
the view of the staff, (based on social work reports) her family have
not been very helpful to her, and they are cautious about encouraging
staying with her parents. However, she now stays with them every weekend
and seems very emotionally attached to her family home. They are both
very elderly, and are her main focus of interest outside of the group
home. Workers have invited her parents to visit but they never come. She
attends the workshop but it holds little interest for her. She is well-
liked by her fellow residents and the staff, but Jean is her only close
friend.

MARY

Mary is a great story teller. Her recent memory is poor and it
frustrates her constantly in everyday life, but the past can be recalled
in the finest of detail and helps her to keep her sense of who she is or
was. She loved her family dearly and regrets that they drifted apart,
years ago, so that she is now alone. She was devoted to her parents and
never married. Sometimes, when describing these childhood scenes, Mary
becomes so animated - bringing it to life for me. Her eyes are bright
and she acts out the gestures and the voices of the people she remembers
so well. We sit and listen, while she tries to bring elements of the
past lives to the present and the other residents begin to recall bits
and pieces, pictures from their memory. Kathleen looks up from her

silence, "Oh!" and smiles.

I'm seventy one. I was born during the war. We lived in a house in Clerkenwell and we lived in this area for all my childhood. My mum's maiden name was Kate Tooley, so on her fathers side was their granny Tooley. Her grandma's maiden name was Sheehan. She was Irish in origin, and Catholic, but she was born in Somerstown and several generations of her family lived there. They used to live in 'the rents'. She was very attached to the area.

Mum was married twice. She was Irish, and 1st married a Scotsman, named Kerr, then my dad. She had about 9 kids. Mum had lost twins before I was born, during the war, and she was deeply affected by it. It would have been 9 kids in the family, if mum hadn't lost the twins. Mum nearly died herself – she had a haemorrhage and the twins died shortly after birth, yet she recovered enough to have me, a 9lb baby, a year later! The twins were named John and Mary and I was named Mary to honour them. Mum liked the name because it was her maternal gran's.

Our family, with lots of brothers and sisters, all friends, was very different from my mum's experience, mum being an only child. Me and my brother and sisters used to argue and fight over things, like who'd do the washing up, but we were also friends to each other. Mum had been lonely as a child. Her father was a bad one – thieving and things, and was always in and out of prison. That's why her granny only had one child. People used to call mum 'Danny' because she looked like him, with black curly hair. I think it made her different being an only child at a time when very large families, often over 10 were common – just her and her mum, often at her granny's.

I remember 7 of my brother and sisters; 3 died very young. I was one of the youngest. I felt very close to my half sisters – Catherine and Alice. My eldest sister was more like an aunt to me. Alice was 16 years older and eventually ran her own cafe in the West End. She used to spoil me, because I was so much younger and she was already a working woman. "

"First were my two eldest sisters, then the two boys (including Tom who died), then the twins (born in 1916 and died in May in an air raid in the hospital) I was born the following year. Me and mum used to talk about the night of that air raid quite a lot. She called it the 'Night of Cuffly', though I've no idea what that meant. Kenny was my younger brother. Then there was Jimmy, the little one. Jimmy reminded mum of her son who died. That's why she was so soft on him. He was a bit spoilt because of this, and being the youngest.

My elder brother Tom had bad luck. He had an eye knocked out, during a fight in the street with stones or bottles, when he was only 3 or 4. At 13 he got knocked down and had his leg amputated and died soon after. I remember my mum crying and me wearing a black dress at the funeral, sitting on her knee. When he died, mum couldn't speak for months, she didn't want to know anything or anybody. [The hospital

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My mother was a good woman and sensible. She worked very hard, having had 9 children and with greater poverty than now, but she was very good to us. If she had to smack or scold you, she always kissed you afterwards and treated you. I think mum was protective towards me, because I didn't get on well at school and couldn't reckon up. I had a head injury during the war. I remember a bomb dropping and mum running out with me. They told me I'd had a haemorrhage - my head's not right.

Mum was very neighbourly, and looked out for older people living in the house. She taught us to call people aunt or granny out of respect and felt that it was wrong to just keep to yourself. She used to go out sometimes in the evening for a drink, or to see people up at the Market, and would tell me to keep an eye on my little brother. She had a lot of relatives up that way and we used to go there a lot. She was a strong woman and my dad was a very mild and considerate man. She had a hard life, but easier than many, mum thought, because at least she'd had a reasonable gap between children - 3 years for most, and had the strength to feed them.

My dad worked driving carts, between markets out of town, shops and so on. It was the equivalent of a modern day van driver. He was injured in the First War and lost part of his arm. He didn't always have work, and I remember having to go and get food parcels at one point. It was terrible, the unemployment in the twenties and there wasn't the welfare system there is now! Relief was associated with shame, but my father said "you can't afford to be ashamed if you want to eat".

He was a good man. He liked steady women, rather than flighty ones, you know what I mean - didn't like them to wear make up. He worked for the same firm for 40 years and was really broken up when he was made redundant in the 30's. He used to buy us sweets on his way home; I especially remember the large pear drops he used to get. You can't imagine the difference in the situation now with the twenties, when people had to apply for relief despite the shame.

We were brought up Catholics. I had my 1st Holy Communion in St Peter's, the Italian Church. It wasn't very rigid for us though - we used to go to the Methodist Sunday school and we went to the local schools. My elder brother and sister went to a better school, because my mum was separated from my dad for a few years, during the war. She went to live at my gran's house, which was just a few streets away. My gran was a landlady and my aunt had been renting three rooms in the house. She left to go back to Wales when the war was on, because of the bombing and we took over those rooms. Later, in 1926, the collieries were closing down, and there was no work so she had to come back again.

I went to the local school and also to one near Farringdon, where they taught cooking. I got caught playing truant once! A neighbour saw me in the swings and mentioned it to my mum. She said the police would be after me. Education wasn't seen as so important, for poorer people,

but we still had to go. I had to take Jimmy, who was a bit spoilt, and didn't want to go. I didn't get on well at school. My mother took a bad fall before having me and was in Barts for 3 months. I'm not sure if this might have affected me. My sisters got on well at school and Cath got a scholarship. "

I asked if she'd like to see an exhibition – old photographs of London life – at the London Museum. She said she liked history and told me how she was told off at school for taking books into classes, and told that she should read them in her own time. She shared my opinion that ordinary peoples' history was more interesting than 'kings and queens'. She seems very attached to her childhood neighbourhood and all the associations it holds:

"Where we lived, it was fairly close knit. It was an Italian quarter and the Italian neighbours were very fond of children and friendly. I remember Mrs Ricci, who was always calling me in for spaghetti. London now is all foreign and cosmopolitan. What I mean is, people don't mix with their neighbours like my family did. It's all strange and different now – the buildings, the people, the way people mix. It's a new world to me!

You know that woman who came here, she reminded me of granny Mckay who lived above us in the house. I used to go up to her for errands, and to keep her company and listen to records with her in the evening. My elder sister, Catherine, was different and wouldn't go along with that sort of thing. I used to go to Soho a lot, because Alice worked as a barmaid in Old Compton Street. Also mum worked in a cafe, where the proprietor used to give me chocolate, and the chef used to cook crepes for me to take home to my little brother. I used to like going to the theatres to see the musicals and films, in the gods. "

"I used to live just by there, in the Peabody buildings, do you know them?"

"No, but I knew the Peabody Buildings in Clerkenwell very well. My teacher, Mrs Owen used to live in one. I suppose all these things have changed now and the buildings gone. "

She was surprised at my observation that pockets of these areas had changed very little. We talked about details like Chapel Market shops being open on Sunday, the theatres and the schools that are still going. She pointed out that even if some areas haven't changed so much, you've got tower blocks just down the road.

One day we all started talking about the house and the residents told me how homes have changed. She recalled her mum showing them how to light the big old fires, and how quick she was, making paper rolls and so on. She demonstrated the technique for me and the others watched, recalling them as she did so. We all talked about how changes in houses have gone with changing lifestyles.

When we went to the exhibition, Mary told me more about her community. She explained that she'd never been a good traveller and tended to stick more to her local area because of that. As we came towards the City she began to recognise where we were going, and seemed increasingly relaxed, looking at buildings and side streets to try and place them. When we got off the bus I worried that the walk might be a bit daunting, (since she's often reluctant to go out) but she was very confident. She commented on how the area had always been full of insurance companies and banks. She thought the number of shops and cafes had increased:

"In my day, all the clerks had to go up to Goswell and City Road. There was a large ABC and Lyons stores. These flats over here were popular with city people who like to be close to work. Some of these buildings have hardly changed. The Mission's still there. It reminds me of going to the Methodist Sunday School and getting told off if I missed it! We used to get the bus down through here. I often went to St James Park, on the bus, with my brothers and sisters.

I used to get pocket money on Saturdays for sweets, so my mum wouldn't let me take money for running errands. There was a blind lady living near to us, who used to stand in her doorway if she wanted something. Mum used to tell me to go and see what she wanted - a loaf of bread or some chops. We used to buy meat for the shillingworth and the butcher would sometimes give me one on top. Mum would always give it to someone who needed it. All the shopkeepers knew me as my mum's daughter and I could trust them to give the right change.

In that area, in the 20's, there were gangs of youths who fought each other in the streets, with stones, knives, glass. They only ever attacked other gang members and we didn't get involved. The gangs used to hang around St John's Square and the Smithfield end of Clerkenwell. This was how my brother Tom was hurt - mum had left him at the bottom of the stairs to carry up shopping from the market and he had wondered off on his own. He was hit in the eye by broken glass, which some older boys were throwing at each other. "

One day I suggested shopping at Holloway Rd. Mary said, "Ooh, I haven't been that way for ages." I asked if she'd like to down to Angel but she said she didn't want to go there, "I've got my reasons." She started to wonder again about how much it might have changed. I asked if she found the idea of going there again difficult, after all this time. She shrugged this off, saying she didn't go there much really, or her mum, but then started talking about the area, giving me the impression that it was an old haunt.

Mary feels that the wars had a great effect on her, and have something to do with her depression and "head not being right":

"I reckon that wartime experiences were very important to my generation and that childhood experiences do affect your adult personality. They affected my mind, made me nervous. I'd be bashing and crashing with temper during the Second War and my mum used to give me cigarettes to calm my nerves.

I think I was brain damaged in the war as a baby – must've been, otherwise why was I black and blue and unconscious for 2 days! Look at this in the newspaper – a little boy dies after a delayed operation – how many babies are still dying or damaged!" [She sighed, looking rather sad and regretful], "I was born unlucky."

"It was down in the shelters that I started smoking. My mum and brother Jimmy started giving them to me because I got so nervous during the bombing. Mum told me to puff and blow, but I soon started inhaling. I gave up years later because it made my throat so bad. I was so nervous about the air raids that I used to get the all clear signal mixed up with the warnings and get into a panic all over again! I can't really remember the 1st war, being so young, but my mum believed it had an effect on me all the same. Mum said London wasn't as bad them – less bombing, less planes, but no proper shelters. They used to go to the railway terminal stables, which were quite deep, just round the corner. Mum's first husband was a boxer, who went into the army and was killed, leaving her to cope with 2 young children.

They say it was a war to end all wars, but there are little wars now all over the world. Some places you'd never heard of all that time ago. I was in London during the bombing in both wars. My mother had never wanted to leave. We used to have an underground shelter near our home and I remember my elder brother, who was a musician, stopping out at night, or playing to entertain people.

During the 2nd war my nieces and nephews were evacuated, to nice places in the country. My brothers children, I think, were evacuated to Cornwall. They made friends with the family and kept in touch. My younger brother Jimmy was in a Scots regiment during the war, and

served in Germany or Italy. He was injured in the war and died a long time after, mainly as a result of his injuries. Kenny might still be living in Islington now. My sister's child was only two years old when war broke out and she was evacuated to Cornwall. It was a lovely home and she was happy. Catherine worried about her and whether she'd forget her, but she never did. She used to write regularly and when she went to visit she would come running out to her shouting "Mummy!". The people were very kind, brought her up and educated her properly. I wonder where she is now? She'd be middle aged now of course. I think she went to America to live after marrying.

I had worked in factories before the war, so I became a munitions worker, and worked at Plesseys in Ilford, in the Central Line tunnel. Before the war it was difficult to get permanent work. I used to do stints in different places. I worked on and off in a big sweet factory. We used to be able to eat all the sweets we wanted, but I got sick of them quickly enough. Again after the war many women lost work. I stopped to look after my mother. She was in her 70's by then and ill."

Jane found it odd, when talking to Mary that romance with men never came into any of it. She asked her, "surely you must have met some of those soldiers, working in London?" - but she'd been at home with her mum.

Mary has spoken far less about the period of her life after the war. She thinks her head injury and "head not being right" had something to do with her "not getting on" and not marrying:

"I used to have a strong family, but after a time I drifted away from them, living in lodgings instead of my own home. Several went abroad and others I saw less and less of. My younger brother got married and had two girls and a boy. Its a long time since I've seen them. I only used to see them occasionally before going into hospital. It was sad to lose contact with family and friends, but there it is.

I was very fond of my niece Helen. I remember when she was the age of your children, so bright and happy. She could be a grandma now! I think its sad when people lose touch with their families like this, don't you Dot? All your family are a long way away aren't they. You're lucky to have a boy and a girl, Chris, "a pigeon pair" as my mum would say.

Wasn't it terrible that fire at King's Cross! My brother and sister in law live in Islington, and travel regularly through 'The Cross'. I wonder if they're OK. [She was talking in the present, as though they live there now. I wasn't sure if this was the case or whether she was thinking as though in past time.]

Shall we go out shopping later then, for that coat? I don't want to buy a black coat - it shows up dirt too much and I wore black for years after my parents died, until it got too much. My mum, dad, and eldest sister all died very close after one another. "

She fell silent for a few moments, then turned her attention back to the group home. Because her short-term memory is so poor, the past is an important reference point for the present. It is clearer also because it has more meaning for her own identity. Grief is a part of that identity, but she turns back to the present, to the relations and chores of the household as a means of distancing herself from her feelings of loss.

"Do you know Jean is still in bed! It's disgusting at that age, only 50, lying in bed all day. When I was 50 I had 2 jobs and was up at 5 to go to work. I used to work down at the local hospital, cleaning. I can't understand how they can do it, lying around all day. I used to manage it all - looking after the house, helping with my brothers and sisters, going out to the market and all that - before I had the nervous breakdown. I suppose I was taking on too much.

In the hospital I did domestic work too, making 30 beds a day, and did teas for the admin. block. The nurses were kind and good on the whole. Even in recent years I got more exercise at the hospital than here; I used to go for walks with some of the women. I miss that now and there's really less company and less places to go, because I don't know the area. The people at this new day centre are friendly enough, but they're all old women and the staff tend to talk to me like I'm an invalid.

I get so frustrated now because I forget things and its really difficult even to learn my way around. It makes me feel terrible. Its makes the rent and everything seem more confusing. I'm trying to work out what its all about - staff tell me it's old age, but I've had the problem for a long time and I don't feel that old. Once my mum told me that people forget things they're not very interested in. I reckon my memory was once OK, but it's been bad for a long time. I think it might have been to do with ECT, but I can't remember much about the time when it was done. I had a few courses and my memory's been bad since then. You know that was when my hair went gray, just like that, overnight! My mum had lovely dark curls, just like yours. You should grow it longer. She used it push it into shape, like this. [She showed me how to do it] I've always had to set mine. That's the Irish, with beautiful curls, but my dad was english of course.

I asked her what the hospital was like in the past. Had it changed much?:

"The hospital changed in the time I was there. At first many wards

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were locked, although in practice staff did let a lot of people go out. I was on X, a relatively independent ward, right from the start. The staff had always been good and got on with patients well, some nurses especially so, like the sister who came to visit us here. The hospital hasn't changed me as much as old age has. I don't get so bothered or irritable about things since turning 70."

In many ways, Mary is the mainstay of the house. She is, in the words of the staff "very capable" [see also chapter 7] and does much of the housekeeping, despite her forgetfulness, as she likes to be in a reasonably tidy environment. Keeping busy is also, she feels, a means of dealing with her depression, so that she finds it difficult to share out tasks on a rota, and tends to intervene and criticise those who are slower to do their share. Talking is important for her, particularly since she is completely cut off from the family which was the centre of her life, and she finds change very difficult now. Unfortunately, both her activeness and her irritable moods, when feeling depressed or frustrated, were seen purely as problems, while her abilities, not least in bringing past experience alive for the other residents, remain largely unfulfilled.

JEAN

Jean is quiet and hard to get to know. She likes the house and spends much of the time lying in her room, coming down regularly to make a cuppa. She rarely talks very much and hates being questioned, but like Kathleen she often enjoys sitting with other residents or regular visitors, to listen or join a conversation. Her mum moved away from the area shortly after her move out of hospital to stay with her sister. Jean told me that she was too frail to live alone, but this means she can visit less easily and sometimes Jean tells me (rather hopefully I feel) that she's thinking of coming back to her old house, up the road.

Jean was born only a couple of streets away in 1934 and went to the nearest primary school. Her family lived here for a long time, but she was in hospital from a very young age and so had no adult life outside hospital. She still knows the area quite well, but now her [step] mother

has gone she is quite isolated within it. There is no-one else she knows. Her only friend is Kathleen.

"Our house was just in Anson Road. You go to the corner and its two streets down. Mum's sold it now - got a lot of money for it! She's with my sister who moved out to Herts. She's 87, too old to visit except by car. That's why she doesn't come to see me so much now. My sister's husband has got a car and drove them down at Easter, brought me presents and a cake for the house. I can't go and visit her now. The bus takes so long I'd have to stay, I'm too frightened to be coming back alone at night time.

I had a younger brother who died as a baby, of a bad heart. Mum left him in the cradle one night and next day found him dead. She was heartbroken. I died too when I was a child. Mum said I stopped breathing and they had to revive me. I was lucky.

I was evacuated during the war to a farm in Dorking in Surrey. I remember helping, picking fruit and potatoes. It was a lovely place. The place was owned by a major. It was a mansion! - with servants: a German one, a French girl and an English girl called Betty. We used to help on the farm and they cooked and did the house. The major's children were all grown up. I was only a little girl when I went."

Since Jean spent all her adult life in Claybury, there is little that is not part of her life there, apart from the occasional visits to and from her family, yet she has very little to say about these years. Her childhood was partly spent away from home and she has said very little about her teenage years. Her memory appears to be quite poor, and her notion of passage of time is quite confused, and contrasts strongly with the clear and detailed way some of the other residents may describe a scene.

"I had a job in a dry cleaners. I worked there from leaving school until going into Claybury. The woman promised to give me a job there when I came back. I had to write out tickets for the customer and stick them to the clothes for the order. I used to get good pay, half for myself and half for mum, but that was 38 years ago."

One of the day centre members remembered her from Claybury. Said he used to see her, along the corridors, when he was sweeping them. "You looked very sad sometimes. Are you alright now?". She just nodded. Her parents used to visit at intervals, like Christmas and birthdays, and bring her presents, and she used to go to see them from hospital.

"Dad died a few years ago, after he had a minor operation. It caused a stroke and heart attack. Mum still hasn't got over the shock. He just went in for an ingrowing toenail. I wanted to go to his funeral, from the hospital, but I missed it. I don't like going near doctors and dentists myself. I go for my injection. I've got used to the clinic now. You wouldn't have thought it would you, for such a little thing, but he was very old to have an operation."

Her relatives are really pleased with the move, and say she has changed dramatically since leaving. She was thought by staff to be "very institutionalised" and unlikely to change her habits, yet she began to care for herself again. Her 'treatment' in hospital has left her unable to concentrate well, and she rarely reads or watches TV and finds the idea of meeting strangers quite daunting. I found it difficult to get to know her well, yet she is a very good friend to Kathleen, and she always welcomes visits to the house and joins the others conversation, despite her own quietness.

DOROTHY

Dorothy is a tall and elegant woman, despite her 72 years of age, her long stay in hospital (over forty years) and the side effects of the drugs she takes. When she first moved in, she hardly spoke, except in direct response to a question or remark addressed to her. She told me she had always wanted to leave, having hoped to return to Scotland to be near her family. Her parents are dead now, but she talks of them as though they were alive. Again, it seems she was unable to go to their funerals. She shows great interest if Scotland is ever mentioned, taking great pleasure in other peoples' interest in her country and was delighted when I said that I had always wanted to go there, to see what it was like for myself. After living in the group home for several months, she began to change and to gain in confidence in everything she did, so that remarkably, she began to be able to talk about herself and a life which, although severed by her entry into hospital, had clearly been one of rich experience. .

"I was born in Scotland in 1915. I grew up there and remained there until coming to London at the age of 21. It was a smallish town, part

of Lowland Scotland, with several factories and surrounded by countryside. We were Presbyterian and my parents went to church occasionally. After I left to go to London, they moved further north.

My mother was 40 when I was born. I wish I could go and see my parents. I haven't had any contact with my family for some years, I'm not sure how long ago but I know whereabouts they live. I've a brother in Newcastle who visited me in hospital a long time ago, but I never visited him because of the distance. I also had an aunt and cousins near London, who I haven't seen for may years. I think they didn't like visiting someone in Claybury -people don't want to come and see you in Claybury because its Claybury - and the hospital advised me not to write to them. I think they saw my relatives as being 'unhelpful'.
"Perhaps, if it was stigma about a relative in psychiatric hospital, they might feel differently now you've left?" *"Hmm."*

On one occasion, when we were talking together, Mary asked me what my husband did and when I said musician she started to talk about members of her family who were musical. I asked Dorothy if she'd ever learnt to play an instrument:

"Yes, a mouth organ" [she laughed]   "and also a little piano. My parents had had enough of my elder sister playing the piano by then and so they wanted me to stop."

I talked to the residents about my visit to Singapore. Dorothy and Mary were very interested. Mary said she'd never travelled anywhere much and never been out of the country. I asked Dorothy if she'd been abroad:

"Yes, to Switzerland, America and Canada, but it was a long time ago. I went to visit my sister in Canada. I went on a boat, but I can't remember much about it."

"When I came to London, my younger brother was already living here, but I had no other contacts. I worked for the Civil Service. I worked in Somerset House, and then in the War Office, throughout the war period. When I first arrived I lived in Kensington, in a hostel. My last flat, before going into hospital, was in Shepherd's Bush, but I was only there 6 months. When I became ill I went to the nearest hospital. I stayed there only a short time and was then taken to Claybury. I don't know why I was on a Haringey ward, as I had no connections with the area and hadn't even been there before.

I wanted to go back to my parents. I would have had to have gone to a hospital in Scotland, then to my parents. I feel that if I hadn't come to London I wouldn't have been ill."

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I had become aware that Dorothy was more talkative and would initiate a conversation rather than just answering people. The change had taken place gradually, but was particularly noticeable after she started to attend an elderly people's centre, run by the local council, where she really enjoyed the activities and the sociability. I had taken my knitting to the house with me and showed it to her. She was very interested and asked me questions about it. She told me she used to do fair isle, and smiled approvingly when I said it was a traditional Scottish skill. I asked if I could borrow one of their magazines to use the knitting pattern:

"When I was a young woman I loved reading these magazines, especially for the knitting patterns. I used to be mad on them, but now I've lost my interest. I used to do a lot of knitting before I went into hospital. I carried on at first, in the OT department. I made a fair isle pullover with a similar pattern, which was sold, but never made one for myself. I stopped when my hands began to shake and I couldn't concentrate any more.

I was on another ward for some time before moving to X, so I didn't know the other patients very well. I used to work as a typist in the hospital and helped produce the hospital newsletter. It was good because it helped keep me in touch with what was going on. I also did OT - crafts, knitting and so on. I used to enjoy such things, but I haven't got the confidence now, though since going to The Elms, I've started to do things which I gave up long ago. "

Leaving hospital for Dorothy appears to have been like a re-awakening. She had been a very lively person with a responsible job, who took holidays and loved the theatre and films. Although very withdrawn at first, and described by the hospital as severely institutionalised and unlikely to cope outside hospital, she began to open out again and to pick up on old interests and skills. The group home was an important step for her, which was maintained when she attended a day centre where she could revive her interests in a sociable atmosphere. She was scathing about the hospital and fairly self-contained in the home, although Mary came to depend strongly on her quiet companionship. Her story embodies the value and potential of a community care policy, but it has come rather late in the day for her. She is getting older now and rather frail, and (as later chapters will discuss) the group home has never really incorporated the concept of ageing into its philosophy.

In these accounts, although they vary greatly in their length and detail, certain patterns can be drawn out. The first point is that the majority of people in this situation have the desire to talk about themselves. Unfortunately however, their lives as psychiatric patients have not made this easy. The lack of interest among hospital staff in their pre-hospital identity can be linked to the creation of an altered identity in the institution. The residents had relatively little to say about life in hospital, reflecting its low value for them, yet they did not ignore their identification as patients, and they were concerned particularly to find explanations for their problems, looking for possible physical or moral causes. At the same time, there was a need to talk about aspects of life which are not part of the illness identity. Several residents complained to me about the way reports have been written on them for so long, explaining that they had grown used to such continual observation, but resented at times the way in which it was done, to report on their behaviour and without positive value for them. In contrast, they were surprised and relatively pleased to find that someone thought their own accounts of life, of experiences such as living in wartime London, were interesting.

The recollections are mainly about the ordinary lives of the residents before they went into hospital, their backgrounds and their families. However, there is also an attempt to find in those lives, some reason, some way of explaining why things came to result in entry to a psychiatric hospital and the social status which went with it; the isolation and stigma which led to further painful losses. No conclusions were drawn, but instead, from time to time, aspects of the past would be recruited again and re-examined in this light.[a] At other times, events were recalled more for their own sake and to share common experience.

In the histories related to me, three main areas stand out. Firstly was the factor of hardship in the lives of their generation, material poverty, hard work and family stress. These things were matters of common experience for working class people. Secondly was the factor of war, experienced either as a child, or adult. Among the stories of the male residents, which are not given here, are those of armed service as

soldiers or seamen. The war meant separation from family, with great variation in experience, and often loss of close kin. A third, and often related, feature of their lives was that of grief. One of the residents told me that she had been grieving all this time – mourning the loss of her loved ones but also the loss of her own life.

They bring out the individuality of those who, as patients, had come to be seen as somehow less than a person. The splitting off produced by the entry to hospital is mirrored in the image of the person as patient (as something which functions badly and passively receives services to correct this disorder) disjoined from her more complex identity. The life history is an attempt to make sense of one's experience and to create continuity within a discontinuous life.

The accounts also give some glimpses of the achievements and enthusiasms of the residents – a past career of which one was proud; of making a home or bringing up children and now of being a grandparent; of working skills or the discovery of creative interests. These things were not part of the case history, yet they were the necessary foundations for rehabilitation. In the chapters to follow, I explore the move and the preparations for it and describe the routines of life in a group home. As this process developed, the importance of such *ordinary* knowledge, of getting to know the patients, unfolded.

The aim of the closure, on the broader policy level, was to achieve a re-integration of 'chronic' psychiatric patients into their own community, as far as such a community could be said to exist. If rehabilitation was to be more than a matter of retraining in life skills, but to become a rounded and self-sustaining process, the carers needed to understand more about the motivations of their clients. In order for the residents to regain a positive self-image, carers must be able to form such an image themselves, of the patients as people. If they were to foster the personal skills of residents, and encourage re-integration within the community, the unperceived need was to know who the patients were.

NOTES TO CHAPTER THREE:

1. Examples of historical material using oral histories of ordinary people include White's 'The Worst Street In North London' [1986] and Blythe's 'Akenfield' [1980].

2. The total of 20 residents includes one resident who stayed for less than one month, and several residents who moved in shortly before the end of the study. The full number of residents only applies to the later part of the study, during which time Carrier Lane and the other houses gradually became fully occupied.

3. Wing and Brown's conclusions have been questioned more recently on two bases. Firstly that the patients had no supported facilities on offer and often no known prospects of a home to move to. Secondly, the large proportion of uncertain or ambiguous answers were not interpreted as potentially positive. [See Abrahamson and Bremner 1982] Nonetheless, negative responses did increase with years of stay.

4. Although black men and women are over-represented in current psychiatric inpatient numbers, the proportions of black people among the 'old long stay' population are much lower.

5. These figures are based on the current admission, except for two people who had brief spells out of hospital during that period. Those whose length of stay was less than ten years had generally experienced one or more previous admissions to psychiatric care.

6. The modal age of patients is given as 60-65; 45% of patients had a stay of 20 years plus. [TAPS 1988 p 15 & 17]

7. In order to protect confidentiality this is a fictionalised version of actual summaries, with personal details altered, but keeping to the format and type of information given.

8. The accounts are mostly taken from notes made by myself, but a few passages were written down or dictated by residents. I have kept as closely as possible to the residents own words, including use of idioms or dialect. I was wary of asking residents if they would mind being tape recorded, but in future I would introduce this option, and the option of having a dictaphone, into which the subject can record what s/he wishes to say. In this way a very full and 'emic' perspective could be achieved, which involves subjects fully in writing their own histories.

9. For reasons of brevity I have edited out repetitive passages in their accounts, but clearly the need to go over certain events repeatedly is significant.

CHAPTER FOUR

LEAVING HOSPITAL: POLICY AND IDEOLOGY

In this chapter I outline the policies on selection, rehabilitation and preparation for leaving hospital, of the different agencies involved in the group home projects and describe how these policies worked out in practice in the case of each home. I examine the ideas the agents have about rehabilitation, and the criteria for selection of patients to move to community projects. My argument is that failures to communicate and reach agreement on these ideas, have contributed to problems in the process of reprovision.

Selection and Preparation of Patients To Move to Group Homes:
The Formation Of Policy

In each project there are three main agencies involved in the policy and practice of selection and rehabilitation of prospective group home residents: the local authority social services, the health authority, and the voluntary organisation running the project. It is important to realise also that the district health authority was not closely involved in running the psychiatric hospital, so that health staff were effectively divided between district based, and hospital based staff, as well as between managers and clinical staff. Policy is developed (in theory at least) within the agency, and on a joint basis through committees such as the Task Force, joint planning teams and locality or project based planning groups.

The selection and preparation process for each project was necessarily influenced by the formation of policy in its local district as well as by the approach of the caring organisation. In each case the process was quite different. In Haringey for example, the differing interests of Task Force representatives, which revolved at the most basic level around whether the hospital should close at all, prevented it from becoming an effective policy group. The differing perspectives of the

groups involved were of great importance for policy development, but strategic difficulties, including the timing of these projects in relation to the overall closure programme, also played a part.

In the first two years of reprovision, from 1983 to 1985, the health authorities concentrated on planning at the broader level. It was generally agreed that assessment of the long-stay patients was an important baseline for reprovision, yet the first project studied suffered considerable delays because assessment had not progressed. The difficulties in establishing assessment and rehabilitation procedures reflect the significance of the transition required in creating a community based service, but relate also to the underlying difficulties, for the different groups involved, in developing a coherent, common, strategy for change.

In Islington, assessment was managed by the officers of the district health authority, drawing in social workers, hospital-based health service staff and psychologists. Early disagreements between social service and health officers, over the nature of assessment, were never fully resolved, but a working agreement was formed. Although progress was said to be slow, assessments were available, from 1985, and therefore could be taken into account in detailed project planning, albeit at a late stage. The summaries of these assessments were available to give information to managers of voluntary projects, and staff involved with rehabilitation' in time for them to be used to assist the selection process.

In Haringey, although a resettlement team was planned, the early assessments were done by the community psychiatric nurse [CPN] who was the only member of this team in post until 1987, when input was provided by the Community Psychiatric Research Unit, into developing assessment and preparation, involving hospital and community based staff. Despite the close work of social service and health officers on planning, basic differences in approach to assessment remained, as in Islington, between health and social service authorities, and between hospital and district based health workers. Not only did the process not, in the early stages,

draw in hospital based health workers or social workers, but the CPN met with considerable opposition from nursing staff, whom he felt were not ready to accept that the closure programme was being put into practice.

To understand this situation and the resulting lack of progress, we are drawn back to the nature of the closure decision itself: many hospital based staff perceived it as a negation of their efforts to care for patients, and a decision made, like many others, by a higher and distant authority, regardless of their working experience or personal needs. Nursing staff, in particular, had little authority in the running of the hospital and many now felt they would have little involvement in the running of community services. The lead given by Claybury consultants, who withdrew from planning until agreement was reached in 1985 that the closure would be reviewed in the light of ongoing evaluation, did little to help the morale, or the practical implementation of the policy at the hospital level. [Tomlinson 1988a]

Initially, the hospital was not divided into sectors for each district, but three "front runner" wards were allocated for rehabilitation and preparation for discharge. By 1986, progress had been made, by the CPN working with ward staff, in establishing ward based assessment and rehabilitative activity. The residents of the first house in Adelaide Road came from one of these wards. At this stage the voluntary organisation did not have a direct role or presence in the process. At the beginning of 1987, the hospital was sectorised, with wards allocated to each health district. Therefore, it was only at a late stage that the numbers to be rehoused were known, let alone the overall pattern of patients' needs. The CPN had to re-establish his work on the newly allocated wards, devoting considerable time to working with the ward staff before assessments could recommence.

Within the planning groups, discussion took place, not only on how to carry out assessments, but also on what basis. Significant differences in approach emerged between health professionals and social services, and also within the health service, between hospital and district based staff. The key difference was centred on whether assessment should be

essentially clinically or socially based and on how far the assessment should involve the patient and take account of his/her own perceptions of need. Hospital consultants and hospital based staff in general, favoured use of existing tests, which were centred on clinical or 'objective' measuring of *behaviour* and *social functioning*, such as the 'Hall and Baker' schedule. Social services staff put forward an alternative model, which was fairly comprehensive, described as a "getting to know you" model,[2] and was oriented more towards assessing how the patient would manage, and what support s/he would need in a non-hospital environment. It also incorporated the factor of client choice, with the aim of integrating this into the planning process itself.

In Haringey, the detailed document drawn up by social services, along these lines, was not accepted by the health authority, and a considerable amount of discussion appears to have taken place between agencies, with little apparent progress. In Islington, both clinical and sociological approaches were incorporated into assessment, and the policy of client choice ensured that patients were allowed to read and comment upon their assessment summaries. Therefore, although provision was not designed around a 'client-centred' assessment of needs, this was taken in to account in the process and modified plans to some extent.

Haringey resettlement staff also had to work with a split of clients between two hospitals, with different approaches in each. At Friern, the assessment was consultant led, and carried out by one consultant, an occupational therapist and a psychologist. This group developed their own assessment process, which used clinical measures but also took up the social service proposal of looking at social networks of patients to use as a guide to placements.[3] At Claybury, the CPN, together with the community psychiatrist appointed in 1987, used both the 'Hall and Baker' tests preferred by the hospital, and a model developed by the Community Psychiatric Research unit, which was geared more towards looking at how patients would manage in a community setting. Staff in this district, therefore, lacked a coherent single basis for the assessment process.

The significance of these two rather different approaches, the clinical and the sociological, is explored in this chapter, but also has wider implications for the consideration of community care philosophy and how it is put into practice. The problems between and within different approaches can be focused on the concept of *dependency* as used in the assessments. All the agencies involved used dependency as the key criterion in selection of patients for community based care. It became apparent, during the course of observing rehabilitation practices, that this criterion represented several concepts, relating to the differing perspectives of the carers. The difficulties experienced in reaching agreement indicate that these were not easily interchangeable. Its wide usage, however, reflects the general significance, for the nature of care, of the social and moral status attributed to psychiatric patients.

The failure of many staff to communicate, or even to recognise, these conceptual differences led me to look more closely at the decision making process. Within the constraints of this study, I was not able to observe the early planning stages, or to cover the range of planning groups in operation. Instead I concentrated on the lower level of project groups where the general issues of assessment, selection, and rehabilitation were being discussed. The issues of dependency and of communication between organisations will be discussed below, as a central theme of this chapter, and related to the issue of rehabilitation.

Policy and process for each project

1) Adelaide Road, Haringey.

This project was initiated by the voluntary organisation, which formed plans for the purchase of two houses to provide group homes as part of the reprovision programme. The health authority, in 1985, were still in the preliminary stages of drawing up their strategy, with only one 'core' project substantively planned for the area. They felt that the group homes pre-empted their developments in assessment and in provision

of back up services, but with the concern to secure sufficient suitable residential places, saw them as an offer they could not refuse. This was the first project to come into operation in the district, and many of the difficulties it has encountered reflect its position in the development process – it bore the brunt of problems in forming a coherent closure policy and of putting policies into practice.

Early in the development process, the issues of selection and preparation of possible residents were raised by CRT. In April 1985 the relevant social services manager assured them that "a process of identification and preparation of suitable clients from Friern and Claybury" had begun. Despite the lack of an agreed policy it appeared as though no major problems in finding residents were anticipated. The housing development was expected to take one year. In September 1985, CRT requested that a "profile of prospective residents" be prepared, arguing that the budgeting for running the homes would depend to some extent on the residents nominated.

It was initially planned for residents to come from a Core Unit, a joint health and local authority project, rather than straight from hospital. The Core Unit was to have provided rehabilitative experience for patients moving out of hospital, with the hope of moving on to more independent accommodation. However, the group home project developed more quickly, so that in early 1986 it was decided to take patients directly from hospital. A steering group was subsequently set up including health, local authority and CRT officers involved with the project.

In March 1986 it was agreed that the "Front Runner Group"[4] should negotiate access to Haringey wards at Claybury, for identification and assessment of clients, but CRT were told that it might be difficult because of the high dependency level of patients due for discharge. [This comment – either the nature of the apparent difficulty or the implications of the dependency concept were not explained.] CRT argued that it was essential that the people who run the project be involved in

the selection of clients, pointing out that the houses were only three months from expected completion.

In the first house, the residents came from Claybury and in the second the initial three residents came from Friern. The process was quite different therefore, in each, even though they were run as one project. In Claybury, a list of prospective residents was drawn up by the CPN, in the ward setting, with a right of veto given to CRT. A basic plan for rehabilitation for each resident was drawn up and put into action with ward nursing staff. This had the advantage that preparation began in the ward setting, with staff who knew the prospective residents. Nursing staff explained that they tried to work with each resident on their needs for living in the group home - individual points such as trying to smoke less, or to get along in a social group, and shared activities such as going shopping and cooking a meal - but that any activity was severely curtailed by the ward's lack of facilities and institutional restrictions. In effect therefore, they were limited in what they could manage. Its main disadvantage was that the carers who would be supporting the residents outside, and who had far better facilities for preparing their clients, were not able to get to know or work with them until visits to the house began, relatively late in the process.

For the second house, with residents moving from Friern during 1987, an assessment process had still not been established. CRT were allocated wards to visit, in a way that appeared to them quite random. A slow process began, of selecting wards deemed suitable by CRT, then holding discussion groups on these wards, which would lead gradually to selection of a possible group. The ward chosen was also a female ward, so that, although the homes had originally been conceived as mixed, family style homes, all the initial residents of Adelaide Road were women. Assessments or summaries were not done until a prospective group had been selected, although discussions were held with ward staff during the visiting process, and some background information provided. In this process, the voluntary organisation was more involved, but very much in the absence of any other work, and the residential staff for the home had not been included in hospital visits. No background work took place

for the voluntary organisation to build upon, and no structure existed for involving hospital staff positively in the assessment or preparation process. As a result prospective residents visited the house, only to be later rejected as unsuitable, leading to potentially damaging disappointment.

2) Carrier Lane, Haringey

This was also an ordinary, family-sized house, close to Adelaide Road, which had been run as an unstaffed home. Its condition had gradually deteriorated, until the organisation secured 'closure money' to improve it and rehoused the previous residents. Selection of residents began shortly after the Adelaide Road residents had left the hospital and funding was agreed for the staff to be appointed three months before the completion of work, to enable them to work with ward staff.

The voluntary organisation was allocated two (male) wards to work on and set up a weekly discussion group on each ward, focusing on issues around leaving hospital, recalling known aspects of life before hospital, "landmarks" and talking about the skills needed to cope with life in a group home or hostel. In many ways this group was similar to that run by the CRT officer, at Friern hospital, for Adelaide Road. By now however, some groundwork had been done at the hospital and towards greater communication between the groups involved. Assessments on the patients in both wards were in process during the following three months, managed by the CPN and community psychiatrist, but involving ward staff. CRT's residential staff were able to participate in the visiting process, enabling them to get to know the patients, to liaise with hospital staff closely over assessments, and to begin to build up relationships of greater mutual understanding between hospital and community based workers.

3) Thorn Street, Islington

The Thorn Street group home was a large house, easily able to
accommodate seven residents and several staff, and therefore was the
least like a family home in character. It was bought by a Housing
Association, to be managed by the voluntary organisation in
collaboration with the health authority, which would be the main revenue
funder for the project. For several reasons it was agreed that this
house should provide care for people assessed as 'medium dependency';
these were linked to the size of the house and difficulties experienced
in gaining planning permission, so that the health authority agreed it
should have 24 hour sleep-in staff cover. The voluntary organisation had
traditionally been involved in providing much lower levels of care and
saw its main role in caring for people 'of low dependency' but hoped
that once the residents settled in and made progress, the need for 24
hour staff could be re-assessed.

Health workers involved in the plans for Islington, recognised the
potential value of drawing in workers with experience of community based
care, to explore the subject of leaving hospital with both patients and
staff, and as a foundation for more specific project work later on. CRT
managers were therefore given a consultancy role, and held "activation
sessions" on several wards, from late 1985 to May 1987. Similar work was
also being done by the social work department. Two posts allotted for
rehabilitation/closure work were integrated with the teams work, to
provide a general focus on rehabilitation, and ward discussion groups
were run by social workers and the hospital chaplain. The activation
sessions provided significant groundwork for both selection and
preparation of prospective residents, for the eventual move out of
hospital. CRT's director described their purpose as to "build up contact
with the patients and explore possibilities of the world outside
hospital, and to form a view of who may be suitable....dealing with
psychopathology and problems of institutional chronicity, and addressing
the issue of what will be lost in leaving hospital".

Summaries of the assessments and a list of patients assessed as requiring 24 hour, non-nursing care, was provided in July 1987. Thus decision making was partly influenced by the 'activation sessions' on the ward, as well as by the more formal assessment process. The significant overlap in the lists of possible residents, drawn up by the voluntary organisation and by the health authority, reflected the closer nature of practical co-operation and communication in this case.

It was agreed that residential staff should be in post at least three months before the house completion, so that they could recommence ward based groups, and begin a process of visits outside the hospital. From November 1987, regular project/selection meetings were attended by CRT staff and the key health workers involved, in which the individual prospective residents and the preparation process could be discussed. These meetings functioned as a basis for easier liason, which was taken forward by the appointment of a "transitional team" in the health authority. This team's role was to work with individuals and patient groups in the hospital, to liaise with all staff involved in closure projects, and to attempt to form a contact point between hospital and community. Therefore, the roles in selection and rehabilitation of the transitional workers and the residential workers were perceived as similar, albeit with different bases - hospital and community - and different conceptual approaches to mental health care.

In contrast to the Haringey projects therefore, CRT workers in Islington were given a clearer picture of how to relate to the hospital, with access to key health workers involved in the reprovision and to a social work department which was active in working with patients for rehabilitation. In this situation, the structures for change were relatively well developed, but problems still arose around the conceptual bases for selection and aims for rehabilitation.

The criteria of client selection; dependency

As I have outlined in the first part of this chapter, the assessments of
patients were supposed to be the main basis of selection, by providing
the data for planning of project types and numbers, and providing the
information relevant to selection of residents for particular projects.
These group home projects came into operation early in the reprovision
process. They were clearly, from the voluntary organisation's viewpoint,
and in the written strategy, designed to cater for clients assessed as
being of "low or medium dependency". As such, they encountered the fears
of hospital workers that reprovision projects would simply select the
"easiest" or "less dependent" patients, leaving them to cope with an
increasingly problematical client group and lowering morale.

We can see, from these points, that classification focused repeatedly on
the notion of dependency, so much so that specific projects were being
designed to cater for a certain dependency level and assessments were
also geared towards such planning. For the planners of group homes, the
main dividing line for levels of dependency fell between those thought
to require 24 hour staffing and those requiring 10 hour staff cover in
the community setting. This lined up approximately with the assessed
levels so that low dependency was lined up with ten hour staffing (or
less), medium dependency with 24 hour staffing (with a worker sleeping
in overnight) and high dependency, with 24 hour full staff cover,
usually with nursing staff.

What is dependency? In all the caring agencies involved, dependency was
an assumed category i.e. one whose meaning is taken for granted. One
could say therefore that it was operating as a cultural category, where
members of a particular group assume it has essential meaning within
their culture. Its use in schedules of various types appear to suggest
that it is a clearly defined classification of the patient's state. The
role of dependency in the selection and preparation process, therefore,
is as an organising concept. Its use in practice is symbolic, in that it
stands for other concepts which are being dealt with, but which are not
clearly articulated. This includes concepts such as ability/disability,

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capability, stability, insight, co-operativeness, deviancy or conformity, which are also used by the agencies, but do not form organising concepts in the same way.

Turner, in his analysis of symbolism, [1967 ch.1 & 1957 p29] describes the key properties of symbols as being polysemy, condensation and unification. Polysemy refers to a word or image which has a number of potential meanings. The meaning that is invoked by use of the symbol depends on the context of its use and the level of meaning attatched. Condensation and unification refer to the ability of a number of concepts to be drawn together in one image. [Firth 1973 p79] Turner shows that symbols tend to work on two main levels of meaning, manifest and latent, which can also be described as conscious or sub-conscious.

The notion of dependency, is used to sum up essential qualities of the patient and his or her situation, by which the professional can determine what his needs are, in housing, support, medical care, occupation, socialisation and so on. The crucial point is that it is not necessarily, or exclusively used in the primary linguistic sense of 'being dependent on others'. The voluntary organisation, because of the philosophy of care they operate, do regard dependency essentially in this way, although they sometimes use terms such as 'high dependency' as an exclusion category for other reasons. Many professional health workers, however, use dependency more as a category of individual pathology: a patient described as high dependency is regarded as more ill, rather than, for example, as more institutionalised than others.

Lakoff [1987] points out that categorisation is basic to our thought and perception. It is mostly automatic and unconscious, leading to the impression that we just categorise things as they are. Metonymy, the capacity to let one thing stand for another for some purpose, is one of the means by which we form categories. He argues that meaningful symbolic structures are built up from imaginative capacities, especially metaphors and metonymy. but that categories tend to be based on a "prototype" from which a range of meanings can be built up. One example he uses is the concept of *anger*, where the folk notion of the

physiological effects of anger, is the source of a general metonymic principle. Hence we talk and think about anger in terms of heat, agitation, internal pressure, explosion, violence, madness. Dependency, as an organising concept, is understood and thought about in terms which suggest that it uses folk notions of childhood and socialisation as the source of such a general principle.

In later chapters I will explore the wider uses and implications of the concept of dependency, and the associated notions of vulnerability and disability, particularly in the 'family model of care' and the notions of mental illness to which it is applied. At this point I want to concentrate on its significance in client selection and preparation for leaving hospital.

The Hall and Baker schedule, which was used as part of the assessments at Claybury, aims to provide objective measurement of a patient's level of dependency, on a rating scale of severity, from low to very high, or very severe dependency/handicap. Carson and colleagues [TAPS 1987/88] describe it as a "behaviour rating scale designed too assess people with a major psychiatric handicap" [p3] The scale attempts to combine two, rather different assessments into an overall "score", where 0 "represents a standard of behaviour acceptable in the community; a score of 144 represents total dependency" [p3] It attempts to measure both behaviour regarded as deviant and to provide measures of social functioning, integrating these into a general concept of handicap, which in staff practice was interchangeable with dependency. The findings were to provide individual pictures of each patient's problems and general profiles of problems for each ward, to be taken into consideration in reprovision. For the prospective residents of Carrier Lane, the Hall and Baker scores were to be used as guidelines for selection and rehabilitation. Observation of the processes for this case suggests that the assessments were not objective in the way its use envisaged and had relatively limited practical use for the preparation of individuals for the move out of hospital.

The design of the scales were such as to emphasise any lack of potential on the patients' part, firstly through emphasis on rating of problem behaviour, secondly through the context of the rating in an institutional environment, and thirdly through its reliance on one set of raters.[5] In practice, the group home workers who took part in selection felt the assessment was biased against seeing any potential for discharge, and relied far more on their own observations which were less systematic, but more varied in their bases.

The following examples show how it was used for one patient, (called Howard here) who was selected for the group home and for another Claybury patient who was not selected. In addition to this schedule, the other aspects of the assessment are set out. In effect, the 'objective' assessment was compared with the assessment made by the resettlement team. These provided the baseline information given to group home staff, which was considered by them alongside the conclusions of their own observations and interaction with patients, on the ward, and on visits outside.

HOSPITAL ASSESSMENT - Howard.

HALL AND BAKER ASSESSMENT:

Category of Behaviour	Scale of severity - Low/Medium/High
Deviant behaviour	Average
General behaviour	Severe
Dependency	High
Overall	Most severe handicap category of long stay, suggesting need for high level of care and supervision, in terms of daily living activities, personal hygiene and speech disturbance.

SELECTION ASSESSMENT: (Conducted by - community psychiatrist. Attended by - charge nurse, student nurse, group home worker, researcher.)

DIAGNOSIS: In case notes: ? schizophrenia, ? mental handicap.
Assessed as : Open

MEDICATION: Response to medication has on the whole been favourable.

PSYCHIATRIC HISTORY: Last admission following outburst at home. Mental state was, unkempt, self neglected, perplexed, restless, generally unco-operative and some persecutory ideas but no evidence of overt

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hallucinations or delusions. Seemed to be quite emotional on subject of parents but not frankly depressed. IQ tested as either 51 or 60. Diagnosis at time made as 'personality disorder with underlying subnormal intelligence'. During acute episodes has stopped eating causing weight loss and occasionally incontinence.

PERSONAL HISTORY: No notes

CURRENT NURSING VIEW: For last six months settled on ward, working regularly for the first time and seems to be enjoying it.

SOCIAL WORK REPORTS: None.

SELF CARE - Nurse: Would deteriorate without prompting/supervision, but with this OK.

CARE OF PROPERTY AND ENVIRONMENT: No comments

DOMESTIC SKILLS: No comments

SOCIAL SKILLS - Nurse: OK. CRT staff: Friendly and pleasant.

OUTSIDE SKILLS- Nurse: OK at basic level, public transport and shopping.

DAILY ROUTINE - Nurse: As well as hospital workshop and a day centre in Haringey, has hobbies - chess, TV, table tennis.

NETWORKS: - Nurse: parents would be delighted and relieved of guilt at leaving him in hospital. Some interest from wider family, but not regular contact. Has friend on ward who is being considered for the move.

INTERVIEW: Conducted by community psychiatrist: presented as pleasant and appropriately dressed. Response to most questions was "I don't know". Seemed quite keen to be settled in a small group home. Speech sparse, though able to smile appropriately, his mood appeared to be unremarkable, probably happy, affect appropriate. Denies having any abnormal perceptual experiences and no evidence of any delusions or passivity experiences. No obsessive or phobic phenomena elicited. Awareness of self, place and possibly time. [Psychiatrist expressed dissatisfaction with classic psychiatric terminology]

IMPRESSION: The nurse felt he was being non-committal but deep down really wanted to go.

RECOMMENDATION: Priority - need to explore his various skills; training in social skills, orientation management. In view of past experience, he needs to be maintained on some form of medication for a prolonged period following discharge. Should maintain relationship with his friend on the ward.

HOSPITAL ASSESSMENT: BILL, BORN 1926.

HALL AND BAKER :
CATEGORY   Scale of severity - low/med/high - reason ?

Deviant Behaviour   High - verbal aggression and talking to self.
General Behaviour   Med/High - lack of social activity.
Dependency   High - requires structured environment with high
                       level of supervision and extensive training in
                       social, speech skills and some aspects of self
                       care.

GENERAL ASSESSMENT

MEDICATION: Oral & injectable neuroleptics. DIAGNOSIS: schizophrenia.

PSYCHIATRIC HISTORY: Uncertainty over details of first admission.
Notes suggest several readmissions, present one since 1982. Reason for
last admission - self neglect, some delusions. Had been in a voluntary
organisation hostel and attended a CRT Day Centre prior to this. Nurse
said he was transferred to a locked ward in 1983 because he was
disturbed and wanted to discharge himself against their opinion.

PERSONAL HISTORY: No comments

NURSES ASSESSMENT/CURRENT VIEW: For long time was very disturbed on
this ward and spent most of time in bed. In last 4/5 years felt to be
much more settled. Has refused medication on several occasions in
past, but not recently, apart from the odd dose. Sits in same chair
all day every day and moves little except from chair to bed.

SOCIAL WORK REPORT: Was living in difficult conditions and pestered by
local kids. His mother was relieved at his hospitalisation, taking
pressure off her. She said she'd done all she could for him, but still
showed some affection for him.

SELF CARE - Nurse: Not bad with reminding. May do things like wash,
dress, shave without supervision.

CARE OF PROPERTY AND ENVIRONMENT - Nurse: OK. Aware and tidy.

DOMESTIC SKILLS - Nurse: We don't really know with no facilities on
the ward. He helps out with washing up etc. in the kitchen.

SOCIAL SKILLS - Nurse: Does greet people, spontaneous interaction and
etiquette.

OUTSIDE SKILLS - Nurse: Occasionally shopping for tobacco and bird
food. Expects he could use bus or phone.

DAILY ROUTINE - Nurse: Spends all day in his chair. Doesn't work. Few
interests.

NETWORKS: Not thought to have friends but gets on OK with others in ward. No visits recorded for years, or known contacts through letter/phone.

INTERVIEW: Notes by Community Psychiatrist. Interview described as "hard going": A Said he didn't mind being placed in Haringey, but was happy in Claybury. He sat through interview without any overt odd behaviour. His speech was only in response to direct questions, even then it was very sparse, sometimes off the point. At one point he started talking inconsequentially and said he was talking to God. In addition he has poor articulation and not easy to make out what he's saying most of the time. Mood one of flat affect, possibly slightly agitated because of interview. [He was trembling slightly] No marked clear delusions. However may be chronically hallucinating, talking to his voices. No obsessive or phobic behaviour. Difficult to test his cognitive functions, though aware of the ward and the hospital. Was unable to state his age and his memory of admissions & intervening years appears blurred. All this may be indicative of his negativism or reluctance to answer questions. [He said that he likes to be alone and keeps himself to himself.]

IMPRESSION: Community Psychiatrist summarised main points from records – "period marked with intermittent florid symptoms and disturbed behaviour, which has more or less subsided now. Remains unmotivated and reluctant to engage in structured activity. On the whole a loner."

RECOMMENDATION: Will require considerable stimulation to co-operate with any exploration of his dormant skills and interests. Though able to take care of himself with some prompting, he will require training in social skills, domestic skills and use of public facilities if he is to lead a fairly independent existence in the community.

The community Psychiatrist asked CRT staff how they felt about him. They said it was hard to tell, they needed to spend more time with him. They had some doubts and were happier with Bert and Brian.

Although the 'Hall and Baker' schedules and general assessments overlapped to some extent, the former was focused more on clinical assessment of behaviour, while the latter was more concerned with levels of skill in various areas of everyday living. This may explain why, on certain points, the two assessments contradicted each other. As outlined above, the group home staff were also sceptical about the way in which the schedules had been done, and therefore regarded them as unreliable. In their experience, it also failed to fit with the impressions of the person they had formed in other contexts. This was the case for Howard, with whom they had spent time outside the hospital. His participation in hospital and group home visits suggested that the ratings had

overestimated his disabilities and ignored other important factors, such as his enthusiasm for the possible move.

It is interesting to note that, for a group home catering for people assessed as low to medium dependency, three out of the four residents selected were classified under 'Hall and Baker' as medium or high dependency. Howard was assessed as having very few skills in areas such as domestic or self care and the general summary was that he would be dependent on a high level of support in the community. The group home staff felt that he needed a lot of care and rehabilitation, but were confident that they could help him acquire the necessary skills due to his good motivation towards the home and positive social relations with themselves and another prospective resident. They disagreed with the nursing view that he had ongoing, active psychiatric disturbance. The patient who was not selected, was assessed in similar dependency category by Hall and Baker, i.e. high, but with a more severe rating for deviant behaviour. He was thought by group home staff to be actively disturbed. He showed a higher level of everyday skills than Howard, but was thought to lack motivation towards doing things and to lack positive social relationships.

These are only two detailed examples of assessment, from one hospital, but excluding 'Hall and Baker' they are typical of the other assessments done. The Friern assessments followed similar basic outlines to the general assessments above: psychiatric history and details; personal and social history (if any given); everyday skills in areas such as domestic, social and occupational activity, plus level of self care. In the Islington sector, the patient was assigned a level of dependency on the basis of the levels of such skills, plus degree of any behavioural or social problems. This level was then 'matched' to types of accommodation offered, in order to draw up lists of possible residents for each housing project.

What is particularly striking about the assessments, (from a rehabilitation viewpoint as well as a sociological view) is the almost total absence of commentary on the personal and social history and

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activities of all the patients. Their life histories (as conveyed to me in the group home context) appear absent, like a great empty space in the documented lives of these people. As a result the picture of their lives is reduced, objectified and thereby distorted into the case history of a patient.

The general assessments (and this is why I have reproduced two in detail, omitting only a few details which would identify the particular individual) give glimpses of the person, which in an ideal preparation context could have been explored by nursing staff as well as those working in a community base. Two main reasons for this rather sketchy picture can be pointed to. Firstly, the nurses comments here and on many other occasions reflected on the restrictions of the hospital environment, so that nurses and even patients themselves had little knowledge of what they could actually do in everyday life. Secondly, the lack of personal and social history, (with exceptions for a few patients who have had individual social work support) is a more general reflection of the lack of interest in the aspects of patients' lives which do not, from a clinical viewpoint, appear to relate to their patienthood.

In looking at all the summaries given, the relative absence of the patient's viewpoint is also noticeable. Although all willing patients were interviewed as part of the exercise, this appears to have been aimed more at getting a general impression of the patient, rather than getting the patient's general view of the situation. The possibilities for patients to also provide input into the process, and to choose the projects which they feel would suit them, is hampered by the limited and very piecemeal information available to them, as long-stay patients who have often lost touch with life outside the hospital. In Islington, the practice offered more opportunity for the subject of the assessment to have a say, firstly, because all patients were given the chance to read and comment on the summary of their assessment. Secondly, measures were taken by both the health and social service managers, to give information on the reprovision, through hospital newsletters, through individual social casework, and through talking to patient groups about

their plans and aims. Thus, a process gradually developed by which patients would have increasing knowledge, and a better chance (subject to being assessed as suitable by the relevant workers) of making a guided choice as to what accommodation will suit them best.

CRT regards its role in reprovision as caring for people who are "of low or medium dependency". It is significant, therefore, that selection of residents by them, does not necessarily agree with the categorisations in hospital assessments. Patients who are assessed as high dependency, may be regarded as "suitable" whereas patients who are assessed to be fairly independent in general living skills, but who it is thought may be disturbed in some way, may be regarded as "unsuitable". These differences in meaning have contributed to the problems in identifying and agreeing lists of prospective residents between the organisations involved.

At Claybury, nursing staff gradually changed their views of what the voluntary organisation was doing in selection - At first they would suggest that 'so and so' might be good, because he had certain skills, shown through helping on the ward, or that someone was "no good" because he was not very "capable". Several patients who were regarded as relatively low dependency by ward staff were excluded from the voluntary organisation's list on the grounds that they would be too disruptive. In other cases, group home staff explained to me that capable people often had higher expectations and were therefore more likely to be disappointed by life outside, or to cause more problems due to underlying emotional problems. One charge nurse, towards the end of visits at Claybury, commented that at last he understood - they wanted "the quiet ones".

The assessments of hospital based staff, therefore, put greater weight on certain areas of skill, or coping abilities, as well as paying attention to the patients "mental state". The voluntary organisation tends to regard practical skills as areas which can be dealt with after leaving hospital, with improved facilities and environment for rehabilitation. They tend to avoid those who are perceived as having

active or disturbing (rather than fixed) psychiatric symptoms, or those who appear to have failed to respond to their visits, in hospital or on group home visits.

Implicit criteria of selection

The examples given above show that the bases of selection are not easy to define within the existing psychiatric categories, particularly diagnostic categories. The agencies rely heavily on general notions of dependency, using the concept as a way of understanding what firstly, in their own view is *suitability* for community care and secondly what is *suitability* for a group home. A question by a planner in the social services, to a meeting of the 'voluntary consortium', addressed the issue which appears to have been taken for granted by most of the groups: "Are patients being selected to fit in with projects, or are they to select the right project for the individual patient?" The problem of differing orientations on selection, between agencies, is summed up in the comment by the director of the organisation that, what they regard as "pathfinding" was regarded by the consultant concerned as "creaming off".

If the voluntary association were simply trying to "cream off" patients in selection, then this conflicted with their selection of patients for Carrier Lane, where the residents selected by CRT were classified as mostly being of medium to high dependency. The debate assumes that there is a shared notion of what 'creaming off' actually means, yet the continuing debates over the bases of assessment suggest that it is less clear than hospital workers may assume. The notion relates to two main fears: firstly of declining morale in a closing hospital, as some patients are selected while those left behind may appear as failures; secondly the fear that those left behind will be increasingly difficult or expensive to care for and to place in the community. The use of two rather different categories (deviancy and social functioning), combined into a single "score" as attempted by the Hall and Baker tests creates confusion, as well as failing to recognise positive characteristics of

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the person, on which a rehabilitative practice may be built. Its apparent objectivity, therefore, may have very little value for implementing community based care.

The voluntary organisation, (which was active in selection and rehabilitation rather than assessment itself) does not to have clearly set out criteria for acceptance, but has a limited number of stated exclusion factors, such as [illegal] drug or alcohol related problems. It was the case rather that they were working out their criteria for reprovision in practice, but guided clearly by their views of what a group home should ideally be like. Their selection implicitly also attempted to address the issue of motivation, which cuts across the planning concerns about 'creaming-off' of patients. Understandably they felt encouraged to work with those patients who showed some interest in leaving hospital.

It is important to note though, that motivation for moving was rarely apparent when they first approached the hospital. A few individuals showed immediate enthusiasm, while the majority were very reserved until they had time to talk around the issue, to make visits to the area and the home, and to become more familiar with their possible future carers. Their willingness to consider the move, or even make visits, was often also affected by the attitudes of nursing staff – an interested and enthusiastic nurse could help patients to explore the prospect of moving, while a nurse who lacked information or motivation towards community-based care could be very discouraging. Motivation, therefore, is closely linked to the process of preparation, incorporating some chance for the prospective resident to weigh up what the move would mean for him/herself.

The following notes, from a residential staff meeting, illustrate both what CRT's criteria were in practice, and how these were evolved and passed on to workers.

The manager asked the Carrier Lane staff to describe how the "allocation" was done. Kate [the supervisor] explained the first stage: they were allocated two Haringey wards. Sectorisation was done

more by numbers than actual area of origin, but trying to take into account the relevant area or social links. They got a loose list, from the CPN, of possible people and started open groups for people on each ward. She suggested the final result bore out the openness of their approach because the four selected weren't on the original list. She described the 13 group meetings held as "quite lively", though most participants didn't go on the home visits. The basic subjects of the meetings were around thinking about leaving hospital. She felt one should go in with some specific idea or plan.

The manager asked the group home workers "If asked what were our criteria, what would you say?" They found it hard to set this out clearly, except in terms of qualities of a known individual, but described what would be viewed as positive or negative factors:

POSITIVE FACTORS	NEGATIVE FACTORS
Interest in project	
Potential [not explained further]	
Quiet	Noisy or interrupt.
	Demanding attention continually
	Aggression
	Being very disturbed

The two workers were pleased at getting two friends to move to the same house. The manager commented that group relations were an important factor. She asked if there are any other personality aspects they wouldn't accept. Staff thought there was a question of judging levels of aggression. Not sexual problems, but most potential residents wouldn't come into this category - most had gone in with schizophrenic symptoms or just broke down in some way.

Kate asked them to describe how they whittled dowm the numbers. They felt it was a combination of sitting in on interviews and contact with individuals on the ward.

The manager brought in the factor of people's links being "unsuitable" eg. having friends who are disruptive or drug abusers. She posed the question to staff - where did they think they had the greatest success? One worker said "with the long term schizophrenic and over a long period." Kate asked where they were the most unsuccessful? Another worker said possibly the ones who are superficially the most capable but have underlying emotional problems. She explained that in Adelaide Road, at first they'd worried more about some, who turned out to be the most easy going. The managers concluded that someone who has a lot of hostility isn't going to get on in a group home.

This discussion suggests that what the organisation is primarily concerned with in selection is finding people who they feel will fit within their model of the group home. This has led them at points into conflict with health or local authority staff, who, as shown above, tend

to focus more on levels of skill and to argue that notions of suitability are problematical, perhaps unfair.

The following case shows how the general agreement over lists of prospective residents, and the formal criteria for selection, in terms of dependency level, could obscure more basic conflicts over the role of the group homes and the expectations that residents should be selected to fit with the norms of a particular caring environment:

Alfred was put on the list for Thorn Street by the transitional team. He was very keen to leave hospital, already had friends in an area not far from the house and went out regularly. He did not follow any structured day care in the hospital, preferring to occupy himself and sometimes visited a drop-in type day centre in the borough. He had previously been referred, by hospital social workers, to CRT's existing group home in the borough, which only had ten hour staff cover, but had not been accepted, because they felt petty thieving could be a problem.

In a selection meeting the transitional team leader advised them to reconsider him for this house, and to speak to his social worker, saying he'd "come a long way".

In April he visited the house for the third time. Carol [worker] told me she was thinking of leaving. There were various problems, but the immediate factor was that, in her view, the management were messing them and others about over the selection of residents: Alfred had been spoken about at a previous selection meeting, with Kate and the transitional team manager there; transitional workers had been spending time with him on the ward and he'd visited twice. They and the transitional team felt it was going well. He was very keen and getting to the point of wanting to choose his bedroom. When she had tried to arrange the next visit, the manager simply said "We don't want him, he's too difficult, he won't go out [i.e. to a day centre]." Carol was angry, partly because she thought it wasn't right to be so particular, but more so at the way it was done. She felt it was unfair to let him come to stay then turn him down flat, and that it was wasting other workers' efforts. If they weren't willing to have him, they should have made it clear sooner. She was also angry because she thought the staff were being treated as though stupid, and argued that if they had the proper staff level, they could manage more disturbed people. She felt that as it was a 24 hour registered home, the current balance was towards relatively able people. The transitional team manager had pointed this out to her and she agreed.

In the May selection meeting, Kate said that the director's past knowledge of him, coupled with the recent background summary sent from Friern meant that, in their view, given the necessity of maintaining good neighbourhood relations, he wouldn't be suitable. The transitional team, however, felt he wouldn't present major problems.

They said he spends a great deal of time out of the hospital and there are no reported difficulties with him in the community; he's friendly with other residents and keen to leave. The transitional worker reported he'd worked well with her and was making a positive effort to improve his skills. She added that he isn't violent or aggressive, but sometimes shouts, owing to his deafness. Kate said she would talk to the director again. Kate later reported that it was decided that he could come.

A few days later, I was talking to staff in the group home office. Maria [group home worker] telephoned the manager, and incidentally told her about the last visit of 4 prospective residents, including Alfred. The manager told her "We don't want him". Eve, a very quiet woman, who liked the house but was very uncertain about leaving hospital, was the only person she regarded as suitable.

In the June selection meeting, Kate said that she was concerned Alfred would scrounge off another resident, David. Jenny, [group home worker] said "But Ada does that and David just tells her to go and get her own cigarettes from the filing cabinet." Kate said she wasn't very impressed with him in the meeting they'd had at the hospital. The transitional worker, Helen, said he wasn't very good in groups. Jenny said she thought he'd been great on the visits, fitted in very well and had a useful bit of motivation for doing things. Helen described him as the only person who's really keen. She also reminded them that he's also fairly deaf, though at one time the doctors had refused to acknowledge this.

In the following selection meeting, staff reported that Alfred had stayed the weekend with no problems. Another visit was to be confirmed. After several more weekend stays, both Eve and Alfred moved into the house. In the following selection meeting [one vacant place remained] there was discussion of one neighbour, who had been complaining about the house, and about Alfred and had been quite threatening to residents and staff. He had asked why were there bars on the windows if the residents were not dangerous? [The basement windows have bars as a precaution against burglary.] Staff said they were encouraging Alfred not to sit on the bench in the street. When the transitional team manager asked him how things were, he had said that some people in the street were a bit rude. He advised that avoiding them was the best idea and Alfred agreed. Other neighbours were reported to be friendly and quite OK.

When I visited the house several weeks later, Maria told me she thought things had improved in the house since Alfred and Eve had moved in, as they're more talkative and encourage the others to talk and do things. She told me, however, that problems with one or two neighbours were continuing. Someone had pushed a note through the door, and a 'journalist' had called wanting to come inside and interview them. Staff were sure his interest was likely to be negative and refused to speak to him. She was sorry for Alfred, who seemed to be getting most of it - someone in the street has told him he's not to go in the pub. This person had also been abusive about other residents, making racist and homophobic comments. She commented that

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when the neighbour came to the house to threaten them, he had been taken aback by Eve answering the door, because she was very smart and 'together' looking. It didn't alter his stance however. They felt he was a particularly aggressive and prejudiced person. Maria said the managers' attitude was, of course, 'I told you so', but she was pleased that, now he's here, they were backing him up fully.

This case highlights both how decisions are made, and on what they are founded. It is clear that for Alfred, all the official criteria of selection were considered less important than the implicit consideration of public acceptability. The managers, having known him previously, felt that he was unable to maintain face, [6] Alfred's problem was not one of dependency or handicap per se, or of disturbed or distressing behaviour. His problem was one of deviancy in a broader social sense – he scrounged, he was open and friendly, ready to talk to people in the street, he talked too loud and looked rather scruffy. There were particular reasons for their concerns, that some local people had shown themselves to have prejudiced and exclusionary attitudes. [7] The area was relatively affluent, having been gentrified in recent years, but with an otherwise stable population. The factor of class, (or at least the perceived class position of psychiatric patients) therefore, may have been inherent in the implicit criteria of selection. This case showed that motivation per se was not considered without some assessment of suitability from a management point of view.

It is notable however, that the central concerns of the voluntary organisation were skirted around in the selection meetings, and other excuses were given for not wanting to house him, which were felt by most workers involved to be invalid. At the price of avoiding *open* conflict, the differences of view between the agencies were not generally openly addressed in meetings, even though all the participants felt there was a problem, and discussed it in various contexts outside the meeting. [Tomlinson 1988b] This case also brought out certain conflicts between the voluntary organisation management and staff, where staff felt that their work was undervalued by being ignored, when management made decisions without taking their views into account.

In order to understand how these view are arrived at, it is necessary to look at the philosophies and practices regarding rehabilitation in the two settings. Briefly, in many ways the hospitals are set up to contain or control psychopathology, and hospital care is difficult to separate from these functions. In this setting, ordinary living skills have been marginalised, and attempts to introduce practical rehabilitation have made little progress. In the group home, rehabilitation can become a normal part of the routine, and therefore the level of anxiety about skills is low. However, in a small living group, which is idealised as "family like" and "ordinary" the issues of managing interaction within the group, and of maintaining control, without jeopardising the former values, are surrounded by greater anxiety.

Such anxieties are expressed sometimes in concern about whether the prospective resident will "fit" in the group, but also reflect worries about whether the person will be socially acceptable in the community. These issues in selection, therefore are very pertinent to the broader policies on community care. Firstly, although there is concern that group homes will have to deal with the stresses of living in a more intimate group, very few options had been planned for self contained, but highly supported accommodation.[8] Carers may need support to accept that a certain level of difficulties in sharing are understandable and will need to be gone through in settling in to a group home. Secondly, the anxieties about social acceptability in the neighbourhood need to be explored, if the residents are to achieve a greater degree of social integration beyond the home.

From the patient's view, the ideals of suitability, or 'fitting in' to the group home can be rather confusing, perhaps even misleading. The following extract, from my diary of house visits, show how their approach could appear contradictory to the residents:

Visit to Adelaide Road, November 1987.
One resident, Jane, was confused about something the worker had said to her about the selection of residents: that on a Friern visit, a nurse had said of one patient, "He's no good, he can't do such and such" and she replied, "we can cope with people like that." This implied to Jane that they wanted helpless people rather than independent people. Therefore, she couldn't understand what the

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supervisor had been saying to them, for months in Friern, about having greater independence and so on if they moved to the group home. Then, she got the impression they were looking to take the most able and independent people, and now she couldn't work out where *she* stood or what they wanted.

The relationship between selection of residents and rehabilitation

For the voluntary organisation providing residential care, rehabilitation is both an aim and a means of enabling long stay patients to move into community based care. Their support for 'community care' policies is related to the view that long hospital stays can lead to the loss of skills and relationships and to behavioural problems, which we call institutionalisation. It follows therefore that some form of rehabilitation is viewed as a key part of the process of selecting and preparing patients to leave hospital.

They are related in policy and in practice, because rehabilitation is found to be marginal to the hospital but central to the reprovision programme. The process of assessing patients for reprovision has attempted to outline, albeit in a very limited way, needs for rehabilitation, as well as those for residential and day care.

All those working towards the hospital closure agree that rehabilitation is a key aim and means of community based care. However this does not guarantee that ideas of what rehabilitation means, or how it can be achieved, are fully shared or implemented. The broad closure plans suggest that rehabilitation is viewed as integral to the alternative forms of care. In this context *care* is seen firstly as supported accommodation and secondly as *day care* which may be sheltered work or leisure or activity categorised as intensive rehabilitation. The much slower development of day care plans may reflect the initial concern that adequate accommodation must be available, before the details of rehabilitation can be pursued. The lack of progress on rehabilitation in the hospital context, however, can more clearly be related to the

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contradictions between residential psychiatric care (which has a controlling as well as caring social function) and rehabilitative aims of developing patients' autonomy.

The meanings of rehabilitation

In terms of the hospital closure plans, it means enabling people to move out of hospital into either independent or supported care, in such a way that they can cope with daily living as well as possible. There is an implied aim, in the planning of hostel type care, of the patient moving (literally, by moving on) in steps towards a more independent lifestyle. However, the longer term care offered by group homes reflects a view that, for long-stay patients, this progression is likely to be limited. This is why group homes are also called "homes for life". The emphasis is on rehabilitation as "training" to enable patients to leave hospital, whereas policies for more sustained rehabilitation, after leaving, are slower to develop. CRT's stated aim is to enable patients "to lead fuller and more independent lives". In practical policy it is focused on the development of basic living skills, especially domestic ones. Much of the work therefore, is addressed to the relearning of skills which were lost, or at least discouraged, through living in an institution.

In the hospital setting, concern about rehabilitation has increased with the closure plans, but few facilities have been developed. The wards often lack facilities for practising domestic skills and little attention is given to the retaining of living skills, beyond that provided in occupational therapy or workshops. A rehabilitation unit at Friern provides a three week course, which is widely thought to be helpful, but totally inadequate. The base of the Transitional Team is a sort of house within the hospital, which is now used by them for rehabilitation work, but was previously very underused. At Claybury, a rehabilitation unit is actually available for patients to move into before leaving hospital, but thereby is even more isolated from everyday ward life. This unit was not used for these projects, but for shorter stay patients preparing to leave.

Some facilities for rehabilitation do exist in the hospitals therefore, but they had not been fully utilised. Furthermore, the nursing staff at both hospitals felt left out of the rehabilitation process. Some complained that the facilities, such as cookers and washing machines, weren't present on the ward, and that their attempts to introduce "normalising" practices into the ward routine were often thwarted by institutional or administrative pressures. Others complained that they could do little with the staff numbers available.

This lack of confidence in rehabilitation in the hospital setting, also exists among community based careworkers. The CRT staff used hospital visits primarily as a means of assessing patients and of introducing and encouraging the idea of going out from the hospital. The group home itself, and to some extent its local area, was returned to repeatedly as a focus for discussion. Even though for the Islington project, the rehab. house was available for preparing meals or for getting away from the ward to talk, the home was used as soon as possible for most activities, even before the furniture had arrived.

A lot of significance was attached to the need for patients to orient themselves towards the outside; to gradually get used to the idea of leaving the hospital. The idea of leaving, in abstract, is more difficult for the carers as well as for the patients to approach. Once they could see what they might be going out to, it became easier for patients to discuss and to think about what group-home life might be like for them. This orientation also resulted from the discomfort that staff felt in the hospital environment, where they were outsiders, and possibly not fully accepted.

The two cases below are examples of the two main components in the preparation of prospective residents for leaving hospital. They were not only rehabilitative exercises, but also means for the voluntary organisation to discuss the prospect of leaving and to observe patients in both settings, as part of the selection process:

A ward discussion group on leaving hospital

The discussion group took place once a week for several months, on one
of two wards where patients were being considered for leaving hospital.
Ward A where the group was held was an all male ward, and interested
patients from ward B (a mixed ward, also long-stay) would attend,
usually accompanied by an interested nurse. The meetings were open, so
that any patient could attend and hopefully benefit by greater activity
and interest, beyond the confines of the ward. Group home workers aimed
to encourage general interest in 'the community' while also trying to
form a 'core group' of prospective residents.

There was delay in starting as it was almost tea time, and those who
leave the ward during the day were in the process of returning from
the workshops. After tea and the 'medication round' about 9 people sat
round, all men except for Ada, who had come up from ward B. The
student nurse who accompanied Ada and Maurice joined the group and
showed interest in the project, planning to come on the next visit.

Carol did most of the talking, since the other group home worker
didn't know anyone and was new to the project. I noticed that she
talked mainly to the patients she was already familiar with,
especially those who had already visited the house. The main focus of
the discussion was on the house and the idea of moving out to a home
of this sort. First she asked a few people why they thought we were
all here together. Maurice said "for a meeting". She asked "What's
the purpose of the meeting?" David - "About moving?" "Yes, about the
house which some of you have been to see." She then talked about the
hospital closure and looking for alternative homes. She asked what
[the initials] CRT meant and then discussed with Maurice what
rehabilitation might mean - living in a house, learning to do things
for yourself like cooking. She asked those who had visited what they
thought - did they like it? All said yes or just nodded. She asked Raj
about the stairs, was he worried about managing. He said no, it was
OK. She spoke to all those who had been expected to go on visits,
trying to encourage them to come next time. One man said his brother
didn't want him to go, so he didn't want to visit.

A visit to Thorn Street from the hospital

We went to the wards to meet people. Ward B staff were friendly and
helpful, but the amount of joking going on suggested some tension. eg.
Carol - "Can we take Maurice?" Charge nurse - "You can keep him! He's
packing his suitcase already!" John [worker] went to talk to him while
he was getting ready to come out. Another man, who had been on the
previous visit, wasn't around and so didn't come. Carol went through
the list of people from the ward, who might go if she could get them
from the workshops. The staff nurse said that Ada was feeling too

grumpy to go out. The other woman on the list had gone the previous week to visit the house and CRT staff were worried that she found it a bit stressful. The ward staff said not to worry because she was like that [anxious] in the ward anyway.

At the main workshop, the occupational therapy staff said they weren't aware of what was going on, and weren't being kept in touch, so Carol and Maria went into their office to talk to them. Jim and David agreed to come on the visit. Both were rather unsure, saying that the nurse had told them not to go. Carol told me this was one particular nurse who is opposed to people leaving. She had discussed it earlier with the transitional worker. We went on to West workshop. Maurice went in to tell them why he wasn't doing pottery that day and they wished him well. There were no patients there able or willing to go that day. Maria said that one man wouldn't go because he'd been told not to.

I went with David in Carol's car. She talked to both of us. He seemed very relaxed, joining in the conversation at times, knew where we were and said he knew the local area of the house quite well. On arrival, we went straight to the kitchen to make tea. There was still no furniture, but a lot of household equipment had arrived. It was possible to make a meal, but with nowhere to sit down. The workers explained they had been expecting a furniture delivery, which didn't turn up, and the men didn't seem bothered by it. They had another look round the house, while Carol tried to work out how to put the oven on.

The process of making and eating lunch was quite disorganised, but the men didn't look bothered by this. They spoke little, but smiled occasionally and were all willing to participate. They helped with lunch, stirring the soup, cutting up some tarts etc. The staff were in a very jokey mood with each other and fooling around. I didn't feel this reflected a relaxed atmosphere, but that the staff were fairly nervous. They all like the house, and say they're looking forward to working there. The men said they were happy to come for lunch on Monday, even though they couldn't be sure the furniture would be in. George, who had been unsure whether to come at all, nodded in agreement.

February 1988 – Visit to Thorn St from the hospital

Five patients visited with 3 workers, Carol arriving later after talking to the ward staff "about things". When I arrived, John [worker] was just going in with Maurice and Ada to the kitchen. We looked around the house to see what other furniture had arrived. Ada sat down in the living room, smiled and said she liked it. Back in the kitchen, they sat down with John to set the new alarm clocks and put batteries in, while I put the kettle on. Ada and Maurice both decided they would like coffee. John said they would go shopping, have some lunch, then dinner later, and return to the hospital by about 6pm.

Ada seemed very pleased to be there – friendly, talking a little, smiling. She was also very attentive to Maurice – when we went shopping, for example, she picked up his coat for him and said "Come on, Maurice". In a while, Carol and Maria arrived with David, George

and Raj. Raj was wearing a smart new cap and everyone said it really suited him. It was very cold and I noticed that everyone except Maurice was not really adequately dressed - no overcoats, scarfs or gloves. Ada had on a thin dress, shoes, pop socks and jacket.

While we were having tea, Carol asked David what were his worries about staying overnight. He said he was worried he wouldn't be able to go and see his sister in Hanpstead, if he comes to live in the house. He had explained that she was frail and would find it difficult to get to the house to visit him. Carol assured him they would make sure that it would be OK, offering to go with him until he's worked out the way, and to collect her in the car if she wanted to come and see the house. She asked if there was anything else he was bothered about, but he didn't say so. She asked Raj if he had any problems or worries and he just nodded in an agreeable way. She also spoke to Maurice about the possibility of his family coming to see the house.

After tea and biscuits, John asked everyone what they wanted for lunch, but got no response. He made a few suggestions and asked if they liked the idea of these. This brought out more opinions and ideas. With some input, he wrote out a shopping list and we split into two groups, one for the supermarket, one for the vegetable market. At the shops, Maria took care to include Raj and David in finding the items on the list, deciding how much to get etc. All the shopping was put into a wheely basket, which George pulled back to the house.

When we got back, all the prospective residents were quickly involved in some aspect of unpacking and preparation: David made tea for everyone, Ada buttered rolls, while John filled them. Maria sat down and helped Raj with the peeler for the carrots. At first he was unsure what to do, but quickly got the hang of it. Maurice and George helped prepare the other vegetables. Everyone was involved in some way. Even if the individual tasks were relatively simple, they were things they would hardly have had the chance to do while living in hospital. Sitting at the table Maria, George and I talked about Cypriot food and Cyprus. Lunch was very informal - rolls followed by cake, started while some people were still chopping vegetables for the supper. John began to clear stuff away before Maurice had quite finished and he quickly asked for a piece of cake before it was taken away.

Methods of rehabilitation

The areas in which rehabilitation is practised, broadly follow the lines used in assessment. The main areas CRT staff aim to cover are: domestic skills, self care, social interaction, and occupation. The cases above show that rehabilitation is very much focused outside the hospital, on learning to manage in the group home. The major emphasis is practical,

on domestic skills and on shared activity. Specific issues which arise
in this process, such as David's concern about losing touch with his
sister are briefly discussed with residents. The general aim is to
encourage a positive view of leaving hospital. The home functions as a
base for rehabilitation, which is easily contrasted with the hospital
setting. In the residential staff view, therefore, rehabilitation begins
in the home and is part of home life; once the residents are
sufficiently encouraged and prepared by their visits to move in, it will
be continued as part of domestic life, and in day care outside the home.

The view that rehabilitation does not work in the hospital setting is
widely shared. The community psychiatrist, during his assessments, said
that he wasn't keen to move people into a hospital rehabilitation house,
even if it had been available. He felt it could be relatively
ineffective, considering that it would entail an extra move. Although
community based staff viewed nurses as being uninterested in
rehabilitation, this is also an institutional stereotype. The nurses who
spoke about it suggested that frustration and fatalism engendered by the
hospital regime, plus sheer lack of facilities and encouragement were
key problems. This view is shown in the comments of two nurses who came
to visit their former patients in Adelaide Road, some months after they
had left:

> They were reassured to see the residents were being properly cared
> for, explaining that nurses were concerned about where patients were
> going to. They described how they try to prepare people for leaving on
> the wards, and try to include rehabilitation as part of general care.
> The sister said that traditionally they had tried to do such things,
> like cooking a nice meal with a small group, through from choosing and
> buying food, to serving it in a nice setting and eating together. This
> had been stopped however, because administrators thought nurses were
> after free food. Now, she said, they were telling them to do it, as
> part of the rehab programme! She described other things they did –
> encouraging going out to shops, occasional outings by coach (with
> patients not herded together but able to go off as they pleased). They
> tried to encourage people to walk and get out of the institutional
> shuffle, to do their own washing if a machine was available. This was
> also stopped at one point because administrators thought nurses were
> bringing their own washing.

The residents also describe how difficult it was to maintain their

abilities in hospital, and feel they have lost much of the confidence they need to do things, even going out, or talking to other people. Jane explained this by describing the confusing and contradictory ways she was treated in hospital. She commented that it seems the way to "get on" in hospital is at odds with any aim of rehabilitation, especially as far as independence of thought or action is concerned.

In Islington, however, despite the limitations of the hospital setting, preparation for leaving was provided by voluntary organisations, by an active social work department, and from 1988, by a transitional team. Despite difficulties in working out their relative roles and responsibilities, and in establishing rapport with the ward based staff, they were able to provide the necessary links between hospital and community. The support which was provided to patients, in thinking about leaving and in preparing themselves for the move shows up in the very positive views held by all the Thorn Street residents about leaving hospital and, except for one case, in the transition to living outside the hospital.

In this chapter I have looked only very briefly at rehabilitation, focusing on the very limited measures taken to prepare people for leaving hospital and living outside. The wider issues of rehabilitation will be returned to again in looking at everyday life in the group home.

Concluding Points

I have written about selection and rehabilitation together, because the selection of group home residents, in policy and in practice, is guided by the carers' view of the patient's rehabilitation potential. This potential is assessed in terms of practical skills on the one hand, but tries to look at aspects of the person, which it is thought will enable them to "get on" or alternatively "fail to respond" in the group home and the community setting. The principles pursued therefore, relate closely to the other principles of care which are followed by CRT. Their

understanding of rehabilitation is developed on the principle of resocialising the patient.

The process of selecting and preparing patients to leave hospital and move into the care of a voluntary organisation is marked by problems in communication between the different groups involved. Certain tensions lie between the voluntary and statutory sector, who may not fully understand, or trust, each other's ways of working. They also follow the lines of 'inside and outside' between *the hospital* and *the community* where community based workers feel outsiders to hospital work and hospital workers feel alienated from community based work.

Similarly, the step from living in hospital to moving outside, is considerable from the viewpoint of many long stay patients. The issue of leaving in itself is a very significant one for them, which despite the focus on going out to the group home, appears to have been neglected by the rehabilitation programme. It is dealt with mainly by focusing on the important practical issues surrounding leaving and starting a new life. However, in two out of three projects, little or no back up support was available for the residents through social workers, psychologists or counsellors of some sort.

Without this sort of support, (in two out of the three projects studied) and with very little input from residential care staff, beyond practical caring, there was little opportunity for broadening the scope of rehabilitation to consider feelings about leaving home, since hospital is the only home some patients had, and the losses or gains which may be felt as a result. The concerns which are brought to light in the selection and preparation process, relate to the broader concerns about community care, felt by hospital and community based staff. The commitment of residential staff, and their confidence in community care, is considerable. However, the questions over the "suitability" of prospective residents and over the limits of rehabilitation, relate to broader concerns about how to achieve such care.

In the next chapter I look at the process of leaving itself. In the attempt to make hospital closure a reality, the service providers have paid far more attention to the provision of accommodation than to the actual process of moving out of hospital. I will argue that problems arose because of the failure to fully and imaginatively consider the complex set of issues symbolised in the simple word 'leaving'.

NOTES TO CHAPTER FOUR:

1. Initially rehabilitation was developed mainly by the hospital
    social work team, until the health authority's Transitional Team
    became involved in 1988. Significantly, little progress was made in
    involving nurses until after the study period, 5 years into the
    closure programme.

2. An account of the use of this approach with long-stay patients is
    given in Thomas and Rose [1986].

3. This work did not commence until after the Haringey residents had
    moved into the group home.

4. A group of representatives involved in planning for closure
    projects.

5. Although inter-rater reliability was checked by using two nurses to
    do separate ratings for each patient, this does not imply general
    reliability or objectivity of the results.

6. For the particular use of this term see Goffman [1971] "The
    presentation of self in everyday life".

7. These problems originated in the need to apply for planning
    permission to use 'family housing' for a 'group home for the
    rehabilitation of psychiatric patients'. See the discussion of
    planning categories in chapter 2.

8. Planning development since 1988 in Islington and Haringey has
    focused more on this area, with a number of highly supported
    individual bedsits planned, and several purchased in houses or
    blocks with added communal facilities. These aim to allow greater
    separation, for people who prefer not to share, without creating
    problems of isolation or lack of support.

CHAPTER FIVE

LEAVING HOSPITAL: TRANSITION:

Leaving hospital as a rite of passage.

"You must remember, we're all ten year patients", Jane said. She was trying to explain to me the stresses they were all feeling about the visiting process and the prospect of moving: "backwards and forwards" she said, made her feel more unsettled. For herself, she would prefer a clear cut thing, just to move in one go. She said so many people were telling her different things and giving her conflicting views. she herself could see many points on either side and felt very unsettled about it. Gladys wasn't keen to go back either, she liked it, she'd stayed there and made up her mind. "we're all ten year patients - there is so much re-adjustment..."

For the residents of the group homes, all of whom were long-stay patients, the admission to hospital was a major life event. Its significance, in terms of their personal and social identity, was such that they are largely seen by others as patients or clients, rather than as ordinary people. I found myself asking why it is that the residents are still seen primarily as patients after leaving, whatever they are now called - resident, member, etc. Their status in the eyes of others had not altered in the way I had hopefully expected.

Social and anthropological research has shown that in a wide range of situations, major life crises are marked out and managed through ritual. Life crises may be both the normal developmental stages of life, or special changes, events which alter one's relationship with the natural or social world. The anthropologist Van Gennep, in 'Rites Of Passage' [1960 p11] argued that they are marked by three phases: separation, margin (or limen as in threshold) and incorporation. In the first phase the subjects are separated symbolically, and commonly by physical removal, from their previous state. The second stage is marginal in many senses: the subjects are, as described by Turner, "betwixt and between" two positions. [Turner 1967 ch.4] They are also outside the normal social world and outside of any clearly sanctioned state. Therefore the

ambiguities felt about people undergoing critical changes are expressed and framed symbolically by their marginal, or liminal state. The third phase is one of reincorporation: the person returns to the normal social realm, but in a changed state.

Ritual is used as a way of identifying the nature of the change and of structuring it in a meaningful way. It is also understood to be a means of structuring the stresses involved in change, giving it a meaning or significance which enables the person or social group to cope with the process of taking on a new life status.

The major crisis, of admission to hospital, is one that many people are reluctant to talk about because it was a painful experience and one of which the memory may be blurred. In contrast, in Ramon's paper on leaving hospital, [1988] she describes how important it was to the group (who were younger and not long stay patients) to talk about their admission to hospital. The construction of time therefore, is significant in the experience of these people. As time passes and the identity of hospital patient becomes more fixed in the course of life, the entry to hospital seems to lose its relevance for now. The long stay patients are leaving, but they are not fully discharged from the patient role. In describing their lives, residents could talk easily about the pre-hospital past, of childhood, ordinary life and changes. As the entry to hospital was approached, their stories seemed to die away - just as their ordinary lives had seemed to do. They had learned to live in hospital and largely to accept this as their home, yet the little they had to say about long years in hospital reflects their perception of its value in their lives.

Hazan in 'The Limbo People' [1980] describes how, in a centre for isolated elderly people, the perception and recollection of time was altered through membership, by a focus on the present and general resistance to reflection on the past. The 'old days' of hardship and social isolation as young people in the East End were often treated comically, although at times this view would break down into "uncontrollable nostalgia", while war time was viewed as "the heyday of

sharing, joint effort and unconditional friendship." [p 95] Members who knew each other before centre membership, however, rarely made reference to their pre-centre experiences, and any attempts to discuss issues of loss, such as the Holocaust, or loss of contact with family, were commonly opposed and described as "opening old scars" [p91].

Those who talked about their admission characterised it as a sort of ending, and thus in some way irreversible in its impact. Even though they are now living outside again, they are unable to simply pick up from where they were before. Entering hospital was an experience of departure from the person's ordinary life - the personal history halts at the entry to hospital. Entering the institution is like entering the liminal ritual state. Direct comparisons have been made with marginality in rites of passage - the removal from normal social rights and obligations, the removal of previous social identity, geographical and social isolation. The ritual state of marginality is also marked by notions of dangerous power and vulnerability, associated with the special nature of the person who is outside the usual natural and social pattern of life. Mary Douglas, in 'Purity and Danger' [1984] shows how the ambiguity which is characteristic of the liminal state leads to notions of ritual pollution and danger:

"consider beliefs about persons in a marginal state. These are people who are somehow left out of the patterning of society, who are placeless. They may be doing nothing morally wrong, but their status is indefinable. Take, for example, the unborn child. Its present position is ambiguous, its future equally. For no-one can say what sex it will have or whether it will survive the hazards of infancy. It is often treated as both vulnerable and dangerous. The Lele regard the unborn child and its mother as in constant danger, but they also credit the child with capricious ill will which makes it a danger to others." [p95]

and describing traditional initiation ceremonies:

"During the marginal period which separates ritual dying and ritual rebirth, the novices in initiation are temporarily outcast. For the duration of the rite they have no place in society. Sometimes they actually go to live far away outside it. Sometimes they live near enough for unplanned contacts to take place between full social beings and the outcasts. Then we find them, behaving like dangerous criminal characters. They are licensed to waylay, steal, rape. This behaviour is even enjoined on them. To behave anti-socially is a proper expression of their marginal position." [p96]

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The entry into the psychiatric hospital (among other total institutions such as prisons or monasteries) has been described by Goffman as a 'rite of degradation' or 'mortification of the self'. [1968 p24-32] A number of sociologists have written about the stage of entry into the institution, but few have examined the impact of leaving. Why not? Goffman expressed a lack of confidence in the possibility of re-entry into the normal social world, not because of the difficulty of such a change for the patients, but because of the social role these institutions play. His lack of commentary on 'community care' was based on a conviction that if the hospitals closed, the wider society would react against it. Thus he had little to say about alternative forms of care:

"if all the mental hospitals in a given region were emptied and closed down today, tomorrow's relatives, police and judges would raise a clamour for new ones; and these true clients of the mental hospital would demand an institution to satisfy their needs." [p334]

For the long stay residents of the institutions, the liminal phase of transition became indefinite, and no end process was envisaged, until the closure decision was made, by agencies far removed from themselves and their carers. Their stay in hospital was not seen as a stage in a process of removal, followed by reincorporation into normal social life. It had come to be seen as a permanent state. For many it was their only home.

If the aim of the psychiatric hospital is curative and rehabilitative, to remove distressed or ill people from their previous lives, to make them patients undergoing treatment, and to re-introduce them to a new life as ex-patients, then we might expect leaving to be treated as a ritual process. So, looking at how the act of leaving is handled may tell us something about how and why the residents were still viewed essentially as patients, still in a marginal state. It may also tell us something about the experience of critical change from the patients' viewpoint and the disappointments and sense of loss, despite hopes of a better life, they sometimes felt. To answer this question I will look at

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many issues of lifestyle within the group home, but also at the way departure from the hospital and entry into the group home was made.

Social identity, understood as how I am seen by others, can be distinguished from personal identity, how I see myself. As long term hospital residents they had been admitted to a status where identity is rarely differentiated eg. friend, workmate, parent, tenant, local resident. Instead everything was subsumed under the identity of patient, centred on their perceived illness. The residents did not want to see themselves as patients, but as individuals with a personal history which was mediated by, but not negated by patienthood. To differing degrees they expected that leaving hospital would lead to an altered lifestyle and new status. They anticipated a significant change, perhaps difficult to cope with after so long, but perhaps leading to a restored identity within the ordinary world of family, or neighbourhood.

The experience of leaving hospital

The following are diary accounts of the day of leaving hospital for two of the group homes. These accounts will be analysed and compared with later events to show their significance to the residents:

Moving in day, 90 Adelaide Road.

The residents of this house had been selected and prepared for the move largely by hospital staff and within the hospital setting. As with all group homes they had already made a number of visits to the house, gradually increasing in length from a few hours to four days, before it was decided that they should move in. The main period from selection of the resident group to moving in, lasted approximately six months. Reflecting the greater hospital role in this case the residents were brought to the house by hospital staff and not collected by the group home staff.

> I was standing out in front, about 10.30am. talking to the worker
> Clare, when the minibus arrived. All four residents seemed fairly

tired, except Jean perhaps. They said they had been up early on the ward and had a busy morning already. Mary said she felt tired and not really very well. She looked to me quite flustered, far less relaxed and on top of things than she had appeared during their last visit. She sat in the living room briefly, having made herself a coffee. Clare made tea for everyone, but Mary saw to things for herself. She was bothered about the lack of net curtains in her bedroom, and said that *normally* one has such things. She went up to sort and hang her things, declining an offer of help "if you need it" from Clare, saying it was quite easy for her to manage. Then she had a lie down.

The nurse and a hospital driver who accompanied them, stayed briefly. The nurse checked they had the phone number of the ward, so they could ring up for a chat and to let her know how they were getting on. She also promised to pop in and see them if she was in the area and asked them to write occasionally. She explained to Clare and myself, that not only was it a big change for the residents, but also for the staff, who became very attached to patients over such a long time. Although she spoke to all of us about the "great change" she was not discouraging towards them and wished them to "be happy and make it a home".

When the nurse left, people said goodbye to her but didn't get up to wave. Some joking had gone on between the nurse and Jean, "It'll be a great change. No me to boss you around any more and tell you, Jean take a bath, clear out your wardrobe Jean, wash your clothes!" Jean laughed at this. Clare said "Oh well, you'll have me to boss you around instead".

Both Kathleen and Jean, those who had expressed some reluctance about moving and lack of belief in the hospital's closure, seemed fairly happy and unperturbed by the actual move. I recalled the staff comments that those with the highest expectations will find it most difficult to cope with change.

Dorothy, as on previous visits, didn't talk much and was possibly a bit irritable or tense – the nurse suggested to her that she was in a bad mood, then turned to Clare to say that it was very understandable, given the trauma involved in moving home. When I asked her if she knew the area, she said "No, not at all"....she told me that she really wanted to go and live with her parents in Scotland, rather than Adelaide Road, but added that it was OK as 2nd choice. In a following visit, I asked if it felt like 'a home' to her. She said "No, home is in Scotland, with my parents". But she felt she was "on the way towards going home.....but its a long way". She said she thought the house was "a little part of Claybury"

The Move To 98 Adelaide Road

As the voluntary organisation was more involved at the hospital in this case, I was able to visit the residents in the run-up towards the move.

Extracts from these visits are given as background to the moving day
itself. The visits left me with the view that their departure was
marginalised within the ward, with little interest and communication
about the move outside the group who were making the move. This pattern
was reflected in the nature of the move itself, a sort of quietness, as
though emphasising an overall stability within the system and lack of
change in their place within it:

Hospital Visit - the week before moving:
As the provisional moving day approached, Kate [the supervisor]
cautiously broached the subject of moving with Hilda. She asked her
how she'd found the visit - "Very nice" - then said "how about going
for longer?" Hilda thought she meant another longer visit, so she
said, "No, this time you should take all your things with you. If you
like it you can stay as long as you like."

Hilda said she wanted a full week off [the workshop] in which to pack,
explaining that she had a lot of stuff, and things to sort out. She
rejected the idea of the nurse helping, wanting to do it all herself.
She explained that she had lots of tickets and things to sort out,
which she couldn't throw away and said she would buy a bag to add to
her suitcase.

Hospital visit - 3 days before moving:
Margeret was in a side room, washing some clothes by hand, to have
them ready for Friday. She was smiling and said she was looking
forward to it. Kate told her that the arrangement to come back to the
workshop daily was OK. Hilda was just returning to the ward. She said
she'd just been to sort out her bus pass. Kate asked if she'd been
getting on OK with packing. She said yes: she'd packed a big case and
bag, but still had a lot of stuff on the top shelf of her locker which
she had to get down and pack. She was worrying about getting all her
stuff over in one go, because she had such a lot, so I said I'd help
carry things and that there was lots of room in the van. She asked
Kate if she'd be able to "go home" eventually. Kate took her to mean
to her relatives, and asked if she'd contacted her brother about her
leaving. She encouraged her to invite him to the house for a visit.
Hilda seemed a little surprised that they could visit and was very
thankful. She expressed uncertainty about whether it would be *her home*
in several ways. eg. She asked if mail from relatives should be
addressed c/o Adelaide Road, and was told there was no reason why
people shouldn't simply write her name and address - 'care of' no
longer being necessary.

Leaving The Hospital:
As the worker, Carol, and I arrived in the minibus, we met Jane
walking along and she got in to show us where to go. Carol ended up
parking outside a fire escape which leads directly onto the ward, and
went up through it. There were very few patients around, most having
gone to the workshops. Those who remained were sitting in armchairs
watching TV. One woman said goodbye to Jane and asked if they'd be

coming back for a visit. The sister handed over medication for 2 weeks and outpatient appointment cards to the worker. All their property was already packed up, each person having a bag and/or case plus one or two bin bags. Only Jane had things for around the house, a couple of cardboard boxes with pottery and paintings in, plus a carrier bag with some plants.

The departure was very low key. [I recall it now as being almost silent, a rather dismal affair.] Most patients weren't on the ward anyway and the staff made minimal fuss. The sister passed their belongings down the fire escape, calling a domestic worker to help her. The three residents helped, even though I was there to carry bags. They all ended up standing at the bottom of the fire escape, in the pouring rain. No-one went back up and no-one came out to say good-bye. There was no final wave. All three were due to revisit the hospital on Monday, to sort out financial matters, and Margeret and Hilda were expecting to return regularly to the workshop. Margeret was taking a week's break to settle in first, but Hilda felt she'd taken up her entitlement with the week off for preparing to leave.

Jane told me, in the van, that they'd had a drink on the ward the previous night, as a sort of farewell do. Carol asked if she was pleased to be leaving and she said "yes and no". Later in the day she talked about the significance of the move several times, talking about "starting to rebuild our lives". She felt she was a bit old now to start again; 20 years younger she would have really gone for it, but she said "I'm different now, from when I left before, and would go about things in a different way."

The journey to the house was quiet. I asked everyone if they knew the area. All did, to some extent. Hilda said she hadn't lived in the area for 30 years. She'd lived in a nearby road, but it was so long ago. Margeret said she used to live quite near here, her family home, some years ago. Jane said she never actually lived in the borough, but knew the area quite well.

On arrival I helped them in with their belongings, carrying some heavier stuff upstairs for Margeret and Hilda. Margeret decided to take the back bedroom and Hilda was quite disappointed, because she'd thought they would be sharing the double room. Margeret said she might change, she'd see what it was like. Jane had planned to have the downstairs room, but it was now occupied by the volunteer, who would be living-in in the spare room for up to a year. Jane left some of her boxes downstairs so that she could think about where their contents should go. She asked the others if they would mind having some pottery and such like in the living room and they said they didn't mind at all.

Jane soon went to put the kettle on and checked out whether there was tea and general food stuff in the kitchen. She made coffee for everyone. Meanwhile, Kate arrived with the registration officer, who was visiting both houses for approval of their 'registered care home' status. He was introduced to me, the staff and the new residents.

Carol, who had driven the van, stayed while the regular worker was at the neighbouring group home.

I sat down in the lounge with the residents for a while and we talked. Hilda said she was a little tired, but not dozy. Jane asked me a few questions about the house, finances, day care etc. and I suggested she ask the worker when he arrived. All three had contacted some relatives about leaving hospital. Hilda opened and read a letter which the nurse had handed to her, on the ward, just before leaving. She said it was from her sister-in-law, saying they'd like to hear from her. Margeret said she's been going home on Saturdays to visit her daughters. Jane showed me a photo of herself, as a child, and a boy who I took to be her brother. She also showed me one of her cat, now dead, at her old house, and one of her ten year old grandson. She said her daughter didn't live far away. Margeret said her daughters were going to come and visit the house....

Around 12am. the worker, Frank, came down briefly from the other house, with some food, and the residents decided to cook baked beans, toast and eggs.   Jane offered to cook me some and I gratefully accepted. Hilda was still a bit hesitant about the cooker, but was reassured by the mains switch and a quick run through with Frank on how to handle it. The cooking was shared out readily so that Jane did the beans and the eggs, Margeret the toast, while Hilda buttered it and laid the table. When we sat down together to eat, Jane commented on how different even food out of a tin tasted. The hospital beans tasted watered down, she said, and having food straight from the cooker to the table made it tastier and more nourishing. Even though Hilda was hesitant about the cooking process, she was not in the least uninterested, saying she was very hungry and very much enjoyed the meal. She offered to dry up afterwards, rather than wash, because she's nervous of putting her hands in the water. Over lunch we started talking about our marriages and religion.

After a short rest, with a cup of tea, in the living room, I walked up to the shops with Jane and Hilda. They didn't wait for me to lead the way, but went on ahead, only asking me for advice on where different shops were. In the greengrocer's, Hilda fancied cherries, but decided that at £1.59 lb, they were too expensive, so she bought a peach for herself and one for Margeret. Jane wondered if we could go in to a clothes shop without buying anything; she wanted to look for a present for her great-grandchild. Hilda looked at the girls dresses, thinking of her great niece.

When we returned Jane started thinking about what she would do with her time in the home and decided to start on the garden quite quickly. She planted her mint straight away and put her pot plants out in the rain. With a gesture, she suggested they were a bit droopy, "like me".

In these two cases there is a noticeable difference in the role of the staff who worked with the residents. In the first case, a nurse who was

committed to rehabilitation, but had worked on their ward for many years accompanied them out of hospital. She talked about the move with her patients, emphasising the importance of the move, putting it in a positive light. At the same time, the continuity between hospital and group home was emphasised by the new carer, trying to judge how far to offer help and comparing her role to that of the nurse. In the second case, nurses had played a minimal role in rehabilitation and shown little positive interest in the move. Their negativity was confirmed, when Hilda and Margeret visited the ward in workshop lunch hours, by nurses' attempts to question how well they were faring in the group home. The residents, however, over a long period of discussion groups, had been able to consider the implications of moving and make a positive personal decision about it. Their approach to leaving is marked by the depth of discussion about the move itself — the reconsideration of their remaining family ties, their roles in the house, the quality of life it offered to them, where even the food tasted different.

It became apparent to me that the process of leaving, in itself, was generally important and could affect the overall view of leaving for the residents and for those, staff and patients, who remained in the hospital setting. For one person, it influenced her view of the hospital and her relationship with it afterwards. The fact that, as she saw it, she had been slipped out of the back way, ignominiously, was quite worrying to her and had played on her mind. It affected her view of her status as someone leaving the hospital and this uncertainty was tied up with the fact that she had continued to return on a daily basis to the hospital workshop since leaving.

Although one could argue that it was merely lack of thought on the part of staff, she perceived the way in which they left the hospital as significant and deliberate. My observation of 'leaving days' for three of the houses suggested that little thought had gone into the act of leaving, as an occasion in itself, and that this gap responded to the insecurities of the staff themselves about managing transition. Staff time and discussion had been directed into the longer and more stretched out process of visiting, firstly for hospital-based selection and

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preparation, then to become familiar with the new home. Planning the visiting process required staff to balance the need for time to explore the issue of leaving and arrive at a decision, and the need to fill places without too long a delay. The approach to leave-taking was not considered to be a major issue for planning or for future care. It was viewed as the outcome of the selection and rehabilitation work which had taken place over months or even years and it was not thought important to set it out as a special event. It was more the case that emphasis on the act of leaving was implicitly avoided, as though workers believed that by not stressing something, they would avoid the problems of stress among residents, while at the same time responding to their own ambivalence and anxieties about the changes taking place.

Implications for the transition

After three months living in the house, staff became concerned about Hilda, who was repeatedly 'unwell' and who had recently stopped going to the hospital workshop, as she had done on a daily basis since moving. The Community Psychiatrist was invited to visit by the group home management. This was to be a general introduction to everyone, but was mainly to see Hilda who was thought to be physically and mentally unwell. They thought it was a good time for him to come and get to know the house and the residents, but the request was initiated by the fact that Hilda had been failing to attend the hospital workshop and staff were concerned about her:

> **Visit Of Community Psychiatrist To Adelaide Road:**
> Doctor P. asked Hilda how she was. She told him that she'd been rather ill, but the police surgeons were looking after her. He asked if she did anything in the house. She said yes, and described cleaning and cooking that she'd done in the last few days. When he asked her about everyday things such as going shopping, she showed herself to be capable and managing pretty much as usual.
>
> When he asked what she did during the day, Hilda said she'd been going to the hospital workshop, but couldn't go now, because someone was against her going - Mildred Drake, her aunt, was trying to stop her. Although she hadn't known it at first, she said, her aunt was in fact the ward sister. She knew she didn't want her to go there, because when they left hospital she sent them down the fire escape, instead of

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going out of the front door, as they should have done. The doctor looked perplexed and queried her about this. Jane confirmed this and commented that, when she thinks about it, it was rather strange.

January 1988 - Residential Staff meeting:
Clare [worker] said "Hilda is making endless excuses not to go back to the hospital workshop". She thought that Hilda was enjoying the time off but said the main problem was that she thinks someone at the hospital doesn't like her. The manager said "she's a very deluded lady". Kate asked if it was time to put a bit of pressure on her, would she respond well? Clare pointed out that she's getting a bit frail, so that maybe two days a week would be enough. She suggested that if Hilda doesn't like it there, they should think of an alternative. The manager felt to have an alternative was a good idea, as it might make her more keen on the hospital workshop option. Clare explained that Hilda was still bothered about the way they left hospital, "by the back door" - she really felt the sister must dislike her to make her go out this way. This wasn't taken as a serious issue by the management. She was said to be very paranoid and they linked it to her "grandiose ideas".

Change and Loss: the impact of leaving hospital

There is an argument that any major life change should be approached cautiously because of the stress it produces, even where the transition is seen as positive. However the way in which the prospect of leaving hospital was approached contrasts with the later attitudes displayed by staff towards problems in settling within the home, or any possibilities for moving on to more independent accommodation. It was as though the move was the end point to be achieved through the rehabilitation process, not a point of transition into a new lifestyle. During the rehabilitation stages of hospital and home visits, possible problems in adjusting to the prospect of leaving were carefully weighed up, but once the person had left, problems with transition were reassessed as problems arising from individual pathology and were dealt with in a relatively precipitate manner.

When leaving hospital is contemplated, not only the feelings associated with change now, but those concerned with the original loss, of one's previous life, may need to be worked through. One resident jokingly told

me that a community centre she was interested in had a 'bereavement counselling group'. She said "I'm grieving, but for something else."

Marris [1974] draws analogies between bereavement and other forms of life change. He argues that a conservative impulse, expressed in grieving, is crucial: critical changes can only be coped with if new events are put into a framework which continues to be meaningful for the person undergoing them. He stresses that if change cannot be worked through in this way, it leads to disorientation and depression. The importance of ritual in this case is in providing a culturally sanctioned process of mourning loss, which incorporates the conflicting emotions involved into a meaningful framework. For people who have lived in a psychiatric hospital for many years the 'death' of the hospital means moving home and loss of a familiar life, however unsatisfactory it may have been.

He argues that changes such as the loss of homes in slum clearance [ch 3] are like bereavement because it "threatens the whole structure of attachments through which purposes are embodied".

"If we believe the meaning of life can only be defined in the experience of each individual, we cannot at the same time treat that experience as indifferent ....
Such change implies loss and these losses must be grieved for, unless life is meaningless anyway. Thus the management of change depends on our ability to articulate the process of grieving." [p91]

In a social survey of women and depression, Brown and Harris [1978] found that life changes, such as moving home, made people more vulnerable to problems like depression and when combined with other stresses, may be a factor in precipitating depression. Similarly, even where the existing home is valued very little, because the conditions were poor or life there unhappy in some way, a loss may be felt. The hospital was not viewed by these residents as a proper home, but they had accepted that it was where and how they had come to live. It had become a familiar place and so offered some sort of security, even while they held onto some hope of leaving. A policy of gradual introduction to a new home environment reflects these sort of concerns, as well as responding to general theories on problems of institutionalisation. It

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was more noticeable therefore that the staff response to problems of settling in the home environment did not follow the lines of their approach to the issue of leaving the hospital.

Problems arising within the houses were normally noted in written reports and discussed more fully at staff meetings. Staff would firstly be advised to respond within the routine of the group home - eg. by exhortation to get up and about, by checking on medication, possibly to have a talk with the person. If managers were concerned about the person's mental state they would also seek a medical consultation, with the GP or community psychiatrist. Below are the outlines of two cases, in one group home, where staff became preoccupied with problems individuals experienced in settling in, showing the staff response to each case.

Kathleen:

When Kathleen was visiting the group home she said that she liked it but didn't really want to move. She said "the boss said it [the hospital] won't close for at least seven years. I want to stay until it closes." She and Jean suspected that it would never close, the staff didn't seem to think so. Kate pointed out that they didn't really have much choice, since the hospital was going to close and said they may lose their choice if they hang on till closure. Frank told her he'd put it to them in terms of second choice - if their first choice wasn't possible, would they like this as second best. He said their feelings about this were more positive. After several stays she decided to move.

After several months in the house staff reported that she was very apathetic, lethargic and seemed depressed. They spoke to her mother on the telephone who said she was pretty much the same at home. Frank made an appointment for her to see the community psychiatrist. The manager talked about the four crises on leaving hospital:
1) The gate crisis
2) Rejoining family / living in a group.

3) Work

4) Boredom crisis - what's the future?

She advised them of the need to keep stimuli going to prevent people getting depressed. However, I could not find any evidence of response to Kathleen's problems apart from continuing as before, trying to get her up and out to the day centre.

> **August staff meeting:**
> Kathleen was still thought to be unwell - depressed, bored in the house and so, in their view, spending too much time with her family. Kathleen has said that her mum has quite a negative view - thinks she should be in hospital. Staff feel she needs more to do and that going to the new rehabilitation centre run by social services may help her. The manager said "it's hardly surprising, you come out of hospital hoping things will happen, then so what" One worker said "Kathleen said something like that herself the other day".

Almost a year after leaving, staff continued to report that Kathleen was lethargic and lacked motivation in the house or the workshop. Staff seemed to be frustrated with her apparent 'lack of progress' and also felt her home situation [relation with parents] was unhelpful. Clare reported that she'd had a talk with her and told her that if she doesn't keep things up she'll have to go back into hospital; Jean shot up from her bed and said "Can I go too?" Kathleen said that if she can't go and live with her parents she doesn't care where she is. Clare later told me that she didn't think it was helpful to use the threat of going back to hospital as a sanction, and that it wasn't realistic anyway - their beds were closed and the ward would soon be closed too.

Mary:

Out of the four residents in the house, Dorothy and Mary had been very positive that they wanted to leave. Both had little or no remaining contact with family or friends. During the house visits and on the day of moving, Mary was the most active person and quickly began to establish activities for herself within the house [This issue is discussed more fully in chapter 7] After two months staff started to report problems with her. She complained often of feeling unwell or tired, of lack of appetite and became irritable with the other residents

who were much messier and less active than her. The volunteer had
offered to take her out shopping, because she didn't know her way
around, but on the day she refused, saying "I look like a tramp....not
right in the head....the streets are too narrow...." and that she wanted
to go back to the hospital. It was felt that she might feel happier if
she had an outpatient appointment with a psychiatrist.

Shortly after this she told me about how she felt in the house:

> Mary complained that the others weren't doing their share of the work,
> so I said "Perhaps if you left it they would do it?" She said that
> sometimes she just gets into a mood where she feels she has to, and
> being busy makes her feel better in herself. She didn't know why, but
> things seemed to go in phases, feeling either lethargic or really
> restless and finding it hard to get a balance in between. She said
> that she really ought to buy a coat, but was nervous of going
> shopping. "Even if someone goes with you?" She explained that after 14
> years in hospital, the outside world is a bit of a shock - noisy, fast
> and confusing - especially for her and Dot, who didn't know the area
> and hadn't been coming out regularly. Also her memory didn't help, "I
> seem to have lost my sense of direction." She stressed what a contrast
> it is with being in hospital, especially somewhere as quiet and out of
> the way as Claybury. Even the area she knew, she felt, would have
> changed so much it wouldn't be familiar.

In my diary I noted that she often complained of vague illness symptoms,
lack of appetite, and feelings of frustration. Staff reports repeatedly
mentioned problems with her, but mainly in terms of her relationships
with others in the house. They said that she was causing problems in the
home:

May 87 - staff meeting:
Mary was reported as "the main problem" because she had poor short
term memory and was finding it hard to work out some things in the
house. Staff think she may be "dementing" but say that she is also a
problem because she takes over too much of the housework and fusses
over the others. The manager interpreted their suspicions in a factual
manner "they say she's dementing" and presented a scenario [imaginary]
of her washing the stair carpet with bleach.

September 87 - staff meeting:
A problem over sharing of cleaning jobs was reported, especially with
Mary doing most of the heavy work. The manager said "she may be a
mistake in the composition of the household". Frank said that she's
the only one who can be relied upon to do the cleaning properly, but
she tends to prevent others from doing it. He also felt she could

cause Jean and Kathleen to smoke upstairs because they're avoiding her.

October 87 - Staff meeting:
Mary was reported to be in very strange mood this week, aggressive towards Jean and Kathleen and generally difficult towards everyone. Frank said that she's very up and down; Yesterday she really had a go at them; They ignored this anyway; He calmed her down, and after a couple of hours sleep, she was OK.

October 87 - Staff Meeting:
Staff reported continued problems with Mary. Kate asked if they should ask Mary to eat elsewhere if she's being unpleasant. Frank didn't entirely agree - said it wasn't really the right course and pointed out a lot of her moans are right - she does more work, they're very messy and she finds it irritating. He felt the earlier idea of swapping houses wouldn't have sorted it out. The manager, joking said "put them together". [referring also to a resident in another house who was also seen as a problem]. She argued Mary was making the others more withdrawn, but Frank said they're like that anyway. At the next house management committee meeting CRT's manager asked that she should be referred to somewhere else, such as a part 111 home for the elderly.

In both these cases staff, at times, expressed the view to me that it was understandable that residents will experience some disappointments or depression after the initial moving in period. However, the response to these matters was to see them as problems which are part of the person's illness and therefore pathological rather than normal - as a result they considered their response in terms of providing 24 hour cover, referring people on to more dependent forms of care, or by return to hospital. This reaction, by viewing problems as matter of individual pathology, rather than say of settling-in, boredom, or of learning to live as a group, made it difficult for staff to see negativism as potentially healthy - a sign of the autonomy or self esteem which they aimed to nourish in rehabilitation. In a sense, although they were working towards creating an ordinary home environment, they found it difficult to accept ordinary domestic problems as inevitable, or possibly a point to work on for change in lifestyle.

The uncertainty of staff responses, moving between a view of depression as a normal response to major change, or to difficult past experiences,

and a use of pathological labels to characterise a problem, points to the ambiguities of caring work in this context. In the group home, the ideology is about caring which promotes rehabilitation, rather than control, yet their custodianship over the residents and their anxiety to see the home work smoothly, may easily contradict each other.

A few problems developed to a point at which staff felt unsure about whether they were coping. During the period of the study there were three cases of problems which became crises for the group homes. In the two boroughs studied, there was a noticeably different level of back up support. For the Adelaide Road and Carrier Lane projects there was no provision for social work support for closure patients, and the planned community support team at that time consisted of only a community psychiatrist and a community psychiatric nurse. Staff in these projects found it difficult to liase with the statutory services, even though they received a significant input from the community psychiatrist.

For the Thorn Street project, there was a significant and clearly set out system of support for staff and residents in operation when the residents moved into the house, yet one crisis still arose. The problem, therefore, is not necessarily one of lack of facilities or support (although these are very important) but also a question of how community resources are used by the carers and the approaches to care that they take. In the case below, I describe how staff responded to one man's depression surrounding moving into the group home, leading to a 'crisis' and a return to hospital.

George was a 70 year old man, who had been in hospital for five years, having previously shared a flat with a cousin. He had suffered from depression as a serviceman during the war and had been admitted to hospital again after his cousin's death six years ago. He was on the list of prospective residents for Thorn St, since although he was on a different ward, he had been attending the CRT discussion groups in the hospital and was interested in visiting the house. George came to see the house on about the third visit. He participated enthusiastically in the cooking and was interested in all the rooms and especially impressed

with the bedrooms. Afterwards I asked him if he liked the idea of leaving hospital, and whether he knew or came from this area. He said yes, he wants to leave, but doesn't really want to come and live in this house because he would prefer to be nearer his old flat. After several visits however, including overnight stays, he agreed to the move.

The following month, close to the prospective moving date, the transitional team reported that he was "depressed and going down" and had been given anti-depressants. They felt the prospective move might have precipitated the depression but that it should still go ahead. On moving day staff told me George hadn't come on the advice of the ward staff, because he was thought to be depressed. They expected him to visit during the week and hopefully to move in the following week.

March 88 - visit to Thorn St.
George was there. He got up from the living room to let me in. He said he'd seen the doctor yesterday and she asked how he was and if he wanted to come here: She said he could move on Monday and treat the first month as a trial. He said he was happy with this - give it a try for a month - he likes it here and thinks it should work out OK. I asked how he'd been feeling, had he been feeling low? He said "no, not too bad". He had seemed rather sad but got brighter as he talked. He had stayed overnight, said he had a good night's sleep and woke up early; he didn't mind that as he'd slept well. He commented on how quiet the street is - the first few times he didn't sleep so well, but now he's getting used to it.

April 88 - staff house notes
Staff are monitoring how much George eats and drinks. He is said to be spending most of the time in his room. The consultant is visiting him nearly every evening, and advises that he should remain in the house, with her support, until his depression improves, rather than going back to hospital

April 88 - Social Work Team Meeting
George's social worker reported that he had been taken back to hospital: He had been very depressed after leaving and not eating, but was just coming out of his withdrawn state when staff confronted him about declaring his savings to the DHSS. He had reportedly thrown a cup at the worker, who consequently called the consultant. She came and drove him back to hospital. The social worker was angry and generally worried about the way things were being handled, with group home staff being too confrontational about residents' money, lifestyles etc. He felt that staff had no need to do this since he had all George's financial affairs under control, had discussed it with him before and had decided to wait until he was less depressed to handle these matters. He was particularly concerned that they had not

consulted him at all over George's welfare in the house, and that if they had, these problems may not have blown up in the way they did. He said that George has come back to the ward now and is feeling much better.

May 88 - visit to Thorn St
Carol told me that George had thrown a cup when she asked him about his finances and had to be taken back to hospital. She said they've seen him since and he's saying quite firmly that he doesn't want to come back. She didn't see any point in pushing him. She interpreted it as problems coming from him - that he got angry with them because of what he'd done and she didn't question the approach they'd taken.

May 88 - Thorn St selection meeting
Maria [worker] said she'd been to see George. They had a good talk. He's very happy to see them and to come for a meal but he's definite that he doesn't want to move back.

June 88 - Thorn St selection meeting
The transitional worker felt George doesn't know in his own mind what to think about moving back to the house. He'd said he was just visiting to take his stuff back to hospital, but was then reluctant to take it all. They think the money is still an unresolved problem. They felt he was a bit ambivalent and described him as being "a bit high."

June 88 - visit to Thorn Street
George was visiting the house again. He talked to me about being back on the ward and asked if I knew he wasn't well after moving to the house and that the doctor took him back. He said he was OK now. Before he left he told me he might bring his violin next time - would I be there? He wanted to say goodbye to Maria and seemed concerned when he couldn't find her in the house. As he stood on the front door step, before leaving, he looked older - smaller and frail and with a shakiness in his walk. Several times after this I met George, walking in the corridor of the hospital. He was glad to see me and shook my hand warmly, asking about my family and whether I'd been practising the piano, but always, at the same time, very sad.

George was assessed as suffering from depression, which could become severe at times, and the staff, together with the statutory carers and George himself, agreed that he should move in and remain in the house, despite the depression he suffered surrounding the move. The response of staff in the house was to monitor his health and behaviour carefully rather than to offer counselling type support about the move, or indeed to seek it via his social worker. Although George was receiving a high level of psychiatric support during the transition period, and signs of improvement in his mental state were noted, the problem was allowed to become a crisis, when he was provoked into losing his temper with a

worker. The response was to return him immediately to hospital. The workers did not question why this crisis had occurred, and seemed disappointed when their later approaches to him did not result in him moving back to the house.

For about a year prior to the opening of the house George had been attending groups on the ward, which had been run by CRT, broadly around the subject of leaving hospital. However, the decision on where he should move to was made in a relatively unplanned way. His move out was decided upon hastily because a provisional moving date for the other residents had already been set. Likewise, when a crisis occurred, he was moved immediately back to hospital and little discussion took place among the house staff over what had happened.

In another case, where problems arose which the group home staff felt unable to resolve, the response was to try to arrange a move on to more independent accommodation. This case suggested to me that the generally cautious and low-key approach to leaving the hospital was inconsistent with the treatment of a return to hospital or a move on to another home. It was not, therefore, purely a matter of responding to the possible stress of leaving, by a gradual, no fuss approach. The prospect of returning to hospital, with all the inevitable connotations of failure, or of moving to an independent home life, should have been no less significant as a life event or crisis. However, decisions to seek such a move were made without the consideration that had been put into resident selection and in some cases quite suddenly. The possibility of a second move was, unlike the issue of leaving hospital itself, approached very directly with the person involved.

The staff view of Jane was that she was more independent in her opinions and habits than most other residents. Problems had been noted repeatedly with her not wanting to go to the day centre or follow a routine set out for her by staff. After several months, tension developed between Jane and Margeret, which blew up into an argument over some missing clothes. Staff attempted to resolve this dispute by talking to both, and calling the community psychiatrist in to talk to them, but were also advised by

their management to approach Jane about the possibility of moving on. The staff felt that a more independent lifestyle might suit her, but rather than being encouraged to gradually approach the possibility of moving, as a positive step in her life, it was presented to her as a result of problems in the house, and was perceived as being like an ultimatum.

Visit to Adelaide Road – October 1987
I asked Jane how things were going in the house. She was rather confused about it and not very happy. She felt there was pressure on her to move. The staff had brought it up several times and she felt it was unfair, as though everything was being put onto her. She felt this was partly because she was seen as a more independent person. She saw trouble in the house as partly due to lack of staff input, so that she tends to fall into the role of asking others to do things, putting her in an awkward position and maybe causing resentment.

Visit to Adelaide Road – November 1987
I asked Jane about the article which she'd been planning to write for a magazine. She said she'd lost keenness for the moment, to write about moving here. She'd been going to write about how good it was but didn't feel too good this week.

November 87 – visit to Adelaide Rd
Jane was especially surprised that the option of moving to Carrier Lane was suggested to her, the staff knowing her feeling about sharing with men, to then suggest she share with four and no women! Also at the suggestion she might like a bedsitter when the consultant had told her categorically that she shouldn't live alone. She said she didn't want to live in a bedsitter anyway and the only alternative she would consider would be a group of flats with communal facilities, activities and so on and perhaps someone coming in for part of the day. However, she didn't feel ready to face any sort of move yet.

December 87 – visit to Adelaide Road
Jane had written her article. She said she'd played the tape of it to Frank [worker] and he was quite overcome. She asked me what I thought, would they print it? She agreed with my feeling that it was a good thing to have positive articles in the press about community care and said her son felt much the same.

January 88 – visit to Adelaide Rd
Jane seems both interested in and worried by the prospect of moving on. She is worried about living alone because of her past experience, worried that it would be too much for her.

Clare told me they've got the referral form for sheltered housing, but now Jane's not so keen. Clare thinks she always wants to have half a dozen alternatives and draws away from making decisions. She herself had asked her supervisor if they'd keep the place open for her for 6 months but they said this wasn't possible.

April 88 - visit to Adelaide Rd
Jane seemed more positive about the house than at times, saying that
at least in group homes there's always something going on.

May 88 - visit to Adelaide Rd
Jane told me about what the staff had said - that she was the only one
to question things. She said she'd met one man in another group home
who seemed frightened to do so. She explained that once you've been in
an institution you carry it with you, and there is always *fear*,
especially fear that you can be sent back in. She is aware that the
staff may try to use this fear.

By describing these cases I have tried to show how the carers approach
the issue of leaving hospital and to analyse their understanding of why
things are done in this way. Their general view is that after many years
residence in an institution, leaving will be stressful and that many
people will be reluctant to make the transition. Therefore, the approach
to leaving is a gradual one, in which the process of discussion in the
hospital and visiting in the home gradually merges into the moving
process. Although this gradual approach was apparent in most of the
planning and visiting process, it was not carried through in practice to
some of the most significant decision making for the clients - so that a
decision about moving on, or returning a resident to hospital could be
made with little regard for the resident's view or the preparation s/he
might need in order to cope with the change.

In a previous chapter, I have discussed the difficulties experienced in
creating a rehabilitative setting in the hospital. Because the focus of
the group home was directed more towards rehabilitation, I found that
the ordinary processes of daily life were thought to be rehabilitative
in their own right. Little attention was paid to the need to directly
address the issue of leaving, through talking about it, through
reminiscence and so on. The feeling of one woman about the way she had
left hospital was dismissed as delusional and therefore of no
consequence.

In talking to the residents I found that ambivalence about moving was
common, but that this ambivalence did not mean a reluctance to address

the issue. The majority of those who left hospital did want to leave, and to make a new life for themselves, but could be worried and excited about it at the same time. Reflecting on past and present lives, was important as a means of understanding what had happened, in going into hospital, and what will happen, on leaving. For the residents, the day they left hospital was the key point in a major change in their lives, yet it was not treated in the way that we might expect for significant occasions.

Avoidance is associated with uncertainty and with notions of danger, just as when people undergoing life crises enter a state of ritual isolation. The ambivalence about the move was not simply something experienced by the residents, but part of the carers perception of the move from hospital to group home. Hospital staff wanted both to see their former patients well cared for, but also to some extent wanted to see 'community care' fail. The ability of the long-stay patients, the most 'dependent', to leave the hospital created ambiguities for them about their roles. Similarly, the group home staff, who contrasted their roles to that of nurses, as being rehabilitative and caring rather than custodial, experienced contradictions in their approach towards 'community care'. They were attempting to facilitate change, and to manage it, while regarding the patients' situation as essentially unalterable. I concluded that it was their own fears, about the dangers of transition, which led them to avoid any emphasis on the act of leaving. In later chapters I look at lifestyle in the group home and the issues of autonomy, of social contacts and of isolation within the community for group home residents. I will argue that lack of confidence in community care and a consequent lack of direction for change, often works against the chances the residents are given to see leaving hospital positively, as a new beginning.

CHAPTER SIX

HOSPITAL AND HOME

Introduction

This chapter shows in what ways, and to what extent, ward life and group
home life are comparable or differ. This is explored particularly in
terms of its structure, daily routines, and staff/client relations. The
descriptions of places and events reveal a picture of radical
differences in certain areas of life, particularly in domestic life, yet
there are also strong continuities in the lifestyle of many residents
and the position they view themselves as having. It raises the question
of whether the fact of de-hospitalisation means that life is also 'de-
institutionalised'.

The hospital environment was described by Goffman as a 'total
institution'. [1968 p17] The features of a total institution are
summarised by him as follows:

a) All aspects of life are conducted in the same place under the same
    authority.
b) Each phase of daily activity is carried on in the immediate company
    of a large batch of others, treated alike and required to do the
    same thing together.
c) All phases are tightly scheduled and imposed from above.
d) A basic split between inmates and staff.

Critiques of the psychiatric hospital as a total institution have been
around for a long time - Goffman's work was prefigured by Barton's
"Institutional Neurosis" in 1950 and Garfinkel's work in the 50's. It
must be remembered that current hospital practices have been informed at
least, if not altered greatly by such accounts. The important point here
is that the group home is a reforming model of care, set up to replace
hospital care for certain people. It is likely, therefore, to be
modelled in reaction to the situation in which its residents previously

lived. There are several key aspects of the institution on which the new environment may be focused:

a) The design and use of the physical environment.
b) The use of time
c) The staff/resident (patient) relations
d) Relations with the world outside the institution

These aspects include some of the more general characteristics of the ward or the group home, which will be explored in the chapters to follow, particularly the matters of privacy, client choices and client status.

The information on hospital life, in a study focused on group homes, is necessarily limited. The accounts in this chapter are drawn from observation and interaction on the hospital wards during the study period - time spent by myself and the residents there. The residents' accounts of hospital life were given firstly in the hospital setting, but then at far greater length in a series of retrospective views after leaving.

The hospital ward

This description is taken from one hospital ward, from which three of the Adelaide Road residents moved in 1987. They had all lived on the ward for at least a year. Margeret and Hilda said they'd always been on that ward. Jane, along with Gladys (who was subsequently dropped as a prospective resident) had moved there from a back ward, once the doctors began to consider them for discharge. Thus, it was a 'rehabilitation' ward in the sense of being a long stay ward from which a number of people were expected to be discharged into 'reprovision' facilities, but it did not offer an active rehabilitation programme.

The ward has a basic rectangular plan, with two main divisions of space: into the day areas and sleeping areas. Running through the length of the ward is a corridor, which also doubles as eating area,

and bedroom area for some patients. Running to one side of it are a series of side rooms, including bathroom, wc's, nurses' office, and a small side room partly separated from the main area by screens.

The focal point of the day area is the large colour TV set, which is on all day, generally at high volume. Because the partitions in the ward are minimal, its sound permeates all areas and can easily dominate the attention of anyone in the day area. Armchairs are normally arranged around this point, the only exceptions being a few chairs in the smaller side area, and at the far end of the corridor in the sleeping area. The decor of the room gave it a drab appearance. The high walls are painted in dull colours and are noticeably peeling. Several old oil paintings are hung here and there, and on one wall, some of the patients' own artwork. At one end there is a piano, acting as a stand for several potted plants.

The shape of the ward allows one part of the sleeping area to be separated by a wall from the day area, like a dormitory. The remaining beds form a row along what is basically a corridor. They are spaced approximately five foot apart and have draw around curtains for privacy. Each individual's tall locker and chest-of-drawers unit acts as a semi-partition between beds.

The division of space in the ward results in a significant lack of privacy or separation between patients. The residents of the house all felt this was a problem, although they had become accustomed to their situation. The only real separation afforded is that between patients and staff - who have a lockable office and toilet. Even the bathroom facilities are communal, with two baths and four sinks in one room. There is no allotted kitchen facility for patients on the ward.

The daily routine:

The day, as described to me and as observed during ward visits, was highly structured. The parameters of the day are set by fixed rising and bedtimes, and movements on and off the ward during the day are set by mealtimes and medication times. These two 'caretaking functions' also appear to have a ritual function in regularising activity, in such a way that responsibility for one's daily routine is totally removed from patients, and partly from staff. Another noticeable characteristic of the routine, which was bitterly complained about by the residents, was its earliness:

7 am   Day shift begins. Domestic tasks on the ward for some patients.
8 am   Breakfast on the ward.
9 am   Workshops or other structured activity. Frail patients and a
        few others remain on the ward.
11 am   Coffee break in workshops.
12 am   Lunch on the ward.
2 pm   Return to the workshops.
3 pm   Tea break in workshops.
4 pm   Return to ward for tea (last meal of the day)
7 pm   Occasionally bingo or 'social' on one ward.
9.30 - 10pm Official bedtime. Hot drinks before bed/with medication.

Medication is normally dispensed from a trolley, and tied in with meal-times. Flexibility is possible, such as over bedtimes, on special occasions, or if nurses and some patients sit up later to watch a film, but is not really built into the routine. Not all patients attend workshops - the more frail elderly patients may stay on the ward all day and a small minority of patients may attend alternative activities outside the hospital or simply avoid structured day care without remaining on the ward all day.

Therefore, although there are possibilities for flexibility, and routines might vary on different wards (e.g. some rehab wards have now instituted a later 'tea-time' to be more in keeping with normal meal times) there are certain key features of the routine which promote institutionalism among both patients and staff. The routine is markedly like that thought normal for a child, rather than for adults. Its regularity may be useful for the 'smooth running' of a ward, especially if it is understaffed, but it also stifles creativity, or indeed most activity, by failing to provide choices in everyday living. Hence, TV watching may become the dominant activity on a long-stay ward.

While lack of choice was a key feature of the ward routine, the most noticeable feature of the ward environment to me was the lack of privacy for patients, visually and in terms of sound. The structure of the ward demonstrates that individual privacy is not a priority of the ward system. Such a system thereby fails to encourage self esteem among its inmates. In all the wards from which the group homes residents moved, the dormitory was the normal sleeping arrangement, and one which they had become accustomed to. This ward, when we compared it with others, was regarded by the residents as being worse than those at the other hospital, because it had beds on corridor areas. The other residents of Adelaide Road thought this was awful.

The use of curtains and furniture to shield beds was of limited value. Although the residents could gain a little personal privacy from this, it was ineffective in shutting out noise. Both Hilda and Jane told me that they were dependent on sleeping tablets. This pattern had developed due to noise problems on the ward at night. They had asked for something to be done about it and were given sleeping tablets. The solution to

this problem was sought, not by rethinking the nature of the environment, but by recourse to medication, thereby focusing the problem on the person and fostering dependency on drugs. An external source of trouble became their own, internalised, sleep problem.

The problem was not confined to sleeping. The discussion groups on this, and other wards, were marred by the loud presence of the TV. Although the prospective residents thought it was a nuisance, they never got up to turn it off, often because others were watching it. During a discussion group, on another ward, when no-one was actually watching but a large group were trying to talk about their visit to a group home, I decided to turn it off. I felt very self conscious, almost daring, in the walk across the ward to do so. This point makes understandable how hard it is, for workers and patients, to challenge the ward regime. The authority system of the hospital is internalised by those within it.

In the course of many conversations about the hospital, Jane asked me why I thought, after so many years, they had not managed to reform the hospital, to make it a good place to live in:

> She also wonders about what the alternative to hospitals should be. She feels there's got to be somewhere for people to go to, but that they should be different, smaller and enabling people to carry on with more normal things. She suggested that if perhaps they'd spent more on this hospital, to make it a decent place, it would have been OK.

The lack of personal privacy was inherent in the architecture of the ward; the partitions, the shared bathroom, the lack of bedroom space and so on, but it arose also out of the way life was conducted on the ward. Foucault [1979 ch 2 & 3] describes the idea of the 'panopticon' as a model for institutions in the nineteenth century. Institutions, (including prisons, educational establishlents, asylums) were designed to enable complete observation of inmates. Among the main functions of the institution are the regulation of behaviour, a form of discipline made possible by *observation* and *normalising judgement*:

> "a whole problematic then develops: that of an archtitecture that is no longer built siaply to be seen ,,,, but to permit an internal, articulated and detailed control ,,,, an architecture that would operate to transform individuals: to act on those it

shelters, to provide a hold on their conduct, to marry the effects of power right to them, to make it possible to know them, to alter them." (p172) "the discplinary institutions secreted a machinery of control that functioned like a microscope of conduct; the fine analytical distinctions that they created formed around men an apparatus of observation, recording and training". [p173]

The significance of the lack of privacy to the functioning of the ward is reflected in the way staff use the ward space. Most of their time, according to patients accounts and my own observations, is spent in the nursing office. On this ward, with the office door open, one can see much of the day area and part of the sleeping area, and can hear any loud noise on the ward. On some wards, the office is designed with a large glass panel ward-side, through which nurses can view the ward without having to leave the office. When not actively performing any functions, such as writing case notes or attending to particular patients, nurses may also sit with the patients watching television in the day area.

The staff use of space serves to separate the staff from the patient group. Personal contact is thereby reduced, but without affording privacy for the patient group from staff observation. Fear on the part of staff – fear of violence and perhaps of too much contact with distress – helps to produce such a structure, while the structure itself reinforces the overall hierarchy of the hospital.

The lack of privacy also reflects a general attitude towards the patients, who are viewed as a group, and objectified, by being viewed in terms of their symptoms rather than personal characteristics, hence the use of the term "bedspaces" for individual placements in the hospital. In this situation, the importance of privacy is rather different from that which people expect in their own homes. The environment may be constraining on behaviour in such a way that it is difficult for people to act as, or appear as autonomous individuals.

The second feature of the ward is the lack of facilities by which patients can conduct their lives in an active way. The most important deficit here was seen by both patients and many nurses as the lack of

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ordinary domestic facilities, such as for cooking and washing. Most meals are provided from the central kitchens, so that choice is limited and the quality often poor, since food is cooked and saved well before meal times. Special dietary needs for religious, cultural or more personal reasons were sometimes not met - such as Kosher food for orthodox Jewish patients. All wards have a small kitchen, used for patient teas but there are insufficient facilities for patients to prepare food or even drinks for themselves. Instead, snacks, or alternative meals to those on offer from the central kitchen, are bought in the patients cafe.

Domestic work is done on a ward/hospital scale, so that instead of each person having his/her own area to care for, certain (usually female) patients would do domestic work rather than attending workshops. Some leisure facilities exist - a patients' library, pool tables on a few wards and art classes in occupational therapy for example, but they were inevitably limited and isolated from the facilities normally used in the local community. Similarly, the ward exhibited few of the artefacts associated with ordinary home life, such as books or photographs.

Visit to Adelaide Road
Jane said she still couldn't understand why they designed the hospitals as they are; why they don't allow people to continue doing things like cooking their own food instead of the awful stuff, "slops" which they provided. The staff had told her that many patients couldn't do that. She felt they should have smaller places.

Visit to Adelaide Road
Mary asked me about CRT and what everyones roles were. She asked about me and Carol, seeming unsure if we were volunteers or workers, saying we didn't seem like charge nurses. She asked me to explain the shift system because it was different to hospital. She then remembered about me being a student. I reminded them what my study was about and Kathleen said "Well, I'd rather have stayed in hospital. At least there you get your meals regular." I asked her if she felt she wasn't able to get food that she wanted here. She said, "you never didn't used to get enough in hospital. It went down and down, so that by the end there wasn't enough left."

The lack of facilities also extends to problems in safekeeping and care of personal property. The facilities varied, some wards having lockers for everyone, but the general effect was to discourage patients from

caring about things which were important to their self image.

Visit To Adelaide Road
Jane said there were problems with security in hospital. She had a locker at one time and when she lost the key they had to break the lock and wouldn't replace it. On the 'back ward' she had no locker at all. She started describing the back ward to me, when I commented that I'd never been to one of these wards. She laughed and said no-one hardly ever went there, not even the doctors; a lot of the patients were old and confused. She described how you couldn't keep anything. This was why, for a long time, she'd only had a chit' for £3 a week. As a result she built up savings in the patients finance bureau without realising, until the social worker said one shouldn't be treated like a baby and asked for the chit to be changed. She pointed out that there was no incentive to spend money on yourself, if clothes or personal things got stolen.

Visit from hospital to Thorn Street:
I noticed that everyone except Maurice was inadequately dressed for the weather. The men had suits without overcoats or jumpers. David said he did have one. Aldo said he used to have a good one, cost £40, but he moved wards and left it in the locker room; when he went back for it, it was gone.

The ward is an environment which, rather than encouraging the development of new living skills, leads to loss of skills and, for many people, to loss of motivation to care for themselves. Although, for the long-stay patients in particular, it was primarily a place of residence rather than treatment, the hospital is designed around the concept of controlling or containing illness. Even patients who are 'acutely ill' are not usually physically incapacitated, yet the institution is not sufficiently geared towards activity. In this system the concept of rehabilitation is marginal to that of hospital treatment.

The regulation of time, through the ward routines, is a further element in the loss of self direction which the patients experienced. A routine is, to some extent, a means of providing structure which enables people to act, and to feel a certain security in the regularity of their lives. It could therefore be seen to have a therapeutic function. However, with the rigid routine of the ward system, the regulation is removed from the patient and imposed from above in a way which fails to prepare the patient for life outside and can even create problems.

The structure and routine of the ward, tends to work against self
motivation. Privacy and the exercise of choice are difficult to manage
and life is structured for the individual. It creates or sustains a
dependent status which may be carried over into lifestyle after leaving
hospital, even if living conditions are very different. In the hospital
setting the staff/patient relationship is generally relatively distant,
but also one of interdependence, with staff having responsibility for
and some measure of control over their patients' lives. In the group
home, this relationship does persist, but in an altered and in some
senses closer form.

Lunch at Adelaide Rd, after shopping:
Mary enjoyed the trip but was tired by it. She commented on how much
more responsibility there was outside, "in hospital it's all taken off
you". She finds it quite hard after such a long time, she explained,
to manage responsibility for her own life, but she liked the greater
scope. "In hospital they work you physically, but not the mind. My
mind's always been no good though." The residents told me about the
facilities there in the last ten years. I asked Mary if the hospital
had changed in the time she'd been there. She thought I meant had it
changed her. She said it hadn't changed her as much as old age had, "I
don't get so bothered or irritable about things since turning 70".
Later, while doing my knitting, I asked if anyone had done any
handicrafts in hospital. Kathleen said she had been very keen on
sewing and knitting, but had lost confidence now. Dorothy said she had
at first, but her shaking hands made her unable to do such things;
this had developed in the last six years and she'd been given pills to
counteract it.[2]

The Group Home

The house is quite striking in the relative ordinariness of its domestic
style, when compared to the ward and was liked by all the residents on
their first visit. The only reservation expressed was about the
smallness of the rooms.[3] The original room structure of the house has
been retained, except that the second ground floor living room is used
as a fourth bedroom. On the ground floor there is a small living room, a
single bedroom, wc, stair cupboard and a kitchen/diner. On the upstairs
floor are two single and one double bedroom, bathroom and wc. There is a
small front and larger back garden. All the rooms except kitchen,

bathrooms and wc's are carpeted, and are painted in 'cool' colours, such as pale blue. Like the ward, it is centrally heated, but the controls are accessible to the residents.

The living room has four armchairs, with coffee tables between them, a small bookcase with a few books, sideboard, and a large colour TV. The walls are now hung with the photographs and the paintings of one resident, and all available surfaces decorated with plants, flowers, pottery bought in the hospital occupational therapy department sales, and more paintings. Birthday cards from relatives and postcards from staff are displayed for long periods. Coffee cups and magazines lie here and there on the tables.

The kitchen has fitted units, dining table and folding chairs (tightly squeezed in) a large fridge/freezer, electric cooker, and automatic washing machine. All these appliances were unfamiliar to the residents, and electric cooking was unpopular. In this house, the residents learnt to use them quickly, becoming fairly independent in domestic chores from first settling in. In Carrier Lane, in contrast, the residents had few domestic skills to relearn and were far more dependent on the domestic support of the staff. Registered care home regulations require fire safety measures. In the kitchen, no smoking signs, smoke detector and fire blanket are noticeable.

In each house there are several individual bedrooms and usually one shared bedroom (described as being for therapeutic company). They represent the private space in the home. Locks were not allowed on bedroom doors and the rooms remained accessible to staff, but a bedroom door, unlike a dormitory, can be shut and staff or fellow residents can be asked to knock before entering. The bathroom and WC's are the only lockable rooms. The bedrooms had a divan, fitted wardrobe and chest of drawers for each resident. Bedside cabinets, linen baskets, bedside lamps and alarm clocks were also bought, either through residents' or workers' requests, and on the whole were chosen by the staff. This latter point I found surprising, considering the emphasis on residents taking interest in their surroundings. Understandably, decorations could

not wait for a long and drawn out selection process, but less essential and more personal items could have provided more opportunity for rehabilitative activity - shopping, making choices and so on.

The staff office is in the other house, in place of the fourth bedroom, and is also unlocked, but has a lockable desk and filing cabinet, where medication, residents' bank and pension books, and staff notes are kept. The presence of the office is the major difference between the two houses in this project, and in fact this is the only staffed group home without one. It is, therefore, more like an ordinary home in its use of space.

The garden has been deliberately left untended, so that staff can encourage residents to help them plan and care for it. Pets are not allowed, but one worker built a bird table, at the residents' request, and the next door neighbours' cats are regular visitors to the kitchen.

The daily routine

One worker is on duty from 9am to 7pm every day, and so residents can decide when to rise and retire, outside of these times, for themselves. However, there is a policy of structured day time activity and residents are supposed to get themselves up and ready to go out by the time the worker comes on duty. In this house, two residents would leave the house at 9am, five days a week, to return to the hospital workshops. Staff will (politely) tell a resident to get up if s/he is lying in bed very late. Bedtimes are always decided by the individual. In the neighbouring house, one resident has continued to follow her daily pattern as in hospital, (she was an inpatient for 42 years) but the other three residents have chosen to stay up later, and either get up later or take sleeps during the day when they are in the house.

Breakfast and lunch are generally snacks, prepared individually. Those attending day centres have a lunch provided by the meals on wheels service. In contrast, the evening meal is communal and regarded as an important feature of the day. It is cooked on most days by residents, on

a rota basis, with varying degrees of help from the worker. On Wednesday's, when both workers are on duty for the afternoon together, they usually cook a meal for the residents. Shopping and meal planning in group homes is ideally done by residents with staff help, but in practice is generally done by staff. In Adelaide Road however, with one member of staff often having to cover both houses, residents of this house have taken a more independent role in this.

The principle is that the residents should do as much as they can in these areas, choose the food and so on, but staff often say it is easier to do most of it themselves. These patterns show that a changed environment in itself is important, but not sufficient to avoid institutionalism. Staff motivation needs to be maintained, so they can sustain the development of residents skills and interest. Nonetheless, the role of residents in housekeeping increased greatly during their first year of residence. On a day-to-day level this may not have been very noticeable, but looking across a full year, changes in everyday lifestyle were very clear. Visiting relatives were very quick to notice and comment upon such changes, and gained reassurance about the idea of the move from hospital.

The daily routine is planned around the assumption that residents are normally out from around 9 or 9.30 am to 4.30pm. at a day centre. This may account for the lack of structuring in the house during the day, since the staff are encouraged to see provision of a certain amount of structure as necessary for the well-being of the residents. On one hand they view the hospital routine as too rigid and all embracing, but they also hold strong views on the importance of structured activity in rehabilitation of psychiatric patients. What they call "groupwork" is an attempt to balance two principles in rehabilitation: the aim of increasing independence and the emphasis given towards structured (i.e. structured by the staff rather than by residents themselves) and shared activity as a means of developing practical and social skills.

Evenings are the residents' own. Staff attempt to use dinner time and the period following it, as a time for social interaction. Residents may

chat or watch TV after staff leave, or go to their own rooms. They rarely go out in the evenings, for various reasons, including lack of money, lack of confidence and fear of going out alone at night, and tiredness caused by work and/or medication. Occasionally however, they have invited relatives, or a friend from the hospital, to visit for dinner.

In general then, staff try to avoid unnecessarily rigid routines, but will intervene if a resident is thought to be acting in a way which is not good for them, or going against the organisation's policy. The design and routines of the group homes are guided by an explicit policy assumption, that a 'normal domestic lifestyle' is, in itself, a prinicple with rehabilitative power.

The home environment as compared to the hospital ward

The material environment of the group home is planned in direct contrast to that of the hospital environment. The principle of providing housing of a good and comfortable standard, carefully decorated and furnished is one which expresses a different evaluation of the psychiatric patient. The environment carries a symbolic message that the prospective resident is thought by the carers to be 'worth it' in various ways. The importance of this message is reflected in the response of many prospective residents to visiting a group home: in increased interest in the world outside, and in one's self image - in the desire to buy new clothes, have a hairdo and so on. It also indicates something about what life in a group home is ideally like. It is supposed to be different from institutional life and more like ordinary domestic life. It sets up an expectation that the quality of group home life will be fundamentally different from that in hospital.

Within the group home, private and personal space is provided by the person's bedroom. When asked what they like about the homes, residents and visiting patients, mention the factor of having your own room as very important. When I asked Dorothy what she thought about having her own room, at first she said she didn't mind, "You get used to sleeping

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in a dormitory", but later as she grew used to it, she valued it more, and liked to go to her own room to read. However, she pointed out to me that the scale of life in a group home is very different from that on a ward, and people are thrown closer together in such a way that it can be more stressful.

The issue of shared bedrooms is one example of possible stresses in the more enclosed home environment. Although residents had shared in dormitories while in hospital, the bedroom was viewed as essentially private. One health authority, which had established a principle that every resident should be entitled to their own bedroom, (and were willing to cover the extra costs involved) conflicted with the organisation over the two shared bedrooms in one house. The voluntary organisation managers argued that at least one shared bedroom in each house was vital, because many people like to share. e.g. When they moved to Adelaide Road, Kathleen and Jean were already friends, and Kathleen chose to share with Jean because she is afraid of the dark and likes the company at night. This policy tended to work initially, when a group of prospective residents was developing, particularly when there were close friends or couples in the group. However, it caused problems in established group homes when residents who had grown used to having their own bedrooms or sharing with a friend, resented having strangers moved in with them. The issues of sharing bedrooms, therefore, brought out unresolved conceptual questions about the homes - they were supposed to be like an ordinary home, not an institution or lodgings of some sort, yet staff decision making processes, and the financial pressures to fill places brought out contradictions in the group home philosophy.

Space in the rest of the house, excepting the office, is communal. The kitchen and living room require closer interaction between individual residents than would normally be experienced on the ward. The significance of this use of space, is added to by the philosophy of the group homes' running, which stresses the idea of the group home as being like an ordinary family home. [Pritlove 1983 p19] Therefore, there is a demand on residents to interact in a way which, in hospital, was not expected of them. The principle that the residents should interact

within a shared home environment may seem startlingly obvious, but it must be set against the past experience of the residents as hospital patients. The ward environment is not only 'drastically reduced' [Goffman 1968 p24-30] materially, but also socially. The constraints on the person which reduce her/his capacity for maintenance of self, also reduce the capacity of patients to form social groups. Living in a ward system, the residents had to struggle to maintain their social identity in the face of an ordering of time and space and a view which categorised them via symptoms. The significance of this point will be taken up again when looking at the models of group home life in chapter eight. The question which the group home philosophy raises is whether the policies and methods of 'resocialising' residents are appropriate or valuable in the views of the residents themselves.

Domestic activity in the home is given priority both in its design and in the daily and weekly routines. The opportunity for such activities is what is most obviously lacking about hospital life in the eyes of the group home staff. The home provides the appropriate setting for rehabilitation to be grounded in domestic activity and for a model of ordinary domestic life to be set up. Although ideally, tasks are shared or shared out in a communal way, in practice this is maintained by a rota for cooking and washing up, the two main communal activities. Individual residents are responsible for the care of their rooms, but this will be managed by staff for those who do not maintain *normal* housekeeping standards. Domestic activity outside the home, primarily shopping but also gardening, in practice remains more in the hands of staff.

This brief outline of the group home has concentrated on the planning and use of space and time in the group home, as compared to the hospital ward. In the following section, the staff/patient interactions and working practices of the ward are outlined. In this, one can see how activity relates to the structure of the environment, and the assumptions behind these structures.

The status of the hospital patient

All the group home residents were voluntary patients at the time when
they were considered for leaving. Although several had been admitted on
a 'section',[4] this was a very long time ago. A number of patients remain
on one 'chronic ward' for many years, but several described to me the
experience of being moved to or from a 'back-ward' in the course of
their stay. It became apparent, from several patient's accounts and from
the conduct of visits within and outside the hospital, that voluntary
status[5] for long stay patients is not necessarily voluntary in the sense
we might ordinarily expect. [Perrucci 1982 ch 6 & 7]

> Jane told me she thought the notion of voluntary status in a
> psychiatric hospital was unrealistic; that people get taken in like
> this, but often get stuck there. One doctor had told her that if Dr H
> hadn't been the consultant at the time when she was admitted, she'd
> never have stayed in. She pointed out that people [patients and staff]
> are very influenced by what the doctors say and they do have power
> over patients, e.g. if someone wanted to discharge themself and the
> doctor disagreed they could easily put them under a section. Even if
> you have a review, it is very difficult to make your case or complain
> when all these people are standing around listening to you. She knew
> someone in hospital who this had happened to and she simply couldn't
> leave.

The majority of patients considered by the voluntary organisation for
group home care, remained in hospital because they had nowhere else to
go, and had become used to living there. [Bott 1976] Even the few who
still had their own flats outside, were considered by staff to be unable
to care for themselves independently in their own homes. The development
of group homes, offering a combination of housing and staff support,
made their status in hospital more like a voluntary status, but this was
still constrained by the limits of choice for the patients themselves,
who were subject to selection as prospective residents by staff based in
the hospital and the voluntary organisation.

The limitations placed upon long-stay voluntary patients were reflected
also in the way that nurses could prevent patients from leaving the
hospital as an organised group, either by failing to give patients the
encouragement they needed, or even by refusing to authorise outside

visits. Such cases may be the result of negative staff attitudes towards community care. However, they may simply be grounded in a very protective view of their patients, which emphasises disability and dependence on the institution.

Weekly visit to the hospital for ward discussion groups:
Catherine wanted to talk to the charge nurse about what had gone wrong last week, when Carol arrived with the minibus to take a group of men to visit the group home. The nurse said he couldn't agree to a group going out because it hadn't been confirmed, so it wasn't discussed by the ward team. He said he was glad the nursing officer was there with him, so he could sort it out. He was very jokey, friendly even, but obviously cross that a letter of complaint had been sent. He said he couldn't take responsibility for letting a group of patients off the ward. Catherine pointed out that it had happened before when the arrangements had been confirmed and he said "well there are some nurses who will be a bit funny and who don't want this happening." He said the men should be back by 12.30 or they would miss their lunch, and had to be assured several times that the arrangements made, for lunch at the group home, would be OK. In the end they agreed to have the men back by 2pm, for the shift change.

The limitations of voluntary status are reflected in the way some patients have been moved within the hospital and the link of this with the exercise of discipline or regulation of institutional life:

Weekly visit to hospital for ward discussion groups:
On the way back, Frank, [group home worker who had been a hospital nurse] told me he thought it wasn't exactly a back-ward, but a very chronic long-stay one. He commented that often in back-wards you will find several people who are younger and seem more able. He thought nurses liked to keep such people because it made their work easier – one less person to have to look after. Also they could get them to help out with chores. I asked "But how do you think they get on that ward in the first place?" He wasn't sure but thought if they were going through a very disturbed phase they would be transferred, but then they can't leave easily.

Discipline within the hospital environment is not based on physical punishment, but on a regulatory system of sanctions and rewards. Punishment in this system is a matter of withdrawal of rights or freedoms of various types, which are normally taken for granted in ordinary life, but which are limited in institutions. The use of nightclothes to prevent movement off the ward, is thought to be uncommon now, but I observed its use on one ward, when I went with staff to

collect patients for a group home visit. I asked the nurse if he would be able to come and was told that he was not allowed to leave the ward that day. Undesirable movement off the ward may also be constrained by the witholding of a patient's money temporarily, or by replacing it with a parcel of goods, such as toiletries and sweets, equal in value to the patient's personal allowance - what some residents called "being put on parcels". This may well be viewed by the staff concerned as for the good of the patient, a protective measure for example, with someone who they suspect is drinking all their allowance and may get into deeper trouble.

The most extreme form of sanction against patients who misbehave, in the residents views, and in terms of patients' legal rights, was the threat of use of medication or ECT to control behaviour. The use of medication in the hospital is the subject of the next section, but the point here is that compulsory medication can form part of a disciplinary system, even without being resorted to.

The hospital structure and staff roles

The structure of the hospital is hierarchical, with levels of authority ranging from the general managers and the consultants at the top, to the patient body at the bottom. Therefore, the simple hierarchical division between staff and patients, follows the lines of the larger structure within the staff body. This structure is also pyramidal, in that the higher the status of staff, the smaller the numbers, and the lower the status of staff, the more time they spend in direct patient care. There is however, a further division between the types of staffing, which may cut across clear status lines. This lies primarily between medical and other staff, such as social workers (who do provide direct services to patients) or managers, who are commonly regarded by medical staff as "non-caring staff".

The inverse relationship between professional status and patient contact is typified in the role of consultants. Each patient is allocated to the care of a particular consultant, generally determined by the ward, as

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consultants normally have several wards under their care. The ratio of patients to consultants is very roughly 100:1, and long stay patients in fact see very little of them. The usual doctor patient contact on long stay wards is with the Senior House Officer, who works under the consultant, based on one ward, for a training period of six months. Although the SHO's input to the ward may be significant, their short stay means that good, continuing communication between doctor and patient is difficult to achieve.

Hospital notes are used as a means of continuing communication in a situation where staff and shift changes are inevitable. However, it appears doubtful that these are kept well or accurately enough to ensure good understanding between professional and patient. The difficulties experienced in the assessment process, as described in chapter four, demonstrated that hospital notes had significant gaps, even contradictions, and were inadequate particularly for rehabilitation and resettlement purposes. Given the importance attributed to *observation* in the hospital environment, the limits of communication are particularly problematical.

July 87 - Visit to Adelaide Rd.
Jane told me they were all going to see the consultant in a few days. I asked if she'd seen him much in hospital. "No, hardly ever." She said that you see the SHOs but they move every six months. He claimed not to know *anything* about her, even though he'd been her consultant for years. She couldn't understand the point of having a consultant who doesn't even know you. She wondered how this was, when they're making notes on you every day. She commented also that he'd said she was to be "under observation" and couldn't see the significance of this when you're under observation all the time in hospital anyway.

Community psychiatrist's visit to Adelaide Rd.
When he asked the residents who their consultant was they didn't know. Kathleen said she knew the ward doctor and Dorothy said the doctors changed all the time.

Visit to Friern Hospital
On leaving the ward, Kate, [the supervisor] told me about their problems in selection for this house. She felt one of the problems was that, despite the 'social networking' project,[6] the staff, especially consultants, know very little about their patients. She had only recently met the consultant for these patients and he claimed he didn't know anything about her work on the ward.

On a following visit, we met the SHO on the way to the ward. Kate told him that permission for Jane's move had been confirmed. He was very pleased. Kate said they spend more time on patient care and get to know patients better, so its unfortunate that they move on so quickly, breaking up the continuity of care.

The main contact, in terms of time and frequency between medical staff and patients, is that with nurses and auxiliaries on the ward. Nurses attitudes towards their work, and their patients, vary. Therefore, it is difficult, in a short account, to fully represent the working practices and views of all nurses. What is represented are the general patterns of working observed in the hospital, and the residents' own views of the relationships they had with hospital staff.

The nature of contact is not a simple matter of time spent with a person. In order to analyse *contact* it is necessary to examine the nature of interactions, as well as their frequency and duration. The percieved quality of interaction may also be influenced by the informant's view of the person: one hour in private with a doctor or therapist may be valued more highly than longer periods of contact with a professional who has lower status, or who is disliked for some reason. [Raphael 1977] In the study of social networks, analysts [Bott 1971, Perelberg 1985 ch 5] have attempted to define *quality* of interaction, and whether it is percieved as close or distant on the basis of emotional ties, supportivenss and mode of contact (letter, phone, visit etc.) as well as by frequency and duration of contact. Bott points out that infrequent contacts may be regarded as very significant where there are strong emotional ties, or the contact is perceived to be very supportive.

If one of the markers of status within the hospital is the degree of distance from patients, then it is perhaps unsurprising that relationships on the ward are rather distant. There is also the question of what constitutes professionalism in an institution which is defined as a hospital, but where many staff are not involved in acute medical care. [May and Kelly 1982] One resident told me that the younger, more recently trained nurses spend more time out of the office, with the

patients:

> She said that patients were always referred to as "them" not people
> and saw this as a reflection of their attitudes to patients and
> failure to treat them as individuals. The nurses generally sit in
> their office, come out to do a few things, then go back in again,
> thinking they've done a lot of work. They talk to each other rather
> than the patients on the whole. They could be very brusque with the
> frail old women, "putting a flannel around their faces and bullying a
> few people to get out of bed, then retiring to the office saying she
> was exhausted". The younger nurses, she felt, were on the whole better
> - better trained and nicer people; more likely to talk to you and sit
> with you. There was one who used to talk to her a lot, but said she'd
> get into trouble for sitting around if she wasn't careful.

Visit to Thorn Street:
> I asked Maurice how things were in the house. He felt he was not
> getting enough help in the way he needs. He explained that in hospital
> you didn't get enough help for various reasons - the attitude of
> nurses, and there not being enough of them. He said that they stay in
> the office most of the time and don't talk to people very much. The
> patients tend to be thrown together. They don't help people in the way
> that they need, if at all; they didn't help him in the way that he
> needed.

Residents' accounts show that they valued talking to staff and doing
things with them more highly than the more functional staff roles in
doing things for patients and in observing them. They also report very
little time in direct one to one interaction with nursing staff, a
situation which nurses feel is thrust on them by staff shortages.

The residents did not view the hospital staff in general, or the nurses,
as an undifferentiated mass. In contrast they emphasised to me the small
but significant differences which they could make to the quality of
hospital life. In general, they viewed the staff as individuals, like
themselves, with good and bad points, but felt that staff did not
consistently view *them* in this way. The basic split, described by
Goffman, [1968 ch 1] between staff and inmates, was something which the
patients were conscious of.

> Mary told me the hospital had changed in the time she was there. At
> first many wards were locked, although in practice staff did let many
> people go out. She had been on X, a relatively independent ward right
> from the start. She thought staff had always been good and got on with
> patients well, some nurses especially so, like the sister who visited
> them at the house. She thought there were still a few locked wards and

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had seen staff accompanying men out of one. She seems to have fairly
fond memories of the ward.

Jane talked about the nursing staff and differences between them. A
few individuals were outstanding eg. One who was widely liked -
although on a geriatric ward, she made sure that it was homely and
comfortable. In her experience, it was very unusual for staff to pay
such attention to peoples' comfort: some nursing staff seemed to have
a very negative attitude and were generally unhelpful.

As well as the common distinction, which is drawn between *good* and *bad*
nurses, there is the distinction between *ordinary wards* and *back wards*.
On the back-wards, it appears expectations of both staff and patients
were lower, and patients expected very little in terms of treatment,
staff contact, or comfort, on these wards. They may in fact be various
types of wards, such as for frail and confused elderly people, or for
the more disturbed long stay patients. They are defined rather by their
position in the hospital i.e. at the bottom of the hierarchy, and away
from view.

Social workers constitute the third main category of staff involved in
patient care, although they were generally regarded as outsiders in the
hospital. Their availability varied widely between boroughs. At Claybury
the social work service had been provided by the authority managing the
hospital, so that once it was decided to divide the hospital into
sectors, there were no social workers to serve the Haringey patients. In
Friern, there was an active social work team for each borough, but the
Haringey team had little involvement with long-stay patients.
Additionally, a dispute between the health authority and the social
services, over who should finance work for hospital closure, meant that
the social work team had a policy of no involvement with closure work,
despite the general support among social workers for community based
services. Out of the thirteen residents who were Haringey patients, only
Jane had a social worker.

I asked Jane if there was much social worker input on the ward. She
said not for some time, but things changed when the patients bureau
started. They called everyone in to interview them about their
circumstances. The ward staff either didn't know or had forgotten,
[that she was married] since she wasn't visited. She told them she

wanted to get a divorce and they arranged for a social worker to see her.

In Islington, where the social work team had been allocated extra staff for closure work and the team were actively involved in rehabilitation work with long stay patients, several of the group home residents had individual social workers, and a link worker was allocated to the group home.

The role of social workers was viewed by both hospital staff and the group home staff, as being welfare advice or casework and referring people to social service resources, such as day centres or elderly people's homes. Social workers viewed their own role more broadly, as dealing with general problems experienced by patients, rights issues, and offering counselling of various types. Given this gap in role definition, even in the group homes where social work support was readily available, there was a tendency for this source of outside support to be underused. Those residents who had allocated social workers had access to workers who belonged neither to the hospital or to the group home. The social worker/client relationship was a more personal one and was valued highly by those individuals who had such support. Only one resident had contact with a psychologist and generally there was little awareness of their possible role in mental health services. Contact with occupational therapists had been in hospital workshops or art therapy, and did not continue after the move, except for those residents who continued to attend the hospital workshops after leaving.

The attitudes of nursing staff to the hospital and to group homes

The attitudes of nurses towards the hospital closure was perceived as a major problem by community based workers in the reprovision programme. Concern about the closure is very widespread, but the views of nurses on community care, and the reasons for concern varied. Their concerns could be divided in two key areas: firstly concerns about their jobs and

position in the closure plans and secondly, concerns about patient care and professional values. The nurses whom I met in the course of the study expressed frustration to me over the way the hospital is run, and the way they have to work within it, as well as over the issue of closure. These nurses did not form a representative sample of nursing opinion, but were not exceptional among nurses. I think it is fair to say that nurses do not have one clear view of the hospital, and have very ambiguous feelings about the closure in many cases.

Nurses were criticised by other groups for being concerned about losing their jobs and uninterested in community care. It is important to note that when the closure decision was made, no consultation had been made with the majority of hospital based carers, and no agreement was made initially on retraining and redeployment of workers. Although it was open to hospital nurses to apply for jobs in hostels, group homes and so on, at this stage, nurses who had worked in the hospital environment for many years had not received retraining, despite the managerial view that institutional environments influence long-serving staff as well as long-stay patients. Several nurses pointed out to me that the change is a big one for them, as well as for the patients.

Community based workers view nurses as over-protective and therefore as failing to allow patients to maintain the levels of self-direction which they are capable of. They see the nursing role as having contributed significantly to the institutionalisation of patients. Nursing staff reflected this in their concerns about the welfare of patients who are leaving. They repeatedly stressed how much has been done for the patients in hospital, and emphasised their disabilities, expressing doubts about whether they will manage outside.

The passages below demonstrate the positive and negative views held by different nurses, about patient care in the hospital and about community care. They reveal ambiguous feelings about the patients and about how they fare in either setting. They also express feelings of exclusion from forms of caring which are highly valued, and attempts to show that they are not merely 'caretakers' but workers with greatly needed skills

to offer.

Visit to Friern Hospital:
The sister explained, with some annoyance, that the heating is centralised and gets shut off for the entire summer, regardless of weather. She quoted from a memo saying ancillary heaters could be obtained from services if very uncomfortable. She was pleased about the confirmation of the move and had herself heard via the consultants that it would be OK. I asked her about the 'rehab course' they were on, (another 3 week course). She said it was a more "advanced" one, including "social skills" She, personally, was keen on preventing institutionalisation and enabling successful moves out, but wasn't confident of success for all individuals. She wasn't surprised that Gladys had been "dropped" and said that in some ways she had regressed recently. [I wondered whether this was since being turned down] A visit to the Grange had been lined up for her as a possible alternative. She said Gladys recently had been failing to undress going to bed, by way of example. When Gladys walked past the office, she saw Kate and seeming rather confused, said "what do I do now?" The sister said, "You go and take your coat off." The sister said she'd been a community nurse before going to hospital and knew about some of the facilities outside. When Hilda arrived she commented on the cold. The sister suggested she keep her coat on for a while but she said no, she'd rather not. The sister said this was a good thing: having her own opinion and making her own choices.

Visit to Adelaide Road.
When Frank, the worker, came in I told him about the problem in taking prospective residents on a group home visit last week. He said he wasn't surprised, especially with his experience of being a nurse. Although he didn't approve of such unhelpful views he saw there were understandable reasons for it. Jane commented that patients preparing to leave got little encouragement and some nurses were telling people directly or behind their backs that they'd be back. On the back ward, the staff just didn't bother with you anyway. On the others there was more active encouragement of patients, yet the nurses never sat down with them to talk over the move, or anything like that. Even the sister, whom they'd expected to be supportive, didn't in fact offer them any encouragement. She even felt there was some obstruction going on – When Kate started coming to the ward, there was never advance notice of the visits and often she was out when Kate came. The nurse had said to her that Margeret and Hilda would soon be back. She wondered, laughing, what the nurses were saying about her to the others.

Visit to Claybury for Ward Discussion Group
After the session, we said good-bye to everyone as they were having tea and the workers went into the office to discuss the lists. The charge nurse was very helpful – giving information and opinions. He said he was disappointed that one man might not be suitable, he'd like him to leave because he's had an unhappy life. For another prospective resident, he advised talking diplomatically to a relative, who was worried about him leaving.

I asked him if there would be any specific rehabilitation programme in the hospital. He said he'd been trying to work out an individual programme for each man and do general things with them, but came up against many problems - there were no cooking facilities on the ward, not even to make a cup of tea. When he tried to use the gas cooker the supply was cut off. He had asked for flasks of hot water for making tea in the evenings but was told no, because the men might burn their hands. He didn't see why they couldn't have a kettle. He tried to do using phones, but payphones were costly, then they changed them to cards, even more costly. When he found an empty office with a phone in, they disconnected it. He used these as examples of why patients have so few skills and why it is hard to prepare people for leaving. He was also very critical of the new administrative structure, saying managers lacked understanding or medical knowledge of mental illness. He said most of the men had problems like lack of self care, which could improve with a change of environment, so workers shouldn't be too discouraged.

The role of medication in hospital life

For the majority of psychiatric patients, the only forms of medical treatment available are by psycho-active drugs or occasionally by Electro Convulsive Therapy (ECT). Other forms of physical intervention, such as psychosurgery are now very rare, although one of the residents had undergone surgery in the past. The psychiatric hospital, for long stay patients, is a place of residence, where they receive a certain amount of care and control, but this role of the institution is stigmatised. The staffing structure of the psychiatric hospital suggests that its basic purposes are medical: that it is a place which people enter because they are ill, to be given treatment, and hopefully to be cured. The role of medication therefore, as the main form of treatment available, is essential to the medical view of hospital care.

This central place is reflected in the importance given to medication within the ward routines, within the organisation of the hospital and its staffing, and in the legal conditions set around the use of medication in the 1983 Mental Health Act. Unlike other forms of medical treatment, psychoactive medication and ECT are the only forms of non emergency treatment which can be administered without the patients consent. The issue of compulsion in treatment ties in with that of

discipline and regulation of institutional life. Medication can be used both to benefit and to constrain the patient.

July 87 - Visit to Adelaide Rd.
Jane commented on voluntary status with regard to medication. She knew you were supposed to be able to refuse it, but in practice this was nonsense. Nurse M had told her that if she didn't want her medication she didn't have to take it. She felt that patients could only refuse it with the Doctor's agreement. If they wanted to force you, they could put you under a section or make life very difficult. Patients were subject to the decisions of doctors, which in her experience had been inconsistent and appeared arbitrary.

The main function of medication, according to both medical and community based workers is the control of psychiatric symptoms. Opinions as to its relative effectiveness, its use, the different types of medication and their side-effects vary greatly, within professional groups, as well as between medically or socially oriented professionals. None of the professional groups involved, however, rejected its use.

It is noticeable that the different types of drug treatment are generally referred to as medication. Among hospital workers, this reflects the general fact that it is the medical aspect of hospital care for most patients. Among patients it is similarly used to represent the medical treatment they are given, but also tends to mask the general ignorance of what the treatment actually consists of.

When the community pharmacist visited Adelaide Road to explain her work, she asked the residents what medication they received, what they thought it was for and whether they noticed any side-effects. Kathleen knew what her 'side-effect tablets' were called, although she couldn't pronounce the name, but was not aware of what they were for. Most of the residents had a more vague conception of the drugs being to 'make you better' or 'to feel better'. The pharmacist observed Dorothy's shaking hands and explained that this was a common side effect of the medication she was taking, and that one of her tablets was to counteract this. Dorothy was very surprised; no-one had ever told her about side effects, and she had believed it was a symptom of her "nerves".

Medication is normally dispensed in a regular round on the ward, so that the patient has little active involvement beyond swallowing a tablet. A certain number receive 'depot injections' at intervals, instead of or as well as taking tablets. The depot injection administers medication to last one or more weeks, thereby making patients even more passive in their use of medication. On some wards there were training programmes in self administering of medication, for people who were planned for discharge. In these programmes the patient progresses in steps towards managing their medication without supervision. Several of the prospective residents had started on such programmes, before being told that the voluntary organisation did not favour self administration of drugs. Therefore, one of the few ward-based rehabilitation programmes run for patients was rejected by community-based staff.

The language of medication and the routines of the medication round, serve to distance the patients from something which is, at the same time, central to the way their lives in hospital are structured. Medication is talked about all the time, yet not talked about in important ways. In chapter 7, I will show how, in the group home, this relationship with medication is continued in its basic form.

The hospital environment is classed as a medical one, and the existence of medical treatment in the form of drug therapy or ECT is very important for staff to be able to maintain this view. It is very noticeable, therefore how little attention may be paid to the physical health of residents. Observation, although general, is focused on psychiatric pathology. The worker is trained to observe the behaviour of those under his/her care for symptoms of psychiatric illness and signs of disability. The response to the collapse of one patient, a prospective group home resident who had been suffering from lung disease for some time, shows how, within this practice, the physical illness of patients can be passed over.

> Carol [group home worker] said he'd collapsed in the corridor as they were on the way out. Hospital staff walking down it simply stepped over him. She was dumbfounded by this. Clare went back to the ward for help and it was 15 minutes before she could find someone. In the meantime, Carol said, he became more anxious and in the end she walked

him back to the ward because she thought the agitation might be more
dangerous than the walking. When they got there, Clare had just found
a nurse, who sat him in a chair and went to find a doctor to look him
over. She felt that his collapse wasn't taken seriously. The nurse
asked her if he did this sort of thing often, explaining that he
didn't know him because he usually works on a different ward. He died
several days later.

Another prospective resident was described by the hospital as 'mute',
but apart from this, showing no signs of psychotic illness since his
admission, 40 years ago. It is not clear at all why he chose not to
talk. The transitional worker and the group home worker who got to know
him well, said that he would talk in one to one situations, with people
he knew. They also noticed that he appeared to be fairly deaf, but the
ward staff said this wasn't the case.

Visit to Thorn Street:
I asked Raj if he enjoyed the music and got a nod of acknowledgement,
but it appeared as though he hadn't properly heard what I said. Carol
said she'd been speaking to the workshop staff and they said, "Oh yes,
we know he's deaf." She was pleased someone at the hospital shared her
view. She also suspected he had a hip problem which hadn't been
attended to, because he walked slightly awkwardly. This started a
general discussion about psychiatric patients not getting possible
physical problems attended to. Maurice looked up from his food in
interest, but said nothing. I recalled how, when I first met him, he
told me that he thought the hospital system encourages you to be
mentally ill, because this is the only thing you get attention for.

Day time activities in the hospital

Activity in the hospital which is not ward based is called 'therapy',
usually either industrial therapy or occupational therapy. Industrial
therapy is more work based, in a separate workshop and including
unskilled tasks like packaging, and more skilled tasks such as woodwork.
Occupational therapy is generally also a matter of routine tasks such as
packaging, but arts classes are also available. The workshops are
attended by a larger proportion of men, while a number of women patients
work as domestic helps within the hospital. A few, who had good office
skills helped with things like typing. All hospital work is paid, at a
rate of about £6 per week, and although the residents thought it was
very low and underpaid, they preferred this to no extra money. The DHSS

allowance of £7.90, especially for the majority who smoke, was not adequate for even minor expenses. Many patients told me they would like to give up smoking, to save on money, but found it difficult because of the boredom and the habit. Work therefore is therapy because it is "something to do" and is also a means of supplementing the personal allowance received by most patients.

Visit to Adelaide Road
Carol [worker] asked Dorothy what type of work she did in the hospital. Dorothy replied - some knitting and sewing earlier on, domestic work and office work; the typing was mainly for the hospital newsletter, which included things like crosswords, and pieces of information about the hospital. She said she had got to know a bit about the hospital from this, but didn't respond to Carol's question on how the hospital had changed since she went in. We asked her some more specific questions about it. The wards, she said, had got a bit smaller. [i.e. numbers of patients per ward] When she went in, most wards were locked, now most are open; people do go out of the hospital a bit. She wasn't able to describe how she felt about it at the time, but said that she much preferred it unlocked. She also made the observation that it was a lot of change for the staff as well.

Visit to the Day Centre
On the way home there was some discussion about working in the hospital. Jean started to talk about a particular nurse, who had nagged her about working and had been quite rough with her, saying that she was slack with the cleaning work. This, Jean said, was at 6.40am - she used to arrive early for the 7am shift. She told me she'd got shirty with the nurse and "told her to get lost". Getting up time was 6.30. On alternate days she was supposed to wash down stairs and clean the bathroom, before breakfast. Jean thought the nurse had been under stress because she was pregnant and carried on working until the last minute. Mary also recalled her as being a bit of a taskmaster. They used to get paid for this work, but according to Jean it worked out at about £6.50 per week, working 3 hours each morning and afternoon. She thought it was badly paid.

October 87 - Ward discussion group at Claybury hospital:
One man said he was good at cooking, housework and so on, because he'd been in a group home before. He said that during the day he goes to 'OT' and makes lanterns, woodwork and that sort of thing, also sometimes gardening. He pointed out two elderly men and said "so and so do gardening as well."

There is a preference for activity of this sort, and structured activity, over letting patients occupy themselves in their own way. A small number of patients remain on the wards during the day, doing very little, except sitting in a chair and maybe watching TV. A few patients

managed to maintain their own interests or even develop new ones, such as through art or literacy classes. Jane developed a very keen interest in art, but found it was discouraged by ward staff:

> She explained that one reason why she is so set against day centres is her experience in hospital of being pressurised towards doing 'IT', rather than painting.

In the group homes, the daily routine assumes that residents will normally have a day time occupation, which will be at least part time, regardless of age. The residents of the Haringey group homes were all expected to attend a day centre run by the voluntary organisation. Daytime activity for the residents was modelled on that of the hospital and was provided within specialised psychiatric services, rather than within ordinary community facilities. The importance of the day centre and its continuity with hospital life, is examined as an aspect of group home life in the next chapter.

In Adelaide Road, problems have arisen for the residents on the issue of day-time activity. Four of the seven residents are over pensionable age, and all want their rights to retirement to be respected. A significant problem was the absolute shortage of psychiatric day centres and the lack of choice in placements. In practice, therefore, it is often difficult for carers to choose day time activity according to the perceived needs of the resident, let alone for the residents to choose for themselves. Possibilities for activities outside the psychiatric sphere, such as pensioners' clubs, have not been explored and the opportunities for patients on leaving hospital have not widened in the way they might have expected.

The hospital, the group home and the issue of rehabilitation

There are a number of significant contrasts, therefore, between day to day lifestyle in the hospital ward and in the group home. Patterns of living are framed by the scale and design of the home environment – living on a hospital ward makes it much more difficult to enable

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privacy, choice or independence. The simple fact of living in a house does provide a basis for a more 'ordinary' lifestyle. However, patterns of living are not totally constrained by the environment. The use which is made of the ward or home is the main point and is influenced by philosophies of care and how the carers put these into practice. So, it can be argued that the use of space in the ward is influenced by the relatively peripheral role of rehabilitation.

Goffman [1968 ch 4] analyses service models in general and as they apply to medicine and particularly psychiatry. In this model an individual seeks a service from a professional, either to his property, eg a repair, or to his person. He argues that the normal service model is inappropriate when much of the 'therapy' is around day to day functions and contacts are governed by lower staff levels. It cannot be maintained in a situation where almost any modification in the clients' living arrangements can be sanctioned by the service providers. The hospital is understood by professionals in terms of a medical service model, while, at the same time it functions as a place of residence, which provides care and control over those who are categorised as chronically mentally ill. [p321]

The reforming model of care, which influences the thinking behind community care, regards 'chronicity' as something which may be a symptom of institutionalism, rather than illness as such. Therefore it is designed around rehabilitation, and in contrast to the patterns of life of the hospital. However, attitudes towards patients and patterns of care in hospital encourage the view that chronicity is an aspect of the person, rather than of the institution which has framed her/his behaviour. A tension therefore exists, in both settings between these two interpretations of institutionalism.

Despite the differences I have described there is a significant degree of continuity between the hospital situation and that of the group home. It arises out of the dependent status which the patient has lived in and which is passed over to the caring organisation. Although the voluntary organisation's stated aims of "a fuller and more independent life" form

guiding principles in community care policies in both boroughs, there are factors in the practical situation and in the philosophies of care, which may limit such aims. The concept of rehabilitation, wherever it is used, is not value free, and may have different meanings according to the context in which it is used. Similarly, the concept of "independence" is a culturally loaded one in our society. The development of group homes demonstrates that what is being pursued is also *interdependence* within a group. In the case of the group homes studied, this aim is framed within a "family model of care". The model of care used for the group home is therefore different to the medical service model of the hospitals, yet it is adopting patterns of interaction which are formed in the institution.

NOTES TO CHAPTER SIX:

1. The bureau which deals with patients' finances received their DHSS
    payments and issued chits to patients, via the nursing staff, which
    they could use to withdraw their money from the bureau. It was not
    possible for patients to simply deposit money there for safekeeping
    without it being 'managed' for them. The inefficiency of the
    bureau, or restrictions placed by staff on individuals patients
    chits could therefore cause considerable worry for patients.

2. See also the section on medication in chapter 7.

3. This is the smallest group home and this point did not apply to
    other houses, which were more spacious.

4. Section of the 1983 Mental Health Act allowing for compulsory
    admission to a psychiatric unit.

5. Under the 1983 Mental Health Act, voluntary status is now defined
    as informal status.

6. An assessment measure set up by one consultant via the Task Force
    in Friern – see chapter 4.

CHAPTER 7:

EVERYDAY LIFE IN THE GROUP HOME

'The house was comfortable and fairly ordinary looking. Not as luxurious looking as some conversions, or as spacious, but rather what might be expected of a typical family house. Frank thought the difference from hospital wasn't that great, more extending the care into a different setting. He didn't see working methods as being that different, but thought the levels of resident independence were greater, especially at night time. The prospective residents said they really liked the house, found it comfortable and weren't very conscious of the difference in scale.'

The group home, as described in the previous chapter is ideally "an ordinary house in an ordinary street" [1] In trying to understand what life is like in a group home, therefore, we have to look at both the ideals and the practice. The philosophy assumes an understanding of what is *ordinary* and also how ordinariness is valued in this context. This chapter describes in detail what everyday life is like from the viewpoints of residents, and of those who manage and work in the homes. It shows, as far as is possible from the position of an observer, how the lifestyle is experienced by those involved in it. The description is valuable in itself, as a means of understanding what group home life is like, and how it compares with hospital life, but it is also the basis for understanding how the attitudes and practices of caring organisations are formed and how they affect the lives of the residents they care for.

The status of residents in the group home

The voluntary status of the residents when in hospital, as we have seen in chapter six, was affected by the way the hospital is run, and by their lack of choice in where and how to live. Their legal status was less significant for their experience than their practical situation. The status of residents is voluntary as a matter of course - they all made the choice to move to the group home, once selected as suitable

residents by the professionals - but, just as in hospital, the
experience of living in a group home may constrain without any legal
compulsion on residents stay or behaviour in the home. None had an
alternative home realistically available to them outside. The projects
developed as part of the hospital closure programme represent a
hypothetical choice between different forms of sheltered accommodation,
according to the programme in their borough and the stage to which the
programme had developed. In practice, most were only presented with a
choice between moving now, to this house, or staying on to see what will
turn up in the next few years. This lack of choice was particularly
acute for the Haringey residents, who moved out very early in the
process of reprovision and who did not have contact with resettlement
workers, who could inform them of what opportunities might be available
to them.

In the account of the selection of residents for the homes, it was
apparent that the prospective residents were given a passive role in
deciding whether to move. Basically, they could only make the choice if
they were selected positively by the carers, and could then choose not
to move, either by stating their opposition unequivocally, or by
behaving negatively during the rehabilitation visits. On the whole, lack
of information on any possible alternative housing meant that their
limited choices were not well informed. The main exceptions to this
pattern were among the Islington patients, who had social work advice,
and where an overall strategy for alternative housing had already been
made clear to workers involved in resettlement. In these cases, the
prospective residents knew that they had the chance of being offered
housing in a different local area, of a different size, or with a
slightly different style of support.

The residents are licencees of the group home and therefore do not have
the normal legal status and rights of a tenant. Under the terms of the
licence they have permission to reside in the property, must pay the
appropriate fees, and must comply with certain conditions in the
licence. These include conditions on taking a share in housework, and
compliance with all medical advice. Such conditions are additional to

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the usual conditions on behaving in a reasonable manner, which legal tenancy and licence agreements normally set out. The licence ensures that residents have only an insecure status in the home, and that they can be given as little as one week notice to leave if they do not comply.[2]

When preparing for the move, all residents were shown the agreements to be signed, but most were not given advice on its terms. At that point, they were thinking about the more immediate issues around moving, and legal status only became an issue later on, when problems arose for a few people. However, several told me that they valued highly the assurances that the group homes were supposed to be "homes for life" and the feelings of security which this gave. The policy of the carers is that, ideally, these should be homes for life, and should be experienced as 'homely' and secure, but that they need to retain rights to remove residents who present problems to them in the running of the home.

In everyday life, the residents are expected to think of the group home as their own home and to treat it as such. The principle is that they should live within it as though in a family and take interest and care in it as though their own. Rehabilitation activity, therefore, such as housework, gardening, cooking and sometimes entertaining, is tied in with the general philosophy of what the group home should represent for people.

The difference between the general approach to the home and the actual status of residents within it, is a contradiction which underlies the way the homes are run and the way problems within it arise: it is not made clear whose home it is, the residents' or the organisation's. This contradiction only became apparent to staff or residents in the few cases where disputes developed involving the conditions of residence, or when a crisis occurred.

The financial position of group home residents also influences their situation. The fees paid were £147.50 per week, representing the maximum board and lodging allowance paid by the [then] DHSS. It includes not

only licence fee and rates, but fuel costs, food, everyday running costs, and some contribution to staff costs. Remaining costs are covered by the Health Authority. The majority of residents received benefits to pay this, plus a 'pocket money' allowance of £9.25 per week, for their personal needs. The minority who had savings were obliged to pay the fees, until their savings dropped to the DHSS benefit level. Staff encouraged these residents to spend money on themselves, for decent clothes, on personal interests and so on, but it was difficult for some people to accept losing their savings by paying such an unusually high 'rent'. Even those who were entitled to full benefits, found it painful to hand over most of their allowance, while keeping such a small amount for themselves, especially if cigarettes used up most of their money.

The financial situation of a resident, paying housing charges, contrasts strongly with the situation of the hospital patient, who has only a personal allowance. Several found the figures difficult to comprehend, and the budgeting a challenge. Their problems were added to by the general incompetence of the DHSS, leading to arrears of thousands of pounds for the Adelaide Road residents. As a result staff attentions and time were diverted away from the residents to financial problems. This experience, around the move out of hospital, was stressful for workers and residents, and led to unnecessary worries and fears about the future. The experience also encouraged workers to be *more* protective and controlling over residents' finances than they might have been. In Carrier Lane, staff took this further by keeping residents' money in the office, and giving it out a few pounds at a time, much as the hospital staff had done. They explained that it had been like this in hospital for so long, that the residents didn't know how to budget, and therefore it was for their own good. This intervention raises the question, as with the general status of the residents, of how rehabilitation will be achieved, while key aspects of dependency are being maintained.

The sections below explore how relationships operate on a day to day level, amongst residents and between staff and residents. There are two rather different views which can be presented: the formal, policy view of group home living, and the views of the residents. The attitudes of

the workers generally reflect the formal view, but the closeness of sharing in the home leads to some conflict for them between this and a desire to understand the residents' viewpoint. These dilemmas, for workers, are revealed in the analyses of problem solving, in this and the following chapters.

Relationships within the group home

The importance of relationships to the concept of the group home is revealed in various ways, in the selection of residents, in the running of the home and of the day centres, and in the perception and management of problems, including the ultimate rejection of some residents (or prospective residents) by the caring organisation.

A distinguishing feature of domestic and other activities in the group home, compared to the hospital or alternative accommodation such as sheltered flats, is the principle that they should be shared. The requirement that all residents should take their share of household tasks is written into the resident's licence and into the household rota. Tasks should be done together by worker and resident, shared by residents or between them. There is no division of labour according to the different interests or abilities of residents in theory - each person should take her or his turn at each task, but in practice such divisions do occur.

The following case examples show that sharing and mutual support were important in the group homes, but that in practice (and more like an 'ordinary' home in this way) sharing was uneven and reflected the different individuals who lived there. Inevitably, tensions also develop around sharing a home, so that residents (and workers!) may annoy each other, but also give each other considerable help in building up new ways of living.

May 87 - Visit to Adelaide Rd.
Mary complained to Kathleen that she was dropping ash on the floor, "Haven't you got an ashtray?" Kathleen went into the living room

(where there were some) and sat down. Mary finished mopping and turned the oven on high to dry the floor. She told me that she's managing the cooker rings now, but finds the oven handle awkward. She had put the vegetables on, several hours too early. I said "Isn't it Kathleen's cooking day?" She said Kathleen doesn't do it so she has to get things started instead.

July 87 - visit to Adelaide Rd.
I talked to Dot in the living room for a while, then offered to make a pot of tea. I was in the kitchen, emptying cigarette ends out of the Jean's four teacups, when Mary came down. She looked surprised to see me, then said "Are those Jean's cups again? She can wash them up!" She put the bin lid back on straight and said it should have a proper bag in. She said when she was down before, all the cups were washed up, and now Jean had them all out again. As I poured the tea, she told me that Dot took sugar. When we sat down she asked what time the staff would be in, and to tell her about what I'd been doing on my holiday. While we were sitting there, a letter dropped through the door. Mary wondered if it was the local paper or a letter. She picked it up, saying it was for Jean, and left it on the office desk. I noticed that she also went in there to look at the messages at one point. Shortly after this the paper did arrive so she picked it up to read and checked whether the milkman had been.

August 87 - visit to Adelaide Rd.
When I arrived the residents were watching a soap opera on TV. I asked if they watched it regularly. They said they didn't watch it much during the day, except for soaps.

September 1987 - visit to Adelaide Rd.
Mary told me the toilet light wasn't working so I went upstairs. As I walked past her open bedroom door, I noticed that it was neat and attractive looking. At the far end Kathleen and Jean's door was open and I could see cases and bits and pieces strewn across the floor. The bathroom was clean and very bare. I went and knocked on Kathleen's door to ask if I could take used cups down. Jean was in bed. She looked round from under her cover and said yes. When I took 6 cups down, Mary said "Oh, they're all from after this morning because I washed those up at breakfast time." She washed them up. Jane (who lives in the nearby home) came in with some shopping she'd done for them, so Mary gave her a cup of tea and she sat down to roll a cigarette. Frank [worker] was at the hospital with Kathleen to see the community psychiatrist. After some conversation, Jane said she'd have to go down and put the dinner on. She seemed a bit fed up that the others, being out all day, tend to expect her to cook.

This sequence of accounts from day to day life, in one group home, show that, despite the formal rotas and emphasis on structured sharing, much of it was informal and uneven. Residents developed roles, which they could live with, and which fitted with the ideal of being like ordinary family life, yet these were increasingly perceived as problems by the

staff. This point will be returned to in comparing staff and resident
perceptions of group home life. What is also noticeable in this project,
as opposed to the others, is that the residents' daily activities were
relatively independent. Interaction with staff was mostly confined to
certain times of the day, such as the evening meal time and specific
tasks such as giving medication. In the neighbouring house, without a
staff office, the role of staff was more one of visiting helpers, and
residents would call up the road, in passing, to talk to them.[3]

In Carrier Lane, although the general set up was similar, staff and
residents spent more time together in shared activity. This may reflect
two points, both of which may be partly gender related. Firstly the men
selected for the house had a higher assessed dependency level; secondly
the residents of Carrier Lane were all attending day centres for four
days a week, while the Adelaide Road residents spent more time at home.
It is important to remember that four of the seven women living at
Adelaide Road had been married and had children, whereas none of the men
who lived at Carrier Lane had been married, and all except Brian had
spent most of their adult lives in hospital.

March 88 - Visit to Carrier Lane
When Louise came in, she told Bert to take off his coat and hang it
up, since he wasn't going out. Then she asked Brian to come and put
his washing in the drier because it had finished. He woke up, did
this, then went back to his chair. Dennis and Bert followed Louise
into the kitchen to see what she was doing. She made tea and they sat
down at the table to drink it, with hot cross buns. They were eating
very quickly, so she asked if they'd had breakfast. They said no -
just a cup of tea. The staff say that Brian takes on a lot of
responsibility when they're not around, and usually gets breakfast for
everyone. Louise been out earlier to take Howard to the GP then to the
rehabilitation centre.[4] She showed me his weekly programme and said
she thought he was getting on OK at both this centre and their own
workshop. The programme titles were, she thought, just jargon ridden
ways of describing everyday activities as therapy - "going on the
bus" "having a talk" or whatever.

This extract shows that the men were dependent on the domestic and
personal help of the staff in a way which the Adelaide Road residents,
after settling in, were not. Three of the four had only very limited
domestic skills, so that it was more a matter of learning from scratch

than relearning old skills. Only one resident had lived as a working adult outside hospital, the others having entered hospital very early in adulthood. Nonetheless, they learned a great deal during their first year in the house about caring for themselves and about the world outside hospital.

In the Thorn street project, which was designed for 'higher dependency' patients, with more intensive staffing, patterns of interaction in the home differed in a way that reflected the different set up. The larger scale of the house, made it less suited to the idea of a 'family home', and the increased space, made it possible for residents to choose where in the house to spend their time, and to involve themselves in separate or shared activities. It also reflected the better provision of support services, where residents had a reasonable choice of activities outside the home, and had transitional workers visiting to share activities with individual residents.

The attention paid to relationships in the group homes relates to the view that rehabilitation isn't only functional, but is a matter of developing social skills. The account of hospital life showed how difficult it is to maintain social identity or relationships in institutional environment. However, the groupworkers' view of 'social rehabilitation' is also related to their views on mental illness, particularly the idea of the mentally ill person as socially incompetent. It follows that, if the residents are to resume community living, the staff feel that their social abilities must be managed, (by responsible others) and somehow reconstituted.

In deciding who will live in the group home, the staff were shown to be selecting for people whom they felt had the potential and motivation to get on within a group and excluding those who they felt might be disruptive. The visits to the home, before moving, were geared up to familiarising the residents with the home and with each other. The first overnight stay, without staff in attendance, was very important in this respect. The visits were also used by staff as a means of observing the

prospective residents as a group, to assess how well they coped with the shared domestic situation.

The relationships between residents and staff and amongst residents are seen as a means by which social skills can be developed. CRT sees the relationships within the home as a model for other possible relationships: between residents in different group homes and with people outside the psychiatric sphere; family, friends, other people in the community.[5] It is also seen as a means of *training* residents in other living skills and in *managing* their behaviour. When compared to the hospital ward, relations between staff and residents and within the resident group are closer and in many ways more interdependent. The positive evaluation of close involvement is encouraged by the setting itself, in its scale and design and its routines.

The residential 'groupworker'

The staff are called 'residential groupworkers' because of where and how they are supposed to work. The ideal qualities of a residential groupworker and how they are selected, tell us something about the caring organisation's expectations of what group home care should be like. They are not classed as *professionals* and are not generally drawn from highly trained or experienced groups. This is a positive choice and not something which is simply constrained by the level of wages or availability of applicants. The management see the groupworkers' skills as a matter of personal character rather than formal training.

The qualities required of a residential groupworker are described in the job application form as:

"Caring person with practical commonsense, housekeeping skills, stability, stamina, patience, flexibility and ability to encourage improved standards of homemaking where appropriate. He/she will also need the capacity to encourage residents to enjoy what the environment has to offer and to maximise opportunities for enhancing the quality of life of residents, as they occur. Initiative and optimism are also valuable assets."

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When managers talk about their staffing policy, they express belief in
naturalness and an *intuitive approach*. Their distrust of professionalism
is not merely based in lack of confidence in hospital-based psychiatric
care, but also in the view that acquisition of 'psycho-dynamic' ideas or
jargon will interfere with naturalness. They do not attempt to define
naturalness in itself, perhaps because it is assumed that shared
understandings will exist. This is the way in which we all tend to use
such terms, and the idea of naturalness expresses something which is
given. In meetings the staff are encouraged to "use your common sense".
There is also a class-based view that professional workers are too
socially distant from their clients. This rests on assumptions about the
class of clients; that psychiatric patients are uneducated and low
class, and therefore, that their needs and abilities will be
misunderstood by well educated middle class people. The groupworkers
have varied backgrounds and an ethnic mix which compares favourably with
many organisations. The majority are female and younger than their
clients. [6]

Staff induction and training

New residential groupworkers usually work at the day centre for several
weeks before being assigned to a home. Senior staff argue that this is a
good induction, for people to get to know those who they will be working
with in a more general setting.

> One new worker had not been told this, but thought she'd been put
> there to help with the move. She spent much of the time in the main
> room with the day centre staff, interacting with members by helping
> with moving, rather than sitting down talking to them. I asked if
> she'd had any sort of special training at CRT. She said "no", she was
> "learning on the job". She was previously working in a children's
> home.

All new staff read the organisation's training manual. One worker
commented on its conciseness and said it doesn't explore all sides of
each point, but thought it would be difficult to cover it in a book like
that. All new staff had a three month trial period, during which they
were given weekly training sessions, lasting about an hour, by the

manager. These covered several theories of the nature of mental illness, [which will be discussed in chapter 8] and also issues in the running of group homes.

The training by tutorial is limited and tends to focus on certain ideas as being common sense, avoiding theoretical or critical discussion. I was surprised, given the prominence they give to rehabilitation, at the lack of discussion on matters such as the character or effects of institutional care. Workers with little or no previous experience therefore, might know very little about the background to community care policies, or the characteristics of institutional life. This is an important gap in my view, because without such knowledge, workers could not be expected to discern patterns within the home which might maintain or fail to prevent problems of institutionalism.

'Common sense' and the experience of visiting prospective residents in hospital did enable workers to understand some of the main problems facing people who have lived for long periods in institutions - lack of opportunities leading to lack of skills, apathy and so on. However, they did not have sufficient knowledge or experience to consider how far de-hospitalisation in itself will imply de-institutionalisation. Changes in environment were expected, in a rather instrumental way, to achieve a great deal. Staff themselves expressed desire for more training, feeling they had been let down by the assurance that training would be given. They also expressed interest in chances to analyse their roles more, perhaps to discuss some of the ambiguities they felt as individuals on a more general level. They felt this was regarded as unimportant, or even as not being suitable activity for ordinary workers.

The main emphasis is given to learning from the managers and from other residential groupworkers during the course of work. This follows an ethos which values practical experience and caring. The organisation will employ psychiatric nurses and even advertise jobs within the hospital, but in practice few staff are qualified psychiatric nurses and no qualified social workers are employed. The majority of staff have either voluntary work experience or experience of residential caring

work of some sort, although this is not specified as necessary.

September 87 - Visit to Adelaide Road
Two new residential workers started this week, one here. She didn't yet know where she was likely to be working. She had previously done a psychology degree, but wasn't very happy with it, then worked in an old people's home. Frank talked to her for a while about what he thought would be needed, saying that commonsense was vital rather than knowledge or experience as such. I asked him whether knowledge of institutionalisation, medication and so on was useful. He said, "oh yes, you need to learn something about the nature of the illness, institutionalisation and medication; you need to know about the type of behaviour you might come across, so that you can cope, not over-react, and show people what to do to deal with it".

In all but one house (the Islington group home with 24 hour staffing) the staff work alone, in ten hour shifts, with two days on and two days off, regardless of weekends and holidays. Wednesday mornings are unstaffed so that both workers in a home can work together for an afternoon. This changeover is an important time for communication between staff. The workers exchange information on Doctor/clinic appointments, progress with chasing up rent, DHSS matters, and housekeeping. They also talk about the individual residents, reporting any events or problems during the previous few days.

Information is also exchanged on a more formal level, and between workers and management at weekly staff meetings (lasting 1½ to 2 hours) attended by one worker from each home. Additionally there is a monthly meeting, ideally attended by all workers, which is more educational in purpose. At monthly meetings, workers give their usual weekly report on the group home and on its residents. The management then introduce a subject for more general discussion. Issues discussed in these meetings centre on the perceived needs of residents or management issues: eg. household budgeting, nutrition, residents' sexuality, contact with mental health professionals. Much of the discussion of issues in meetings, however, is focused on specific problems which arise in the group homes, and usually centred on a particular resident.

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On a day to day basis staff decide how to use their time and what to do with their time, once certain basic tasks are fulfilled. The basic tasks fall into three main areas:

1) Domestic - seeing that housework and shopping is done, household budgeting, helping with or supervising cooking.

2) Financial - ensuring that residents are receiving the appropriate state benefits and paying their 'rent'.

3) Supervision - ensuring that residents attend day centres or other approved activities;
management of risk taking;
report writing;
administering medication and arranging medical appointments.

Additionally, there is the more vaguely set out task of encouraging residents to take advantage of social or leisure opportunities. For most of the week, the policy is that residents will attend a day centre, which in theory at least will provide such opportunities. For weekends, or other days off, staff will try to arrange visits to other group homes or outings to parks, museums, to shops etc.

Much of the time then, is spent in helping residents with skills they need for independent living and with supervising residents' activities in various ways. This includes trying to ensure that residents engage in activities which the organisation regards as beneficial for them. Supervision, as in the hospital ward, also involves continual observation. Reports are made to management, which are used to assess whether residents are "making progress", "presenting problems", or simply getting along. In the following chapter I shall discuss staff attitudes towards these concepts and other classifications of residents and how the staff pattern of perceiving problems is focused on key individuals who are felt not to fit with the idea of the group home in some significant way.

The residential groupworkers are, on the whole, highly committed and motivated towards group home care, but during the course of the study frustrations increased, which were reflected in an increase in staff turnover. Two main areas of frustration can be outlined. The first, relating to the points above, was over training and status. They felt let down by the level of training offered, feeling that their capabilities were being underestimated in the style of training and management adopted. They were also aware of their lack of professional identity. Despite being generally very assured in their work, they perceived areas where lack of knowledge let them down, such as in the uses of medication and in the handling of personal or emotional problems. Secondly, a number of staff found their work directed in ways which they did not feel were valuable, such as having to spend long hours chasing up DHSS problems, or in having to supervise residents in ways which they felt were unnecessarily controlling.

The following sections explore the key staff roles, through looking at everyday routines in the homes:

Domestic activity in the group home

The outline description of the group homes in Adelaide Road showed how domestic life was a focus for the design and the day to day running of the group homes. They are set up to provide an alternative lifestyle to that of hospital and for the rehabilitation of the former hospital patient. For both purposes the obvious focus, for the staff, is a domestic one. The introductory visits for prospective residents start with cups of tea and progress to cooking meals and shopping. Once prospective residents start to stay overnight and are thought likely to be accepted for the move, they are encouraged to choose bedrooms and to participate in housekeeping.

Domestic activity is, therefore, a practical means of rehabilitation and for the staff to manage activity within the group home. It divides mainly into cooking, shopping and cleaning. The relative balance between

these activities varies between the homes, with the residents of Adelaide Road doing the highest proportion of housework themselves. Cooking is very important in all the houses, focusing on the evening meal and the Sunday lunch. This is because it is a useful homemaking skill, but also a 'commensal' activity and therefore a way of establishing basic principles of sharing. Sharing food is, in many contexts, a way of creating and symbolising kinship. Underlying domestic rehabilitation, there is also the issue of *self care*. Whereas in the hospital environment, patients often care for themselves very poorly, the aim is that group home residents will be enabled to care for themselves, through gaining new skills and a new self image and through caring for each other within the home.

The following accounts show how the home life revolves around domestic activity, so that rehabilitation becomes part of the daily routine:

July 87 - visit to Adelaide Rd.
Dot was alone and said the others were out shopping. She had the TV on but said she wasn't really watching it. I asked if she'd been out or such like since I saw her last. She said she'd been to a barbecue at the other house on Sunday, which she enjoyed, otherwise only shopping. Recently, she has taken more interest in everyday choices such as over food, and no longer says she isn't bothered about things. She also looks very stylishly well dressed. When Frank [worker] and Jean returned, I realised that Kath and Mary were up in their rooms. Jane had gone shopping with them, taking her own list for the other house. Here, shopping tends to be done for the residents by staff, whereas in the other house, Jane does a lot of it and they usually choose between themselves what to cook and buy.

May 88 - visit to Adelaide Road
I called about 10.30. Jean let me in. Frank was upstairs helping her to clean and tidy her room. She washed all the used cups brought down and put her washing on. Frank called me upstairs to show me the mess. He said the main problems are that she hoards things, having large numbers of clothes and not throwing away rubbish. Kathleen has less stuff, but still smokes heavily and the workers are concerned about her smoking in bed. They are now taking her cigarettes and her money away when they leave.

Frank commented that Jean has improved in her ability to start tidying for herself. She had started trying to clear her own wardrobe, because it was full. But, he said, its necessary for him to step in to keep the mess at bay and to ensure anything unhealthy, like stale food, is cleared away. He doesn't like to interfere with the privacy of their room if he can help it, but doesn't see any way of avoiding it. He says things don't look likely to change regarding the mess.

May 88 - visit to Carrier Lane - Shopping Trip
We went to the shopping centre in both cars, as Frank was coming to do
the shopping for Adelaide Road as well. We went first into the
department store cafe, a very smart place. The three men had sausage
egg and chips, and tea, followed by a cake or bun. Dennis was bolting
his food down. Frank told him "there's no rush, take your time and
enjoy it" He slowed down a little. After eating, the men went to clear
the plates away and Louise told them they didn't need to bother in a
restaurant. Bert and Dennis had forgotten their cigarettes, so Brian
gave them a roll up each. Louise said "If you have to wait till you
get back you'll really enjoy it then" and he laughed.

We then went to Safeways. The men went round helping Louise to choose
food. She'd forgotten her list and they pointed out things that were
needed or wanted. She asked them to fetch various things like cleaning
fluid and to choose varieties of things like yoghurt. Brian joked
about the numbers of goods in the shop, while Bert pushed the trolley.

The shopping seemed to me to be used effectively as a rehabilitative
exercise. Everyone was talking about things, choosing, remembering
things they needed, for housework as well as food. The men are not
very talkative, the way the women at Adelaide Road are, but they were
very involved here and talking about things that they were doing. They
keep very close to Louise: in the car park Frank called them over to
come with him, but they waited for her by her car. They seem to be
very dependent on the staff practically and in terms of their sense of
security. I recalled Catherine's comment, that they all go to bed soon
after the worker leaves at seven, and are in their pyjamas by the time
they leave. That is except Brian, who sometimes stays up to watch TV.
Most of their waking hours, therefore, are with staff around.

June 88 - visit to Carrier Lane
At 12.30 Catherine cooked lunch for everyone. I asked how the cooking
was coming along and she said - progress, but slowly and with some
difficulty; partly a problem of sheer lack of skills and partly the
view that its women's work [and both staff are women]. Brian, she
said, was pretty good and could almost cook Sunday dinner unaided. The
others peeled veg, and helped to dish out or put things on. They still
found the electric cooker difficult to understand, especially Howard,
who put on all the rings, grill and oven one morning, thinking it
wasn't going on because he couldn't see any flames.

After lunch, Dennis and Brian cleared up and Catherine put out their
tablets on their mats. She told me she was worried about Howard's
holiday: that his parents wouldn't give him his medication, and also
because she thought they'd fuss over him too much, not let him do
anything himself and make him more dependent. She thought it could
undo a lot of their progress in getting him to understand and
participate in things.

Domestic activity forms a basis of group home life, in the constitution
of a routine which structures time and activity. It is managed by the

staff, particularly in the early months after moving in, and except where residents' capability and staffing pressures combine to allow a more self-directed routine. Time is also structured by the use of medication within the home, and by the use of day centres outside the home. The home routine is less rigid than that of the hospital and allows more opportunity for activity within and outside the home, although in practice most activity except for day centres is home centred, with outings being occasional and organised by staff for the group. Like the hospital routine, time is structured by the staff for the residents, and there is considerable unspoken resistance to allowing residents to adopt more personal and loosely structured routines. The contradictions of a routine, which appears very different, yet shares a basic hierarchical pattern with that of the hospital, is brought out particularly in two areas of group home policy: those around managing medication and the use of psychiatric day centres.

The role of medication in the group home

Medication is the main form of treatment offered to patients in hospital and this pattern continues in the group home. This relates to the idea that psychiatric treatment is mainly concerned with containment and symptom control. Even for short-stay patients who might be described as in 'acute' medical care, medication is generally the only treatment available. Therapy in the hospital environment is generally a matter of doing ordinary things, or artistic work, which in a reduced environment do not appear as 'normal' and are therefore recast as 'therapy'.

All the residents in the group homes studied, with one exception, were receiving some form of psychoactive medication. Those residents who were diagnosed as suffering from depression or related disorders, were receiving minor tranquillizers, and were more likely to receive low doses or have some choice in how many tablets to take. Residents diagnosed as 'schizophrenic' all received major tranquillizers, often in high doses, through either tablets or depot injections, and most have 'anti side-effect' tablets too. Policies on use of medication for people

leaving hospital vary widely, between those who hope to see it gradually reduced and perhaps stopped for some people, and those who argue that medication is vital to enabling psychiatric patients to live 'in the community'.

Interestingly, the division lies along lines which we might not expect from looking at the rehabilitation data. On the whole it was medical professionals, such as community pharmacists and psychiatrists, who had confidence in the benefits of carefully reducing medication, while the voluntary organisation advocated the continuing, or even increased use, and supervision of medication. The medical view tended to be that medication needs monitoring and review and that some patients, particularly the elderly, may be taking more than they need, thus producing avoidable problems with side effects such as dyskinesia or direct effects such as lethargy. The group home staff had only vague ideas about the functions and side effects of medication. The reliance on medication in group homes, therefore was not a clinical matter so much as a management matter:

June 87 - Community Pharmacist's Visit To Adelaide Road
The district pharmacist came to look at what medication people are on and how its being handled. She was following up what happens in the year after leaving, and asked staff to fill out record charts. They were asked to note when anything is not taken, so they can see if somebody doesn't really need it, or if some change may be needed. She advocated bringing people off medication if done in certain ways:
a) gradually
b) at a point when the person is settled down after leaving
c) if there is some reason to think the person is getting on OK
   without it.

She said it requires staff to support, advise and monitor and offered to give talks to staff and/or clients on medication (which incidentally was not taken up). She pointed out that even for professionals it's hard to keep up with different types of drugs.

I asked Mary if she took any tablets and if she knew anything about them. She said she takes one or two little white ones at bedtime. She didn't know what they were called or what for; she'd been taking them for years. The pharmacist asked Dorothy if she knew what hers were. She couldn't remember the name, but said she'd like to try and stop taking them. The pharmacist said that would probably be OK, but recommended that she leave it till she'd been living there a bit longer, then see the GP about reducing the dose with a view to coming off them.

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Staff Meeting:
Groupworkers reported that Mary had seen the GP and was told she could take her tablets as required, and preferably should take none unless she needed them. They also reported that the community pharmacist will be visiting regularly and gave staff a policy document. which is in favour of self medication and reducing medication where possible. The supervisor's reaction to this was suspicion.

CRT regards drugs as the medical treatment which enables patients to live outside hospital. Management and staff say that it isn't a cure, so much as an effective means of controlling symptoms. The most popular analogy is with drug use for conditions like diabetes, which are regarded as permanent and requiring maintenance medication. Among groupworkers, this view is not necessarily based on direct experience of medication effects, but at least partly based on faith. One could say that ideas about medication are *culturally acquired* by the majority of staff, via public knowledge and, via other staff, by their on the job training. It is felt that the views are based on experience, that medication makes community care more workable by controlling pathological symptoms. However, the way in which medication is administered makes it very difficult for them to judge its effects.

Medication is administered by staff, and through the period of my study the closeness of checking and control was increased. Because the staff are not on duty 24 hours a day, they are unable to keep rigidly to such a policy. It also conflicts, in their day to day practice, with their aim of being flexible and not over controlling. If a person is settled and well, the possibility that s/he is not taking the medication is not normally considered by staff. If a person is thought to be "unwell" the possibility that s/he is missing medication is immediately considered, and staff will monitor it particularly closely. eg. In the case of one woman, who was thought to be "deteriorating" a long-standing staff member stated the belief that she was not taking her medication. A new worker had checked with the health centre and confirmed she had not missed any injections. Surprise was expressed. Alternatively, if staff notice that someone has missed medication, or suspects someone hasn't swallowed tablets, they will observe the person more closely for any signs of trouble. Even in cases where reduced medication is prescribed

and monitored by the doctor, staff are advised by their managers to keep
a close eye on the person for any adverse effects:

August 88 – Staff Meeting:
Checks on medication were discussed. The manager emphasised the
importance of checking on this, saying they "have a right not to take
it, but that's not part of our care". On odd occasions they find
people miss an injection or decide to stop going or pretend to take
tablets but don't swallow them. The manager commented that they had
people going [without drugs] for quite long periods without anyone
realising; she talked about people who "slipped away from us by not
taking them"

Medicines are kept by staff in a locked drawer, and are given out to
residents at set times, usually after meals, following the pattern of
the hospital ward. Evening medication is given out before staff leave.
On Tuesday evenings, because they are off duty the following morning,
workers will set out each person's tablets in separate boxes and give
them to a reliable resident, or to each individual. Lunchtime medication
for those attending day centres is dealt with in the same way. The
general duty of the residential worker is to control the use of
medication in this way, to ensure that it is taken as prescribed, and to
report any problems with it. Problems are normally conceived as problems
with the resident's compliance rather than with the medication itself,
or any side effects it may cause. Therefore, a resident's complaint that
the medicine makes him feel sick or dopey or disagrees with him in some
way, is either not taken seriously or is just considered as something
that unfortunately has to be put up with. Most groupworkers have little
or no previous knowledge of psychotropic medication and I found very
little awareness of common side effects, apart from a generalised idea
that it makes the person feel tired. Even this concept is confused, in
practice, with the view that the person's illness causes lethargy and
apathy. Not surprisingly, given the histories of their clients and the
general limits of understanding of how medication works, it is very
difficult for workers to distinguish in practice between the effects of
illness, the effects of institutional care and the effects of
medication.

July 87 – Visit to Adelaide Road:
At 6pm Frank came down with clear plastic cartons, labelled with

residents' names and containing drugs bottles. He went through Hilda's drugs for evening and bedtime with her. She knew what she had to take and when. She took most of them there and then with her tea and saved one for bedtime. She told Frank the night-time one 'got on top of her head'. He didn't understand what she meant by this.

Medication by depot injection is the most passive and controlled form of medication, and several residents complained to me about it because the injection itself is such an unpleasant experience. Getting used to it doesn't mean that patients don't mind it. They also reported feeling rather unwell and drowsy for a few hours afterwards, but this was not complained about as much as the injection itself. Like the occasional complaints about side effects, these problems were not taken seriously, because they tend to be put down to the patient's 'lack of insight' i.e. that it is good for him, but he is not capable of appreciating this. Although it is possible to have medication by tablets instead, the use of injections was not questioned by staff.

The group home licence specifies that co-operation with medical advice is a condition of residence. This is done even though each individual has legal rights not to consent to medical treatment. Residents are not generally aware of such legal rights, since no-one, except in some cases a social worker, has bothered to inform them. Effectively therefore, the taking of medication, if medically advised, is not optional. Furthermore, managers will make judgements about the appropriateness of a medical decision. eg. Kathleen, who was thought to be depressed and very lethargic, had her injections reduced in frequency by the community psychiatrist. The manager indicated clear disapproval to the groupworkers. In the case of a resident who was receiving three types of "anti-psychotic" medication, all in high doses, the workers reported she was having great trouble staying awake and that it still didn't stop the voices she heard. When the doctor reduced one drug there was no objection. "They'd have to knock her out completely to stop them". [i.e. the voices]

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Residents' rights not to take medication are also undermined by the lack of information on their medication and the treatment options open to them. As a result, residents who are not happy, may resort to illicitly cutting down or stopping their medication, without the advice or medical support they need in order to do so safely. Workers do not normally stand over each person to watch them take every tablet, so it is possible to slip the odd one into the bin. One or two residents did this over long periods and thereby reduced their dosage without anyone noticing the change, or noticing any ill effects. However, the majority take their medication as prescribed, and attribute side effects such as tardive dyskinesia (characterised by uncontrollable tremors) to their own illness.

Residents' views of medication are mixed. No-one who spoke to me about it questioned whether it should be used at all (as some did ECT) but expressed unhappiness about the unwanted effects, and perhaps hoped for a change in type or amount of medication to improve their situation.

June 87 - Visit to Adelaide Road:
Mary said she thought they should be able to give her something to make her feel better. She said that sometimes, when she takes the white tablet she feels alright. She had a doctor's appointment on Monday and was hoping to be given something to help her.

July 87 - Visit to Adelaide Rd.
Jane wondered why they didn't do things like have discussions in the group homes. She thought it would be good to all sit down together and talk about things. I asked what sort of subjects and she said interests in life outside. I suggested talks about medication might be useful and she said "Oh no, we hear too much about that", but when I said I meant learning about side effects and what its for etc, she thought that was different from just going on like "is it medication time yet.. have they brought the medication?" She wondered why so many patients in hospital are taking medication without even knowing what its for.

Referring to Hilda's medication, Jane thought it was a bit ridiculous having to take so many different drugs and that the names were too long and confusing. She didn't know a great deal about them and didn't have great faith in them, but accepted that some drugs may work for some people. She thought they were just guinea pigs really and was baffled by the different messages she got at different times from different doctors. She wished that patients were consulted more on what helped or didn't help, because they knew what effect it was having on them, but doctors seemed unwilling to see them as capable of

doing this. She also said that despite the reluctance to let people come off drugs, at the time when she went into hospital, they had been very anti-drug, and had taken her straight off the several drugs she was on, including valium. "This made me go barmy". I commented that if you come off addictive drugs suddenly it will have a strong effect on your body and mind.

Later, Jane told me that both she and Hilda had been off medication for years, apart from sleeping tablets, but were put back on it before leaving hospital. She reckoned that it was very powerful and made Hilda feel very drowsy and heavy headed; this was why she wasn't very happy about it. She said Hilda had been OK for years without it, so she couldn't understand it. She hoped that she would be able to cut down herself, especially on sleeping tablets, now the environmental stress had gone, but she knew she was probably dependent on them.

The case of Kathleen [see also chapter 5] shows how decision making over the use of medication affected one resident, whom staff believed to be depressed some months after moving to the group home. It also reveals how practices are fixed by an ethos which focuses on the presumed value of medication and gives it a central place in the management of everyday life.

July 87 - Visit to Adelaide Road
Kathleen was looking very sleepy and didn't really respond when I spoke to her. I have noticed this on several occasions before and put it down to her not being interested in talking to me at that time. Today, she was almost rooted to the spot and had a rather vacant look. She was ready to go to her mum's house, but didn't leave for several hours. She sat for long periods, then stood up and remained virtually motionless for some time. She said it was the tablets that made her feel like this. She told me that she hadn't been taking them for long and that they made her feel terribly sleepy, "almost as though I'm not there", but that they made her "feel better". I asked what she meant by this and she said they "calmed her"; sometimes she felt her heart was beating hard and she felt like shouting and needed to relieve her feelings. She thought that if she was "anxious and let it out by shouting", it would relieve her feelings. She said that sometimes when she was at her mum's she felt like shouting at her, but if she did, her mum got very upset. She's worried that if she shouts she will "get put back inside" She does think it fairly normal and helpful to let things out like this, but that her mum wouldn't tolerate it.

I asked her what the tablets were and what they were supposed to be for. She wasn't sure of the exact name, but thought they were supposed to be for "calming me down" and to "make me better". However, she didn't know why she'd started having them again after a long period without them. I asked "Do your injections have any effects?" She said yes; they made her feel dopey for a while. She didn't like the injection itself: in hospital, the sister did it very well, talked her

through it to keep her mind off it, and was very gentle; at the health centre the woman really jabbed her and got it wrong the first time and had to do it again. It was very painful and made her jump.

Later on I went into the office to check her medication in the materia medica. [Such reference books are bought by staff, not supplied for them.] The tablets are an anti side-effect drug, which has a number of side effects itself. It appears that she had these introduced shortly before coming to the house, but no exact dates are available.

4th August 87 - Visit to Adelaide Road
I asked Kathleen how she was and if she was getting on any better with her tablets. She didn't seem as dozy as last week, but she was very slow to answer my questions and not very talkative.

12th August 87 - Visit to Adelaide Road by the Community Psychiatrist.
Dr P had an appointment to see Kathleen the following week, because (the staff explained) of her problems with the medication and not feeling very well. He asked what she was having. She couldn't say the name, so Clare [worker] said "they're anti side-effect tablets" and so thought it must be the injection affecting her. Kathleen told him that she didn't know why she'd started the tablets again, after 5 years without any. Dr P said, "when you come to see me next week Kathleen, we can talk about this", and he asked the staff to check on the medication background. Several times Clare asked Kathleen something, but it was clear that she wasn't listening fully; she was a bit dozy again.

18th August 87 - Staff Meeting
Clare reported that Dr P had seen Kathleen and taken her off modecate injections. The manager made a sharp "ooh" noise and said she couldn't understand why they like playing around with these things, especially when someone is doing reasonably well. She said "well they're trained for years.. supposed to know about these things" (in a disapproving tone) and said they'd better keep a close eye on her.

12th september 87 - staff meeting
Kathleen was reported to be still lethargic, but livelier than before.

17th September 87 - Visit to Adelaide Rd:

Extract from Medication Chart:
Kathleen - modecate injection once every three weeks [reduced from two-weekly rather than stopped altogether]. Procyclidine tablets stopped, date not specified.

Catherine [worker] wanted Jean and Kathleen to get up, so they could go for their injections and went upstairs to wake them. Kathleen looked much less drowsy than a few weeks ago and in fact was quite bright. She made herself up, after rubbing a little moisturiser on her face, and it looked more subtle than usual, then she brushed her hair through. Catherine gave them both their clinic cards and they went out. I asked Jean about going to the clinic, was she getting used to it? She said it was OK now, and they didn't have to wait that long,

about 20 minutes. I asked if many people had injections. She said there was always a large number of people and several nurses to do it.

30th September 87 - visit to Adelaide Rd

Kathleen came down looking very different to me from her appearance in August. She said she'd been up earlier, but went back up for a nap. She was moving normally, heard everything that was said, her eyes looked different and she seemed more energetic. I asked her how she'd been feeling lately. She said "Ooh, much better! It was terrible before. I felt like I was in a trance; horrible feeling, it worried me". When Mary came in, she offered to make us tea, despite moaning about Jean messing the kitchen up. Kathleen was especially appreciative of this, thanked Mary and said it was a nice thing of her to do.

Later on I talked to the workers. They felt the change had been helpful for Kathleen. They explained that they feel very isolated from the wider mental health service, and also feel very vulnerable to criticism because of the way they work (which is in most houses mainly alone) eg. They told me that they knew that one resident was only taking one of her two tablets at night [i.e. three quarters of her daily dose] but didn't want to make an issue of it, because they felt she was OK. If there were any problems, they would go to the community psychiatrist. One worker was unsure whether to write it down to cover herself from criticism. She knew and supported the fact that the medication isn't compulsory but also knew how strongly the management felt about ensuring it is taken. The other worker agreed that there was no way they should be trying to enforce medication, and anyway it wasn't their job to make decisions like this - it was the doctor's; but they were in a slightly awkward situation since it is their job to supervise its administration. They pictured the manager "pulling faces" at the idea that people should have less medication.

A number of workers were in fact rather surprised at their supervisory role regarding medication and were resistant to the idea of enforcing its use. However, the structure of the organisation and of the group homes ensured that this role was maintained. Workers explained to me that they were in a position of having to balance risk taking in their work. They were encouraged to avoid risks being taken by residents, (eg confiscating cigarettes to prevent fire risk from people who smoke in bed) but also to avoid taking risks as carers, by reducing supervision. This approach contrasts strongly with the now-common approach to care for mentally handicapped people, and the principles of 'normalisation' which emphasise the positive, educative aspects of risk taking.

Why the strength of feeling about the importance of medication? It responds in some cases to the view that mental illnesses, particularly psychoses, are biologically based. However, the community-based workers also hold the view that social and emotional factors can play a strong role in mental illnesses. Therefore, I would argue that service providers rely heavily on medication as a way of coping with their feelings of responsibility for the residents' welfare, and also as a way of coping with their own fear of crises, of disturbed behaviour or of failure in rehabilitation. Within this conflict furthermore, there is a hidden conflict over the level of self-responsibility allowed to those in receipt of care.

The role of medication brings out the question of how care and control are balanced in psychiatric care, both in the hospital and the group home. Despite the changes in environment and routines the medication routine remains unchanged. Policy on medication is, however, an important area of difference between different voluntary organisations, so that this point does not apply to all group homes. Thus, voluntary care policies could be divided into those which believe that maintenance of medication is necessary for community care, by ensuring symptom control, and those which see it as a medical matter between doctor and patient, and which, without proof of its long term value, are willing to support residents who wish to try and withdraw from it. Significantly, in cases where there is concern about the running of a group home, medication is stressed more than it may have been in hospital. Even where medical advice is given for medication to be reduced for specific individuals, the general policy remains that problems will arise from lack of medication, and not from over-dosage.

The thinking behind this is that medication is maintaining people out of hospital and therefore should be left alone. Problems, again, are seen to be internal to the person and not arising in his overall situation. At the same time, the resident who is allowed to believe that problems caused by drug side effects are symptoms of his own pathology, is internalising the pathology of medication itself, with consequently negative implications for his self image. Thus, while medication may

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have beneficial effects in controlling distressing symptoms for some people (which will of course be beneficial for the staff and group as well as the individual) it may also interfere with the main efforts of staff and residents to change their lifestyle.

The psychiatric day centre and its role in group home life

Similar issues of supervision and responsibility arose around the policy on day care. The general policy of attending a day centre five days a week, was established for residents of unstaffed group homes, before the hospital closure was planned. CRT run their own day centre in each of the boroughs where their group homes were established.[7] These centres are for specifically for psychiatric patients and are similar to the industrial and occupational therapy units of the hospitals. The philosophy behind them is that work is a rehabilitative activity, which even for those who are unlikely to move back into employment, provides occupation and "dignity". Activity within the centres ranges from educational and social activity such as quizzes or classes, to work activity such as packaging and other routine manual tasks. The contract work is not profitable and is paid at a very low rate, varying to some extent according to the effort which managers feel the different members put in. The residents of Adelaide Road received approximately 15p an hour.

The 'workshop' run by CRT was the only centre readily available to the majority of residents in Adelaide Road and Carrier Lane. The residents who attended it spent the day doing routine packing and similar work. Occasionally, when work was slack there would be bingo games, but otherwise little else took place in the centre. Its orientation was towards sheltered work, rather than to education, leisure or social activity. Problems arose in the use of this centre by Adelaide Road residents right from the start.

Four out of the seven women who moved in initially, were over retirement age, and all were over 50. Hilda and Margeret opted to continue

attending the hospital workshop, which was a little further, but no more difficult a journey. Jane refused to attend the centre at all, after her initial visit. All the residents of 'number 90' attended initially for two shortened days per week, with an aim of graduating to three full days, although Mary attended only reluctantly. None of the residents expressed any liking for the place, but except for Mary and Jane, they all continued to go during the first six months.

Among the Carrier Lane residents, two men were over retirement age, but seemed quite content to attend four days a week. Maurice went for one day per week, since he already had a place at a rehabilitation centre, which he had attended from hospital prior to leaving. Brian was not very keen on the workshop either, saying he would prefer gardening work, (which had been his job before going into hospital) but attended regularly. Dislike of the 'workshop' therefore was partly age and gender related - the men found the idea of industrial type work more acceptable on the whole and the residents of Adelaide Road felt that, even if they had done work like this in the past, it was now more normal for them to be retired. One woman pointed out that in younger days you would find the company and social life the main reward from such work, and the income of course, but this workshop offered little of either.

The staff talk less about the positive side of choosing to stay at home, seeing it as more likely to be a problem or to cause problems. In one staff meeting, where they were discussing a resident who was reluctant to attend, Kate commented on this aspect - liking to be at home could be essentially a positive sign, especially if contrasted with wanting to return to hospital. However, the reluctance of certain residents to attend day centres was always interpreted negatively in practice. It was felt that, by staying at home all day, residents would get bored and consequently may lapse into psychiatric symptoms. The option was viewed as one between attending a [psychiatric] day centre or staying at home and getting bored, with little consideration of alternative activities.

The Islington group home residents were offered an initial choice of returning to hospital workshops or attending a local social-services day

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centre, which was focused on educational, artistic and social and leisure activities. This choice was broadened within several months, so that residents who liked working could attend a social services occupational centre for elderly people. [i.e. not a day centre intended specially for psychiatric patients] Additionally there was a social club run by another voluntary organisation, which all the residents were allowed to attend on a drop-in basis, without needing professional referral. For the Islington residents, therefore, it was possible to choose between several places to go in the day time, and fewer problems arose in the handling of day time activities.

The Adelaide Road staff recognised the unsuitability of the 'workshop' for the residents, and attempted to back-up those who were reluctant to attend in pointing this out to the management. However, with few local centres, and no social work support, they found it difficult to get alternative placements. Part-time places for Dot and Mary, at an elderly persons' centre, were only gained after many months of enquiries and applications. What is significant here is that what some residents would have liked - an ordinary local pensioners club, with bingo afternoons and so on - would probably have been more accessible, if the staff had fully explored the possibilities. The reasons for this failure remain unclear, but can be related to apprehension about opening up contacts beyond the psychiatric sphere and the lack of encouragement they received from their supervisors to do so. The day-care issue caused discontent and disappointment among the Adelaide Road residents. Additionally, it caused problems to arise in the group home, which were perceived as problems within the person rather than as problems within the system.

Understanding group home life: staff views and residents' views

The perception of problems by staff and group home residents, as suggested above, is different. The case study below shows how problems around day care were perceived and reported by staff, and how such

problems were interpreted and acted upon, in a way which maintained the situation rather than changed it. Although this case is apparently about one person's day care, my argument is that it represents the wider issues of choice and the status of residents in the group homes:

21.4.87 - visit to Adelaide Road:
I asked the residents (after their first visit) what the centre was like and what they thought of it. Dorothy was fairly non-committal and said she wouldn't know how to describe it, but was able to recall what they did, in her own mind. Mary didn't like it at all. She told me she prefers domestic work; in hospital she used to change 30 beds a day and help clean the ward. She had not participated in the hospital 'OT' but knew it was there. Jean said the day centre work was packaging, describing it in some detail, saying it was pretty similar to the work in hospital.

22.4.87 - Staff Office
Kate said that day time activity had not been clearly decided upon and said she was aware that Mary was not keen on the day centre, preferring "menial work". [I would categorise packing just as, if not more menial, than housework, because it is done very much by rote and fails to give any opportunity for involvement or personal touches which may make a job seem more worthwhile. Assembly work, in this sense epitomises the concept of labour as being alienating. The notion of housework being menial also appears to devalue its role in establishing a home after hospital]

7th May 87 - visit to Adelaide Road:
The staff discussed places for daytime activity. Their own centre can only take four more people, with the extra support worker provided to accompany them. [Presently the live-in volunteer] Also it isn't judged, by the group home workers, to be entirely suitable. The CPN told them the nearest drop in centre was too short staffed to take more people, but thought my idea of a volunteer accompanying them might be taken up. Other centres or clubs were full or too difficult a journey. Kate said an ordinary pensioners' club may be more in tune with Mary's needs; she is quite active in the house, but needs some where to go to be sociable and as a change from the house.

12th May 87 - Staff Meeting
The worker reported that all the residents went to the centre, except Mary, who twice refused to go. All were said to be unenthusiastic but likely to get on OK on a part-time basis. Mary is seen as "the main problem" at the moment. The groupworkers thought a drop-in type place would be better, but they still tried to get her to go, then saw it as a negative fact when she refused. They felt it was partly a desire not to take on something she was unsure of managing, not wanting to fail at something. As she'd expressed a preference for domestic work, Carol suggested finding her a little cleaning job in a protected environment. e.g. to clean at no 98, to get her away from taking over other residents' turns in the house, and then to graduate to cleaning the unstaffed group home adjacent to the day centre; she could travel

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with the others and get paid at a comparable rate. They felt she could see it as a valued role and gain confidence, and that it would do the men there good to have a lady in to clean.

Friday 15th May - Visit to the day centre
I arrived to find the residents and volunteer, Sian, getting ready to go to the centre. Mary was not very clear about where she was going, "somewhere road, I don't know". She hadn't been told about the cleaning plan, but had been persuaded by Clare to try going along to the workshop again. This was their first journey to the centre by bus and was rather long and slow. Both Dot and Mary did not know the area and therefore found it all rather strange.

On our arrival a staff member asked who we were and told Sian that she must stay with the ladies all the time. The women were not greeted or welcomed in any way, but simply told to sign in and hang their coats up.

Mary recognised the place, but still seemed a little perplexed by what was going on. Jean and Kathleen immediately went and sat down at the table where they had previously been packing tennis balls, (three to be put in a net bag and secured with a card tag) and continued the task. Dot also got stuck in, despite the difficulty which her shaking hands caused, but didn't seem to be enjoying it. Mary was very hesitant and found the work fiddly and odd. Although she got the hang of it quite quickly, she did not enjoy the work.

The centre concentrates on packing and assembly work. However, there is a section in which some members are trained for more skilled work. All activity is focused on the routine work and it was not accompanied by very much conversation. Most people sat silently in their position, hardly looking or moving around. One member introduced himself, sat to work with us and asked our names and where we came from. A few members were taking more responsible and active roles, keeping different work tables stocked with goods and boxing up completed work.

After lunch, the groupworkers arrived to talk to Mary about the cleaning idea. They put it to her that the house next door to the workshop really needed cleaning and it would be a great help if she could help there. Mary complained that she was old and should be retired, not working all the time; she'd been working for years in the hospital. Carol explained that it would be instead of the day centre; they thought she might prefer it. They also pointed out that she was doing a lot at home and should cut down her work at home if doing this. Mary seemed rather confused by the request: she'd been brought along to the day centre, then asked about cleaning and didn't know anything about this house. Carol introduced one of the residents to her, as someone she would know from Claybury. He recognised her but they were not acquainted. She commented "it's a big place Claybury, you can't know everybody". She didn't know what the relationship was between the centre and this house and found the whole idea a bit worrying. However, she went with Carol to see it. Payment was not discussed.

Both workers commented on how much they dislike the centre, after asking me my impression. They dislike the management style and the atmosphere it seemed to engender. Sian also felt the building, an old chapel with small high windows, was depressing and unsuitable.

Tuesday 19th May - Staff Meeting
The workers reported that Mary's visit to the house hadn't gone too well: she was unsure of the place and reluctant to do the work; she has now decided she'd rather stick with the others, despite not being keen on the centre work. Dorothy was felt to be managing, but only just. They thought her hands were shakier after the work and that she and Mary are really too old for that sort of thing. Clare put it tactfully, that she didn't really feel the place was right, except perhaps for Jean and Kathleen. She posed the question, "What are they going to get out of it?" She felt the residents had not been given much opportunity to integrate and that it wouldn't provide much of a social function. The manager commented that "people vote with their feet" and that it serves a function for some people. Clare agreed it probably has a function for some, such as people who are trying to get back into work, but that didn't make it right for everyone.

5th June 1987 - Day Centre Visit:
I arrived at the house, expecting that Mary wouldn't be going, but she had obviously decided to give it another try. Sian [volunteer] said, regarding going out generally, that she had progressed since the "difficult day" on Monday, when she wouldn't even go out to the shops. She felt the "get your coat on we're going now" approach advocated by Carol had worked.

23rd June 87 - Staff meeting
Sian reported that things at Adelaide Road are generally OK but there is still some concern over Mary and day care provision; Kathleen and Jean are going quite happily and settling in; Dorothy is finding it physically difficult to manage but does persevere with it; Mary has refused to go the last two times. Sian felt she was thinking up excuses for not going to the day centre, like sore feet or feeling physically unwell.

Friday 27th June - Day Centre Visit
I asked the residents what they'd been doing at the centre with no work available. Dot said "nothing really" The others said "bingo, nothing else". Mary said she didn't want to go today; she didn't like it and she was too tired and wanted a holiday.

Monday 6th July 87 - Visit to Adelaide Road.
The workers are trying to get part time places at an elderly persons' day centre, 'The Elms' for Dot and Mary. They had both been told they might visit a centre, but knew nothing about it.

30th June 87 - Staff Meeting
The residents at no. 98 were reported to be settling in well, with Hilda managing the buses and hospital workshop OK. They reported that Jane doesn't want people to know her psychiatric history when she goes along to places. The manager was doubtful about the idea of going to

non-psychiatric places, but did not explain why. A visit to 'The Elms' had been arranged and Clare said she was in contact with social services about the referrals.

24.7.87 - visit to Adelaide Road
The duty social worker came to do an assessment of Mary and Dot for The Elms. Mary denied all knowledge of it, "What day centre, I can't remember!" She said she didn't want to go anywhere, and that no-one did anything for her, "You get no care, nothing to make you feel better" She was quite annoyed at being "asked questions" and when he asked her name she said he should know, since there's so much written about her. He asked "diagnosis?" She said "What d'you mean?" There was an awkward silence before he asked "How do you feel in yourself?" She said she felt "shocking". However, as he asked about her background and interests she became less angry, so that by the time he got to asking her why she wanted the place, she had become more positive and said she supposed it was something for her to do.

Over the next few months, waiting for the placement, Mary continued to attend the workshop sometimes, with persuasion from the workers. At the same time, Jane began to experience similar problems because of her desire to follow her own interests, such as reading, painting and visiting her family, and her refusal to attend the workshop. Reports at staff meetings began to focus less on day care per-se however, and increasingly on perceived problems within the home. Both women were cited repeatedly as causing problems within their house. Mary's reaction to anxiety tended to be to get cross, and to busy herself with caring for the home. Jane was more articulate than many other residents, but her ability to explain her views did not improve the situation.

August 1987- visit to Adelaide Road:
Jane was still really annoyed about the "9 to 5 business" and the arguments over it. Sian had lost her temper with her one day, when they were expecting visitors, for not getting up early, saying that since she wasn't going to the day centre like the others, she should get up early and do the housework. Jane said that early on, in the hospital, Kate had told them about the day care policy and she had replied that it definitely wouldn't suit her. Later, Kate had told her it was OK, it would be flexible. Jane felt it *wasn't* that flexible if it was brought up as a sanction whenever there was a disagreement about something.

March 1988 - Visit to Adelaide Road
Jane was upset. She'd had an argument with the new worker, who had raised the subject of work. It was giving her the impression, she said, that they are obsessed with the idea that she must "do something" and that they fail to appreciate her claims that she is satisfied with what she is doing and has her own interests and ways of

approaching things. It seemed to me that their persistent efforts to get her 'out and about' are undermining the confidence she's built up in leaving hospital and doing her own thing. She said she was feeling more and more confused by it all and wondering if she was remembering things right. Yet, she was pretty sure that her perception was true.

In staff meetings discussion focused particularly on those individuals who were thought to present problems. As outlined in chapter five and in this chapter, for Adelaide Road these concentrated on Kathleen, Mary, and Jane. It is notable that for Mary and Jane in particular, who tended to question things more, rather than putting up with things that bothered them, their problems were emphasised and their abilities and contributions to the home played down. Problems which were matters of sharing in a group, or of disagreeing with what was offered to them, were interpreted as symptoms of psychological illness. That is, their problems in getting on with the group home routines were seen as pathological and deriving from a assumed general characteristics of psychiatric patients. This view of problems is very significant for philosophies of care, because the idea that mental illness is purely internal to the sufferer, encourages suppression rather than exploration of problems and leads to assumptions that rehabilitation is not really going to lead to change. In the residents' view, these problems were quite normal and understandable ones, and they were also able to describe to me much that was good and positive about their lives.

It could even be argued that they were problems because that is how they had been defined by those with greater power in the system. Preferring personal interests to packaging work, or preferring retirement to the limited satisfactions of a mundane job, can be seen as a good thing, or as a problem, depending on the viewpoint of the person who is defining the situation. Thus, the ability of carers to redefine the behaviour of residents can become a way of regulating their behaviour, but also in effect a way of confusing their sense of identity. The residents, on moving into the group home are first encouraged to make choices, to pay attention to their personal and social identity, to develop their interests, yet when they exercise these choices in a way which is not sanctioned by the carers, they are given the message that they are

incapable of making such decisions, and have to be told what is good for them, regardless of their intuitions and opinions.

Carers have reasons for thinking that such a day care policy is good for residents, but the reasoning also serves to justify a persistently rigid application of policy. The idea that getting out of the home and doing things is advantageous has several bases: One of the key features of 'total institutions' is the way everything is done in one setting. It is more usual and more socially valued to have an occupation outside the home. Even in the case of married women, where it is normative to remain and work in the home, it is now widely recognised that isolation and depression are common problems of such a role. [Oakley 1974 ch 3/4] Secondly, there is the concern that without other interests residents will suffer boredom and loss of motivation, which may result in depression. They also express the view that having too much time alone and inactive may encourage relapse of symptoms such as hearing voices.

The policy was developed before the current hospital closure programme, when former patients in group homes tended to be younger and often still hoped to get back into some sort of working life, with all the benefits - social, financial and psychological - which this can provide. The residents of these group homes are in a different situation however. The majority are past retirement age, yet their normative right to retirement is not recognised. They themselves acknowledge the benefits of occupation and getting out, but do not find a workshop setting congenial. Therefore they are discouraged rather than encouraged from becoming more active outside the home.

It appears that problem definition and problem solving by staff focuses general and quite understandable anxieties about the running of the group home, on certain individuals. It is notable that two of the individuals concerned were more independent than the other residents in their views and were more critical of policy or of other people. Attempts were made to sanction the behaviour of all three, by threats that they could be removed from the home. Kathleen was told that if she didn't get up, and stop smoking in the bedroom, she might have to go

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back to hospital. Jane was told that she should move on to more
independent accommodation [see chapter 5] and moves were made to get
Mary transferred to another home on the grounds of staff worries that
she might be developing dementia.

We can see that the views of the residential workers shifted to some
extent over time and between the residents' and managers' viewpoints. If
we think of the range of views as a continuum between the residential
and managerial poles, the workers tended to oscillate between the two.
This reflects their working base and roles as both close to the
residents' everyday lives and as distanced through their supervisory
responsibilities. Over time however, they tended to shift towards a
managerial position. Conflict between management and workers views was
rarely directly expressed and tended to be deflected, through
negotiation or through withdrawal - with some workers leaving rather
than shifting. Parallels can therefore be drawn between the negotiation
of experience between managers and workers, and that between residents
and workers/managers, where conflicting interests or views are
individualised, and the overall ethos remains relatively stable.

The disputes between individuals who were seen as problems, and the
caring organisation brings out the issue of dependency as one which
underlies the running of group homes. They are designed to enable
rehabilitation, to develop a new lifestyle, yet they are taking over a
regime of care which was established in the psychiatric institution. The
issue of choice is an important one in rehabilitation. The value placed
on making choices is reflected in the domestic routines of the home, the
improved material environment, and the approach of the groupworkers to
'their residents'. However, choices which went beyond the everyday level
of homemaking, were often experienced by the organisation as
problematical.

The choice to leave hospital, however limited its scope, was a major
life decision for the residents, and one which they approached
positively. Similarly, those who had some contact with relatives or
other non-patients, had to re-negotiate their relationships with the

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ordinary social world. The decisions to write to or phone a long lost relative by several residents were very courageous ones. Dorothy, for example, did not only begin to choose what to have for dinner, but to choose what she wanted to do with her time. The choice *not* to take a particular action presented to you, can be viewed positively, as a matter of maintaining one's personal identity. Despite the evident concern and good intentions of the staff, their actions often seemed to stifle the making of important choices and lead to confusion for a person who already lacked confidence in making decisions.

Concluding points

In the group home setting, the qualities valued in residential groupworkers and their roles, ensure that relations between staff and residents are relatively close. This is not simply a matter of being in greater proximity to their clients, and in fact staff spent quite a small proportion of their time in direct interaction with residents, after the initial settling in periods. The main contrast is in the nature of the interaction, where carers aim to work with their clients and talk to them in the course of this everyday activity. As a result, the groupworkers identified more strongly with 'their residents' and felt that their relationships were more supportive and emotionally closer than those between hospital staff and patients. However, as in the hospital setting, those who worked most closely with the 'patients' also had the least influence in planning and decision making.

By working closely with residents, in a setting modelled on the ideals of ordinary family life, they were able to achieve a great deal in rehabilitation terms - residents in all the group homes were able to do more for themselves and for each other, and to make small but important choices in everyday life, which they could not manage in hospital. The view of the caring organisation was that despite problems with some people, the residents had generally made a great deal of progress. The idea of integration, which is so important conceptually for the policy of community care, is, however, given little attention. Thus the

apparent limits of rehabilitation are marked out by carers – rehabilitation is inward looking, focused on the group home, or within the caring organisations facilities, with few expectations on integration with any wider society.

To understand what this conclusion means, we have to look at what the carers' ideas of progress are. My argument is that on one level their idea of rehabilitation, like that of health workers, is an instrumental one. However it is also about the person as a properly functioning member of society. I will examine the precise meanings of this in the next chapter, by looking at the models of group home life and how they relate to the cultural ideals of the caring organisation.

To form a framework of how to reconstitute a properly functioning member of society, one must also have some picture of 'the community' to which people are to be re-introduced. The use of social and cultural norms as guiding principles of group home lifestyle bring out the ambiguities for staff inherent in the community ideal. They seek to encourage normative behaviour, through an 'ordinary' environment, through routines and through relationships within the home. However, because the carers' views on integration are relatively pessimistic – both because they feel the resident has a permanent pathological condition and because they believe society is too intolerant and inflexible to accommodate such a condition – their idea of the community is an almost exclusively psychiatric one, exemplified by the group home and the day centre. Progress therefore, is a matter of 'getting on' and leading a reasonably contented life in the group home, with outside interest and occupation provided by the day centre, and perhaps with visits to and from kin.[9]

Arguably the group home is ordinary housing because of the way it is modelled and because it is set up in contrast to the psychiatric hospital. The general living conditions experienced by residents are different in ways that matter greatly to them – the chance to have privacy, to do what you enjoy, to cook a nice meal, to have a laugh together. Residents also realise the importance of *stigma* to the quality of their lives. The next chapter will explore more fully what changes

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residents experienced in their social contacts and status. However, this more descriptive analysis of group home life has shown that in many ways, the caring organisation backs away from their desire to move out of an isolated psychiatric sphere and into 'the community'. The continued association of *care* with *control* was a theme underlying all the problems experienced by staff in trying to manage the group home life. Care was associated with control over the activities of the residents: their daily routines, their medication, their movements outside the home and even their interpersonal relationships were to be supervised.

We should not forget that with occasional exceptions, all the residents preferred group home life, and had been unhappy in the hospital, to varying extents and for various reasons. They did not, however, come to see it as "really home". A look at the ideas of carers about the group home and about the nature of mental illness, will help us to see how the residents expectations and disappointments arose.

NOTES TO CHAPTER SEVEN:

1. The voluntary organisation's literature uses this phrase.

2. The normal period of notice was increased to four weeks for later projects.

3. This pattern altered after the first year when the two remaining residents, who were more dependent on domestic support from the staff, moved in.

4. Which was run by social services as part of the 'core unit' for the closure programme in this area.

5. Although, as I will later discuss, links outside the psychiatric sphere were not encouraged in practice, but treated with great reservation.

6. They tended to be unmarried, or if married, without small children. This appears to relate to the awkwardness of the shift system, as several workers had older children.

7. They will also run a new day centre being built as part of the closure programme, which is described as a 'high dependency social centre'.

8. These points will be explored further in the next chapter.

CHAPTER EIGHT
MODELS OF GROUP HOME LIFE

'Kathleen wanted to know how long they would stay. I said it might become their permanent home, or they might wish to move on. She didn't think it was like a "real home" and said she'd like to go and live "at home" (i.e. with her parents) when she was well enough.

As we have seen, the group home is based on an idea of 'ordinary housing' which arose in response to the problems caused by living in hospital. The group homes are, ideally, like ordinary family homes, but in practice are unlike this model in many ways. The model necessarily rests on commonly held assumptions about 'ordinary family life', what this consists of and how it is conducted, which may in ideal terms may be more rigid tham practical realities of home life and kinship for many people. This chapter examines the carers' models of group home life and how they relate to the ideals and practices of 'community care' in the context of hospital closure.

The anthropologist Geertz [1973 p93/4] describes models as "maps for" rather than a "map of" things. Models are used by social analysts as a means of building up a theoretical picture of what is happening in a situation. Social and health care practitioners also make use of models in the form of policies or philosophies of care. In this chapter, I will describe how two kinship models are discernable to the observer, which are used as guiding philosophies by the carers:

1)   The notion of the group home and the voluntary organisation as a substitute family.

2)   The notion of staff/client relations as analogous to parent/child relations.

There are two main levels of operation of such models in practice: firstly as a conscious and deliberate policy or guiding philosophy; secondly as a sub-conscious or implicit model. In the second level, a

notion may be alluded to, even discussed in various ways, but never fully acknowledged.

The first model forms part of the guiding philosophy of the organisation, which can be drawn from what its management say and write about it as well as what it does. The observers model, a model 'of' rather than 'for' the system, is drawn from these sources, but also from group home life as it percieved by residents and from analysis of group home life in relation to social and cultural theory. The chapter also attempts to construct a model of the second level of operation, that of ideals which are implicit in the guiding philosophy and observable in the running of the homes, but which are not fully recognised by those who work within them.

The role of choice in group home life

The making of choices is vital to rehabilitation, just as it is to our concepts of personal identity. This study has shown how choice is used as a key aspect of rehabilitation, yet is also experienced as a problem by carers. The tensions which arose for them in trying to both care for people, and to encourage them towards independence by making their own decisions, had a profound influence on the experience for residents. In rehabilitation, 'making progress' or 'doing well' was perceived as occurring when individuals learnt or relearnt how to make everyday choices, and became more active rather than passive in their lifestyle. At the same time, this was framed within a structure provided by the caring regime. The structure was valuable in enabling individuals who had lived in an institutional environment to change their approach to life, but those working within it had difficulty in coping with the major life choices which some individuals wished or needed to make. Workers encouraged residents to cook, to take an interest in themselves and their surroundings and so on. They also valued talking to residents, individually or in groups. However, these activities tended to focus on the smaller areas of choice, rather than on seeing them as a means towards making choices as an exercise of responsibility.

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The tension between care and control is a major one for large institutions such as the psychiatric hospitals. The psychological notion of the 'double bind'[1] is discernable in the institutional situation, where the individual is asked to make choices but not allowed to carry them through, since the validity of the choices s/he then makes are not recognised. In the hospital, patients were asked their opinions about some things, only to find that these opinions were ignored. Alternatively, when certain residents, as hospital patients, were asked to say what *they* thought, they found themselves characterised as unco-operative, difficult or lacking in insight, if what they thought was not what the carers wanted to hear.[2]

Groupworkers and health care staff have to deal with such tensions in their day to day practice. Futhermore, it is difficult to share responsibility unless it is shared at all levels. Consultation with patients on major issues is unlikely, unless it is fully extended to the staff who care for them. In large institutions there is an almost inevitable tendency to regard people as 'bedspaces' rather than as individuals. Even with great effort it is difficult to fit services round the patients, rather than fitting the patient to the institution.

On independence as an ideal

The idea of independence is contained within the principles of rehabilitation used by different groups and in different settings. Independence is a relative concept, and like the opposed notion of dependency, encapsulates a number of cultural connotations of personal value or normality. The idea of total independence implies a lack of need for the mutuality which is found in most social relationships.[3] It fits with the ideal of the 'rugged individual', who fulfills his own needs without recourse to others, which is very much a part of our culture. An ideal of this sort negates and devalues the role of *care* in our culture.

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The concept of independence which is normally used by mental health professionals, particularly those following the *normalisation* approach, is relative to the status of the resident in an institution. [Wolfensberger 1972] Here, an ideal of greater independence is set against a background of lack of choices, leading to passivity, to loss of ordinary living skills and hence to loss of a normative degree of personal autonomy.

When carers talk about their attempt to balance pushing or encouragement with the choice to do nothing, or to balance structure or supervision with independence we should bear in mind the nature of the concept with which they are working. The concept of independence is, of course, directly related to that of dependency which has been shown to be central to the way professionals think about and categorise their clients. Both are drawn from ideas about institutions but also from ideas about madness itself. The idea of the person with mental illness is of one who is not fully social or cultural, and one who, therefore, does not possess full personhood.

In the following sections, I will look at these concepts in more detail and how they relate to our ideas of childhood, adulthood, disability and kinship. We will see that the voluntary organisation's use of family models for care are linked to more traditional ideas found in institutions as well as to traditional ideas about family patterns and relationships; they take on certain relationships and ideas about the nature of the mentally ill or dependent person which encourages the elaboration of these ideas without much questioning.

The notion of the group home as a substitute family

The view of the group home as a substitute family is an important part of the voluntary organisation's philosophy. It derives to some extent from the fact that many long stay patients have lost their kin and other social networks outside the hospital. One aim therefore, is to provide an alternative, quasi-familial, network as a means of rehabilitation.

Since the ideals of 'community care' are vague and loosely developed in social policy, it is not surprising that carers should seek a model of community which is readily available and associated with *normal* social values.

In his book 'The Family' Goode [1964] points out that a view of society as a structure made up of family groups, has been around since Plato. He stresses that the family has important socialisation and social control functions, so that for most people their place in society is constituted by their family group. This could be argued to be less important where occupation is a significant marker of a person's social role. While living in hospital, the psychiatric patient was removed from previous social roles, and in most cases removed from any active kin role. Therefore, the formation of family type groups could be seen as a normative means of trying to reintegrate the *patient* into the *community*. The design and running of the group homes, however, confuses the boundaries of the private and public spheres in the family model. Furthermore, the residents are aware, and are continually reminded that their social role is still primarily that of patient. An important question, therefore, is whether the family model of care changes the social role of the patient, to one which is more positively valued.

The family in modern society is not a uniform institution. Recent social surveys show that the single household is becoming increasingly common in modern Britain, particularly among elderly people. [Willmot 1986 ch2; Anderson 1980 p18] The nuclear family remains the model for family life in Britain, but single parent or 'serial' families are becoming more common and are less likely to be regarded as 'deviant', rather than a particular pattern of nuclear kinship. For most people, kinship provides the main source of care or mutual aid [Bulmer 1987 p72-80] but, as we have seen, the kin ties of the group home residents were severely disrupted by their stay in hospital and current ties were very tentative. Other socially accepted household forms exist, which may be based on notions of community, or simply mutual benefit, examples being the commune, [Abrams & McCulloch 1980] co-ownership, flat sharing and student houses. Similarly, older adults who do not have a marital family

home, often form family households with other relatives, particularly with siblings.

The key alternative model to that of the family, in residential care homes, is that of the therapeutic community. In therapeutic communities the concepts of sharing, of co-operation and close ties among residents are fundamental, but are not tied to specific relationship ties and obligations characteristic of kinship. The ideal is based on the concept of *community* rather than that of the nuclear family. [Bloor 1988; Grove 1989] Those institutions caring for children will often also use the parent/child relation as a model for staff/client relations within the 'community' but this is seen as appropriate because the clients are children, and expected to gradually change their relations with increasing age and education. [Bloor 1988 p43] They are generally democratic in their ideal type, while the family, although a locus of care and nurture, is grounded in differential relationships rather than democratic ones. Like group homes, however, they have to deal with the contradictions of trying to create a locus of care, which is supposed to be supportive and to alter behaviour, thereby giving staff the authority to define and redefine the actions and interactions of residents according to their therapeutic philosophy. [Bloor 1988 p189-198]

The family model of care is grounded in the idea of the nuclear family as the locus of care, in the nurture and socialisation of individuals. The parental relationship is utilised as a model of authority via the caring role. The idea of the substitute family, however, glossses over the significance of power relations within such groups, particularly between different generations and genders. It also glosses over the links of such power relationships to those of class differentiation. The significance of the idea of the resident both as a perpetual child and as member of a lower class, in relation to the carers, needs to be understood the context of this theme.

At the centre of this model is the group home. It forms a household, in the sense of being a domestic residential group, and is related to the general norms of household size. Within this household, there is a

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stress on shared activity and particularly on domesticity. The evening and Sunday meals are perceived as particularly important, as part of what makes it a *home* not just a *hostel* or *lodgings*. It is also perceived as being a family type group and expectations of staff and clients are formed around this perception. A "family atmosphere" and "family spirit" are highly valued. The aim is that the household should "gell" and "work as a group," while ideas about group interaction which are not felt to be family-like are rejected:

Adelaide Road Management meeting
The CPN suggested informal house meetings for airing problems. Clare said they do try and have talks in the evening. The director said it didn't go with running as a family type home. They agreed that it could be done over the evening meal or at weekends.

The model is complicated in practice by the fact that the residents have been (and often remain) kin, outside the structure of the voluntary organisation. Those who have contact with relatives describe this, not the group home, as their family. Kathleen says she's "going home" when she visits her parents and refers to the group home as "the house". Nonetheless, the ideal is maintained and encouraged in staff supervision.

Staff encourage a wider quasi-kinship network to develop between the different group homes and generally throughout the organisation. Relations between group home residents are encouraged by staff arranging regular visits and organised gatherings. Having several group homes within a reasonable distance of each other allows the family notion to be *extended* so that, just as in the "ordinary family", there will be a norm of mutual visiting and celebration of seasonal festivals. Some friendships are formed between individuals in the group homes, and the visits are valued by most residents, but they are largely dependent on the initiative of the staff:

March 88 - staff meeting
The manager is very happy with the weekend visit experiment at one group home and wants to encourage this to be done more. She said, "if its a replacement family, it's normal for people to go and visit other relatives." She feels they've now got quite a network between the houses and that the people in different houses are friends of a sort.

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She asked workers if they could think of anyone who might like to do this. Louise couldn't and didn't think people were that close. She said "a visit for a cup of tea seems to be enough for most people".

Beyond the group homes, the day centres and evening clubs are viewed as possible familial/social networks for ex-patients who live alone or in unsupported accommodation. In this way an overview of a sort of alternative (yet exclusively psychiatric) community is discernable, which is not totally unlike that applied to the design of the asylums in the nineteenth century. Such ideas are grounded in a lack of confidence in the tolerance or coherence of the community in urban neighbourhoods, but also serve to reproduce a belief that the only possible community for people with mental illness is a segregated one.

As noted above, the general notion of the substitute family type group is a conscious one, viewed positively by the staff and management. Within this model, or alongside it, there is the notion of staff/client relations which is partly a conscious one, but is generally far less explicit.

The parent/child model of staff/client relations

In most group homes, despite the family model, the group is very uncharacteristic of the 'typical' nuclear family. Although a wide age range among residents is approved of, in practice most of the residents' ages range from about 50 to 70. The residents are generally of a similar generation, and in fact the main generational difference lies between staff and residents. The residential staff are mostly aged between 20 and 40, and more often female.

However, the relationship is modelled in such a way that the staff should see themselves as quasi-parental figures, and the residents as their dependents. There are several aspects here: the conscious models by which staff characterise their relationship with residents; the ways in which they think about and behave towards them; and the views which

the residents have of the staff. The notion is not necessarily a shared one, or one which is internally consistent.

The staff are in a position of some responsibility towards the residents. There is no legal responsibility however, beyond compliance with registered care regulations, and it is expected (although it often doesn't happen in practice; see chapter 6) that residents should have an allocated social worker to deal with any specific problems. Staff responsibilities, therefore, are governed by their terms of contract.

The degree of responsibility *experienced* by staff is much greater. It involves a sense of responsibility for the general welfare of the residents - to the point where staff may fret if a resident comes in much later than usual, or goes out without saying where. Similarly, a great deal of warmth is expressed about the positive achievements of residents, particularly those who are thought to be the most disabled.

The staff feelings of responsibility were thrown into relief by the disappearance of Bert, a Carrier Lane resident, after he was put off the bus for not having his pass:

> Although he was near home, he became confused by this unexpected incident, took a wrong turn and wandered further away from the house. In the four days in which he was missing, the groupworkers were thrown into a state of crisis, unable to sleep properly or to relax on or off duty. They could not understand the casual attitudes of the police, less still the management who did not categorise it as a major cause for concern. They became very disillusioned with their work by the realisation that in this incident the management did not seem to sympathise with their anxieties and feelings of responsibility for his welfare. They were frightened that something awful would happen to him, while telling themselves that he had probably fallen in with a group of dossers and would be OK. At the same time, they needed to reassure the other residents, who were concerned about their friend. When he was found several miles away, by police, during the night, both workers went out immediately to collect him, and later clashed with management over their reluctance to approve the over-time payments. To the workers, it was unthinkable that they should have left him in a police cell, in a tired and confused state, until morning. When Bert arrived home, he was bathed, and given extra rest and care until the staff were satisfied that he was feeling alright. The next time he went out on the bus, they were anxious, but spoke warmly of his courage in preferring to go alone again.

This case brings out both the contradictions in this model for the role of care staff and for the concept of rehabilitation alongside basic concerns with the maintenance of organisational structure and control. The groupworkers did not talk about the resident as though he were a child, but stressed rather that he had only been out of hospital for a short while, after a stay of over fifty years. Therefore, they felt he was unprepared to cope with the outside world without their protection. They were distressed by the thought that without money or friends to rely on, he would be suffering. They understood their role to be like a parent's in terms of responsibility for their residents, which was not easily bounded by their job contract. They had been encouraged to view themselves in this way, to the point where, before the prospective residents moved into the house, the management described Catherine (to her evident embarassment) as "an expectant group home worker". However, staff are also expected to maintain firm boundaries in their relationships with residents, which will allow detachment from any individual who is thought to create the risk of upsetting the balance of the home.

Although the groupworker's role is not usually described as literally quasi-parental in this way, the tendency to encourage such approaches is apparent in staff meetings, which are the chief means of advising and supervising staff. They are encouraged to think about their work, or to discuss problems, as though they were in a parental role, and even as though the resident was actually a child. The perception of what actually constitutes a problem is also tied in with this model, so that although there is an aim of growing towards greater independence through fostering of "potential", there is also a limit on how much, or what sort of independence, is positively viewed. It is also related to the views on the nature of *mental illness*, and of *normality* held and put forward by management in staff training and guidance. The notion of the mentally ill person as *childlike* is not only used as analogy, but relates to a view that mentally ill people have become stuck at, or have regressed to an earlier stage of development. These points will be explored further in the next section.

One way in which the approach is guided, as we have seen, is through the notion of the substitute family. There is an attempt to provide a more supportive social network - centred on the 'family' of the group home and extended via contacts with other group homes and psychiatric facilities - than is available in the psychiatric hospital. In this way, common ideas about kinship are used in forming policy. The idea of the staff/client relations as quasi-parental forms a component in this central philosophy since, in a sense, the residential worker is a household head, and thereby the head of the 'family'. To the outside observer, it appears that if the household head is the (typically female) groupworker, the head of the extended group is the management of the voluntary organisation. In this model, discipline is viewed as *normative* because it is understood as socialisation; the groupworker having a nurturing, quasi-maternal, role in socialisation, the management having a more distant and authoritative, quasi-patriarchal role. Similarly, the hierarchical structure of the family model of care is comparable to that found in the hierarchies of medical institutions, where overall authority is invested in the (male) role of doctor as expert, caring authority in the (female) role of the nurse and the recipient (infant) role is given to the patient.

However, this approach, to people who are in fact older and in some ways more experienced than their carers, can be reflected in a seeming refusal to recognise the actual age or maturity of a client. One resident became aware of this relationship when she came into conflict with the usual policy of attendance at a day centre. [see chapter 7] Her argument that, being over 60, she wanted to live like an ordinary retired person was not acknowledged. The time she spent in rebuilding her family relationships as a grandmother and the structures she was providing for herself were not regarded as proper activity, in the sense that structured psychiatric day care was. She told me that her status was not what she had originally thought and in fact was similar to that of being in hospital in some ways:

> "it's like it's come full circle; like when I was a child being told to get up and get off for school."

The social contacts of group home residents

So far, we have only explored the contacts pursued by the caring organisation for residents, and have seen how, despite the significance of kinship notions to this, the network aims to constitute an alternative to ordinary kinship. It is an exclusive network and therefore could be viewed as a 'community of interest' [Willmot 1986 p83-85] or alternatively as ghettoisation. Willmot defines 'community of interest' as based on ties of common characteristics, interests or problems. These may include groups for mutual support, sociability or aid. In this case, however, where residents and day centre members do not have open choices to associate in this or other networks, it may more accurately be seen as a continuing form of segregation. Although it is common for long stay psychiatric patients to lose outside contacts, [Clifford 1985] more than half of this group did have some contact, however tentative, with kin. The models of group home life should be considered in relation to this context.

Social contacts can be divided into kin and friends, and also (in this context) divided into those made within or outside the hospital. We have seen in previous chapters that the hospital environment discourages the formation of close and mutually supportive friendships between patients. Nonetheless, among the group homes residents there were two pairs of friends who had been able to leave hospital together. Several other residents mentioned friends who were unable to move with them, because they had been thought to be unsuitable in some way. One friend had chosen not to move because she wanted to return to her own flat. Two friends from hospital were occasional visitors to the houses, and one resident went out regularly to visit friends who were also former patients.

For the majority of residents however, the few friendships existing within the hospital were broken by leaving, and no-one expressed to me a desire to go back and visit. I was not aware of any residents who had been able to maintain friendships outside of the psychiatric sphere, which for most people could be seen as an almost inevitable result of

their long years of hospital residence. [Goldie 1988 p49; McCowen and Wilder 1976 p29]]

In the group homes studied, only 8 (out of 20 residents) had no known family contacts at the point of leaving. For this group, leaving hospital appears to have made little impact on this situation. One resident, who felt that her relatives had stopped contact because of the stigma involved, began to exchange letters with a relative after leaving. However, the social contacts of these residents were not noticeably improved by leaving hospital and, despite the support of a group home, one woman said that she felt *more* isolated since leaving hospital. [Goldie 1988 p53] This she attributed to the smaller numbers of fellow residents and having moved to an area which she did not know, leaving her with no confidence to venture outside the home.

Six of the residents described their contacts as being occasional or tentative [n. b. my words] and this group found leaving hospital made a significant impact on their relationships with kin. One resident, for example began to make and receive regular visits from her children, and began to enjoy watching her grandchildren grow up. Another resident described how her family had abandoned her for years, only making contact again shortly before she left hospital. It appears therefore that for people who had some form of contact, even by rare visits or letters, living in a group home enabled them to rebuild kin relationships if they wished to.

The remaining six residents had fairly regular kin contacts, with visits from a sibling or parent. Kathleen, Jean, Howard and David had all continued to make regular visits outside the hospital. Those who had regular contact with relatives had all moved to a house within reasonable distance of their relatives' homes, so that these relationships could be continued after leaving. Kathleen now lived much closer to her parents and began to spend a great deal of time at their house, regularly staying overnight.

The suggestion from this limited group of people is that leaving hospital to live in a group home can be very helpful in rebuilding kin relationships. The home was a place which relatives could visit, without the stigma or guilt feelings attatched to visiting a relative in hospital. It was also a more readily sociable setting, where residents had the chance to offer tea or a meal, a living room to relax in, or a bedroom for privacy. It was important to the residents to be able to move to a house where such visiting could easily take place. The group home may also have enabled relatives to feel that they could enjoy closer contact, without the possible stresses of living together.

The attitude of workers towards contact with kin or friends was cautious. In some cases this was based on a view that tensions in the family were a problem before the resident went into hospital. For two residents, they felt that the family environment had been very damaging and tried to discourage them from prolonged visits. On the whole, the question of social contacts outside of the psychiatric sphere were regarded ambiguously. On the one hand, sociability was looked on as always a good thing, but the group homes were modelled on the view that residents needed to have a different sort of kinship constituted for them.

We have seen, therefore, that group home residents have two bases of kinship or community available to them. The home itself is seen as a family group, which is linked to a wider 'kin' network which exists within the psychiatric sphere. It is ideally a sort of *alternative community*, grounded in a newly constituted form of kinship. The majority also have their own families, either a family of origin (parents/siblings) or children and grandchildren of their own. Although six of the female residents and two of the male residents had been married, all were separated or divorced from their spouses. The position of the group home resident, seen metaphorically as a dependent child, clearly does not fit with the past or current lives of residents as family members outside of the group home, however delicate those contacts may be.

The attribution of childhood to people who are dependent on others for some form of care is not confined to the psychiatric sphere. There are common threads in these approaches which can be explored, but first we need to analyse the particular aspects of this approach to people who are categorised as mentally ill.

Ideas about the nature of mental illness

In order to understand why the carers can see themselves in such a quasi-parental role, we have looked at the way the group home operates in practice and the pressures towards continuing a supervisory relationship. We also need to see how the view of the worker as parental is grounded in attitudes towards the mentally ill person.

Much of modern psychiatry is described as 'eclectic', taking in a blend of biological, social and psychological ideas. [Clare 1980] The main model on which psychiatry operates is a medical one, in which physical interventions are seen the as the key form of treatment for psychoses. In this model social and psychological factors are taken into account as things which may influence the effectiveness of medical treatment or the ability of the individual to cope with the mental illness. Mental illness is seen as permanent, a condition which sometimes goes into remission but is more often controlled by medication or ECT.

The voluntary organisation managers do not question the medical models of psychiatry, as reflected in their approach to uses of medication, even though they may question its institutional practice. They appear deeply suspicious of 'psycho-dynamic' ideas (regardless of their content) which they associate with psychotherapy and with psychologists or social workers. However, the ideas which are conveyed to and encouraged in group home staff are based on social and psychological ideas about the individual and her/his social role and emotional needs, while very little attention is in fact paid to the medical models of mental illness. The medical framework of psychiatric treatment is

accepted but not seen as part of their role, even though, as supervisors
of medication and so on, these roles do overlap.

Mental illness is generally referred to in staff meetings as *sickness*
"She's very sick, its a shame". "its sad" and "its a shame" are frequent
ways of concluding discussions.⁴ When someone is reported to be "unwell"
it is then necessary to clarify whether the staff mean s/he is
physically unwell or whether they are concerned for some other reason.
When residents are perceived to be presenting problems in the running of
the home, they are more likely to be characterised as *sick* and described
in the terms psychiatry uses to describe symptoms of mental illness.
This may even apply to the way the activities or interests of residents
are characterised:

27.10.87 - staff meeting
Jane had requested permission to use names in a article she's writing.
The supervisor wasn't sure she'd get round to it, saying she had
"rather *grandiose* ideas".

12.1.88 - staff meeting
Staff reported that Hilda was making "endless excuses not to go back
to the workshop" One reason, Clare said, is that she's enjoying
herself at home, and she thinks someone there doesn't like her. The
manager said "She's a very *deluded* lady."

At the same time, they may play down the tendency of some professionals
to explain a patient's behaviour in terms of psychological and emotional
problems, preferring to take what they see as a more *commonsensical*
explanation.

February 1988 - Thorn Street Project Meeting :
Afterwards, Carol was rather dimissive of the psychologist's view of
Maurice's problems. She said that a lot of behaviour was associated
with the hospital, his dislike of the way things were done and said.
However, she agreed that time was going to be a significant issue,
having seen him take 1½ hours to shave. She also thought George's
eating problems might be down to, or aggravated by the awfulness of
hospital food - he's told them its disgusting and seems very keen on
food in the house. She ignored the psychologist's view that his
problems were associated with periods of deep depression.

2.2.88 - staff meeting
Brian was reported to be very well and happy in the mornings, "but
often coming home after lunch, not so good.... twice has stomped out
of the day centre, refusing to talk to anyone". Louise feels he's

possibly missing his long lunch break as he used to sleep during it. The groupworkers were unsure whether he was unwell, anxious or if it was deliberate. They wonder if he feels resentful because of the amount he does for the others.

29.3.88 - staff meeting
Carrier Lane staff reported Brian as being "aggressive, sullen, saying he wants to go back to hospital". They said he was expressing his annoyance mainly through body language, such as pulling at chairs. They took him to see the doctor who increased his medication. They said he was calmer that evening but very aggressive again in the following days. Frank said he was *paranoid.*

In the last example staff attempted to describe and understand Brian's problems in terms of everyday commonsense knowledge and also in terms of psychiatric diagnosis, switching between the two levels of categorisation. Psychiatric terminology itself is often derived from everyday language, while having a profound influence on the way in which behaviour and emotions are commonly characterised.

The diagnostic categories of mental illness are used at times by staff, in thinking or talking about residents, but tend to be along the lines of more everyday usage, and often are not related to the official diagnosis the person has been given. e.g. Residents who are thought to be unhappy, experiencing grief or other emotional problems, are generally described as "depressed", in a way which is not directly related to any clinical category.

The ascription of common-sense or diagnostic categorisations to residents is in part an attempt by carers to find some general understanding of their clients problems. Common-sense concepts, like psychiatric ones, tend to individualise the nature of problems in the group homes and place them firmly within the residents. Hence an organisational or relational problem can be defined as a personal or psychiatric one. [5] Staff would not consciously view these attempts at definition as means of manipulating the status of residents according to the needs of a wider institutional order, but they can be seen to function in this way. While their role is primarily a *caring* one, the authority of carers to make such categorisations, can be reinforced by a

model of benign power, such as that of motherhood, which masks the role of power differences in an institutional relationship.

In the dominant view of the organisation, mental illness is seen to be a sort of faulty socialisation or maturation. The understanding of how this happens appears to be a mixture of ideas about family groups and their role in socialisation, but also tied in with a bio-genetic notion that this is a sickness which is a continuing condition of the person and part of her/his make up. The idea of faulty maturation, in practice, implies that carers are somehow to reconstitute the personality of the sufferers, to 'bring them up' through normative methods of care, education and discipline. The view may be more unsophisticated in its use, as simply interpreting the residents as "childlike" or "childish". Residents are frequently described in these terms, and specific references are repeatedly made to techniques of childrearing as models for how groupworkers should behave towards the residents:

1.12.87 - staff meeting
Staff reported continued eating problems with one resident of a neighbouring group home, who was at times 'gorging' on food and at others refusing meals. One groupworker suggested that she be allowed to cook her own meal [i.e. for her and her husband] separately, but the manager didn't agree with this. She made a comparison with a child and said "If she doesn't eat her meal, the next meal she shouldn't be given anything." Despite the repeated reports about the eating problems of this woman, she was described as being "childish" and using "childish ploys" such as "tantrums" to get attention. It was agreed that she had emotional problems, but these were interpreted within a framework of child training.

9.12.87 - staff meeting
Workers expressed concern about frequent staff changes; that its upsetting the Adelaide Road residents. Kate said she appreciated the importance of security but they need to swap new staff around for experience. The manager made a comparison with children - feeling maybe it's their fault if a parent leaves and described it as "a childish thing."

Adelaide Road workers reported that Hilda was drinking a lot of milk and not eating much. They said they try to persuade her but she's adamant. The manager said its to do with childishness and the comfort you get from milk, and that its not unusual in psychiatric patients. [Hilda told me she believes it is stopping calcium loss, since she thinks she has osteoporosis or some other serious physical illness.]

Workers are trained to think about and deal with residents' problems along the lines of childrearing. Not only is this view of mental illness largely taken for granted, but it also implies a view of what constitutes *normal socialisation*. The particular methods of child training advocated (which could be very loosely characterised as behavioural) are assumed to be commonsense, normal, and so are not discussed in themselves. The childhood model is explicit, in that it is talked about and taught through practice, but it is also apparent that the staff are not aware of how much they rely on this view in their caring and supervising roles.

It could be argued that this view of the mentally ill person is derived from the history of institutionalism - historically and in the history of each individual who enters the in-patient role. In this case, it would be a problem of inheriting relationships from the hospital system, yet the group homes are set up quite explicitly to change the nature of the relationships, to create a more "family like atmosphere". The concept of dependency clearly enters into such a view, but cannot fully explain the attitudes which are formed.

The mentally ill person, in history [Foucault 1967 ch 3] is seen as not fully social or cultural. The 'madman' is popularly viewed as outside the normal moral order, unconstrained by culture or social norms. [Cohen 1989 ch 2-3] Our commonplace views of childhood also tend to see the child as not fully social or cultural, as needing to be trained to become fully a person. This sort of view is also found within class attitudes, which are displayed by those in a more powerful position to those who are seen as inferior. Therefore we can see that in various, related ways, the psychiatric patient is seen as not fully a person, a view which takes in attitudes about class and culture, about childhood and socialisation and about the role of the dependent in relation to normal society

Kinship, adulthood and the notion of dependency

The family model of group home care rests on the metaphor of the psychiatric patient as a child, and of the home as a social group in which these special sorts of children can be resocialised and reintegrated into a more *normal* lifestyle. The idea of 'making progress' and 'doing well' (rehabilitative aims) are clearly crucial to maintaining a model of this sort. So, we can see the structural importance of those residents who were declared to have been very disabled, assessed as very dependent, and who are visibly making progress in the home.

Dorothy was a particular case, who can be structurally opposed to Mary, who was seen as 'the problem' in one group home. Dorothy's hospital based assessment made the following suggestion:

> "chronic schizophrenia, paranoid variety with 43 years duration...will not be able to survive in the community. Transfer to group home or local hospital unit."

In staff diaries she was described as:

> "A really nice, gentle lady, who seems to respond well to encouragement."

After several months in the house, having first been viewed as rather withdrawn, staff noted that she was:

> "opening up a little", talking to staff and going out with them.

Dorothy was seen to make progress, from being very passive and quiet, to being someone who was reserved rather than withdrawn, able to initiate a conversation and always interested in outings. She was seen also to redevelop skills such as cooking and knitting, with increasing confidence. She responded positively to ideals of rehabilitation which imply some sort of developmental progress.

A major problem for staff in using such a model is that, while residents are not normatively dependants, as children are, being adults, they

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cannot realistically be expected to 'grow up' as children do. The fact that the homes were designated as "homes for life" demonstrates that the carers did not really expect their residents to progress towards complete independence from them. Therefore, the notion of progress was both important and difficult to maintain in the way it was used.

In Thorn Street, Ada, who was thought to be slightly mentally handicapped, was often treated (fondly) like a child. Similarly, Howard, who moved to Carrier Lane, was called "a pet" by ward nurses. In contrast, Maurice who was perceived to be intelligent, but continually demanding of staff time and attention, was responded to rather differently. Although the psyhologist had expressed the belief that his problems were very deep seated and unlikely to go away, staff hoped that the home environment would easily change things. At first, they gave a great deal of attention to the behavioural programme devised for him, also talking to him as though he were a child being 'trained'. When, despite settling in well, Maurice continued to require a great deal of staff time, and also expressed the belief that his problems weren't ever going to go away, staff feelings became increasingly negative, and their practices appeared to rely more on ideas of discipline.

In her study of old people's homes, Hockey [Hockey and James 1988] also pointed to the general and pervading use of the metaphor of childhood for elderly people, particularly those in institutional care. She argues that the metaphor is a way in which carers try to deal with the fact of dependency, and the differing power relations of carer and dependent. She also argues that it is a means for carers to avoid confronting the closeness of death: carers, in treating elderly people as metaphorical children, implicitly rely on a circular view of development, where death and birth are brought together; by turning old age into childhood, they can deny the anxieties which the impending deaths of their clients create for them. [p 15-17] The problem of how to cope with death is a particular one for carers in old peoples' homes, but the problems and responses involved in providing care are more general. Their wider argument is relevant to the ethos of caring institutions, and the means by which they deny or avoid those aspects of disability and dependency

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which may be anxiety provoking or contradictory for those providing care.

Such accounts of old peoples' homes show how carers create a childlike image in the way they talk to and interact with residents, and in the types of activities thought appropriate for them. As with the group homes in this study, residents' behaviour may be described as "naughty", while their previous experiences may go unrecognised.[6] Infantilisation in itself was seen by observers to create 'infantile' responses, so that frail people may accentuate their disabilities as a way of resisting the regime of care they are offered. As in the setting of the psychiatric hospital, residents may have to resort to problem behaviours as a means of asserting themselves against staff views.

The notion of *innocence* is accentuated in the old people's homes by viewing them as "sweet" and by not admitting the sexuality of residents. In the group homes, workers generally thought of sexuality as a natural need of residents. Sexual and emotional comfort was seen as something psychiatric patients miss out on, because of institutional practices, but also because of their perceived social disability. However, staff were uncomfortable in pratice with the idea of residents as being sexually active. In one house, two friends who shared a room were found to be sharing a bed. Staff said to me that this was OK, positive even, but they were also very anxious about the possibly sexual nature of their relationship. Whereas one worker felt they should be given appropriate education and advice, they were scolded by another worker for sharing the bed and therefore messing it up.

What was significant here in my view was not so much the actual relationship of the residents, as the rather ambivalent attitudes of staff towards residents' relationships, viewing them as childlike and open to exploitation without their guidance. Although friendship was said to be a good thing for residents, over frequency of visits was discouraged and overnight stays by friends were ruled out, on the argument that chancers might take advantage of them. Similar rules were applied to the use of alcohol, (but with the argument that it mixes

badly with medication) so that a bottle of sherry bought for the occasional glass by a group of residents was confiscated, and locked in the office for Christmas and birthdays only.

The pattern of infantilisation is common in treatment of elderly people, but is also widespread across all categories of disability and dependency. Thus, Alasewski [1988] describes how, in a hospital for mentally handicapped people, the (adult) patients were divided into high grade, low grade and cotton chair wards as being metaphorically human (children), animal or vegetable. He shows that the referents by which patients are placed varies according to level, so that at the hospital level the difference between normality and mental handicap is seen as that between adult and child status, while at the ward level patients were divided into the grades above, and treated accordingly.

Hull, [1988] in a study of community based homes for people with mental handicap, also found that metaphors of childhood were used for residents. She saw these as contradictions in a setting where a reformed, 'normalising' model of care was being set up. In this setting staff denied the old categories and preferred a transformed role from that of custodians to enablers and from care to support. Staff believed themselves to be acting in a normalising way, but continued to assume basic differences between clients and themselves as normal people. She links the staff concern with managing the public presentation of residents, with negating the failure of their own feelings to fit with their ideals.

An important common feature of the positions of people in some form of care, is that of being economically dependent, or at least not economically active. One of the key defining features of adulthoood, in British society, is that of having a job and thereby having economic status. Children are also seen as socially marginal because of their exemption from economic roles, but in this case it is normative, and understood as part of a developmental process. Similarly, people in lower class positions and unemployed people in particular, are seen as marginal because of their lack of economic power and status. Hockey and

James point out that there is a great deal of stress on the idea of the future role of the child and on its progress towards independence. They argue that in this culture, despite being normative, the category of childhood is still anomalous because of the degree of stress on the definition of the person by their occupation. They contrast this view with the anthropological literature on cultures where family roles remain more important markers of the person's identity and social role, and where the status of both children and elders is viewed differently.[5]

Thus the residents of community homes of various types, are still viewed as socially marginal, as incomplete people. The desire to provide 'day centres' for psychiatric patients, should be viewed in this light. Professionals recognise that work is socially and economically valued, and that the residents identification as 'patients' was linked originally to their loss of an occupational role, as well as other social roles. It is doubtful, however, whether the provision of work centres without realistic economic returns, and with the designation of *psychiatric therapy* (rather than occupational status per se) can recreate socially valued roles. The policy also fails to deal with the factor of retirement as an outcome of the adult's working life.

Hockey's work suggests that retirement in itself is a devalued category. The residents in the homes where she worked were not perceived by carers in terms of their previous lives: as mothers, spouses, workers, children, but in terms of their current dependent status, conferring on them the special status of anomalous children. In her case, carers attempted to distance themselves from the imminence of death by viewing the residents as children. Carers in the group homes also attempt to distance themselves from the lived experience of their clients, and from their distress, by viewing them as metaphorical children.

There are several contradictions in the role of the groupworkers in attempting to provide rehabilitation for their residents. The first is the belief that mental illness is permanent, so that only a limited view of rehabilitation can be formed. Second is the low value placed in our culture on providing care, and in receiving care. One attempt to resolve

this is to model the group home as a family and the relationship between staff and residents as that between parents and children. The relations between carer and dependant have an important aspect of differential status and power, but motherhood is seen as a benign form of power. Thirdly there is the view that the mentally ill person is anomalous, not fully social or cultural, childlike but not a child. The common response to anomaly, [Douglas 1984 p4/5] is to create boundaries around anomalies and protect these boundaries by means of avoidance.

The category of childhood itself is also rather complex. It is seen as the natural category of dependency, but, as Geertz [1973 p360-364] points out, symbol systems are not natural, but are socially constructed and maintained. Hockey and James stress that the notion of childhood has developed historically and also varies between cultures. [1988 p8] Similarly, attitudes about what is normal childrearing practice are not simply natural but culturally constructed. It could be argued that in this society childhood (and thereby parenting) itself is stigmatised to some extent, and children are thought of as requiring training and segregation from adult society. The prevalence of the childhood metaphor can be seen as a way of masking power, and also of avoiding the issue of disability.

In the following section a sequence of events in one group home is described to show how these conceptual issues inter-relate in practice. It focuses particularly on the status of residents, on staff attitudes towards them, but also brings out the coherence and strength of the residents' own views of their situation and how it should be understood.

Whose home is it? A case study

The case study method of analysis is often used by social researchers, because it can highlight a number of issues being analysed, within their context. Such studies often focus on crises [Perelberg 1985 chs. 1 & 3] because such cases often reveal patterns of thought and behaviour which are normally less accessible to view. The case study below is given

because it brought out a number of issues which were viewed as important, or as problematic by staff and residents in the group homes. These issues also brought together the practical issues of financing and administration of 'community care' schemes, with the philosophical issues underpinning the aims of such care.

No. 98 Adelaide Road was originally designed to house four or five people. A group of three women from one hospital ward moved in during 1987, the fourth member of the prospective group having been rejected by the voluntary organisation as being unsuitable. The spare bedroom was initially taken by a live-in volunteer who, for the first three months, provided the main staff input into the house. The paid staff were based in an office in the neighbouring house and spent very little time at this house. The three residents had known each other only slightly on the ward, but felt they had grown closer in the process of preparing to leave. In their first six months after moving some tensions, arguments even, arose between residents. However, the considerable degree of practical and social support they gave to each other was often overlooked. When the volunteer left, the management, already under pressure from large DHSS arrears in board and lodging payments, was concerned to fill the vacant place/s. The hospital referred one woman, whose visit to the house went well: both she and the existing residents felt positive about the referral, but she was thought by professionals to be unsuitable for health reasons. Shortly after this, the selection process for Carrier Lane began, based on two male hospital wards. After several months two men were selected as possible residents for Adelaide Road.

October 1987 - Adelaide Road
When Catherine came to pick me up for the hospital visit, she told us she had a list of 6 prospective residents and was thinking of two for this house. Clare, their worker, was taken aback by this, firstly because she felt it was too small for 5, secondly because they were men. She was sure the existing residents wouldn't be very keen on the idea, having been all women in the house so far and coming from female wards. They both felt it could cause problems. Clare considered posing the issue hypothetically to them, to see what they thought.

9.10.87 - visit to Adelaide Road from hospital
Before the men arrived, Jane joked about how they'd all want to go there so she could cook their dinners for them. She told me she'd

heard something about 2 men coming to live there and wanted to know if I thought this was decided. I said I didn't know, but thought there would be a visiting process and that how people get on would be taken into account. Jane felt it wouldn't be quite proper at their age and in such a small house "you'd be going out of your bedroom and bump into a man in the corridor.. ..you're more relaxed with just women around and don't have to get dressed before stepping out of the bedroom" She said these things always depended upon the individuals and even with a woman, it would need to be someone who would get on with everyone. In this house, however, she felt it would simply be too crowded - it was too small and intimate to be mixed. She told me that Hilda and Margeret (who were out at the hospital workshop) share her views about the propriety of it and about the space. She was concerned about Margeret's feelings since she's generally very nervous of men.

October 87 - visit to Adelaide Road
I noticed that the storm had broken their clothes drier and Jane said they could dry clothes on radiators anyway, "at least at the moment....I don't know what it will be like when there's 2 men in." I asked if she'd heard anything of the plans and she said "not really". She didn't think there was much they could do since the workers seemed to have no real say. She thought 5 was squeezing people in and couldn't understand having a shared bedroom when the aim is supposed to be to make life more comfortable for you. She said it was OK if someone wanted to share, but that presupposes finding people who want to share and can get on together.

11.11.87 - staff meeting: selection of residents for Adelaide Rd.
Clare said the residents weren't at all happy about it. The manager assumed they would enjoy mothering a man, but Clare said they wouldn't.

12.11.87 - Community Psychiatrist Visit To Adelaide Rd
He asked what they felt about having 2 men move in, explaining he was doing assessments and looking at possible people at the moment. Jane said there are two problems: that five is too many for the house and that they're not keen on men. He asked what the reasons were and she pointed out the small size of the rooms - did he think it was big enough? He said "probably not, really". He told Jane it was their house and that their views should be respected.

The ins-and-outs of the issue were explored - disadvantages or feelings of impropriety and any possible advantages, since the residents didn't expect the men to be capable of much domestically. Jane agreed with Clare's view that 3 is a difficult number for sharing so that more people could diffuse problems in relations within the house. However she said it was dependent on the individuals selected and what they're like. She jokingly said that if one was tall and handsome she might change her mind, and that they would all have to buy negligees. She said that she and Hilda had been making a joke of it like this, but Margeret wouldn't see the funny side of things that way.

October 1987 - Adelaide Road Management Meeting

The community psychiatrist wanted to talk about the prospective residents. He posed the questions Jane had put to him, and said it wasn't clear how the residents feel.

Kate, the supervisor, said that staff have talked to existing residents; that there will always be problems introducing new people and that staff will continue talking to them. She said it was a house for 5 people. Clare said the residents' first reaction was horror but after a while they became prepared to talk about it and said that if they were nice people maybe they would be acceptable. She felt, however, that they were still very worried.

12.1.88 - staff meeting

The manager reported visiting the house and asking the residents about the men. She said "they giggled a bit and said it would depend on the men." She had suggested they might be able to dig the garden and the residents suggested washing windows. Catherine said the two men had been to visit, that they were both very quiet and the staff view of them was hopeful. The general conclusion was that the abstract idea was more worrying than the reality.

January 1988 - staff meeting

One prospective resident visited for dinner. Staff said they all made an effort to talk to him and were very nice to him. He liked it. Frank said they found him a bit strange - mutters a lot - and worried that work will fall on them as he's not very capable. Frank felt that Hilda's view had changed completely: she agreed to move to the single bedroom, after a talk with Clare, and moved everything herself. Previously she had said it was too small and she would have to leave the door open, even though she'd wanted a door lock if there were men in the house. Kate commented on how their views had changed.

February 88 - visit to Adelaide Road

When she returned from the workshop, Hilda took her dry duvet off the radiator to dry her mac. and I offered to take it upstairs. She said her's was the front room [ie. her original room]. When talking to Jane I asked her about the visit. She said they asked him questions and "he was able to say yes and no, but not a brilliant conversationalist." She thought the other man, who they'd met before was more capable and "with it." She wasn't keen on having the other man around as he'd be a bit of a burden on them. Margeret came in looking rather tired and fed up, said "weather's awful isn't it" then went up to her room until dinner time. She didn't talk until she'd finished dinner and got up to make the coffee. When Jane mentioned the men, Hilda said "Oh lord." She told me the man who visited didn't stop "jawing - talking to himself." Jane wondered if they were visiting this weekend - Frank had said they might be and had got extra food in yesterday, but they'd heard nothing since, they hadn't spoken to any staff since yesterday anyway. I asked Margeret how she felt about it and she said she didn't want a man in the house, she'd feel better if it was a woman. Hilda agreed with her. The general expression was of dismay, but of no point in objecting; that it's all happening regardless of them.

February 88 - visit to Adelaide Road

Jane told me that unless they sort something out, the men moving in won't work out; when they visited for the weekend, on Sunday Frank [worker] was "up and down like a yo-yo." She said one was quite nice and the other one was basically OK but both were going to need a lot of help. She also thought Margeret was unhappy about the situation, but wouldn't say so to the staff. At the weekend, she had stayed in her room most of the time and wouldn't come down, even for dinner. Jane saw some advantage in this - if something worries you stay out of the way, but I suggested it could be more a problem for her, making it that much harder for her to participate. Jane said she hadn't thought of it that way, but thought it was difficult for her because she seems to be very nervous of men and finds it difficult to talk about problems. She also pointed out that its a problem for herself in relations with the staff, because if they *all* feel worried or cross about something, she's the one who says it, so they think it's just her being complaining. She said that one evening the supervisor came round and they just said "Yes and no" to her. I asked how often the manager visited but Jane had never met her - she had been out the time she visited.

March 88 - Management Meeting, Adelaide Road

Kate [supervisor] said the visits of prospective residents were going very well and that they seemed to be getting on fine. She said they didn't want to move the men in until they have re-apppointed the third worker as their domestic skills are very poor.

The residents of this home had all been married and had children. Their marriages had all been unhappy in some way. All had been mothers, and two were still in contact with their, now adult, children. The fact that they didn't want to be put back in the position of cooking and cleaning for men, let alone live with men they did not know, was not accepted. One possible reason for this, is that their standpoint did not fit the status which had been attributed to them by their carers. Although the groupworkers were more aware and sensitive to the experiences of their residents than hospital workers might have been, it was still possible for managers to declare that one resident's marriage had been a delusion. Secondly, because of the distancing created by the status attributed to residents, staff found it difficult, despite their interest in the residents as people, to imagine themselves in their position.

The issue of who should move into this house, and who should have a say in the decision centres on the question of what the group home is meant

to be, and to whom. We have seen that it is designated as "a home for life" and that it is conceived by staff as a "family home". The notion of having both men and women sharing such a home fitted better with the notion of a family home - normally mixed, and with some domestic divisions according to normative gender roles - an idea which is also found in normalisation theory. [Wolfensberger 1972 ch 4] It could, therefore, be rationalised as 'good for' the female resident group. The residents however, had less reason to mystify the pattern of relationships in the home in this way. The community psychiatrist supporting the group homes was working on the philosophical basis that it was supposed to be the residents' own home. Therefore, he told residents that their views on who lives there were important. We have also seen that residents had some difficulty in seeing the group homes as "really home". For some residents, like Dorothy, this was because they identified their parental home as being *really* home. Most residents however, despite family contacts, did not have an alternative to call home.

The approach of the groupworkers was ambiguous because they were working with an ideal model which they could not carry through in practice. Important decision making was in the hands of managers, with no structured means of passing views from the bottom of the organisation's hierarchy into the top. Information was mediated firstly through groupworkers' interpretations of residents' statements or behaviour, secondly through the method of staff reports and discussion in meetings, and thirdly by management assessment of the situation. In this process, residents' views are also mediated through a re-interpretation of their everyday behaviour in terms of psychiatric symptoms. In this way, the ability to sustain an argument can be interpreted as "manic", or wanting bedroom door locks because of strange men in the house, can be interpreted as "paranoia".[7] Minor difficulties in sharing with others or coping with life problems, which in most households are accepted as normal, in this context will be perceived and responded to as though they were pathological.

Within the home environment, amongst themselves and to someone who they saw as outside of the organisation and the psychiatric services, residents were able to state their personal views. In relation to staff, a process of transformation was talking place throughout this period. When they first moved in, some residents responded to staff encouragement by speaking more confidently and by putting forward their own views. Those who believed that the group home meant the security of a home for life, in an ordinary house, as they had been told, were disillusioned. They gradually learnt that to say something which was not desired would not have desirable effects, and as they had done in hospital, withdrew into a more passive position.

In this way, the issues can be recast. The instrumental need of the organisation was to fill vacant places and to relieve the financial pressure on their budget. Residents accurately concluded that this would have to be done, regardless of their opinions, but didn't see why referrals of women couldn't be sought. The issue of the residents' own preferences, and their feeling that strangers were being introduced into their household, was seen as one of psychiatric patients lacking the ability to cope with change. Staff were trying to establish certain norms, of sharing this "family home" yet at the same time, were imposing institutional norms on the residents of the home.[e] The lesson for the residents was that it is not their home at all, but the organisation's; that there is no place where they can receive care, hospital or group home, and call their own.

Norms and their re-inforcement

The staff generally agree that it is part of their rehabilitative role to pass on norms of behaviour, by telling clients what is regarded as socially acceptable and by reinforcing these norms positively. This reinforcement is also modelled on the view of clients as being child-like. The staff are advised to pay attention to 'good' behaviour, to try to avoid giving too much attention to problematical behaviour, and to imagine how they would reinforce appropriate behaviour in a child. The

use of such practices is discussed above, but it is also influenced by the worry that public tolerance of "odd behaviour" is low. Staff worry that if they stand out in any way, residents might make life more difficult for themselves and their fellows.

The general view expressed by staff about any such problems was that the prognosis is poor, but that people should be advised and firmly encouraged to act in a socially acceptable way. Any behaviour which could be threatening to others or causing concern in the neighbourhood (which in practice was extremely rare) was felt to be bad for the organisation and for other residents, as it might increase stigma and they feel the residents are generally very sensitive to public views. Although the significance of stigma should not be underestimated, it is clear that residents in the group homes studied had very little contact outside the psychiatric sphere, except for their own close kin. My observation also underlined the fact that the majority of residents were able to live within the bounds of broad social norms without such guidance by staff.[9] Rather than being threatening figures themselves, the world outside the hospital was worrying for them.

The concern about social and cultural norms of behaviour is an important aspect of the group home philosophy, as it is for normalisaton principles, because it aims for greater social integration, to allow psychiatric patients to live within the community. However, it can also be seen as a restraint on social integration. It is arguable that residents were encouraged to attend psychiatric facilities only and to participate in group activities, because of the fear, on the staff part, of a failure to maintain public face and to achieve integration, for the resident group.

The limits of rehabilitation are linked to this dilemma. The group home offers the advantage to residents that it does not envisage rehabilitation in terms of total independence, and of moving out and moving on. The idea of 'homes for life' recognises the ordinary need which ex-patients have for supportive housing and for relationships of inter-dependence with others. We have seen that at times, these patterns

broke down, when a crisis developed or when pressure was put on one person to move on as a solution to relationship problems [chapter 5]. It is not clear, furthermore, whether the group homes have considered the need to adapt to their clients as they grow older or as their needs change.

While the group homes aim to offer a 'replacement' network for former hospital patients, and stress the value of social contacts for residents, they have not attempted to locate the group homes in their neighbourhoods in any meaningful way. The residents are essentially isolated within the community. It is often said, fatalistically, that 'community' does not exist anyway. Community, in the romanticised sense of a close knit, mutually supportive and internally cohesive locality, is essentially a cultural myth. However, the fact remains that means of social contact do exist, which are neighbourhood or network based, and often focused on some 'community of interest' such as churches, community centres, schools, pensioners' clubs, bingo sessions and so on. In this case, attempts to 'create community' [Cohen 1989] have been confined to the psychiatric sphere and conceived as a form of alternative to ordinary society. Parallels can therefore be drawn between this reform and earlier reforms, such as the creation of public asylums and of the 'moral management movement' in the nineteenth century.

Concluding points

There are a number of different ways of viewing one situation, depending upon the starting point of the commentator, yet very often, in service provision, those at the highest levels have a narrower view. It has been noted that in all types of caring institutions, those who are working most closely with clients have the lowest status and the least power. In this situation, the viewpoint of the clients does not often get consideration; it is seen as sub-cultural because they are below the lowest level of authority.

Reforming institutions of care have looked for benign models for authority, and the family model is seen by them to lend itself to this need. However, family systems, and the role of different members – mother, father, child, sibling and so on – are culturally constructed. Perelberg [1985 ch 3] points out that the family has to deal not only with love and intimacy but also with matters of inequality and differential power between genders and between different generations which alter at different periods of life. In constructing this alternative family model, as a way of normalising dependency, there were a number of options available to staff, both within the family concept and beyond it. Bloor and colleagues [1988] for example, compare eight therapeutic communities, which use differing models of the home or 'community' yet which all incorporate ideas of mutuality and dependency in some way. One resident of a group home preferred to see her worker as like a son, caring for his elderly mother. This created for her a picture of care and respect, which would have been more acceptable to an adult in ordinary society.

The role attributed to the residents is linked to general attitudes about mental illness which view patients as unable to take responsibility for themselves, as being asocial and outside cultural norms, and as childlike or animal-like. These sort of views are applied most strongly however, to those who have been institutionalised, rather than people who suffer from mental illness but continue to live in ordinary society. [Cumming and Cumming, 1957 p102] They are also applied to other categories of people, particularly old people, who are not viewed as ill in the way that psychiatric patients are, yet are still treated in ways which deny their adult social or personal identity.

The family model of the group home is also limited in various ways. Firstly it is limited by the financial and managerial constraints within which the group home is developed. Decisions are sometimes taken, which may be seen to compromise the philosophy of care, but are thought of as expedient. The fact that the home is publicly financed and supported by paid workers, although necessary and desirable, does not fit such an ideal model. There is also a conscious desire not to let the kinship

philosophy run too far, to let workers become emotionally over-involved and unable to make "hard decisions". This brings us back to the factor of differential power relations between staff and residents. Although ideally staff power is seen as benign and nurturing, a decision by management to evict, or to return a resident to hospital signals a break-up of such relationships. In order to achieve such detachment, as well as to deal with managerial priorities, the organisation puts the requirements of staff induction and cover above the attachments staff may form to working in a particular home. On several occasions workers became upset and worried about being moved, partly because of their personal feelings of attachment and loss and partly because they feared the residents would suffer such feelings.

The residents' views of relationships within the group home are quite different from the parent/child model. They are aware of their greater age and that in some ways they are more experienced, even if much of that experience has been in a dependent status. They viewed groupworkers as being different from hospital staff, but still more like nurses than any other term they could think of. The only kinship analogy that (the older) residents have made has quite different value implications - of the staff as being like a son or daughter who takes care of them.

A further limitation is placed on the ideal model of the group home, by the tendency of professional carers to see problems both as evidence for and result of psychopathology. Once the client has been classified as mentally ill and has been given a 'sick role', there is a strong tendency to interpret the ordinary, and arguably quite normal problems, which residents experience in sharing and managing group home life as aspects of illness. The consciousness of their status as patients therefore continues to permeate day to day life. It could be argued that the illness status of residents has played a far more significant role, as discipline, in influencing their behaviour than the reinforcement of cultural norms through which, the carers hope, residents will achieve greater social integration.

The ideas held about the nature of mental illness, and the nature of a normal lifestyle profoundly influence the form of care offered. The idea of the mentally ill client as not only dependent on the organisation, but as childlike in nature, is a major limitation on the principle of increasing independence as part of rehabilitation. In statements about care policy the dilemma may not surface. Ideally, the groupworker is supposed to act as leader, in the sense of being a "facilitator" or "catalyst". The aim is "personality growth" through bringing out personal capacities, within the context of a group and to encourage social as well as individual skills. In their practice, the balance between the responsibility of caring and the aim of facilitating independence appears far more difficult to achieve. The central dilemma, in the transfer of care, remains with the balancing of care and control in an institutional environment.

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NOTES TO CHAPTER EIGHT:

1. Bateson set out the theory of the double bind as a factor in schizophrenia in 'Steps Towards An Ecology Of Mind' [Bateson 1973] which was used by the 'antipsychiatrists' in the 70's. [Laing 1969] Bateson describes it as a situation in which, whatever alternative the person chooses, his statement or action is wrong. [Perceval's narrative 1961 pX]

2. For sociological findings on this matter see the participant observation study by Perrucci [1974 ch 3] and May and Kelly's [1982] study of nursing attitudes towards different patients.

3. See Cohen's description of the case of Bruno [Cohen 1989]

4. See Wolfensberger's [1972] discussion of the range of attitudes towards deviancy, particularly the notion of the deviant as a diseased organism and that of the deviant as an object of pity.

5. This relates to the case of Mary and the day centre in chapter seven

6. The quotation of the poem 'Warning' by Jenny Joseph, in Hockey and James [1988 p20/21] and the poem 'Crabbit Old Woman' (anon.) by Hazan [1980 p27-29] capture this experience poignantly from the viewpoint of the elderly person.

7. Again, this could be seen as a way for carers to deny the adult and sexual identities of their clients.

8. Pritlove also discusses this issue with respect to the reliance on shared bedrooms in homes and hostels for former psychiatric patients. His book gives a very clear description of the problems this caused in relations between residents and in the smooth running of the homes. [Pritlove 1983 p49]

9. Wolfensberger [1972 p28] discusses the dilemmas for mormalisation approaches, when they may be seen as imposing norms on people in an unreasonable way. He stresses the concept should be understood as one of typicality rather than conformity, which in the long term may demand changes in social ideas about the range of normality rather than simply change in those who are regarded as deviant. Such dilemmas are also noted by Pritlove [1983 p22/23]

CHAPTER NINE
CONCLUSION

Age and transition: the sick role and the construction of time

This thesis has unfolded a pattern of passage of time, and of change, in which people whose illness became their identity, are seen as both elderly and as perpetual children. There are two versions of their histories: the history of the sick role and the life history of the individual.

As we have seen, the case history arises out of and confirms a process of reduction and invalidation of the life history, in which transition becomes anomalous. It is in this context in which the transition from 'institution' to 'community' is conceptualised and implemented. The passage of time, for the residents, was enveloped by living in hospital, where past identities and attachments became disjoined, and the present an endless process. Life as a hospital patient required acceptance of past losses and a transition towards old age, and towards death, without transformation of status as kin or elders. In a sense, the infantilisation by which Hockey characterises our cultural response to old age, has been imposed by the permanency of the sick role for long-term psychiatric patients. They have been characterised by an artificial re-construction of time, in which childhood blends into old age, via dependency.

The life histories of the residents reveal a preoccupation with the process of change, returning to more integrated past, and exploring the events which led to the present. The life-crisis of leaving the hospital (and the institutional crisis of its closure, which could symbolically be seen as a form of death and rebirth) has brought out the need for these processes to be re-examined, so that the present and future can be assessed. In these histories, unlike the case histories of the person as patient, the hospital phase of life is reduced, appearing almost empty in some ways. It is not the case that the residents wished to forget, or

to dismiss, their life in the institution, but that they wished to reflect on its lack of value for them, its very emptiness, within the course of their lives.

The altered social reality seemingly created by the institution appears to fix time, in such a way that change on the personal, social or societal level may not be acknowledged. Cohen, in discussing the philosophy of the Italian psychiatric reform movement, argues that:

"from this perspective the psychiatric hospital is a world in which no contradictions can exist. Each person who enters it, whether patient or member of staff, is linked to the others in a way which denies the reality of their experience. All participate in an illusory world, that created by psychiatric discourse. ,,,,in which time has ceased to exist and all relationships have become crystallised." [1989 p133]

The transition from hospital to group home is not a reversal of the process involved in becoming a patient. It would be a mistake therefore, to assert that community care policy means a return to the comunity life left behind. The transition, as in the classic rite of passage, is to a changed yet ideally restored identity. It requires a transformation of the moral role of the person with mental illness.

In this transition, the group home may embody a concept of renewal and restoration. The patient leaves the hospital (institution) to live in a home which is modelled on ordinary family life. S/he is no longer referred to as patient but as resident. S/he is to live and interact, not in an aggregate, but in a group. The rehabilitative aims of the group home are both instrumental and social. The success of group homes in enabling people to leave hospital, despite their vulnerability and the long years of institutional life, rests on such a conceptual framework. How then, are we to understand the contradictions, for residents and staff, experienced in the running of these homes? The concept of the sick role allows the position of the person with illness to be understood as part of society. In ideas about mental illness, however, and particularly the position of the 'chronically ill' who appear to have become stuck permanently in such a state, there is a confusion of social concepts with the mythology of exclusion. My argument is that the 'mental patient' is part of society, not outside of

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it, even when s/he is resident in a psychiatric institution. The continued existence of segregation should not allow us to divorce the experience of its residents from that of the wider society.

The attitudes towards mental illness, among hospital and community based carers, individualise the problems or distress of clients, while at the same time responding to those individuals through categorisation: the patients/residents are 'managed' in groups and are considered as part of a certain (deviant) class of people, yet at the same time the diagnostic categorisations of psychiatry function to separate the residents from their shared experiences within the ward, the group home or the wider social world. They continue to provide a means of discipline over the resident which is not confined to the institutional environment of the hospital. By seeing the client as child-like in nature it is possible for carers to seemingly resolve the dilemma which faces them in providing care. The dependent status of the client can be viewed as normal if it seen as like a child's. It allows the carers to support and protect, but also to retain authority over the resident, without recognising the power differentials involved in their relationship. In this way, the institutional continuities between hospital and group home may go unrecognised.

The group home residents recognise their own vulnerability, as ex-asylum residents, and now as residents of a group home, depending on public financial support and the support of the caring organisation in order to retain this as their home. They do not, however, share the carers assumptions about their needs or their relationships, within the home, or in the wider community. As people with personal as well as institutional histories they do not see themselves as perpetual children. They are aware of how much is missing from their lives, but do not necessarily regard their past (adult) identities as negated by their illness or institutionalisation.

Some conclusions on method

My methodological aims have been to use anthropological enquiry as a means to explore a ngelected area of social policy research - that of the experiences and perspectives of the recipients of services, and particularly those who are viewed as presenting problems of chronicity and institutionalism. I suggest that satisfactory communication is possible, if given the necessary time and interest. The openness of such an approach may enable apparently voiceless people to find their voice and shape it themselves. It requires the researcher, perhaps, to go back to basic assumptions, which may feel rather insecure, but which will allow coherent and significant themes to develop. It works particularly well, therefore, as exploratory study. In a sense the researcher will need to maintain the sort of uncertainty which would be valuable for care workers themselves, who are keen to share responsibility and ideas with their clients, yet find the difficulties in doing so frustrating and confusing.

My conclusion is that, through this method, a fuller understanding can be achieved of the way such services work out in practice; of the different levels of discourse which exist in any situation and the significance these views of reality have for action and interaction. The in-depth nature of such research may limit its generalisability, across different systems. However, the comparisons which can be drawn with other care settings, with other client groups and with wider social situations, suggest this is not an absolute limitation of qualitative research. I feel that although such work is very grounded in the particularities of everyday life, its more general implications should not be ignored.

From de-hospitalisation to de-institutionalisation

This study shows that long-term psychiatric patients are able and willing, with adequate support, to make the transition to life outside hospital. It focuses however, on the difficulties experienced by carers

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in assessing and establishing the forms and levels of support which individual patients need in which to achieve a satisfactory life outside. It demonstrates that group homes provide an improved quality of environment, both in the objective terms of standards of housing, physical care, and so on, and in the subjective views of the residents. ' The improvements in observable quality of life are relative to that of the impoverished hospital environment, so that in various ways residents can be seen to be 'better off' while still facing the problems of poverty and insecurity which they share with many other disadvantaged individuals.

The group home represents a means by which patients can leave the long term custodianship of the hospital without simply being expected to cope alone. As a protective environment, however, it takes on and retains many of the contradictions of the hospital regime. In chapter two, I outlined how much of community care policy has failed to be elaborated on the conceptual level, leaving it without a coherent view of how to provide adequate and enduring services, which are geared up to the needs of current hospital residents and those who may need some form of residential or domiciliary care in the future. Chapters four to eight describe and analyse the way in which such a policy has been developed in the context of a particular hospital closure programme and by a particular care agency. The analysis shows that as an exercise in de-hospitalisation, for long-term care, the closure process is working. The idea of community care tends to gloss over the two conceptually and practically distinguishable principles of de-hospitalisation and de-institutionalisation. The latter is more complex and apparently more difficult to achieve, but (setting aside the economic motivations of current political policy) remains an important motivation for community care, pursued as a means of social reform.

However, the contradictions inherent in community care development have not been fully explored and consequently the means or objectives of de-institutionalisation have not been clearly laid out. It is concerned with the removal or alteration of those forms of control which negate the person's previous self-identity, replacing it with that of

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patienthood, a permanent sickness role; forms which undermine, rather than facilitate, the means by which positive personal and social identities can be restored. De-institutionalisation requires the restoration of self-respect and the ability to make constructive choices, in order to achieve the autonomy which is culturally considered essential to a valued, rather than deviant, social role.

The provision of care is intricately bound up with the exercise of authority by carer over dependant. This issue will not be closed with the doors of the psychiatric hospital. In order for it to be grasped carers must be enabled to recognise (and not to mystify) the nature of their power and the role it plays in their relations with clients. Through awareness of their own motivations, and of the abilities and desires of their clients, carers may be enabled to foster the reciprocity through which authority can be shared. If the moral status of the 'mental patient' can be reconceptualised in this way, the balancing of risk and responsibilty can be used by carers[2] as an exercise in fostering the positive and educational potential of risk-taking, rather than as an exercise in the elimination of fear. The former encourages autonomy, without rejecting responsibility, while the latter implies continual control.

One means, I suggest, towards resolving the contradictions experienced by carers and residents is through concepts of reciprocity and interdependence, which cut across the opposition between dependency and independence as stigmatised and idealised markers of identity. The fundamental importance of reciprocity in the creation and maintenance of social relationships is reflected in much anthropological writing. [Bourdieu 1972 p4-5] The importance of reciprocity to ordinary relationships was reflected within the homes by the sharing of cooking, the centrality of the evening meal and the birthday gifts which the more isolated residents, as patients, had not received for years. Most significantly, the desire among residents to give - the little treats for grandchildren, the coins for my children "to buy you sweets", the cakes for me to try - all reflect on the need felt by residents to be able to participate in the social world not as merely passive

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recipients, people who are done to, but as people with some role, however small.

Although certain aspects of policy (such as the emphasis on the chance to work, in day care, and the emphasis on sharing of tasks in the home) can be seen as responses to such ordinary needs, I feel they are lost opportunities while they remain segregated and imposed rather than positively valued, by the residents themselves and by the wider society. We can see many of the roots of frustration, in the case studies I have presented, in the lack of opportunity for residents to participate in ways which they felt were socially normative and valued, and particularly in activities which they saw as appropriate to elders.

The view of the mentally ill person as 'other' and as 'perpetual child' is a barrier to mutuality since it characterises mental distress as an internal and inherent quality of the person, one which is asocial, outside of normal cultural boundaries and therefore either threatening or anomalous[3] It can be broken down by approaches which seek to rediscover and acknowledge both the individuality and the social needs of the person who has been categorised as 'patient'. At the same time, the individualising of the forms of illness, deviancy or distress, which take place on the broader political level, as well as in the care of the group home residents, should be understood as a barrier to exploration of our common experience and to the development of means of communal support and integration.

The willingness of many long-term psychiatric patients to leave hospital is closely related to their perceptions' of the life which will be possible for them outside. Their expectations of life are neither impossible nor unreasonable and are often severely circumscribed by the experience of long years of institutional lifestyles. The group home residents can enjoy a quality of life which is both more ordinary and more exceptional than what they had come to accept as hospital patients, but the legacy of confinement is still with them.

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NOTES TO CHAPTER NINE:

1. Goldie 1988 similarly relates that the majority of his respondents expressed a preference to remain outside hospital and for the greater autonomy it allowed, even though they suffered greatly from poverty, poor living standards and lack of social opportunities. He argues that it is very much a case for sustaining and improving the resources available to ex-patients in the community, rather than for retaining psychiatric hospitals.

2. As is now an accepted aspect of training for community based care of mentally handicapped children and adults.

3. See Douglas, 'The Abominations of Leviticus' in 'Purity and Danger' 1984. Also Cohen 1989: Chapter 2 'Social and non-social: the construction of a moral domain'

BIBLIOGRAPHY

Abrahamson D. & Bremer D., 'Do long-stay patients want to leave hospital?' in Health Trends 1982, Volume 14, p 95-97.

Abrams P. & S., Humphrey R., & Snaith R., 'Neighbourhood care and social policy', HMSO, 1989.

Abrams P. & McCulloch A., 'Men, Women and Communes' in Anderson M. (ed.), 'Sociology of the family' Penguin, Harmondsworth, 1980.

Alasewski A., 'Institutional care and the mentally handicapped' Paper given to the nursing and anthropology association conference, 'Understanding Disability', London 1988.

Audit Commission, 'Making A Reality of Community Care', HMSO, 1986.

Avebury K., 'Is There A Voluntary Movement For Mental Health?' in MIND, 1983.

Banton R., Clifford P., Frosch S., Lousada J. & Rosenthall J., 'The Politics Of Mental Health', Macmillan Education, UK, 1985.

Barker I. & Peck E., 'Power In Strange Places', GPMH, London, 1987.

Barton R., 'Institutional Neurosis', John Wright, Bristol, 1976.

Baruch G. & Treacher A., 'Psychiatry Observed', Routledge and Kegan Paul, London, 1978.

Basaglia F., 'Breaking the circuit of control', chapter 6 in Ingleby, (ed.) 1981.

Basham, 'Urban Anthropology: the cross cultural study of complex societies', Mayfield, Palo Alto, 1978.

Bateson G., 'Steps towards an ecology of mind: collected essays in anthropology, psychiatry, evolution and epistemology', Paladin, London, 1973.

Bateson G. (ed.), 'Perceval's Narrative. A patient's account of his psychosis, 1830-1832', Stanford University Press, California, 1961.

Beers C.W., 'A Mind That Found Itself', Doubleday, New York, 1948.

Bloor M., McKeganey N., & Fonkert D., 'One Foot In Eden. A sociological study of the range of therapeutic community practice', Routledge, London 1988.

Blythe R., 'Akenfield, portrait of an English Village', Pantheon Books, New York, 1980.

Bott E., 'Hospital And Society', British Journal of Medical Psychology Vol 49, 1976, p97-140

Bott E., 'Family and social network: roles, norms and external relationships in ordinary urban families', Tavistock, London, (2nd ed.) 1971.

Bourdieu P., 'Outline of a Theory of Practice', Cambridge University Press, English Edition, first published 1972.

Brackx A., and Grimshaw C., (eds.) 'Mental Health Care In Crisis', Pluto Press, London, 1989.

Brandon D., 'Voices Of Experience: consumer perspectives of psychiatric treatment', MIND, London, 1981

Brandon D., 'Community care as a mirage' Talk given at LSE 1987.

Brown G.W., and Harris T., 'Social origins of depression: a study of psychiatric disorder in women', Tavistock, London, 1978.

Brown P., 'The transfer of care: psychiatric deinstitutionalisation and its aftermath', Routledge, London, 1985.

Brown P. (ed.), 'Radical Psychology', Harper and Row, New York, 1973.

Bulmer M., 'Neighbours: the work of Philip Abrams', Cambridge University Press, 1986.

Bulmer M., ' The Social Basis Of Community Care', Allen and Unwin, London, 1987.

Busfield J., 'Managing madness. Changing ideas and practice', Hutchison, London, 1986.

Carson J. et al., 'The Hall And Baker Rehab. Survey Of Claybury Hospital 1987-88', TAPS Unpubl.

Castel R. & F., Lovell A., 'The psychiatric society', Colombia University Press, New York, 1982.

Clare A., 'Psychiatry In Dissent. Controversial issues in thought and practice', Tavistock, London, (2nd ed.) 1980.

Clifford P., 'Cane Hill Hospital patients' needs survey' Main Report. NUPRD, London, 1985.

Clifford P. & Holloway F. 'Evaluation of the closure of Cane Hill hospital' Unpubl. proposal 1986

Cohen A., 'Creating Community: an anthropological study of psychiatric care in Bologna, Italy 1960-1987', Phd. London 1989

Cohen A. P., (ed.), 'Belonging: identity and social organisation in British rural cultures', Manchester University Press, 1982.

Conrad P., 'On the Medicalisation of Deviance and Social Control', chapter 3 in Ingleby (ed.) 1981.

Cumming E. & J., 'Closed Ranks: An Experiment In Mental Health Education', Harvard University Press, Massachusetts 1957.

Dayson D., 'Differences in outcome between staffed purpose planned group homes and other forms of care', paper given to the TAPS annual conference, London, 1989.

Dear M. J. & Taylor S. M., 'Not On Our Street', Pion, London, 1982.

DHSS, 'Better services for the mentally ill', HMSO, London, 1975. Command 6233.

DHSS, 'Care in the community. A consultative document', HMSO, London 1981.

DHSS, 'Caring for people. Community care in the next decade and beyond', HMSO, London, 1989. Command 849.

Douglas M., 'Purity and danger, an analysis of concepts of pollution and taboo', Ark Paperbacks edition, Routledge and Kegan Paul, London, 1984.

Evans Pritchard E., 'Oracles, Witchcraft and Magic Among The Azande', Oxford University Press, 1937.

Firth R., 'Symbols, Public and Private', George Allen and Unwin, London, 1973.

Foucault M., 'Madness and civilisation: a history of insanity in the Age of Reason', Tavistock, London, 1967.

Foucault M., 'The birth of the clinic; an archaeology of medical perception', Tavistock, London, 1973.

Foucault M., 'Discipline and punish: the birth of the prison' Penguin, Harmondsworth, (UK ed.) 1979.

Fowler N., 'Working Together. An Introduction' in Mind, 1983.

Frankenberg R., 'Village on the Border: A social study of religion, politics and football in a North Wales community', Cohen and West, London, 1957.

Freeman H. G. & Simmons O. G., 'The mental patient comes home', John Wiley and Sons, New York, 1963.

Freidson E., 'Profession of medicine: a study of the sociology of applied knowledge', Harper and Row, New York, 1970.

Gans H., 'The urban villagers: group and class in the life of Italian Americans', Free Press, New York, 1982.

Geertz C., 'The Interpretation Of Cultures: selected essays', Basic Books, New York, 1973.

Gennep A. Van, 'The rites of passage', Routledge and Kegan Paul, London, 1960. (Orig. Publ. 1908 in French)

Gianichedda M. G., 'A future of social invisibility' in Ramon and Gianichedda, 1988.

Gluckman M. (ed.), 'Closed systems and open minds: the limits of naivety in social anthropology', Oliver and Boyd, Edinburgh, 1964.

Gluckman M., 'Politics, Law and Ritual in Tribal Society', Basil Blackwell, Oxford, 1982.

Goffman E., 'Asylums. Essays On The Social Situation Of Mental Patients And Other Inmates', Penguin, Harmondsworth, 1968.

Goffman E., 'The presentation of self in everyday life', Penguin, Harmondsworth, 1971.

Goldie N., '"I hated it there but I miss the people" A study of what happened to a group of ex-long stay patients from Claybury Hospital', South Bank Polytechnic, Health and social services research unit, research paper no. 1. 1988.

Goode W., 'The Family', Prentice Hall, New Jersey, 1964.

Gove W. (ed.), 'Deviance and mental illness', Sage, Beverly Hills, 1982.

Greenberg Dr. R., 'Skeleton in the DHSS cupboard' in Pulse, November 5, 1977, p8-9.

Griffiths, Sir R., 'Community care: an agenda for action. A report to the Secretary of State for social services', HMSO, London, 1988.

Grove B., 'Therapeutic Communities - halfway home?' in Brackx and Grimshaw, 1989.

Halpern S., 'Why this bulldozing will not clear the dumping ground' in Health and Social Service Journal, August 5, 1977, p1128-1129.

Hannerz U., 'Exploring the City: inquiries towards an urban anthropology', University of Colombia Press, New York, 1980.

Hazan H., 'The Limbo People. A study of the constitution of the time universe among the aged', Routledge and Kegan Paul, London, 1980.

Heginbotham C., 'Towards A comprehensive Mental Health Service' in MIND, 1983.

Marris P., 'Loss And Change', Routledge and Kegan Paul, London, 1974.

May D. & Kelly M., 'Chancers, pests and poor wee souls: problems of legitimation in psychiatric nursing', Sociology of Health and Illness, Vol 4, No. 3 1982.

McCowen P. & Wilder J., 'Lifestyle of 100 psychiatric patients. Some cost and policy implications for rehabilitation', PRA, London, 1976.

MIND 'Working Together? Voluntary and Statutory Mental Health Services, A report of MIND's 1982 annual conference', MIND, London 1983.

Murray J., 'Better prospects: rehabilitation in mental illness hospitals: a report on facilities in 84 hospitals', MIND, London, 1977.

NETHRA, 'The future provision of services for the mentally ill: a consultative document', 1982.

NETHRA, 'Regional Operational Plan for 1985-1988: Friern and Claybury Strategy.

Oakley A., 'The sociology of housework', Robertson, London, 1974.

Parsons T., 'The Social System', Free Press, New York, 1951.

Perelberg R.J., 'Family and Mental Illness In A London Borough', Phd, London, 1985.

Perrucci R., 'Circle of madness: on being insane and institutionalised in America', Prentice-Hall, New Jersey, 1974.

Pritlove J., 'Group homes, an inside story', University of Sheffield unit for social services research: community care. 1983.

Radcliffe Brown R. & Fortes M., 'African systems of kinship and marriage', Oxford University Press, Eleventh Impression, 1975.

Ramon S., 'Psychiatry In Britain. Meaning and Policy', Croom Helm, London, 1985.

Ramon S., 'Leaving Hospital' in Openmind, No. 34, August/September 1988.

Ramon S. & Gianichedda M.G., 'Psychiatry in Transition. The British and Italian Experiences', Pluto Press, London, 1988.

Raphael W., 'Psychiatric hospitals viewed by their patients', King Edward's Hospital Fund for London, 2nd ed. 1977.

Rapoport R. & Roscow I., 'Community as doctor: new perspectives on a therapeutic community', Tavistock, London, 1960.

Rawlings W.B., 'Everyday Therapy. A Study Of Routine Practices In A Therapeutic Community', Phd. Manchester, 1980.

Hockey J. & James A., 'Growing up and growing old: metaphors of ageing in contemporary Britain', ASA Conference Papers, London, 1988.

Hollingshead A. & Redlich C., 'Social Class And Mental Illness: a community study' in Gove (ed.) 1982.

Hughes D., 'How psychiatric patients manage out of hospital: Community provision, living standards and financial needs', Disability Alliance, London, 1978.

Huxley P., 'Quality measurement in Mental Health Services: A Discussion Paper on Quality of Life Measurements', GPMH, London, 1986.

Ingleby D. (ed.), 'Critical Psychiatry: the politics of mental health', Penguin, Harmondsworth, 1981.

Jones K., 'A history of the mental health services 1845-1971', Routledge and Kegan Paul, London, 1972.

Kay A. & Legg C., 'Discharged to the community: a review of housing and support in London for people leaving psychiatric care', GPMH, London, 1968.

Kleinman A., 'Patients and Healers In The Context Of Culture. An Exploration Of The Borderland Between Anthropology, Medicine And Psychiatry', University of California Press, 1980.

Korman N. & Glennerster H., 'Closing a hospital: the Darenth Park project', Bedford Square Press, London 1985

Lakoff G., 'Women, fire and dangerous things: what categories reveal about the mind', University of Chicago Press, 1987.

Landy D. (ed.), 'Culture, disease and healing: studies in medical anthropology', Macmillan, New York, 1977.

Lavender A. & Holloway F., 'Community care in practice. Services for the continuing care client', Wiley, Chichester, 1988.

Lehman A. F., 'The well being of chronic mental patients. Assessing their quality of life', Archives of General Psychiatry, Vol. 40, April 1983.

Littlewood R. & Lipsedge M., 'Aliens and Alienists: ethnic minorities and psychiatry', Penguin, Harmondsworth, 1982.

Mangen S. (ed.), 'Mental Health Care In The European Community', Croom Helm, London, 1985.

Mangen S. & Rao B., 'United Kingdom. Socialised System - Better Services?' in Mangen (ed.) 1985.

Margolius O., 'Friern Hospital 1985-1988. Movement and Accumulation of the Long Stay Population', TAPS, 1989.

Rosenhan D., 'On Being Sane In Insane Places', Science 179, 1973, p250-258

Scheff T. (ed.), 'Being mentally ill: a sociological theory', Weidenfeld and Nicholson, London, 1966.

Scull A., 'Decarceration: community treatment and the deviant: a radical view', Prentice-Hall, Englewood Cliffs, 1977.

Sedgewick P., 'Psychopolitics: Laing, Foucault, Goffman, Szasz, and the future of mass psychiatry', Harper And Row, New York, 1982.

Segal S. & Aviram U., 'The mentally ill in community based sheltered care: a study of community care and social integration', Wiley, Chichester, 1978.

Skultans V., 'English Madness. Ideas on insanity 1580-1890', Routledge and Kegan Paul, London, 1979.

Skultans V., 'Madness and Morals: ideas on insanity in the nineteenth century', Routledge and Kegan Paul, London, 1975.

Szasz T., 'The myth of mental illness' in Scheff (ed.) 1966.

TAPS., 'Preliminary Preport on Baseline Data from Friern and Claybury Hospitals', London 1988.

Thomas D. & Rose N., 'Getting to know you. A reflection and review of an individualised approach to service planning', Manchester Health Authority, 1986.

Tomlinson D. (a) 'The Administrative Process of Claybury and Friern Reprovision' TAPS, London, 1988.

Tomlinson D. (b) 'Let the mental hospitals close...' Policy and Politics Vol 16, No. 3, 1988, p179-195.

Tomlinson D. (c) 'A Report on the Clerkenwell Project', Unpubl. 1988.

Turner B.S., 'Medical power and social knowledge', Sage, London, 1987.

Turner V., 'The Forest of Symbols', Cornell University Press, 1967.

Turner V., 'Symbols in Ndembu Ritual' in Gluckman (ed.) 1964.

Wallman S. 'Eight London Households' Tavistock, London, 1984.

White J. 'The worst street in North London: Campbell Bunk, Islington, between the wars', Routledge and Kegan Paul, London, 1986.

Willmot P., 'Social Networks, Informal Care And Public Policy', Policy Studies Institute, London, 1986.

Wing J.K. & Brown G.W., 'Institutionalism and schizophrenia: a comparative study of three mental hospitals 1960-1968', Cambridge University Press, 1970.

Wolfensberger W., 'The principle of normalisation in human services', National Institute of Mental Retardation, Toronto, 1972.

Young M. & Willmot P., 'Family and kinship in East London', Routledge and Kegan Paul, London, 1957.