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Resettlement of Old Long-Stay Psychiatric Patients: the Use of the Private Sector

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A follow-up study of 17 old long-stay psychiatric patients resettled in private facilities for the elderly is reported. Resident satisfaction with the placement and functioning (using the CAPE Behaviour Rating Scale) was assessed, together with the quality of the physical and social environment, and the regime characteristics in the establishments. All residents were satisfied with life and their functioning had improved significantly. The private facilities were more resident-orientated, and had a generally superior social environment to their local authority 'old people's home' counterparts. The physical amenities, safety features, and architectural choice available were of a similar standard to those in local authority old people's homes, but there were fewer prosthetic and orientational aids and on-site recreational amenities.

There is a developing literature reporting varied outcomes following resettlement of old long-stay psychiatric patients (e.g. Farkas *et al*, 1987; Harding *et al*, 1987 *a*, *b*); however, this generally relates to large groups of people placed in a variety of community facilities. There has been little research into the use of specific types of accommodation, especially residential homes. Linn *et al* (1985) investigated the use of nursing home accommodation for the resettlement of psychiatric patients in the USA, and found that residents fared considerably worse in these on a variety of dimensions than did people in hospital wards. However, there are many ways in which nursing homes in the USA differ from residential homes in the UK, and thus direct comparisons of the two are probably unwise. For example, the average size of nursing homes in the Linn *et al* (1985) study was 120 beds, a great deal larger than private residential homes for the elderly in the UK, which usually house 8–20 residents, or local authority Part III establishments (i.e. local authority old people's homes), which typically house 40–50 residents (Willcocks *et al*, 1986).

In the UK, the most popular alternative to traditional care for old long-stay psychiatric patients has probably been the 'group home' (Ryan, 1979; Morris, 1981), but this type of relatively independent, communal living places high demands in terms of both skills and motivation, and is not appropriate for many of the more disabled residents (Shepherd, 1984). For those who lack the necessary skills and motivation for group home living, more supervised and supported accommodation is necessary. Often this is provided by long-stay hostels run by local authorities and voluntary bodies, or local authority Part III establishments for the elderly, but there are problems. In particular, there is a large shortfall in the number of places available in such accommodation, but there are other difficulties.

The first of these is that many Part III establishments are large and institutional in nature and practices (Willcocks *et al*, 1986). Of the 100 local authority old people's homes surveyed by Willcocks *et al* (1986), 68% had more than 40 residents, and 20% more than 50.

Secondly, many of the residents of Part III accommodation have disabilities of different types from those of long-stay psychiatric patients. In particular, many are disorientated and confused, and the environment is tailored to their needs rather than to the particular disabilities of long-stay patients, who often remain cognitively intact although still in need of a high level of support.

Thirdly, there are geographical limitations on placement in long-stay hostels and Part III accommodation, which often means that people are resettled in a place which is less than ideal for either themselves or their relatives. The catchment-area organisation of local authority accommodation of both types means that people may have to return to their borough of origin, despite the fact that decades spent in hospital mean that they no longer have any contacts there. Further, it is usually not possible to resettle people in groups or with friends they have made in hospital, who often originate from different boroughs. Although free from catchment-area constraints, voluntary hostels are not available in all areas of the UK, thus again the geographical choice is limited, and people are often resettled many miles from their previous homes and from any remaining relatives and social contacts.

Thus the available Part III and long-stay hostel accommodation offers limited choice and flexibility for resettlement purposes. This, together with the

shortage of places available, has led many to turn to the private sector. This sector is rapidly expanding as a result of the Department of Health and Social Security (DHSS) system of payments for residential care, which make the provision of residential homes an attractive business proposition. In consequence there is a wide variety of small private establishments available in most areas of the UK. These fall broadly into two categories: 'residential homes for the elderly', and 'very small homes'.

Residential homes for the elderly are small establishments (usually housing 8–15 people) and usually consist of large old houses, staffed and converted in line with local authority registration requirements. Despite the relative uniformity of these registration requirements, such homes are very varied in standards, practices and client group served. Some cater for more able elderly people, others take more confused and dementing residents. Often such establishments are run by nurses experienced in the care of the mentally ill.

'Very small homes' are homes housing three people or less and are therefore not liable for registration with the local authority. They are generally run in ordinary houses, with owners living either on the premises or nearby. In order to attract DHSS residential care payments they must satisfy the conditions laid down in the DHSS letter of August 1987 entitled "Supplementary benefit: very small homes". These regulations require, for example, that at least two responsible people, with at least one year's experience of caring for the relevant client group, are engaged in care duties; that at least one such responsible person is on duty throughout the day and night; and that residents have unrestricted access to the home at all times. Such homes must be distinguished from 'supportive lodgings', which do not offer 24-hour staffing or such a high level of input (and thereby attract a much lower level of DHSS payment).

There are clearly advantages and disadvantages with the use of private accommodation, but with the pressure to reduce the number of long-stay hospital residents, such facilities appear to represent an extensively used but underinvestigated resource.

The purpose of this study was to monitor and evaluate the initial success, or otherwise, of placing old long-stay psychiatric patients from a large London teaching hospital in private facilities. Most of these people were resident in a large old long-stay unit of the hospital which it is hoped will close soon, with limited community developments for residents currently planned. Thus the available options for the majority were either resettlement in existing accommodation in the community, or return to the main hospital. In the light of the extreme shortage of suitable voluntary or statutory provision in the area, for many the private sector was the only option.

Method

Subjects

Seventeen old long-stay hospital residents (seven men and ten women) who had been resettled in private residential homes for the elderly or 'very small homes' were the subjects in this study. Their mean age was 72.1 years (s.d. 7 years), and mean length of continuous hospital stay was 23.6 years (5–44 years).

Materials

Functioning of residents

The functioning level of the residents was assessed using the Behaviour Rating Scale of the Clifton Assessment Procedure for the Elderly (CAPE; Pattie & Gilleard, 1979). This scale provides a measure of an individual's level of behavioural disability and has been widely used to assess the functioning level of elderly psychiatric and psychogeriatric patients. The rating scale is completed by an observer familiar with the subject's behaviour, and provides a measure of four principal areas: physical disability (Pd), apathy (Ap), communication difficulties (Cd), and social disturbance (Sd).

Quality of the physical and social environment

The quality of the physical and social environments in each of the homes used was investigated using measures developed by Willcocks *et al* (1986) in their similar, but much larger, cross-sectional National Consumer Survey of 100 public sector residential homes. This measure was used as it was considered important that the quality of private care should be compared with that available in the equivalent, non-psychiatric, public (local authority) sector facilities, and not with the hospital care that all residents had previously experienced. This was done because, if community care and resettlement are to present positive advantages for people with psychiatric disabilities, it is not sufficient to take the poor practices and facilities obtaining in most old long-stay areas of large psychiatric hospitals as the point of comparison. The scale considers four dimensions of the social environment that research has shown to be important.

(a) choice/freedom: the degree to which residents have a choice or degree of freedom over their lifestyle; e.g. meal times, going out, getting up
(b) privacy: the availability of privacy, both personal and in interactions with others
(c) involvement: degree of resident participation in the organisation of home life, and their knowledge concerning how the home is run
(d) engagement/stimulation: the degree to which staff encourage resident autonomy and independence.

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In terms of the physical environment, scales developed by Willcocks *et al* (1986) were employed to assess the following key dimensions.

(a) physical amenities: those features of the environment which add to convenience or increase comfort; e.g. toilets within 10 metres of lounges and dining rooms; bedside lights
(b) social/recreational aids: facilities which encourage recreational activities or increase social interaction; e.g. more than one television; chairs in the entrance hall
(c) prosthetic and orientational aids: aspects of the physical environment that enable residents to negotiate the setting and carry out activities of daily living without unnecessary dependence on staff; e.g. WCs that will accommodate wheelchairs; noticeboards
(d) safety features; e.g. call systems
(e) architectural choice: features of the environment that allow control and choice; e.g. control over bedroom heating; windows that open.

These scales were completed by a senior staff member in the home. High scores indicate a more progressive style of organisation and social environment within the home, with an emphasis on residents being treated as individuals with some control over their lives, and a high level of physical amenities.

Regime characteristics

In order to offer an overall assessment of the characteristics of the regime in the home, two further scales developed by Willcocks *et al* (1986) were employed: resident-oriented practices (those aspects of the physical and social environment designed to facilitate resident actions), and staff-oriented practices (those aspects of the physical and social environment designed to facilitate staff actions). High scores indicate a high level of facilities in each domain.

Resident satisfaction with life at the home

Resident satisfaction was assessed by interviewing residents using an adaptation of parts of a schedule developed by Willcocks *et al* (1986). This involved the following components:

(a) overall satisfaction with life in the new environment, measured on a four-point scale, from very satisfied; this was compared with a retrospective judgement concerning satisfaction with life at the hospital on the same scale, and a question concerning whether or not the person would like to return to the hospital
(b) satisfaction with staff, assessed by a series of questions concerning the person's satisfaction with interactions with staff
(c) adjustment to home life, measured by a series of items concerning how easy the person found adapting to life at the home when they first moved in
(d) worries about aspects of home life.

Procedure

Prior to all resettlement plans, all residents at the long-stay unit were assessed using the CAPE Behaviour Rating Scale. This scale was administered by a senior nurse from outside the unit on the basis of information gained from the staff working there. For all those residents who had been resettled in private facilities, a follow-up survey was conducted in which a psychologist interviewed each of the residents using the modified Willcocks *et al* (1986) instrument designed to assess satisfaction with home life. All interviews were conducted in private and the residents were informed that their replies would be confidential. A social worker, trained in the use of the instruments, completed the CAPE Behaviour Rating Scale for each resident in conjunction with staff at each home. The questionnaires concerning quality of the social and physical environments and regime characteristics were completed, in the manner described by Willcocks *et al* (1986), by senior staff at the home assisted by a social worker.

Results

Placements

Of the 17 people resettled, 12 (70%) had been placed in five private residential homes for the elderly, and the remaining 5 in three 'very small homes'; 13 (77%) had been placed within small groups of people whom they knew from the hospital, and four had been placed alone. At the time of the follow-up, residents had been living in their new community accommodation from 1 month to 13 months.

Satisfaction with the placement

Twelve of the residents said that they were very satisfied with life in their new homes, and the remainder were "fairly satisfied". No one was "not very satisfied" or "not at all satisfied". None of the 17 residents said that they wanted to return to the hospital: four said that they were equally satisfied with life in their new accommodation as they had been in hospital, and the remainder (76%) said that they were more satisfied with life in their new accommodation. The reported satisfaction of those who had been in their new accommodation for some time and those who had only recently moved in did not differ.

Thus, all residents were satisfied with their new homes and wanted to remain, and most preferred life there to life in hospital.

Resident functioning

The CAPE Behaviour Rating Scale scores of residents can be seen in Table I. The total scores before and after resettlement, and scores in the four principal areas, were compared using Wilcoxon test statistics. The comparison showed a significant decrease in total Behaviour Rating Scale scores, indicating an overall decrease in disability level ($T = -18$, $P < 0.05$). There was no significant change in scores in the areas of communication difficulties and social disturbance, but there was a highly significant decrease in apathy scores ($T = -12$, $P < 0.01$), and a decrease in physical disability scores ($T = -18$, $P < 0.05$).

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TABLE I
CAPE Behaviour Rating Scale scores before resettlement and at follow-up (n = 17)

	Before resettlement		*At follow-up*		*Wilcoxon* T
	Mean	s.d.	Mean	s.d.	
Age: years			72.1	(7.0)	-
Length of hospital stay: years	23.6	(14.3)	-	-	-
Total Behaviour Rating Scale score	8.8	(6.1)	5.6	(4.0)	$T = -18$*
Physical disability (Pd) score	2.7	(2.9)	1.4	(1.7)	$T = -18$*
Apathy (Ap) score	5.2	(3.5)	3.7	(2.5)	$T = -12$**
Communication difficulties (Cd) score	0.1	(0.5)	0.3	(0.6)	$T = -54$
Social disturbance (Sd) score	1.1	(1.7)	0.6	(1.1)	$T = 31.5$

*$P < 0.05$; **$P < 0.01$.

This indicates that most of the improvement in overall functioning could be accounted for by a substantial improvement in residents' constructive engagement with, and involvement in, their environment, and a decrease in the input they required for bathing, dressing, going out, etc.

In order to check that a 'honeymoon effect' in those who had only recently moved did not unduly bias these findings, the changes in CAPE Behaviour Rating Scale scores of those who had been resettled for some time and those who had only recently moved were compared. There was no significant difference in the changes in scores of these two groups ($U = 19$, $P < 0.05$).

Quality of the social environment

Scores on the four scales relating to the social environment were compared with those obtained in the Willcocks *et al* (1986) study of a representative sample of 100 local authority old people's homes. This was achieved by converting the scores for each of the private establishments into z scores using the means and standard deviations obtained in the Willcocks *et al* study.

These scores showed that the quality of the social environment in each of the private homes used was higher than that found in the average local authority old people's home: in all areas the average score of the private homes used was at least one standard deviation higher than that of their statutory counterparts. In comparison with local authority homes, the private facilities used scored, on average, 1.7 standard deviations higher on the 'choice/freedom' scale (range 0.7–2.2), 1.4 standard deviations higher on the 'privacy' scale (range 0.8–1.8), 1.0 standard deviations higher on the 'involvement' scale (range 0.2–1.5) and 3.0 standard deviations higher on the 'engagement/stimulation' scale (range 1.6–3.4). In particular, these scores indicate that the average engagement score (the degree to which resident autonomy and independence were encouraged) was equivalent to that of the best 1% of local authority homes, and the average choice/freedom score (the extent to which residents had choice/freedom over their own lifestyles) was equivalent to that of the best 5% of local authority homes.

Thus it is clear that the quality of the social environment in the private homes used was superior to that found in most local authority old people's homes: residents had greater choice/freedom, more privacy, and a greater involvement in the organisation of home life, and were encouraged towards greater autonomy and independence.

Quality of the physical environment

Scores in the areas of physical environment assessed were also converted to z scores to permit comparison with the standards obtaining in the local authority old people's homes in the Willcocks *et al* (1986) study.

In comparison with local authority homes, the private facilities used scored, on average, 0.9 standard deviations higher on the 'physical amenities' scale (range 0.2–1.6), 0.5 standard deviations higher on the 'architectural choice' scale (range −0.4–1.0), and 0.2 standard deviations higher on the 'safety features' scale (range −1.5–1.8). However, the private homes scored lower than the local autority homes on the 'prosthetic aids' scale (mean z score −2.4, range −4.3–0.4), the 'orientation aids' scale (mean z score −0.9, range −1.8–0.2) and the 'social/recreational amenities' scale (mean z score −0.3, range −1.0–1.7).

This suggests that, whereas the physical amenities, architectural choice (features that allow the individual control and choice), and safety features were of a similar standard to those found in most local authority homes, there were generally fewer prosthetic and orientational aids and social/recreational amenities provided on site. The private facilities were not, in general, equipped with lifts, handrails, specially converted WCs, signs, colour-coded routes, on-site bars, recreational rooms, etc.

Regime characteristics

The scores on scales relating to resident- and staff-oriented features of home life were converted to z scores in the manner described previously, to allow comparison with

those found in local authority old people's homes. This indicated that the private homes were more resident-oriented than their local authority counterparts (mean z score for resident-oriented policies scale 1.3, range 0.15 – 1.9), and had lower levels of staff-oriented policies (mean z score – 1.8, range – 1.4 to – 2.2). Thus it appears that the private facilities had more aspects of the physical and social environment designed to facilitate resident actions, and fewer designed to facilitate staff actions, than the local authority homes: they were more resident-oriented environments.

Discussion

This follow-up study clearly showed that the old long-stay residents resettled in private accommodation were all at least equally satisfied with life in their new homes as they had been with life in hospital, and none wanted to return to hospital. Although not directly comparable in this context because of the different previous accommodation of the subjects, the Willcocks *et al* (1986) study found that only 45% of the 1000 residents of local authority old people's homes interviewed maintained the same level of satisfaction before and after their move. The high level of satisfaction is gratifying given that all but two of the people resettled were reluctant to leave hospital: they were not a group who were highly motivated to leave and had the unit not been designated for closure, many may well have remained in hospital unnecessarily.

Not only did residents express satisfaction with their new surroundings, their functioning, as measured by the CAPE Behaviour Rating Scale, improved significantly. As might be expected with a group such as this, communication difficulties and social disability scores remained static despite resettlement; however, it is particularly interesting that their apathy scores decreased dramatically. This is particularly important in the light of some of the problems that have been experienced with the use of group homes for old long-stay hospital residents. Ryan (1979) found that with inadequate supervision underactivity in group homes was a major problem.

The significant decrease in physical disability scores was rather surprising, but probably resulted from a decrease in staff input in such areas as bathing, dressing and going out, resulting from the private facilities' emphasis on individually tailored care. In the hospital unit where most of the sample had been living, block treatment was prevalent, and, for example, the routine required that everyone be supervised while having a bath, irrespective of their needs.

Any conclusions drawn from the present data must be cautious in the light of the small sample size, and short and variable length of follow-up. Clearly, longer-term follow-up would be desirable, but clinical experience suggests that a high proportion of unsuccessful placements break down in their initial stages. The short-term results are promising and suggest that further exploration of this type of facility would be worthwhile. The results obtained here are quite different from those of Linn *et al* (1985), who found private nursing home accommodation in the USA to be a less desirable alternative to hospital admission in terms of resident satisfaction and functioning. The studies are not directly comparable in terms of their methodology and client group considered (the Linn *et al* study involved a considerably younger group of patients, with a mean age of 62.6 years, a large proportion of whom suffered from organic brain syndrome). Nevertheless, the marked difference in results does suggest that UK private residential accommodation for the elderly is not comparable with US nursing home accommodation, and may represent a desirable alternative to hospital admission for old long-stay psychiatric patients.

Turning to the homes themselves, the quality of the social environment within them is superior to that found in most local authority old people's homes–the statutory alternative for elderly people in need of sheltered and supported accommodation. People in smaller private accommodation had greater choice about their lifestyle and privacy, were more involved in the running of the home, and were encouraged to a greater degree of autonomy and independence than they probably would have experienced if they had been placed in Part III accommodation (and certainly greater than they experienced in hospital). In addition, the policies in the homes used were more resident-oriented and less staff-oriented than those in most similar local authority establishments, or in hospital: the social and physical environment was designed to facilitate resident, rather than staff, actions.

In terms of the physical environment in the private facilities, the physical amenities, safety features, and architectural choice were at least comparable with those found in most similar local authority provision, but there were fewer prosthetic and orientational aids available, and fewer on-site social/recreational aids. This is probably a reflection of the more domestic style of the accommodation: there may be a 'trade-off' between the introduction of such aids and the domesticity and normality of the environment. This would mean that such private establishments are relatively unsuitable for people with needs in these areas.

This study does not purport to offer a representative picture of the social and physical environments in

private facilities. The establishments used in this study were vetted and selected before resettlement was considered, and several potential places were rejected. Instead, these data probably reflect what can be found in the private sector, rather than what is typical of that sector. The possibility of such selectivity is a key feature of the private sector: there is a greater range of choice available in the current financial climate than pertains in the statutory domain.

Despite the apparent advantages of private facilities, the potential problems associated with their use must not be underestimated. Their quality is variable, and careful assessment and selectivity is required. They have no statutory obligation to continue to provide care: although standards are monitored, there is nothing to prevent private facilities going out of business. Finally, the use of DHSS funding is a matter of concern. Currently rates are high enough to make such homes a viable economic proposition for their owners. However, if there are changes in the system, or the benefit level drops in real terms, then the placements could be in jeopardy. Continued monitoring and follow-up on the part of the resettling team is therefore essential. It is critical that the resettling team, or some other statutory group, undertake indefinite monitoring and follow-up of residents resettled in such facilities, and that careful resettlement plans are made.

In the resettlement process described here a detailed follow-up and continuing care plan for each resident was drawn up prior to discharge. This included specification of a continuing care key-worker (from among the team who was looking after the person in hospital) and specification of the minimum frequency with which the person had to be visited. The team is committed to long-term follow-up and support without limit of time. Intensive, and indefinite, follow-up of this sort is necessary given the non-statutory nature of the placements and the degree of support and advice that the staff of the private facilities require (from difficulties with the DHSS to individuals' behavioural problems). The continuing cost and staffing implications of this must not be underestimated, but current results indicate that private homes for the elderly are a resource that cannot be ignored.

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