



The High Support Hostel in Ireland:

A descriptive study using the

Needs for Care Assessment

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Abstract**Background**

A description and evaluation of the high support hostel system was indicated to determine whether the needs of residents were being met in community placements.

Method

Ten hostels staffed with 24hr nursing care were studied and a stratified random sample was taken of 50% of the residents of each hostel. Medical Research Council (MRC) Needs for Care Assessment (NFCA) was conducted with 61 residents.

Results

The NFCA indicated the mean number of clinical problems and social problems per person was 4.1 and 3.9 respectively. The main areas of unmet need were: "positive psychotic symptoms", "tardive dyskinesia", "neurotic symptoms" and "occupation". The ratio of met to unmet needs was 3:1 with the mean number of clinical and social unmet needs 1.3 and 0.7 per person respectively.

Conclusions

There were unmet needs for both clinical and social problems. The high level of clinical problems indicates a need for assessment and medication review. Unmet need for "occupation" indicated that some residents require work and occupational activities. Half of the hostel residents were long stay elderly residents requiring long term care

INTRODUCTION

In Ireland the number of people in long term care in psychiatric hospitals has fallen and at the same time the number of people in long-term community based accommodation has increased (Health Statistics, 1993). Policy documents like *Planning for the Future* (Government publications, 1984) recommended accommodation that included high support hostels with 24hr nursing staff. High support hostels were envisioned as providing an alternative living environment for patients with high dependency needs who were becoming new long stay in psychiatric hospitals. There exists a number of well described alternative community based facilities designed to meet the needs of former new long-stay patients with high levels of psychiatric illness and disability (Wykes, 1982), (Garety & Morris, 1984), (Gibbons & Butler, 1987), (Simpson *et al.*, 1989).

Needs based assessment has led to resource allocation on a more individual basis tailored to the circumstances and individual need (Slade & Thornicroft, 1995). The *Needs For Care Assessment* (NFCA) was developed specifically by the Medical Research Council (MRC) to measure the needs of the long term mentally ill. Descriptions of the concepts and use of this standardised assessment procedure were published by the unit (Brugha *et al.*, 1988), (Brewin *et al.*, 1987), (Brewin & Wing, 1989). Validity and reliability studies have reported very good inter-rater reliability rates and a high level of agreement between raters and treating psychiatrist (Van Haaser *et al.*, 1994).

The NFCA has been used in a variety of settings including day hospital attenders, long-stay hospital in-patients and homeless hostels. (Brugha *et al.*, 1988), (Pryce *et al.*, 1991a, 1993b), (Hogg & Marshall, 1992). There has been no published study on the use of this instrument in high support hostels. The standardised assessment was considered appropriate for the hostel group as both functioning and care provision are evaluated.

METHOD

Aims and objectives

This aim of this study was to evaluate the high support hostel accommodation in one health board area. The objectives of this study were: to describe the high support hostel accommodation, to carry out the NFCA with residents in each hostel, and to discuss the findings in light of existing policy documents.

High support hostels

For the purpose of this study high support hostels were defined as community based residential accommodation with 24 hour nursing care. Hostels open and functioning at least one year and located outside of hospital grounds were included in the study. The sample was drawn from all the high support hostels in the Eastern Health Board. Ten hostels were studied, 9 urban, and 1 rural. This excluded two hostels, one on the basis that it was on hospital grounds and one that was open less than one year.

Sampling

A stratified sampling technique was used and a random sample of 50% of the population of each hostel was selected for further study with the NFCA. Of the total population of 139 residents, 71 were sampled. Ten residents were excluded for the following reasons: 3 refusals, 2 deaths, 2 hospital re-admissions and 3 moves to lesser support environments. No significant difference was found on variables; age, sex, diagnosis and length of stay in hospital, with our final sample. Informed and written consent was obtained from the sample of 61 residents.

Data

Information on hostels and basic socio-demographic data on residents was gathered using a staff interview, chart review and semi-structured questionnaire. The questions covered aspects of the hostels functioning and the resident's participation in programmes and attitudes.

The data collected included:

- (a) Basic description of the hostels: size, bed numbers, staff and functioning
- (b) Patient characteristics and demographics; age, sex, diagnosis and attitude to placement
- (c) MRC Needs for Care Assessment

Interviews with residents were of 40 minutes duration and completed by a psychiatrist. A resident attitude and satisfaction questionnaire was also administered. Subsequently, a MRC "Needs for Care Assessment" was performed by an assessment team consisting of a Consultant Psychiatrist, Senior Psychiatrist, Community Psychiatric Nurse (CPN) and a Research Psychologist. A MRC researcher who had extensive experience with the NFCA provided training. The method of assessment followed was as set out in the MRC "Needs for Care Manual" (Brewin & Wing, 1989).

The NFCA uses a systematic procedure that evaluates the need status of patients on 21 clinical and social categories. The schedule makes use of other instruments including: the Present State Examination, 9th edition P.S.E., (Wing *et al.*, 1974) for assessing clinical symptoms; the Abnormal Involuntary Movements Scale (A.I.M.S), (National Institute of Mental Health, 1974) to assess the presence, extent and severity of Tardive Dyskinesia; the Mini Mental State Examination MMSE (Folstein *et al.*, 1975) to assess cognitive functioning and the Modified Social Behaviour Schedule (SBS) (Wykes & Sturt, 1986) to assess the presence and severity of problem behaviours.

RESULTS

Description of Hostels

High support hostels were low visibility large terraced or semi-detached houses in largely urban neighborhoods. Approximately 14 male and female residents live together often sharing a room with one or two others of the same sex. Day staff consists of 2 psychiatric nurses, a nurse's aide and a domestic/cook. Staffing varies considerably between hostels. Programmes of a recreational and/or therapeutic nature were offered and these were generally informal. Some residents attend facilities outside of the hostel during the day. There was a homely atmosphere but there was also a need for attention to maintenance. The staff wears informal clothes and assumes a relaxed attitude. One room is set apart as an office where medications and files were kept.

Residents help with chores and duties in the hostel which were organised, supervised and prompted by the staff. Residents attend a local general practitioner for their medical needs and a psychiatric outpatient's clinic for psychiatric review and medications.

The majority of the hostels 8 (80%) have been opened in the past 5 years, but 2 (20%) have been open 20-25 years. The hostels were all located in domestic houses, with the exception of one. Capacity of hostels varies, with the average number of bed places 14.6, range of 10-20. The 10 hostels had 146 places in total. Five (50%) of the hostels were within walking distances (less than 2km) of the area hospital the other 5 (50%) were more than 5kms away. All of the hostels were under the ownership of the health board.

The majority of hostels do not have a written policy statement. When staff were asked to comment on what they considered the function of their hostel, 7 (70%) of hostels were said to provide

a mixture of functions, rehabilitation, support/shelter and crisis intervention. Staff in one hostel considered its main purpose was for rehabilitation and training. Staff in 2 (20%) hostels saw the primary function of the hostel as solely shelter and support.

Aftercare and monitoring for individuals living in the locality in nearby lesser support environments was provided by 3 (30%) hostels. These hostels' supported 10-23 other people. This support ranged from help with medication, to provision of a day care or a drop-in centre with casual support and social contact. Five (50%) of the hostels had a respite bed for crisis intervention. These were often used for ex-residents who required brief periods of a higher level of care. One hostel provided two crisis/respite beds.

Characteristics of residents

Of the sample of 61 subjects, 35 (57%) were female, and ages ranged from 31-84 years with an average age of 58 years. One quarter of the sample was over 65 years old. The primary diagnosis was schizophrenia for 37 (60.7%) residents, a range of other diagnoses were represented at less than 10%, these included: manic depressive psychosis, depression, personality disorder, mental handicap, schizo-affective psychosis, alcohol dependency syndrome, organic brain syndrome, and anxiety neurosis. The MMSE mean score was 21.2 with a range of 8-29 (sd=5.2).

The length of continuous stay in hospital prior to hostel residence ranged from less than 1 year to 40 years with a mean of 12.1 years. Thirty-one (51%) subjects had been hospitalised for more than 5 years on at least one occasion and were considered old long stay. New long stay residents who had spent less than 5 continuous years in hospital comprised 29(47%) of the sample. Length of hospital stay for one resident could not be determined.

While the majority of subjects come straight from hospital to the hostel, 53 (87%), five (8%) came from a lower support hostel, two (3%) came from another high support hostel and 1 (2%) came directly from home. The mean length of time spent in current hostel placement was 3 years with a range from 5 months to 13.5 years.

Over one third of subjects have some physical disease or condition (22) 35.3% requiring medical treatment, separate from their psychiatric illness. These included a range of common disorders: hypertension, chronic chest complaints and arthritis. Eight (13.1%) had a current problem with alcohol or substance abuse.

Behavioural characteristics of residents

The scores on the Modified Social Behaviour Schedule are shown in Table 1. This illustrates problem behaviours that occurred at a moderate or severe level within the past month according to staff report.

Thirty seven (61%) residents had no re-admissions to psychiatric hospital since their move to hostel accommodation and for those with a re-admission 20(33%) of these had only a short stay. Five (26%) stayed less than one week and 10 (53%) stayed less than one month. Only one admission lasted more than three months. Psychiatric relapse, accounted for 16 (80%) of re-admissions. Two people were re-admitted to the psychiatric hospital during times of physical illness. One person absconded from the hostel and was re-admitted to hospital as part of a behavioural plan and one required admission to stabilize following a grief reaction to bereavement.

Table 1. Moderate or severe problem behaviours of residents

N=61

BEHAVIOURS	SUBJECTS
No problems	3% (2)
Depression	43% (26)
Suicide (threat and/or attempt)	12% (7)
Anxiety	49% (30)
Slowness	41% (25)
Underactivity	53% (32)
Overactivity	39% (24)
Elatedness	21% (13)
Odd gestures/mannerisms	53% (32)
Delusions/hallucinations	36% (22)
Attention seeking	41% (25)
Aggression(verbal and/or physical)	33% (20)
Obsessional	31% (19)
Unusual non-verbal communication	41% (25)
Impaired conversation	49% (30)
Initiation of conversation (30)	49% (30)
Eating habits	33% (20)
Other problems: alcohol abuse	8% (5)
Inappropriate sexual behaviour	7% (4)

Involvement with the police as either victim or perpetrator was minimal. 57 (93%) had no involvement with the police. Four (7%) were victims usually of petty theft or mugging, no hostel resident had any contact with the police as a perpetrator during the time they had been resident in the hostel.

Hostel staffing

The staffing of the hostels was not uniform. The range of staffing levels was between 1-3 nursing staff on duty during the day, and, in all cases, only one night nurse. Sixty percent (6) of the hostels had the help of a nurse aide during the day and all but one hostel had the assistance of a domestic. The mean number of staff on duty during the day was 3.5. This mean figure contains both nursing and non-nursing staff. In addition, many hostels have student nurse placements.

In the hostels the residents actively participate in the general running of the household. This was in part for therapeutic purposes allowing staff to train residents in daily living skills. The staff prepares a rota, and residents perform a variety of household chores. In all hostels, tasks were completed, with the assistance of the staff members. The residents were rarely solely responsible for tasks. The residents shop with staff in 4 (40%) of the hostels while in 4 (40%) of the hostels the staff were solely responsible for shopping for the hostel. In the remaining 2 (20%) of the hostels goods were delivered from the hospital stores. The staff and residents prepared meals together in 7 (70%) of the hostels, the staff were solely responsible in 1 (10%) hostel and in 3 (30%) an outside agency the hospital prepared and delivered meals.

Programme and progress review

The majority of hostels 6 (60%) had at least 75% of residents leaving routinely during the day for a variety of outside services and activities in the locality. While in 3 (30%) of the hostels only 25%

to 45% of the residents routinely left the hostel for the day. In one hostel only 10% of residents left the hostel during the day.

Formal and informal programmes and therapies were offered in 9 (90%) of the hostels. Some of these included: behavioural therapy, social skills training, light industrial work and craft activity groups and outings. No informal programmes were attended and/or offered to 14 (23%) of residents in the hostels. The internal programmes were primarily informal that is, without regular review of goals, and were run by the nursing staff. No programmes were attended outside the hostel by 34 (56%) of residents.

A psychiatrist was involved in a formal programme review with the nursing staff in 8 (80%) of the hostels. None of these reviews involved direct input from a general practitioner, social worker, occupational therapist or psychologist and only 3 (30%) hostels involved a community psychiatric nurse review.

Staff Comments

Staff were asked if they felt supported in times of crisis and 7 (70%) felt that they had adequate support but 3 (30%) felt they would need better support. There was a general feeling from staff in 4 (40%) of hostels that they could manage hostels better if they had their own budget for maintenance and repair. Two (20%) of hostels suggest that if there was more nursing support when residents were seriously physically ill they could be maintained in their hostel environment rather than be readmitted to hospital.

Staff were asked whether they felt the hostel residents could move to a lesser supported environment, 2 (20%) of hostels felt that it would be unrealistic for any of their group of residents to move to lesser support. This was due to severity of illness and the elderly age of residents. One

hostel was designed as a training hostel and staff envisioned that 75% of the hostel residents could move in time to a lesser support environment and more independent living.

Resident attitudes

The majority of residents 50 (82%) were happy and content in the hostel. Nevertheless 19(31%) expressed a desire to be moved elsewhere, including home, hospital and lower support hostel. Some of these residents expressed contentment but also wanted to move to other accommodation.

Needs for care assessment

The results of the NFCA indicate a high level of disability both currently and in the recent past, see Table 2. The mean number of clinical problems per person was 4.1, (3.4 current, 7.2 recent). The mean number of social problems per person was 3.9, (3.7 current, 2.6 recent). Met and unmet needs for the 21 subcategories of clinical and social and functioning are shown in Table 3.

programmes and activities but they wanted staff to provide these programmes as they felt unable to do this for themselves.

Needs for care assessment

The overall high rating of problems demonstrated that hostel residents have high levels of psychiatric and social disability. The findings indicate high support hostels were maintaining residents in the community with higher levels of disability than psychiatric inpatients (Pryce *et al.*, 1991).

In the month before the interview, the most common clinical and behavioural problems were positive psychotic symptoms, drug effects, neurotic symptoms, violent and socially embarrassing behaviour. These problems were present in a majority of subjects. This indicates a need for regular psychiatric assessment and review of medications. Signs of dementia were rated by MMSE in 16% of subjects, although presentation was not at the stage of being a management problem; half of these had an unmet need for further assessment.

The high support hostel appeared to meet some needs across the broad range of problem areas. However, there were significant difficulties in the areas of personal hygiene, ability to household shop and in the management of money and communication. Each subject had at least one problem area with a mean of over four clinical problems and almost four social problems per person.

Education and occupation were rated either as not applicable or not known if it was felt that any remedial intervention in this area would be inappropriate due either to the clinical status or the age of residents. Only a small number of residents were found to have a problem with education but the NFCA threshold was found to be low. Eighteen percent of residents were noted as having a problem in the area of occupation and of these 73% were recorded as having unmet need.

There were some difficulties using the NFCA in this high support hostel setting. One of the main problems was the sheltered service type of hostel. These hostels often did not give patients the opportunity to train for independence in individual shopping, getting meals, and using public transport. Thus, these areas were difficult to assess but were rated as needs for assessment if the overall clinical picture appeared to suggest that the resident could be expected to move to a more independent setting.

The homeless hostel residents with mental illness group studied in Oxford (Hogg & Marshall, 1992) had many similarities to the group in the high support hostel study. This is not surprising as it had been shown previously (Marshall, 1989) that the residents of homeless hostels can have disabilities similar to psychiatric long stay inpatients. It is of note that the group in psychiatric care had significantly more problems with drug side effects and fewer problems with occupation, use of public amenities and socially embarrassing behaviours than the homeless. The increased clinical input and emphasis on occupation in the psychiatric high support hostel study should have produced less medication side effects in a constantly supervised group. The fact that high support hostels had fewer people with socially embarrassing behaviours could be explained by the fact that high support hostels were less tolerant of behaviours due to substance abuse. Patients with persistent problems with alcohol or drug abuse were not generally accepted as residents. Both study groups experienced difficulty in assessing social needs where meals were provided and managed as part of an overall service delivery.

least for some individuals sheltered work and occupation opportunities should be made available. There was difficulty in distinguishing which factors exclude individuals from community residences. The high levels of disability maintained in the community by the high support hostel system in this study were comparable to or higher than those maintained in psychiatric hospital as measured by the NFCA by previous studies in the U.K. (Pryce *et al.*, 1991). Further research could contribute to our understanding of this problem. Finally, the needs for community placement for the new long stay and acute psychiatric patients leaving hospital should be considered. The number of places in highly staffed hostels taken by elderly, chronic residents in need of support and shelter accommodation should be re-evaluated and a better use of resources should be considered.

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