

Back to the asylum

Danny Allen

As hospitals close and relocate, our patients are increasingly being moved between different sites and out into the community. A move back to a large institution, however, is rare. This article describes the move of an in-patient facility located in a general hospital to an old psychiatric hospital with which, historically, it did not have very strong links.

The Susan Britton Wills (SBW) Unit was opened in 1969 as a clinical facility for the Professorial Department of Mental Health (Bennet *et al.*, 1989). It was based in the old Sisters' Home attached to Bristol General Hospital (BGH) near the city centre and ran a flexible service combining in, out and day patient care (Bennet *et al.*, 1988) as well as dealing with ex-patients who used to drop in.

After a period of debate it was decided that the financial and management problems of having to staff a unit at some distance from the rest of the service, particularly when difficult to manage patients had to be transferred to the main hospital, meant that it would have to move. The in-patient unit was contracted and the remainder of its beds were moved to Barrow Hospital, the main psychiatric facility for the trust area, situated outside the city.

Practical aspects

After several planning meetings it was accepted that the move was inevitable and as in other cases (Bowen *et al.*, 1993), it was discussed in patient groups. Certain aspects remained unresolved until just before the move. An initial idea that 25 patients receiving depot injections from in-patient nursing staff could be maintained by the day hospital was impossible because of inadequate staffing levels and as the community psychiatric nursing service was understaffed patients had to go to their general practitioners for injections.

The plan was to reduce the beds from 26 to 13 over the six weeks prior to the move in order to reduce the overall number of beds in the service. However in the absence of an enhanced community service, patients continued to require hospital admission during the changeover period and consultants at Barrow took a proportion of the cases for a limited period, resulting in some

disruption to continuity of care. After the move one consultant remained at the SBW day hospital while the other took over the care of all the patients who have moved as well as all those admitted to Barrow over the preceding six weeks.

Another aspect of the move was the need to arrange alternative patterns of support to the patients who used to drop in to SBW. Telephone callers were directed to the new unit but the day hospital could provide only a limited service for casual callers. Patients who had been given depot injections at the unit, some of whom had not been seen for some time by a doctor, were reviewed in the out-patients department, and their need for community follow-up assessed. This resulted in a few patients, who had viewed the SBW Unit as their only community support, being allocated to community psychiatric nurses (CPNs) and social workers in the longer term.

Psychological aspects

Five months before it was due there was little enthusiasm for the move among both staff and patients. To some extent this was inevitable as change is always difficult; but there was also a feeling that a move to the 'asylum' was a retrograde step. A number of patients and ex-patients felt psychologically dependent on the unit; a few had been in-patients for quite a long time and two of these felt able to be discharged rather than take what they perceived as a regressive step. They both remained outside hospital while continuing to get support from the day hospital; although both had subsequent admissions to hospital these were only brief.

The few patients who were eventually to make the transition from one hospital bed to another were identified only in the few weeks prior to the move as they were those considered too ill to be discharged. Staff had been preparing the patients psychologically for some time prior to the move and most settled in quicker than many people had expected. This may also have been aided by the physically pleasant environment and space in the new ward, the SBW Unit having been allowed to run down and being rather cramped. After an initial period of uncertainty over jobs in the new unit a new team,

consisting of staff from the SBW Unit and those from Barrow Hospital, started to form.

Comment

Moving individual patients between hospitals is a relatively frequent occurrence and can have important effects on patients (Shugar *et al.*, 1980). These days it is also relatively common for whole units, usually for long-stay patients, to move from large old hospitals to new, often smaller and more community-orientated facilities (Thornicroft *et al.*, 1991). For economic and administrative reasons other long-stay patients have been moved between hospitals (Jones, 1991). Although descriptions of acute units moving do exist (Bowen *et al.*, 1993) there is no record of an acute unit moving into a psychiatric hospital from a general hospital.

Where social and illness behaviour have been measured (Jones, 1991; Thornicroft *et al.*, 1991) there was an improvement in social functioning and behaviour in those patients who moved to a rehabilitation unit, whereas there was a deterioration in those moved to another large psychiatric hospital. Unfortunately it was impossible to do a comparable study on our cohort of patients since the nature of an acute unit means that the group of patients who moved was not known until shortly before the move and some had been admitted only a few weeks before. Some patients decided to 'vote with their feet' and indeed this may have been a healthy decision, but for others the move was traumatic although the notable lack of reported problems is reassuring and mirrors Bowen *et al.*'s (1993) findings.

One must have reservations about any move from a community based unit to an asylum. The management argument was that at times the SBW Unit was dangerous to run and that, despite high staffing levels, it was not self-sufficient, in that patients too difficult to manage there had to go to the observation ward at Barrow Hospital. Ultimately, of course, savings could be made by having both fewer beds and nurses. The idea of reducing in-patient numbers was not based on any imminent or existing community provision. Quite the contrary; the community nursing service was understaffed due to an ongoing review of skills mix and there was no hope of the community needs of the SBW patients being met until a considerable time after the move.

The resulting assessment of some previous attenders highlighted deficiencies in the pre-existing service, in particular the lack of co-ordination in their care. The move provided an

opportunity to examine their needs more fully and in some cases led to a more structured care plan. Unfortunately, due to a lack of clear documentation on everyone who used to drop in, it is impossible to say what befell many others although a certain proportion were later formally referred to the day hospital.

Conclusions

The problems of the move highlighted several aspects which could have been better managed. More sophisticated data on the existing activities of the unit would have made planning more realistic. A properly commissioned study of ways in which all the patient-care activities of the unit could be managed elsewhere would have obviated the last minute arguments as to where people would go when the unit closed. Clearer patient-centred management of the transfer of patients between consultants with the active involvement of the consultant body would have smoothed the transition. Clearer delegation of agreed plans through the management structure would have reduced the feelings of resentment and frustration on the ground.

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- Danny Allen, Senior Registrar, Blackberry Hill Hospital, Manor Road, Fishponds, Bristol BS16 2EW