Tuke House

Initial experience of a new community service for neurotic illness

DAVID NEWBY, Lecturer in Psychiatry, Manchester Royal Infirmary, Oxford Road, Manchester (formerly Tutor/Honorary Registrar, Department of Psychiatry, University of Leeds); B. LAKE, Consultant Psychotherapist, and A. C. P. SIMS, Professor of Psychiatry, St James's University Hospital, Leeds

'The number in each room rarely, if ever, exceeded ten. Here, I generally found several of the patients engaged in some useful or amusing employment. Every class seemed to form a little family . . . I incline to think, that the probability of recovery is greater, where a moderate number of patients associate together . . . I incline to think the number ought in no case to exceed fifteen'.

Samuel Tuke, 1819, *Practical Hints concerning the Building of Wakefield Asylum.*

Community care for psychiatric illness has been a prominent issue since Enoch Powell's memorable rhetoric in 1961,[1] but a major concern has been to know how best to provide it. The inadequacies of many forms of community care have been highlighted;[2,3,4] Jones[5] has described the resulting conflict as *Scull's Dilemma:* ". . . If it is wrong to get patients out of the mental hospital, and wrong to keep them in, what are we to do with them?" Various workers have pointed out that the implied dichotomy between the two patterns of care is inappropriate; the two are not incompatible. The question then becomes how best can hospital-based psychiatric services and practitioners adapt themselves to provide a comprehensive treatment extending into the community. Tyrer[6] has recently described one model for developing this by providing psychiatric clinics wholly based in general practice health centres.

Community care is particularly pertinent to the treatment of neurotic disorders: First, the effects of *institutionalisation* need to be avoided in treating neurotic patients; active participation in treatment is encouraged, rather than being a passive recipient; hospital admission may imply a handing over of all responsibility for the patient, resulting in inappropriate *illness behaviour*. Second, despite the problem of defining cases, community surveys indicate a prevalence of at least 10 to 15% in the general population for minor psychiatric disorders, only some 5 to 10% of these being referred by their general practitioner for psychiatric intervention. Clearly this leaves a potentially large 'hidden demand' for treatment of neuroses in the community. The present paper is intended to give a preliminary description of one model for meeting *some* of this demand in the shape of a community day unit for the treatment of neuroses.

Development of the Tuke House project

Discussions leading to the establishment of 'Tuke House' (named after Samuel Tuke, the Quaker mental health care reformer) began within the East Leeds Community Health Council in 1980; a paucity of provisions for treatments of neurosis and minor emotional disorders was recognised.[7] A joint planning group was set up including the District Community Physician, the Mental Health Adviser of the Social Services Department, the Secretary of the Community Health Council, the Regional Director of MIND and a consultant psychiatrist. This planning group assessed the needs for community treatment of neurosis, examined the feasibility of the proposed project and worked towards implementation. This culminated in the project being granted Joint Financing (both Local Authority and Health Authority) in October 1981 for a 'probationary' period of three years.

The treatment setting and approach

Early on the decision had been made that the project should be sited away from the hospital mental health services, but close to the 'consumers'—in this case within Chapeltown, a deteriorated inner-city suburb of Leeds where psychiatric morbidity was high. An ordinary domestic residence (a large Victorian semi-detached house) was chosen to provide an environment familiar to the future members rather than an overtly clinical setting. Essential repairs and minor modifications were carried out to make the house basically suitable for this purpose, but scope was left for members to make their own contribution to improving the structure and facilities. The centre was opened for treatment in 1983.

The core personnel involved are a co-ordinator and deputy co-ordinator, a part-time social worker (five sessions weekly), a community occupational therapist (ten hours weekly), a psychiatric trainee (five sessions weekly) and a consultant psychiatrist (two sessions weekly). The first two workers, being full-time in the centre, have a key role in the treatment programme on a day-to-day basis, and the decision had been taken that their professional backgrounds would not be stipulated in advance. In the event the first individuals employed were, respectively, a psychiatric nursing officer and an experienced social worker.

All aspects of treatment are conducted on a multidisciplinary basis, including the assessment procedure. Referrals from many sources and also self referrals are now accepted (the centre had been publicised in the media at the time of its opening), although referrals initially were mainly from general practitioners, hospital psychiatrists and social services. All referrals are seen for assessment in the house itself, and the procedure involves interviews with the psychiatric

https://doi.org/10.1192/S0140078900017569 Published online by Cambridge University Press

trainee and at least one other member of staff. New referrals frequently attend more than once for assessment and for them to visit Tuke House informally.

The role of the psychiatric trainee is to 'screen' for organic or psychotic morbidity which would preclude therapy in this setting, to assess referrals for suitability for treatment at Tuke House and to engage in the treatment programme. Other members of staff during assessment often focus on specific issues such as the prospective member's aims and expectations, and whether these are relevant to the approach offered. 'Self-responsibility' is central to the treatment ethos, and the ability of the potential member to formulate goals is an important factor. Selection is ultimately based on as few *exclusion criteria* as is practicable for offering treatment:

1. presence of major functional psychosis, organic psychosis or mental handicap;
2. physical illness which could preclude full participation in treatment;
3. indication of current serious suicidal intent or internally directed violence including repeated, continuing and uncontrolled self-abuse which would cause a major disruption to treatment e.g. drug/alcohol abuse, eating disorder, self-mutilation;
4. externally directed violence which could harm members, staff or the local community;
5. inability to make commitment to 3-month course either on whole-time or part-time basis either because of difficulties from employment or inability to make voluntary regular commitment;
6. after full explanation of treatment subject excludes him/herself.

Following the assessment interviews, each referral is discussed amongst the staff and a consensus decision made, but in view of the emphasis on self-responsibility, the ultimate criterion for treatment is whether the potential member decides to accept the offer of a place. Members entering for treatment have a wide variety of moderate or severe difficulties across the spectrum of neurotic and personality disorders.

The treatment ethos

Treatment is based on a group approach in a setting in which the members can engage in interpersonal and social learning. The treatment ethos is characterised by an educational rather than a sickness model. It is essentially pragmatic, open to regular monitoring and adaptive change. It provides the opportunity for approximately ten members to engage in a 'living and learning' process, currently based on a seven hour day, five day week, over a 13 week period. It accepts those suffering from neurotic disorders which are not responsive to other treatments and who want to play an active and responsible part in their own therapy and are thought likely to fit into and benefit from the culture of the unit. The focus is on learning both to explore and share interests with peers and in learning to give and receive mutual support, and to recognise and cope with resistance achieving their own goals.

The differences between staff and members are recognised in their roles but minimised by the explicit recognition that both members and staff are engaged in a learning process which is goal-directed. The sharing of decisions amongst staff of different disciplines, and between staff and members is regarded as desirable, and is both discussed and encouraged. This includes decisions about admission, discharge and the goals of therapy, particularly during the process of assessment. Rules are kept to the minimum necessary for the safety and the well-being of all.

Therapy includes the detailed diagnostic and therapeutic assessment described above. Considerable time and effort is spent on clarifying the problems of potential members, discussing ways in which they would like to change and in exploring approaches to learning which they find most helpful. Potential members are therefore advised to visit Tuke House and meet and discuss with the therapeutic team the various treatment approaches and their reaction to them. A clear understanding of the therapy and of the role of member and therapist is emphasised.

Members are helped throughout to find out what they want from therapy and, as far as possible, to make target goals for themselves for the 12–13 week course, and to discuss plans for achieving them. The treatment is so geared that it is continuously negotiable and responsive to individual needs. Members meet in both informal settings and in a series of formal groups. Three groups in the week are focused on problem solving, self management, and social coping skills and are concerned with increasing the members' personal and social competence at home, at work, and at leisure. These may include role play and relaxation exercises. One group in which all members engage has a distinctive psychodynamic profile but could be described as an 'eclectic interactive' (Yalom type) approach.[8] The emphasis is on appropriate self disclosure, reflection and interpretation. A health education seminar followed by discussion is given each week; this provides useful information on subjects of interest to members, such as stress, anxiety and depression. Each member also has an individual *counselling* session of approximately three-quarters of an hour weekly, which takes up any difficult or previously unexpressed problems relating to therapy. An important feature of the counselling relationship is the change in individual therapist midway through the course. This helps members explore issues of change and dependence and provides a preliminary opportunity for a therapeutic understanding and management of such matters before the end of the course. An afternoon is given for companionable sharing of activities such as ten-pin bowling, swimming, and so on. They also play table tennis and other games in the House, and have time to share their personal attitudes and reflections with each other.

Home visits which allow work at Tuke House to take account of marital and family dynamics and environmental factors are undertaken when appropriate by the social worker either alone or with another therapist. Family therapy is arranged for members who wish to work on their problems during and after the programme ends. Members

https://doi.org/10.1192/S0140078900017569 Published online by Cambridge University Press

and staff also share in maintaining the house and garden, and provide daily lunches for themselves. Staff members keep each other fully informed about their work, and meet for weekly supervision of their therapy by an external monitor.

Arrangements are made before the course ends for six, weekly one hour group 'bridging' sessions for members who wish to reinforce their new learning and more companionable relationships at home, work and leisure. Longer term group therapy contracts are arranged for members who wish to continue to work together on insufficiently resolved interpersonal problems. Members are also free to contact Tuke House for advice following termination if other resources are temporarily unavailable.

Each therapeutic approach is contained within, and hopefully enriches a broad companionable exploratory and supportive milieu, in which members learn to explore their resistances to therapy, share feelings and problems, reappraise goals, fashion increasingly constructive and confident self attitudes, and develop more mature and congenial peer group and family relationships.

Three treatment groups proceed through the House each year. The House closes for a few weeks at the end of each group. This allows for staff leave, further training, and the assessment of new referrals. It also prevents the accumulation of long term attenders. Experience suggests that the predetermination of the duration of treatment encourages active participation of members in setting objectives, and also enhances their sense of the value of the treatment.

Evaluation and research

Priority has been given to evaluation of therapeutic effectiveness and usefulness; the research programme aims at examining the treatments' overall efficacy, elucidating the processes of change, and appraising cost-effectiveness in relation to other treatment approaches. Implicit in this has been the need for refinement of instruments that evaluate process and outcome. Pending the results of this, a consideration of 'consumer satisfaction' is perhaps pertinent. Overall, feedback from group members has been favourable. Many members express awareness of the 'novelty' of the treatment setting and approach, and a common theme is recognition of the benefits of treatment outside an institutional approach. One member commented "there ought to be a Tuke House at the end of every street".

The experience of staff members is worth commenting on. Working in a new treatment venture inevitably carries many demands due to the uncertainty of an untested and unpiloted area and operating in a multi-disciplinary team also carries its own uncertainties. Apart from developing a new service model, Tuke House has provided a training experience allowing staff members to explore and deal with these kinds of uncertainties. In a way their efforts in this respect have sometimes reflected the group members' experience in treatment. Experience of the staff has so far suggested that a multi-disciplinary approach is particularly apposite and practicable in this community treatment facility.

Tuke House is one model for genuinely community-based care which initial experience suggests is viable. Its efficacy and cost-effectiveness is yet to be demonstrated.

References

[1] Powell, E. (1961) Address to the National Association for Mental Health Annual Conference.

[2] Donovan, C. M. (1982) Problems of psychiatric practice in community mental health centres. *American Journal of Psychiatry*, **139**, 456–460.

[3] Clare, A. W. (1980) Community mental health centres. *Journal of the Royal Society of Medicine*, **73**, 75–76.

[4] Jones, K. (1979) Integration or disintegration in the mental health services. *Journal of the Royal Society of Medicine*, **72**, 640–648.

[5] —— (1982) Scull's Dilemma. *British Journal of Psychiatry*, **141**, 221–226.

[6] Tyrer, P. (1984) Psychiatric clinics in general practice. *British Journal of Psychiatry*, **45**, 9–19.

[7] Sims, A. C. P., Green, W. J., Hoult, G., May, M. & Williams, J. (1985) Tuke House: An experimental community mental health centre for the day treatment of neurotic disorder. *British Journal of Clinical & Social Psychiatry*, **3**, 67–69.

[8] Yalom, I. D. (1975) *The Theory and Practice of Group Psychotherapy*. New York: Basic Books.

Call for Proposals

Proposals for presentation at the 1988 conference of the Association for Death Education and Counselling (ADEC) are now being accepted. The theme is 'Out of the Shadows–Into the Light through Death Education and Counselling' and the conference will be held from 22–24 April 1988 at the Crowne Plaza Hotel, Orlando, Florida. ADEC consists of professionals and lay persons whose goals centre around the promotion of death education, death-related counselling and grief management in educational institutions, residential facilities, churches, community and non-profit making organisations and related settings. Presentations at the Conference will be either research reports, scholarly papers, practice reports/experiential papers or roundtables. Requests must be postmarked no later than 15 December 1987 and notification of acceptance will be made by 15 January 1988. Further information: Dr Darrell Crase, Health Education Division, Memphis State University, Memphis, Tennessee 38152, USA.

https://doi.org/10.1192/S0140078900017569 Published online by Cambridge University Press