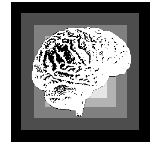

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The development of supported mental health accommodation and community psychiatric nursing in Oxfordshire

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Abstract
Overcrowding in British mental hospitals was a major service and political concern when the NHS was introduced in 1948. From 1959, a number of projects were initiated locally in Oxfordshire, based from Littlemore Hospital Oxford, to provide alternative accommodation, primarily for long-stay residents. Two NHS hostels were opened and a network of group homes was developed from 1963. These were administered through the hospital League of Friends and supported by the community psychiatric nursing service led by Helmut Leopoldt. From 1977 a separate local charity, Oxfordshire Mind, also provided supported housing for younger patients. These developments can be seen as an early local case study of the provision of non-hospital (supported) accommodation and other forms of support for people with long-term mental health problems.

Keywords
Community psychiatric nursing, group homes, Helmut Leopoldt, Littlemore Hospital Oxford, supported mental health accommodation

Introduction

In 2022 there are two local charities based in Oxfordshire providing supported accommodation for people living with mental health problems. 'Response', previously known as the Oxford Group Homes Organisation (OGHO), provided housing, support and positive activity for 364 people in 2021. Employing 187 staff, they actively manage over 70 properties of their own, and work with an extensive network of housing associations and private landlords, as well as offering a number of other services, including domiciliary care support for people with serious mental illness requiring such support. 'Oxfordshire Mind'[1] has 94 residents in 20 housing projects across the county,

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with an emphasis on providing transitional housing as a bridge to moving to more independent accommodation. Housing is only one of the services provided by Oxfordshire Mind: they also have a primary care team of 29 people, who deliver one-to-one support sessions for people whose mental health issues or other social or lifestyle issues impact on their well-being. The publicly funded National Health Service (NHS) mental health services for Oxfordshire are managed by the Oxford Health NHS Foundation Trust, which also manages services providing physical and mental health and social care for people of all ages living in four other counties as well as Oxfordshire. Community Psychiatric Nurses (CPNs) are now regarded as essential core members of all community mental health teams.

The national background

The steady growth in both the capacity and range of facilities for the mentally ill from the mid-eighteenth century has been well-documented, as in the classic studies of Kathleen Jones (1972). Although individual parishes funded the placement of individuals in both generic workhouses and private madhouses, the public funding of dedicated accommodation began in 1808 when counties and boroughs were permitted (but not required) to construct asylums at public expense (although few did so). In 1834 the New Poor Law required parishes to combine together into Unions, and to construct workhouses, where lunatics who were not considered dangerous were accommodated. Despite this provision, the number of those known to the parish, county and borough officials continued to grow, leading to the Lunatic Asylums Act of 1845 that required every county and borough in England and Wales to erect an asylum. The problem of overcrowding in the steadily expanding national network of publicly funded lunatic asylums quickly became apparent. Alongside the consequential, ever-continuing increase in the size of the asylums, there were early examples of projects to provide accommodation in the community for people who would otherwise be living in an asylum. In 1858 John Bucknill, the Medical Superintendent at the Devon lunatic asylum, had relieved overcrowding by opening a temporary branch at a seaside house in Exmouth, and by housing patients in cottages in the neighbourhood (Bucknill, 1858).

A more significant project, 20 years later, was the establishment in 1879 of the *After-Care Association for the Poor and Friendless Female Convalescents on Leaving Asylums for the Insane*, led by the Rev. Henry Hawkins, chaplain of Colney Hatch asylum in Middlesex (later known as Friern Barnet Hospital). This scheme was essentially a supported lodgings system, with voluntary 'lady visitors' supporting the residents. By 1889, 143 different cottage homes had been used, and from 1894 men could access the service. The association continues to the present, known for many years as The Mental After Care Association (MACA), and now as Together (Strong, 2000). From the 1850s a system of 'boarding-out' lunatics in ordinary homes was widespread in Scotland (which had different legislation for the provision of public asylums), especially in rural areas (Tuke, 1889), but this system was never adopted formally in England.

In the twentieth century, the numbers of psychiatric in-patients continued to grow inexorably, but only two completely new major hospitals were built between the world wars: the voluntary Bethlem ('Bedlam') Hospital, which moved to its fourth and final site at Beckenham in Kent in 1930, and the public Runwell Hospital in Essex in 1938. Additional capacity was only achieved by extending existing hospitals, with the additional accommodation often built to a poorer standard than the original buildings, and with 'temporary' buildings often used for decades. Overcrowding became widespread to the extent that, at the end of World War II, patients were sleeping in corridors. This problem was so serious that in 1950, very early in the life of the NHS, gross overcrowding in the mental hospitals, and the problems associated with it, were discussed in the Cabinet Committee on the NHS (Webster, 1988: 160).

This challenge was compounded by two other factors. Maintenance of the hospitals had been neglected during the war, leading to their poor physical condition, not least as a number were over 100 years old and most had been built before the end of the nineteenth century. Secondly, during that war some 35,000 mental hospital patients had been moved from their original hospital to others; this mass evacuation emptied entire hospitals so they could be re-designated as Emergency Medical Service hospitals for military patients. Together with the departure of younger medical and nursing staff to the armed forces, this meant much poorer standards of care and treatment during the war, and this major disruption was repeated at the end of the war as patients were relocated back to their original hospitals.

The national post-war priorities for building reconstruction were for housing and industry, meaning that the funding available for hospital development was very limited, even though by 1954 the Minister for Health, Ian Mcleod, declared that he regarded the capital needs of the mental health services as 'unquestionably taking priority over anything else' (Webster, 1988: 337). Although the report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency (1957), which led to the 1959 Mental Health Act, discussed alternatives to hospital accommodation, and although a handful of local authorities provided hostel accommodation, very little alternative accommodation was provided.

A number of factors then contributed to the drive to move the care and treatment of psychiatric patients from the old, large and often remote mental hospitals. These included the introduction of phenothiazine drugs from the mid-1950s (although the direct effect of the new drugs is disputed), and new approaches to the clinical management of the hospitals, as illustrated by the slim book setting out a simple seven-stage process to address the problems of institutionalisation, written by Russell Barton (1959), the Medical Superintendent of Severalls Hospital at Colchester.

Government statistics between 1954 and 1959 showed that the total number of in-patients was already beginning to reduce from the peak number of 151,000 in 1955. The major challenge was presented by the long-stay patients (usually defined as those with a continuous period of in-patient care of more than two years), most of whom had a diagnosis of chronic schizophrenia. While a proportion of these patients were of working age, others had grown old in the hospitals, so their psychiatric problems were compounded by both chronic general health problems and the frailty of old age.

Confronting the challenge

Enoch Powell, the Minister of Health between 1960 and 1963, had visited the mental hospitals, and he too was appalled by what he saw. His unexpected clarion call at the 1961 National Association for Mental Health annual meeting (Powell, 1961a, 1961b) – 'the mental hospitals will close!' – and his subsequent 1962 hospital plan, gave both a clear rhetorical and policy lead. But where should the patients go? There were three immediate and pressing practical challenges in discharging chronic psychiatric patients from hospital:

- Where would they live?
- How would they be supported medically, financially and socially?
- What would they do?

The present article focuses on the first two questions, and the last is addressed in the article on Restore in this issue (Leach, Agulnik and Armstrong, 2023).

Appropriate non-hospital accommodation had first to be found, and then funded. Early re-housing projects used both private and council-owned properties, with some early projects purchasing their

own properties, as shown by the following early examples. In Somerset the local authority found accommodation for 275 patients over a 10-year period from 1960, through a boarding-out scheme using private accommodation (Parry-Jones, Buchan and Beasley, 1970). In Colchester a scheme was developed which accommodated 40 patients in eight houses, with four of their houses being council-owned properties (Fox, 1972). In Bristol the Transport and General Workers Union lent sufficient money to the Bristol Industrial Therapy Organisation (ITO) to purchase a small house (Early and Magnus, 1968).

A significant venture was undertaken in 1959 by Elly Jansen, a Dutch theological student in London, who realised that help was needed for those newly discharged from mental hospitals to adjust to day-to-day living. She rented a house in Richmond, put up a notice in the local hospital, and waited three months before the first applicant appeared. The house became her first therapeutic community, or halfway house, for mental patients, This initiative led to the Richmond Fellowship, which grew to 50 houses throughout Britain, and the Fellowship became a campaigner for more general aspects of community care (Richmond Fellowship, 1983). The Richmond Fellowship continues as one of the larger voluntary sector providers of mental health supported housing in England; more recent published studies have used the term ‘supported accommodation’, and that term will be used hereafter (e.g. Killaspy and Priebe, 2020).

Given that the patients who were discharged were mostly heavily institutionalised, they also required several forms of support as well as provision of housing. There were three forms of personal and social support for those who left a psychiatric hospital, alongside support given by any family members still in touch with them. As in the early MACA projects, volunteers could provide a service. Secondly, the ‘Duly Authorized Officers’ (DAOs) employed by local authority public health departments could provide support. The DAOs were the re-named ‘Relieving Officers’ initially created by the 1834 Poor Law Amendment Act, whose duties included both support in the community, and supervising the transfer of certified patients to the mental hospitals. The DAOs were later re-named again as Mental Welfare Officers (MWOs) in the 1950s. Little historical research has been done into the function of these officers – mostly men with no formal training – apart from one oral history study of their work in supporting people with both learning difficulties and mental illness. This showed how many of them went far beyond their statutory duties to provide long-term community support (Rolph, Atkinson and Walmsley, 2003).

The third option for support was through the redeployment of hospital mental health nurses who already knew the patients and who remained employed by the hospitals from which the patients were being discharged. The earliest published example of this new form of psychiatric nursing was established in 1954 to support patients from the London Borough of Croydon, who were served by nurses from Warlingham Park Hospital in Surrey, seconded to a mental health centre because of a lack of psychiatric social workers in the borough (May and Moore, 1963). John Greene (1968), later to be a significant national leader in the development of psychiatric nursing, described the service at Moorhaven Hospital near Plymouth set up in 1957, using nurses who were also working in the hospital, and so occupying dual roles.

Broader accounts of the early development of community psychiatric nursing (CPN) are given by Hunter (1974) and by McCrae and Nolan (2016). Hunter saw the development of community psychiatric nursing as being in two phases, the first of which he called the ‘after-care or continuing care’ phase, which is a good summary of the work at Oxford described in this article. His second phase he called ‘more diverse functions’, specifically to include the development by nurses of psychotherapeutic and behavioural treatment roles. McCrae and Nolan provide an interesting example of two recently qualified mental health nurses who in 1962 were immediately recruited as mental health officers in Liverpool on the strength of their nursing experience, but who were given no further training for their new role. Carr, Butterworth and Hodges (1980) give a full account of

CPN practice in the late 1970s, with the senior author, Paddy Carr, being a major figure both in the development of formal CPN training and in the formation of the Community Psychiatric Nursing Association in 1976.

Developments in Oxfordshire

When Dr Bertram Mandelbrote moved from Coney Hill and Horton Road Hospitals at Gloucester to Littlemore Hospital Oxford as Medical Superintendent in late 1959, he was accompanied by a few key staff who were in effect ‘poached’ from Gloucester, including a mental health nurse, Helmut Leopoldt, who was appointed initially as the rehabilitation officer at Littlemore.

Although there was no other accommodation outside the hospital then available, Mandelbrote took a number of steps which were foundational to later developments, alongside his internal reforms within Littlemore Hospital, including creating the Phoenix Unit. While at Gloucester, he had encouraged the formation of an active League of Friends, and he replicated this on moving to Oxford. In 1960 he promoted the establishment of a League of Friends for Littlemore Hospital, which was later to be the main vehicle for funding non-NHS accommodation (see Millard et al., 2023). The next step was to open two hospital hostels, Thorncliffe House in 1961 and Stapleton House in 1962, which enabled hospital staff to gain experience in rehousing long-stay patients. This sequence of events has been recorded both in formal documents (such as the hospital annual reports) and also in a number of unpublished memoires and internal papers, most of them by the community psychiatric nurses involved in the projects.

Helmut Leopoldt

Helmut Leopoldt had originally come to Britain as a German prisoner of war, and after the war had trained as a mental health nurse in Gloucester. Probably his first publication was an article on after-care visits (Leopoldt, 1958), written while he was still at Gloucester, quoting the developments cited above that had already taken place at both Warlingham Park and at Moorhaven Hospital. In his role as rehabilitation officer at Littlemore, and later as senior nursing officer, he led the development of the community psychiatric nursing service which both prepared residents for discharge and obtained accommodation, and then provided the ongoing social and clinical support for patients as they moved from the hospital.

Thorncliffe House and Stapleton House from 1961

Thorncliffe House, formerly a large private house, was purchased by the Ministry of Health in February 1961 and established as a hostel for patients from Littlemore Hospital: this was an unusual venture for the NHS at that date, and must have required skilled negotiation to obtain the capital funding. The initial expectation was that Thorncliffe House would function as a half-way annexe for patients who were in full employment, but who still presented problems in community resettlement. A second similar property, Stapleton House, was opened in April 1962, initially intended for long-term patients who were likely to benefit from living in a smaller homely setting. Unlike Stapleton House, none of the patients were in work when it opened. Both hostels were several miles from Littlemore Hospital, and were intended to ‘bridge the gap’ between hospital and community life. In comparison with other supported accommodation projects elsewhere, it is noteworthy that both hostels were administered as in-patient areas, with statistics counted as if they were in hospital, so the patients were not technically discharged.

The Physician Superintendent's Report for 1962–64 noted that both hostels had 'stood up to the initial testing period well and no complaints from the local community have been voiced'. It was initially expected that patients would stay for a maximum of six months at Thorncliffe House, but it was soon found that some patients required a longer period of residence before they were able to move on. For more elderly patients, community provision had been made through local Authority Part III accommodation and by the opening of Orchard House by Oxfordshire County Council (unpublished report, Littlemore Group of Hospitals, 1964).

Group homes from 1963

The next step was the placement in 1963 of an advertisement 'by a psychiatric nurse' (almost certainly Leopoldt), seeking accommodation for a single 'middle-aged stabilised schizophrenic' who was working as a kitchen porter in a local factory. A single bed-sitting room was found in a house, the rest of which was rented by a family. When that family moved away, the landlady regarded him as a good tenant, and she enquired whether there 'were any more patients like him', so actively inviting the hospital to provide other suitable tenants. Five former patients who were known to get on with each other then moved in, and it was 'from this apparently casual beginning that the whole of the local Group Homes Organisation developed' (unpublished report by Bolsover, 1982). Leopoldt (1965) claimed that this was the first group home not only in Oxfordshire, but probably in the country.

The first mention of the League of Friend's possible involvement in housing was in January 1965, when the League committee discussed a suggestion for renting a house for ex-patients, and referred to an existing project using a hospital staff house. NHS financial regulations did not allow the hospital itself to rent properties, but the committee agreed they would be willing to undertake the responsibilities of a landlord, and the League, together with Oxford Rotary Club, became joint Trustees for the project with the first rented house opening in November 1965. It was this second property which led to the League effectively becoming an independent group home organisation.

The group homes were initially ordinary houses rented from willing owners, either private owners or Oxford City Council, but the project constituted both a personal liability financial risk to the owners, and a clinical risk because of the probable need to manage episodes of disturbed behaviour by residents. The owners were assured of financial underpinning from the League, through use of the charitable status of the newly established League and the skills of its bank-manager treasurer, and of active nursing support. Evidently both the owners and League members had confidence in Mandelbrote's and Leopoldt's ability to deploy nursing staff flexibly in new roles in the community (unpublished interview with A. Bamborough, 2001).

The practical work of selecting residents and preparing this first and later houses for occupation was led by Diana Hoggins (termed 'assistant matron'), who was congratulated by the League committee on her 'excellent management' (see Minutes of the League of Friends, 1961–1969). Her ability to choose potential residents based on their capacity to support and to relate successfully with one another depended on her knowledge of their social relationships in the Phoenix Unit environment, and in other wards for more disabled patients.

By May 1969 there were seven houses with a total of 42 tenants. An article by Hoggins (1970) was published in the *Nursing Mirror* and was successively updated by her; the last 1974 (unpublished) version provides details of the 20 properties included in the scheme up to that date. These included furnished and unfurnished flats and houses, most of which were rented on one- to three-year leases, and one of which was purchased by the League. Four of the rented houses were owned by a relative of a patient at Littlemore, and in one case the owner was currently herself a

day-patient at the hospital. Hoggins' narrative account of the development of the scheme illustrates the many practical steps involved:

> Owing to full occupancy and careful husbandry, we have been able to accumulate a small reserve, repay all initial rents paid by the League of Friends, pay the pocket money and expenses of the Community Services volunteers, buy second-hand fridges, spin dryers, lawn mowers, pay for decorating and the materials etc. Gifts of extra clocks, radios, carpets, furniture and household goods have been gratefully accepted. Some shops and firms have given generous terms and discounts re linen, coal, hardware and groceries. (Unpublished, Hoggins, 1974: 2)

The summary information for 1973 showed that, from 1963, 176 former patients had become tenants in group homes, with 103 current residents, some of whom had previously been in the Warneford Hospital, the other NHS psychiatric hospital in the city. Hoggins considered that the success of the scheme was due to three factors: a positive realistic rehabilitation and resettlement programme within the hospital, with the prospective residents learning skills in small groups and making their own decisions; teamwork between hospital and community staff, with the majority of the residents well-known to Hoggins and the project doctor; and the continuity of care with staff multi-tasking beyond their formal roles.

Dewhurst, McKnight and Leopoldt (1974) give other details of the scheme over the first 10 years, facilitating the resettlement in the community of many long-stay patients whose recovery was incomplete, and who otherwise would have faced permanent or much longer terms of institutional care. One of the authors of that article himself rented out seven properties to the scheme, and he considered that the standard of cleanliness and care and maintenance of furniture by the residents was superior to the general run of previous short-term tenants! The most important criterion was not so much the nature of the residents' psychiatric conditions, but the likelihood of good functioning outside hospital. All the tenants, except those over the age of 75, were engaged in some form of daily activity, either in full-time remunerative employment, or attending some form of sheltered work.

The authors point out that during this 10-year period the Oxford self-supporting group-home scheme had become one of the largest in the country. Despite the advantages of the scheme, it also had several drawbacks:

> Being largely financed by private landlords there is always the possibility that the present smooth organization may be disrupted, to the tenants' detriment, if a landlord decides to sell his property at the termination of the three-year lease (as has happened on two occasions), or in the event of a landlord's death properties may have to be sold to pay death duties. (Dewhurst et al., 1974: 203)

Paradoxically, one factor in the success of the OGHO was the fact that Oxfordshire Social Services Department was then among the lowest spenders on mental health care in the country: in 1993 Oxford Mind noted that Oxfordshire Social Services Department, while directly employing social workers within the mental hospitals, did not provide any dedicated residential accommodation for people with mental health problems (Oxford Mind, 1993). The unforeseen consequence of this was that NHS nursing and ancillary staff were given the freedom to act with greater autonomy in providing continuity of care across institutional boundaries, without competition or conflict with the local authority. This freedom, encouraged by Mandelbrote and his associated senior nursing staff, was commented on in the witness seminars that were conducted around the work of Mandelbrote and the Phoenix Unit (Millard et al., 2023).

Another contemporaneous article was the evaluation between 1973 and 1975 of a group home for eight men in 'a northern city', probably Bradford (Pritlove, 1976). This article was unusual in

presenting a conceptual model of residential accommodation for people with mental health problems, differentiating between a 'transitional' model – where independence lies beyond the group home – and a 'compensatory' model – where independence is found within the home. The article showed that half of the residents were still as dependent on staff as they were at the beginning, demonstrating the importance of residents learning to make their own decisions within community accommodation.

Leopoldt (1979: 55) defined a group home as:

> a home for a group of people, men and women, not unlike a family home. Instead of family ties, however, the cohesiveness, support, tolerance and quiet affection within the group stems from the common experience of mental illness, long years of being in hospital and friendships formed during these years.

This definition assumed that the group of residents within each home already knew each other well. While this assumption was valid in the early years of the scheme, in later years the residents within a new group home did not necessarily know each other well, so judgements about how a group would relate to each other became a more important element of selection. The OGHO group homes scheme later became an independent charity and, much-expanded, is still active as Response.

The community psychiatric nursing service

A key element in the success of these projects was the support of the community psychiatric nursing (CPN) team. Leopoldt (1979) describes four stages in the development of the Oxfordshire CPN service. Stage 1 was the appointment of a rehabilitation officer in 1960 (a post first occupied by Leopoldt), who co-ordinated all work and employment problems facing in-patients, day-patients and out-patients. Within the hospital, patients knew that there was a nurse they could approach for work-related matters, and externally community workers, employment agencies and personnel officers appreciated this centralised service. Stage 2 was the growth of the group-homes scheme from 1963, already described.

The third stage was assigning CPNs to what was then termed psychogeriatric care, or the care of the elderly mentally infirm in the community. A core part of their work was teaching specific aspects of care in family homes, old people's homes and warden-controlled flats, as well as in hospitals. This was essentially a combined consultation and teaching role, including short-term direct clinical involvement. This pilot project developing psychogeriatric community psychiatric nursing along these lines was separately reported in an unpublished paper by Leopoldt and Corea (1975).

The fourth stage was the introduction of a GP attachment scheme from 1972. At this point in time, local authority Medical Officers of Health (MOH) were the employers of community nurses and health visitors; the then MOH Oxford, FJ Warin, was instrumental in promoting the CPN attachment scheme, for which 'planning was short, implementation swift, and the following critical discussions long' (Leopoldt, 1979: 56). This element of the service developed so that in 1979 four nurses were deployed to health centres. The typical pattern of working for the three longest-established CPNs was working half of the time with eight GPs covering a population of 18,000, and the other half of the time working for hospital consultant teams.

The strongest reservations, unsurprisingly, came from within the hospital, where it was argued that the vast majority of identified psychiatric cases in general practice were 'neurotic' and so were unlikely to benefit from specialist help, and it was feared that widespread attachment of psychiatric nurses to health centres would deplete their numbers in hospital even further. However, a survey suggested that: many of the patients formerly seen by GPs, District Nurses and Health Visitors

were being referred to the CPN; there was a more selective approach in relation to referral to psychiatric consultants; and the GPs thought that admissions and even sectioning under the Mental Health Act had been prevented.

Leopoldt organised a symposium on 'Contemporary themes in psychiatric nursing' at Oxford in 1978, with a subsequent publication (Leopoldt, 1978a). This includes a chapter by him on 'alternatives to hospital', which is a reflection on his 15 years' experience in that field (Leopold, 1978b), and a paper published the following year provides an overview of the Oxfordshire CPN service (Leopoldt, 1979). The claim in a number of these articles is that the Littlemore community psychiatric nursing team was among the earliest in the country.

Oxford Mind housing from 1977

Starting a few years later, a second source of supported accommodation in Oxfordshire was provided by the re-formed Oxford branch of the national charity Mind. As well as providing supported housing, Oxford Mind developed a number of day centres throughout the county, which were one source of social support for the residents, as well as for others with needs for social support.

The national MIND had been founded in 1946 as the National Association for Mental Health (NAMH) by the merger of three national voluntary organisations that provided services for the 'maladjusted, emotionally disturbed or mentally handicapped to any degree', one of these organisations being the Central Association for Mental Welfare (CAMW). The national body was, and continues to be, a campaigning, lobbying and information-providing organisation, with local affiliated branches established as independent local charities; depending on their size and resources, they provide a range of information and support services. The NAMH was renamed as MIND in 1972, and the lower case version 'Mind' was introduced in the 1990s.

In 1965 Mandelbrote reported to the Littlemore Hospital HMC that he had been visited by a Mrs Fisher of the NAMH with a view to establishing a branch in Oxford, but this was 'a complicated problem which required careful consideration' (Medical Superintendent's Report, 1965). Mandelbrote had previously given a presentation in 1964 at the NAMH conference, and earlier in 1965 he had hosted a visit to Littlemore of a group of Chairmen and Secretaries of local NAMH groups, so he was clearly aware of the interests of the NAMH.

However, it was not until December 1966 that a meeting at Oxford Town Hall discussed setting up a steering committee for a local mental health association. The first public meeting of the new association was held in April 1967, chaired by RB McCallum, Master of Pembroke College. The association was for a number of years called the Oxford Association for Mental Health (OAMH) and was initially affiliated to the NAMH – interestingly, in 1913 there had been a local Oxford branch of the CAMW. *A Brief History of Oxfordshire Mind*, written by Jane Hope (2007), describes the first 40 years of Oxfordshire Mind, and in Chapter 6 ('Living with Mind: the Housing Service') she gives a clear account of the introduction by Oxford Mind of a housing service.

One of the first services set up by the local association was a support group for relatives, which became one of the longest running services. This group, which had started in December 1967, only eight months after OAMH had been formed, began to think about housing. While OGHO provided accommodation mostly for older people who had spent some years in hospital and who were moving out of hospital, there was a gap in provision for younger people. What was distinctive about the OAMH thinking was that it was focused on those people with long-term mental health problems who were currently either living with their families, or on their own where their living conditions were very poor, or where the long-term sustainability of family support was fragile. This focus arose from the concern by members of the group about making provision for their own adult children when they themselves would not be able to look after them.

This build-up of people from the 1960s in the emerging community services with severe long-term mental disorders, but who had not been institutionalised, had been noted nationally. The National Schizophrenia Fellowship had been formed in 1972 as a self-help group, whose members were mainly parents of young adults who had been diagnosed as schizophrenic. They had sponsored a publication aptly called *Tied Together with String* (Priestley, 1979), which described how family members did the best they could with their own resources to keep their disturbed relatives at home and out of hospital for as long as possible. The increase in numbers of long-term users of mental health services who had never been long-stay in-patients was most apparent in the new mental health day centres (Cross, Hassall and Gath, 1972). John Wing and colleagues at the Medical Research Council Social Psychiatry Research Unit went on to conduct research studies with this group of service users, often referred to as high-contact services users (for example, Brugha et al., 1988).

In 1975 OAMH accordingly set up the Oxford ‘Hostel Project’ group to discuss with Helmut Leopoldt and his team, who had 12 years of experience of assessing potential residents and providing regular support, the need for CPN support for any such scheme. The unpublished OAMH Annual Report for 1975–1976 set out the aims for this sheltered accommodation project, in the light of the lack of dedicated local authority-funded accommodation already noted. In October 1977 the first Mind house, Yorke House, was opened as a group home for five people. The work to prepare the house was carried out by Mind volunteers who selected and supported the residents, and this small committed group of volunteers continued as the primary support for over 10 years, until the retirement of one particularly active volunteer meant that a part-time paid worker was appointed. A social worker in the NHS mental health service, who was also a Mind member, became aware of the squalid conditions of some former patients living in bed-sit accommodation. This prompted a local conference on ‘Long-term housing needs of the recovering mentally ill’, which led in turn to the employment of a housing and project development officer, Julia Barrell, who surveyed the provision of housing needs of mentally ill people in Oxford (Barrell, 1985).

Unsurprisingly, this identified a big gap in housing for younger people with serious and enduring mental illness, which led to the purchase in 1987 of two houses, with the financial support of a Housing Association. This development became known as the East Oxford Housing Project, with an underlying principle of offering people a home, where they could stay as long as they liked, with residents making decisions, including contributing to the appointment of staff. A Housing Development Group was set up in 1992, and they were able to fund a Housing Development Worker between 1995 and 1997. By 1997 the team of workers had grown to the point where some form of staff management structure was required, and a Housing Manager was appointed.

In 1991 a survey was carried out of all the accommodation available in Oxfordshire for people with mental health problems (Gaunt and Young, 1991). This was published by Oxfordshire Mind essentially as a directory, listing eight agencies providing accommodation for homeless people (two of which specifically included provision for people with mental health problems), and seven agencies providing accommodation for people with specific problems. These included the OGHO provision, which at that date comprised 35 group homes with 174 places, and 4 registered care homes providing 40 places for more elderly former patients. The provision by Mind listed separately Yorke House and the East Oxford Housing, together providing 15 places.

Discussion

From 1961 there were a number of stages in the development of supported mental health accommodation in Oxfordshire, the first being for former in-patients of Littlemore Hospital. The two

NHS hostels in 1961 and 1962 were followed by the first group home in 1963. From 1965 a network of group homes, administered by the League of Friends formed through Mandelbrote's initiative, and supported by the CPN service developed by Leopoldt, grew to the point where it was probably the largest in England. These developments took the Littlemore League of Friends well beyond the then accepted boundaries of the work of leagues of friends of psychiatric hospitals. These arrangements were risky, but were based on mutual trust between the leaders of the League and the clinical staff who were responsible for selecting, preparing and then supporting former residents.

The national literature in this field has emphasised the role of supported accommodation in re-settling long-stay patients, but the initiatives taken by Oxfordshire Mind illustrate other concerns, including addressing the accommodation needs of those who had never been long-stay patients, and improving the quality of life for those with mental health problems living in private single accommodation. While the formal clinical support provided by the CPN service was important, agencies providing alternative accommodation typically arrange other forms of support, and the contribution of positive and empowering relationships as one aspect of social support is discussed by Leach (2015).

Garety (1988), in reviewing the development of supported accommodation as one element in the development of community care, suggested that there was often a common sequence within a locality, moving from living-in/working-out schemes, and pre-discharge flats/houses, to hostels, to group homes, to supported housing, and finally to independent living. Other options included lodgings, boarding houses and other forms of hostel accommodation, such as those run by the Salvation Army. She also contrasted the reduction in mental illness beds in England from 104,000 in 1971 to 69,000 in 1983 – a reduction of 35,000 – with the rise in the provision of specialised alternative residential provision from 4145 in 1975 to only 5564 in 1984. Consequently, in much of England most of those discharged patients were not adequately accommodated or supported, and this led to numbers of them becoming homeless, or entering the prison system (Macpherson, Shepherd and Edwards, 2012). The provision of alternative supported accommodation in Oxfordshire described in the present article certainly did not meet all the demand, but provides a case study of developments within one locality in a sequence similar to that described by Garety.

More recent reviews of supported accommodation have drawn attention to a number of issues that were not considered formally during the period of these early Oxfordshire developments, when the imperative was to enable discharge from hospital, making creative use of available resources but with a lack of any clear policy guidance or dedicated funding streams. Reviews such as that by Macpherson and colleagues (2012) stress that effective and sustainable supported accommodation should be affordable and of a decent standard, emphasising key quality issues. Helen Killaspy and her colleagues in a number of publications point out that around 100,000 people live in mental health supported accommodation, but there is little evidence to guide how best to provide this accommodation for people with continuing high levels of need (Killaspy and Priebe, 2020). They have suggested a simple taxonomy of mental health supported accommodation, suggesting five accommodation types based on four domains: staffing location, level of support, emphasis on move-on (reminiscent of Pritlove's 1976 transitional model), and physical setting (McPherson, Krotofil and Killaspy, 2018). So 60 years after the earliest projects described here, there remain major definitional concerns in this under-researched field.

A recent book on supported housing considered generically (Irving-Clarke, 2019) takes an historical perspective to the field, and introduces the concept of 'path dependency' as an analytical framework, over the period from the Poor Law through the campaigns for supported living for people with learning disabilities and the disability rights movement of the 1980s. Path dependency

has been used historically in examining how institutional practices may constrain the life of organisations, and in economics it refers to the tendency to depend on past practices and decisions to attain a desired outcome, rather than current conditions. Irving-Clarke uses this term to analyse the critical 'junctures' in the path of supported housing provision, and how these have limited, and continue to limit, the policy choices available. This book and the articles in this Special Issue all demonstrate the role of specially created voluntary bodies in creating new paths, which were not achievable through statutory agencies.

Lastly, very little of the psychiatric rehabilitation and resettlement literature nationally has been written by mental health nurses. Even by the 1962–4 Annual Report (Littlemore Group of Hospitals, 1964), Helmut Leopoldt was credited with eight professional articles, either published or in press, and the present article cites a number of other formal and unpublished papers by him. He was probably unparalleled in this period for his publication rate as an NHS-employed mental health nurse. The only other NHS mental health nurse to write so plentifully in this field was John Cheadle, working and writing together with Dr Roger Morgan (see, for example, Cheadle and Morgan, 1972), the consultant psychiatrist at St Wulstan's Hospital near Malvern, uniquely established in 1961 as a psychiatric rehabilitation hospital for the whole of the NHS West Midlands Region.

Helmut Leopoldt was responsible for the development of the community psychiatric nursing service in Oxfordshire and, with Diana Hoggins, was the driving force in developing support for both the OGHO and Mind housing schemes. He was by any standards an unusual mental health nurse, recognised by his appointment as MBE in 1982. Alongside the contribution of voluntary mental health bodies and volunteers, the broader contribution of mental health nurses historically to community developments remains undervalued. McCrae and Nolan (2016: xi) draw attention to this in the powerful preface to their book *The Story of Nursing in British Mental Hospitals*:

> Until recently, the history of mental health services was largely presented as the history of psychiatry, written by psychiatrist-historians . . . it was, in essence a history from the perspective of doctors. They did disservice to those who were closely involved in the day-to-day lives of their patients, consigning their stories to a footnote in the history of psychiatry.

Alongside the better-known history of community psychiatric nursing, the contribution of mental health nurses to the support, rehabilitation and resettlement of those formerly inappropriately accommodated should be better acknowledged.

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Note

1. Oxfordshire Mind was initially founded as the Oxfordshire Association for Mental Health in 1967. It has subsequently gone through a number of name changes while essentially continuing as the same organisation, although publications and reports have been published under the different intervening names.

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