Psychiatric hospitals viewed by their patients

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by Winifred Raphael BSc FIPsS

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We especially appreciate the cooperation given so readily and generously by the staff and patients of the nine hospitals which took part in the first survey.

Since then, eleven other psychiatric hospitals have sent us results of surveys they have conducted using the method described, and my gratitude is extended to them.

Winifred Raphael

Steering committee

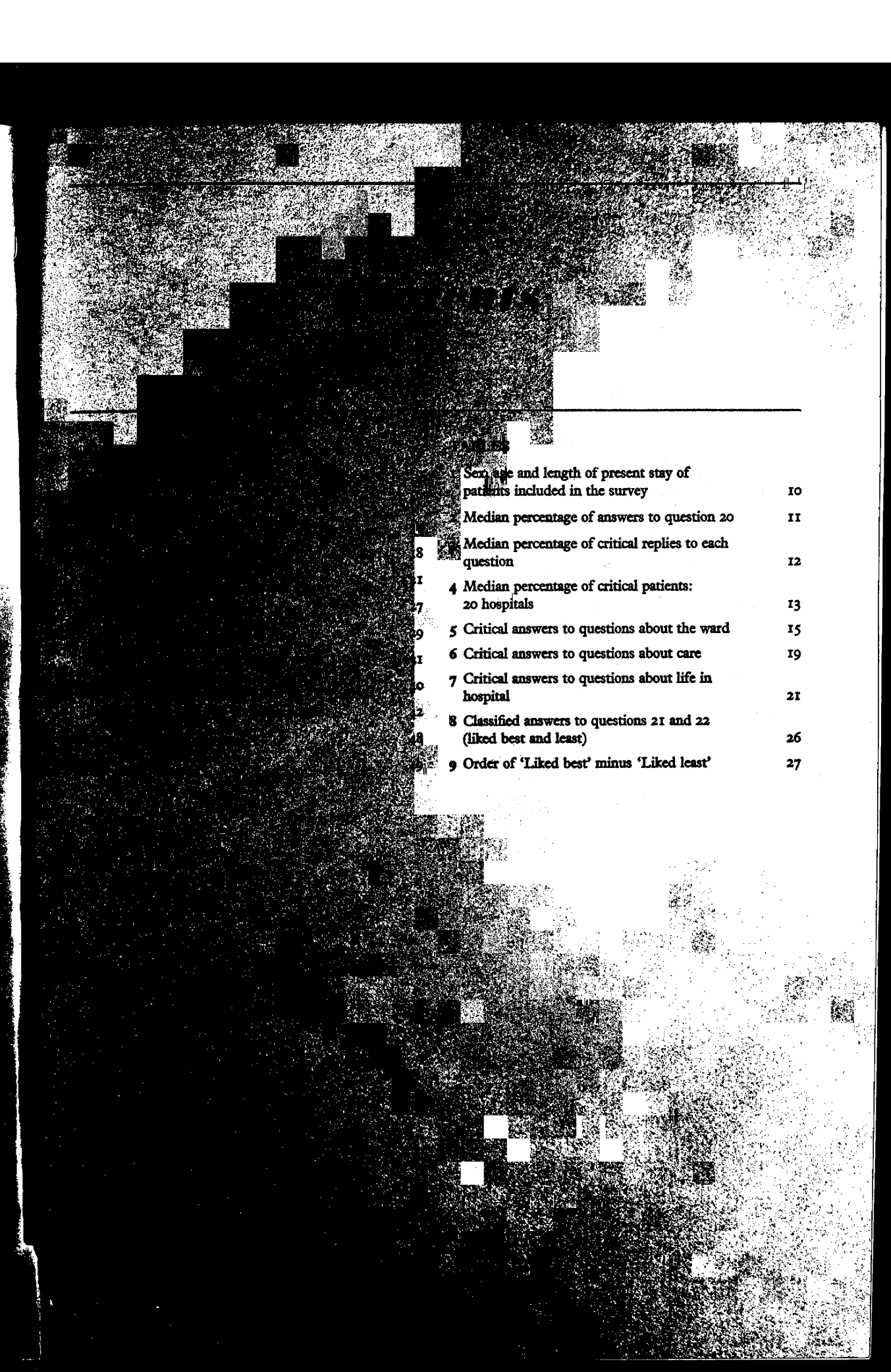
Foreword

Since the first editions of Mrs Raphael's reports of surveys in general and psychiatric hospitals were published, the health services as a whole, and mental health services in particular, have undergone major organisational change. More attention is now being paid to the 'consumers' who, through taxes, pay for health care.

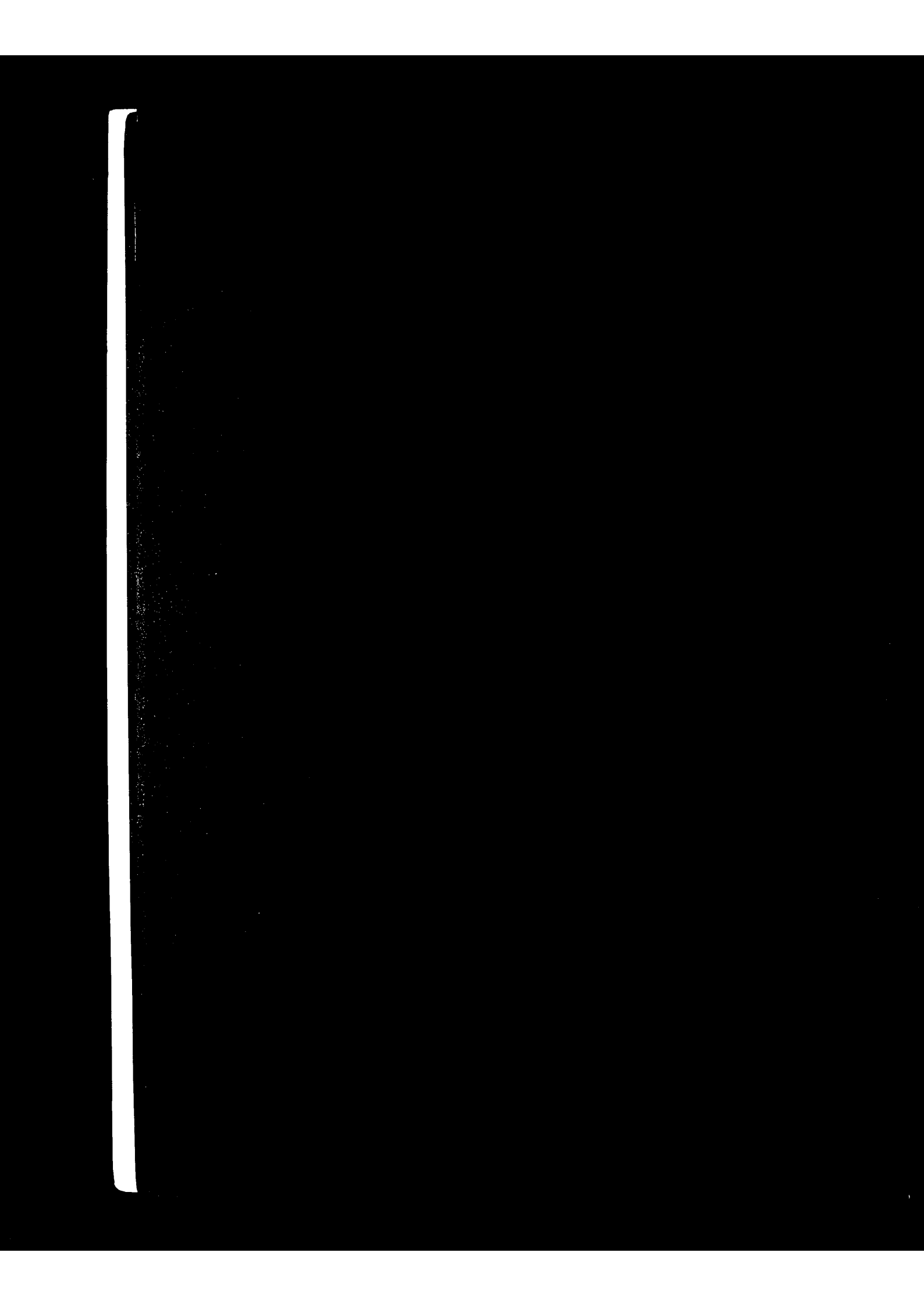
When *Patients and Their Hospitals*[2], which deals exclusively with patients in general hospitals, was first published in 1969, many people doubted whether psychiatric patients could in a similar way comment on *their* care and surroundings. Mrs Raphael has demonstrated unequivocally that they can. The method she has devised provides hospitals with a simple and reliable way [illegible] the views of their patients and [illegible] those of other hospitals.

This second edition of *[illegible] Their Patients*, published in [illegible] edition of the survey of general [illegible] Mrs Raphael's work continues to [illegible] practical way of monitoring the [illegible] hospital service.

A C Dale
1977



TABLES



Summary

Life in hospital

Both industrial and occupational therapy were liked, and over three-quarters of the patients were satisfied with their food although some complained that it was stodgy. Many said they were often bored and would like more social activities especially in the evenings and at weekends.

Liked best and least

What patients liked best were social activities, staff, treatment and the feeling of security. Comments most often given on what they liked least were about noise and overcrowding of the ward, the need for better classification of the patients and the need for more freedom especially in the locked wards. Over two-thirds of the topics raised spontaneously, both among those liked best and those liked least, depended on human rather than on physical factors.

Action

Each hospital circulated the report of its findings among staff, and discussions were held on the action to be taken.

Since the original survey, eleven other hospitals have sent in reports of findings of surveys they have conducted using the same method. Their results, together with those of the first nine hospitals, are shown in Table 4 (page 13). It is interesting to note that the later results are more favourable, except for one topic—patients feel more than ever that they do not see their doctors enough.

It is hoped that many psychiatric hospitals will find the method here described a useful way of monitoring patients' views. The questionnaire and instructions for conducting the survey are on pages 31–41. In addition, the checklist on pages 42–47 was devised for staff who wish to find, for each ward, where they stand on the points most frequently mentioned by patients in the survey. These pages may be copied for use in hospitals and there is no need to obtain permission from the publisher to do so. For ease of copying, an extra questionnaire is inserted separately at the end of the book.

Aim and method

Patients tend to stay longer in psychiatric hospitals than in general hospitals. They may be there for months, sometimes years, and many have to return. Most are in good physical health; they can lead an active life and their occupations, whether work or recreation, have a therapeutic as well as a social purpose. Their views on life in the hospital must include not only the wards but the workshops, clubs, libraries and grounds.

Surveys of patients' views are important in all types of hospital to supplement the knowledge already possessed by those who care for them—doctors, nurses, administrators, therapists and others. Many patients hesitate to give their views unless specifically invited to do so, with the promise of anonymity. Those who spontaneously offer comments without a survey tend not to be a typical sample but to have extreme views, either favourable or critical. Knowledge of the patients' opinions can stimulate action for change and can assist the choice of priorities when possibilities for change are limited by shortage of money or of staff. Patients appreciate the opportunity of contributing their views—one, for example, said, '*What I like about the hospital is the effort to do things as shown by this questionnaire*'. And many expressed gratitude at being invited to give their thoughts freely and confidentially about life at the hospital.

Development of method in three psychiatric hospitals

Since so little work had been done on attitude surveys with patients in psychiatric hospitals, it was essential to experiment with methods, especially as one of the main aims was to develop a type of survey that could be applied by individual hospitals for their own use and for comparison with other hospitals. Three methods were tried in comparable wards in each of three large psychiatric hospitals. In some of the wards in each hospital the surveys were conducted by means of individual interviews; in others, by means of written questionnaires, one simple, one more complex. Both interviews and questionnaires were partly structured, in that specific questions were asked which required a Yes/No answer, two general questions (21 and 22) allowed more choice of answer, and additional comment was invited. The trials were made with 958 patients in 57 wards. The method finally chosen for the rest of the enquiry was the simple questionnaire shown on pages 40-41.

The questionnaire contravenes certain accepted practices in that there are only two possible answers, 'Yes' and 'No', for most questions, and especially that 'Yes' is always the favourable answer. Therefore, another questionnaire was tried experimentally which covered the same topics as the first, but the questions were rephrased so that half the favourable answers would be 'No'. The answers to the second questionnaire showed no closer correlation with the rank order of answers from the interview than did the first questionnaire; it was answered by a smaller proportion of patients and was more difficult to analyse. The interview method gave the fullest results but was far more time-consuming, needed trained interviewers and was not practicable for the hospitals to use themselves if anonymity was to be preserved.

The coefficient of correlation used for the survey expresses the degree of agreement between the answers to the two questionnaires and also the interviews. Perfect agreement would give a correlation coefficient of 1.00 and no relationship would give 0.

The following correlation shows a marked relationship or agreement between the three methods employed and all are statistically significant at the two per cent level; that is, the confidence limits indicated are likely to be exceeded by chance less than twice in one hundred times.

Correlation of interview and first questionnaire	$= +0.84$
Correlation of interview and second questionnaire	$= +0.83$
Correlation of both questionnaires	$= +0.81$

It can be seen that there is a close correlation between the rank order of questions according to the percentage of patients giving critical answers, whether the questions are presented by interview, by the first questionnaire or by the second.

The surveys started at all the hospitals when the cooperation of the medical, nursing and administrative staff had been enlisted. The wards to be included were selected to be representative of the various types of ward in the hospital according to both the physical structure of the ward and the kinds of patients resident. In most cases there were several

wards of a similar nature and here the ones to be surveyed were selected by chance, such as by the throw of a dice.

In the pilot survey it was found that in the geriatric wards most patients could not usefully participate. These wards were excluded in the next stage.

Do-it-yourself trials in six other hospitals

The staff at six other large psychiatric hospitals were asked to undertake the survey themselves in about twelve wards each. Although the hospitals did not form a random group, they varied considerably in region from Cumberland to Sussex, in size from 742 to 1699 beds, and also in outlook.

The organisers issued very full written instructions and also paid a preliminary visit to each hospital, except one, to explain how to conduct the survey. Four points were emphasised.

1 The interest of the staff and of the medical and management committees should be stimulated and they should see the results.

2 The patients should be encouraged to take part, but not in any way pressed to do so, and their help should be acknowledged.

3 The promise of anonymity should be strictly observed and staff should not help patients to fill in a questionnaire even if asked to do so.

4 Action should be taken quickly on the matters raised when it was desirable and practicable to do so.

Validity of findings

'But can you get useful information from mental patients?' was the comment offered by many people on hearing of the survey. One of the most striking findings was that only 2 per cent of the patients who sent in questionnaires failed to give rational answers, and only 3 per cent handed in very incomplete questionnaires. It is not possible to guarantee the validity of any survey, but the remaining 95 per cent of the questionnaires was analysed and the majority of the comments given expressed sensible appreciations or constructive criticisms. Generally, there was fair similarity between the answers to the questions on factual matters in any one ward, even though the patients responded to the questionnaire simultaneously so had no opportunity to consult with each other.

The tabulated results in this report come from 2148 patients in the nine hospitals. Basic information about the patients who took part is given in Table 1.

The proportion of patients who answered the questionnaire in the wards concerned varied from 85 to 52 per cent in the different hospitals.* The figure depended on the proportion of long-stay wards with elderly patients, some of whom were senile, and on the interest promoted among the ward staff and the patients. It was impossible for some of the patients to participate because they could not see to write, did not speak English or were too ill. Others were apathetic about joining in and were not pressed to do so, and others, mainly elderly people, tried but found the questionnaire baffling and returned blank forms.

*One hospital had a lower figure, but this was the one not visited by the author and the questionnaire was applied differently.

TABLE 1 Sex, age and length of present stay of patients included in the survey

Sex	Men	51 per cent
	Women	49 per cent
Age	Under 30	14 per cent
	30 to 64	67 per cent
	65 or more	19 per cent
Length of present stay	Short (under 1 year)	38 per cent
	Medium (1-4 years)	18 per cent
	Long (5 years or more)	44 per cent

General indications of patients' views

Question 20, 'Do you like your stay here, apart from being away from home?', offered four possible answers: 'Very much', 'In most ways', 'Only fairly well', and 'No'. The median* percentage of answers is given in Table 2. The fact that over half gave one of the first two answers is fairly satisfactory, considering that many of the patients were suffering from depression. The number of satisfied patients is, however, much lower than the number answering similar enquiries in general hospitals[2] where it was 94 per cent and has now increased to 97 per cent, and in psychiatric units attached to them, where it was 81 per cent.[1] As might be expected, patients in short-stay wards were much more critical than patients in long-stay wards. This was probably partly because they tended to be younger (and it is found in hospital surveys that the younger patients are more critical than their elders) and partly because they had not become habituated into accepting conditions.

At the first two hospitals surveyed the patients were also asked, 'Would you be pleased if your doctor said you could leave next week?'. But the question was subsequently dropped because the reasons for the answers were so complex that it was difficult to classify them. For example, a lot of people answered, '*No, because I have no home to go to*', or, '*Yes, although I like being here it would mean that I was cured*'. The proportion who said they would be pleased to leave was 48 per cent at one hospital and 63 per cent at the other.

Another indication of the patients' general attitude to their hospital was gained from the 202 people who answered in general terms the questions on what they liked best and least. While 158 gave general praise: '*The hospital is a very good one*', '*The excellent way the hospital is run*', '*I like the general atmosphere*'; only 44 people gave general criticism, '*Nothing to like here*', '*A feeling of becoming institutionalised*'. (See also page 27).

*Median is the middle percentage of the group of hospitals when the percentages are arranged in order.

TABLE 2 Median percentage of answers to question 20

Answer	Whole group	Short-stay wards	Long-stay wards
Very much	18	14	23
In most ways	36	37	33
Only fairly well	29	27	32
No	17	22	12

The popular press and general public often have a picture of patients being incarcerated in psychiatric hospitals against their will. With the great majority of patients the truth is very different and they are grateful that their mental illness is being treated. Nearly half would be sorry if they had to leave and indications are that this figure would be considerably higher if more of the elderly patients were included. Indeed, the proportion of patients who accept the hospital as their home where they can avoid the problems, personal or financial, of living outside its open gates, is sometimes a serious matter for concern.

Relative satisfaction with different topics

The preliminary survey at the first three hospitals suggested 19 topics that seemed most relevant to patients' views on their hospital, and a direct question was asked on each of these. Eight were on the ward, four on care and treatment, and seven on life in hospital, including meals, clothing, activities and relations with other patients. In Table 3 (see page 12) the median percentage of critical answers to each question is arranged in order of level of criticism. The two columns on the right show the median percentage of critical comment from wards that are primarily short-stay and from those that are primarily long-stay (including medium-stay). Only eight of the nine hospitals supplied data that could be divided into short and long-stay, which explains why the median of the total group in some cases is not intermediate between the short and long-stay medians.

Looking first at the results for the whole group it is satisfactory to note the comparatively little criticism about the ward itself, nurses' care, work and occupational therapy. The main criticisms, each coming from about a third of the patients referred to noise, boredom and their feeling that they did not see their doctors often enough or receive enough information from them.

As well as studying the amount of criticism given by the

TABLE 3 Median percentage of critical replies to each question

Order of whole group	Question (abbreviated)	Whole group	Short-stay	Long-stay
1	Dormitory	9	10	6
2	Day room	10	12	9
3	Nurses' care	12	15	8
4	Work	13	19	8
5½	Occupational therapy	14	11	15
5½	Space	14	15	16
7	Other patients	15	18	13
8½	Feel free	17	23	11
8½	Lavatories	17	20	12
10	Washbasins and baths	18	17	14
11	Clothes (hospital)	19	24	15
12	Meals	22	31	14
13	Lockers	24	26	18
14	Privacy	25	32	17
15	Ward quiet	28	37	19
16	See doctors enough	31	41	25
17	Interest	36	41	26
18	Doctors tell enough	39	44	34
		percentage not participating		
19	Social activities	(47)	(42)	(39)

whole group it is interesting to compare the relative views of the short-stay and long-stay patients (the latter including the medium-stay). On the whole, the order is similar but the short-stay patients tend to be far more critical on all topics (except occupational therapy and the amount of space in the ward)—sometimes twice as high a proportion complained. Since physical conditions for short-stay patients are often better than for long-stay, it appears that after a time patients get used to a situation and take less notice of the disadvantages. Indeed, some of the long-stay patients had been so many years in hospital that they may have found it difficult to remember standards outside for comparison. And, again, more of the short-stay patients were young people, and in hospital surveys the young are generally far more critical than their elders.

Table 4 gives, for each question, the median percentage of criticism for the nine hospitals surveyed 1970–71, the eleven other hospitals which conducted their surveys later, 1972–74, and the total 20 hospitals. The interquartile range—that is, the range of the middle half of the hospitals—is given for the total group. This table allows individual hospitals to compare their own results for each question with those of the group—to see whether they are average and come within the interquartile range, or particularly good and below it in having less criticism, or poor and above it in having more criticism.

Patients were invited to give explanations and suggestions to supplement their answers. Many responded and their contributions have been summarised by topic. Typical comments are quoted in the next section and are an important aid to interpreting the bare statistics.

TABLE 4 Median percentage of critical patients: 20 hospitals

Rank order	Question (abbreviated)	20 Hospitals Median	Interquartile range	9 Pilot hospitals 1970–71	11 Hospitals 1972–74	% Change over period Improved	Equal	Deteri-orated
1	Dormitory	8	5–10	9	6	3		
2	Day room	9	7–11	10	8	2		
3	Nurses' care	10	6–13	12	7	5		
4	Work	11	7–16	13	9	4		
5½	Occupational therapy	12	8–13	14	10	4		
5½	Other patients	12	8–15	15	10	5		
7½	Space in ward	14	10–16	14	11	3		
7½	Washbasins and baths	14	11–20	18	14	4		
9	Feel free	16	12–19	17	15	2		
10	Lavatories	17	12–20	17	15	2		
11½	Meals	18	13–25	22	18	4		
11½	Clothes (hospital)	18	14–24	19	17	2		
13	Lockers	20	16–27	24	18	6		
14	Privacy	22	18–28	25	22	3		
15	Ward quiet	23	15–27	28	16	12		
16	See doctors enough	32	28–36	31	34			3
17	Life interesting	33	27–38	36	33	3		
18	Doctors tell enough	39	35–43	39	38	1		
	Like hospital—'only fairly well' or 'no'	40	36–45	46	38	8		
	Social activities participation	Percentage not participating 47	40–54	47	45	2		
	Forms returned	4019		2148	1871			

Median When the hospitals are arranged in order of level of criticism for each question the median is the level of the middle one.

Interquartile range is the range of the middle half of the hospitals according to their percentage criticism. Below the range comes the most satisfied quarter of the hospitals, above it the least satisfied quarter.

The ward

The eight direct questions on the physical environment all concerned the ward. Sometimes comments were offered on other environmental factors, especially the grounds, and these are summarised later.

It is clear from Table 5 that most patients are satisfied with their dormitories and day rooms but have many complaints about lack of privacy, poor storage accommodation and, above all, noise. The sanitary annexes received far less criticism than in comparable surveys in general hospitals.[2] Most of the hospitals had lovely gardens and grounds and these were often a source of great pleasure; indeed, they were frequently given in answer to the question, 'What do you like best about the hospital?' The rather grim exterior of some of the hospitals, the long corridors and the widespread buildings were seldom mentioned, nor was the distance from home or from shops and pubs.

Space

The patients did not seem to consider overcrowding a serious problem except in a few wards, but in these it was much disliked. One said about a day room, '*There is barely room for everyone to sit down*'. Other patients found the dining area too small.

Overcrowding of the dormitories was heavily criticised in the few wards where it was mentioned.

The beds are too close together.
Can touch the next person.
I get oppressed if others are close.

People disliked beds down the middle of the ward. They liked the feeling of protection of a wall at their heads. One or two elderly long stay patients said they hesitated to report that the dormitory was overcrowded.

For fear I might be the one to get sent home.

Quiet

There was more criticism about noise than about any other factor in the ward especially from the short-stay patients. Over a quarter of the whole group of patients complained about it. It was worse in wards with just one day room, or an area partitioned only by room dividers.

Most wards had television on all the evening, some during the afternoon as well, and many had a radio or record player on most of the day.

Ward life is governed by TV or radio.
The TV is on loud enough to accommodate the hard of hearing.

It is true that most of the patients liked television but those who did not suffered considerably.

Can't read, talk or even snooze.

Since there is such a diversity of views here, perhaps the only solution is to have a quiet room away from the music.

When noisy can go into quiet room.
There is another room available for reading or writing.

Noise from other patients is a particular problem in some acute wards.

The patients walk up and down.
There are a few rowdies.

At night, a few patients shout out and make disturbances, and some people also mentioned '*footsteps*' and creaking doors '*when others go to the lavatories*'. A group of nursing assistants who chattered at night was a cause of much distress in one ward of sick old men. The amount of noise at night depended on the size of the dormitories and also whether they were divided into sections.

A few patients, especially the young ones, found the noise did not bother them. Others expressed gratitude for '*the refuge of a quiet room*' or a bedroom to themselves.

Day room

The low level of criticism about the day rooms shows how successful have been attempts to make them modern and cheerful, changing them often from vast Victorian spaces into friendly lounges. Attractive, bright carpets and curtains were specially liked, also 'modern' pictures.

Newly painted, wonderfully improved.

Splendid room like a hotel.
Comfortable, clean and warm.
Nice colouring.
Spacious.
We have three rooms and a free run of the place.
The door opens into the garden.

Room dividers and plants helped to make a large room look less forbidding and institutional and a second or 'quiet' room was much appreciated. The provision of enough comfortable armchairs meant that each patient could have his 'own' armchair as in a club—an important asset in making people feel at home.

The criticisms came mainly from people in wards described as '*dingy*', '*shabby*' or '*depressing*', where the walls and ceilings needed painting or even repairing, the pictures boring, the furniture set out unimaginatively, and the carpets missing or worn out. Paint of a very strong, unusual colour was often disliked.

Purple coloured ceilings.
Navy blue paint on walls horrible.
Our pictures should be more cheerful.
Pictures not up to date.
Only 47 comfortable chairs for 60 people.
The chairs are arranged in rows instead of in groups.
Arrangement rigid.

Very few criticised the temperature or the lighting but some deplored the lack of facilities for activities.

No ping-pong table.
Should have ward library.

Dormitory and bedroom

There was less criticism about the sleeping accommodation than about any other topic, and this held for patients both in short-stay and long-stay wards. This seems surprising when most people are not used to sleeping in dormitories. However, a few patients disliked it.

Don't like sleeping in dormitory, people wander in.
Not normal, sleeping with others.

Very favourable comments came from people who were lucky enough to have a single room.

The independence of having a room to oneself.
I can have my books.
I have my own ornaments and eiderdown.

But some people liked the dormitory and enjoyed the communal life.

Beautifully warm, spacious, pleasing.
I like company.
There is a warm, friendly feeling about it.

However, they liked to have curtains between beds. Few wards had them, although in some a wardrobe and chest of drawers were placed between beds to act as a divider.

Beds were said to be '*comfortable*' with '*plenty of blankets*' and '*sheets and pillowcases clean every week*'. Some patients suggested having coloured bedspreads instead of clinical white. A few patients mentioned the lighting.

TABLE 5 Critical answers to questions about the ward

Question		Percentage critical		
		Whole group	Short-stay	Long-stay
3	Is there enough space in the ward?	14	15	16
4	Is the ward generally quiet enough?	28	37	19
5	Is the day room pleasant and comfortable?	10	12	9
6	Is your dormitory or bedroom comfortable?	9	10	6
7	Is your locker or cupboard satisfactory?	24	26	18
8	Do you get enough privacy in the ward, bathroom, and so on?	25	32	17
9	Are the washbasins and baths satisfactory?	18	17	14
10	Are the lavatories satisfactory?	17	20	12

Centre light too bright.
Need bedside lamps.

Lockers and cupboards

In many psychiatric hospitals, patients are only supplied with small bedside lockers similar to, or even less roomy than, those supplied in general hospitals where most patients stay for only a week or so. In a few cases, it was found that patients had to share a locker or did not have any at all. The result was that many patients could not bring or buy their own clothes but had to wear those provided by the hospital. Some had pitifully few other possessions. Those patients who brought their own clothes had to keep them in suitcases under their beds, hung on communal rails, or locked in the ward store room.

Have to have carrier bag and case under bed.
Everything gets creased.
Locker not tall enough for coats and frocks.
Won't take hanger.
Keep suits at home.

Another source of difficulty was that often the lockers belied their name by not locking!

Clothes and slippers get stolen.
Things vanish, especially cigarettes and undies.

People 'borrowed' clothes from the communal rail or wardrobe and patients hesitated to ask busy nurses for their possessions locked in the store room.

Sometimes they won't give them out.

Table 5 (see page 15) shows that there were more complaints about storage space than about any other aspect of ward life except noise and lack of privacy. The only people who expressed appreciation were those who had single rooms with a chest of drawers and a wardrobe or hooks on the door, and those few who had individual tall lockers in the ward.

Privacy

Dislike was often expressed about the constant pressure of humanity around, of being in a group very mixed in age, type of illness, interests and social background. Many were unhappy at living closely with people very unlike themselves with little possibility of privacy by day or night. A quarter of the patients criticised this aspect of hospital life—the short-stay patients much more than the long-stay.

It is not normal for people to live together.
Feel terribly exposed.
Want to be alone more.
Always with others.
Don't like having visitors here, can't merge the two worlds.
It is like being in the middle of Hyde Park.

The exceptions were the lucky few who had single rooms and, to some extent, those who could escape social pressures by going into the grounds. Often single rooms cannot be provided but again some patients said they would feel happier if there were curtains between beds. There was some resentment when people from other parts of the hospital infringed the privacy of the ward or used the ward as a short cut.

Dislike patients from other wards wandering in.
Outsiders constantly coming through.

Lack of privacy in the bathrooms, washrooms and lavatories received some criticism—though less than might be expected as seldom, if ever, was there screening between the washbasins. Occasionally, there were not even curtains between two baths. Sometimes the bathrooms and lavatory doors had no locks and were open for anyone to enter. It should be noted that locks can be bought which can be opened easily by a nurse in case of emergency.

Only a few people said they did not mind lack of privacy, or had made their own adjustment to it.

Not used to privacy.
Get used to lack of privacy.
I always bath at a quiet hour.

Washbasins and baths

Some of the hospitals had given priority to the provision of good sanitary annexes. Indeed, in none of the psychiatric hospitals was there the serious criticism we often found in surveys of patients' opinions in general hospitals.[2]

Bathroom gorgeous.
Hot bath at any time.
Clean and lovely.
Basins excellent.

But critical comments were frequent, and these centred on four topics: shortage, equipment, lack of cleanliness and privacy.

Only two baths for 23 people.
A continuous queue for the bath.
We only get one bath a week.

Sometimes this shortage was due to the bathroom being locked at certain hours.

Bath closed at 8.15pm.
Cannot take bath when you like.

Patients suggested many improvements.

Showers would be preferable and more hygienic.
Need shelves above basins on which to put toilet things.
Warm water runs out of cold taps—this was said frequently.

Lack of cleanliness was only mentioned occasionally.

Dirty because patients don't clean them.

And there were one or two complaints about beetles or ants.

Many of the women wanted facilities for washing and drying clothes, especially underclothes. Some wards had washing machines which were greatly appreciated. In others, there were requests for washing machines and spin dryers, or a drying room. Most women are used to laundering their clothes and the opportunity for doing this adds to the normality and dignity of their life in hospital. Several people said that they wore hospital underwear because they did not want their own to go to the hospital laundry.

Lavatories

A far smaller proportion of patients criticised the lavatories in psychiatric hospitals than in general hospitals.[2] Criticism was similar to that of washbasins and baths—shortage, equipment, lack of cleanliness and privacy—but the balance of criticism was different. Few patients spoke of shortage, except in one hospital where some of the lavatories were locked up at night, but many commented on their dirty condition. They stressed that this was the fault not of the staff, but of the patients.

Could be cleaner.
Some patients dirty the floor.
Filthy in the morning.
People don't follow the rota for cleaning.

Several people suggested that more disinfectant was needed and should be left in the lavatories. New lavatories were said to be required in some wards because the old equipment did not flush properly or tended to overflow and occasionally there was a shortage of toilet paper. Again, people spoke of the embarrassment of having no locks or even engaged signs.

People barge in.

Care

It seems probable that the first two direct questions in this section, 'Do you see the doctors enough?', and, 'Do they tell you enough?', stimulated more criticism than would have been given spontaneously: indeed, it came from about one-third of the patients. Some of the answers indicate that many patients did not realise that part of the treatment may be to reduce their dependence on their doctor and also to get the patients themselves to discover the cause of their illness rather than for the doctor to tell them.

The question on nurses' care produced many enthusiastic tributes. In addition, answers to question 21, 'What do you like best about the hospital?', frequently referred to the staff in glowing terms and included doctors, nurses, social workers and others. There was considerable difference between the views of the short-stay and long-stay patients on the question of feeling free.

Seeing doctors enough

This question produced surprisingly critical answers from all hospitals, even though some of the patients seemed to think that it was only necessary to see a doctor for physical ailments.

No reason to see him.
Get enough doctor.

The comments suggest that most psychiatric patients had a great dependence on their doctors, and felt a need to see him at regular intervals. They greatly appreciated him when they did, and doctors were described as, '*sympathetic*', '*civil*', '*courteous*', '*pleasant*', '*marvellous*'.

Doctors can give you reassurance and confidence.
Can explain feelings to him.
Can see him any time when it is urgent.
Will listen to you.
See the doctor every day.

However, there was a heavier volume of complaints from patients who felt that they were not able to see a doctor often enough.

Desperately need to see a doctor more often.
Haven't seen a doctor for months.
For years.
Think cases should be reviewed more frequently.

There were many similar remarks especially from the short-stay patients, though in fact the doctors tended to see them more often. Patients who worked outside the hospital sometimes found it difficult to have an evening appointment to see the doctor.

The attitude of some of the doctors was criticised.

Doctors hardly look at us or speak.
Discourteous.
Examine us in public.

Many patients, realising the low ratio of doctors to patients, understood the difficulty.

Too many patients to each doctor.
Doctor overworked.
Doctors have little time to interview patients properly and are constantly interrupted.

Some patients said that they only saw a doctor if they had some physical complaint, but more felt that physical health, including dental care, was neglected.

Don't see the doctor for physical illness.
Neglected physically.
No treatment for foot.

Some criticisms concerned the type of psychiatric treatment.

Would like private talks instead of meetings.
Incessant talking, would like to solve my problems, not just talk about them.
Too many soporifics.
Should be allowed to refuse ECT.

No dissatisfaction was expressed about the great number of foreign doctors, except by one or two patients who said they were unable to understand English.

Doctors telling enough

More criticism was expressed on this then on anything else.

It may be that the nature of mental illness and its treatment sometimes tended to make the patient forget much of what *had* been explained. However, it is interesting to ask why the patients feel there is so little communication with doctors. Is it entirely because the doctors think it unwise to give information to the patients on their diagnoses and prognoses? Is it because they are too hard pressed to spare the time? Again, is it because still so little is known about some mental illnesses that doctors hesitate to commit themselves? Or do they think the patients would not understand or want to know?

Very many patients stated that they wanted to be told more about their condition.

Doctors ask questions but don't tell anything.
Don't give satisfactory answers.
Don't bother to tell one.
Would like to know my diagnosis in precise medical terms.
Would like to know how I am getting on.
Would like to know if I am crazy or not so I could improve.

A few comments just described the doctor as '*evasive*' or '*reticent*'. However, some replies to this question were less critical.

They tell if asked.
Tell me anything I want to know.
My doctor knows exact diagnosis and is very helpful.
Know only too well myself.

Nurses' care

A good relationship with the nursing staff seems to counteract some of the criticism that patients have about doctors.

Nurses more reliable in telling you things.
I have to ask nurse to explain it all afterwards.

It was good to see how very happy most of the patients were about the nursing staff, from the most senior to the most junior, but especially about the sisters and charge nurses.

Matron and assistant matron will go out of their way to spend time with you over what may appear to be trivial things.
Sister worth her weight in gold.
Two of the best charge nurses in the world.
Nurses very friendly and kind.
They would do anything for us.
Wonderful people.
Very nice, both white and coloured.
Cooperative, efficient and patient.

One aspect of the relationship noted by the patients with particular satisfaction was that the nurses treated them courteously.

They give me respect.
See patients as adults on equal terms, not as pathological cases or children.
I feel wanted.

They spoke of the support given by the nurses and the important part this plays in well-being and recovery.

When you get fears Sister reassures you.
They help us with our problems.
Staff are always ready to listen and help.
Comradeship, reliability and understanding of the male nurses.

There were a few adverse comments about poor relationships with patients, excessive discipline and regimentation, and shortage of nurses.

They shout at us.
Not sympathetic about insomnia.
The nurses are sometimes cross with me but one needs reassurance when one is in a panic.
The way they treat old people.
The difficulty of having two charge nurses of different personality.

Only in one ward out of all nine hospitals was bullying mentioned.

Use too much violence in restraining patients.
Knock new patients about.

TABLE 6 Critical answers to questions about care

Question		Percentage critical		
		Whole group	Short-stay	Long-stay
11	Do you see the doctors enough?	31	41	25
12	Do they tell you enough?	39	44	34
13	Do you get sufficient care from the nurses?	12	15	8
14	Do you feel reasonably free?	17	23	11

Hit in face because I refused tranquilliser.

This was brought to the notice of the hospital management and immediate action was taken.

Patients in some wards commented on the authoritarian attitudes of some of the nurses.

Treated like children.
Not democratic enough.
Staff sometimes despise patients.
Too much care.
Treated as insane and not as if I were a human being.
Punish patients by stopping vouchers and sending us to bed.

A number of patients expressed sympathy about staff shortage.

Sisters have to do all the work with very little help.
Not enough staff to help with disturbed patients.
Old people wander about due to lack of supervision.
Nurses overworked.
No time to take us for a walk.

But criticism of any kind about the nurses was rare and, including the comments on staff shortage, was only expressed by 12 per cent of the patients.

Comments about social workers were very occasionally included, both favourable and critical.

The social workers are very helpful.
The social workers should have closer contact.
Too autocratic.

Feel free

There is a frequent misconception by the general public that most patients feel imprisoned in psychiatric hospitals. This is, perhaps, a hangover from the days when all hospitals had closed gates, many locked wards and padded cells. All the hospitals studied were typical in that there was free access for the great majority of patients to go as they liked in and out of the hospital. They were free to visit local shops and pubs and many went home from time to time.

All the wards were unlocked in one of the hospitals. In the others, there were two or sometimes four locked security wards and in these, two locked wards were included in the survey. They were for patients who need protection from hurting themselves or other people. Some had been admitted on order from the courts. Some of the other wards were locked at night to prevent outsiders from entering, disturbing the inmates or stealing their possessions, or to stop old, confused people from wandering out when there was little supervision.

Naturally, there was a much more critical response about freedom from patients in the locked wards, though even some of these said they felt reasonably free. A few people, including potential suicides, said they had asked to go into a locked ward, but more resented being in them.

Locked doors terrify me and make me feel like a criminal.
Hate jangling of keys.
Kept here against my will.
In prison one is told when one will be free but not here.
Locked wards are still unpleasant even if you have parole to go into the grounds.
Patients in locked wards should go out every day.

From the unlocked wards, comments were much more favourable.

You are free.
As free as can be.
Can walk out at any time.
Can get leave till 11pm.
Given sensible latitude but some patients have to be looked after and doors locked.

Views about rules varied.

No set rules.
Can go to bed when I like.
Under no compulsion to do anything.
Too many rules and regulations.
Have to do as you are told.
Can't even make a cup of tea on your own initiative.

Critical comments came far more from the short-stay patients. Presumably, the long-stay patients had come to accept conditions as reasonable or had become institutionalised. But still different views were expressed by some patients who liked a measure of control and the regularity of life at the hospital.

I feel safe here.

Some wards had a studied policy of permissiveness. These were generally wards for young, short-stay patients or wards where patients were preparing for leaving hospital. They appreciated the easy atmosphere, but some of the young women in the short-stay wards were critical.

Too free and permissive.
Need to keep terrific control of yourself.
Patients try to stay in hospital because of the emotional relationships they have made with the male patients.

An immense variety of views was expressed about freedom and control. Some liked full freedom, some felt they needed a measure of control, and in both groups some were satisfied and some dissatisfied with what they were experiencing.

Life in hospital

The assorted list of topics grouped as 'life in hospital', include food, clothes (if provided by the hospital), activities, and patients' views of their fellows.

As Table 7 shows, on all topics except occupational therapy, short-stay patients were much more critical than the long-stay. Presumably, in time, patients get used to life in hospital and fret less at its limitations. Whether this is a good or a bad thing is hard to say.

Question 17 was different in nature from the rest because it asked for *facts*. It was assumed that patients took part in social activities because they wanted to. Such activities were always voluntary. All the other questions asked for *views*. Therefore, the statistics on Question 17 are not comparable with the others.

Meals

Views varied considerably. In three hospitals, about a third of the patients were dissatisfied; but two hospitals had a fine record, only nine per cent were dissatisfied. Again we found that long-stay patients were much less critical than short-stay.

As in general hospitals, there were many comments on

TABLE 7 Critical answers to questions about life in hospital

Question		Percentage critical		
		Whole group	Short-stay	Long-stay
1	Do you generally like the meals?	22	31	14
2	Are your clothes satisfactory (if supplied by the hospital)?	19	24	15
15	If you do work while in hospital do you like your work?	13	19	8
16	If you do occupational or art therapy do you like doing it?	14	11	15
18	Do you find life in hospital interesting with plenty to do?	36	41	26
19	Do most of the patients in your ward get on reasonably well together?	15	18	13
17	Do you take part in any social activites such as concerts, games, dancing, bingo and so on?	percentage not taking part (47)*		

*This figure is not divided into short- and long-stay because some hospitals did not make this division.

stodginess and on the shortage of fresh fruit, salads and vegetables.

Less starchy food.
Too much carbohydrate.

There was also some adverse criticism about the meat—'*tough*', '*unappetising*', '*tasteless*'. On the whole the puddings were well liked, though some of the women said they were putting on too much weight.

Supper was the most criticised meal, partly because of its timing. It was considered to be too close to tea.

Supper needs to be more substantial.
Supper boring.

Patients also mentioned that breakfast eggs were *always* boiled, never fried.

On service and presentation, most were satisfied but a few were critical.

Got to have meal quickly or miss it.
Scramble like a rat race.
Have to queue for food.

It is difficult to prevent mass cooking from becoming monotonous in any institution, and psychiatric hospitals are no exception.

Food appalling.
Badly cooked vegetables.
Potatoes unappetising.
Meals lack variety.
Food is cold.

Some patients said that a choice of menu such as some general hospitals offer would solve many of the problems. Patients mentioned that diet meals and food for the aged tended to become dull and monotonous, and deplored the absence of a dietician.

In most hospitals, the meals also received a lot of praise.

Marvellous.
Tasty.
Fruit three times a week.
Meals varied.
Always an alternative.
Meals always hot.
Like meals in a luxury hotel.
We can always have second helpings.
Can go and make a cup of tea when we want to.

Patients appreciate being consulted about the food.

Group discussions have improved the food.
Now get fish as well as stew.

In some hospitals, however, patients said they had no chance to complain.

We never see the catering manager.

Clothes

In one hospital, over 60 per cent of the patients wore their own clothes. In another, 29 per cent did so. The median was 50 per cent. Of course, the figures are much higher for short-stay than for long-stay patients and exclude those in the senile geriatric wards. Many factors seemed to influence the proportion of patients who provided their own clothes

emphasis in the hospital booklet on bringing clothes

adequate wardrobe accommodation

provision of washing machines and drying facilities, especially in the women's wards

opportunities to buy clothes either in boutiques in the hospital (some of which had occasional fashion shows), in shops outside or in sales of good second-hand clothes organised by the hospital's league of friends

encouragement from the ward sister or charge nurse.

These points were raised during the interviews we held with patients at the first three hospitals rather than as comments from the written questionnaire. They are included in this report because buying and owning clothes seemed to be important aids to feeling normal. Hospital clothes, even when specially supplied for use by only one person, do not stimulate the same feeling.

Few comments were made in the questionnaire about the clothes provided by the hospital. One or two people were appreciative.

Fit well because they were made for you.
I've got two suits.
Sister adapts clothes lovely.

Several people appreciated the care of the clothes, particularly the fact that they were washed regularly.

I get clean knickers every night.

More people, but still not many, were critical. They complained of poor fit and workmanship.

Short of large sizes.
Gave me 38 inch trousers, need 32 inch.
Clothes worn out.
Look institutional, unattractive.

Work

People in hospital often find that one of their problems is how to fill their time, especially if they feel physically well. That they generally welcome the chance to work is reflected in the low proportion of patients who said they disliked their work. There were fewer criticisms about this

than about any other topic except dormitories, day rooms and nurses' care.

Keeps your mind occupied.
Couldn't stand doing nothing.
I feel I am necessary.
Work varied and not too repetitive.
Enjoy company of other people at work rather than the job itself.

Many patients worked in industrial therapy departments on jobs which varied from repetitive small assembly work to the manufacture of furniture. But the patients often said there were too many unskilled factory jobs. Some patients did jobs in the hospital, mostly domestic jobs in their own wards or in other wards where the patients were too ill or too frail to help. Others helped in the laundry, the gardens and grounds, the printing department, typing or, occasionally, the library.

Two main criticisms were voiced. Some people disliked their particular job and others complained about the pay. Although the hospitals had special departments for allocating jobs to patients, taking psychiatric opinion into consideration, some patients did not approve of the particular allocation. Considering the numbers of intelligent people who become psychiatric patients, there seems to be much justification for these complaints.

Jobs should be matched to talent.
Not skilled enough.
No work that uses brains.
Should have work other than factory work.
Would like work that carries responsibility.
Organised for industry not for patients.

Other criticisms came from patients who disliked domestic work.

Dislike cleaning and washing up.
Don't like cleaning up after other people.

But a few patients, both men and women and usually the older, long-stay patients, took great personal pride in cleaning 'my' ward.

I like to make the ward nice and tidy and clean.

The second main complaint was about the low pay.

Lack of fair pay.
It won't keep you in tobacco.
Cheap labour.

The maximum amount of pay for patients in hospital is laid down by the Department of Health and Social Security, but many patients said they received far less than this. Others were satisfied.

Get £2 a week for cleaning lavatories.
A short day's work to get our money.

Occupational and art therapy

Not many critical comments were made about occupational or art therapy; indeed, the chief suggestions were for increasing frequency or scope. There were many appreciations.

Occupational therapy interesting.
Like it best of all.
Very pleasant people.
Can have a quiet think while doodling.

Some patients enjoyed sewing, knitting and weaving, although a few said the materials were poor. Additional subjects were suggested.

Should have cookery classes.
Cake making.
Practice on typewriter.
Should have courses which would help you when you leave.
Occupational therapy monotonous.
Need more handwork and carpentry.
Should have hobbies room.
Need more mental stimulation.

Also, in some hospitals, it was stated that more trained staff were needed, particularly 'art leaders'.

It is interesting to note a reversal of the usual findings in that more short-stay patients than long-stay patients were satisfied with occupational therapy. Possibly, where the size of the department was limited, the short-stay patients were offered more opportunities.

Interest and boredom

In spite of all the efforts to organise industrial and occupational therapy and a variety of social activities, there were many hours when patients needed something else to do. Some people were fortunate, they liked reading or walking in the grounds, but many men and women, used to being busy, found the time dragged. The effect of boredom on top of mental illness seemed insidious and was sometimes shown by a slow shuffling walk or by people sitting around without even a book or a newspaper. Over a third of the patients complained of lack of interest—a higher level of complaint than about any topic except lack of information from the doctors. It was felt more by short-stay patients, but even among the long-stay more than a quarter were bored. The dullest times were said to be the evenings and Sundays.

Nowhere to go on Sundays and evenings.
Need more evening activities in the ward.
Even the staff are bored at weekends.
Art department and occupational therapy close too early.

Some people felt that boredom arose from excessive care rather than lack of recreation.

Everything done for you.
Looked after too much.

Others suffered from lack of care.

Can't join in or see TV, need new glasses.
Visitors should be organised for those who have none.
Feel lonely.

Some patients thought that boredom was part of their illness. One patient suggested patients could organise activities themselves to combat boredom.

A few people found life full and interesting.

I keep myself busy.
I like helping people.
Like the varied life, life is boring at home after being in hospital.

Other patients

This question provoked a great variety of views.

It varies from patient to patient.
The majority of patients get on well but it depends who is on the ward.
A few violent or disturbed patients can worry everyone.
Some patients can't get on with anybody.
Better segregation would make for greater happiness.
The ward is too large and too mixed and morbid with contrasting people.

Many patients paid tribute to the companionship they found.

A sense of togetherness.
Able to make real friends.
Other people are more understanding than friends outside.
Trying to help others puts my own problems in perspective.

A number of people had made special friends of the opposite sex.

We have become engaged.
He is my best friend in hospital and has helped me recover.
I like being with my girl friend.

In two hospitals in the pilot survey, we found just under half of those questioned liked mixed wards: 57 per cent of the men and 40 per cent of the women.

Mixture makes life more interesting.
Improves atmosphere—less bad language.
Related male ward is a good idea: I like talking to men.

Some of the women were critical.

Men too scruffy.
Men swear at you.
Men present when women should be alone.

Indeed, in one unit for young people where the day rooms were shared, some of the young women were very bothered.

Some people get emotionally tangled and not necessarily unmarried patients.
Sexually promiscuous.

Most of the hospitals had separate wards for the acutely ill, physically or mentally, and for the very elderly. The rest of the patients were classified into groups by sex, length of stay and, sometimes, by the district where they lived or by the consultant psychiatrist responsible for them. So each ward had a conglomeration of people varying in age, intelligence, background, and degree and type of illness, who were forced into the intimacy of living together by day and by night.

Three types of patient were frequent causes of distress to their fellows. First there were the '*rough, dirty types*'.

Make obscene jokes.
Swear, curse and fight.
Have to mix with ex-convicts that steal from you.
Some women bitchy.

Then there were those whose illness made them frightening.

Attacked by patient who went to stab me.
Had teapot poured over my head.
Two patients hurt others today.
They are frightening.

The third difficulty was felt by young men or women who were with a number of old people.

Should not keep young people with older whose needs and interests are very different.
Not enough people of my age (24).
Old, old women round me.

An occasional elderly person objected too.

Should have the young together.
Those noisy juveniles.

Social activities

Figures given in Table 7 (see page 21) show the proportion of patients taking part in social activities (almost half) rather than whether social activities were liked or not. It was assumed that if people joined in social activities, which were always voluntary, it meant that they liked them.

Some of the comments were interesting and constructive. Much enthusiasm was shown for bingo, dancing, the club, over-60s club, library, cinema, parties. Other amenities liked were the hospital shop, the hairdresser and the Townswomen's Guild. The church and services for the various denominations were appreciated more by the middle-aged and elderly, while the grounds were enjoyed by all ages. Some criticism centred on difficulties in taking part because of poor organisation and information.

There should be a social welfare officer to coordinate activities (could be a patient).

There is not enough information available on hospital activities.

These could be announced in a hospital magazine or booklet, with perhaps a map of the hospital, it was suggested. And more use could be made of ward notice boards.

Other criticisms included the times of activities, the problems of patients in locked wards, and many suggestions were made.

Lack of organised activities in the evenings.
Everything closes at 7.30.
Patients in the locked wards can't join in.
Acute patients should have separate recreation.
More mixing of the sexes.
Too many men compared to women.
Club too noisy.
A music room with therapist.
Special activities for young people.

More games (snooker and ball games), holidays and outings were asked for. Some complained there was no suitable transport for 'chair' patients to join in. One patient commented,

We need more social therapy like this enquiry.

TABLE 8 Classified answers to questions 21 and 22 (liked best and least)

Topics are given in order of frequency of mention. The letter **H** indicates that the topic depends primarily on human or organisational factors, the letter **P** that it depends mainly on physical factors.

Liked best	Number of comments	
Social activities: club, bingo, parties, dancing, cinema (169), church, library, hairdresser, shop (38), TV and radio (30), occupational therapy (22), coach outings (18), sports and games (12), visits (9), concerts (8), walks (5)	331	H
Staff: especially nurses and doctors	302	H
Treatment and security: security and peace of mind (80), treatment and drugs(77), treatment for physical illness (2)	159	H
Ward: day room and decor (53), ward in general (35), dormitory and beds (21), comfortable, warm, airy (15), clean and tidy (13), single rooms (11)	148	P
Freedom: feel free (119), permissiveness (20), regular life (5)	144	H
Grounds and buildings: grounds (139), buildings (2)	141	P
Meals: food (109), service (19)	128	P
Other patients: companionship, help each other (83), mixed wards, other sex (5)	88	H
Work: interesting (45), pay (24)	69	H
Liked least		
Ward: noisy (38), overcrowded (27), dingy (17), sanitary annexe (12), lack of privacy (11), lockers (3), ward in general and miscellaneous (29)	137	P
Other patients: need better classification (54), patients frightening, swear, fight, unfriendly, or subnormal (52), for or against segregation of sexes (16), theft from lockers (7)	129	H
Freedom: not free (53), early rising (38), locked wards (27), doors locked at night (6), too permissive (4)	128	H
Meals: meals in general (68), dislike the food (21), need more variety and choice (13), service, rushed meals (7)	109	P
Social activities: bored, especially at weekends (60), club hours of opening, need more entertainment (16), need more day trips and coach rides and facilities for chairbound patients (16), need more games, walks (9), need more vocational courses (3)	104	H
Staff: nurses impersonal or shout at you (33), staff (in general) (26), shortage of nurses, changed too often (14), doctors remote or discourteous (13), need more contact with social workers (2)	88	H
Treatment and security: don't see doctors enough, not told enough (28), treatment in general (23), taking pills and having ECT (6)	57	H
Grounds and buildings: buildings bleak and cold, long corridors, badly signposted, too spread out (12), gardens (2)	14	P

Liked best and least

The last two questions on what patients liked best and least about the hospital brought particularly illuminating answers, giving an indication of the matters on which strong views were held, irrespective of whether a specific question had been asked. Although some patients found the questions difficult to answer, others listed several matters. Altogether, 2317 comments were given on specific matters, of which 1490 were favourable and 827 critical. In addition, 202 general comments were given, ranging from, '*Hospital is all wonderful*' to '*Nothing to like here*'. Of these, 158 were favourable and 44 critical.

Classified answers

The specific comments were classified under nine headings: seven were a compressed version of topics already described and two others were added as so many patients included them. These were treatment and security, and also grounds and buildings (see Table 8).

A very crude estimate of the relative satisfaction with the nine topics can be made by subtracting the number of critical comments from the number of favourable comments (see Table 9).

It is interesting to note that 72 per cent of the things liked best depended on human factors (including organisation) and only 28 per cent on physical factors such as the ward, food, grounds and buildings. Similarly, 68 per cent of things liked least depended on human or organisational factors and 32 per cent on physical factors. This shows how the contentment of patients in psychiatric hospitals depends far more on kindness, skill and organising ability than on the physical factors that are often considered first when trying to ameliorate conditions. It is realised, of course, that the level of kindness, skill and organising ability depends on having enough staff of a satisfactory level of training and experience.

TABLE 9 Order of 'liked best' minus 'liked least'

staff	214
social activities	207
grounds and buildings	127
treatment and security	107
meals	19
freedom	16
ward	11
work	8
other patients	–41

Comments about treatment and security, and about grounds and buildings, were often given by patients when asked what they liked best and least about the hospital. Since no direct questions were asked on these topics, the patients' views have not been summarised statistically but the general tone of the comments seems too valuable to miss.

Treatment and security

It was decided to exclude questions on treatment from the questionnaire, but so many patients paid tribute, in the supplementary general questions, to their treatment and its beneficial effect on their mental health that their comments are given below.

Very good treatment.
Everything possible done for me.
Being helped back to a normal way of health.
ECT has helped me radically.

Some appreciated '*the sedation, drugs, etc*', others praised '*group therapy without drugs*'.

Comments on results of treatment varied but were usually optimistic.

Am improving slowly but surely.
Will get over neurosis and get confidence.
I'm cured.

Other patients were critical of their treatment. Many felt they had too many drugs.

Taking those damn tablets.
Too much of the needle, nasty side effects.
Medication very strong.
Should move forward from drugs.

Only a few said they feared ECT and a few criticised the

group therapy and said they would prefer private talks. The lack of treatment for physical illness received further criticism.

Dental treatment inadequate.
Not enough physical treatment for older patients.
Have not got spectacles so can't read.
Nothing done for my rheumatism.

The feeling of security was an aspect of life in hospita enormously valued by many patients.

It's a refuge and gives security.
Can think about myself on neutral ground.
Gives reassurance against depression.
The quiet and rest from everyday worries.
Safety.

Their comments make one regret that the old term 'asylum' has such unfortunate associations that it cannot now be used, for it is as an asylum—'a place of retreat and security' —that many patients appreciate their hospital.

Grounds and buildings

All nine hospitals had gardens, eight with extensive grounds, beautifully kept. These were enormously appreciated. It was made abundantly clear that wandering or sitting in spacious grounds served as a welcome antidote to the crowded wards and departments.

The beauty and peace of the grounds.
The gardens and freedom to use them as one's own.
The grounds have a soothing effect.
The grounds are beautiful and extensive.
The wonderful views from the windows.

The few comments made about the buildings were almost all critical.

Too sprawled out.
Long corridors.
Bleak and cold.

Action

For many reasons, it was important for each hospital to consider in detail action to be taken on the individual suggestions, not least because it would have been unfair to ignore the willing and trusting cooperation given by the patients. Therefore, reports on the findings at each hospital were widely circulated within that hospital—usually some 200 copies among staff and committees. In addition, more detailed information was provided for the charge nurses or sisters about their particular wards, always remembering the guarantee of anonymity. After sufficient time had elapsed for this information to be studied, series of working parties were organised to consider which suggestions should be acted upon. The survey organiser in each hospital was secretary and took on responsibility for seeing that decisions made by the working parties were carried out.

At one hospital the results were compared with predictions made by staff at an interdisciplinary study day. The staff were further stimulated when comparing their forecasts with actuality, especially as the patients' views were far more favourable than they had expected.

Numerous changes were reported by the various hospitals. These included improvements in hospital organisation, patients' facilities, equipment, ward structure and also in staff attitudes. Two hospitals contributed to an article, *Practical Results of Surveys*.[4] In some cases, staff had recognised the need for changes well before the survey, but the patients' views were valuable in helping them to decide on priorities. Other views had not been known before. One hospital wrote to the author, 'Without exception the ward sisters and charge nurses felt that the survey was valuable as it brought to light some viewpoints of patients which were important and which might otherwise have not been expressed'.

Changes in levels of criticism between 1970 and 1974

Table 4, page 13, shows the median level of criticism for the nine surveys made in 1970–1 and the eleven made in 1972–4. It is striking that less criticism was made during the later period on all questions except one, 'Do you see the doctor enough?'. This may represent a real improvement in psychiatric hospitals, part of which may be due to greater interest in the views of the patients.

Comparison with psychiatric units in general hospitals

The report of a further survey on psychiatric units attached to general hospitals was published in 1974.[1] It included a question for staff and patients with experience of large psychiatric hospitals to compare life there with that in the units. The latter were preferred because of higher staff-patient ratio, less stigma, generally more modern buildings, more comfortable conditions for patients, a smaller community, and contact with other hospital departments. But large psychiatric hospitals had the advantages of better facilities for long-term patients and for classifying patients into appropriate groups, larger grounds, wider choice of social activities, industrial therapy, and better professional and social conditions for staff.

Extending the survey

The questionnaire and instructions for conducting the survey are on pages 31–41. Staff may also find the checklist on pages 42–47 useful. It was compiled from points most frequently mentioned by patients in the nine hospitals which undertook the first study.

It is the author's hope that more psychiatric hospital staff will become interested in regular monitoring of their patients' views, and that the method here described will be of some help in their studies.

Instructions for conducting the survey

1 The first step is to obtain the general support of the senior medical, nursing and administrative officers. It is important for all three groups to be interested, and to be prepared to consider results seriously.

2 One person should be selected to be the survey organiser, who will be responsible for the conduct of the survey, analysing and reporting results and following up subsequent action. This is a time-consuming job. The success of the survey largely depends on the tact, persistence and persuasive powers of the person selected. He or she could be one of the senior officers, a member of the community health council, a management trainee, a member of the league of friends, or an outsider such as a postgraduate student from the local university.

Preparation

3 Up to 12 wards, not more, should be selected. Most psychiatric hospitals are too big for all the wards to be included within reasonable time. All the patients in the selected wards should be invited, but not directed, to take part. It has been found advisable to exclude wards for geriatric patients because so many of them find the questionnaire difficult to answer. All the other wards should be divided into four groups: short-stay men's, short-stay women's, long- and medium-stay men's and long- and medium-stay women's. The wards from each group should be chosen by chance; for instance, by throw of a dice. Some adjustments may be needed to secure adequate representation of all types of ward; for example, new and old wards, villas, locked wards, rehabilitation wards, drug units, mixed wards. The final list of selected wards should provide a typical sample of the patient population of the hospital.

4 The aim and method of the survey should be discussed with all senior officers, and with medical and other relevant committees and the community health council.

5 It should also be explained and discussed in detail with the sisters and charge nurses of the wards selected for the survey. An introductory letter about the survey should be sent to them first. For suggested wording see page 34.

6 If the hospital has a newsletter, a brief description could be included in this. Three main points must be covered.

Aim To discover the views—satisfactions and suggestions for improvement—of a typical group of patients. Many views will already be well known to the staff, but the results can be used to help decide priorities for action, and can be compared with views of patients in similar hospitals.

Method All the patients in the sample will be asked to answer a written questionnaire anonymously as soon as they receive it, but no pressure will be exerted on them to do so. Some specific questions are asked in the questionnaire and there is plenty of space for additional comment and suggestion.

Reporting back The results will be reported to all staff and to the relevant committees, so that action can be taken when desirable and practicable.

Organisation

7 The survey organiser should fix a time for each ward, with the sister or charge nurse, when most patients can be present or can be asked to come back from industrial or occupational therapy units. It has been found that a convenient time is half an hour before a meal, while patients are sitting at table.

8 Have enough pencils sharpened ready for each ward, and have a larger envelope on a side table in which patients can place their completed questionnaire themselves.

9 No pressure is to be exerted on those who do not want to take part. Some will not be able to take part because of language difficulty, poor eyesight, mental condition, or other reason.

10 When the patients are ready, the survey organiser explains the general idea, gives a guarantee of anonymity, asks them to put their questionnaires into the large envelope when they have finished. He then hands out the questionnaire and pencils and reads the instructions at the top of the form, reminding the patients that their comments and suggestions, in addition to their answers, will be useful.

11 Staff are discouraged from helping patients, even if they are asked to do so, but one patient can help another and the survey organiser can repeat the instructions to an individual patient if he or she seems not to have understood. The survey organiser stays with the patients and waits until all have finished. It usually takes about half an hour, but if a patient takes much longer he/she should be given another five minutes and then asked to hand in the questionnaire as far as it has been answered. Some questionnaires may be left blank and these should be collected up.

12 While the patients are answering the questionnaire, a quick count should be made of those in the ward who did not want to take part. This count should not include those who sat down to complete the questionnaire but returned blank ones, or those who could not take part because of their mental or physical condition, language difficulty or other reason.

Analysing numerical results

13 The direct answers YES and NO, as well as answers to questions on sex, age, and so on, are summarised separately from the additional comments and the answers about what is liked best and least about the hospital. The wards are arranged in order—short-stay men's, short-stay women's, medium- and long-stay men's, medium- and long-stay women's, and each ward is summarised separately. First, the questionnaires should be sorted and those excluded that are irrational, very incomplete (less than half the direct questions answered) or blank. The results of the remaining questionnaires should be entered on work sheets (see page 35), ward by ward. Each work sheet has space for six wards, so usually two will be required, and the total for the hospital entered on the final sheet only. It is quicker if the survey organiser has an assistant who can read out entries to be made.

14 On questions 1 to 19 it has been found that more patients answer YES than NO, so it is less effort to record only the comparative few who answer NO or who do not answer. Reading down each questionnaire enter a stroke opposite N for each question where the answer is NO, and a stroke opposite NA (no answer) for each question which has not been answered. The strokes should be small and entered in groups of five, four strokes and a cross-stroke—𝍸.
The only exception is question 2, where entries are made for YES opposite Y, and NO opposite N, but no entry is made for 'no answer' as patients are instructed only to answer if they have clothes supplied by the hospital.

15 On questions B, C, D and 20 enter all answers classified as on the form and also 'no answer'. The totals in all cases should be the same for any one ward; that is, the number of patients whose forms are being analysed. On question B, if no answer has been given the sex can be filled in if the ward has patients all of the same sex.

16 Complete summary sheet (see pages 36–38) for each ward, and on the final page only for the hospital as a whole. On questions 1 to 19 (except 2, 15 and 16) enter

Ans = the number answered YES or NO (total forms analysed minus NA not answered)
N = the number answered NO
%N = percentage NO, $\frac{N}{Ans} \times 100$

The calculation of the percentage is very quick if a slide rule or calculator is used.

17 On question 2 enter the number having hospital clothes (YES plus NO) and the percentage dissatisfied with them

$$\frac{No}{Yes + No} \times 100$$

18 On question 15 enter for 15a the number doing work, YES, and for 15b the number doing work who dislike it, NO, and find the percentage of those doing work who dislike it

$$\frac{No \text{ (to question 15b)}}{Yes \text{ (to question 15a)}} \times 100$$

Question 16 is treated in a similar way.

19 On questions B, C, D and 20 calculate the percentage giving each answer, omitting those who gave no answer. The total in each case should come to 100.

20 As well as obtaining information on the hospital as a whole and on individual wards, figures can be calculated, if desired, for separate groups—short-stay patients compared with medium- and long-stay patients and for men compared with women. The order of entering the different wards recommended in paragraph 13 will facilitate this.

21 Complete the form, Numbers of Questionnaires Completed and Attempted (page 39), for each ward and for the hospital as a whole.

22 You may find it interesting to compare your results with those of the 20 hospitals in the original survey (see Table 4, page 13). The method is to mark questions that come into the top quarter (fewest critical) with a plus sign, and those in the bottom quarter with a minus sign.

Summarising comments

Rough summary

23 The most interesting but most difficult part is to summarise the comments. Prepare six large sheets of lined paper.

1 Comments on questions 1 and 2 headed 'Meals and Clothes'
2 Comments on questions 3 to 10 headed 'Ward'
3 Comments on questions 11 to 14 headed 'Care'
4 Comments on questions 15 to 19 headed 'Activities'
5 Comments on question 21 headed 'Best'
6 Comments on question 22 headed 'Least'

24 Rule a vertical line about two-thirds of the distance from the left-hand margin. Write the comments to the left of the line and the ward code letter of each person making the comment (or one differently worded but with the same sense) on the right of it. On sheets 1 to 4, also rule a horizontal line about a quarter of the way down the sheet. Write favourable comments above the line and suggestions or criticisms below it.

25 Enter the questionnaires a ward at a time, but it is easier to complete sheet 1 for all the questionnaires in the ward before starting on sheet 2. Read through a number of questionnaires to find the main comments and write in appropriate headings. For example, for question 1 on meals there might be

quality
quantity
excess of 'stodge'
variety and choice
service
temperature
diet meals.

Under each heading leave enough space to write in a number of typical comments and telling phrases. Each time a comment is repeated (not necessarily in the same words) underline it but remember to put the ward letter of the person making it in the column on the right. It helps analysis if different coloured ink is used for men and women.

26 Some patients write a general comment such as 'satisfactory' or 'poor' against a question or even against a whole section. These should not be entered because they just confirm the YES or NO direct answer and do not add specific information.

27 Note that questions 21 and 22 do not need horizontal lines; 21 is all favourable, and 22 nominally all suggestions and criticisms. However, under 22, patients often write some such complimentary comment as 'nothing I dislike' and it is as well to record these at the bottom of sheet 5 under 'general'. The comments under 21 and 22 can be conveniently recorded under nine headings; 'staff', 'freedom', 'ward', 'meals', 'treatment and security', 'work', 'patients' activities', 'other patients', 'grounds and buildings', with, of course, subheadings under each. For example, under 'staff', the subheadings might be 'nurses', 'doctors', 'staff in general', 'social workers'. Questions 21 and 22 give important information; they indicate what patients believe to be the best and worst of the hospital, irrespective of specific questions asked. A full summary of the results of these two questions should be given in the report.

28 Repetitions of previous comments are often given in questions 21 and 22. These are, however, entered on sheets 5 and 6 with the ward letter of all patients giving them to show where the greatest weight of approval or criticism lies.

29 Sometimes, patients make obvious mistakes in marking the questionnaire such as crossing out YES or NO instead of ticking it, or in giving praise under question 22. Make adjustments to fit in with the patient's intended meaning.

Final summary

30 Six similar sheets are needed, except that a column is ruled for each ward and for the total. Generally, the headings from the rough summary have to be regrouped and compressed and the most appropriate quotations selected. This usually involves considerable change and the final summary is shorter and has fewer subheadings than the rough summary.

31 After each comment, show in the appropriate column the number of people from each ward who made it, and give the total figure for the hospital. Add vertically the totals of appreciative comments under each of the nine headings, for each ward, and for the hospital as a whole, and then similarly the critical comments.

32 Prepare an outer page for the summary of comments listing ward code, ward name, number of forms analysed. This enables an estimate to be made of the proportion of patients from each ward making each comment.

33 Some patients will praise a situation which others criticise. Divergent views are to be expected; patients are different, and ward conditions are different. Both favourable and critical views are entered in the summaries. Indeed, in the report it is useful to show under each of the nine headings favourable comments minus critical comments, listed in order of size of the resulting figure, to show the balance of opinion.

Report and action

34 The report should be circulated widely among all staff and committees and deposited in the medical and nursing libraries, and the patients' library too. The report should include an explanation of the aim and method, number of patients taking part, overall satisfaction figures, numerical results and comments on specific questions, patients' suggestions for action. Survey organisers may find it useful to tabulate results in the form used by the author of this report (see list of tables in the contents page).

35 In addition to the main report, it is useful to make a full summary of the comments from each ward or department selected for the survey and to let the staff concerned have copies of these. This summary will be too detailed for wider circulation but will provide information for action specific to the ward or department.

36 A survey on which no action is taken and results not reported to the staff and patients is worse than no survey at all. A meeting of the senior officers (including at least one member of the medical staff) should be held for general discussion on findings and to determine ways of stimulating action. Often, the best method is to appoint a small working party with the survey organiser as secretary. An early meeting should also be arranged for sisters and

charge nurses of the wards concerned, possibly two meetings, one for each shift. Other interested staff should be invited, such as the principal nursing tutor, catering officer, psychologist, heads of occupational and industrial therapy departments, and of the maintenance department, club leader, and so on. The staff should be thanked for their cooperation and informed of the many topics praised by patients, and of their suggestions and criticisms. Full discussion should be encouraged. The survey organiser should be present at all meetings, including those of specific wards and departments. He should record all decisions on action to be taken.

37 Remember to thank the patients for taking part, by notes or letters to the wards, a ward notice, or a note in the hospital newsletter if there is one. They should be assured that their suggestions for change are being seriously considered, and some examples should be given where change has been decided. If there is a patients' committee, the report should be discussed with its members. A copy should be deposited in the patients' library.

38 Some hospitals have found it useful to give the local press a summary of the results of the survey, or for the survey organiser to be interviewed.

39 After about three months, and again after six months, lists should be compiled of the changes that have been made as a result of the survey. Sometimes, the effect of action can be found by repeating a part of the survey, using a shortened form of questionnaire, confined to questions on the matters concerned, to see whether the patients' opinions have altered.

LETTER TO WARD SISTERS AND CHARGE NURSES (suggested wording)

Dear.....

We are planning to do a survey of patients' opinions of this hospital to find out what they like about it and what suggestions they have for improving it. Our hospital is too big for all the wards to be included so we have chosen the wards by chance and your ward has turned up in the draw. The wards chosen are..... (list).

The survey organiser is..... He/she will come to the ward at a time convenient to you to explain to you and your staff how the survey will be conducted and to show you the questionnaire. He/she will also arrange to come and carry out the survey at a time convenient to you. It will need to be a time when most of the patients are in the ward and you may find it necessary to ask them to come back from the occupational or industrial therapy units. It has been found with many other surveys that the best time is half an hour before a meal, with the patients already sitting at the tables. But you may find some other time more convenient.

The organiser will explain to the patients the idea of the survey and how it will be conducted. The whole thing should take no more than half an hour. The questionnaires will be answered anonymously, and it is a voluntary occasion. The patients must not be pressed to answer. Also, the staff must not help them, even if the patients ask them to. The survey organiser will be explaining and discussing all these points with you.

We shall send you a report of the results, but of course the names of patients will not be mentioned in it.

Thank you for your cooperation.

Yours sincerely

Principal Nursing Officer

WORK SHEET

N = No NA = No Answer Y = Yes

Ward		Total	Total	Total	Total	Total	Total	Hospital Total	
1 Meals	N NA Y N								1
2 Clothes									2
3 Space	N NA								3
4 Quiet	N NA								4
5 Day room	N NA								5
6 Dormitory	N NA								6
7 Locker	N NA								7
8 Privacy	N NA								8
9 Basin, bath	N NA								9
10 Lavatory	N NA								10
11 See doctors enough	N NA								11
12 Doctors tell enough	N NA								12
13 Nurses' care	N NA								13
14 Freedom	N NA								14
15a Work	N NA								15a
b Like it	N NA								b
16a OT-AT	N NA								16a
b Like it	N NA								b
17 Social activities	N NA								17
18 Interesting	N NA								18
19 Other patients	N NA								19
20 Like stay	VM IMW OFW N NA								20
	Total								
B Sex	M F								B
	Total								
C Age	-30 30-60 65+ NA								C
	Total								
D Stay	-1 1-4 5+ NA								D
	Total								

SUMMARY SHEET

Ans = Number answering that question
No = Number answering NO
%No = Percentage of those answering whose answer is NO

Ward	Ans No %No	Ans No %No	Ans No %No	Ans No %No	Ans No %No	Ans No %NO	Hospital Ans No %No	
1 Meals								1
2 Clothes	(Y+N)N $\frac{N\times100}{Y+N}$	(Y+N)N $\frac{N\times100}{Y+N}$	(Y+N)N $\frac{N\times100}{Y+N}$	(Y+N)N $\frac{N\times100}{Y+N}$	(Y+N)N $\frac{N\times100}{Y+N}$	(Y+N)N $\frac{N\times100}{Y+N}$	(Y+N)N $\frac{N\times100}{Y+N}$	2
3 Space								3
4 Quiet								4
5 Day room								5
6 Dormitory								6
7 Locker								7
8 Privacy								8
9 Basin, bath								9
10 Lavatory								10
11 Doctors seen enough								11
12 Doctors tell enough								12

13 Nurses' care								13
14 Freedom								14
15a Work	Yes —	Yes —	Yes —	Yes —	Yes —	Yes —	Yes —	15a
b Like it	No $\frac{No \times 100}{Yes 15a}$	No $\frac{No \times 100}{Yes 15a}$	No $\frac{No \times 100}{Yes 15a}$	No $\frac{No \times 100}{Yes 15a}$	No $\frac{No \times 100}{Yes 15a}$	No $\frac{No \times 100}{Yes 15a}$	No $\frac{No \times 100}{Yes 15a}$	b
16a OT-AT	Yes —	Yes —	Yes —	Yes —	Yes —	Yes —	Yes —	16a
b Like it	No $\frac{No \times 100}{Yes 16a}$	No $\frac{No \times 100}{Yes 16a}$	No $\frac{NO \times 100}{Yes 16a}$	No $\frac{No \times 100}{Yes 16a}$	No $\frac{No \times 100}{Yes 16a}$	No $\frac{No \times 100}{Yes 16a}$	No $\frac{No \times 100}{Yes 16a}$	b
17 Social activities								17
18 Inter-esting								18
19 Other patients								19
	Ans %	Ans %	Ans %	Ans %	Ans %	Ans %	Ans %	
20 Like stay								20
VM								
IMW								
OFW								
N								
Total	100	100	100	100	100	100	100	

Sheet continued overleaf

SUMMARY SHEET continued

B Sex M F								B
Total	100	100	100	100	100	100	100	
C Age -30 30-64 65+								C
Total	100	100	100	100	100	100	100	
D Stay -1 year 1-4 years 5+ years								D
Total	100	100	100	100	100	100	100	

NUMBERS OF QUESTIONNAIRES COMPLETED AND ATTEMPTED

Wards													Total Hospital
A Forms analysed Men Women													
Total													
B Forms excluded Irrational Incomplete													
Total													
C Total forms Filled in (A+B)													
D Blank forms returned													
E In ward, able to answer but not attempted													
F Total not participating (D+E)													
Percentages Percentage $\frac{A}{C} \times 100$ (Forms analysed of those filled in) Percentage $\frac{A}{C+F} \times 100$ (Forms analysed of total patients in ward able to answer)													

Confidential

Questionnaire *Psychiatric hospitals viewed by their patients*

Will you kindly help the hospital by writing what you like and dislike about it and what you think should be improved? Your answers will be confidential; we do not want to know your name, but your views and those of many other patients will all be seriously considered.

Please read each question carefully and put a tick in the brackets (✓) by the answer that expresses your view. By each group of questions there is a space for you to write explanations and suggestions.

A	Name of your ward	.....
B	What is your sex?	**Man ( ) Woman ( )**
C	What is your age?	**Under 30 ( ) 30 to 64 ( ) 65 or more ( )**
D	How long have you been here this time?	**Under 1 year ( ) 1 to 4 years ( ) 5 years or more ( )**

QUESTIONS		ANSWERS	EXPLANATIONS AND SUGGESTIONS
1	Do you generally like the meals?	**Yes ( ) No ( )**	**About meals and clothes:**
2	Are your clothes satisfactory? (Only answer if they were supplied by the hospital.)	**Yes ( ) No ( )**	
3	Is there enough space in the ward?	**Yes ( ) No ( )**	**About the ward:**
3	Is the ward generally quiet enough?	**Yes ( ) No ( )**	
5	Is the day room pleasant and comfortable?	**Yes ( ) No ( )**	
6	Is your dormitory or bedroom comfortable?	**Yes ( ) No ( )**	
7	Is your locker or cupboard satisfactory?	**Yes ( ) No ( )**	
8	Do you get enough privacy in the ward, bathroom, and so on?	**Yes ( ) No ( )**	
9	Are the washbasins and baths satisfactory?	**Yes ( ) No ( )**	
10	Are the lavatories satisfactory?	**Yes ( ) No ( )**	
11	Do you see the doctors enough?	**Yes ( ) No ( )**	**About your treatment:**
12	Do they tell you enough?	**Yes ( ) No ( )**	
13	Do you get sufficient care from the nurses?	**Yes ( ) No ( )**	
14	Do you feel reasonably free?	**Yes ( ) No ( )**	

Continued overleaf

QUESTIONS	ANSWERS	EXPLANATIONS AND SUGGESTIONS
15a Do you do any work while you are in the hospital?	**Yes ( ) No ( )**	**About your work and your social activities:**
b If so do you like your work?	**Yes ( ) No ( )**	
16a Do you do occupational or art therapy?	**Yes ( ) No ( )**	
b If so do you like doing it?	**Yes ( ) No ( )**	
17 Do you take part in any social activities such as concerts, games, dancing, bingo and so on?	**Yes ( ) No ( )**	
18 Do you find life in hospital interesting with plenty to do?	**Yes ( ) No ( )**	
19 Do most of the patients in your ward get on reasonably well together?	**Yes ( ) No ( )**	
20 Do you like your stay here, apart from being away from home?	**Very much ( ) In most ways ( )** **Only fairly well ( ) No ( )**	

21 What do you like best about the hospital?

22 What do you like least about the hospital?

Thank you for your help

CHECKLIST HOW GOOD IS YOUR HOSPITAL?

Hospital

Ward

Date Signature.....

				Action to be taken
ABOUT THE WARD				
Day room				
1	Is there a second room away from the sound of TV?	Yes( )	No( )	1
2	If the room is large, has it got dividers with plants to make it cosier?	Yes( )	No( )	2
3	Are there enough comfortable chairs for all the patients?	Yes( )	No( )	3
4	Are the chairs arranged in groups rather than in rows?	Yes( )	No( )	4
5	Is there cheerful coloured paint or wallpaper in good condition?	Yes( )	No( )	5
6	Has the day room got attractive curtains?	Yes( )	No( )	6
7	Has it got carpet in good condition?	Yes( )	No( )	7
8	Has it got pictures suitable for contemporary taste?	Yes( )	No( )	8

Dormitory or bedrooms

9	Is the dormitory divided into bays with one or only a few beds in each section?	Yes( )	No( )	9
10	Has every bed got a wall at its head?	Yes( )	No( )	10
11	Are there coloured bedspreads?	Yes( )	No( )	11
12	Has each patient got a bedside lamp?	Yes( )	No( )	12

Lockers and cupboards

13	Has each patient got a locker by his bed?	Yes( )	No( )	13
14	Has each patient got a private cupboard long enough to hang his clothes?	Yes( )	No( )	14
15	Does his locker lock with a key?	Yes( )	No( )	15

Privacy

16	Is there a curtain or divider between adjacent beds?	Yes( )	No( )	16
17	Is there screening between the washbasins?	Yes( )	No( )	17
18	Is there screening between the baths?	Yes( )	No( )	18
19	Are there locks on the lavatory doors?	Yes( )	No( )	19

				Action to be taken
Washbasins and baths				
20	Are there enough washbasins and baths to avoid patients waiting?	Yes( )	No( )	20
21	Are there shelves and hooks by basins and baths?	Yes( )	No( )	21
22	Are there facilities for patients to clean basins and baths after use?	Yes( )	No( )	22
23	Can patients wash and dry their own clothes (washing machines, spin dryers, and so on)?	Yes( )	No( )	23
Lavatories				
24	Are there enough lavatories by day and by night?	Yes( )	No( )	24
25	Are there facilities for patients to clean lavatories after use?	Yes( )	No( )	25
26	Are the lavatories close to all parts of the dormitory?	Yes( )	No( )	26
PATIENT CARE				
Doctors				
27	Are there enough doctors to see all patients regularly?	Yes( )	No( )	27
28	Is there enough treatment for physical ailments (including rheumatism, dental treatment, provision of spectacles, and so on)?	Yes( )	No( )	28

29 Are doctors willing to give the patient information about his condition and progress (in suitable cases)? Yes( ) No( ) 29

Nurses and social workers

30 Are there enough nurses
a by day? Yes( ) No( ) 30a
b by night? Yes( ) No( ) 30b

31 Are nursing assistants given some training? Yes( ) No( ) 31

32 Do the patients know they can consult social workers when they need to? Yes( ) No( ) 32

Freedom

33 Is there a minimum of locked wards and are no patients in them who need not be there? Yes( ) No( ) 33

34 Do patients in locked wards get taken outside daily? Yes( ) No( ) 34

LIFE IN HOSPITAL

Meals

35 Is the food well cooked and served? Is there an opportunity for patients to discuss this with the catering officer or catering committee? Yes( ) No( ) 35

			Action to be taken
36 Are fresh fruits sometimes served, also salads?	Yes( )	No( )	36
37 Does the menu avoid being excessively starchy?	Yes( )	No( )	37
38 Is there a choice of menu?	Yes( )	No( )	38
39 Is there sufficient gap between tea and supper?	Yes( )	No( )	39
Clothes			
40 Are patients given an opportunity to buy clothes in the hospital or outside or by sales of good secondhand clothes?	Yes( )	No( )	40
41 Are hospital clothes attractive, up to date and clean?	Yes( )	No( )	41
Work and industrial therapy			
42 Is there skilled work available (including some that will help patients when they leave, for example, typing, housework, carpentry)?	Yes( )	No( )	42
43 Do patients get adequate pay?	Yes( )	No( )	43

Social activities and occupational therapy

44	Are there enough activities at evenings and weekends?	Yes( )	No( )	44
45	Is there a social centre or club for patients?	Yes( )	No( )	45
46	Is there a library, shop or canteen where friends can be taken?	Yes( )	No( )	46
47	Is there a social welfare officer to coordinate activities?	Yes( )	No( )	47
48	Are there newsletters or posters to inform patients of activities, and a map of the hospital and grounds?	Yes( )	No( )	48
49	Are there opportunities for music, snooker, outside ball games, outings for chairbound patients?	Yes( )	No( )	49

Relationships between patients

50	In allocating patients to wards, is enough attention paid to age (especially keeping adolescents together) and type of illness?	Yes( )	No( )	50
51	Are there some joint wards for men and women?	Yes( )	No( )	51

References

1 RAPHAEL, W. *Just an ordinary patient: a preliminary survey of opinions on psychiatric units in general hospitals.* London, King Edward's Hospital Fund for London, 1974. pp. 48.

2 RAPHAEL, W. *Patients and their hospitals: a survey of patients' views of life in general hospitals.* London, King Edward's Hospital Fund for London, third edition 1977. pp. 46.

3 RAPHAEL, W. *Survey of patients' opinion surveys in hospitals.* London, King's Fund Centre, 1974. pp. 22. (King's Fund Project Paper No. 9)

4 RAPHAEL, W. *and* PEERS, V. *Practical results of surveys. Health and Social Service Journal,* vol. LXXXIII, No. 4337. 2 June, 1973. pp. 1254, 1256.

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Confidential

Questionnaire *Psychiatric hospitals viewed by their patients*

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Please read each question carefully and put a tick in the brackets (✓) by the answer that expresses your view. By each group of questions there is a space for you to write explanations and suggestions.

A	Name of your ward	.....
B	What is your sex?	**Man ( ) Woman ( )**
C	What is your age?	**Under 30 ( ) 30 to 64 ( ) 65 or more ( )**
D	How long have you been here this time?	**Under 1 year ( ) 1 to 4 years ( ) 5 years or more ( )**

QUESTIONS		ANSWERS	EXPLANATIONS AND SUGGESTIONS
1	Do you generally like the meals?	**Yes ( ) No ( )**	**About meals and clothes:**
2	Are your clothes satisfactory? (Only answer if they were supplied by the hospital.)	**Yes ( ) No ( )**	
3	Is there enough space in the ward?	**Yes ( ) No ( )**	**About the ward:**
3	Is the ward generally quiet enough?	**Yes ( ) No ( )**	
5	Is the day room pleasant and comfortable?	**Yes ( ) No ( )**	
6	Is your dormitory or bedroom comfortable?	**Yes ( ) No ( )**	
7	Is your locker or cupboard satisfactory?	**Yes ( ) No ( )**	
8	Do you get enough privacy in the ward, bathroom, and so on?	**Yes ( ) No ( )**	
9	Are the washbasins and baths satisfactory?	**Yes ( ) No ( )**	
10	Are the lavatories satisfactory?	**Yes ( ) No ( )**	
11	Do you see the doctors enough?	**Yes ( ) No ( )**	**About your treatment:**
12	Do they tell you enough?	**Yes ( ) No ( )**	
13	Do you get sufficient care from the nurses?	**Yes ( ) No ( )**	
14	Do you feel reasonably free?	**Yes ( ) No ( )**	

Continued overleaf

QUESTIONS	ANSWERS	EXPLANATIONS AND SUGGESTIONS
15a Do you do any work while you are in the hospital?	Yes ( ) No ( )	About your work and your social activities:
b If so do you like your work?	Yes ( ) No ( )	
16a Do you do occupational or art therapy?	Yes ( ) No ( )	
b If so do you like doing it?	Yes ( ) No ( )	
17 Do you take part in any social activities such as concerts, games, dancing, bingo and so on?	Yes ( ) No ( )	
18 Do you find life in hospital interesting with plenty to do?	Yes ( ) No ( )	
19 Do most of the patients in your ward get on reasonably well together?	Yes ( ) No ( )	
20 Do you like your stay here, apart from being away from home?	Very much ( ) In most ways ( ) Only fairly well ( ) No ( )	

21 What do you like best about the hospital?

22 What do you like least about the hospital?

Thank you for your help

Psychiatric hospitals viewed by their patients

by Winifred Raphael BSc FBPsS

After Mrs Raphael's first do-it-yourself survey report of patient's views of general hospitals was published in 1969, many people doubted whether psychiatric patients could in a similar way comment on *their* hospitals. Mrs Raphael and over 2000 patients demonstrated unequivocally that they certainly can. The report describes what patients think about ward life, the staff, food, clothes, work, play, privacy, treatment, hospital rules and routine, and includes instructions for conducting the survey, the questionnaire and checklist used.

The demand for this second edition, published in conjunction with a third edition of the report on general hospitals, *Patients and Their Hospitals*, indicates that Mrs Raphael's work continues to be recognised as a practical way of monitoring patients' views of hospitals.

'. . . should be compulsory reading for anyone responsible for developing the service . . .' *British Hospital Journal*

'. . . The King's Fund has pioneered a method of finding out how these hospitals are seen by patients – real patients – actually in them.' *The Economist*

THE HOSPITAL IN THE NATIONAL HEALTH SERVICE

Before the National Health Service Act, 1946, there were two distinct systems of hospital provision in this country—the voluntary hospitals and the public or municipal hospitals. They had quite separate origins and histories and were quite differently organised and financed. The history of the more ancient voluntary hospitals stretches back to the early Middle Ages when they were founded by pious churchmen. Others, such as Guy's Hospital, were built in the 18th century by rich citizens, proud of their towns, but the greater number were built to provide for the needs of the large population which flowed to the towns as a result of the industrial revolution. The provision of hospitals by public bodies has its origin in the early public measures for protecting the sick poor in the 19th century, and later in that century the measures taken to combat the spread of epidemic infectious diseases.

In the years before the National Health Service Act there was a growing tendency for the two systems to get closer together, but it is only in recent years that the conception has developed that a general comprehensive National Health Service should be provided out of public funds not only related to the sick poor and infectious diseases but one catering for the hospital needs of the ordinary member of the public.

In 1929 the principle was finally accepted that general hospital provision was a proper activity of the major local health authorities rather than part of the Poor Law machinery. In 1946, the National Health Service Act gave us a comprehensive Health Service "designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis, and treatment of illness."

The National Health Service can be divided into three parts:

1. The Hospital and Specialist services
2. The General Practitioner, Dental, Pharmaceutical services, and
3. The Local Authority services.

It is generally true to say that all matters concerned with the health of the individual while he is living at home are covered by the second and third of these groups, though in some cases specialists on the staff of

(*b*) Special Hospitals, such as those mentioned above.
(*c*) Sanatoria for tuberculous patients.
(*d*) Mental Hospitals; Mental Deficiency Institutions.
(*e*) Hospitals for the chronic sick.
(*f*) Maternity Hospitals.
(*g*) Accommodation for convalescent hospital treatment and medical rehabilitation.

Of the hospital beds in this country, about 40 per cent are in mental hospitals and mental deficiency institutions. The general hospitals contain the majority of the remaining 60 per cent of the beds, and each is, as a rule, far larger than the specialist hospital dealing with one particular disease or condition, though these hospitals are slightly more numerous.

In all these hospitals, the service is obviously dependent on the medical and nursing staff, but it is the administrator whose job it is to provide the co-ordination of all that happens in the hospital, and there is no element which does not to some degree come within his scope. All the varied services that go to make up a well-run residential institution are needed in a hospital, and the provision of these services is the responsibility of the administrator, who must, above all, be sensitive to the atmosphere of the place he serves.

The kind of person, therefore, who is needed for this profession is one who will come to know all departments of hospital life by personal contact, who is prepared to associate himself with everything that happens in the hospital, sometimes at some sacrifice of leisure time.

Though the provision of these services is the duty of the hospital authority, the responsibility for their smooth running rests on the administrator who must have both the ability to get on with people of all kinds, and the intelligence to see things in their proper perspective, giving personal attention where it is needed, and inspiring respect from those with whom he works.

Hospital Administration can be summed up in the words of one hospital administrator:

> "The object of good hospital administration is to create a congenial and sympathetic environment in which the many skilled services and facilities for investigating and treating illness and accident may be brought to bear upon the patients' needs quickly,

The practice has already begun of arranging exchanges between the administrative staff of hospitals and the administrative staff of Regional Hospital Boards, so that those who plan and control at the centre may be as familiar as possible with day-to-day hospital problems and so that the hospital officer can get a broader picture of the scope of the hospital service in which he is serving.

THE TEACHING HOSPITALS

In addition to the responsibilities and duties common to all hospital administrators, the administrator of a Teaching Hospital has a special task to perform because of the place occupied by the Teaching Hospitals within the framework of the National Health Service.

The organisation of the Hospital Service is based largely upon three principles which were well outlined in a report produced by a Committee on Medical Schools* before the introduction of the Health Service. These principles were: Firstly, that properly planned and carefully conducted medical education is the essential foundation of a comprehensive health service. Secondly, that the care and treatment of the sick reaches the highest standard when it is associated with the conduct of teaching and research. Thirdly, that every practical means should be sought to bring every hospital into association, directly or indirectly, with a teaching centre.

Consideration of the principles shows in what way the duties of the Teaching Hospital administrator differ from those of his colleagues in the non-teaching hospitals. The provision of medical education means that the administrator must work in close co-operation with the university and medical school authorities; the maintenance of the high standards associated with teaching and research means that he must continually be seeking ways of improving and developing these standards, and that he must always be ready to support plans for experiment and research in any field of medicine or management; the need for every hospital to be associated with a teaching centre means that the administrator must co-operate not only with the University, but also with the regional and local hospital authorities, so that the influence of the Teaching Hospital can be as widespread as possible.

**Report of the Inter-Departmental Committee on Medical Schools, published by H.M. Stationery Office, 1944.*

To the patients in hospital, the importance of the services provided for him by the medical and nursing staff is self-evident, but there are also other staff providing other services which directly affect the patient. The following plan gives some idea of the staff for whom the administrator is responsible and of the services which they carry out. In many cases, control is delegated to the heads of departments, but upon the administrator lies the ultimate responsibility for the efficiency and co-ordination of staff and services alike.

THE PATIENT	STAFF	SERVICES
Before entering the Hospital	Almoners Appointments Clerks, Admissions Clerks.	Appointments and Admissions, Information on the situation, position and procedure of the Hospital. Relations with the public and Press.
Arriving at the Hospital	Hall Porters, Receptionists, Lift Attendants.	Reception and direction of patients.
In the Out-Patients Department	Almoners. Appointments Clerks, Medical Records Clerks Medical Secretaries.	Appointments System, Medical Records and Medical Correspondence. Social Service and liaison with local or national authorities.
	Other professional and Technical staff. Canteen Assistants.	X-Ray, Laboratory, Dispensary, etc. Canteen and Waiting-room services.
Going to the Wards	Admissions Clerks, Finance Dept. Staff.	Admissions procedure. Pay-beds and amenity-beds, Disposal of clothes and belongings, Information for relatives, visitors.
	Porters.	Transport to wards.
In the Wards	Professional Staff.	Almoners, X-Ray, Laboratory, Physiotherapy, Occupational Therapy, Dispensary, etc.
	Clerical Staff.	Medical Records and Correspondence
	Catering Staff.	Catering and Diets.
	Supplies and Stores Staff.	Supplies and Equipment.
	Laundry Staff.	Laundry and Linen.
	Engineering Staff.	Heat, Light, Power, Steam, Water, etc.
	Porters and Domestic Staff.	Maintenance of Buildings and Equipment, Safety and Fire Precautions; Patients' welfare and amenities:—
	Chaplains. Telephonists. Voluntary Workers.	Religious Services; visiting, Telephone enquiries, Library, Trolley-shop, newspapers, entertainment, etc.
Leaving the Wards & returning home.	Almoners, Drivers and Transport Staff, Clerical Staff.	Transfer to Convalesent Home, Transport, Correspondence and reports to family doctors or local authorities.

In many mental hospitals the functions of Group Secretary, Finance Officer and Supplies Officer are united in the person of one man who bears responsibility for all these offices and is assisted by an appropriate staff.

It is important to appreciate that in the administration of mental hospitals there are vital legal principles connected with the liberty of the subject, of which the administrator must have a thorough knowledge.

It is impossible in a short pamphlet of this kind to attempt to give any full account of the wide range of duties performed by the members of the different departments in a Group or hospital. It is hoped that the foregoing may serve to give some idea of the kind of work involved. It is difficult to give a summary of the qualities most needed in this or any other Service as distinct from professional or technical ability, but it is certain that success in hospital work calls for the qualities of leadership and initiative coupled with tact and a wide humanity. In a new service changes may of course occur both in the administrative structure of hospital authorties and in the precise functions of the officers. The foregoing is simply a general picture of the situation at present.

The Hospital Service is a great new experiment; all engaged in it now and for years to come have a great and fascinating task, that of discovering new and more efficient ways of ensuring that the Hospitals which form a big part of the nation's life and economy do their share in service to the community.

GRADUATE ENTRY

Possession of a University degree is a valuable qualification in that it has involved a disciplined course of study but since hospital administration is not a subject for a degree course in any university in this country, graduation does not provide a technical qualification. It is probably true to say that the social discipline learned by residence in a community such as a university is of value in hospital work.

All graduates entering the profession of Hospital Administration would be well advised, therefore, to study for the diploma of the Institute of Hospital Administrators.

FURTHER QUALIFICATIONS

Administration: The generally accepted professional qualification for Hospital Administration is the diploma of the Institute of Hospital Administrators, details of which can be obtained from the Secretary, The Institute of Hospital Administrators, 75 Portland Place, W.1. It should be pointed out, however, that possession of the diploma, though ensuring a sound basic knowledge of hospital practice, does not of necessity guarantee that the holder possesses the personal qualities required for senior posts.

Finance: The qualifications available are several. Some employing authorities prefer senior Officers in this department to have specific professional qualification in accountancy, though others accept the Diploma of the Institute of Hospital Administrators with specialisation in accountancy. The usual professional accountancy qualifications are the Institute of Chartered Accountants, the Society of Incorporated Accountants and Auditors, the Association of Certified and Corporate Accountants, and the Institute of Municipal Treasurers and Accountants.

Medical Records: Many of the posts in this branch of the Service, including some senior ones, are held by women. It may well be that what has been said above about university graduates is particularly applicable in this department because of its close association with the medical staff and any research work they may do.

Supplies: There is no specific training of a technical kind for Supplies Officers, but commercial experience is clearly helpful. Training is as a rule largely a question of experience in a Group or hospital Supplies Department, though there is a special paper on Supplies in the examination for the Institute of Hospital Administrators diploma.

In the case of a Hospital Secretary, the salary range at its maximum is from £540—£685 for the smallest hospital or sub-group, and from £1015—£1120 for the largest.

Different scales of salaries apply to Secretaries of Teaching Hospitals and Regional Boards, the maximum being £2250 for Secretaries of undergraduate Teaching Hospitals.

Immediately below these posts in seniority there are four grades—D, E, F and G, which apply to administrative posts of differing responsibility, whose salaries are as follows:—

	Minimum	*Maximum*
Grade D	£480 p.a.	£570 p.a.
Grade E	£545 p.a.	£645 p.a.
Grade F	£610 p.a.	£735 p.a.
Grade G	£710 p.a.	£835 p.a.

Grade C, whose salary scale is from £440—£515 p.a. is for those officers who supervise sections or departments or who are engaged upon individual clerical-administrative work of greater responsibility than Grade B.

The two junior Grades of A and B have salary scales based on age. These range from £160 p.a. at the age of sixteen in Grade A to £480 p.a. at the maximum of Grade B, usually reached at the age of thirty. The maximum salaries in Grades A, B and C for women are approximately four-fifths of those for men, and above Grade C, salaries for men and women are equal.

The Hospital Service has a contributory pension scheme and there is a generous sick pay scheme. Annual leave varies with salary, rising to thirty working days for staff earning over £1100 per annum.

All salaries and conditions of service for administrative and clerical staff are negotiated by the Administrative and Clerical Staffs Whitley Council, which is one of several Whitley Councils.

The above is designed to give only a general outline of the salary scales and conditions of service in 1953, and those requiring more precise information should consult the appropriate circulars issued by the Ministry of Health and the Whitley Council.

(A.C. Circulars Nos. 17, 30 and appendix to No. 30.)

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