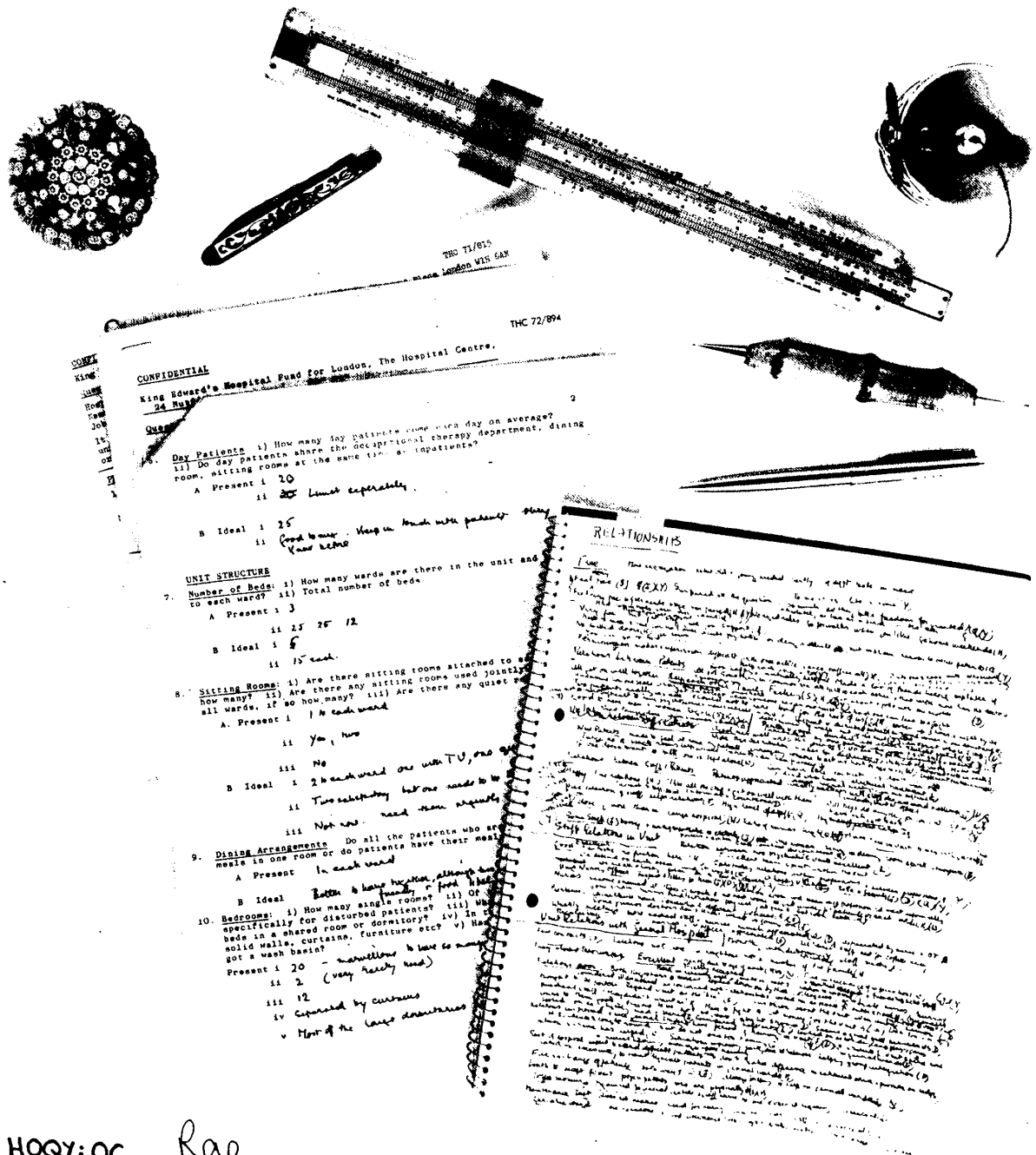
Just an Ordinary Patient

a preliminary survey of opinions on psychiatric units in general hospitals

Published by King Edward's Hospital Fund for London



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Just an Ordinary Patient

a preliminary survey of opinions on psychiatric units in general hospitals

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* Until his death on 5 July 1974.

Foreword

Mrs Raphael's earlier studies, *Patients and Their Hospitals*[6] and *Psychiatric Hospitals Viewed by Their Patients*[7], have been best sellers, and I have no doubt that this, her latest report, will be also. In it she records in her customarily clear and readable way the views of patients and staff in a cross-section of the new psychiatric units in general hospitals. Her long experience and great skill in observing human relationships and reactions have enabled her to produce a perceptive and penetrating study which will undoubtedly make an important contribution to the development of psychiatric care in this country. It complements admirably many of the official publications such as *Hospital Services for the Mentally Ill*[2] and the hospital building notes.[3,5]

As Mrs Raphael implies, it is frequently difficult to draw any firm conclusions from the conflicting views expressed, but one must accept that the broader strategy of psychiatric care is a very complex matter, involving many factors which she could not study in depth. It must also be remembered that 'the patients' are not a generic group, although we often talk of them as if they were – almost as if they belonged to a group different and separate from those of us who happen to be well. Thus, there is no such thing as 'the view of the patient', there are as many views as there are patients. A statement of the obvious, no doubt, but it is the obvious that so many of us are inclined to overlook. Nevertheless, the report gives clear pointers in various directions and provides a fund of useful information and ideas on which those concerned with the running of the psychiatric service can draw.

The Steering Committee are privileged to have been associated with Mrs Raphael in this project and, like her, hope that the 'action' margin on each page will be freely and effectively used.

A C Dale
1974

Author's acknowledgements

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Watford General Hospital, Shrodells Wing
West Middlesex Hospital
Wexham Park Hospital, Slough

Winifred Raphael

Contents

Summary

Purpose and Method The purpose of this survey differs from that of the two previous surveys, also financed by the King's Fund. These aimed at providing general and psychiatric hospitals with a technique for finding the views of their own patients, which has been very widely used. The study reported here is an exploratory enquiry on the views of both staff and patients about psychiatric units in general hospitals, mainly in London and southern England. It does not attempt to be a comprehensive attitude survey. Fourteen units were included; at the first seven individual interviews were held, at the other seven written questionnaires were completed by small groups. The report expounds the diverse views of over 300 people but does not often attempt to evaluate them.

Name and Site of Unit Patients preferred the unit to have a name that did not reveal the nature of their illness. To stimulate staff recruitment and the integration of patients with the local community the unit needs to be central in its catchment area, with good transport. In large areas two or more day hospitals may be required. Views varied on the location of the unit within the hospital; most favoured a separate building attached by a corridor and deplored the unit being on one floor in a high block. A garden, or at least a patio, was important.

Size of Unit, Length of Stay and Allocation of Patients Most units seen had about 50 beds but the staff thought the ideal size was 120 beds divided into wards of 25 to 30 beds. The average length of stay was between four and six weeks. Methods of allocating patients to wards differed: progressive patient care, remaining in the same ward, and by category of illness or age of the patient. Nearly all wards were mixed – men and women.

Inpatient Accommodation In some units the patients' daily life was centred in their ward, in others in the unit. People felt that at least two sitting-rooms were needed, one with television, the other a quiet room. Most patients appreciated single bedrooms but some preferred a small dormitory divided into cubicles. The number of 'protected' rooms (where patients could not injure themselves) varied from none to two for each ward. Some units needed more space to store the possessions of patients who had left their lodgings.

Staff Accommodation There were complaints from most units about the shortage of offices. The plan of some wards made it difficult for nurses in the office to see their patients. A unit staff room, common to all professions, was greatly liked and facilitated good relationships.

Care and Treatment Many patients appreciated the comparatively high ratio of doctors but deplored the fact that so many people were present when they were interviewed by consultants. The ratio of nurses to patients varied from 1 : 1 to 1 : 4. The community health nurses employed by three units reduced the length of patient stay and the number of people who needed to become inpatients. Active steps had been taken in some units to coordinate the work of hospital and local authority social workers. Group therapy was appreciated by many, but others found it monotonous if it was held frequently over several weeks. Some arrangements for applying ECT needed improving.

Activities and Meals Varied and interesting activities, both individual and group, were organised by the occupational therapy departments in most units, but at two there were serious organisational clashes. Patients particularly appreciated projects in which they helped the local community.

Parties, to which relatives were invited, and outings were often organised. Comments about meals were usually very favourable, especially about the choice of dishes.

Relationships

The patients stressed the mutually helpful relations they had with each other except sometimes when extremes of age were together or if a patient was acutely ill or noisy. Unit staff were happy together, but often there were serious problems in relations with the rest of the hospital. Some units, by varied methods, had overcome these difficulties.

Comparison of Units with Large Psychiatric Hospitals

Patients and staff who had experience of large psychiatric hospitals were asked to compare these with the units. Units were much preferred because of more medical treatment, less stigma, modern buildings, smaller size and situation in local area. However, the large psychiatric hospitals were considered better for long-term patients, greater classification of patients, the large grounds, wider choice of social activities and for industrial therapy.

Day Patients

Group discussions were held with day patients at the first seven units. The extent of their integration with inpatients varied. Some had industrial as well as occupational therapy and most appreciated social activities.

Limitations in Use of Information

The report is only a summary of what some people think about their units and does not attempt to make recommendations on unit organisation. The marginal columns in this report are for readers to note topics that may be worth considering in their own situation. One or other of the questionnaires (Appendix A or B) may be useful to apply in some units.

Purpose and Method of Survey

It is the policy of the Department of Health and Social Security for general hospitals to include psychiatric units. The units already existing differ widely in their structure and organisation but there is little information available on the attitude of staff and patients towards these variations. The King's Fund therefore decided that an exploratory study of the subject might be useful. Its preliminary nature and the use of group interviews precluded it from being a systematic attitude survey, producing tabulation of opinions and reaching firm conclusions. However, the impressions gained may help those planning or running such units to pick up some fresh ideas and the marginal column is left on each page to enable readers to mark topics for further consideration. The enquiry was primarily concerned with conditions for inpatients but some examination was made of the day patients' situation. The organisation of psychiatric outpatient departments was not included.

Fourteen units were included. The procedure varied between the first seven and the second seven units. At the first seven the investigators visited each unit and after preliminary explanations held individual interviews with some 30 people, staff and inpatients, based on the questionnaire shown in Appendix A, page 38, and then held a group discussion with some day patients. The results from these seven units showed such an amazing diversity of views on certain topics that a second questionnaire was designed, concentrating on these topics and asking for information both on the present situation and on what would be considered ideal in a new unit. This second questionnaire (Appendix B, page 40) was applied in the seven other units in a rather different way from the first. After a preliminary visit and explanation, five small groups in each unit were asked to give their views – doctors, nurses, other staff and two groups of patients. In four of the seven units the answers were given at interviews with the investigator, in three units written answers were returned separately by each group. Thus, general views were obtained from the first seven units and views in more depth on specific topics from the second seven units. All the units received short reports about themselves to enable them to take action on the findings, except for the three units returning written questionnaires which already had the information.

Individual interviews were held with 203 people at the first seven units – 18 doctors, 66 nurses, 24 other staff and 95 inpatients and, as well, discussions were held with groups of day patients at each unit.* Accurate figures cannot be given of the numbers concerned at the second seven units as the answers came from small groups and some were returned by post, but probably they were about half as many as at the first seven. Therefore, the report is based on the views of some 300 staff members and inpatients as well as seven groups of day patients.

There were striking variations in policy and practice between the units visited. Some of these were due to physical factors such as location of unit, size, whether purpose-built or adapted, and proximity to the main hospital. Others were the result of policy on such matters as the method of allocating patients to wards, whether the patients' life was more ward-centred or unit-centred, and provisions for treat-

* Of the inpatients, 52 per cent were women and 48 per cent men. Their ages were: under 30, 30 per cent; 30-59, 59 per cent; 60 or over, 11 per cent.

ment, occupations and social activities. Views were sometimes diametrically opposed not only between units but between individuals in the same unit. Often one doctor would have quite different views from another, and it would be grossly inaccurate to speak of views of 'the patients' as if they were a generic group. The report aims to expound these contrasting views and does not attempt to evaluate them.

Name and Site of Unit

Name The name by which the unit was known and which appeared above the door and on signposts in the grounds sometimes caused strong feelings. Most units were known as 'the psychiatric unit' or 'the department of psychological medicine' but others had less descriptive names – 'North Wing', 'Churchill Clinic' or 'Ward G3'. The medical staff tended to favour a name including the word 'psychiatric' or 'psychological': '*Nothing to be ashamed of*', '*We are coming out of the dark ages*'. The opinion of the nursing and other staff was divided, but most of the patients strongly objected to such names: '*It makes people think you are mad*', '*It advertises our complaint*', '*The unit gets called the nut-house*'. They asked whether it was the function of the unit to educate the general public at the expense of patients who felt a descriptive name could seriously prejudice their position with friends and employers.

Site in the Catchment Area If there is a choice of location the unit should be at the most accessible general hospital. One of the main advantages of most units over large, more remote, psychiatric hospitals is that patients are able to remain integrated with the local community. They can go home at weekends, have frequent visitors and after they leave they can return as day patients or outpatients. There can also be a closer association between the hospital staff and general practitioners, local authority social workers and home nurses. Recruitment of staff is also affected by location. At one unit, three miles from the nearest town and with a very poor bus service, it was so difficult to obtain staff that fewer than half the beds could be occupied. Another unit was divided into two parts several miles from each other; this distance was deplored by staff and patients and the section farther from the main hospital was said by the staff to have inadequate medical care in emergencies. When the catchment area is large it is important to have more than one day hospital, '*convenient drop-ins for drop-outs*' as one person expressed it.

Site in the Hospital Four of the units were part of the main hospital building, another four units were in separate buildings but joined to the main hospital by a corridor, and six were in completely separate buildings in the grounds. Strongly held opinions were expressed about the advantages and disadvantages of these alternatives.

Those in favour of the unit being housed in ordinary wards in the main hospital – often the doctors – were largely motivated by the psychological effect. Such a position emphasised the fact to patients, friends and the general hospital staff that '*psychiatric illness is an illness like any other*' – a phrase used repeatedly. The doctors also thought it might facilitate friendly contacts with colleagues. Those against complete physical integration stressed the special requirements of psychiatric patients who are usually physically fit so that wards needed to have a different design. It was considered extremely important for the unit to have its own external entrance and easy access to the grounds. If the unit was close to other wards there were problems of noise penetrating from it late in the evening from television and sometimes from parties with singing and dancing.

The staff said that nurses in other wards complained that disturbed psychiatric patients wandered in and frightened their patients; for example, a nurse from a maternity ward said '*One of the patients terrified a new mother by saying "I want a baby"* '. A unit patient said '*You bump into other patients in the lift who look at you as if you were*

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queer'. Both patients and staff thought that if the unit was in the main hospital it limited the admission of seriously disturbed patients: '*We can have more difficult cases if we are a little separate*'. The situation is particularly acute if the unit is housed in a tower block above or below other wards.

The majority of both staff and patients were in favour of the unit being housed separately but joined to the main building by a corridor. It could then be planned to meet the special needs of psychiatric patients, while allowing access to the amenities of the main hospital, such as staff refectory and shop, as well as facilitating the transport of patients, food trolleys and goods.

At three of the units that were completely separate, staff and patients appreciated the low, friendly buildings with a domestic look: '*Nice appearance, not like a hospital*'. A separate hostel block for patients well enough to go out to work was included in one unit for longer-stay patients, but the staff thought it would have been better on a site right away from the hospital. It was suggested that provision for extension should be made when building a psychiatric unit, such as foundations strong enough to take an extra floor.

Garden

Where there was a well kept garden with flowers, seats and possibly facilities for games, the patients made such remarks as: '*It is salvation having a garden*', '*We get right away from the hospital atmosphere there*'. Where there was no garden it caused real distress: '*I crave for green trees, grass and a bit of nature*', '*Depressing – no grass or trees*'. In one unit the League of Friends had provided a delightful garden with a patio and a goldfish pond which served as a point of interest. Even a small terrace on to which the lounge opened, or a few seats with tubs of flowers outside the front door made all the difference to the feeling of restriction, but some units that could easily have planned such amenities had not used the opportunity. Sometimes a garden was available for the whole hospital and this was liked, but staff and patients wished there could also be a small additional garden where unit patients could sit while they were still under close supervision. Some patients complained: '*I never went out of the ward for a month*'.

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Size of Unit, Length of Stay and Allocation of Patients

Size of Unit The units visited varied in size from 30 to 101 beds, most having between 40 and 54 beds. DHSS's plans for the future are for units of about 90 to 120 beds and this size agrees with that considered ideal by most of the staff. They thought that no ward should have more than 30 beds (some now have 50 beds) and smaller wards were preferred. Patients tended to approve of whatever sized unit they were in, probably due to the fact that most had no experience of other units.

Length of Stay

The average length of stay at the various units was usually between four and six weeks. It obviously depended on a number of other factors besides success of treatment:

- readiness to admit patients likely to stay a long time, especially the elderly
- readiness to transfer patients not responding to treatment, and local facilities for such people
- demand for admission and consequent early discharge to admit other acute cases.

Admissions Some units admitted all psychiatric patients from their area and even brought local patients from related but distant large psychiatric hospitals to the unit. More units admitted all patients except those aged over 65 who were senile or demented, adolescents and court cases. A few units excluded drug addicts and alcoholics; more accepted some of them but not in segregated sections.

Transfers The demented elderly were sometimes kept in the unit for three or even six months but if they were not improving, and their condition seemed irreversible, they were usually transferred, especially as they depressed other patients: '*It is sad to see what we might become*'. Very few younger people were transferred – they might be, for example, a patient who had come from another catchment area, one who was mentally handicapped or, very occasionally, a chronic schizophrenic. The staff at most of the units said they could generally keep the acutely disturbed, including those who were noisy and aggressive, but not the few patients who, after a year or even two years, showed no sign of responding to treatment: '*They clog up the system and are a dreadful burden on the unit*'.

Demand for Admission At many of the units the demand for admittance was heavy. At one it was so serious that the staff said patients had to be discharged at the earliest possible moment, and that about two a week were transferred to an associated large hospital many miles away. In many units people wished they had an associated small home and sheltered workshops for psychogeriatric and other long-stay patients, and some suggested it should be close enough to allow for rotation of staff. They also wished for more local authority homes for those patients who could not return to their own homes.

Allocation of Patients

On the important matter of allocating patients to wards there were fundamental differences between the units visited. Three methods were used.

Progressive Care The patients all started in an admission ward and remained there while they were acutely ill and then progressed to one of the rehabilitation wards. This was the most usual method of

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allocation and tended to be preferred by patients and staff. The patients said they were encouraged to progress and realised on transfer that they were getting better. When recovering they did not have the trying experience of remaining with others who were acutely ill. Staff said it had the advantage of segregating those who required close supervision.

Staying in One Ward The patients remained in the same ward for the whole of their stay. This method of allocation was the second most frequent. It had the advantages that the patient remained with the nurses he knew and that the new patient could see how others had progressed. Each ward could be under the care of a different consultant and this avoided difficulties when consultants had different clinical methods.

Category of Patient In a few units, patients were allocated by their illness or age. In one unit the division was between the psychotic and the neurotic, in another drug addicts went to a certain ward, and in three there were special mother-and-baby units. The elderly were kept together in some units, often to the relief of other patients: '*Mixing with the very old makes me depressed and sets me back*'. Opinions differed on the advisability of categorising patients. Those in favour spoke of the ease of giving special treatment and care; as one doctor put it '*We can't separate different types of patients enough – chronic psychotics worry mild depressives*'. Those against said it reduced flexibility of intake and that everyone mixing helped to develop a therapeutic community.

In all but two units the wards were mixed by sex, men and women sharing the same sitting-rooms. This was liked though sometimes small additional sitting-rooms were provided, each for one sex only, and these also were appreciated. Some wards had completely separate sleeping accommodation leading off different corridors. In others men and women shared the same corridor but, of course, with separate dormitories, and in these it was possible to vary the number of men and women according to the demand for beds. Usually, the sanitary accommodation was separate but in one unit where it was not differentiated there was no criticism – it was described as '*like at a hotel*', and in another unit with a shortage of lavatories and bathrooms some people wished these could be used by either sex.

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Inpatient Accommodation

Location of Wards It was suggested that admission wards should not be on the top floor in buildings of several storeys because of the risk of suicide and that it was '*too like being locked away*'. They should be planned so that close supervision could be maintained and the exit easily watched from the nurses' office: possibly the first floor is best. Separate wards for old people should be on the ground floor for ease of reaching the dining-room, therapy departments and garden. If lifts are available for patients to use themselves the location of the elderly is perhaps less important, but in several units the lifts could only be operated by staff. In one unit the lifts opened straight into the ward sitting-room on each floor and this was found to be disturbing.

Sitting-rooms Day accommodation varied according to whether the daily life of the patients was mainly centred in their ward or in the unit as a whole. If it was ward-centred most of their sitting-rooms were there, and patients took their meals, and in one unit even had their occupational therapy, in the ward. The advantages claimed for this plan was that it made the ward like a home – '*We are like a family*' – and that it was easier for a disturbed or inadequate person to relate satisfactorily to a small group than to the whole unit. Some of the staff believed that it was better for patients' life to be unit-centred because patients gained by identifying with the larger group, and problems of staffing were simplified. One unit even locked patients out of their wards during the day, except for the acute ward, but this was agreed by staff and patients to be a bad mistake. At most units the practice was halfway between being ward-centred or unit-centred. The newly admitted and acutely ill patients remained in their wards all day, eating and having occupational therapy there, though possibly they might go into the garden. All the other patients shared common sitting-rooms, dining-room and the occupational therapy department though they generally had the use of the ward sitting-rooms as well.

Most units had at least two sitting-rooms for each ward, one with television and the other a quiet room where patients could escape to read, write letters or sit and talk undisturbed, and sometimes a small extra room for interviews or for seeing visitors. However, some of the smaller units had no ward sitting-rooms and the patients complained of just having a crowded noisy lounge. The ideal plan for the rooms common to the whole unit was said to be a lounge, large enough for unit parties, with television and a piano, a small music room with a record player, a quiet-room-cum-library, and a games room. In some sitting-rooms patients admired the brightly coloured curtains, the carpets and 'up to date' pictures. Comfortable armchairs of varying designs and colours were appreciated; patients mentioned that there should be enough for all patients and some visitors, and that the chairs should be arranged in groups with coffee tables and not in '*institutional straight lines*'.

Bedrooms and Dormitories Of the 14 units visited six had between a third and a half of their beds in single rooms, four had about 20 per cent and four had only 12 per cent or less. Many of the patients were delighted to have their own bedroom: '*It makes an enormous difference to have so much privacy*', '*I can see my visitors without other people around*'. Most of the rooms were well furnished with a chest of drawers, a wardrobe, a small armchair and nice curtains, and some had their own washbasins. However, in a few units patients described the rooms as '*grim to look at*' and said '*Our spirits would lift if the rooms were more cheerful*'. No window

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curtains were provided at one unit and the patients seriously complained that the daylight woke them early. The staff liked single rooms for the patients because they could be used for men or women.

However, quite a number of patients preferred the company of a dormitory: '*It's nice and friendly*'. The newer units had small dormitories of four, five and six beds, but three of the older units had larger dormitories with up to ten beds. With few exceptions the beds were separated from each other, usually by curtains but sometimes by solid divisions or by furniture, so that each patient had a cubicle: '*I've got a little bit of home and feel more relaxed*'. Most dormitories contained a washbasin with curtains round it and some had their own lavatory just outside. In some units the staff complained that privacy had not been sufficiently considered; the bed curtains left gaps or there were no curtains round the basins.

Patients appreciated the divan beds, also the nurse-call systems and bed lights, though sometimes the switches were placed too high to be reached easily. Heating radiators just behind the bedheads were strongly criticised in one unit. Some people suggested that if the bedrooms and dormitories were painted different colours the place would look far less like an institution.

The need was expressed for protected rooms in which patients could not injure themselves, but there were widely different views in apparently similar units on both the number of rooms and the amount of protection required. In one unit there was found to be no need for any protected room, but the ground floor rooms had armour-plated glass windows. In some units people seemed content with only one protected room for the whole unit; this had an enclosed washbasin and a reinforced glass window which opened only six inches. In another unit the protected room had been soundproofed. One unit had two protected rooms in each ward, with all electrical and plumbing equipment covered in, reinforced ceilings and walls, and a bell just outside the door for the staff to ring for help. Staff in several units appreciated having one or two observation rooms, easily seen from the nurses' office, for patients who were acutely ill either physically or mentally.

Sanitary Accommodation

Sanitary accommodation was generally satisfactory: '*Spacious, clean, and allowing privacy*'. However, the lavatories in two units were disliked; the seats were too low and to flush the pan one had to stand on one foot and push a lever on the wall with the other – a difficult exercise. In one unit the lavatory doors had been designed to leave a large gap between the lower edge and the floor, and in another there was no lavatory big enough for a nurse to assist a patient if necessary. The bathrooms were mostly liked: '*Hot water at all hours*', '*A nice hot towel rail*', but in some units more baths or shower-baths were needed. Criticisms were made of the '*stark and cheerless appearance*' of some bathrooms and others lacked hooks for dressing gowns. (Special hooks were used in some that gave under a heavy weight.) Two units had a shampoo room for women and these were appreciated. In another, a spray attachment for washing hair was requested. The doors of all lavatories and bathrooms for both staff and patients at one unit were painted distinctive colours, one colour for men and one for women.

Most patients stay some time in their unit, so facilities for washing clothes are needed. Satisfactory arrangements for this existed for

women at all but one of the units. In some, men were excluded from the laundry rooms, although in others quite a number of men used them. One fair-sized laundry room for the whole unit, well equipped with sinks, a spin dryer, drying cabinet and ironing board was generally preferred to a small laundry room with less equipment on each ward. Often, no washing machine was provided and patients did not seem to mind this if they had sinks. In one unit housewives were encouraged to do their family wash and so keep in touch with their homes; another unit took in the laundry of a local home for mentally handicapped children as a social project.

Amenities

Patients usually had good storage space, each having a wardrobe as well as a dressing-table or bedside locker. Some of the wardrobes were criticised as being too narrow to take coat hangers or too small for heavy overcoats as well as other clothes. Sometimes there were no individual towel rails fitted to the lockers. Suggestions came from three units that at least one drawer should have a lock, otherwise pilfering or 'borrowing' was made easy and frequently happened. The staff spoke of the urgent need for a large locked room or cupboard to store the possessions of those patients who brought a lot because they had left their lodgings on entering the unit.

A soundproof pay-box telephone available for both inpatients and day patients was a much appreciated amenity but was not always provided.

One patient who worried about the fire precautions made a suggestion that might have wide application. Locked exit doors could have a glass-fronted box containing a key laid across two contacts, so that in case of fire an alarm would sound in the porters' lodge when the key was removed.

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Staff Accommodation

Complaints on the shortage of offices were made in almost all the units visited; architects seemed to have seriously under-estimated the need. Doctors, psychologists and social workers all needed to hold confidential interviews, and the patients as well as the staff suffered from lack of privacy when offices were shared by two or more colleagues. A consultant at one unit said: '*We have emotional situations due to competition for offices among young doctors*' and, at another unit: '*We have to fight for free space – only three rooms for six doctors*'. A junior doctor from yet another unit said: '*There is nowhere for doctors to store their papers permanently here, so we are pushed into spending more time at our associated mental hospital.*' Often, two psychologists or social workers were expected to share a single office though they needed to interview patients simultaneously.

The nurses said they required one office for the senior nursing officer, one for the day hospital nurse, one for the community health nurse, as well as one on each ward. The situation of the ward office was important and at one unit a large office with a glass wall facing the centre of each ward corridor was appreciated: '*The staff can see and be seen and the patients feel free to come in and talk to us*'. 'Race-track' wards were criticised because of the problem of supervising patients. The nurses' station at one unit overlooked the patients' sitting-room from a higher level. Although this made observation easy it was disliked by both staff and patients, some of the latter remarking: '*They look down on us; it is embarrassing*'. Some offices let sound through and confidential conversations could be overheard, either because the walls were too thin or because partitions were not carried up to the ceiling. The clerical staff sometimes worked in very crowded conditions. A number of units had been forced to remedy the shortage of offices by converting single rooms meant to accommodate patients, thus reducing the number of inpatients who could be admitted.

Staff common-rooms were greatly appreciated, especially if they were shared by all disciplines and used by them for having tea and coffee together. This daily meeting helped the exchange of information and promoted good relations. A staff room was particularly useful for night staff, for people who brought sandwiches for lunch and for people who needed to relax after a difficult time with patients; the staff room in the general hospital was often too distant for these purposes. Sometimes the staff room housed a small library and a rack with professional journals. At one unit there was no staff room but an enclosed area of the unit cafeteria was regularly used at coffee and tea times by all professions, including doctors, and stimulated an outstandingly friendly atmosphere.

One unit had no staff changing-rooms and nurses had to change in a cupboard. Changing-rooms in other units had inadequate staff lockers – too narrow or short – or had no washbasin or looking-glass. Whether the staff wore uniform or not, adequate changing accommodation was needed.

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Aspects of Care and Treatment

Medical Care The ratio of doctors to patients in units was much higher than in large psychiatric hospitals – at one unit it was said to be four times as high as in the psychiatric hospital in the same group. A fairly usual pattern was for each patient to be seen by the consultant once a week and by a junior doctor every day or at least three times a week. Great appreciation was expressed by the patients about the medical care: '*Doctors extremely sympathetic and kind*', '*The complete physical examination in bed when I first came gave me confidence*'. Patients, with some exceptions, were satisfied about the information they and their relations were given: '*I appreciated the frequency with which we could see the doctors and hear from them how we are getting on*', '*When I was told it was my thyroid it was like winning the pools*'. At one unit the patients' relatives were seen weekly if they so wished. This situation was very different from that existing in many hospitals, both general and psychiatric, where lack of information is a potent cause of distress among patients.

However, many patients complained about one matter – the fact that when interviewed by the consultant they were surrounded by up to 12 other members of the staff, and in teaching hospitals sometimes up to 20: '*It is like a round table conference*', '*Scared to tell him anything*', '*Shattering shock to find yourself with all those people*', '*So many people I don't tell him half*' – such remarks were legion. One patient, a consultant himself in another specialty, said he had never been able to discuss his real situation. Other patients did not mind: '*They are learning and you just tell the truth*'.

Some of the medical and nursing staff felt that there was too much pressure on the doctors because of the high admission rate and because registrars were called so often to the general wards. At two units it was said that junior doctors disliked being there as they were on call every other night. There were difficulties in recruiting medical staff. Some doctors knew little English, others were inexperienced, for example, at one unit neither of the house officers had had any psychiatric training and there was no registrar.

Nursing Care The ratio of nurses to patients varied from 1:1 to only 1:4, but was usually about 1:1.5 or 1:2. An unusual situation in one unit was described by the nursing officer: '*We have too many well qualified nurses so that there is not enough for them to do and little chance of promotion*', but a far more usual complaint was of shortage of nurses; one unit had only 21 out of an establishment of 37. Of the trained staff, the proportion of men to women was said to be uneven in some units but this was often considered to be unimportant. In one large unit nearly all the ward charge nurses were men but there were no complaints from the women patients. However, at another unit a men's ward remained closed because there were no male charge nurses available for it. The appointment of permanent night nurses, available locally, it was suggested at one unit, would reduce the high number of nurses leaving.

Warm praise of the nurses was given by patients at all the units visited: '*Darlings every one of them*', '*When you want to talk to them, night or day, they are available and approachable*', '*The informality of the staff makes it easier for you to communicate – no officialdom about it*', '*They reassure us*'. There were, naturally, a few criticisms such as at two units where several patients criticised some of the nurses in a female ward as '*abrupt*', '*can't be bothered*'.

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Social Workers and Community Health Nurses

Social work in the units was in process of change partly because of the reorganisation of local authority social work and partly because of the appointment of community health nurses to some units. The unit social workers approved of both of these changes as they are now often working under great pressure. Many said that they only had time to deal with such practical matters as the patients' problems with finance, jobs and housing and regretted that they were seldom able to do casework, support the relatives or gain information for the doctors.

Considerable care had been taken in several units to coordinate the work of the hospital and local authority social workers. An impressive account was given in one unit of how unsatisfactory relations had been improved by discussing all admissions with the local authority social workers, by jointly deciding who should help each patient during and after treatment, and by holding fortnightly meetings and regular joint conferences at the hospital. Social workers in other units spoke of the value of regular meetings between the two groups of social workers, sometimes weekly. One consultant helped with the training of the local authority social workers, and often doctors attended the meetings. There were, however, some problems when the unit catchment area was spread over different local authority areas. For instance, the social worker at one London unit had dealings with three local authorities whose many social workers were each involved with only a few psychiatric patients.

The social workers were usually closely in touch with other bodies such as The Samaritans, marriage guidance councils and the police. One hospital had a bureau to help find accommodation for patients, often through other patients. In general those patients who had had occasion to consult their social workers were very appreciative, especially over help with housing, but sometimes patients did not realise that help was available. To meet this problem the social workers at some units visited all patients in their wards, made contact by holding group sessions with discussions and quizzes, planning social evenings and so on.

Three units had appointed community health nurses and more wanted to do so. These nurses knew the patients while they were still in hospital and helped them when they went home by advising them, performing various nursing tasks, and supporting the relatives. The community health nurse from one unit even held group sessions in patients' houses. The influence of these nurses was striking. The doctors could discharge the patients earlier; in one unit it was said that the average length of patient stay had been halved from six weeks to three and the number of return visits considerably reduced due to the work of two community health nurses. In some cases the nurses were able to give people such help that they did not need to become inpatients at all. A unit with a large catchment area was just starting to employ three such nurses, each responsible for one section. They all returned to the unit on the same day, once a week, for a meeting and to get to know their future patients. Relations between community health nurses and social workers were excellent and both said there was no overlapping of function. In other units the ward nurses made occasional domiciliary visits to help their own patients who had been discharged, or to visit outpatients who had failed to attend.

Treatment: ECT and Group Therapy

The survey was not originally designed to collect opinions on treatment but electro-convulsive therapy (ECT) and group therapy were so often mentioned that for the second group of units the questionnaire was modified to include questions on these two topics.

The arrangements for giving ECT varied enormously. In some units there was a well planned suite with a waiting room, a treatment room, and a recovery room; in others, patients had to wait in a corridor, be treated in a dormitory and recover on an ordinary dormitory bed, probably belonging to another patient. Patients particularly minded having to wait in public if they were feeling apprehensive. Some patients disliked ECT: '*Trying – you lose the sense of being yourself*', and one was grateful to be allowed to forego shock treatment as she was so apprehensive about it. More patients found it helpful: '*ECT has done me a world of good*', '*After having it we find the change for the better quite incredible*'.

Some units counted themselves to be therapeutic communities with group therapy as the active part of treatment. They held daily or weekly meetings of patients, attended by a multidisciplinary group of staff or by different members of the staff in turn. In other units the application of group therapy was more selective and was confined to small groups of people with similar problems, say, agoraphobia sufferers or people aged over 55. These smaller groups were often organised by one enthusiastic staff member – a registrar, a psychologist or a charge nurse. A few units had no group therapy; a nurse said '*The very short stay makes group therapy difficult as it takes two or three weeks to get used to a group*'. Most patients liked group therapy when it was with a small group with related problems and missed it if it was not held: '*I've had group therapy elsewhere and think it a good idea*'. However, patients tended to get bored when there were meetings daily: '*I've had it daily for several months*', '*It would be alright if it was once a week*'. Some doctors and patients deplored the situation where the doctors' time was taken up by group therapy at the expense of individual patient care.

In addition to group therapy, unit or ward meetings were held at most of the hospitals to discuss conditions and activities. These were generally conducted by occupational therapists or nurses but sometimes a community meeting of the whole unit was held with medical, nursing, and other staff present. In one unit all the doctors attended such a meeting daily and in two units a patient acted as chairman with a term of office of about two weeks. On the whole, patients liked giving their views about the running of the unit, if, and only if, some notice was taken of their recommendations and they were informed about the action taken. A rather unpopular scheme was found in one unit where, instead of the whole group discussing activities in occupational therapy, two patients in turn made the choice and the rest of the group had to follow their decision for all to paint, or go for a walk or whatever was chosen.

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Patients' Activities

Organisation of Activities All the units made some effort to offer occupational therapy. In eleven of them there was a special department attached to the unit, either in the same building or near it, and generally used by inpatients and day patients. This varied from one small overcrowded room in the basement to which many patients refused to go, to suites of five rooms specially planned for different activities, a gymnasium and a practice kitchen – such departments provided a welcome change of environment. In two units patients were supposed to use the main hospital's OT department (in one they were welcomed, in the other they were not), and in one unit all OT was done in the wards. For patients too ill to attend the department, occupations were usually taken to the wards, and in one unit a special small OT department was included in the acute ward. The number of occupational therapists attached to the psychiatric unit varied from one to six, with an average of two or three. There is a national shortage and some units could not fill their establishment; this generally resulted in a lack of ward visits to the very ill. One unit had a fine force of voluntary helpers, including art and music students who taught their own subjects, and another student who taught yoga; in other units a part-time art teacher was supplied by the local education authority; in some, crafts were taught by skilled tradesmen.

Acute problems had arisen in two units, and were still not solved at the time of the survey, due to the fact that occupational therapists were under the control of the consultant in physical medicine. At one of these units there was only a general OT department and it was almost entirely oriented to helping patients with physical defects. Only two unit patients attended and those only twice a week. The occupational therapists described the situation as '*extremely unsatisfactory*', unit doctors and nurses said '*It is one of our major problems*' and the patients said '*It is incredibly boring here*'. The patients had just started to organise a programme themselves, doing hobbies in the morning and joint activities in the afternoons, but the occupational therapist thought this venture unlikely to succeed for lack of a suitable room and because of the short stay of the organising patients. At the other hospital with a problem all the occupational therapists had been withdrawn from the unit department for many months due to a difference of opinion that could not be solved, even at regional board level, on which consultant should control the occupational therapy of the psychiatric patients. The nurses had done their best to provide patients with activities but the full facilities of the very fine department remained unused. The patients were largely engaged in packing articles for the hospital's central sterile supply department, and said that though they were glad to be useful they would have liked to work at something more creative. In all the other units relationships seemed satisfactory, including the hospital where about half of the unit patients attended the general OT department some minutes' walk from the unit. The mixing of physically and mentally ill patients was, in fact, counted an advantage there as it was said to give the psychiatric patients confidence when they left. In other units the opposite view was held – that psychiatric and physically ill patients have different needs, and that more psychiatric patients can attend if the OT departments are separate.

Since people in psychiatric units are immensely varied in age, intelligence, tastes, type of illness and degree of ability, a wide choice of occupations is needed if everyone is to find something to interest and stimulate him. The freedom for each patient to select his activities was

much appreciated: '*No-one forces you to do anything*', '*We can always change over to another activity if we wish to*', '*The organisation is fabulous, you can do what you want to*'. The different occupations offered can be roughly classified under occupational therapy, work in or out of hospital, parties and outings, recreation – games, television, library and so on. Although occupational therapy has been given as one subheading, in fact occupational therapists generally helped to organise all types of activities, often jointly with nurses and patients.

Occupational Therapy

The activities listed under this heading are very varied and can be classified into individual activities, group activities, physical activities.

Individual Activities

Arts: painting, drawing, pottery, jewellery making, music therapy

Crafts: carpentry, printing, metal work, stool seating, dressmaking, embroidery, mosaic work, toy making

Rehabilitation: cookery, typing, clerical work

Group Activities

Play reading, quizzes, discussions, producing a magazine, building a boat, painting a fresco

Physical Activities

Gymnastics, exercises to music, dancing, relaxation sessions, walks, visits to the local swimming baths

A usual timetable was for individual activities to be undertaken in the morning, possibly prefaced by a short period of physical exercise, followed after lunch by relaxation (in the few units that offered this) and then by group activities. Most patients enjoyed both individual and group activities, probably art, carpentry and dressmaking best. A few of the less sociable patients found the afternoon quizzes and discussions trying and wished they could continue with their individual activities. Some suggested having different activities for men and women during the afternoon. There were several requests for more activities aimed at helping patients to earn a living when they left but their short stay made this difficult to organise except for some who had profited from the typing classes.

Work in or out of Hospital

Work in Hospital Policy varied on the advisability of asking patients to work for the hospital. In all units those who were well enough were expected to undertake the light duties they probably did in their own homes, such as making their beds, preparing coffee and tea and washing up. The patients considered this reasonable and sometimes prepared a rota for the tasks. A few hospitals asked the patients to help with packing for the central sterile supply department, with clerical work, printing hospital forms and gardening. Work in a wide range of departments was offered at one hospital – the ambulance office, x-ray department, sterilising department, doctors' dining-room and needle room. In another hospital, those patients who wanted to helped in the geriatric wards. All this work was unpaid but no-one expressed resentment and usually the patients said they were glad to help. Industrial therapy was considered unsuitable for short-stay units and in the one unit where repetitive light assembly work was offered the patients said they found it boring.

Work for the Local Community Two units had organised special pro-

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jects for helping the community and more hoped to do so. In one unit a project group got information from the local social services department, the WRVS and the hospital medical social work department about people who might like help by having their homes decorated, their gardening done or just being visited.

A report on these activities stated 'The members of the project group and members of the community have worked very hard and quite successfully at public relations and it is extremely nice to have patients' relatives offering their help as well'. At the other unit a small group of patients went once a week with a staff nurse to help local elderly people with house painting or gardening and were decorating a new hostel for homeless people. At both units community work was said to be a marvellous success: '*Grand to be doing something constructive for others*'. It is obviously therapeutic for patients to be giving as well as receiving help.

Continuing with Own Work Occasionally patients who were teachers or students were able to go on with their own work outside the unit but gained support from living there.

Parties and Outings Social evenings were held in all the units. Eight units held them weekly, four monthly (supplemented at one unit by weekly social afternoons limited to patients) and two less often – to the regret of staff and patients. Parties were organised by a committee of patients sometimes helped by staff; in one unit each ward in turn organised a party and invited the patients from the other wards. The programme needed to be varied to cater for the tastes of young and old, and to include at various times, dancing with spot prizes, singing, cards, bingo, films and so on, often with refreshments prepared in the occupational therapy kitchen. Usually the day patients and some ex-patients were invited, as well as all the inpatients and relatives, including children aged 12 or over. One unit invited patients from a neighbouring unit for the mentally handicapped and found they mixed in quite happily. Sometimes parties were financed from hospital funds but in two units patients covered the cost themselves, either by a sale of articles made from scrap or by asking those who could afford it easily to pay five pence for themselves and for each guest. Some hospitals had a social club-house and parties were held there. In other cases the local community had formed a club for those who had been mentally ill and patients were encouraged to attend before and after leaving the unit.

Plans for outings were usually made jointly by patients and occupational therapists. In a few places they were organised weekly but in most units less often. They were very varied and included visits to theatres, cinemas, skating rinks, art galleries and local parks, river picnics and coach trips. The choice was widened if the unit had its own transport. The League of Friends at one hospital had presented a mini-bus, and at another the staff and patients were collecting to buy one for their joint use. As well as the more ambitious organised outings the nurses often escorted small groups of patients, who were not yet well enough to go out alone, to local parks and shops.

Recreation A garden large enough for games was appreciated, especially for games in which both elderly and young patients could join – such as clock golf, miniature croquet, and tennis. Football and cricket were not so suitable, since they take up a lot of ground and can only be played by the young.

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Active indoor games that were liked included table-tennis, billiards, volley-ball, darts and skittles and, in one hospital, hockey with sticks made from rolled newspapers. It was an advantage to have a games room or gymnasium. In the wards many patients enjoyed cards, Scrabble, draughts, chess, jigsaw puzzles, and bingo with sweets as prizes.

Television was provided in all the units, sometimes in the lounge, sometimes in the ward sitting-rooms, sometimes in both. There was distress in one ward because the sitting-room was too small to allow all the patients to see television, and in another unit where patients were sent early in the evening from a lounge with television up to their ward where there was none. Most people enjoyed having television if there was also a quiet room available so that they could escape from it when they wanted to, and though there were sometimes disagreements on the choice of programme the staff considered it '*well worthwhile even if it causes problems*'. Radio was mildly enjoyed providing it worked properly, could be adjusted to different channels and was not in the same room as television so that they could not be on simultaneously. At one unit all the single bedrooms were wired for radio and this was much appreciated. Record players (and in one case, the use of a large record library) were available in some units and much liked, especially by the young. One unit had a music room and others a piano but some patients longed for more opportunities to play or listen to music which they described as '*a form of therapy*'. A few units had a small library for patients but in more cases a book trolley was brought from the main hospital library.

Freedom of Action

At the first seven units visited the patients were asked 'Do you feel reasonably free?' but so much did they take their freedom for granted that the question was subsequently dropped: '*Absolutely as free as a bird in the air*', '*No rigid rules; go for walks when you like*'. Some patients made such qualified replies as '*Feel very free after the acute stage has passed*', and a nurse said '*We have to keep some control over acute psychotics and drug addicts, but explain the reason to the other patients*'.

Hours of rising and retiring often annoy patients in general hospitals but this difficulty was seldom met with in the units where the times were described as '*flexible*' and '*reasonable*'. Patients usually got up when they liked provided they were in time for 8 o'clock breakfast, but in two units patients in a women's ward were called about 6 am which provoked such remarks as '*Ridiculous as we do not have breakfast till 8*'. In some units there were no fixed bedtimes, in others it was supposed to be 10 30 pm but the regulation was not strictly enforced, and only in two units were there complaints that bedtime was unreasonably early.

Visiting hours were usually generous, and once the patients were past the acute stage most of them could go out when they liked and return home for weekends. With such conditions and a wide choice of activities in the unit, boredom was usually avoided. This is a serious problem in many large psychiatric hospitals. However, a minority complained that they felt bored in the evenings and specially at weekends. The nurses were very conscious of this and tried to compensate by taking patients for walks or to a film show at another hospital in the group. One occupational therapy department had posted up a notice 'Bored at weekends? You can have material from occupational therapy if you want it'.

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Meals

The majority of patients expressed satisfaction with the meals in most of the units: '*Sufficient, good quality and a good choice of menu*', '*Excellent in quality and quantity*', '*So good I haven't one criticism*'. In almost all units a choice of several dishes was offered for the main meal from which inpatients could select on the previous day. Unfortunately, in a few wards the choice was only theoretical as the nurses chose on behalf of the patients '*to save arguments*'. One unit had its own chef who cooked on the premises and would always make special dishes if asked. In another it was said '*The chef will always cooperate, he is a marvel*', and a third was helped by frequent visits from the catering officer. All the wards had their own kitchens and the patients were generally free to use these whenever they wanted to make hot drinks.

In over half the units all the patients who were well enough took their meals together in a unit dining-room rather than in separate wards. They were often joined for lunch by the day patients but if this caused overcrowding the day patients sometimes had separate sittings. Generally, but not always, service was on the cafeteria system and there were sometimes complaints about long queues or about surly service from the counter staff. There seemed to be a good case for training the cafeteria staff in the problems some patients had, for example, in making up their minds.

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Relationships

Patients Many patients stressed the happy and mutually helpful relations they had with fellow patients: '*We help each other a lot*', '*Made a lot of friends here, I didn't have friends before*', '*Eight of us plan to meet regularly after leaving*', '*We all talk to each other and that helps more than the doctors*', '*So many patients worse off puts one's own case in perspective*' – such remarks were frequent. New patients at one unit were made to feel at home by the patients arranging for one of them to act as each new patient's special host or hostess. These good relations were helped by having several sitting-rooms and many single rooms or cubicles where patients could have privacy when they did not feel like mixing: '*If one doesn't want to talk one is left alone*'. But not everyone was so happy and difficulties were often said to centre on the need for more segregation of patients by category.

Staff Relations between different members of the staff within the unit were usually described as excellent: '*Fantastic – no friction here*', '*Satisfactory relations within professions and between professions*', '*We are very much of a team*', '*We are helped by free exchange of ideas and suggestions between staff*', '*The high involvement of all staff in day to day management*'. One consultant made a point of attending all staff selection interviews to ensure that a person was chosen who would fit in well. Regular staff meetings were much appreciated, both those where the staff of all disciplines were present to discuss policy, new patients and changes in old patients, and those for separate groups of staff. At one unit a weekly 'journal meeting' was held, attended by senior staff of all professions who gave, in turn, summaries of relevant articles from the various professional journals. Another unit was experimenting with sensitivity training for staff. The value of a staff common-room in stimulating good relations has already been reported.

Problems arose when consultants in the same ward varied in their methods of treatment, when nurses became strained due to the stress of their work and had no staff room in which to relax, and when responsibilities of nurses and occupational therapists overlapped.

The Unit and the Rest of the Hospital In some hospitals these relationships were excellent, in a few they were deplorable, and in others they hardly existed. On the whole good relations developed when the medical staff in other specialties were sympathetic to psychiatric treatment, when there was generous two-way exchange of facilities, treatment and knowledge, and when the group or hospital nursing administrative staff were actively interested in the unit. Relations were also helped if general nursing students had the option of spending a period in the unit as part of their training. In such cooperating hospitals comments were made, such as: '*The unit has fitted in extremely well*', '*It makes a happy addition to the hospital*', '*There is a free exchange of information*', '*Mutual respect and friendship between general and unit staff*'. Relations were very unhappy at other hospitals: '*Suspicion about the unit even among senior consultants*', '*The general medical advisory committee did not want to have a psychiatric unit and there is still not much cooperation*'. Some consultants were said to be critical of the treatment given in the unit: '*The patients all ought to be behind bars*'. At several units it was said that both registrars and nurses were looked down on by their colleagues in the general part of the hospital: '*They despise us – regard the unit as the "bin"* ', '*The social life of our unit staff is only among themselves*'. The nurses said they were considered ill-disciplined as their work was '*just talking to people*'. At one hospital the group officials and committees were said

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'*not to be oriented to starting or running a psychiatric unit*', the administrative staff were described as '*uninterested*', and '*The maintenance department does not see the need to hurry even when we have exposed live wires. All this built up into a tragic situation*'.

Where relations were bad, problems often arose about the treatment of patients who had taken overdoses of drugs and came in as emergency cases. The usual agreement was that these patients should be treated physically in the medical wards and when they had got over the effects of their drug they should be visited by a psychiatrist to decide whether they needed psychiatric treatment and, if so, whether it should be as inpatients, day patients or outpatients. However, sometimes the non-psychiatric staff were dissatisfied with this arrangement and in one hospital they even sent patients to the unit while they were still unconscious and the cause of the overdose unknown. Another difficulty met with occasionally was in getting a unit patient transferred if he needed advanced medical or surgical care. This even held with ex-patients; some doctors in the general wards were said to think that if a patient had once been in the unit he should always return there even if he had recovered from his mental illness and his present trouble was medical or surgical.

In hospitals with a shortage of medical or surgical beds it was suggested that the unit was the easiest department to move elsewhere. The unfortunate clash about occupational therapy departments at two hospitals has already been described.

In other hospitals the unit appeared to be quite separate. Comments were made such as: '*There seems to be a steel grill between us and the rest of the hospital*', '*Relations not close; we are more like a neighbour than a member of the family*', '*We have few contacts*'. And a patient said laconically '*Our only contact with the rest of the hospital is the food trolley*'.

In hospitals where the relationships were good, active steps had often been taken to stimulate friendly cooperation. One essential was said to be a satisfactory transfer system: '*Colleagues unhesitatingly accept that one can send patients across to the general wards and vice versa*'. In addition the unit doctors were willing to visit the general wards when requested, to advise on any patients showing psychiatric symptoms, and sometimes spent a great deal of time in so doing. Nursing staff gave the same help and one unit had allotted to a senior sister the specific job of helping nurses in the general part of the hospital with patients who had mental troubles. Relationships among nursing staff had been greatly helped in two hospitals where the unit nursing officer had acted as nursing officer in the general part of the hospital. In one he did so for over a year before joining the unit, in the other he still took his turn there although in charge of the unit. At one hospital all nurses joining the unit had two or three days' induction course in the general wards. When a new unit was opened the 'general' sisters and staff nurses were sometimes invited to coffee mornings to see over it and were offered lectures on modern psychiatric treatment. There were usually excellent relations between the general and unit occupational therapists and social workers. At two hospitals joint meetings were held regularly between the senior unit staff and the hospital secretary or assistant secretary (called 'linking meetings' at one of them) and were found very useful. At some hospitals the League of Friends or the WRVS had provided amenities or ran a unit shop, but in others the voluntary groups took little interest in the unit.

Comparison of Units with Large Psychiatric Hospitals

Levels of Satisfaction Expressed At the first seven units visited each of the patients was asked 'Do you like your stay here apart from being away from home?' and given a choice of four answers. It is interesting to compare the results with those obtained from previous surveys when similar questions were asked of patients in short-stay wards at nine large psychiatric hospitals[7] and in medical and surgical wards at ten general hospitals.[6]

Percentage of Patients Giving Each Answer

Answer	Psychiatric Units	Psychiatric Hospitals (Short-stay Wards)	General Hospitals Medical and Surgical
Very much	41	14	53
In most ways	40	37	41
Only fairly well	13	27	4
No	6	22	2
	100	100	100
Number answering	91	806	1301

It can be seen that the level of satisfaction expressed by the unit patients was much higher than that of patients in psychiatric hospitals and not much lower than those in other wards in general hospitals.

Advantages of Units

At the same seven units staff and patients were asked if they had had experience of a large psychiatric hospital. Most of the staff had worked at one but only a minority of the patients had attended one. All those who had had such an experience were asked to say in what ways the unit was better and in what ways the large hospital was better. There was considerable agreement on the advantages of each place, and, though the general level of satisfaction was much higher about units, there were certain ways in which the large hospitals were thought superior. Some people made almost fulsome comments about the units: '*There it was third-class, here a first-class Pullman*', and even '*The difference between purgatory and heaven*', but one thoughtful patient said '*I feel I'm liking it too much here – it is an easier way of life*'. Other people thought it unfair to draw a comparison when there were such vast differences in staff-patient ratio and also, at the time of the survey, in expenditure allowed, and when many of the units were in new buildings.

The main advantages of the unit over the hospital are given roughly in order of frequency of mention.

Treatment better Because of the higher staff-patient ratio there is closer and more friendly contact. The treatment is more progressive and varied and this attracts good staff who become involved in the multidisciplinary team.

Less stigma It is less embarrassing for patients: '*People need only know one is attending the general hospital*', '*Not a nut house*', '*Neighbours don't know one has had psychiatric treatment*', '*Easier for giving references*'.

Building often more modern Units allow more privacy as dormitories are smaller and there are many single rooms: '*A palace compared to*

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the big psychiatric hospitals', '*This is a hotel*'.

Smaller community The small size enables it to be more friendly. This holds for patients: '*We all know each other and help each other*', and for staff: '*Doctors and nurses work closely together*'.

In own area Easy for patients to go home and for visitors to come. Helps contacts with local authority social workers. Simplifies finding accommodation before discharge. '*Patients not separated from own area and dumped on Epsom Downs.*'

Shorter stay The stimulating atmosphere and intensive treatment means rehabilitation is easier. No-one becomes institutionalised.

Liaison with other departments in the hospital Medical, surgical and ancillary services are available on the spot. Sick patients in the general wards can be seen by a psychiatrist.

Food better

Advantages of Large Psychiatric Hospitals

The advantages of large psychiatric hospitals over units are shown in order of frequency of mention.

Better facilities for long-term patients A more suitable place for those who are likely to stay a year or more including psychogeriatrics and inadequate people without families: '*It is not human to discharge chronic schizophrenics with no place to go to, they become inhabitants of the London tube stations*'. Hospitals were also considered more suitable for court cases and the very disturbed and aggressive.

Classification of patients Better classification possible if young separated from old, psychotic from neurotic. Can segregate those needing to be guarded from harming themselves or others.

Large grounds The restful situation of most large hospitals allows patients to feel less confined, to enjoy the gardens and sports.

Wider choice of social activities Large hospitals have more ways of diverting and occupying patients, such as a social centre, library, shop, hairdressing departments, cinema, games, dances.

Industrial therapy Patients can work and earn money.

Professional advantages Concentration of staff allows for interchange of opinions, better training opportunities, more staff to call on in emergencies, fewer night duties and so on.

Staff conditions Generally, there are staff clubs, staff houses or flats and more consulting rooms.

Rehabilitation Less pressure to discharge patients to make room for others urgently needing to come.

The point was often made that units and large hospitals are not the only alternatives for psychiatric patients. Many people suggested that long-term care could best be given in small hospitals and homes, or by the development of community services, especially for psychogeriatrics and very inadequate patients without families.

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Day Hospitals

Integration with Inpatients The enquiry was chiefly concerned with inpatients but some consideration was given to the conditions for day patients. Many of the matters raised by the two groups were the same and have already been reported but topics that referred specifically to day patients are summarised in this section. The proportion of day patients who had previously lived in the unit ranged from 50 to 100 per cent.

In some units there was complete integration between the two groups, in others none whatsoever. The most usual situation was to share the OT department, to eat in the same dining-room but sometimes at different times, to have one lounge for day patients only but to share one of the general sitting-rooms. The day patients generally did not go into the wards at all. They usually had their own treatment room though in some units the need for such a room for day patients had been forgotten. Generally, there were one or two nurses specifically in charge of the day patients, and the psychologist and social worker spent a good deal of time with them.

Opinions varied on the advisability of integration. The staff in favour stressed the need for continuity of treatment with the same doctors and nurses, and the patients said: '*When we were inpatients we made friends – we would feel isolated if we were separated*'. The point was made that both groups were encouraged by seeing patients progress from the inpatient to the day patient stage. Those against integration thought that the day patients, especially those who had never lived in the unit, would be depressed by meeting patients far more ill than they were themselves. If the unit was overcrowded, particularly the lounge and dining-room, the inpatients tended to resent the presence of day patients. Some felt that they were outside the familiar group: '*We can relax at weekends and evenings when they are not here*'.

Activities The longer average stay of day patients allowed them to have industrial therapy in some units. They were paid on a points system at one unit, which was considered unfair as it included points for behaviour. As with inpatients, day patients often wished for training that would help them to find jobs when they left and at one unit the local resettlement officer called every month to discuss occupational problems. The day patients of some units spent a fair amount of time out of doors and went on expeditions and outings, but in other units they complained they were kept indoors all day, not even having a chance to sit outside during the lunch break. In one hospital there was a crèche for the children of staff and of day patients. Social evenings and club meetings were generally successful; to some, day patients could bring friends and often held joint parties with the inpatients. The unpunctuality of ambulances bringing day patients to the unit and taking them home again was often a problem and made attendance irregular.

Attitude to Attending the Day Hospital The day patients were mostly enthusiastic about attending: '*The day hospital is like a rock*', '*Look forward to coming if only one day a week*', '*Enjoy coming, if not here I would be lost*', '*Less of a shock when one returns to normal life*'. Tributes were paid to the staff: '*Staff and patients welded into an optimistic friendly group*'. Medical care was praised: '*Well off for doctors*', but in a few units patients regretted that they could not see the doctor more often and that physical illness might be neglected: '*I've never had a physical examination*'. Patients' views differed about group therapy. Some found it helpful if they did not meet too often, many felt isolated from the doctors when they

Use this column for your Action Notes

only saw them as members of a group and this latter view was shared by some of the doctors. More information about their progress would be welcome, some said; for example, the reason they had been taken off tablets. Tributes were paid to the nurses, especially to the day patients' sister, and to the psychologist: '*Always someone you can see about your problems*', '*The staff have obviously succeeded in making the patients look on them as colleagues in a joint enterprise*'. At one hospital a day patient was allotted the task of welcoming new patients. Suggestions were made for an information leaflet to be given when patients first came, or even before they arrived, and also for a list of staff names to be posted up.

Limitations in Use of Information

Perhaps it is because many psychiatric units in general hospitals are comparatively new that there were such extraordinary variations in their organisation – differences not necessarily inherent in their situation. No-one can yet count as an expert on them. All that is attempted in this report is a summary of what some people think about their own units and what they consider would be the most satisfactory arrangements if they were starting a new unit. No attempt has been made to give the perfect answer about unit organisation – there is no single solution – but some matters have been reported that may serve as examples and others that can only be regarded as warnings.

Those responsible for psychiatric units may find it useful to invite some of their staff and patients to answer, anonymously, one of the questionnaires attached but they should only do this if they are prepared to give serious consideration to the results.

Commentary by R K Freudenberg

This exploratory study, which does not claim to be a comprehensive attitude survey, has elicited the views of the staff and patients of a number of psychiatric units in general hospitals as they exist to date, so that we have views of both the providers and users of the service. The units studied reflect the differing and developing concepts of their function which have emerged over the last 10-20 years – from a restricted use for a selected number of patients to a more comprehensive one aimed at nearly all psychiatric problems needing inpatient or day patient care for a defined district.

It is not surprising, therefore, that many diverse views are expressed. The fund of useful information and ideas produced, to which Anthony Dale refers in his foreword, will prove very valuable not only for those running the service, but also for those involved in its planning, often inevitably many years before implementation in practice. This situation makes studies such as the present one all the more important. They will broaden our thinking and, as Mrs Raphael so rightly concludes, some of the reported matters will serve as examples, others as warnings.

The strategy for psychiatric care is very complex and to do justice to this it has, over the years, been increasingly developed. The complementary value of this study to existing publications, like *Hospital Services for the Mentally Ill*[2], *Policy for Action*[1], or the recently published and revised *Hospital Building Note No 35*[3], is considerable because the information comes from real life experience. It is also gratifying to find that many of the questions raised support the reasons for the present thinking of the Department of Health and Social Security.

The preference of patients that the name of the unit should not reveal the nature of their illness reflects the still existing fear and prejudice connected with psychiatric disorders and suggests this as an important topic for mental health education.

Two serious drawbacks of the large institutions built in the past are their physical isolation from the community they serve and their large catchment areas. This situation impedes easy contact with the community and tends to increase the duration of patient stay. The study confirms the advantages of a central position for the unit and the possibility of maintaining contact with the community.

The differing views expressed by staff about the siting of their units reflect the present position and the variation in unit design. It is expected that by careful architectural planning in the future even units which are structurally part of the main hospital design will be sufficiently separate from it to meet the special needs of psychiatric patients.

The fact that most staff thought the ideal size for a unit to be 120 beds with wards of up to 30 beds is interesting, because this is the likely average size of units serving a district with a population of 250 000, based on the ratio of 0.5 beds for adult mental illness per 1000 of the population. The present DHSS thinking for this kind of unit is to provide progressive patient care on each ward, because this would facilitate continuity of care by the same team based on one ward and avoid problems between consultants with differing policies. This, however, is a matter for local agreement.

The future design differs fundamentally from the past ward concept;

the daily life of patients will be centred in the day hospital, which will contain day and dining-rooms for both inpatients and day patients and also rooms for group and occupational therapy. For these last there will be additional day space in the ward which otherwise is mainly a dormitory area.

It is reassuring to see that the majority of the staff in the units studied feel that even acutely ill and disturbed patients can be treated there. *Hospital Building Note 35*[3] suggests that two protected rooms could be provided for such patients if required. Many professionals hold the view that protected rooms are no longer necessary, as pharmacotherapy and special nursing supervision can generally cope successfully with this problem.

The lack of staff offices in many units brings out the special needs of psychiatric services where the interview with the individual patient is such an important part of assessment and treatment. The 120-bedded unit of the future provides for 24 staff offices, which should prove adequate.

It is interesting that one problem so commonly found in the larger psychiatric hospitals, that the doctor is not seen frequently enough, has been overcome. The question of coordinating the work of community health nurses and psychiatric community nurses, which is also touched upon in the survey, is a complicated one. This should become easier, however, in the reorganised National Health Service in which district nursing officers will be in a better position to tackle the problem. There is also room for experimentation to assess the advantages or disadvantages of having specially appointed psychiatric community nurses or ward and unit nurses who also do psychiatric community nursing. The latter arrangement allows for continuity of care by the clinical team as long as special treatment is required. The expansion of this kind of work could have a profound influence on the pattern of health services in the future.

A medical team should be responsible for all outpatients, inpatients and day patients coming from the districts they cover which will often coincide with the local authority social service area. Otherwise, a two-tier psychiatric service can readily develop. The coordination with social work departments of local authorities and their various facilities will be improved with the help of the future district mental health planning teams.

Very useful suggestions are made for activities in occupational therapy departments. It is increasingly felt that psychiatric rehabilitation has all kinds of special aspects and should therefore be separately provided for and be part of the responsibility of the psychiatric team. Future psychiatric day hospitals in psychiatric units in district general hospitals will, therefore, have their own occupational departments with an adequate number of places for both inpatients and day patients.

The report confirms the importance of separating elderly demented patients from younger age groups. This problem should disappear once separate additional provision is available for elderly demented patients.[4] The new psychiatric departments will then be concerned with the adult mentally ill and those elderly suffering from functional

disorders. The difficulties revealed by the study about persistently disturbed patients confirm other findings showing that a proportion of patients need longer to respond to treatment. This new long-stay group may well need additional provision, and more research is in progress to ascertain the size and kind of provision required.

Both patients and staff in the units surveyed emphasised the advantage of psychiatric departments in district general hospitals because of their easier accessibility, smaller size and lesser stigma in comparison with the larger psychiatric hospitals built in the past. This is an endorsement of the present policy of the DHSS which aims at providing a comprehensive psychiatric service for each district. The district general hospital is to have a psychiatric department which is expected to deal with all kinds of the adult mentally ill patients from its district apart from certain specified exceptions. Special groups like children, adolescents, alcoholics or drug addicts, will need additional provision, but not in every district general hospital psychiatric department. Each area or region, however, will require at least one such unit to serve each of these special groups. Similarly, patients who cannot be adequately treated in the open wards of the psychiatric department because of persistently disturbed behaviour, but who do not require the maximum security of a special hospital, will need to be accommodated in special regional security units. All these hospital services need to be backed up by local authority services, particularly the social services department, with social workers, residential accommodation of different kinds, day centres and occupational facilities. It is anticipated that the local networks of services will eventually replace the large psychiatric hospital. It is hoped that many psychiatric units in district general hospitals will avail themselves of the methods offered by this study to look at themselves critically and constructively.

APPENDIX A Questionnaire used at First Seven Units

CONFIDENTIAL

King's Fund Centre, 24 Nutford Place, London W1H 6AN

Questionnaire for Staff and Patients in Psychiatric Units attached to General Hospitals (to be used as basis for interview)

Hospital	Date	Patient ( ) Staff ( )
Name	Time in unit	Previous stays
Job	Sex M( ) F( )	Age (patients only)

It will help the planning of further units elsewhere if you will comment frankly on this unit especially on matters that are particularly satisfactory or that need to be improved or altered. Your name will be kept confidential.

PHYSICAL SURROUNDINGS

1	General plan site and appearance	1
2	Day rooms	2
3	Dormitories: bedrooms	3
4	Bathrooms, WCs	4
5	Facilities for washing clothes	5
6	Privacy	6
7	Lockers and storage space	7
8	Garden	8
9	Staff only Staff accommodation	9
10	Other matters on physical surroundings	10

ACTIVITIES AND DAILY ROUTINE

11	Meals: quality and amount	11
12	Times of getting up and going to bed	12
13	Television, radio, record player	13
14	Occupational and art therapy, work	14
15	Social activities, club	15
16	Whether enough to do	16
17	Other matters on activities	17

PATIENT CARE AND RELATIONSHIPS

18 Medical treatment: see doctors enough 18

19 Told enough how you are getting on 19

20 Enough care from nurses 20

21 Enough help from social worker 21

22 Feel reasonably free 22

23 Relations between patients 23

24 Relations between staff and patients 24

25 Staff only Staff relations in unit 25

26 Staff only Unit relations with the general hospital 26

27 Other matters on care and relationships 27

---

28 Have you ever stayed or worked in a large psychiatric hospital?
Yes ( ) No ( )

If so, how does this unit compare with it?
Ways in which this unit is better

Ways in which the large hospital was better

---

29 Patients only Do you like your stay here apart from being away from home?
Very much ( ) In most ways ( ) Only fairly well ( ) No ( )

---

30 Day Hospital (for those attending or working there)

---

31 Other comments

APPENDIX B Questionnaire used at Second Seven Units

CONFIDENTIAL

King's Fund Centre, 24 Nutford Place, London W1H 6AN

Questionnaire on Psychiatric Units attached to General Hospitals
(to be answered by individuals or groups)

To each of the following questions would you kindly write:

a) the present situation at your unit - its advantages and disadvantages
b) the practical ideal for a unit at a new general hospital.

If there is not sufficient space add another sheet of paper marking the number of the question.

Hospital Date

Answered by doctors ( ), nurses ( ), other staff ( ), patients ( )

GENERAL ORGANISATION

1 Name What is your unit called? Does it include the word 'psychiatric'?

a Present

b Ideal

2 Location of Unit in Relation to General Hospital Is it a separate building in or out of the grounds, a separate building but attached to a corridor or right in the main building?

a Present

b Ideal

3 Allocation of Patients to Wards i) Are wards mixed male and female? ii) Are patients allocated according to type of illness, progress towards recovery, consultant in charge or some other way?

a Present i

ii

b Ideal i

ii

4 Sections Are there separate sections for adolescents, mothers with babies, old people, drug addicts, alcoholics and so on, or are such patients mixed with others?

a Present

b Ideal

5 Long-stay Patients How long do patients remain if they are likely to need long-term care, including old people, long-stay schizophrenics? Are they transferred elsewhere?

a Present

b Ideal

6 Day Patients i) How many day patients come each day on average? ii) Do day patients share the occupational therapy department, dining-room, sitting-rooms at the same time as in-patients?

a Present i

ii

b Ideal i

ii

UNIT STRUCTURE

7 Number of Beds i) How many wards are there in the unit and how many beds to each ward? ii) Total number of beds?

a Present i

ii

b Ideal i

ii

8 Sitting-rooms i) Are there sitting-rooms attached to each ward, if so how many? ii) Are there any sitting-rooms used jointly by patients from all wards, if so how many? iii) are there any quiet rooms?

a Present i

ii

iii

b Ideal i

ii

iii

9 Dining Arrangements Do all the patients who are well enough have their meals in one room or do patients have their meals on their wards?

a Present

b Ideal

10 Bedrooms i) How many single rooms? ii) Of these how many are adapted specifically for disturbed patients? iii) What is the maximum number of beds in a shared room or dormitory? iv) In these is each bed separated by solid walls, curtains, furniture or some other means? v) Has each room (shared or single) got a washbasin?

a Present i

ii

iii

iv

v

b Ideal i

ii

iii

iv

v

11 Laundering Arrangements What facilities are there for patients to wash and dry their own clothes?

a Present

b Ideal

12 Offices Are there enough offices for the staff, medical, nursing and others? If not where is there a shortage?

a Present

b Ideal

13 Staff Rooms How many staff rest rooms and changing rooms are there in the unit? Are there enough?

a Present

b Ideal

PATIENTS' ACTIVITIES

14 Meals i) Can the patients choose meals in advance from a menu? ii) Do they have early morning tea?

a Present i

ii

b Ideal i

ii

15 Occupational Therapy i) What activities are liked by the more intelligent patients? ii) Do the patients do any work for the hospital? If so what? iii) Do the patients work on specific projects outside the hospital? iv) Are any occupations planned for evenings and weekends?

a Present i

ii

iii

iv

b Ideal i

ii

iii

iv

16 Social Activities i) How often do patients have social gatherings and outings and who organises them? ii) What sports and games are available?

a Present i

ii

b Ideal i

ii

17 Garden i) Has the hospital got a garden in which patients can sit and is there a section specially for the unit? ii) Do all patients, apart from those in bed, go out daily?

a Present i

ii

b Ideal i

ii

PATIENT CARE

18 Home Visits and Contacts i) Are these often done by nurses as well as by social workers? ii) Are there regular meetings between the hospital and local authority social workers?

a Present i

ii

b Ideal i

ii

19 ECT Where do i) inpatients ii) day patients receive ECT and rest after it?

a Present i

ii

b Ideal i

ii

20 Group Meetings i) Do the patients have meetings on the running of the unit or of their ward and if so who conducts them? ii) Do they have group therapy sessions and if so who conducts them?

a Present i

ii

b Ideal i

ii

21 Consultants How many people are usually present when a patient is interviewed by a consultant on a ward round?

a Present

b Ideal

---

22 What are the specially good points about this unit?

23 What are the special problems or difficulties of this unit?

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