Mental Hospitals

FUNCTIONS AND PROBLEMS OF PSYCHIATRIC UNITS IN GENERAL HOSPITALS

BY

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It is now recognized that the social environment in which emotionally disturbed people are treated has considerable influence on whether they recover or remain ill. The present opinion of the Minister of Health and his advisers appears to be that the environment of the large mental hospitals is less favourable to patients' recovery than that of a psychiatric service integrated in general hospitals. Accordingly it is proposed gradually to replace mental hospitals, as treatment centres for acute cases, with small units of 30 or more patients (*Hospital Plan for England and Wales*, 1962).

The White Paper outlining these proposals does not explicitly state why these new units will be therapeutically superior to the hospitals they are to replace. Pharmacological and physical methods of treatment can be given as efficiently in mental as in general hospitals. New buildings cannot in themselves induce mental health. Clearly, therefore, it is thought that the therapeutic gain will come from a change in the *social structure* of the treatment of mental illness, made possible by the presence within the community and the small size of the new centres. Since the basis of this immense scheme is development of new psychiatric social organizations, it is fundamental to have a clear conception of what forms they should take. Fortunately since the last war, specifically following the "Northfield Experiment" (Bion and Rickman, 1943), understanding of what promotes mental health in hospital has rapidly increased. Realization came that social organization could in itself have a powerful healing (or reverse) function. The concept of the hospital as a "therapeutic community" (Main, 1946) developed, transforming, through administration, the approach to and treatment of mental illness.

Common Aims

Therapeutic communities, whatever their ideology, share common aims (Kräupl Taylor, 1958; Bierer, 1959; Maxwell Jones, 1959; Cohen and Haldane, 1962). They see their functions not only as caring for the ill but as providing the opportunity for the ill to care for themselves and each other, believing this to be an important part of getting well. To this end they replace authoritarian staff-patient relationships with an egalitarian approach. They try to include in their framework, as realistically as a hospital permits, those interpersonal social activities, responsibilities, and hence anxieties which the patient has found intolerable in the outside community from which he has retreated or been expelled. It is precisely the controlled *appearance*, not suppression, of the destructive and reparative patterns of behaviour released by this environment, and their understanding by patients and staff, which has a therapeutic effect. In other words, we best help patients to become and remain well, not by isolating them from

reality, but by allowing them problems of everyday life and helping them to understand why they have been unable to resolve them. This apparently simple idea, in fact, means a profound change in the aims and organization of psychiatric hospital practice. The emphasis shifts from medication and symptomatic relief to insight derived through personal relationships. Provision of these "everyday problems" is, of course, the function of hospital administration, which thus becomes an essential therapeutic tool. An awareness that psychiatric treatment and organization are inseparable must cause concern for the future as we realize that the new units will inevitably be included in the general hospital's administration.

General hospitals are, with variations, authoritarian societies. For them the patient's role is simple. It is for him to be a good patient—that is, co-operative and obedient. The patient is told what to do—in fact, largely relieved of any need to think or care for himself. He can lie back confident that he is someone else's problem, rather than a problem for himself or to others. Since the chief interest of those who treat him is his body, he naturally tends to be regarded as an object or case rather than as a subject or person. In fact, too close identification with him as a suffering, frightened person may be discouraged as an interference in the efficient investigation or manipulation of his body. His passivity thus becomes an advantage, and the elaborate organization of the general hospital has evolved around the needs of the patient viewed in this way.

The regression this encourages in the physically ill is used with great skill on his behalf by his attendants. The patient's inactivity, concentration on the self, egocentric view of people around him as need-satisfiers, etc., is temporary and useful in the business of recovery. For the mentally ill the situation is reversed. His illness *is* regression. To promote it does the patient the maximum disservice. (I shall not discuss exceptions here.) The extent to which we assume authoritarian roles is the extent that we stabilize the dependence we are so anxious to avoid. This pathological regression = invalidism = institutionalism. It is, of course, precisely the antiregressive—that is, rehabilitative—forces inherent in a therapeutic community which have made it an integral part of modern psychiatric hospital administration.

So we are faced with the difficulty that a general hospital's orientation is the reverse of that necessary to the function of a psychiatric community. This, after all, should not surprise us. It is the inevitable consequence of the historical dichotomization of patient into body and mind which it is the exact purpose of the Mental Health Act, 1959, to bridge. This does mean, however, that the transfer of treatment from mental to general hospital will not only resolve but will introduce problems for patients, psychiatric staff, and general hospital.

It is with three problems arising from the fundamental differences between the needs of the two communities that the remainder of this paper deals.

"Bed Fixation"

The first is what might be called the general hospital's "bed fixation." Architecture, organization, and *thinking* of a general hospital revolves round "the bed." It has become automatic to think of the patient as someone who occupies a bed—who *is* in bed. Thus the Minister of Health, Mr. Enoch Powell, referred to the building

of psychiatric units of "20-80 beds" (speech to the National Association for Mental Health, March, 1961), when what was presumably meant was units for 20 to 80 patients. This outlook has come about from thinking of patients as incapacitated, and in acute physical and in some acute psychotic illnesses this remains true. But for most psychiatric patients what is needed is not only bed space. They also need space for living as a community. In the West Middlesex unit for 74 patients, 40% attend only in the day. A further 20% go home at week-ends. Over 90% are fully dressed and mobile. This requires a different use of space and far more space than is usual in general hospitals.

To incorporate the psychiatric unit, as suggested in the *Hospital Plan for England and Wales*, on the ground floor of a building otherwise used as a general hospital might risk the needs of the latter imposing itself on the former. It would seem wiser, therefore, to develop such units as buildings in their own right. Architectural form and size will require the closest collaboration between architect and psychiatrist. Otherwise quite unsuitable models based on the needs of a general hospital, which are after all the only needs with which most hospital architects are familiar, will be built.

Conflict or Organization

The difference between the needs of a general hospital and a psychiatric unit, to which I have referred, is the outward expression of the internal conflict between the two organizations. Hospital administration, management committee, etc., have a responsibility to the entire hospital, of which the psychiatric unit will be a small part (less than 10%), and a newcomer at that. The newcomer's pressure for its own organization will be countered in turn by pressure from the parent body towards conformity with traditional practices—that is, towards medical and away from psychiatric techniques. Two aspects of this counterpressure are particularly relevant to therapeutic function.

The presence of disturbed people means periodic deviations from the general hospital's codes of behaviour. Fear, by the psychiatric staff, of the latter's disapproval can be considerable and instantly communicates itself to patients, with restrictive therapeutic effects. Psychiatric nursing staff are particularly vulnerable as they may find themselves torn between the wish to please matron and her organization, of which they are part, and the psychiatric unit with its often contradictory aims. The handling by the psychiatrist of these staff anxieties is an essential part of the therapeutic programme. Otherwise there is a danger that patients, in being made to conform and get well, may be denied a right to be ill. This is particularly true for the very disturbed patient who requires special handling with facilities to make this possible. However, this fear of "what the neighbours think" may be expected to diminish as the parent body itself becomes less anxious and therefore more tolerant, or even influenced to change its ways.

Realistic Work Policy

A much more serious problem is the formidable capacity of the general hospital to provide all services for patients, with its dislike, common to all administrations, of departure from the system. The appeal of "having it done for you" is remarkably attractive to

patient and staff alike. It needs constant vigilance, and a very single-minded belief in the aims of a therapeutic community to resist this seduction. The automatic tendency of central administration to cook, clean, carry, wash, sew, paint, repair, garden, etc., is a serious obstruction to therapy through occupation, something very different from occupational therapy. The latter is largely craft activity developed and still useful for disabled patients and for passing the time. It is, however, quite remote from the realistic goals of work and service in everyday life. Primarily to occupy patients, whose reality-testing is already uncertain, with occupational therapy is to undermine still further their self-esteem, and increase rather than decrease the problems of returning to the outside community. For example, to give a woman who is terrified that she can never be a good mother a basket to weave is to confirm in her mind the belief that she is unfit to care for her child. To really help her we must give her facilities to look after her baby in hospital.

A start to the solution of realistic work therapy has been made at the West Middlesex with employment, in a voluntary capacity, of less-disturbed patients in many of the hospital departments.

The psychiatric hospital with its own administration has the immense advantage of being able to adapt itself to therapeutic goals. Psychiatric units in general hospitals will have to incorporate similar facilities. This may mean some degree of autonomy, and will require the most understanding co-operation from all concerned. It is important that this appreciation of differences in aims and functions by both parties should be there beforehand. It should not be left to arise somehow after the new centres are built. The return of psychiatry to medicine is much needed, but there is a danger that the price paid could be conversion of psychiatry into medicine. Many would feel this price to be too high.

The development of experimental units to explore these and many other problems, to pioneer solutions, and to serve as empirical working models for the new psychiatric service would seem urgent if the aims of the *Hospital Plan* are to be realized without serious loss to patient and taxpayer.

Summary

The organization of the psychiatric unit as a therapeutic community is defined and contrasted with the organization of the general hospital, defined in this context as an antitherapeutic community.

The conflict between the functions of the two communities, and some of the problems arising from this, are considered.

The danger of the general hospital being used as the model for the new psychiatric centres is noted.

The need for teams of psychiatrists and architects to collaborate in planning psychiatric units around their therapeutic function is suggested.

The development of research units to explore problems and serve as working models for the new psychiatric service appears necessary.

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CLOSED-CIRCUIT TELEVISION IN A MENTAL HOSPITAL

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When this new hospital for the mentally subnormal was under construction a closed-circuit television unit was installed which covered the combined day- and dining-rooms of two wards and two rooms in the occupational therapy department. This plan was intended to cover a patient's conduct and activities during the whole day if necessary.

It was hoped that this equipment would be of value in the following fields: (1) Observation for prolonged periods by trained personnel such as medical staff, psychologists, sociologists, etc., of various types of mental aberration found among the subnormal, particularly psychotic states in children, which result in intellectual arrest. (2) Controlled trials of drugs in a variety of psychiatric conditions. In many hospitals the results of drug trials rely greatly on the reports of nurses, and some features may be missed when a high proportion of the nursing staff are inexperienced in this field. (3) Side-effects of new drugs such as dystonic reactions, ataxia, Parkinsonism, etc. (4) Observation of patients undergoing abreactive treatment with drugs, such as lysergic acid diethylamide. (5) Observation of parent-child relationships during visiting periods.

The experiences gained in installing the equipment may be of help to others.

Television Equipment

The first problem was how to cover a large day-room measuring 45 by 45 ft. (13.5 by 13.5 m.), yet when necessary focus on one particular patient and follow him about the ward. This was solved by installing remotely controlled cameras which move laterally 180 degrees, horizontally 180 degrees, and also change the focal length of the camera lens (pan, tilt, and zoom). The cameras employed are quite small, measuring 10 by 6 by 6 in. (25 by 15 by 15 cm.), and are mounted in a corner of each room on a wall bracket at about a height of 7 ft. (210 cm.) (Fig. 1). They incorporate staticon tubes 625 lines per inch in a fully interlaced system. A 23-in. (58-cm.) observation monitor was installed in the central hospital block in a consulting-room and the television apparatus was built into what looks like a normal office desk at which the operator sits (Fig. 2). There are four controls on the desk—two for fine focusing and zoom, a four-way switch to change from camera to camera, and a short lever resembling the control column in an aircraft which moves the cameras in any direction.

Background sound effects were obtained by installing a polydirectional microphone in the centre of each room; a switch on the control desk changes the sound effects from ward to ward. A special telephone was installed beneath each camera so that an observer can speak to the nurse in the ward about her cases.

Initial Experience

The apparatus has been in use for four months and has so far proved to be robust, no mechanical difficulties having been encountered. It can be operated by a completely unskilled person. At one period the question of putting some kind of guard round the cameras in the ward was contemplated in case a very disturbed patient might damage them, but this has not been necessary.

Apprehension expressed by a nurses' union because the nurses would also be the subject of observation was met by agreeing to notify the ward sister before the apparatus was switched on.

If incidents of special clinical interest occur a 16-mm. cine camera, which is kept adjacent to the monitor, can take cine film at 24 frames per second.

Some difficulty has been experienced in obtaining adequate overall lighting to cover the whole room, but so far no lighting additional to the normal ward lighting has been installed. The occupational therapy rooms have fluorescent lights and these give a better picture

FIG. 1.—Day room with a T.V. camera on wall bracket to the right of the wall picture.

FIG. 2.—Television desk and monitor. Monitor is normally 6 ft. in front of desk.