EVOLUTION IN THE MENTAL HOSPITAL

REVIEW OF A HOSPITAL POPULATION

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A large proportion of all patients under care in mental hospitals show no serious disturbance of behaviour, and their retention is determined largely by social factors. Cross *et al.* (1957) surveyed the chronic population of a large mental hospital, and found that most of the patients had been under care continuously for 10 years or more; only a very small proportion required constant vigilance, while about two-thirds needed only "routine care." The degree of supervision accorded seemed to depend as much on ward tradition and administrative policy as on the patients' mental disturbance. Nearly one-half of the patients were totally unemployed, and many of the remainder had only spasmodic or nominal employment. The investigators concluded that there was a need for imaginative schemes of occupation and rehabilitation, and that all intermediate stages of care should be tried, between the mental hospital on the one hand and normal family life on the other.

Garratt *et al.* (1958), from a study of the four Birmingham mental hospitals, found that of a large number of patients reviewed 75% needed only limited hospital facilities, while 12% needed no hospital facilities whatever, and remained in hospital for entirely social reasons. Furthermore, of the large group requiring only limited hospital facilities, 86% were fully ambulant, and 49% needed no nursing supervision in hospital. These patients would have been better off in hostel accommodation with a lower ratio of bed-space and more amenities for normal activity. As Garratt *et al.* pointed out, however, patients in this category are not necessarily well enough to live alone; on the contrary, many need to belong to an organized community which can offer them assistance with training and employment. Among patients no longer needing hospital care two main types were distinguished—those suitable for hostel accommodation and those well enough for boarding out.

The above investigations were carried out on typical mental-hospital populations, and at the time were probably quite representative. It is possible that the pattern has changed appreciably during the past three or four years. More active discharge policies, the development of special "rehabilitation units" within some hospitals, the systematic use of tranquillizing drugs, and the increase of day-hospital facilities and out-patient treatment clinics may have played some part in breaking up the chronic population of the mental hospitals. After an initial increase in the discharge rate, it is probable that advances in physical treatment have served to increase the proportion of patients with only mild symptoms, so that the proportion of patients retained for purely social reasons may have increased. This is suggested by our figures. The discharge rate for those in hospital over one year was static from 1952 to 1954, appreciably increased in 1955 on the introduction of promazine therapy, and fell to "pre-chlorpromazine level" in 1957. In 1958 the introduction of industrial

therapy coincided with the highest-ever discharge rate, and this returned to "chlorpromazine level" in 1959, but went to its highest level yet in 1960 (Table I).

TABLE I.—Yearly Discharge Rate of Those in Hospital More than One Year

Year No.	1952	1953	1954	1955	1956	1957	1958	1959	1960
	28	29	27	40	39	31	59	39	77

Present Investigation

To test these hypotheses, and to provide an estimate of the need for mental aftercare accommodation in Bristol, it was decided to carry out a survey of the current population of Glenside Hospital (formerly the Bristol Mental Hospital), which holds the bulk of chronic psychiatric patients in the city. The Royal Commission Report (1957) proposed that in future patients suitable for mental aftercare should be the responsibility of local authorities. This view has been widely accepted in principle, but in most areas suitable accommodation does not yet exist. It will be necessary for each local authority, when planning such accommodation, to have a reliable estimate of the size and complexity of the problem.

There is one aspect, however, in which the current situation at Glenside Hospital may be of particular interest. The most significant change in this hospital in recent years has been the development of industrial work. Since a small experimental unit was established at Banstead (Carstairs *et al.*, 1956) industrial therapy has spread rapidly in mental hospitals, and there are now a large number of hospital workshops in production. Most of them, however, are still on a small scale, and the unit at Glenside is probably the largest and most productive in the country. If this form of occupation becomes generally accepted as an important factor in the rehabilitation of mental patients, as the Piercy Committee and Standing Mental Health Advisory Committee (Ministry of Health, 1958) have recommended, the growth of industrial work at Glenside, and its effect on the hospital milieu, may be an interesting augury for other hospitals.

The development of the industrial unit in this hospital, and the subsequent formation of a company—Industrial Therapy Organization (Bristol) Ltd.—has been described in a previous paper (Early, 1960). It is too soon to evaluate the effect of these projects on the pattern of patient-discharges. There can be no doubt, however, of the improvement in morale of both patients and staff, following directly on the establishment of the industrial units. For the first time a large proportion of the hospital population are fully and usefully occupied, and, perhaps more important, patients have been given the prospect of earning their living in the outside world. Not only are those patients formerly regarded as potentially capable of work now actually becoming self-

TABLE II.—Increase in Patients' Earnings Since the Introduction of Industrial Work

	1957	1958	1959	1960
No. of patients	1,200	1,172	1,169	1,147
Hospital workers and basic allowances	£6,820	£5,980	£6,194	£7,082
Industrial earnings:				
In hospital	—	£3,731	£8,706	£10,043
I.T.O. (10 months)	—	—	—	£7,943
Open employment	—	—	—	£3,750*
Total	£6,820	£9,711	£14,900	£28,818

* This is a rough figure calculated on the average of nine patients earning £8 a week for a full year.

supporting, but many others, once thought hopelessly deteriorated and unemployable, are now proving that they can make a useful contribution. Over the past three years patients' earnings have increased rapidly and continuously (Table II), and if the present trend continues the hospital population will soon contain a sizable proportion of wage-earners who will need only suitable accommodation to become independent and self-supporting.

Survey

The patient-survey was carried out, therefore, with particular reference to the need for accommodation and outside employment. A form was designed, covering 34 items with a possible bearing on patients' social needs. A copy was then completed for each patient who had been in hospital for at least three months continuously. (Patients under care for less than this time were excluded: short-stay patients were unlikely to present the same kind of aftercare problems.) The schedules were completed by two members of the medical staff working in close collaboration and with frequent discussion to ensure uniformity of method. Information was obtained from individual case-notes, visiting-cards, and central hospital records; by questioning the nursing staff; and by interview with patients whenever necessary. The information obtained was then transferred to Hollerith punch-cards for analysis.

Results

Age-and-Sex Distribution.—The total number of patients included in the survey was 1,012 (453 men and 559 women). A high proportion of both sexes were in the older age-groups—particularly so among the females (Table III).

TABLE III.—Age-and-Sex Distribution

Age	Male	Female	Total
Under 65 years ..	354	316	670
65 and over ..	99 (21.8%)	243 (43.6%)	342 (33.8%)

Patients' Status.—Only 52 patients (5.1%) were detained, the remainder were informal admissions. This represents a marked change in the hospital pattern during the past three years, the corresponding figure for 1957 being 792 (66%).

Duration of Stay.—737 patients (72.8%) had been in hospital continuously for over five years, and 862 (85.2%) had been in continuously for over two years.

Patients' Behaviour.—615 patients were rated as showing no antisocial tendencies and a further 239 only mildly antisocial behaviour, of a kind which in itself would not warrant retention in hospital. From this point of view, therefore, 854 patients (84.4%) were not in need of custodial care. It is interesting to note that, of the whole population, only 30 male and 8 female patients had any kind of criminal record; this group accounted for a large proportion of the patients still under detention. The problem of disposal of patients with a history of assault or dangerous paranoid tendencies is a real one, though relatively minor in estimating the needs of the hospital population.

Nursing Care and Supervision.—122 patients were rated as needing no nursing care whatever, while a further 355 required only the minimal supervision which would normally be provided in a long-stay annexe or aftercare hostel. From this point of view nearly one-half of the population (477 patients, or 47.1%) were not in need of hospital facilities. Furthermore, 334 patients were judged to require absolutely no restriction of move-

ment, and a further 287 were well enough for complete freedom within the hospital grounds; these patients were all suitable for aftercare accommodation apart from their acquired dependence on the hospital regime and, in a small minority, recurrent need for medical treatment. Of the 159 patients confined to the hospital wards, a proportion were not fully ambulant, while the remainder were almost all frail, confused, or demented senile patients.

Outside Contacts.—344 patients were never visited or taken out by relatives or friends, and in 201 of these cases it was not possible to identify any possible outside support. (Of this group of patients isolated from the outside world, 84 (56 males, 28 females) were regarded as mentally normal or suffering from only mild abnormality.)

Patients' Employment.—55 patients were employed outside hospital, and 34 of these were regarded as suitable immediately for aftercare accommodation were any available; 224 other patients were engaged in industrial work in the hospital. Thus a total of 279 patients (29.3%) were being paid by outside employers. Only 372 patients (36.7%) were totally unemployed, and this number coincided largely with the senile group, which comprised one-third of the patients under survey. With regard to the fitness of individual patients for open employment, this is an aspect of prognosis on which, like most psychiatrists, we are profoundly ignorant. 64 patients were designated as fit for immediate employment; this is really guesswork, but when it is considered that most of the patients had been in hospital for over five years continuously a low figure is to be expected. Clearly there is a great need for training schemes and the provision of sheltered employment.

Type of Accommodation Required.—Only 558 patients (51.1%) were rated as needing psychiatric hospital care (and in 25 of these cases the principal diagnosis was mental deficiency). Of the remainder, 83 needed geriatric or chronic-sick hospital care, 254 required supervised aftercare, 67 were suitable for unsupervised aftercare, while 50 required no accommodation (Table IV), and were either approaching discharge or could be discharged with some pressure on relatives (one of the practical problems here is shortage of social workers). In all but the first two categories of patient—that is, those in need of hospital care—the main criterion employed was that the patient's discharge should not cause any serious disturbance of the community or undue hardship to relatives.

TABLE IV.—Type of Accommodation Required

	Male	Female	Total
Psychiatric care	288	270	558
Geriatric care	21	62	83
Supervised aftercare	118	136	254
Unsupervised	17	50	67
No accommodation required	9	41	50
Total	453	559	1,012

Of the patients regarded as suitable for supervised aftercare, 73 were 65 years or over, while of those fit for unsupervised accommodation 32 were in this age-group. Of the "supervised aftercare" group, 20 were already working out from hospital and a further 199 were being paid by outside firms for work done in hospital. Of the "unsupervised aftercare" group, 14 were working out and 49 doing industrial work in hospital. In point of fact, of the total group of patients regarded as suitable for aftercare accommodation, virtually all except a proportion of the older age-group—mainly elderly

female patients—were already engaged in some form of industrial work and earning an average of over £1 weekly.

Discussion

These results suggest that there is an immediate need for aftercare accommodation for over 300 patients, most of whom have been in hospital continuously for several years, have only mild psychiatric symptoms, and no longer need either in-patient treatment or custodial care, but who cannot at present be discharged from hospital because they have no family support and have become dependent on institutional care. Furthermore, 83 patients (21 male, 62 female) were straightforward geriatric cases not needing the facilities of a mental hospital.

To solve the problem of overcrowding, and to make economic use of medical and nursing staff, it is essential for mental hospitals to maintain an active discharge policy. If the mental hospital is allowed to continue to fulfil the functions of a hostel, and a geriatric and chronic-sick unit, this must deprive psychiatric patients of the care which is their right, and will serve only to discourage medical and nursing staff. Thus there is every incentive to discharge chronic mental patients from hospital whenever possible. The effect, however, of discharging psychiatric patients prematurely or without adequate provision may well be serious for the patients' relatives and for the community; moreover, such patients relapse quickly in a high proportion of cases. To pursue a deliberate policy of discharging chronic patients, without regard to the facilities existing for their resettlement, is irresponsible, and likely to discredit the whole concept of "open door" psychiatry. In short, although a large proportion of mental hospital patients may be regarded as not in need of hospital care, it is highly undesirable that they should be discharged on these grounds unless suitable alternative accommodation exists.

There is no clearly defined point at which the care of a chronic mental patient should be transferred from hospital staff to local authority. We believe that in the long run only joint schemes, which have in addition the co-operation and good will of local industry as well as of the major voluntary organizations, can successfully deal with the problem. If aftercare accommodation is to be provided by the local authority, hospital psychiatrists and social workers who are already familiar with the patients should participate in their supervision; similarly, hospital nursing staff should play a part in the care of those of their former patients who go to training workshops.

The term "supervised accommodation" is usually taken to mean aftercare hostels with one or more nurses in charge. While this type of accommodation has undoubtedly a part to play in rehabilitation, and may be the best attainable at present, its disadvantages must be borne in mind. Transition from chronic ward to hostel may mean simply the exchange of one institution for another, unless it is regarded as a transitory stage on the road to normal life. The problem must be conceived in dynamic terms; it is not a question of providing permanent accommodation for a large number of disabled persons, but of offering patients every facility for resocialization. If the provision of training workshops is one aspect of this programme, a second is training for normal home life, while a third is the establishment of therapeutic social clubs and the introduction of patients to existing clubs, so that the discharged patient does not spend his leisure in isolation.

It is hoped to develop in Bristol a scheme for housing discharged patients in a group of standard council houses adjacent to the hospital; from these they will attend the training workshop and later go to normal employment, and as their social recovery progresses they will move to houses, flats, hostels, or lodgings elsewhere in the city to complete their resettlement.

Although no controlled comparison has been possible so far, our impression is that long-stay patients obtain greater benefit from industrial therapy as practised here than from attending a course at the Ministry of Labour industrial rehabilitation units (Wing, 1960). The placing of discharged long-stay patients in open industry is proving easier through I.T.O. with its local contacts than through the Ministry of Labour.

How great a change may ensue in psychiatric practice from the development of social methods is a matter for conjecture. At one extreme of opinion it is held that all such measures are of necessity only makeshifts of the kind to which resort is always made in medical practice until the appearance of a specific therapy. That such specific treatment can be found for the major psychoses is by no means certain; unless or until it is found, the prevention of complete social disability, and of loss of normal contacts so often arising from psychotic illness, must be regarded as one of the most important goals of treatment. Moreover, in a large proportion of the current mental hospital population the major problem is one of institutional dependence rather than gross mental disorder, and here social measures alone can be effective.

With the development of a realistic employment and discharge policy, especially if sheltered workshops can be provided, a large proportion of hitherto unemployable chronic psychotics can reasonably hope to hold their own in the community. This will bring the overcrowding in psychiatric hospitals to manageable proportions, and will ultimately enable the development of the comprehensive hospital (McKeown, 1958). Smith *et al.* (1960) have shown that even in a large old hospital the gradual introduction of general medical cases is possible. Along these lines, the psychiatric hospitals can be prevented from becoming depositories for the aged and the chronic, the function which the old public assistance institutes fulfilled and which nobody wishes to see re-established.

Summary

The pattern of the mental hospital is changing, and must continue to change. To obtain current information on the needs of mental patients in Bristol, and in particular on the need for aftercare facilities, a survey was made of the mental hospital population. The present situation was thought to be of particular interest in view of the development of industrial therapy and the increase in patients' earning power.

The results suggest that little more than half the population require psychiatric hospital treatment; one-third are over the age of 65; one-third are suitable for aftercare accommodation of one type or another, and of this group a high proportion are potentially self-supporting.

There is urgent need for the provision of aftercare accommodation, but this must be regarded as a step on the road to complete resettlement.

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WINCHESTER ADDRESS

On May 24 the Winchester Division of the B.M.A. entertained the Minister of Health, Mr. J. ENOCH POWELL, in the New Hall of Winchester College, where he delivered this year's Winchester Address. His address dealt with the relationship between doctors and politicians, and we published it in full in our opening pages last week (May 27, p. 1479) under the title "The Elephant and the Whale." Our picture this week shows the Minister with the chairman of the Winchester Division, Mr. P. R. MITCHELL.

The meeting was attended by over 400 doctors and their guests from the Division's catchment area, which besides Winchester includes Alton, Andover, and Basingstoke.

Chairman's Welcome

In introducing the Minister, Mr. MITCHELL said that as a boy at school in Edinburgh he had been encouraged to learn something, not only of the history, but also a little about those who through the centuries had contributed most to that lovely city. Whenever a distinguished guest visited the school they had been required to nominate the individual whom they felt it was most appropriate that he should meet. Perhaps because on this occasion they were privileged to meet in Winchester College—by the kindness of the headmaster—he had recalled this rather entertaining mental exercise, and had begun to wonder which of those who, in so many different spheres, had done so much for the ancient city of Winchester their most distinguished guest would have liked to meet—politician, poet, author, scholar. Their guest had all these attainments, so that even in Winchester the field of candidates was somewhat narrow. Finally, however, he had selected one to whom this city owed a considerable debt of gratitude.

[Hampshire Chronicle

The individual he had in mind was in the early eighteenth century a prebendary of Winchester Cathedral. In 1736, exactly 225 years ago, he, too, had delivered a Winchester Address—which must surely have been the first of its kind. It took place in Winchester Cathedral before, as the official record stated, a gathering of persons of the most consequence and of every denomination and party. Its main object was to explain the necessity for and the establishment of the County Hospital in Winchester, of which he was the founder. He thereby had given Winchester the distinction of having the oldest of the provincial non-teaching hospitals in the country. His name was Dr. Alured Clarke, and, not content with founding the Royal Hampshire County Hospital, later, when he became Dean of Exeter, he had also founded what was now the Royal Devon and Exeter Hospital. "I think our guest might have liked to meet him."

Mr. Mitchell then invited Mr. Enoch Powell to deliver the Winchester Address, which he did. At its close Dr. A. M. SMEATON, of Basingstoke, chairman-elect of the Division, proposed the vote of thanks to the Minister.

To-day's Drugs

With the help of expert contributors we publish below notes on a selection of drugs in common use.

Zoxazolamine

"Flexin" (McNeil Laboratories).

Chemistry.—This substance is 2-amino-5-chlorobenzoxazole and has the following structural formula:

Pharmacology.—Zoxazolamine was originally introduced as a skeletal muscle relaxant, but is now also used as a uricosuric agent in chronic gout because it inhibits tubular reabsorption of urate. In regular dosage it effectively increases the renal output of uric acid, lowering the level in the plasma, and depleting the tissues of tophaceous matter. Small doses of salicylate (1-2 g. a day) antagonize this uricosuric effect of zoxazolamine, and should not be given concurrently.

Therapy.—Administration of the drug must be continual, because plasma levels of uric acid soon rise above normal again if treatment is discontinued for even a day. Zoxazolamine is not advised for the treatment of acute gout; indeed, acute attacks may initially be precipitated by the regular use of any effective uricosuric agent. In time, however, the incidence of acute attacks diminishes in patients maintained on uricosuric therapy. The urinary output of uric acid should be kept up, and the urine should be alkalinized by concurrent administration of alkalis such as sodium bicarbonate. Acute attacks of gout may be treated by the usual agents (for example, colchicine or phenylbutazone) without discontinuing uricosuric therapy.

Weight for weight zoxazolamine appears to be some two to four times as effective as probenecid and about the same as sulfinpyrazone. It is wise to start dosage at very low levels, gradually increasing to $\frac{1}{2}$ -1 tablet (125-250 mg.) 8-hourly. The tablets should always be taken with food, and plentiful fluids taken between meals. For those patients who do not respond satisfactorily another uricosuric agent may be given in addition; some patients derive more benefit from two such agents than one alone—for example, zoxazolamine + probenecid or zoxazolamine + sulfinpyrazone.

Side-effects.—These are usually mild and are relatively uncommon. Zoxazolamine may cause gastro-intestinal upsets, dizziness, drowsiness, rashes, and, very rarely, toxic hepatitis. Diminished renal function is not an absolute contraindication, but dosage in such cases should be more circumspect.

N.H.S. Basic Price.—50 tablets for 25s. 10d.