IMPACT OF NEW METHODS OF TREATMENT IN A PROVINCIAL MENTAL HOSPITAL

BY

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Increasingly and against severe administrative difficulties it is emerging in the mental hospital that work, as an activity in itself, and as a convenient and important medium for the establishment, maintenance, and deepening of interpersonal and group relationships, is of great value in the treatment of the major mental disorders and the resocialization of the chronic patients in mental hospitals. The denial to chronic patients of the right to relate themselves, through work, to their fellow men is one of the glaring anomalies of present-day mental hospital organization and management. This matter has become of much greater significance since the introduction of the drugs known as tranquillizers, whose place in treatment of mental disorders is already assured and by whose use, either alone or together with well-established methods of treatment such as E.C.T., the disruptive effect of psychotic tension can be virtually eliminated. One would expect a significant alteration in the pattern of mental hospital statistics with the application of the total therapeutic resources now available, and particularly since the introduction of the tranquillizing agents and the demonstration of the importance of a programme of rehabilitation.

The purpose of this paper is to describe the application of a programme of work and occupational therapy combined with increased nursing interest, together with the energetic use of the tranquillizing drugs and E.C.T. in a provincial mental hospital over a period of 18 months from January 1, 1956, to June 30, 1957, and to review the results obtained.

The hospital has 710 beds (368 male, 342 female), and is situated 2½ miles from the county town of 40,000 people. In the county there are four or five small towns, and the total population served by the hospital numbers more than 300,000. The medical staff consists of a superintendent (consultant), two assistant psychiatrists (senior hospital medical officers), and two junior hospital medical officers. During the period under review there was one occupational therapist, and since November, 1956, there has been an almoner. The nursing staff is shown in Table I. These figures compare unfavourably with those of other mental hospitals in Scotland and with the national average.

Position on January 1, 1956

The hospital is divided into a male and a female side. In January, 1956, the male side consisted of the admission ward of 30 patients and six wards for long-stay patients, each ward having between 30 and 40 patients. There was only one unlocked ward; 32 male patients were non-ambulant and 50 were able to work out of the wards, mostly in the hospital gardens under supervision. The remainder of the male hospital population were not engaged in any activity besides domestic duties in each ward, the majority spending most of the day sitting on benches in each of the ward's day rooms. The female side in January, 1956,

TABLE I

	January, 1956		January, 1957	
	Male	Female	Male	Female
Qualified nurses	31	16	41	22
Nursing assistants	8	20	7	16
Student nurses	4	6	6	11
Total	43	42	54	49
Staff/patients ratio	1/6.5	1/7.6	1/4.7	1/6.3

consisted of one admission ward of about 30 patients and seven wards for long-stay patients, each ward having between 30 and 40 patients. Only one ward was unlocked and there were 72 female non-ambulant patients. There was no regular occupation for the majority of the female patients although the small occupational therapy department took 10 to 15 women a day, and a number of others worked in the kitchen, in the laundry, and in general sewing work for the hospital.

Table II shows the admissions, discharges, deaths, total hospital population, drug costs, and costs per patient-day for the years 1951-7. It will be seen that the admission and discharge rate before 1956 is comparatively low and the total hospital population is fairly stabilized. The drug bill shows a tendency to increase, as does also the cost per patient-day. Before 1956 many cases were refused because of lack of accommodation. From January 1, 1956, no patients were refused. Most cases were admitted by direct referral from general practitioners in the area, following interview at psychiatric clinics or domiciliary consultations, or by direct transfer from general hospitals. A vigorous attempt was made at all times to treat patients outside hospital if possible.

Introduction of a Programme of Rehabilitation

In January, 1956, an attempt was made to improve the conditions mentioned above. On the male side long-stay patients were classified according to behaviour and activity into seven groups. Three groups of 15 men each were able to work in the hospitals and gardens as before. One nurse was allotted to the special care and attention of each of the remaining groups of 10 patients whose behaviour ranged from severely deteriorated to "markedly less disturbed." For the deteriorated group there was initially habit-training

TABLE II

Year	Admissions			Discharges			Deaths			Hospital Population*			Costs March 31 Yearly		
													Per Patient/Day		Drugs
	C	V	Total	C	V	Total	C	V	Total	M	F	Total	Hospital	Regional Average	
1951	49	8	57	20	5	25	57	0	57	305	278	583	s. d.	s. d.	£
1952	84	76	160	38	54	92	52	2	54	294	287	581	8 8	12 6	489
1953	97	94	191	47	80	127	49	7	56	299	299	598	9 11	13 0	503
1954	79	75	154	37	64	101	51	7	58	283	307	590	11 2	13 9	1,005
1955	76	108	184	44	89	133	35	5	40	271	315	586	12 4	14 2	1,035
1956	111	332	443	173	229	402	61	7	68	282	308	590	12 5	14 10	1,102
1957/ to 30/6	57	176	233	54	163	217	17	5	22	254	308	562	15 5	16 0	2,004
													16 2	17 7	4,487

C = Certified. V = Voluntary.

* At June 30.

and later work varying from ashing hospital paths to grass-cutting, lawn-mowing, or gardening. For the other groups of less-disturbed patients the programme consisted of such work in the occupational centre as wood-cutting, locker construction, formica-covering of tables. There was also physical training and games, gardening in individual plots, and group discussions, using as a basis a schools educational broadcast on current affairs or an educational film. A specimen programme is shown in Table III.

TABLE III

Work Period	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9.30-10.30 a.m.	P.T.	P.T.	P.T.	P.T.	P.T.	Garden work
10.45 a.m.-12 noon	Group discussion	Educational film	Current affairs (schools)	Occupational centre	Garden work	P.T. games
2.30-3.30 p.m.	Individual gardening	Bowling	P.T. games	Schools broadcast	Film show	Visiting hours
3.45-5 p.m.	"	Gardening	Individual gardening	Nature ramble	"	

As the scheme progressed a successful attempt was made to employ larger and larger numbers of patients on outside farm work and indoor assembly work (Miller, 1957). Nursing participation in the actual physical work being undertaken by the patient was encouraged, so that each group formed a team in which the nurse played the part of leader, spending almost his entire working-time in the company of his patients. Five to eight active patients remained behind in each of the wards to assist in the general domestic duties. The patients were encouraged to work by payment of a small sum of money (5s. or 7s. 6d. weekly, according to quality and standard of the work). Later an incentive was provided by their ability to earn a wage at outside farm work.

On the female side, because of the number of patients over middle age who were not physically active, shortage of suitable occupations, and shortage of nursing staff, the group nursing methods were not introduced to the same extent. The occupational therapy department, however, devoted itself to the treatment of women patients, taking 60 long-stay patients daily. A physical training class was started, performing simple routines such as marching, dancing, exercises with medicine balls, etc., to take 35 patients each morning; and a badminton class was begun. Some other patients worked on small individual plots in the hospital grounds, cultivating vegetables and flowers; and a group of 15 to 30 women were able to work outside the hospital, mainly at farm work.

Use of Electric Convulsion Therapy and Tranquillizers

Coincidentally with the above programme and using the commonly accepted indication for the administration of E.C.T. (that of affective abnormality) and those of psychotic tension, overactivity, excitement, and aggressiveness for the administration of tranquillizers, these two treatments were given a trial, as follows:

Male patients: 16% of the long-stay patients had a trial of chlorpromazine alone; 7.6% had a trial of E.C.T.; 23.2% had a trial of E.C.T. together with a tranquillizer; and 1% had a trial of reserpine.

Female patients: 37.2% of the long-stay patients had a trial of chlorpromazine alone; 5.2% had a trial of E.C.T. alone; 16% had a trial of E.C.T. and a tranquillizer; and 8% had a trial of reserpine.

Accurate figures of the occurrence of jaundice are not available, but no more than 10 cases occurred during the period under review. There were no deaths attributable to the use of tranquillizers. Two deaths occurred in chronic

patients within 24 hours of the administration of modified E.C.T. The causes of death were coronary thrombosis and fat embolism.

Improvement of Living and Social Conditions in Hospital

A general attempt was made to improve living conditions in the widest sense for the patient in hospital. The wards were decorated in turn, using light pastel colours. Harmonious colour schemes were obtained from the free advice of a colour consultant. The dietary of the patients was generally improved. Dining accommodation was improved by the introduction of stacking chairs and tables for use in each of the wards, thus removing the institutional atmosphere of dining *en masse* and releasing the dining-hall for use as an occupational centre. Patients were individually measured for new clothing and obtained a working suit of clothes and a suit to be worn in leisure hours. Latterly television sets were obtained for eight of the wards. A social club was formed for the patients and run by them. More dances were organized, and an increased number of outside societies and concert parties visited the hospital and willingly came to provide entertainment. An increased contact with the general community came through an increase in hospital visiting hours, from twice weekly to daily visiting, and by encouraging visits from outside clubs, social groups, guilds, etc., to come and see the hospital. Relatives were encouraged to take patients on week-end leave.

Position after 18 Months

The admission and discharge figures for 1956 and 1957 show a dramatic rise. At the same time there has been a fall in the total hospital population. A discharge rate of 90% was achieved in 1956, and for the first six months of 1957 the figure was 93%. The death rate has dropped. Despite the thrice-increased admission rate, the total hospital population has fallen from 600, at January 1, 1956, to 562, a fall of 7% and the number continues to fall. The drug bill has increased, but this is not serious when taken in conjunction with the greatly increased number of patients treated. The cost per patient-day has increased, but is still below the regional average and probably well below the national average. During this eighteen-month period 56 patients who had been in hospital for more than two years were successfully discharged to the community. Of these 56, 5 had been in hospital for more than 20 years (2 female and 3 male), 10 for more than 10 years (3 female and 7 male), and 15 for more than five years (10 female and 5 male).

Table IV shows the number of patients admitted during the period who were still in hospital on September 30, 1957. It will be noted that the majority of patients who have

TABLE IV

	Schizophrenics	Senile Dementia	Organic Dementia	Affective Disorders	Others
Male	12 (4)	3	6 (2)	4	7 (1)
Female	9 (1)	18	14 (1)	13 (1)	2

Transfers from other hospitals are bracketed.

remained are not schizophrenics but suffer from senile or organic dementia. Many suffer from a complication of physical illnesses as well, which helps to prevent their discharge. Twenty-one women were over the age of 70 and 14 over the age of 50. Three of the males were over the age of 70 and 12 over 50 years.

Improvements Within the Hospital.—The hospital has now only one locked ward for male patients and none on the female side. No more than 10 patients were non-ambulant in the hospital at the time of the survey, September 30, 1957. A large number of patients, both male and female, were able to go out of the hospital to work, with considerable financial benefit to the Department of Health.

The totals vary according to season but are in the region of 50 men and 15-30 women daily, at peak periods.

There is much less resistance to admission and there is a better feeling towards the hospital in the general community. The hospital has become a treatment centre for acute cases and at the same time a place where those patients whose illness does not respond initially to treatment can remain, able to maintain, through occupation and the use of drugs, meaningful relationships with other people in their environment whether it be patients, nurses, physicians, relatives, or friends, until their illness has resolved, or at least their behaviour has modified sufficiently to allow of their consideration for discharge.

Comments.—These results have been obtained by the intensive application of fairly new yet already well-tried methods. They have been achieved by a small medical and nursing staff, despite the vast increase in the out-patient and domiciliary services. The cost for the treatment of each patient has increased, but is still less than the regional average. There has been no capital expenditure in the construction of new premises. Accommodation for occupational centres and the occupational therapy department has been obtained by intelligent improvisation and by making use of the accommodation left vacant as a result of the increased discharge rate. The utility of the programme would seem to be unquestionable in terms of service to the community and improving the lot of long-stay patients in hospital.

Conclusion

It would appear from this short-term review that even without greatly increased medical or nursing staff, without greatly increased expenditure of money, without new buildings, and with only the present facilities and therapeutic resources available, the mental hospital can be run as an efficient unit, the problem of overcrowding can be solved, the accumulation of schizophrenics can be reduced to manageable proportions, and the chronic patient returned successfully to the community.

I thank Dr. H. J. B. Miller, physician-superintendent, Glengall Hospital, Ayr, for allowing me to publish this article.

REFERENCE

Miller, H. J. B. (1957). *Lancet*, 2, 87.

AUSTRALASIAN MEDICAL CONGRESS (B.M.A.)

TENTH SESSION IN TASMANIA

[FROM A SPECIAL CORRESPONDENT]

The tenth session of the Australasian Medical Congress (B.M.A.) was held in Hobart, the capital city of Tasmania, from March 1 to 7, 1958, under the presidency of Mr. J. B. G. Muir, a Hobart surgeon. It was a major undertaking for the Tasmanian Branch of the B.M.A. to accept responsibility for the organization of such a gathering, but enthusiasm and much hard work, especially on the part of the honorary secretary of the Congress, Dr. FRANKLIN FAY, overcame all the difficulties and the Congress was a great success. Full co-operation was given by the various public authorities, especially by the University of Tasmania.

The Governor of Tasmania, Sir RONALD CROSS, opening the Congress, said that in all Australia there was no organization more highly regarded than the British Medical Association, and he extended to all visitors a warm welcome from the friendly Tasmanian community. The Congress had only once before been held in Tasmania, in 1934; and since the Commonwealth of Australia consisted of two islands, a northern island and a southern island, he felt that there must be some very good reason why the sessions of Congress were not held alternately in one island and the other. He was sure that many of the visitors should spend

more time in Tasmania, such a paradise on earth it was. He found it hard to express the keen appreciation that laymen had of medical research, knowledge, experiment, and practice. Laymen had trust in and respect and affection for the men who worked early and late at all sorts of unseasonable hours to bring succour to those in need.

"The Health of the People"

Mr. J. B. G. Muir then delivered his presidential address on "The Health of the People," a phrase which he traced back to Pericles, who in his oration to the Athenian dead had defined health as that state of moral, mental, and physical well-being which enables a man to face any crisis in life with the utmost facility and grace. Many centuries later Disraeli had spoken on the health of the people, defining it as "the real foundation on which all their 'happiness' and all their power as a State depend." In other words, besides including an important medical factor, in so far as the physical health of the individual was concerned, the maintenance of the health of the people had progressively become a vital political and economic force throughout history. The medical profession was directly or indirectly connected with all aspects of the health of the populace in an advisory capacity, but directly and in a practical way with the health of the individual in every aspect of disease.

Modern medicine was costly, continued Mr. Muir, not so much because of individual fees as because of the multitude of estimations and tests required for the proper conduct of a complicated illness. However, no member of the community was debarred because of expense from any measure which would help to cure him. Public hospitals covered those in the low income group, and health insurance was available to all. On the question of whether the cost of medical care was excessive, too much of a financial strain on the wage-earner, opinions would naturally be based on the success or otherwise of the treatment given. However, there was a general feeling that State assistance was indicated in some measure.

A number of people would advocate a completely free national health scheme such as there was in Britain, but the great and increasing cost of such a service should be remembered. Moreover, the general practitioners working under the British scheme were far from happy and contented in their work, and were completely under the control of the bureaucratic machine. Experience had shown that when services were free they were not appreciated, and exploitation of the doctor's time with frivolous consultations was a frequent occurrence. Time-consuming filling-in of forms and certificates was inseparable from any medical scheme, but appeared to be much worse on a full-time basis.

Insurance Scheme Advocated

To prevent exploitation, each individual should bear at least part of the cost of his illness, small enough not to cripple him financially, but enough to make him appreciate his responsibilities, to prevent abuse of the system, and to contribute towards the total cost. Medical and hospital insurance could cover the need if it was made universal and compulsory, and if it accepted for treatment all human ailments, particularly pre-existing disease. Norway had adopted such a compulsory health insurance policy after a slow and carefully planned evolution. It had, in fact, managed to combine "compulsory health insurance with maximum freedom for the doctor to pursue his own career in a system which brings out a maximum sense of responsibility in both the physician and patient."

Obviously some such scheme, covering all sections of the community and which would also permit free practice by the profession, was the best scheme for promoting a high standard of health in the people, because medical advice would be sought early in illness without fear of expense. It had always been the aim of the British Medical Association to uphold the complete freedom of the doctor in his practice. The most important assets of a doctor were the