Middle Articles

A Therapeutic Community in an Acute Admission Unit of a Mental Hospital

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In April 1963 we resolved to run an admission unit comprising male and female patients in a mental hospital as an integrated therapeutic community. Martin (1962) described succinctly the improvements in morale among staff and patients and the happier atmosphere in a unit run on community principles. He stressed the adverse effects that the hierarchical regime in the traditional mental hospital unit exerts upon staff and patients alike. He described the running of a therapeutic community using the entire staff personnel, including doctors, nursing-staff, social workers, psychologists, occupational therapists, and whatever other members of hospital staff may be involved in working in a hospital unit. We drew on Martin's suggestions and experience, but modified our own community as we found necessary in view of the circumstances and personnel in our own hospital.

Physical Structure

Our acute admission unit consists of a three-story villa built in its own grounds as an independent unit in the mental hospital grounds. There are 31 beds for females and 30 for males, and the unit is always mixed—that is to say, meals, recreation, and occupational therapy have always been shared by males and females in common.

The three-story structure is subdivided as follows: the middle floor has recreation, dining-hall, and occupational facilities; the lower floor contains rooms only for admission cases and for cases of acute and sometimes prolonged illness; and on the top floor ambulant patients requiring the minimum of observation reside.

The unit admits patients with mental disorder of all sorts—psychoses, neuroses, psychopaths—and excludes all those with long-term illnesses and those who have had more than three previous admissions, although there are exceptions. The unit accepts refractory disturbed cases. The average duration of stay is six weeks.

Previous to 1 April 1963 the unit had been run on orthodox lines with separation of medical staff for male and female patients. The structure was hierarchical, with no communal meetings and very little liaison between the various departments and people working in the villa. The sexes had always mixed for meals, recreation, and occupations, but never in discussion or in staff liaison.

In evolving our therapeutic community we decided to run the entire unit as a single entity. The mixing of the sexes was accelerated and all staff, apart from nursing staff, were responsible for male and female patients. All patients' activities were fully mixed, and the male and female nursing staff were

encouraged to develop an interest in one another's patients, such as sharing the supervision of occupation, recreation, and group discussions.

Meetings

Meetings are held on three days a week, attended by all patients, male and female, in a large lounge. Only those who are so disturbed in speech and behaviour as to disrupt the discussions severely are excluded. At first we had the patients sitting in a large circle, as Martin advises. We changed this practice because of the large number of patients and the limited size of the rooms, which caused cramping. Seating is arranged in rows before a table at which the patients' chairman and vice-chairman sit.

Every large meeting of patients is presided over by a chairman, elected from among them. The chairman is so chosen in order to encourage his or her fellow patients to speak, thus maintaining a diversity of opinion and expression. The chairman is helped by a vice-chairman, elected by the patients and promoted to chairman every two weeks so that nobody presides for more than a fortnight. A patients' secretary keeps the minutes of meetings, and a patients' treasurer collects small weekly subscriptions from them to buy prizes for social functions—for example, bingo, dances, etc. Four other members, in addition to the chairman and vice-chairman, constitute the patients' committee which helps in organizing social functions and games. There is no direction on the part of the staff on the committee except to prevent the election of a patient obviously incapable of undertaking the role. The above appointments are the only personnel structuring, and are made entirely by the patients and virtually without staff interference.

Staff Meetings

Every Monday morning a staff meeting is held attended by two consultants, a senior registrar, one registrar, two junior hospital medical officers, sister-in-charge, charge nurse, and any juniors available, male and female nursing officers, padre, psychiatric social worker, psychologist, and occupational therapist. Others attend by requests arising out of ward problems, and include caterers, hairdresser, porters, and kitchen staff.

Staff meetings discuss administrative matters of the previous week, complaints, and plans and suggestions for the forthcoming week, including topics for patients' meetings described below. We use the technique of feed-back—that is, feeding back into this meeting as much of the happenings in the ward during the previous week, including behaviour of patients, difficulties of patients, staff difficulties with individual members of staff and with patients. The staff endeavour to be frank

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without being trivial. Arguments arise and discussions are held, but decisions are reached by common assent. Suggestions are thrown in empirically about all sorts of activities in the ward, including occupation, meetings, general administration, physical treatments, control of routine drugs, and general administration.

Meetings in the hospital are held at consultant level, at consultant—junior staff level, and at heads-of-department level, which includes nursing, psychiatric social department, psychological department, and senior male and female nursing staff. Decisions are all fed back to the staff villa meeting: thus there is feed-back from patients to staff and from staff to patients at all levels.

Patients' Meetings

Meetings are held on Tuesday, Wednesday, and Friday mornings, each lasting for 45 minutes.

Tuesday Morning.—This is a business administrative meeting held by the patients and members of staff. Here the chairman, vice-chairman, and committee are elected, and patients' complaints to staff and staff complaints to patients are heard. This is the forum where feed-back to patients from the staff meeting of the previous day occurs. Any complaints not immediately dealt with are referred back to the appropriate hospital department and are also reported back to the staff meeting at the beginning of the week. Patients confront one another with their behaviour problems. Patients deal with these largely by themselves, but staff intervention may be necessary to explain and to arbitrate. Patients and members of the staff may lose their tempers, but no insecurity or unhappiness results on the part of the patients, as all conflicts dissolve into discussions about motive and intention; and at least one doctor is present as well as other members of staff where possible.

Wednesday Morning.—All members of the staff and all patients, except those obviously too ill, are requested to attend. A subject has already been chosen, arising out of patients' interests and discussions of the previous week; it is introduced to the meeting by a member of the staff, who may be a doctor, the psychologist, a psychiatric social worker, or a member of the nursing staff. The subject is one of clinical interest, such as the meaning of nervous tension and its effects; phobias and fears; responsibility and licence; conflicts in family life; the role of the wage-earner in the family; aggression—its origin and effects; insecurity and its causes. The subject is introduced for five minutes in very simple terms. Comments by the patients ensue. They are encouraged to quote from their own personal experience, and do so extensively. The chairman controls the meeting and remarks are addressed to him, but altercations may occur which require intervention, usually by the chairman. Members of the staff tend to hold back so as to give the patients the responsibility for the discussions, but often they intersperse remarks and suggestions. Patients are called to order by the chairman, but a manic patient may, rarely, require verbal restraint by a member of the staff. The meeting may terminate with a brief summary by a member of the staff and suggestions for further discussion.

The Wednesday morning meeting is followed immediately by a short staff meeting which comments on the contents of the previous meeting and on the behaviour of individual patients, and makes observations in general.

On Wednesday evening four small groups meet, each of 10 to 12 patients split up from the entire unit. Each small group meeting is held under one member of the staff—a doctor, a sister, a charge-nurse, or a social worker. Patients at these meetings amplify the subject of the morning and contribute their own views far more personally. It is found that patients who are shy at the large meeting are far more forthcoming at the small group meeting. Usually the member of the staff

in charge gives explanations and encourages people to talk, and the atmosphere is quite relaxed.

Friday Morning.—The patients themselves select one or two subjects for discussion. These are chosen from topics relevant to illnesses that bring them to hospital. Comments of patients on behaviour in the ward may be freely discussed. At this meeting the coherence of the community is abundantly in evidence. A member of the staff is present to help and encourage.

At all meetings wandering from the subject is accepted, and it is up to anybody present, including members of the staff, to lead the discussion back to the original topic if this is felt to be necessary.

How Does the Community Operate, and What is its Purpose?

At the outset meetings were held as open permissive congregations of patients, who were encouraged to speak spontaneously on any subject. We continued this approach for about three months. It was found that patients were unable to tolerate the lack of structure of the meeting and the permissiveness this entailed. Meetings degenerated into trivial lists of complaints far removed from clinical psychiatric import. It was soon realized that the purpose of this sort of community must be to create a generous and freely co-operative atmosphere—the atmosphere of a community of people living together with a therapeutic intention aided by trained personnel.

The second purpose was to deal as effectively as possible with the problems which commonly bring patients into hospital. These could best be dealt with by introducing a topic which troubled one or several patients and allowing them to discuss it among themselves, with the staff helping as informally as possible. It was found, at first, that the discussions held at fixed times led to informal groups getting together and heatedly thrashing out the topic with each other at a more personal level. This was channelled into better-organized meetings of small groups at the patients' request. All day long, however, the patients discuss the topic among themselves apart from meetings, indicating a continuous and maintained interest. At no time does any member of the staff prod or compel patients to enlarge upon any topic through the day: it is always informally stimulated and elaborated upon by patients.

The third purpose is educational and didactic. Whenever staff participate it is in an effort to explain and to influence attitudes, responses, and behaviour generally.

As part of the educational and informative aspect of the community, one evening a month we introduce speakers from such varied social agencies as the Marriage Guidance Council, Citizens' Advice Bureau, and the children's department of the local authority. These talks explain the functions of the agencies and the ways in which their help can be obtained if necessary. At all times the educational talks aim at preventing the social causes for breakdown and consequent hospital admission. We hope that social education will complement the sort of insight that psychiatrically trained personnel give to patients.

Additional Functions of the Community

Occupational therapy, hobbies, and social and leisure activities are encouraged in groups or in the community at large. Staff try to be present whenever possible and to join in. Exhibitions of work done by patients are held in the lounge of the ward, and include painting, pottery, basket-work, etc.

We use all other methods of treatment—for example, E.C.T., drugs, abreaction. Every patient is seen individually at least once a week, but many are seen more often if psychotherapy is required. Specific short-term group psychotherapy is under-

taken where the needs of a small group of patients require it, and the results are reported back to the staff meeting when helpful.

Results

1. There is open communication between all patients and members of staff in the unit and between all members working in the unit.
2. The patients do not feel quite so tied to their individual doctors so far as topics and general matters are concerned, but they do identify themselves with their individual doctors over personal therapy.
3. The atmosphere of the unit is open, free, and informative. There is a general spirit of friendliness between members of staff, who feel they have no need to harbour grievances of any sort or to store up hostile tendencies and energies. They can allow free rein to their feelings and understand each other much more intimately. Complaints are never smoothed over or shrugged off, but are thought out to their logical solution.
4. Hierarchical structure relaxes for the benefit of the patients as well as staff. Nursing staff, for instance, feel they can communicate and criticize freely and, in return, accept free criticism from other members of staff and patients.
5. Nurses participate more directly in obtaining an understanding of and insight into all the patients of the ward. They know what doctors, social workers, and psychologists think about individual patients. The nursing staff undertake the management of small groups and feed back their own observations to the unit staff meeting, thus deriving confidence in establishing their own points of view about patients and in handling them.
6. Patients spontaneously developed their own social club to operate after discharge from the hospital, and to serve as a bridge for adjustment between hospital and community. This social club arose out of the pattern and idea of community discussion. It has been in operation for three months, and functions very well without any members of staff being present.

It is held in the day hospital premises in Hove on one evening a week.

7. We feel that the educational role of this community is of the greatest importance; for the patients pick up positive information from one another, from staff, and from visiting lecturers which is derived from practical living situations and which they can, in turn, use in their homes and personal lives.

8. The therapeutic community with its group meetings provides the staff with much useful information about their patients. Symptoms that are otherwise unobtrusive may present themselves at meetings, and there is an opportunity to watch the patient functioning as a member of a wide social group. Diagnosis, prognosis, and treatment may all gain, especially through group meetings, where often aggression, fantasies, passivity, and other behavioural features are brought into play.

Conclusion

We are under no illusion about apathy and disinterestedness towards community therapy shown by many of the patients at various times. However, feed-back demonstrates that much of the material is absorbed, creating responses which we believe may continue to operate long after the patient's discharge. Community therapy is, in fact, an open forum that allows for emotional conflict, for role-playing, for venting disgusts, aggressiveness, negative opinion, and for all the varied interplay of social activity and its effects upon the individuals which constitute the value of this regime.

According to the experience in our unit excessive permissiveness, as well as excessive direction, is not tolerated by psychiatric patients: it is the action of the middle of the road that is most effectively accepted. Staff influence and advice must be allowed to participate in this kind of community.

REFERENCE

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"The Best is Yet to Be"*

An Evaluation and Comparison of General-practitioner Medical Services

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By making a comparison with other people's ways of doing things the British system of medical services can benefit. More understanding of health services and the organization of general-practitioner medical care can help to make the British scheme more acceptable. In making comparisons, however, it must be remembered that only in some countries are organized medical services available to all the people as in the United Kingdom.

What are the various systems and the nature of organized medical general-practitioner services? The most notable examples of payment by salary are found in the Soviet Union, the Iron Curtain countries, Central and South America, Greece, Israel, Portugal, and Turkey. These are State salaried services.

State Salaried Services Russia

The Russian system, a State-organized service available to all, can in brief be described as a polyclinic system which is attached to the hospitals. Doctors serving these clinics provide all out-patient care as well as domiciliary attention; they alternate their duties with part-time services in hospital either on a day-to-day service, or, alternatively, switch from one type to the other at longer intervals. Doctors are in the ratio of one to every 560 of the population, a ratio bettered only by Israel.

This close attachment to the hospital does not of necessity make the life of the "sectional doctor"—for so he is described—more interesting; like his Western contemporary he too often becomes a mere sorting clerk, and there seems to be the same reluctance to go into polyclinics and the same deep

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