KING EDWARD'S HOSPITAL FUND

FOR LONDON

REPORT

of the

SUB-COMMITTEE ON MENTAL

and

MENTAL DEFICIENCY HOSPITALS

IN THE LONDON AREA

MARCH 1955

10 OLD JEWRY,
E.C.2.

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INTRODUCTION

In the first half-century of its work, the King's Fund was concerned with the support, benefit and extension of the voluntary hospitals of London, and therefore had little or no contact with mental and mental deficiency hospitals. When the National Health Service Act was implemented in 1948, the need for the Fund's maintenance grants to voluntary hospitals ceased, as did also the distinction between the voluntary hospitals and those formerly administered by the local authorities, including mental hospitals. After a period of waiting, to see in what ways the Fund might best serve the hospitals, it became clear that there was still room and need for voluntary help to provide many things that the rigidly limited Exchequer funds could not be stretched to cover. The partnership of statutory and voluntary resources has been warmly welcomed by successive Ministers of Health, and action taken by the present Minister has opened the way to further development of this partnership. In 1949 the Fund began its first visits to mental hospitals, and gave its first grant.

The hospitals coming within the purview of the King's Fund are those situated within the Metropolitan Police District, and also those outside it that take a substantial number of their patients from London. In the case of the mental and mental deficiency hospitals, the proportion in the latter category is higher than it is in the case of general hospitals, since it was formerly the policy to build " asylums " in country districts away from the centres of population which they served. Some twenty-seven mental hospitals, with a total of about 46,000 beds, may be regarded as serving the Fund's area, and some nine mental deficiency hospitals, with a total of 14,093 beds, giving just over 60,000 beds in all.* Almost all these hospitals have been visited by representatives of the King's Fund, and nearly all have received one or more grants since 1949.

* These figures give an average of 1,667 beds per hospital. Small mental deficiency units in general hospital groups and observation wards or other psychiatric units in general hospitals are not included in the total.

REPORT

The Sub-Committee have met nine times, and have consulted with Dr. W. S. Maclay, Senior Medical Commissioner to the Board of Control, Sir Geoffrey Vickers, V.C., Treasurer of the Medical Research Council and Chairman of the Research Committee of the Mental Health Research Fund, some of the leading psychiatrists and physician-superintendents of mental hospitals, the Chairman of the Management Committee of a mental hospital, and others.

The observations and recommendations of the Sub-Committee are submitted herewith.

(a) The existing situation and needs in the mental hospitals.

In considering *the existing situation in the mental hospitals*, the two factors which stand out most prominently are (i) the legacy of old and often gloomy buildings inherited from the past, and (ii) the fundamental changes taking place in the whole attitude towards the mentally ill, and in their treatment, social as well as medical.

(i) *The legacy of the past.* Until the nineteenth century there were no public institutions other than workhouses to which the mentally afflicted of London could go, with the exception of Bethlem, which began its work for the insane in 1403, was plundered by Henry VIII and re-established as one of the five Royal Hospitals about 1555, St. Luke's, founded in 1751, and the "Lunatick Ward" of Guy's (1728).

In 1808 an Act of Parliament gave powers to counties (through Justices of the Peace as County Councils did not then exist) to build asylums, and in the first half of the nineteenth century five of the great mental hospitals of London and Middlesex were erected under these powers: Hanwell Asylum (now St. Bernard's), Wandsworth Asylum (now Springfield), Stone House, Colney Hatch Lunatic Asylum (now Friern Hospital, New Southgate) and Brentwood Asylum (now Warley Hospital).

In 1867 the Metropolitan Asylums Board was created, with power to provide "auxiliary" asylums for chronic and incurable cases, these asylums to be "intermediate between union workhouses and the principal curative asylums." Within the next twenty-five years three great institutions, each now of over 2,000 beds, were set up to serve the London area: Leavesden, St. Lawrence Caterham, and Darenth. Early in the present century three additions were made to the units controlled by the Metropolitan Asylums Board: Tooting Bec, the Fountain Hospital, and the Manor Hospital. In the two latter the accommodation is still largely in corrugated iron huts. Leavesden cost only £121,674 to build and the entire cost of land (84 acres), buildings, services, furniture, equipment and the laying out of the grounds worked out at only £86 per bed. St. Lawrence, at £89 per bed, was slightly less frugal.

Meanwhile the County Councils, created in 1888, took over the old mental hospitals (as distinct from the institutions of the Metropolitan Asylums Board). Before the end of the century they had provided some 10,000 additional beds for the London area in new hospitals at Banstead, Cane Hill, Claybury, Hill End and Bexley. Shortly after the turn of the century there was a great spurt in the establishment of mental hospitals, and almost all the remainder of the mental and mental deficiency hospitals serving the London area date from this time. Long Grove, built 1905-1907, was claimed to be the first mental hospital planned with detached villas to assist in the classification of patients. By that time the barrack-like conception was disappearing in favour of units grouped on a semi-circular plan around a central administrative block The only new hospitals (as distinct from extensions to existing ones) built since the 1914-1918 war are: West Park (built on pre-war plans), Shenley and Runwell, and the new Bethlem at Beckenham.

In general, however, it may be said that the average age of the mental hospitals is well over fifty years and that the majority date from the time when the mentally ill were looked upon primarily as potential dangers to the community. It was thought best to segregate them away from centres of population, in districts where land was cheap, so that extensive grounds might isolate them still further from the community. Notwithstanding the work of Pinel, Tuke and others at the end of the eighteenth century in advocating freedom from restraint, some of these nineteenth and early twentieth century buildings and airing-grounds suggest that "prison" would be a truer designation even than "asylum." Second to the protection of the community came the custodial care of the inmates. These were herded in enormous wards, of a size not found in any other type of hospital, with cells for the solitary confinement of the more disturbed patients. Sometimes dormitories were provided for the patients from two or three wards and contained perhaps 160 beds or more, in close-packed rows. Patients were not expected to have any possessions, and no lockers were provided. In some hospitals, the patients' clothes are still rolled into bundles and tied to their beds at night, since no storage space is provided for them. Washing, bathing and toilet facilities were primitive and inadequate, even by the standards of the last century, and in some cases have remained so until the present day.* Overcrowding occurs to a degree unknown in other hospitals. A mental hospital cannot refuse to admit a certified patient, even if there is literally no bed, and the patient has to lie on a mattress on the floor. There is of course no equivalent of the Emergency Bed Service for mental hospitals. Each one (with the exception of teaching and research centres such as Bethlem and Maudsley and a few specialised units elsewhere) has its own catchment area. Where new housing estates have grown up, there may have been a great increase in the population and therefore in the demands on the hospital, which was probably already over-taxed.

* It may be of interest to recall that as long ago as 1858, Miss Nightingale was recommending that wards in military hospitals should have wash basins with hot and cold water in the proportion of one to four beds, and water closets in the proportion of one to eight beds.

As regards the feeding of the patients, the paramount consideration was to keep down expenditure both on provisions and on catering staff. There was therefore only one kitchen for patients and staff, which might have to serve meals for 3,000 or more at a time. The patients were given only one cooked meal a day, and no evening meal. Lifts were not thought necessary, and food was transported long distances, often by patient labour. It must have been cold by the time it reached the wards, where no adequate kitchens or serveries were provided for heating plates or food, or even, in some cases, for making tea.

As regards staff, a minimum of medical supervision was all that was considered necessary, and little accommodation was needed beyond a house in the grounds for the medical superintendent. The recruitment of nursing staff was not the problem it is now, since here again, the minimum to preserve order was thought sufficient. The nurses, male and female, were in many cases of the " warder " type, and were expected to scrub floors, deal with foul linen by hand, and generally to undertake the domestic work with such help as they could obtain from the patients. Often they were required to sleep in small rooms adjoining the wards, so as to deal with any disturbances which might occur at night. The provision of amenities for staff, and the fact that the nurses were largely cut off from contact with the outside world, were not matters for concern. The Nightingale conception of the Matron as " mistress of the household " and responsible to the governing body not only for the nursing care of the patients but also for all domestic matters affecting the well-being of patients and staff does not appear to have been accepted in the mental hospitals in the same way as it has in all other hospitals in Great Britain, and indeed throughout the Dominions. This fact may have an important bearing on the standards considered adequate for patients and staff, and also on the calibre of the women available for the higher posts in the mental nursing service.

These few instances of conditions that were accepted generally, and that exist in some places today, have been selected from many which might be quoted. They have been brought forward, not with the thought of casting any slur over all the work accomplished in the nineteenth and early twentieth century in tackling the vast problem of the care in the insane and still less of failing in recognition of the great work of the Board of Control in requiring certain minimum standards, but rather to indicate what difficulties face the present generation in bringing buildings and material conditions in line with modern standards of patient care and of amenities for staff. During the war the interests of the mental hospitals were often subordinated to the requirements of the Emergency Medical Service, and when the war was over the imminence of the transfer of the mental hospitals from the County Councils to the Regional Hospital Boards delayed a start upon the accumulated arrears of maintenance. The regional authorities were faced with a difficult task in allocating limited resources among the many urgent claims. Since 1948 much progress has

been made. In the course of visits, we have been impressed with the efforts that have been made at some hospitals, such as Warley and Friern, to modernise the old buildings, and particularly to brighten them by plastering the brick interior walls, by redecorating in varied colours and by providing pictures. Much has been spent, but it represents only a fraction of what is needed to modernise buildings of this size and age, let alone to provide them with amenities. Even if the Government and the regional authorities prove able to increase the priority accorded to the mental hospitals, new needs and higher standards will quickly absorb whatever may become available. Against such a background the possibility of some help from outside sources such as Leagues of Hospital Friends, or from a body like the King's Fund, provides a stimulus and encouragement out of all proportion to the actual amount given. There is still an immense field for voluntary help, and the Fund would like to see active Leagues of Friends attached to all hospitals; even if in most cases they cannot afford financial help on a large scale, they can be very valuable in enlisting and maintaining local interest and support.

Our first conclusion as to the needs of the hospitals is, therefore, that there is room for a continuance and increase of the "ordinary" grants which the Fund has been making over the last four or five years for the improvement of conditions, for the provision of recreational facilities for patients and staff, for equipment which will allow of a better standard of catering, and so on.

(ii) *The changes in treatment.* We have stated earlier that the second prominent factor in the existing situation in the mental hospitals is the change taking place in the whole attitude towards the mentally ill and in their treatment. This factor is of course inextricably mingled with that of accommodation, but it carries many other implications. Here again, a brief glance over the past is necessary. Until 1930, only persons certified as insane could be admitted to public mental hospitals, and there were no psychiatric out-patient clinics sponsored by local authorities. This meant that mental disorder had to be firmly established and indeed conspicuous before the patient qualified for care or medical advice. There was little hope of recovery unless the illness remitted naturally in the course of time, and no provision for treatment in the early stages of illness, or for preventive measures. One might almost take as an analogy a situation where no preventive measures were taken against tuberculosis, and no treatment made available to patients until they were incapacitated from work, at which stage they could be confined in a sanatorium indefinitely, with loss of all civil rights. A concomitant of this situation was that in the minds of the public "lunatics" were sharply differentiated from the rest of the population, and insanity was regarded with fear, if not derision. All this was changed by the passing of the Mental Treatment Act of 1930, which emphasised the importance of early treatment, provided for the admission of voluntary patients without loss of civil rights, and empowered local authorities to provide clinics and other services for those who did

not need to be admitted to hospital. It has been well said that "few Acts of Parliament can have surpassed this one in the boldness of its conception and in its great humanity and it is not surprising that it has been copied by many other countries."

At the present time the majority of admissions to mental hospitals are voluntary, i.e., their treatment has been taken in hand at a stage before certification has become necessary. In the period since the passing of the Mental Treatment Act, great advances have been made in the treatment of mental illness. Between 1934 and 1938 four physical treatments were introduced: cardiazol convulsant therapy, insulin shock therapy, pre-frontal leucotomy, and electro-convulsant therapy. The last three of these have been modified and improved with such successful results as to reduce the demand for individual psycho-therapy, which in any case could never have been available to all patients, owing to the excessive demands it makes on the time of qualified staff. Many of the chronic and deteriorated patients now in hospital are a legacy of the pre-1930 days, whereas a large proportion of admissions at the present time come in at an early stage and stay for a few weeks only. We are warned, however, that there is no room for complacence, that treatment is still very largely empirical and among the short-term patients the rate of relapse is considerable, and above all that there is urgent need for far more research into the causes and treatment of mental disorder. While research does not come within the Fund's normal sphere of activities, we have not been able to shut our eyes to the fact that this particular field of research seems to have been inadequately served so far, in money and also in manpower.

In the meantime, all who have advised us on the needs of the mental hospitals have emphasised the importance of giving the patient an environment and regime much more like the conditions of ordinary life than has been customary in mental hospitals. It is claimed that by providing useful occupations in which the patient can take an interest, and social activities which break down the old conception of being set apart and isolated by mental illness, recovery is more rapid and more complete, so that relapses and re-admissions are cut down. Further, the same principles applied in day hospitals or in psychiatric out-patient departments may reduce substantially the demand for in-patient beds and check cases of psychiatric illness at an early stage. In addition to providing more effective treatment and ultimately reducing the demand for beds, these methods must do much to ameliorate the lot of the mental patient, who probably suffers more from the old regime even than from the legacy of old buildings. They are said also to prevent deterioration among those who cannot be cured, and they should in time help the acute staffing problem, since they make the work of the nursing staff (male and female) more interesting and in a sense more responsible. In Appendix I we have given brief extracts from the Third Report of the Expert Committee on Mental Health of the World Health Organization (1953), since these summarise most clearly the advice we have been given on the subject.

Clearly, the legacy of old buildings and of the old regime, coupled with financial stringency, has not admitted of changes in the patients' environment to keep pace with the great transformation in the principles of treatment in the last twenty years, and indeed in the type of patient now admitted to mental hospitals. But here and there pioneer work has been undertaken to provide, within the existing framework of the hospital, a more normal way of life and a much more cheerful environment for the patients.

Our second conclusion as to the needs of the hospitals is, therefore, that there should be more pioneer schemes of this nature, not only because of their value to the hospitals in which they are situated, but also to serve as prototypes which may stimulate other hospitals to follow suit, and to bring their methods and conditions more into line with the new outlook on mental illness. To sponsor such schemes would be in accord with the Fund's policy, e.g., in demonstrating what can be done to rehabilitate and adapt an old ward for geriatric patients at the West Middlesex Hospital or in providing the endocrine unit at New End Hospital. As expenditure on pioneer schemes would naturally be on a larger scale than the ordinary grants, we shall refer to them as *major schemes.*

(b) **Recommendations on the ways in which the Fund might give the most effective help.**

We have indicated on page eleven the need for a continuance and increase in the *ordinary grants,* similar to those made by the Management Committee in the last few years to improve conditions and to provide amenities. Above we have suggested the value of sponsoring some of the *major schemes* now being planned, but held up because there is no hope of obtaining the necessary money through the Regional Boards. In this section we propose to discuss possibilities under these two heads. In accordance with the Fund's practice, only schemes put forward with the approval of the Regional Hospital Board would be supported.

1. Ordinary Grants.

It may be useful to review briefly the amount given in *ordinary grants* to mental and mental deficiency hospitals in the years 1949-1954 inclusive, the proportion given to various objects, and the kind of improvements which they have made possible. Grants to a total of £134,797 had been voted by the end of 1954—the annual total rising from £5,000 in 1949 to £45,965 in 1953 and £52,131 in 1954. They were spread over 31 hospitals, some of which have received two or three grants. Only four hospital groups among those that appear to be eligible for assistance from the Fund have received no grant as yet; no applications have been received from these, except that one has put forward for consideration a major scheme, to which reference will be made later. Grants have varied in size from £90 (for mattresses for a nurses' home) to £7,000 (for a hut to be used as an occupational therapy centre), and £7,720 in two grants for a recreation hut. The largest total of grants going to any one Mental Hospital Management Committee is £12,890 to St. Ebba's and Belmont, for a variety of objects, and the next is £10,220 to St. Lawrence, Caterham.

Mental deficiency hospitals received £27,196 out of the total £134,797 given by the Fund. We are told that the waiting list of mental defectives (which runs into many hundreds in the Fund's area alone) represents one of the gravest social problems of the day. It is the cause of untold hardship and stress, and leads in some cases to the breakdown and consequent admission to mental hospitals of their relatives who have been endeavouring to look after them at home, sometimes with several younger children. Shortage of staff probably takes precedence even of shortage of accommodation or finance, as a limiting factor. Hence anything which can be done to make life and work in a mental deficiency hospital more attractive to the staff (by providing amenities and modern equipment and labour-saving devices) seems of special value.

The objects for which the grants have been made may be grouped as follows:

IMPROVEMENT OF CATERING (kitchen equipment and lay-out, electrically heated trolleys, food lifts, refrigerators for ward kitchens, tea urns, etc.)	£29,699
ACCOMMODATION AND EQUIPMENT FOR OCCUPATIONAL THERAPY	£17,190
RECREATIONAL, SOCIAL AND EDUCATIONAL FACILITIES FOR PATIENTS (recreation halls, cinema projectors, bowling green, tennis courts, playground, shelters, etc.)	£51,553
WARD AMENITIES (television, wireless installations, mattresses, lockers, curtains, pictures, etc.)	£14,577
RECREATIONAL FACILITIES AND OTHER AMENITIES FOR STAFF (tennis courts, mattresses, furniture for nurses' homes, changing room accommodation, improved classrooms, etc.)	£17,028
MISCELLANEOUS (equipment, gardens, etc.)	£ 4,750
TOTAL ...	£134,797

In addition, applications for ordinary grants for similar objects to a total of about £50,000 (January and February, 1955) are outstanding. Consideration of these has been deferred until the Management Committee have had an opportunity of considering future policy. Applications are now coming in from mental hospitals at a greater rate than at any previous time. It is clear that while the Fund's grants have effected many improvements, which are valued by the hospitals, they have only touched the fringe of what needs to be done. It would be possible to spend almost any sum on ordinary grants in the next few years simply to help to make up some of the leeway of conditions in mental hospitals.

To take *catering* as one instance, in the last few years the Fund's Catering Advisory Service has made detailed surveys in nine mental hospitals at the request of their Management Committees. It is estimated

that the minimum sum required to provide satisfactory catering facilities in these nine hospitals is £137,000, made up as follows:

KITCHENS		
Equipment	£37,500	
Structural alterations	£33,200	
		£70,700
WARDS		
Kitchen equipment		£28,400
DINING-ROOMS		£ 7,700
FOOD DISTRIBUTION EQUIPMENT		£10,500
SERVICES		£19,700
		£137,000

Taking these nine hospitals as a representative cross-section of the thirty-six, one arrives at a figure of £548,000 as a rough estimate of the amount required to put in order the catering facilities in the mental hospitals serving the Fund's area. This is probably a very conservative estimate since the nine hospitals, regarded here as a quarter of the whole number, include only 11,000 out of the total of 60,000 beds. The estimate of £548,000 does not allow for dividing up the large kitchens referred to earlier into smaller units, so that meals can be cooked in reasonable quantities and nearer the time of serving. Such division and decentralisation may well be the key to improvements in catering in mental hospitals.

The whole question of catering in mental hospitals calls for attention. The statistics of two of the Metropolitan Regional Hospital Boards show the average cost of provisions per patient per week to be approximately:

	In General Hospitals	*In Mental Hospitals*	*In Mental Deficiency Hospitals*
Region A	26/9	18/2	17/-
Region B	24/9	16/-	15/9

The cost is known to be lower than these figures in many mental and mental deficiency hospitals, but taking a reasonable average the cost of provisions is at least 9/- (or well over 50%) higher in general hospitals. Some of this difference is due to the fact that approximately 10% of the patients in general hospitals may be on therapeutic diets, and that there is a larger proportion of staff to patients. After allowing for this, there still remains a considerable difference, which is only accounted for by the greatly reduced amount spent on milk (which averages only 4-5 pints per week), meat, fish, fruit and vegetables and even groceries. It is estimated that to bring the standard up to that of the ordinary diet in general hospitals an increased expediture of 5/- per head per week would be needed. An appetising and healthy diet would seem to be of importance in the treatment of the many voluntary patients whose physical condition needs to be built up, and who have full or even heightened consciousness of the conditions they meet in hospital. To confront these patients with

standards of feeding derived from the institutional past may well hinder their treatment. Moreover, in mental hospitals there are many able-bodied men and women engaged in outdoor or domestic work and needing a full normal diet. Experience shows that grants towards the improvement of catering equipment, together with the expert advice of the Catering Advisory Service, can accomplish much, and it is greatly to be hoped that official policy will permit of a gradual stepping up of expenditure on provisions in mental hospitals, to a level comparing less unfavourably with that prevalent in other hospitals. Catering staff from mental hospitals participate in the courses at the School of Hospital Catering at St. Pancras, but it may be that courses specially arranged for them would be of additional value.

Turning to the other headings of the ordinary grants, cases might equally well be made out, if space permitted, for the importance of the grants to increase the *facilities for occupational and other forms of therapy,* and for *recreational and social activities for patients,* indoors and outdoors. As regards *ward amenities,* the great value of television, even for disturbed and confused patients and low-grade defectives, is coming to be realised, and there is no doubt that a television set in a ward effects considerable saving in the time and effort of the nursing staff, too often quite inadequate in number. Under this heading also, there is a great leeway to make up in providing comfortable mattresses, and also pictures, curtains, and other means of brightening the wards.

The claims for *recreational facilities and amenities for staff* are stronger than in general hospitals, for reasons stated previously, and also as means of helping in the most acute problem of recruitment, a note on which is given in Appendix II. Little has yet been spent on *grounds and gardens.* The grounds of many mental hospitals are in a satisfactory condition, and some are beautifully laid out and kept, but there are still things to be done here and there, and in some instances work is needed to remove the all-too-evident restrictions on the movement of patients, formerly thought necessary

Enough has been said to indicate that any estimate for ordinary grants for objects under these six headings which cannot be hoped for from Treasury funds, could rise to astronomic heights.

2. GRANTS FOR MAJOR SCHEMES.

Various schemes have been outlined to the Sub-Committee, all of which might be regarded as bridgeheads in the great advance and transformation now taking place in the treatment of mental patients, but we think it would be well to concentrate on three of them at present.

A. *Occupation Centre at Goodmayes* (1,300 *beds*). Dr. Somerville, the Physician Superintendent, has outlined to the Sub-Committee plans for a

centre to provide much more than occupational therapy, in the restricted sense in which the term is usually understood. Its aim is not only to treat the patient at the more acute stage of his illness, but also to prepare him thoroughly for his return to the community outside and help him to adjust to, and make his way in, the environment to which he will return. For this purpose, a hut, a few materials for " arts and crafts " and an occupational therapist are not enough. A new building is planned, that would include rooms for light metal work, carpentry, printing, typing and office work, pottery and basketry. It is hoped to interest local industry in the project, so that the training given at the centre may lead to the resettlement of patients in similar work after discharge, thus reducing the likelihood of relapse. The centre would also include a room for lectures and films, a library and reading room, conference room, recreation room, and also a kitchen where women patients could be trained in the domestic arts (it is said that in surburban and new housing areas there are many breakdowns among housewives who have had no preparation for homemaking and have no " roots " in their new community). The lay-out would include land for small allotments and out-door recreations. It is hoped that the centre would also serve for the patients of a " day hospital " which is planned in connection with Goodmayes. Day hospitals are claimed to be a means of lessening the present overcrowding of mental hospitals and reducing the expenditure on in-patients. Dr. Somerville writes :

> " With such a functional unit we hope it would be possible to provide the more comprehensive treatment which would enable patients to be returned to the community much sooner than at present and with greater hope for their making satisfactory readjustments to the community especially in the occupational sphere. We hope that the existence of such a clinic would sensitize local authorities, local bodies generally, and local industry to an appreciation of the special needs of those who have suffered from a mind illness, and so reduce the possibilities of a relapse. Apart from the obvious humanitarian aspect of such a project, there are also economic advantages to be taken into account. Moreover, if such a scheme received the support of the King's Fund, it might well become a prototype of the occupational clinic of the future. This project would be an experimental attempt to (partly) solve the need for additional mental hospital beds (which can only be provided at great expense) and an attempt to renew an interest in the community in the care of its less fortunate and handicapped members. It is estimated that the cost involved in erecting and equipping such a clinic might approximate to £25,000. Such a clinic would form a permanent tribute to the work of King Edward's Hospital Fund."

More detailed plans and estimates are being prepared. The Regional Hospital Board have approved the scheme in principle. It is not

anticipated that any large charge on the Board's funds will be needed for maintenance.

B. *Social Centre at Warlingham Park* (1,100 *beds*). Dr. T. P. Rees, the Physician Superintendent, was a member of the Expert Committee on Mental Health of the World Health Organization, whose report is quoted in Appendix I. His evidence to the Sub-Committee followed the same lines and is the basis of much that has been said above on the changes in treatment. It need not, therefore, be recapitulated here. At Warlingham Park an almost unique degree of freedom and responsibility is given to the patients. When a party from the Staff College for Ward Sisters spent a day there recently, Dr. Rees made patients responsible for showing them the hospital. The sexes mingle freely. Patients are expected to be away from the wards soon after 9 a.m. It is therefore desirable to provide alternative accommodation for them throughout the day. Dr. Rees prefers that patients should be occupied in ways they can recognise as useful to the hospital, such as gardening, farming, repairs, trained domestic work, sewing, etc., rather than in occupational therapy in the narrower sense, though this is used as well. It is a necessary part of this conception, Dr. Rees holds, that a mental hospital should include a village centre, with shops, hairdresser, bank, library, and cafe for patients, visitors and staff, in order that patients may be helped back to normal social activities. For this, the present premises at Warlingham, as elsewhere, are ill-adapted. Such facilities as do exist—canteen, etc.—are largely improvised, inadequate in scale, and scattered about the hospital. His application is for a grant to build a social centre designed for the purpose, again to serve as a prototype. It would certainly do this, as Warlingham Park attracts large numbers of visitors, and Dr. Rees' work is known nationally and internationally. The arrangement of the hospital buildings and grounds lends itself well to the project.

C. *Community Centre and Day Hospital in connection with the Psychiatric Out-patient Department at Bromley Hospital.* This scheme was recommended to the interest of the Sub-Committee as an important piece of pioneer work by Dr. Maclay, of the Board of Control. The Bromley psychiatric out-patient clinic is said to be the largest outside London. It deals with 300 new patients annually, total attendances being about 3,300 a year and home visits 1,100. Dr. Morgan and Dr. Elizabeth Tylden are psychiatrists attached to the clinic, whose special aim is to keep patients out of hospital. They regard the establishment of satisfactory social relationships as the most important element in remedial work. This can be done most easily in a close-knit community such as Bromley. They have built up around the clinic a number of social activities, and have enlisted a wonderful amount of voluntary help, somewhat on the lines of a League of Friends. Great importance is attached to providing full occupation and adequate social contacts for the patients, who join and themselves manage discussion groups, art groups, amateur theatricals, etc. Much of the work of the clinic takes place in the evenings, since patients are encouraged to remain

at work whenever it is possible. The accommodation for all these activities, and for the clinic itself, including the play-groups for maladjusted children, is totally inadequate. The proposal is to buy a house of some size, not necessarily very modern, with a garden, and to adapt, furnish and equip it for all the activities of the clinic and day hospital. Although this application comes through the Management Committee of a general hospital group, it should be of direct service to the mental hospitals, in reducing the admission and readmission rates (as can be demonstrated by patients now attending the clinic) and also again as a pattern for dealing with mental illness. The scheme has the approval of the Regional Hospital Board and the support of all the psychiatrists in the Bromley, Orpington and Sidcup groups, as well as of the local general practitioners.

To sum up, these three major or pioneer schemes are consistent in aim and principle, while showing interesting variations in design and function. All aim at giving the patient purposeful activity in conditions which will help him to adjust to ordinary life and social relationships.

Scheme A (*Goodmayes*) applies the principle to in-patients and possibly later to day-hospital patients, and aims at reducing length of stay and risk of relapse by the more complete rehabilitation of the patient.

Scheme B (*Warlingham Park*) applies the principle to in-patients, and is a fundamental part of the methods at Warlingham Park, where the patient is made to feel he is trusted and given responsibility.

Scheme C (*Bromley*) applies the principle to out-patients, and aims at reducing the demand for beds in mental hospitals—an urgent problem made more urgent by the great shortage of staff.

Three pioneer schemes of this nature might well call for total expenditure approaching £100,000. We recommend them all to the consideration of the Management Committee. We believe that these schemes, well founded by the King's Fund, and run as they would be by personalities well known in the mental hospital world, might have far-reaching effect and might further that advance in treatment and transformation in the lot of the mentally ill, to which we have referred earlier.

CONCLUSION

Our conclusion is, therefore, that an allocation of not less than £250,000, spread over three years, could be spent to excellent effect in the mental hospitals. If £100,000 were spent on major schemes there would be £150,000 for ordinary grants under the six headings given previously (page 14). The Management Committee might feel that £50,000 of this could well be spent on catering facilities, since provision for grants to mental hospitals was not included in the special allocation of £50,000 recently made for catering. This would leave only £100,000 for all other ordinary grants to the mental hospitals with their 60,000 beds. It is not suggested that these proportions should be adhered to rigidly, but they are put forward to give some idea of the basis on which the Sub-Committee have arrived at a minimal figure of £250,000. If the Fund's resources permit we would like to see a larger allocation.

We believe that no more urgent claim can be made on the Fund at the present time, nor any more in keeping with its purpose and worthy of its support.

APPENDIX I

EXTRACTS FROM THE THIRD REPORT OF THE EXPERT COMMITTEE ON MENTAL HEALTH *

" *The atmosphere of the hospital*

" The most important single factor in the efficacy of the treatment given in a mental hospital appears to the committee to be an intangible element which can only be described as its atmosphere; and in attempting to describe some of the influences which go to the creation of this atmosphere, it must be said at the outset that the more the psychiatric hospital imitates the general hospital, as it at present exists, the less successful it will be in creating the atmosphere it needs. Too many psychiatric hospitals give the impression of being an uneasy compromise between a general hospital and a prison. Whereas, in fact, the role they have to play is different from either : it is that of a therapeutic community . . .

" Another important element in the creation of this atmosphere is the *preservation of the patient's individuality*. In too many psychiatric hospitals still the patient is robbed of her personal possessions, her clothes, her name and, should her head be lousy, even her hair. Every step, therefore, that can encourage the patient's self-respect and sense of identity should be taken even at the cost of considerable inconvenience.

" Another element in this atmosphere is *the assumption that patients are trustworthy* until their behaviour proves the contrary to be true. The locking of wards creates the urge to escape; the removal of knives and other elaborate and insulting precautions have provoked many suicidal attempts. High walls, bars, armour-plated windows, bunches of keys, uniform clothing, and all the other paraphernalia of the prison make modern psychiatric treatment impossible. It has now been amply demonstrated that only a very small minority of patients needs to be in locked wards in a well-run mental hospital. This does not imply that disturbing behaviour on the part of a patient should be ignored. On the contrary, *good behaviour must be encouraged* and anti-social behaviour met by appropriate measures. The patient who disturbs others must be removed and told why—not as a punishment, but because he disturbs others—but he should be re-introduced at the earliest opportunity. It is also necessary to mention specifically the desirability of patients being under the care of female nurses as far as possible. The introduction of female nurses into a disturbed ward improves to a remarkable extent the behaviour of patients and the atmosphere of the ward.

" Patients must not only be assumed to be trustworthy; they must also be assumed to retain *the capacity for a considerable degree of responsibility and initiative*. The running of many activities, therefore . . . should devolve upon the patients themselves.

* World Health Organization Technical Report Series, No. 73, September, 1953. THE COMMUNITY MENTAL HOSPITAL.

"The relationship of a hospital with the citizens of the community in which it is situated is an important element in the creation of this atmosphere. The locked door not only keeps the patient in—it keeps the public out. Everything should be done to encourage visitors to the hospital who should have access to the hospital itself and not specially prepared and segregated visiting rooms. These visits should include not only the relatives of the patients but also the relatives of the staff. The life within the hospital should, as far as possible, be modelled on life within the community in which it is set. In a western country where men and women mix freely at work and in recreation, it is obviously desirable that they should do so when in the mental hospital. In a country where men and women use the same restaurants, it is obviously ridiculous that the sexes should be segregrated for feeding in the hospital.

"Finally, in a community where most people are actively engaged in working or learning, the same should be true of the mental hospital. *Activity,* in fact, is one of the most important characteristics of the therapeutic community. But it should be planned and purposeful activity, and the planning of the patient's day is probably the most important therapeutic task of the hospital psychiatrist."

APPENDIX II

THE STAFFING OF MENTAL HOSPITALS

(NOTE SUBMITTED BY THE DIVISION OF NURSING OF THE KING'S FUND).

It is difficult to express in a brief note the gravity of the present staffing situation in mental and mental deficiency hospitals. The prospects for the future give even more cause for concern.

The following figures may throw some light on the present position. A Working Party appointed to advise the Birmingham Regional Hospital Board on the standards of staffing required in mental hospitals has recently recommended, after taking into account all categories of patients, that the average ratio of total nursing staff to patients should be 1:4. In England and Wales at present the ratio does not reach 1:6 patients, i.e. an increase of more than 50% is needed to bring the numbers up to this realistic and unambitious standard. "Total nursing staff" in this context includes all on day and night duty, all those engaged in administrative work and also assistants and nursing orderlies. The ratio of nursing staff to patients in mental deficiency hospitals is even lower.

The report for 1953 for the Board of Control stated that while mental hospitals in England and Wales were overcrowded to the extent of 18,923 patients, 1,099 beds were out of use owing to shortage of staff.

As regards the prospects for the future: the Fund's annual report for 1953 pointed out that the number of student nurses in all mental and mental deficiency hospitals in England and Wales had fallen by more than 25% since 1948 and was only 4,530—a ratio of one student nurse to 42.5 patients as compared with one to 3.1 patients in general hospitals.

It is possible to argue that no valid comparisons can be made between the ratio of staff to patients required in mental hospitals, and that in other types of hospitals, owing to the different nature of the work. Be this as it may, no one with knowledge of the conditions would regard the present numbers of trained staff or of student nurses as adequate. The shortage must in itself tend to encourage wastage, in the excessive demands it makes on individual nurses. On a visit to a mental hospital recently, a question was addressed to a young nurse who was apparently in charge of a large ward with many patients. She confessed that she did not know the answer, as she was a new student nurse and it was only her third day of ward work. To persevere in such circumstances must require courage. For others more advanced in their training and for those in charge of wards, it must be disheartening, if they really care about their work, to know that the right standards of patient care cannot be maintained for lack of staff. A good ward sister or male charge nurse can control the behaviour of an amazingly large number of patients, but when a ward seems completely peaceful, with only the sister in sight, it may be

the result only of great skill (born of long experience) and unremitting effort and watchfulness on her part. The greater freedom now allowed to patients does not necessarily lessen the stress on the staff, on whom lies the responsibility for preventing suicide and aggressive behaviour. It is not surprising that for various reasons, some inherent in the nature of the work, the wastage rate is high, but it becomes the more important to do everything possible to counteract this tendency.

The report of the General Nursing Council for the year from 1st April, 1953, to 31st March, 1954, showed that only 750 mental nurses and 175 nurses for mental defectives completed their training and qualified—a decrease on the figures for the preceding year. An annual output of only 925 nurses, even if they remain for the rest of their working life in mental nursing, cannot be expected to keep up the present total of approximately 15,400 trained staff, already admitted to be inadequate.

Mental and mental deficiency nursing is not likely ever to have more than a very limited recruitment appeal, and therefore preventable drawbacks and causes of wastage must be tackled. At one large mental hospital in the provinces where an examination was made into causes of wastage in the years 1950-53, it was found that 82% of the women and 80% of the men left without completing training. Of the men who left, it was stated that no less than 60% did so owing to financial difficulties. In a survey of student nurse wastage in all kinds of hospitals in the Birmingham area, it was found that the wastage rate during training was 81.5% in mental hospitals and 79.4% in mental deficiency hospitals. The great majority left at their own request and not through failure in examinations. The proportion giving financial reasons as the cause for leaving was higher than any other—29.4% in mental deficiency hospitals as against 0.9% in general hospitals.

These figures suggest that *some financial readjustment* might be a strong factor in retaining staff in mental and mental deficiency hospitals. While it is outside the province of the King's Fund to take action on this, we feel bound to place on record our conviction that a much greater differential is needed in the financial rewards, as between mental and general nursing. One way in which this might be achieved without introducing too many anomalies into the existing training allowances and salary rates is by introducing much higher dependants' allowances for staff in mental hospitals. At present, for instance, a married man who enters a three-year mental training on completing his period of national service receives only 15/- a week as dependant's allowance for a wife or other adult dependant and 8/- a week for the first or only child, with a training allowance of only £255 in the first year. It is small wonder that many of them find it impracticable to keep homes going on these rates and give up all thought of qualifying. We have been impressed with the work of both the men and the women in charge of wards, and we feel that it is of the utmost importance that conditions, financial and otherwise, should be such as to build up a stable body of trained staff.

Grants from the King's Fund which will make the nurses' work easier, and provide amenities and recreational facilities, seem to us of particular importance, above all in mental deficiency hospitals (where the work has an even more limited appeal than mental nursing has), because of the contribution they make towards solving the problems of recruitment and wastage. As regards making the work easier, we have in mind such things as improvements in sanitary annexes and in washing facilities, bedpan washers in sick wards, better ward kitchens and also pleasanter classrooms where required.

The Fund's Nursing Recruitment Service is able to guide a small proportion of its candidates into these hospitals, but much more needs to be done to demonstrate that mental nursing ranks equally with other branches of nursing. Staff from mental hospitals are welcomed in all courses at the Fund's Staff Colleges. But the outstanding success of the recent course specially arranged at the request of the Ministry, for twelve ward sisters and eight male charge nurses from mental hospitals, indicates that special courses of this nature, possibly extended in time to Matrons and Chief Male Nurses, and also to staff nurses, male and female, have a real part to play in encouraging the trained staff to persevere in their exacting tasks, as well as in increasing their efficiency and helping to promote good relationships.

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