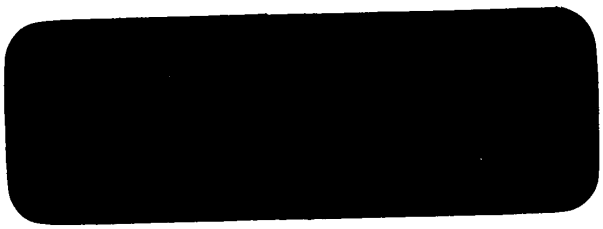
King's Fund Hospital Centre

IMPROVING THE EFFECTIVENESS OF HOSPITALS
AND SERVICES FOR THE MENTALLY ILL
AND MENTALLY SUBNORMAL



IMPROVING THE EFFECTIVENESS OF HOSPITALS AND SERVICES FOR THE MENTALLY ILL AND MENTALLY SUBNORMAL

IMPROVING THE EFFECTIVENESS OF HOSPITALS AND SERVICES FOR THE MENTALLY ILL AND MENTALLY SUBNORMAL

A collection of papers presented at conferences held at The Hospital Centre in 1966 and 1967 at which hospital staff described their efforts to improve patient care in and out of hospital

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PREFACE

In 1964 and 1965 two important circulars were issued by the Ministry of Health. One HM 64 (45) gave advice on how the effectiveness of hospitals for the mentally ill could be improved. The other HM 65 (104) dealt with improving services for the mentally subnormal. In December 1965, the Royal College of Nursing held a three-day meeting in Church House, under the chairmanship of Professor R.W. Revans, to discuss these two documents. The meeting was attended by representatives of staff and management from hospitals throughout the country and various people spoke on the subjects discussed in the two circulars.

After the meeting, Professor Revans suggested it would be useful if a series of small working meetings were held where hospital staff could discuss what progress they had made towards implementing the improvements suggested.

The Royal College of Nursing were unable to spend more money on meetings for mixed staff since its first responsibility was to its own members. The Hospital Centre was approached to help and the proposed meetings were held there.

Professor Revans considered it was important to discuss difficulties and failures as well as achievements. With this in mind, representatives of hospitals that apparently had been fairly successful in improving their services and hospitals that had not been so successful were invited in equal numbers to each of the meetings.

Three meetings were held for staff from psychiatric hospitals and two meetings for hospitals for the subnormal. At each meeting papers were read by representatives of hospitals that had been fairly successful with their improvement programmes. It was left to the hospital staff to decide for themselves the content and presentation but it had to be limited to 15/20 minutes per hospital so there would be adequate time for questions and discussions.

Each meeting was chaired by Professor Revans, who put forward the idea of having the papers collected and published. The speakers were asked but not pressed to let The Hospital Centre have a copy of the papers they had read. It has been possible to collect most of the papers and they are presented here. The book is divided into two self-contained parts which have been edited separately. Part I deals with psychiatric hospitals and services and Part II with the subnormality services.

The views expressed are of course those of the participants in the conferences and do not necessarily represent the views of the King's Fund.

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FOREWORD

It must by now damage one's reputation again to observe that the most significant feature of today is the rate at which things are changing. Where it is possible to measure the speed of some activity, such as the multiplication or division of numbers, it is easy to show that there is now in the lifetime of one man more change than in the previous two thousand years. While it may be that comparatively few persons earn their livings at making or operating computers, and that fewer still occupy the trendy profession of astronautics, yet the ideas and the technologies that make possible such devices as space rockets and marine boring rigs have indirectly invaded the lives of us all.

Change is, of course, no new phenomenon. The British saw a lot of it in the Nineteenth Century, and not only in the trail of the steam engine; we gave up transporting prisoners, hanging children for theft and other barbaric practices. But change, on the other hand, is not just absorbed. We have to learn to live with new ideas, and if we do not learn, the very ideas may eventually destroy us. Much British industry has been destroyed, like ship-building and textiles, because those within it - managers, engineers, craftsmen and labourers alike - were unable to understand what was changing around them. Their outlooks had become set; their minds, as if cement had been poured over them, were able to respond only to what was familiar, traditional and morally right. New ideas were 'foreign' if they were seen as threatening; 'outlandish' if they departed from the accepted order; and 'Continental' if they aroused lively expections of actual indecency. The British seem to associate change with other nations, while it remains their duty to preserve the status quo - that is, to close their eyes rather than to open their minds.

One innovating idea of sinister foreign origin is that administrators should know something about the causes for which they work. It is true that the notion has recently been aired in the Fulton Report on the Civil Service, but it had long been known to foreign students of the administrative process. That somebody spends his day in an office writing letters about such and such a subject is thus no guarantee whatever that the activities to which the correspondence makes verbal references are affected by them; indeed, the verbal references themselves may in no way describe the existential state of affairs. They are pictures in the imagination of the letter writer - romance, fantasy or even hallucination born in the rhythm of the typist's keys or in the mellowed voices of the committee. When several different administrators are concerned with the same field, their individual imagina-tions are enriched by a still further distraction: How to deal with the threat of competition, or, in the jargon of administration, how to avoid over-lapping. And during all this, while the energies are bent to keep up the output of letters and to process the visible machinery of budget and conference, conference and budget, the outside world is changing; the gap between what is going on and what the administrators imagine to be going on eventually becomes so wide that even the administrators have been known to be disturbed by it. When this critical stage is reached, it becomes advertised as "The Technological Gap" although it is, both in origin and in nature, a managerial or administrative gap. It is a gap that cannot be bridged by technology but only by the reform of the administration.

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It is thus inevitable that the life history of systems for running things should be characterised by violent jerks. In one sense of the word, Fulton is a jerk; so is the Green Paper. Those within the administrative machinery who feel their sudden twinges do not like them and grow very voluble when the strain has to be taken up; on the other hand, those who suffer under the administrative gap that the jerk is designed to close do so in silence, since they are neither articulate nor organised for protest. Thus it is that administrative reforms are normally forced upon a system from outside; it is the wider world, of which the service administered forms part, that rises in impatience against the sheer inefficiency of the service as a whole.

There is a way out of this paradox that I believe the world of mental health to have discovered. It is to take a new look at the nature of authority. It is to ask "What precisely is the function of the boss? Who, indeed, has the power and what is achieved thereby?" ..... The therapeutic community (that does not abolish but that rethinks the natures of expertise and of influence) is essentially an invention of the psychiatrists, it is an attempt to improve the collective learning of individuals by diminishing the technical distinctions and by improving the social interactions between the teachers and the taught. The patient may teach the doctor more than the doctor may help the patient; identification removes the barriers of ex-cathedra. The same general principle may be lifted from the mental ward and applied to the wider field of administrative problem-solving. It may no longer be a disturbed or hesitating patient discussing his problems with others, but an administrator conscious of his difficulties (and with humility and grace enough to learn) who is sharing his experience with others. Administrators incapable of that change within themselves known as learning will take it for granted that all improvement, all progress, all innovation flows only from fresh external benefits: new laws, new techniques, new budgets. But those who can join the therapeutic group will gain new skills, new ideas, new approaches from each other; those who give most will learn most, those who assert they have nothing to learn will give nothing at all.

Identification is a marvellous human capacity. When Roger Bannister ran a mile inside four minutes he not only broke a world record, he told a thousand athletes that they could do the same thing if they only took the trouble. In the hospital field similar miracles are also possible. What one hospital has done to solve its problems can be done by others. If only the will exists to do so. The barriers to such cross-achievement are generally ignorance of where others have succeeded; if Bannister's run had never been published, the magic limit would still not have been passed. The examples of what is possible, given in this report, should serve to stimulate all who study them. If only administrators could more often lift their eyes unto the hills of demonstrable success, and more often see answers to their problems in the real achievements of their fellows rather than the maturation of their own paper ambitions, we should be a healthier society. It is a mark of maturity that one learns from one's neighbour; in an age of change it is also perhaps our greatest need.

R.W. Revans

November, 1968.

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IMPROVING THE EFFECTIVENESS OF HOSPITALS AND SERVICES FOR THE MENTALLY ILL

PART I

IMPROVING THE EFFECTIVENESS OF HOSPITALS AND SERVICES FOR THE MENTALLY ILL

Thursday, 6th October, 1966 and Thursday, 3rd November, 1966

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INTRODUCTION

Many factors have been responsible for the changes in the pattern of psychiatric care during the past 20 years. The introduction of new drugs and physical treatments coincided with changing attitudes to mental illness and its treatment. Mental hospitals have slowly metamorphosised from authoritarian prison-like institutions into therapeutic communities.

Attempts are now made to treat people with major psychiatric illness in the community and many psychiatrists look upon the admission of a patient to hospital as a partial defeat.

The importance of meaningful employment, organised patterns of activity and freedom to participate in the running of the hospital has been more generally accepted.

In parallel with these improvements in patient care, changes have occurred in management and staff relationships. In progressive hospitals, emphasis is now placed on good communication, free informal discussion between all grades of staff, and the involvement of all in the development and administration of the service.

Unfortunately, these changes have not occurred evenly throughout the country. Some hospitals have made more progress than others and some are still only half-heartedly escaping from the restrictive past. In 1964 the Ministry of Health issued an important circular giving advice on how mental hospitals and their associated services could be improved (H.M.(64) 45). This document is reproduced as an appendix (appendix I). It describes how the mental hospital should not simply be a place for in-patient treatment, but the centre of a comprehensive psychiatric service for the community. The importance of pre-admission assessment of the patient is stressed and the need for out-patient clinics, day hospitals, domiciliary visits and co-operation with the community and community service.

The physical, social and psychological needs of patients are considered and methods of moving from custodial to therapeutic care briefly described.

An important part of the document deals with obstructions to improvement and how they can be overcome.

Many hospitals have identified their obstructions to improvement, overcome them, and now provide possibly the best psychiatric service in the world. The methods used have been described in the literature, but the literature is not necessarily consulted, and some hospitals, in all parts of the country, tend to isolate themselves and operate in ignorance of what others are doing.

One method of dealing with this problem is for staff members of progressive and not-so-progressive hospitals to get together and informally discuss their successes, failures and the reasons for their differences. The meetings organised by the Hospital Centre are an example of this.

Three meetings took place on the 23rd June, 1966; 6th October, 1966; and 10th January, 1967. Ten hospitals were represented at each meeting, five who had been fairly successful in implementing improvement programmes, and five

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who had not been so successful. Doctors, nurses, administrators and social workers read papers, most of which are represented in this book. Many facets of patient care were discussed, ranging from staff relationships to up-grading hospital buildings. Unfortunately, the discussions that followed the papers were not recorded. However, notes were made of the main themes and the problems and imagined problems of other hospitals will be described in 'Discussion and Conclusion'.

This is not a blueprint for improving psychiatric care. It is a demonstration of what ordinary workers in psychiatry can do to make enlightened progressive humane treatment of the mentally ill a reality.

1 IMPROVING PATIENT CARE

J. Ingram, Senior Psychiatric Social Worker
R.F. Kempster, Principal Nursing Officer
P.H. Rogers, Deputy Physician Superintendent.
St. Crispin Hospital

St. Crispin Hospital, Duston, Northampton, was built in 1876 and is a typical county mental hospital of a thousand beds and serving a population of about 450,000 in the County and County Borough of Northampton. It is situated on the borders of the town and near the centre of the county, which extends to some sixty by thirty miles. The hospital provided a traditional but progressive pattern of patient care until 1963 when, after a period of serious shortage of social workers, a scheme was introduced which amalgamated the social workers of the county and of the hospital. Clinical teams were started in May 1965 and a unified nursing administration in February 1966.

The established pattern of clinical work in the hospital and community had become unsatisfactory as the tempo of work increased over the past ten years or so. Patients were at risk from too many changes of ward, with divided responsibility amongst doctors, nurses and social workers.

Good treatment requires good communications and relationships between staff and staff, and staff and patients, and these are difficult when numbers are large. Good treatment also depends upon the skill of the staff, their numbers and deployment. The grouping of manageable numbers into three clinical teams appeared the logical answer in the particular circumstances of St. Crispin Hospital.

Each of the three teams consists of medical, nursing and social work personnel, having responsibility for about 330 beds in one third of the hospital, in wards affording roughly comparable facilities, and serving a segment of the catchment area with about one third of the total population. Each team has out-patient clinics in centres in its own area. The elderly, sick and patients with very disturbed behaviour are nursed in four 'shared' wards in each of which each team has about a third of the beds.

Preliminary informal discussions on how to evolve a workable system of clinical teams extended over a year or so. More formal discussions between representatives of the doctors, nurses, social workers and administrators lasted about another year. An early opportunity was taken for a doctor to explain the tentative proposals in principle to all the sisters and charge nurses and to invite their suggestions. The speaker on that occasion was advised to wear a bullet-proof waistcoat! In the few months prior to the inception of the scheme the nursing staff were complaining, with some justification (due to shortage of staff at the time) that the doctors were dragging their feet and urged that the scheme should be established without more delay.

As the pattern of team work has settled, it has been possible to include in each team a representative of each of the rehabilitation departments - physical, occupational and industrial, and also of the nursing training school. Each team also has a medical secretary, whose work is mainly concerned with that team and who is becoming increasingly a centre of communication.

After just over a year, only preliminary comments are justifiable, but the advantages seem clearly to lie in a closer relationship and better communication amongst the staff of the teams and much better continuity of

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care for patients in and out of hospital. Responsibilities are more clearly defined and better understood by all. From the doctor's point of view, one is much better able to know family doctors and one's colleagues, and to use one's beds more effectively.

There have been disadvantages. May 1965 saw a major upheaval in that the use of a number of wards was changed and many patients suffered a change of ward and staff caring for them, with corresponding distress of varying degrees. This, of course, subsided, but in the period of reorientation and adjustment that followed, some of our longer-stay patients received less indirect doctor time than had previously been the case, since the immediate emphasis tended to be on effective treatment of short stay patients. The shared wards are the least satisfactory aspect of the present arrangement since the ward doctor, having responsibility to the consultants of three teams, has correspondingly divided loyalties. The numbers of the patients involved is not large and we hope that time may lead to a more satisfactory arrangement. The department of rehabilitation, not included in the team pattern, has been feeling its way for the best working relationship and to some extent has felt left out. This is improving now that its representatives are taking part more fully in the discussions within each team.

Predictably, competition between the teams is felt in varying ways - in material facilities available, in locations and character of catchment area, in clinical approach and in quality of team spirit. Such competition has potentialities for good and ill, but on the whole is at present and looks like continuing to be generally healthy. There are few in the hospital who would wish to go back to the old method, and, understandably, these few are mostly amongst those who have worked longest under the old system. We have problems of course, material ones in the large size and inconvenient arrangement of many of the wards, and personal ones in the shortage of doctors and other trained staff, especially social workers, but the system has shown it is workable and has substantial advantages for patients and staff, for community and hospital.

The shortage of trained social workers in the Mental Health Service is part of a general shortage, but despite this, increased demands are being made for their services. One way of improving the effectiveness of any service, especially one short of manpower, is to arrange for the removal of any overlapping and duplication. In some situations two or more social workers are necessary in helping with complicated social problems and effective co-operation has to be maintained to make this a success, but in others overlapping and duplication is not necessary and is damaging to the people we are trying to help, and so must be eliminated.

One such area of overlapping occurs between psychiatric social workers in mental hospitals and those in local authority mental health departments. In Northamptonshire the first tentative proposals to overcome this were put forward by Dr. J.J.A. Reid, medical officer of health, Northamptonshire County Council, to St. Crispin Hospital in Autumn 1962. After full discussion with the appropriate committees and the necessary approval had been gained, a complete amalgamation of the social workers in the County Council mental health department and St. Crispin Hospital social work department was inaugurated in 1963. This means that every social worker in the joint scheme is working both for the hospital and the local authority. Except for officers in a training capacity all are authorised mental welfare officers.

Besides removing the overlapping that so often occurs between the two departments, this joint scheme promotes another important aspect of the psychiatric care, namely continuity. It also provides a wider and better

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base for training. During the first year each social worker was made responsible for a small area of the county. This enabled continuity of social work help to be provided to the patient and his family at every stage of treatment, but it meant that each social worker had to get to know the whole hospital organisation which was most difficult, especially for the several new members of the department. This limited the effective working relationship with psychiatrists and nurses and appeared to be hampering the development of the service. The hospital staff also, I feel, found it difficult to relate to a new department 'en masse'. It also meant that social workers were working in relative isolation from one another.

This situation was changed by the introduction of the clinical teams. The social workers were divided into three teams to cover areas corresponding to those covered by clinical teams, and area social workers were appointed to lead each team and be responsible for the day-to-day administration of the service in their area. There is a senior psychiatric social worker and a senior mental welfare officer who are jointly responsible for the overall development of the service with the senior psychiatric social worker having special responsibility for training.

Social workers now have support from other team members, guidance from a team leader and with regular meetings of the clinical teams will know all those concerned with the psychiatric care provided for a particular area. They will also get to know the general practitioners, other social workers, voluntary agencies and the general community resources, providing effective paths of communication and co-operation between community and hospital which is the basic need in any modern treatment plan.

May 1965 not only saw the inception of the clinical team system, but it was also in this same month that matron's retirement raised the question of the future pattern of nursing administration. The Chairman of the Hospital Management Committee, together with the chairman of the nursing committee, consulted senior nursing staff at a full meeting of the sisters and charge nurses committee. The result was an overwhelming majority in favour of unified nursing administration. Consultation with the Oxford Regional Hospital Board and the Ministry of Health followed, with the result that a principal nursing officer was appointed in October 1965, supported by the following establishment of nursing officers:

deputy principal nursing officer

3 senior nursing officers

6 nursing officers

It was inevitable that such changes would have considerable impact on the traditional role of the nursing officers and demanded a complete reappraisal of their duties.

From the outset it was apparent that an integrated nursing service was complementary to the clinical team system. It presented an opportunity to give all nursing officers a considerable clinical interest and a definite sphere of responsibility.

This changing pattern of patient care and the reorganisation of the nursing department received the full support of the St. Crispin Hospital Management Committee. The construction of a purpose built office suite was approved, and was designed to facilitate team work.

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Work study was also implemented to review the complete office procedure, many records have now been transferred to other departments, some have been eliminated, yet others are mounted on specially designed, easily maintained display boards. This study has resulted in a marked reduction in the amount of office work undertaken by senior nurses. In addition a more senior clerical grade has been introduced into the nursing administrative team.

After full consultation with doctors, ward sisters and charge nurses, each nursing officer was given a considerable degree of autonomy within a clinical team, and closely identified with its work.

Nursing officers play their part in supporting ward sisters and charge nurses in their teaching responsibilities. Together with a member of the tutorial staff they are responsible for nurse training within their team area, including the organisation of a weekly student nurse seminar.

Hours of duty have also been revised to give a very high concentration of nursing officers' time between 9.00 a.m. and 5.00 p.m. on week days. Only one officer is on duty after 5.00 p.m. and the same one officer before 9.00 a.m. next morning. This senior nurse is the liaison officer with the night staff and also presents the report to colleagues at the daily 9.00 a.m. conference and to the physician superintendent during the course of the morning. These duties are shared by three senior nursing officers and six nursing officers - two only operate at the weekend. The effectiveness of our system of communications has been enhanced by the informal contact possible in the small group. The formal arrangements for communications are as follows:

DAILY CONFERENCE

All nursing officers - 9.00 a.m.

WEEKLY

Inter Team Meeting. This committee is responsible for general policy and its membership comprises group secretary, consultants, principal nursing officer and the senior psychiatric social worker.

Clinical Team Meeting. An informal meeting of all senior members of the clinical team, i.e. medical staff, ward sisters and charge nurses, social workers, occupational therapists, remedial gymnasts, tutorial staff etc., and student nurses, as these meetings are regarded as an excellent teaching medium.

Student Nursing Seminar. A discussion on nursing affairs arranged by the team tutor and nursing officers for student nurses and pupil nurses.

EVERY THREE WEEKS

Ward Sisters and Charge Nurses Committee. Detailed minutes of this meeting are prepared and circulated to all medical staff, group secretary, heads of departments and all wards.

Needless to say, the whole lay administrative organisation of the hospital is also geared to the clinical team system, without physical attachment to any one team. Because everyone has had faith in the system right from its inception, we believe it is proving to be the success that we hoped it would be.

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2 THREE HOSPITALS IN ONE

Mrs. J.H. Knifton, Matron, Shenley Hospital.

Shenley hospital is one large hospital in the throes of dividing into three separate units under one central administration.

The hospital was built and opened in 1934 to accommodate 1,800 patients. It was built on a Villa system; there being a total of 56 wards, scattered over a large area, the number of beds in each varying from 20 to 48. In spite of taking down over 300 beds in the last 7 to 8 years, the number of patients in hospital is still over 2,000 and there is still overcrowding. Although sited in Hertfordshire, its catchment area is Harrow, Willesden, Wembley and part of Acton.

The female side consisted of two divisions of 600 beds each under its own consultant team, whilst the male side was one division of 800 beds with a consultant in charge. The unsatisfactory part of this arrangement was that consultants and doctors only cared for the specific sex of whichever division they were attached to. This meant that consultants and junior doctors seeing patients of both sexes in out-patient clinics would not be able to continue treatment of a patient after admission if their sex did not coincide with that doctor's particular division.

Before we could attempt any changes, months of planning and discussion took place with nursing, medical and lay administrative staff; and finally, it was decided that we should start by making an admission ward for both sexes in each division. When this phase was completed, we could then continue to re-arrange wards and their functions, and so have three divisions of a practical size to administrate.

To enable us to start this scheme, we had to empty one ward which was used as a 'Mother and Baby' unit. Rather than close down this successful unit altogether, we took over an empty doctor's house in the grounds and converted this to provide five beds for mothers and babies. Here our League of Friends were able to help us considerably by providing the money for 80% of the furniture and furnishings for the house. We are hoping to take over another house in close proximity in the near future, building a link between the two, so as to increase our beds to ten without having to greatly increase the staff.

Now - having an empty ward - we were able to do a certain amount of up-grading and re-decoration, and make this ward available for 20 male and 20 female patients for 'B' division, serving the Borough of North Brent. The next step was to up-grade and re-decorate another Villa, which was formerly an all male one, to provide a mixed admission unit for 'H' division, which admits from the Borough of Harrow. At the present time, work is about to begin on admission wards for the 'A' division - Acton and Brent South.

Each division - to a great extent - will be self-contained, staffed by consultants, junior doctors, 1 senior nursing officer, 2 nursing officers, ward sisters and charge nurses, psychiatric social workers, occupational therapists and medical ancillaries. Student and pupil nurses will move from one division to another whilst in training.

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There is one administrative block where all senior medical, nursing and lay administrators have worked together; but with the breaking down into three divisions, medical and nursing administration will move out into the central part of each division, leaving only the administration common to all three to continue functioning in the block. At the same time that we are planning these separate divisions, there will be some parts of the hospital which will be common to all - for example, the Mothers and Babies Unit, the maximum security ward on 'H' division, and certain occupational therapy departments such as engineering, carpentry, art, domestic science and industrial.

Some of the reasons for making changes are that each division will have a closer liaison with a section of the catchment area, which will mean better relationships and closer working with general practitioners, medical officers of health, psychiatric social workers in the area; and will also link up with psychiatric services in the general hospitals, hostels and day centres. The patients will be able to receive something approaching continuity of care.

I would like to say that the hospital had been making these plans many years before the Ministry of Health's recommendations were published, but due to problems - one being extreme shortage of money - it is only within the last 18 months that we have been able to introduce the initial stages. It is hoped that now a start has been made, the changes will continue.

Mr. Vickers, the chief male nurse, and myself, have found that our task has been made easier by the co-operation of all grades of staff. It was necessary to spend a great deal of time in consultation with doctors, sisters and charge nurses with regard to their needs in the new units, as well as deciding on colour schemes, choice of furniture and furnishings. We have also be assisted greatly by staff and patients in the carpentry department, who have made many new items of furniture for us, including dining room tables, and wardrobes.

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3 IMPROVING CARE

T.W. Raymond, Chief Male Nurse, Naburn Hospital.

OUTLINE OF IMPROVEMENTS AT NABURN

Naburn Hospital is situated 3½ miles east of York and has 440 beds (204 male and 236 female). With Bootham Park Hospital of 200 beds, it caters for a catchment area of 220,000 people. The area extends into the three Ridings of Yorkshire, and also includes the city of York. This poses a few problems in the resocialization of the chronic patient.

I would like to describe what we are trying to do for the chronic population of the hospital.

Twelve or thirteen years ago we decided to deal with the problem of locked doors and the rehabilitation of the chronic patient. We had to find how locked doors could be replaced. This was done gradually by finding work within the grounds, of a constructional nature. This was the beginning of our rehabilitation programme, and by 1957, all wards were open and we have never had to lock a door from that time.

The industrial unit was opened in part of the social centre in 1960. The major problem was the finding of suitable in-work because of scarcity of factories in the locality; however, the industrial officer, by travelling in a twenty mile radius managed to find work for the full employment of 60-70 chronic patients.

The patients' recreational and cultural needs have also been catered for. The educational authority of the East Riding supplies teachers for night classes which take place every night from Monday to Friday in term time. Subjects include art, carpentry, motor maintenance, book-keeping, secretarial work, typewriting, shorthand and domestic science.

The diversional needs for resocialization are catered for in regular visits to the city for shopping, visiting theatres and swimming. A hired minibus is used. The patients are able to take care of themselves, go in self-selected groups, generally under the supervision of a patient prepared to look after the group. These visits are supplemented by regular use of public transport. The main objective is to allow the patients to conduct themselves without the need of nursing staff.

THE BEGINNING - AN EXAMPLE

In 1954 there was on the male side of Naburn Hospital a ward of 36 patients who presented very difficult medical and nursing problems. These patients included some suffering from epilepsy. All were characterised by disturbed conduct. Because of this the ward was locked and they were often destructive and quarrelsome, being, at times, violent both to themselves and to the staff. It seemed then that they were quite unemployable, and were not considered suitable for treatment in the occupational therapy department.

Their medical treatment in 1954 consisted mainly of sedative drugs chloral and bromide, paraldehyde and soluble barbitone). The majority had had various forms of physical treatment, including electroplexy, insulin therapy or both; and three patients had had leucotomy with little or no improvement.

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As the result of discussions with the medical and senior nursing staff, it was decided to begin a planned programme of rehabilitation in which work would play the major part.

The first problem was to classify the patients into diagnostic groups and create a unit which was specifically designed for the treatment of those suffering from schizophrenia. Ward E2 was, therefore, opened as a ward in its own right and under its own administration. It had previously been attached for administrative purposes to an adjacent ward. It had 22 beds and 22 patients were transferred, these being the youngest and most active of the schizophrenics. They were also the most disturbed and the problems they presented in the new ward gave rise to initial apprehension, both amongst the medical and nursing staff, particularly since the ward in which they were now placed had, as part of the programme, to be a non-observation ward. That is, there was no permanent night nurse on the ward, although it was visited at 15-minute intervals during the night hours. A further six schizophrenic patients remained on their original ward. Therefore, this report deals with the progress of a group of 28 schizophrenic patients, whose ages range from 20 to 50, and whose minimum length of stay in hospital was two years.

The first object was to find work which could be usefully done by the patients as a group during the day. At that time Naburn had a great deal of privet hedging around the perimeter of the gardens and a large number of diseased and badly-shaped Scotch pines which had been planted when the hospital was built. With the Head Gardener's agreement it was planned to start a large scale project of removing such hedges and trees and to clean and tidy the shrubberies which, at that time, abounded in the hospital.

The patients were fitted out with working clothes and protective clothing, that is waterproofs and duffle coats. Best clothing was issued for evening and week-end wear.

The problem of using such a group of patients and in welding them together into a working and workable unit was a difficult nursing problem. The patients were quite disabled by their illness and had not done any sustained work for several years. As a first step they were graded according to physical and mental ability into small groups which ranged from six to ten. The more deteriorated patients were in the smallest groups. Nurses were allocated to each group so that the nurses and patients might become identified in the work they were doing. It was necessary to allocate two nurses to each group because of nurses off-duty arrangements. It was planned that, as patients improved in their behaviour pattern, they would be transferred to a group in which the work was more complex and in which behaviour was less disturbed.

The working day commenced at 9.00 a.m. and ended at 4.00 p.m. with a two hour break at lunch-time. On Saturdays they worked from 9.00 a.m. to 11.45 a.m. This is a total of 27¾ hours a week. They were paid in kind with goods of their own choosing up to a value of 10/- per week, depending on the ability of the patient to appreciate such comforts and goods. This payment was never intended as a rate for the job but purely as an incentive.

The project presented a considerable challenge to the nurses, because not only had the working day of the groups to be organised, but the recreational and diversional habits outside work had also to be reorganised. For the first few weeks the patients had, in fact, to be mustered and taken as a group to their place of employment. It soon became clear that once the habit of work had been established they commenced on their own volition.

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The nurses, during this initial period, took up with enthusiasm what was an apparently new nursing approach to the problem of rehabilitation of deteriorated, and, at times, chaotic schizophrenic patients.

As the project developed, the need for more difficult, skilled and time-consuming work became obvious. This need was met by painting the perimeter railings, building soil-retaining walls and making roads and kerb stones for the roads. The alterations of ward gardens and the landscaping of the grounds at the back of the hospital also presented opportunities for such work. A further step was the acceptance of work outside Naburn Hospital, generally within the York 'A' Group of Hospitals but also for local farmers.

As time went by, the groups of patients merged into one collective group. The more deteriorated patients, as well as the most disturbed, became both more quiet and more proficient.

During the latter part of this project, the newer tranquilising drugs which at that time were being introduced into psychiatry helped a great deal, but it was clear that the greater nursing care and personal attention which this project made available to patients had a great deal to do with the progress that was, in fact, achieved.

It soon became evident that no longer did Naburn have a turbulent ward full of destructive, unpredictable and untidy patients. The amount of destruction to ward furniture and the amount of violence became negligible and in the end non-existent. This formerly closed and disturbed ward was opened in 1957 and Naburn was one of the first psychiatric hospitals in the country to have fully open wards.

In reviewing the progress which has been made by this group of 28 patients who were first brought together in 1954, it may be noted that the original group has now dwindled to six. Four patients have been discharged, five have become attached to the general store, where they do useful work, two have died, and the remainder work in the industrial therapy unit. There is little doubt that, if this project had not started, all the patients who are now gainfully employed would, at the present time be completely unemployable and utterly deteriorated. The experience gained in the past ten years has proved that the occupation of the individual in work that he or she finds interesting and worthwhile, is an essential part of treatment.

Since the project started, there have been great changes in psychiatric treatment, including the introduction of new drugs, increased emphasis on rehabilitation in and out of hospital and re-orientation of nurses ideas of psychiatric nursing. The public in changing its attitudes to mental illness and more patients work outside hospital. In a way, these changes have been an expansion of this project.

The 28 patients who started this project ten years ago have done work which is of quite exceptional merit and improved the amenities of the hospital; more important, their personal pride and self-respect has been restored.

Tribute should be paid to Mr. Ayre and Mr. Thorne and all the nurses for the part they have played in this venture. Credit should also be given to the medical, administrative and ancillary staff for their co-operation, encouragement and support.

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4 SOME PROBLEMS OF IMPROVING PATIENT CARE

W.H. Clayton, Secretary, Naburn Hospital

The field of the circular is very large and I therefore propose to confine myself to one or two problems, from an administration point of view, which were met in carrying out various ideas.

We all know. that pocket money can be paid to certain patients. When we were considering the setting up of the industrial rehabilitation unit, we were aware that patients employed in these units were unable to receive £2, or more, as behond this figure they lost any benefits to which they were entitled and they would also have to pay for the appropriate insurance stamp.

I decided to discuss the question of insurance with an officer from the local office of the Ministry of Social Security. Among the many subjects talked about was the question of earnings and when I suggested that patients should be allowed to receive pay in accordance with their production, which in some cases would be higher than £2, the official and immediate reaction was that this would be quite wrong. However, we examined the insurance record of a number of patients and it became apparent that because of their illness, their insurance record gave them benefits for only a limited time or none at all, but there were occasions where, if a person was able to contribute a weekly insurance stamp, they would guarantee themselves a benefit from social security. This would mean that if and when a patient was discharged from hospital, they would qualify in their own right for payment, and this might avoid the necessity of seeking National Assistance.

The officer from the Ministry of Social Security appreciated the idea behind this, but felt that it was not in keeping with the intention of the National Insurance Acts; he did, however, agree to discuss this with his manager. It, in turn, was discussed at area level and eventually by head office. These talks commenced some 18 months to two years ago and approximately six months ago I was informed by the local office of the Ministry that they were prepared for a scheme to be introduced as an experiment in York. This meant that patients who were able to earn sufficient would be allowed to receive the amount earned and also pay a self-employed insurance stamp. This, I felt was quite a progressive step but, unfortunately, this principle has still not been accepted by my own management committee.

Some four or five years ago we opened, at Bootham Park Hospital, a day hospital for the reception of day patients. It has now been decided that the day hospital, as such, will cease and patients requiring treatment on a daily basis are being referred to Naburn Hospital. Bootham Park Hospital was conveniently situated for transport services, but Naburn Hospital, being outside the city boundary, presents difficulties in this direction, and we are finding great difficulty in persuading some patients to attend. Local ambulance services can be used, but the very nature of this service means that the time of arrival and departures are quite unreliable and are not suitable for day patients attending such a positioned hospital.

As a final and personal thought, I would mention that in 1959 we saw the disbandment of the Board of Control. As a point of discussion I would say that I feel that this is a retrograde step and there is now no one body or inspectorate who can apply a yardstick or who visits all the psychiatric hospitals to see if everything possible is being done.

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5 IMPROVING PATIENT CARE IN HOSPITAL

Miss W. Joy, Matron, De La Pole Hospital.

Anything which can be done to give patients a greater degree of privacy is to be encouraged, and we are always looking at this problem and trying to solve it. Smaller wards obtained by division of larger ones give a greater feeling of privacy, and for personal possessions a private bedside locker is essential but, of course, this can only be done in those parts of the hospital where space and money permit.

The question of clothing has always been with us in one form or another, but the problem today is somewhat different from that of a few years ago. There used to be the odd few private patients whose relatives or guarantors were obliged to provide suitable clothing as and when it was deemed necessary. The remainder of the patients' clothing was supplied by the hospital. The latter apparel was sadly lacking in variety and colour, and no great attempt was made to fit and alter the clothing to the needs of the particular patient. Nowadays, the improvement in the choice and quality of personal garments has been considerable, especially as far as the ladies are concerned. At De La Pole, female patients capable of taking care of their clothing are fitted for two summer and two winter dresses. A firm is invited to send some 400 dresses and about 250 are purchased about twice a year. A good variety of washable dresses is supplied for the less reliable patients. Similarly, measured suits are provided for the male patients. The hospital tailoring department is responsible for measuring and fitting and the foreman tailor visits the woollen and worsted firms of the West Riding, purchasing rolls of good quality cloth at reasonable prices. The result is a good quality suit in a price range of £5. 5. 0d. to £7. 7. 0d. After years of searching we have found a suitable "Sarille Nylon" material for suits for the incontinent which will withstand any amount of laundering.

In these days of the welfare state, more patients are coming into hospital with incomes from a variety of sources, e.g. various benefits, and pensions, and many of them take a keen interest in buying their personal requirements from local stores, and the hospital shop, where stocks of clothing are gradually building up. Every year I personally spend some hundreds of pounds on behalf of those who cannot get to the shops. This is all bound to have a beneficial effect. It causes an awful lot of extra work, but I am quite sure it is all well worth the trouble in the long run and we find that, as a result, the patients take much more interest in, and care of, their clothes, which is surely what we are after.

The old parole-card idea - 'parole within the estate' 'parole beyond the estate' was an abominable system. It lent itself so easily to abuse; furthermore, the withdrawal of the parole-card was often used as a corrective measure in cases of misdemeanor. The effect of this on some patients can well be imagined. We have found in our own hospital, that the most beneficial results are obtained when everything is done to create an atmosphere of freedom within the hospital buildings and grounds. Patients are encouraged to arrive at their own decisions within reasonable limits.

Rooms originally designed to accommodate disturbed patients have been transformed into single rooms with a built-in wardrobe, an easy chair, bed-light and wall heater.

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Gone are the days when long-stay chronics only came to the surface when a renewal certificate was due. Each patient now receives individual attention and is discharged at the earliest possible date, though many of them are encouraged to attend the hospital for treatment, as day patients.

We have no special wards at our hospital reserved for intensive treatments; the whole hospital is used for this purpose. I personally am of the opinion that intensive units may be the cause of unrealistic fear and apprehension and are not conducive towards the removal of the so-called stigma of mental illness.

Our patients are in close touch with the outside world - a theme which we endeavour to develop in every way we can. Some live in the hospital and work daily in the city in ordinary employment. Others undertake group contract work. We permit short leave for a day or a weekend as often as possible, and visiting is allowed every day of the week. Members of voluntary organisations and church associations visit the patients who have no relatives and also invite them to their monthly meetings, outings and to their own homes. Evening classes conducted by education authority teachers are held regularly, and visits to the swimming baths, theatres, amateur theatrical shows and sport activities all provide contact with the public.

Only in exceptional circumstances such as epidemics, will you find more than a dozen patients in the wards of our hospital during the day. Many activities are in progress, made possible by the re-deployment of the existing staff. Lack of finance is restricting any increase in nursing staff numbers and there is a great problem in the recruitment of suitable cleaning staff to undertake ward cleaning formerly done by patients under nursing supervision. Regarding cleaning, we have come up against a problem which no doubt is common to other hospitals situated as we are about five or six miles from a city. The majority of our cleaning staff are recruited from various areas of the city, which results in rather heavy weekly expenses in bus fares. Because of this, many potential workers are 'snapped up' by the city hospitals and it seems apparent that of the cleaners we can recruit, many turn out to be sub-standard and have already been rejected elsewhere. Even if hospital transport could be arranged it would not be the answer. We think the answer is some sort of subsidy towards the fares, and until this difficulty is resolved, the problem is likely to be with us for many years. We keep putting pressure on the Ministry of Health but there have been no positive results.

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6 CO-OPERATION WITH THE LOCAL COMMUNITY

K.C. Bailey, Medical Superintendent, Tone Vale Hospital

The distinction between the hospital and the community which continues to be perpetuated, is entirely artificial as, although the psychiatric hospital is often geographically at a distance from where the patients are admitted, the patient has been and will be again, it is hoped, in the community and his relatives continue to be there. It is usual for the community to group itself by common interests such as occupation and recreation, and similarly, psychiatric patients and their relatives tend to be such a group as are the workers in the mental health services who are concerned with them. It is essential, therefore, that we rid ourselves of this idea of separation and the emphasis should be on integration within the community by breaking down the old barriers and prejudices of mental illness, and by ourselves being known and accepted in the community. It is essential that we should be known to be useful and to supply the psychiatric services that are required and thus be needed by the community. In this respect, it is always useful for those of us who work in mental health to take an active part in community life by joining such things as Rotary Clubs, Round Tables etc. It is amazing how being known personally dispels the fear of mental illness.

If one were to start on virgin ground and organise the ideal psychiatric health service, one would not wish to start with the psychiatric hospital as was done previously, but with the provision of services in the community, including social work, out-patients clinics and psychiatric units, integrating in the general hospital. The Consultant Psychiatrist should not be appointed to a hospital but to a community. The South Western Regional Hospital Board has divided its region into clinical areas and the Consultants are appointed to a clinical area with a base at the appropriate hospital. Hence, as suggested by the Mental Health Act, the emphasis is on community service and every admission to hospital is an indication of failure, because the case has not been seen early enough to be treated entirely in the community, in the day hospital or in the general hospital. The only complaint against Mr. Enoch Powell, who, when he was Minister of Health, proclaimed that we would pull down mental hospitals, is that he did not do so.

A large number of long-stay patients in this hospital did not require expert psychiatric treatment, but care and attention, and I, some years ago, suggested that the Welfare Authority of the County should take over the hospitals as Welfare Accommodation, and that a small acute psychiatric unit should be provided in the local general hospital. It is imperative to be active in the treatment of the psychiatric patient and the tendency to care for them in the back wards of hospitals is demoralising both to the patients and staff.

If we were properly integrated into the community, and made use of the goodwill available and the help of the voluntary workers, the need for large psychiatric hospitals would disappear. The important emphasis, therefore, must be on integration rather than co-operation with the community.

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7 CO-OPERATION IN THE LOCAL COMMUNITY

A.H. Baldwin, Chief Male Nurse, Glenside Hospital

Co-operation with the community appears at first a comparatively simple and commonplace issue, and indeed it was on this basis that I rather lightheartedly embarked on preparing this paper. In a short time, I discovered how far off the beam I really was, and that to properly cover this subject, I would have to become deeply involved in a discussion on relationships and communication which are so obviously the fundamentals of this subject. I discovered also that the field involved was so important, and so comprehensive, that it was beyond my capacity to compress it into a mere fifteen minutes of discussion, and that at best I could only manage to merely skim the surface.

It seems to me this is a matter which tends to develop unobtrusively and perhaps automatically over a long period, becomes an accepted part of routine and then loses its importance in the general mass of everyday occurrence, with the result it takes an analysis such as this to really establish in one's mind not only its singular importance but also the vast field it covers. Even though one is intimately concerned with these matters on a daily basis, it is, nevertheless, astounding to discover exactly how great is the range and variety of media contributing towards the co-operation of hospital and community. Without any effort, and in a very short time, I compiled a list that is staggering, and ranged from the people living and trading locally, through the various voluntary organisations and educational establishments to a multifarious collection of public departments and employees.

The initiative and ultimately the responsibility for promoting co-operation must rest with the hospital authorities, although in some instances various voluntary bodies - sometimes referred to as interfering so and so's - have been known to participate quite actively in this respect. I do not think there can be any set pattern of approach. The methods employed in a heavily populated, highly industrialised urban area are unlikely to be appropriate in a thinly populated rural area. Hospitals must develop their own methods in the light of local circumstances. It is the fundamentals that are identical and the standard of their application which determines the degree of co-operation.

In my experience, and I believe we have proved this to some extent, the most effective and perhaps the most positive co-operation with the community is promoted by methods which serve to bring the patients into direct contact with the public at large, in whatever capacity and by whatever means.

Obviously it is necessary to get the people on your side, make them part and parcel of the whole procedure, educate and inform them, lift the veil of mystique which tends to cloak psychiatry, and in general promote a sympathetic relationship. Once such relationships and co-operation are created, support will follow automatically. I know that without it, any resettlement scheme for long stay patients is a very doubtful issue, indeed I would go farther as say that no such scheme is possible with public support. Whether we like it or not, and despite all the new methods, unless the people are prepared to co-operate and accept these patients into their society, the potential of any resettlement scheme is immediately lost and the readmission risk is increased.

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I cannot imagine a worse start than we suffered following the Sheasby murders, indeed one could have been sympathetic to the local people if they had rejected our efforts to co-operate, but somehow we have overcome these obstacles and enjoy not only their confidence but also their very active support.

The most positive and the most effective co-operation we have with the community actually developed as the result of an accident. I refer to the industrial therapy organisation, the idea of which was promoted by a lay person, and we just developed it. Since that time it has grown to such comprehensive proportions that now it would be almost impossible to determine exactly what contribution is made by the hospital and what by the community.

Arising out of it is an organisation displaying the most active and far reaching co-operation with the widest section of the community it has been my privilege to experience. The degree of co-operation is perhaps best illustrated by two examples:-

The employees on the factory floor readily accept patients who work there. They are made aware of their idiosyncrasies and learn to accept and support them. At the same time nurses are also accepted into the factory in a supportive role.

Perhaps a more significant example is the reaction of the dockers, who employing the tightest closed shop policy in industry, also accept patients as workmates.

The overall management of the industrial departments is more or less equally vested in lay members of the community and the hospital authority, the lay members forming the board, the staff the actual management. At no time can I recall a complaint of interference from either side.

It is perhaps worth mentioning that as a result of co-operation with the community in this respect, the patients based on Glenside Hospital were able to earn something in excess of £85,000 in 1965 which, by any standards, is profitable co-operation. The same organisation has made it possible for approximately one third of our total patients to be constantly employed over a period of 6/7 years. Provision has also been made to employ a number of patients individually or in groups in industry proper. The tenancy of a petrol filling station, operated by patients, has been obtained and included in the general organisation.

On reflection, I think perhaps the greatest benefit we have derived from all this is that the patients are brought into daily and direct contact with the community. It follows, quite automatically it seems, that if you can manage this you tend to engender not only a sympathetic relationship but also a desire in the minds of the people to co-operate and support the efforts you are making. The result is that from a very modest start the matter snowballs into a comprehensive and perhaps a somewhat complex system of co-operation with the community. One simple example of this is our car wash service which is by no means the acme of planning and installation. It has been operating continuously for seven years with a steadily increasing clientele, in spite of several ultra-modern plants with comparable charges and numerous automatic systems competing with it. Such contact also proves a sound medium for securing work for the industrial departments and jobs for individual patients.

Typical of the snowballing effect is the development of the housing association, an offshoot of I.T.O., and similarly supervised. The Board or Committee is composed mainly of lay members of the community, and their

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overall function is to acquire the tenancy of property and provide accomodation for the patients passing through the resettlement scheme. To date, they have acquired an hotel and six cottages, providing accommodation for some fifty patients, and in so doing have opened up several new avenues of co-operation with the local community.

It is interesting that the hotel is situated in the residential Clifton area of Bristol and the patients have been accepted by a variety of communal groups, ranging from the church close by to the pub around the corner. This is quite remarkable since, a year previously, the local council purchased a large house with a view to converting it into a hostel in the same area, but the local populace reacted so vigorously with petitions and protests that the idea was dropped. I wonder what would have happened had the hospital taken the initiative? Perhaps equally remarkable is the fact that the hotel was made available by the generosity of a large trade union, an example of further valuable co-operation.

A mutual arrangement has been made by the hospital which provides psychiatric supervision of the patients, the general practitioner catering for their physical needs. A natural development of this arrangement would seem to be the provision of a community psychiatric nursing service, and I would predict if this can be achieved, it will serve to consolidate both the extent and the standard of community co-operation I have tried to describe.

So far as co-operation with the community on an official basis is concerned, the local mental health authority should be a very important medium. I am not sure to what extent, and whether in our own particular situation this is the case. At times I have the feeling that the local authority resents any intrusion into the community by psychiatric hospital staff. I may be committing an injustice in saying this and it could well be that this attitude is provoked by a sense of frustration. I know they appreciate the prestige value of their community services and I believe that they are incensed by the fact that mostly they have to function on the remnants of the block grant. This is not a very happy position and certainly not one that reflects a positive state of co-operation with the community. In passing I would say that in my humble opinion this section of the mental health service is not satisfactory, and the only solution is one comprehensive psychiatric authority.

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8 CO-OPERATION WITH THE LOCAL COMMUNITY

J.A. Whitehead, Assistant Psychiatrist, Severalls Hospital

The mental hospital should be part of the community. Few, if any, are. Too often the area served by the hospital is so large and widespread that co-operation and final integration is almost impossible.

Severalls, with an inpatient population of approximately 1,250 serves a community of 740,000 scattered over a large area including most of Essex and part of Hertfordshire. Colchester is situated near the eastern boundary of the catchment area. This means Severalls is the maximum distance possible from some of the population it serves. Land in this area must have been very cheap in 1912, or perhaps there were more disreputable reasons for choosing a site for the county mental asylum.

The hospital is divided into five general psychiatric units or firms, a psycho-geriatric unit and small surgical unit. Each general psychiatric unit is not responsible for a specific part of the catchment area. Each treats patients from anywhere in our community. This policy was introduced because it was considered important that general practitioners and patients should have a choice of psychiatrist.

A small general hospital psychiatric unit in Bishops Stortford, Hertfordshire, is associated with Severalls and plays an important part in the care of patients in the Hertfordshire area. A pattern of community care, centred on this unit, has been developed during the four years since it was opened.

I will try to describe what has been done at Severalls to improve our relationship with the community.

Outpatients clinics in general hospitals can play an important part in bringing psychiatry to the community. 25 clinics are held each week in nine centres scattered rather unevenly over the catchment area. Domiciliary visits by psychiatrist can prevent admissions, improve relationships with the general practitioners, and help the psychiatrist to understand the community's problems. Unfortunately, because of the fees involved, psychiatrists cannot ask to do these visits, and some general practitioners are loth to help in filling what they consider are the already over-full pockets of hospital specialists. One solution to this problem is unpaid visits. As well as paid visits, unpaid visits are carried out by Severalls' staff. Junior medical staff and nurses often accompany consultants.

Day care as well as benefiting patients, brings the hospital into closer contact with the community. Between 120 and 140 day patients come to Severalls every weekday. The majority require ambulance transport. There has been some resistance on the part of the hospital management committee and regional hospital board to day care, but this has been overcome. Regular meetings with members of the ambulance service has built up an excellent relationship with this important local authority service.

General practitioners, who should be the keystone of community medicine, are too often ignored by hospital staff. At Severalls, the general practitioner is informed when one of his patients is being discharged. He is sent a brief report stating when the patient will be discharged and what treatment and aftercare is required. This is followed by a detailed report after the

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patient has left the hospital. General Practitioners are encouraged to visit the hospital where they can discuss their cases with the hospital doctors and see their patients if they wish. Clinical meetings and lectures at the hospital are open to them and recently four general practitioner clinical assistants have been appointed.

Regular informal working meetings take place between hospital staff and local authority psychiatric social workers, mental welfare officers, health visitors and welfare department workers. Less regular meetings occur with Medical Officers of Health, ambulance personnel, Ministry of Social Security Officers, probation officers and some home help department staff. The local authority psychiatric social workers and mental welfare officers have the use of an office in the hospital.

There has been some mutual distrust and misunderstanding between local authority workers and hospital staff. This has been, and is continuing to be corrected by informal meetings and working contact.

The local Disablement Resettlement Officer visits the hospital regularly to see patients and discuss their problems with medical and nursing staff.

A large number of patients and their families are visited in their homes by hospital social workers and nursing staff. Visits may take place before admission, families are visited whilst the patient is in hospital and patients are followed up after discharge. This service does not replace local authority services, but augments them. Visits are carried out with the co-operation of local authority workers and not in spite of them. The development of home visiting has been resisted at times by hospital management, the local authority and the workers involved. At the shop floor level mutual understanding has slowly developed. Management has found it a little more difficult to learn.

The psycho-geriatric unit emergency service was originated to deal with medical, psychiatric and social emergencies in the home and is run in conjunction with the day hospital. When an elderly person is referred as an emergency or a day patient has difficulties at home, a team goes out prepared to deal with all the various problems that may be present. The object is to keep the patient in the community if possible. The team may consist of a nurse and social worker or a doctor, nurse, social worker and local authority mental welfare officer, depending on the type and complexity of the emergency. There is an arrangement with the local authority for nurses to act as night sitters if necessary and be paid as such out of local authority funds. This service and home visiting by hospital personnel not only helps patients and educates staff, but increases contact between the hospital, general public and local authority staff.

The various voluntary organisations in the district arrange visits to the hospital and assist patients in the hospital and in the community. There is a very active League of Friends. There is still some distrust of voluntary workers by hospital staff which is again being slowly eliminated as a result of working contacts.

Visiting of patients is unrestricted, so improving the free flow of people in and out of the hospital and subducting the artificiality of regulated hospital visiting hours. Relatives' conferences are held regularly in the hospital and are open to all as well as relatives. Often community workers give talks and demonstrations. The most important part of the meeting is the free discussion that always follows the more formal part of the meeting.

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A very large number of talks are given yearly by the different grades of hospital staff to various local organisations. Each talk is followed by an invitation to visit the hospital. Seeing the hospital is possibly more useful in promoting understanding than formal talks to groups in the community.

Regular courses are held in the hospital for health visits, nurses, voluntary workers and the clergy.

I hope I have shown that we have tried to go out into the community and have encouraged the community to come into the hospital. I do not claim this is a great success story. We have done all these things, but it does not mean we have done them well. There have been certain difficulties and we have had our failures.

Like most psychiatric hospitals we have a large catchment area. It is mainly rural and includes part of two counties. It is difficult to develop and maintain relationships with all the local authority and voluntary workers in the area. We could, of course, have continual meetings and never see or treat a patient. One partial solution to this problem would be for each unit to have a specific part of the catchment area. However, this would mean that general practitioners and patients could not have a choice of psychiatrist.

Some members of the nursing staff are suspicious of local authority workers and even of our own social workers. Sometimes these suspicions are mutual.

We are lucky and unlucky in having large numbers of staff houses. Lucky because staff are a little easier to find when accommodation can be offered. Unlucky because the houses are all together near the hospital. In the shops and public houses in the village all you see are hospital staff and patients. Informal contact with members of the general public is reduced and isolationism encouraged.

Some hospital doctors and some general practitioners treat each other as enemies. Telephone conversations about patients are sometimes uncivil. These attitudes, often the result of lack of understanding, must produce poor relationships between general practitioners and hospitals and in time must harm the patient.

Co-operation does not cost money. It is brought about by freedom to have informal meetings, freedom to enter the hospital without restriction and formality and freedom for hospital staff to go out into the community and treat patients where treatment is most effective.

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9 DEVELOPMENT OF PERIPHERAL OUT-PATIENTS & DAY HOSPITAL SERVICES

(i) ORIGINS

W.L. Milligan, Physician Superintendent, St. James' Hospital.

In indicating the approach of St. James' to H.M. Circular (64) 45, I intend to deal with the subject under three headings; firstly the constitution of the medical committee which considered the circular; secondly, a brief account of the findings; thirdly, the action taken.

The medical committee of St. James' are two in number, firstly the senior medical staff committee which discusses detailed matters, and consists of all psychiatric consultants and senior hospital medical officers, and a representative elected by the junior medical staff. The medical advisory committee, which was constituted in 1958, is an official sub-committee of the management committee and deals with medical policy. It consists of four members elected by the senior medical staff committee, two non psychiatric consultants elected by the visiting consultants, the medical members of the management committee: - including a pathologist, who is chairman, the medical officer of health of the city of Portsmouth, a general practitioner (representing the local medical committee), and myself. The senior medical staff committee and the medical advisory committee meet on the first and second Tuesdays of each month respectively, and the group secretary attends all meetings.

When the medical advisory committee considered the circular, it was found that practically all the recommendations had been carried out by St. James' for many years. The pioneer work of my predecessor, the late Dr. Thomas Beaton, is too well known to require further mention, but, having regard to paragraph 1 of the document "but the standards reached seldom survive their originators" we considered our standards critically. On comparing our present day work with that of twenty years ago, we found that, whereas the admission rates were about the same, the number of patients seen in the community had increased fourfold. In 1947, for instance, attendances at the out-patient department and visits by medical staff to patients outside the hospital totalled 5,000. Since then, the extent and scope of the work has expanded steadily and consistently, and last year psychiatrists from St. James' recorded more than 20,000 attendances and outside visits. The annual number of new patients seen has increased from 1,200 to nearly 4,000 whilst the number of first admissions under the age of 65 has actually decreased to approximately 450. With regard to the statistics given, it should be noted that 85% of these patients come from Portsmouth itself (population 220,000), and the majority live within a $2\frac{1}{2}$ mile radius of the hospital. This indicates the intensive work at present carried out in the community of the city of Portsmouth. I would stress, however, that we are not at all complacent but are conscious of our limitations, particularly in regard to the shortage of trained social workers.

Approximately twelve years ago, the catchment area of St. James' was extended to include the urban district of Havant and Waterlooville, all of which is within a radius of eight miles of the hospital. The population of this area has increased from about 20,000 to its present level of 95,000, and is expected to reach at least 130,000. Two consultants live in the area and we have regular contact with the general practitioners, and with the three mental welfare officers who attend our case conferences each week. Provisions for this area have been constantly under review, but, while considering the circular, the medical advisory committee asked the group

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secretary to carry out a survey to indicate the present needs. On the basis of his report, a recommendation was sent to the regional hospital board via the hospital management committee that, after an appropriate increase in medical establishment, a combined day hospital and out-patient clinic be provided in that geographical area, which will then become the responsibility of one of our consultants and his team.

It was also resolved to ask the regional hospital board to establish another day hospital and out-patient department at the designated district general hospital situated in the northern part of the city. This would provide improved services for the rapidly developing surrounding area. I am pleased to report that the Wessex regional hospital board has agreed to both proposals and working parties have been set up in conjunction with the appropriate local authorities. It is hoped that these extensions to our facilities should be functioning within the next two years, and, if our catchment area remains as at present, the maximum distance that any patient will have to travel to an out-patient department or day hospital will be four miles.

(ii) INVESTIGATION

D.J. Downham, Group Secretary, St. James' Hospital

The Ministry of Health, in its memorandum on improving the effectiveness of hospitals for the mentally ill, amongst many recommendations, laid emphasis upon the following:-

(i) the need for patients to be recognised as useful persons who can still make a contribution to the community.

(ii) that hospitals should make a special effort to improve communications with the communities from which their patients come.

(iii) that out-patients clinics should normally be held in the most convenient centres for patients.

Following its consideration of the memorandum, the St. James' Hospital management committee laid particular stress on the recommendations that psychiatric out-patient facilities should be available in all areas where there was a heavy concentration of population, and it was decided to conduct a survey of patients from the Havant, Leigh Park, Emsworth and Hayling Island areas in order to establish whether the numbers attending the hospital out-patient department justified a separate clinic located in that area. This area has a population of approximately 60,000 which is likely to increase to 70,000 in the next few years.

A questionnaire was drawn up in consultation with medical and nursing staff and the staff of the medical records department. The questions posed called for a simple 'yes' or 'no' answer and covered the time taken by patients to travel to the hospital; whether they were accompanied; whether the patients preferred to be seen at a local clinic; and the services patients actually received whilst attending the hospital.

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The survey was conducted over two periods of four weeks and every patient attending from the four areas was interviewed. Of 130 patients questioned, 118 preferred to attend an out-patient department in the Havant area. Of the twelve patients who objected, six worked in Portsmouth itself and would not have found an alternative clinic helpful.

A comparison of travelling time and cost of fares revealed a considerable saving for the patient if there was a clinic in the Havant area.

Actual travelling periods:

Leigh Park to Havant by bus 8 - 11 minutes

Leigh Park to Portmouth by bus 45 - 57 minutes

saving to the patient in actual travelling time approximately 45 minutes.

There would be a further increase in travelling time spent waiting for buses, particularly in the journey to Portsmouth, which automatically involves a change of bus. The journey to Portsmouth could also involve the patient in a whole day away from work instead of perhaps half a day if there was a clinic at Havant.

Comparison of fares:

Leigh Park to Havant	1s. 4d. - 1s. 8d.	return bus fare
Leigh Park to Portsmouth	3s. 7d. - 4s. 0d.	return bus fare

saving to the patient approximately 3s. 4d. per person.

For each patient the financial saving may not seem enormous, but to the patient who was accompanied it became more significant. During the period studied 130 people were accompanied by a total of 85 other people. There was also a hidden problem for the patients with children who were forced to make arrangements for their family to be cared for during their visit to St. James' out-patient department. A clinic nearby would inevitably reduce the worry and problems of patients with children and dependents.

A well attended out-patient department, centred on the hospital, helps to break down the fear of the local hospital, and to encourage lines of communication with the neighbouring community. It was considered, however, that this was not reason enough for holding back the establishment of out-patient services to patients who lived a long way away from the hospital and who were inconvenienced by centralised out-patient services at the main hospital.

At the present time, all psychiatric out-patient referrals from general practitioners come direct to St. James' hospital out-patient department. If a psychiatric out-patient service were available to the general practitioners of the outlying areas under discussion, it seemed likely that the volume of work would increase and that a latent demand in these areas might be revealed

From the survey of patients from the Havant, Leigh Park, Emsworth and Hayling Island areas, of the total of 130 attendances during the eight week period there were: -

93 (72%) female patients (average 11 per week)

37 (28%) male patients (average 4 per week)

50 (38%) seen by consultants (average 6 per week)

80 (62%) seen by other medical staff (average 10 per week)

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25 (19%) first visits (average 3 per week)

29 patients failed to keep their appointments (average 3.5 per week)

The total number of patients from Havant and outlying areas was 20% of the total out-patient attendances at St. James' during the period of the survey. Of the 130 patients seen, only two pathological tests were required, two E.E.G. records made and only two patients were seen by the social worker.

A separate survey during the period January to June 1965 (inclusive) revealed that there were:

544 attendance (including new patients)	(average 21 per week)
104 new patients	(average 4 per week)
100 patients failed to keep appointments	(average 4 per week)

The findings of the survey suggested that there were enough new and old patients coming from these areas to hold two consultant out-patient sessions in the Havant area each week.

There was overwhelming support, both medical and administrative, for bringing the psychiatric hospital services closer to the community which they served. There would be an advantage to many patients, both financially and in the time saved travelling, to have a clinic at Havant. There was enough work coming from these areas (1/5th of the total out-patient attendances, excluding children and neurology) to warrant the setting up of a clinic, and there were enough new as well as old patients coming from these areas to support two consultant sessions. It seemed likely that the volume of work from the outlying areas would increase.

The findings of this survey have been accepted by the St. James' hospital management committee, and it has been decided to link the new out-patient clinic for the Havant area with a day hospital and, at the same time, to invite the local authority to share these premises. This concept has been accepted by the regional hospital board and money has been promised for a new building to house all these services.

A joint working party has been set up with the regional board, the local authority and the hospital management committee to consider:

(a) the siting of the new clinic and day hospital

(b) the range of services to be provided

(c) the extent of joint services between the hospital and the local authority

(d) the operational policy for the unit

The group medical advisory committee has decided to re-organise the medical team system so that each team is identified with a definite area and will be responsible for providing a comprehensive mental health service for this community. The first of these teams will be based on the Havant clinic/day hospital service.

The management committee has now called for a further survey for the northern sector of the catchment area, covering a population of about 80,000. This again has shown the need for a peripheral clinic and day hospital, which would in turn become the fulcrum for a second team based on a geographical area.

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(iii) PREPARATIONS AND NURSING BACKGROUND

Miss K. Baldwin, Matron, St. James' Hospital

Whilst the plans for the peripheral out-patient department and day hospital are still in their early stages, there is ample opportunity to do some reconnaissance and to consider the staffing needs of such services, some methods of obtaining suitable people, of ensuring continuity of care, and of keeping in touch with other services in the hospital and the community. Although, as always, one must expect the unforeseen to arise, preparations can be made on the basis of certain firm principles.

Wise selection is a good step towards success. Some of the most suitable staff may well be found amongst those already in post. Acquainting them with the new project, not only by the written word, but by face to face contact, is likely to arouse their interest and to make them feel involved. Individual potentialities will become more clearly defined during subsequent discussions. The tone will be set by the personality of the one in control and his or her deputies. Those appointed will need to be from a later school than that from which emerged the overbearing, over authoritarian people whom some of us may perhaps remember. They will need to be not only articulate, but able to converse with patients with various tastes and from different levels of society.

Staff establishment

The grades and numbers will be dependent on:

(a) the extent of the facilities.

(b) interpretation of "occupational therapy" by the nursing staff and others.
This could be limited to the traditional skills of weaving, toy making and basket making, for which nurses with experience and ability in handicrafts have proved invaluable; or it could include such accomplishments as sketching, painting, sculpture and drama; or those which provide more physical exercise such as gardening, tennis, and bowls; or helping in appropriate ways other patients and with the general running and upkeep of the department, e.g. cooking, dusting and decorating.

(c) whether the patients will be encouraged to bring children with them. If so, whether there will be limitations on their ages, or whether provision must be made from infancy, the toddler stage, or nursery school age. Whether they will be with the patients or in a separate creche, and cared for by local voluntary help or our own paid staff.

There will be a need to gain the co-operation of the non-nursing services; social workers, the children's department, public health department and so on.

As the trained staff of the future can only emerge from the students of today, those still in training must be given opportunities to gain the experience available in such departments.

Methods of staffing:

The choice will lie between:

Finding staff from the adjacent district and limiting their experience to this one unit, or drawing on those in the main hospital.

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The latter will be preferable, but there is good reason to suppose that there will be plenty of applicants from the peripheral areas. At present, many applications are received but they are for jobs in the main hospital. Unless these candidates can give an assurance of satisfactory transport arrangements, they are rejected in favour of those living locally.

The main hospital

We have no nurses' home, and there is no evidence that this is a drawback to recruitment. The hospital appears to advertise itself from within. Complacency and self-satisfaction need to be avoided in an area such as ours, where a comparatively large number of those in the immediate neighbourhood wish to work in the local psychiatric hospital and where applications tend to exceed vacancies. Bearing in mind that this is a naval town and seaside resort, turnover of staff is not excessive. The fact that the first, second and third year students are usually numerically equal, calls to mind such paragraphs as numbers 12, 33 and 34 of the Ministry circular.

Analysis of the circular reveals that the forty or so paragraphs can be grouped in three main headings, and are approximately equally divided:

(i) those largely related to nursing staff attitudes and initiative

(ii) those dependent on constructional alterations and extensions

(iii) those dependent on provision of additional medical staff.

It seems reasonable to question whether there are nowadays any hospitals falling spectacularly short of the services recommended, since resolve and ingenuity have so largely overcome the obstacles which the restrictions of space and finance create.

Day care, referred to in paragraphs 6, 7 and 8 is provided here in the hospital itself, about a dozen patients being treated in whichever wards are most suited to their individual needs.

Paid occupation outside and within the hospital, and contact with voluntary associations such as the League of Friends, have widened the horizons of a large number of patients who accept hospitality and attend a variety of functions outside the hospital.

The provision of a group of part-time staff working from 6.00 p.m. until 10.00 p.m. ensure that adequate help is available for those patients wishing to remain up late. The time of rising is largely left for the individual patient to decide.

To minimise the value of formal and informal training is to dispute that the quality of staff and standards of patient care are indivisible. Just as treatment for the patient begins at the moment of entry into hospital, so training for staff should begin at that point. A carefully arranged induction programme for the first day of duty tends to make each new member feel from the start part of the hospital, and someone who matters to others. Such a programme may be time consuming, but its effect is to reduce the rate of staff departures, and their volume of replacements and the time necessarily expended in interviewing and selecting them.

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The not entirely universal custom of extending certain privileges to part-time staff such as release from all weekend duties, places personal relationships at risk and makes pressures and provocations more traumatic unless the reasons for such a practice are made clear to their full-time colleagues.

Study days for trained staff and visit to and by other hospitals stimulate interest and create new ideas with beneficial effect not only on those participating, but on their colleagues and the patients.

Perhaps there is an inclination for the word "patient" to be used too often. It would be interesting to observe the effect of taking a leaf from the book of those department stores which make a feature of certain weeks, e.g "Garden Furniture Week", "Irish Linen Week" and have a "No Titles" week in hospital, when we would be people looking after other people. The effect might be more positive than the most hopeful have envisaged.

New projects and established departments alike require, among their ingredients for success, trust and understanding throughout and a resolute intention of the leaders of the teams to make all their colleagues feel that they matter, and to give at the same time due regard to the essential disciplines and to the will to work harmoniously together.

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10 ATTEMPTING TO SOLVE STAFFING PROBLEMS

B. Pitt, Consultant Psychiatrist, Claybury Hospital.

At Claybury, we have gone some way towards meeting the recommendations of H.M. (64) 45 Paragraphs 33-37. It is suggested that improvements may be made piecemeal by focusing on one section of the hospital, concentrating staff there and aiming to produce a really active and successful unit, whose influence will percolate through the rest of the hospital, and whose reputation will help to encourage new recruitment. The rest of the hospital can then be dealt with by stages in the same way. Such a process has been going on at Claybury for some years, beginning with Forest House, the mixed ward for severe neurotics who are treated for many months with intensive group psychotherapy, and serving a particular catchment area and run wholeheartedly along therapeutic community lines. Claybury's present reputation rests largely on these units. There are, however, snags, and instead of the whole hospital going on to develop similarly, a sizeable split has appeared between those wards where the action is, which get lots of visitors and publicity, and "the Chronic Hospital" which feels more out of things than in the bad old days when there was very little treatment.

At the time this circular appeared, the situation seemed at a stalemate, but this year we have advanced a stage further by developing a new firm to facilitate one of the largest and relatively most neglected group of patients - the elderly. This firm, with its own medical staff, already admits all patients over sixty-five, and within a couple of months will do so via a new mixed psychogeriatric admission ward. Throughout the last year, interest in rehabilitation and, above all, in the possibility of making many mentally ill old people well and discharging them, has been growing. Therapeutic community techniques have been tried with some success. Although as yet the firm comprises wards all over the place, an attempt has been made to give the staffs of these wards an idea of their part in the whole area of psychogeriatric treatment and care, and a sense of belonging to the firm, by holding regular meetings.

Paragraph 34 emphasises the value of free communication via staff meetings. These have been in operation in Claybury's therapeutic community wards for some time. There is also a weekly meeting in one of the committee rooms which is open, at least in theory, to all the staff, at which various hospital topics are raised and discussed. Here, last summer, the "Chronic Hospital" was able to voice some of its grievances, particularly against the consultants, and less directly, the senior nurses who were felt to neglect them.

This led some of the senior staff to look again at what they were doing, while pointing out the real difficulties arising from limitations in their time. At the same time, the traditions of doctor dependency, and the scope for greater authority, initiative and responsibility to be used by the staffs of the less active wards, were examined.

Another communications venture was the attempt by one of our senior registrars to hold regular staff meetings with all the night nurses - a group notoriously likely to feel excluded and to be used as a scapegoat. This venture was not really successful, because it appeared that the night staff wanted much more to meet and discuss things with their own day staff and doctors than to ventilate their feelings with a single representative.

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The next paragraph urges that before opening a new unit, staff and members of the H.M.C. should visit other such units functioning elsewhere and that some should be seconded to such a unit for two to three weeks. In connection with opening our Psychogeriatric Unit we have made several visits to other psychiatric and geriatric hospitals, and have been surprised to discover how much we have to learn from progressive geriatric units. There has been no secondment of staff as yet, though I hope to spend a week working in a geriatric hospital.

Our H.M.C. has participated in "interest sessions" throughout the year, when they have studied directly various areas of the hospital's working.

We have made least progress with paragraph 36, which suggests redeployment of existing staff to make the best use of them by getting ambulant patien not undergoing intensive treatment off the wards by day by out of ward occupation and eating at a central canteen, thus freeing the staff of their wards for other activities. Many, but perhaps not the majority of patients, work off their wards. Much industrial therapy, though centrally administered, is carried out on the wards; we have no sheltered workshop as yet, nor have we a central canteen for patients.

Two years ago two of our consultants took time off to survey the work of all the wards, and made sweeping recommendations along the lines of paragraph 36, which would have meant major changes, especially as regards reducing the supervision of many long-stay patients. These changes were never implemented. I'm not sure that the objections were ever made clear. Perhaps too much was offered at once. There was a two year gestation period, with intensive discussion involving nurses at all levels, before the mixed admission wards were opened simultaneously with very little bother. On this occasion, a "package deal" was proposed, and by and large rejected as such. Also, Claybury seems to me still very much a ward-centered hospital, and there has been an increasing emphasis on the wards having fewer patients and becoming more home-like. The idea of large blocks with little sense of a ward community, eating communally, has therefore been met in some quarters with dismay. Perhaps too the staffs of these wards have been unsure of their role off the ward. Anxieties about meeting G.N.C. requirements for students assigned to the wards have also been expressed.

There is a strong feeling that patients should do their own chores, as they would at home, before starting work, rather than use domestics who, in any case, often cannot be obtained. I will not pretend that there are not several wards where the chores are in the hands of one or two willing, and thoroughly institutionalised, horses. Possibly nursing staff shortages have never been such as to necessitate redeployment. Energetic recruiting has kept our numbers up; indeed, there was a time last year when we apparently had too many! I think we shall move in the direction indicated by this paragraph soon. We are just opening a large new occupational therapy block where larger numbers of patients may be employed, and we are facing up to the need for radical reorganisation of our firms with decentralised administration.

Paragraph 37 indicates the value of frequent conferences of the therapeutic team to review patients' progress. This happily, is inevitable where there are regular ward and staff meetings.

Finally, I would like to mention how, increasingly, wards are relieved of other than therapeutic duties by the development of such services as portering and a central supply. The staff available for these tasks are often of indifferent qualities, so techniques have to be found which can still make effective use of them; e.g. the issue of a standard pack from the stores to wards eliminates errors made by storemen. There is a general shortage of tradesmen and work which cannot be performed by hospital staff may have to be put out to contract. Whatever method is used, nurses will spend more time doing the job for which they have been trained.

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11 DESCRIPTION OF A MIXED STAFF CONFERENCE

J. Greene, Chief Male Nurse
P. Moore, Senior Administrative Clerk
K.F. Weeks, Consultant Psychiatrist
Moorhaven Hospital.

This is an account of an experimental four day conference which was held at Moorhaven hospital in February 1966 for a group of representatives from various departments of the hospital, and a description of the developments in the year that followed.

Refresher courses for trained nursing staff have been taking place for some years. They usually take the form of a study week for twelve trained nurses of the staff nurse, deputy and charge nurse/ward sister grades. The programme consisted mainly of informal talks and discussion periods, clinical case demonstrations and visits to sheltered workshops, geriatric units, and the like. Having worked through the majority of the trained nursing staff it was suggested that the scope of the refresher courses be widened. The chief male nurse and a consultant psychiatrist were invited to plan and run a mixed staff conference as an experiment and to act as joint chairmen. About this time there was a good deal of discussion in the medical press about the King's Fund Hospital Internal Communications project, and this gave encouragement to us. The following twelve people were invited, by letter, to take part in a four day conference of staff from a cross section of hospital departments:- the catering officer, the deputy group engineer, a senior administrative clerk, the deputy treasurer, an assistant matron, a ward sister, a charge nurse, the clinical instructor, the head porter, and a psychiatric social worker. A senior doctor had to withdraw for reasons beyond his control.

Moorhaven has 761 beds and the total staff complement is about 526. Facilities already existed within the hospital for the most senior heads of departments to meet as frequently as the need arose, but it was obvious that there remained a large number of fairly senior staff who had no form to express their views or discuss mutual problems together.

The theme chosen for the conference was, 'The function of Moorhaven and its place in the Health Service'. The comfortable lounge of the Nurses' Home was made available, and no telephone or other hospital activity disturbed the atmosphere. The chairmen acted as group leaders and kept all the sessions as informal as possible.

The proceedings got off to a good start with Mr. Mickelwright, former Principal of the King's Fund Administrative Staff College, and now Chairman of the Starcross Hospital Management Committee, and the Regional Staff Training Committee. He created just the right mood by skilfully drawing upon his experience as a teacher, administrator, a member of the Regional Hospital Board and as Chairman of the Hospital Management Committee. The Group Secretary, and Physician-Superintendent, each presented a fascinating description of their jobs in relation to the function of Moorhaven hospital. All these were lengthy sessions and plenty of time was left for questions and discussion. The Matron, Deputy Chief Male Nurse and Head Occupational Therapist took part in a symposium on "Meeting the Patients' Needs". At another session, six members of the group each described their role in the hospital organisation. This enabled all the members to comment on the strong and weak points of those departments and discuss the reasons for them.

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Interviews with nine patients by the two group leaders proved to be one of the most useful sessions. The patients were selected to represent recent admission medium and long stay patients, and some on the point of discharge. They related their experiences of anxieties and fears about coming into hospital; the desperate need for candid explanations before admission and reassurance on arrival in a strange environment.

We heard their views about introductions to staff and other patients and the first meeting with a doctor. Above all, they expressed a feeling of relief on receiving help. They talked about the hospital catering; the amount of privacy available on admission, as compared with longstay wards, and facilities for keeping personal possessions were mentioned. They discussed social problems concerning the treasurer's department; and for the benefit of the engineer, commented on noise, lighting and heating. The value of this session lay in the way in which it was clearly demonstrated how the staff of each department can contribute to the well-being of the patient. It also gave those members of the group, not responsible for direct care, an insight into the effects of illness upon individual patients.

In the final session the group were left to assess the value of the course and consider attitudes and communications within the hospital setting. They appointed a rapporteur and subsequently, prepared a report which was presented to the hospital management committee.

The substance of the report was that the conference had met a long standing need for such a group of staff to meet and discuss common problems with colleagues of other departments. They liked the informal atmosphere which helped them to express their views more freely. Although the theme was the function of the hospital, it soon became apparent that its successful functioning was the immediate concern of all the members of the group, and any improvement in staff efficiency and job satisfaction, must indirectly be of benefit to the patients. The group reached some firm conclusions such as an orientation period being of value to all staff and not just doctors and nurses. The importance of team work should be emphasised and all who have a contribution to make should be made aware of it, although it was obvious the glamour of the work tended to be associated with nurses and doctors. It was of great value to get an insight into the reasons for the anti-social behaviour of some patients so the tolerance of all staff could be improved. Although everybody seemed to feel that communications within Moorhaven were fairly good, there were weaknesses, and these should be studied with a view to improvement. This could be done by an interdepartmental committee of some kind which could meet at regular intervals. The question of counselling of staff was thought to be very important. This should not be left to chance and it should be recognised that people often preferred to refer their personal problems to somebody in another department.

The final conclusions were that staff in all departments of the hospital like to identify themselves with the successful functioning of the hospital and have a strong sense of loyalty towards it. The group were pleased they had not been bogged down with petty matters, but were really trying to understand how they could develop the concept of an enthusiastic co-ordinated team with a single purpose. A final suggestion was a follow-up one day conference after six months.

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The Follow-Up Session

The follow-up session was attended by all the original members of the group, and at least one member returned from holiday to take part. There was satisfaction with the Hospital Management Committee's reaction to the group report on the four day conference and a review of happenings in the hospital over the previous six months seemed to show that some suggestions had been taken up and there was really a feeling that interdepartmental understanding had been increased.

Most of the discussion centred round the suggestion of an interdepartmental committee. Some felt this should be purely a representative committee. Others thought an elected body would soon get overloaded with matters such as Conditions of Service. However, an attempt was then made to define the aims and objects of such a body with the following results:-

(a) An interdepartmental committee or conference would be of value especially as an aid to management in considering specific problems and producing ideas for discussion and consideration.

(b) It should take the form of a study group and one should be set up in Moorhaven hospital.

(c) The study group should not make policy decisions, this being the function of top management, but offer advice on the implementation of policy decisions.

(d) It should undertake detailed studies of specific problems and particular aspects of internal administration e.g. the study of a topping-up system for cleaning and chandlery supplies.

(e) The group could also study and report to heads of departments and the Hospital Management Committee on ideas and suggestions put forward by staff and patients to increase efficiency, improve economy and smoother running of any departments.

(f) They should co-opt when necessary other people who could assist the study group.

The members present offered to continue as the First Study Group for the experimental period, if the Hospital Management Committee agreed, and they expressed a wish to retain the two group leaders and the rapporteur.

On December 21st, 1966, the Hospital Management Committee discussed the above mentioned proposals and they gave their approval for setting up an Informal Study Group. They asked for a report at the end of six months and for recommendations on future mixed staff conference, for the benefit of as many staff as possible.

On February 8th, the group met again. They received the Hospital Management Committee's approval to work on the lines suggested. It was decided to make a small list of subjects for study and the priority they should receive. A topping-up service of all possible supplies was thought to be the most important, but its wide implication had to be considered fully. As an experiment, the Catering Officer would try out the system with dry stores and sundries for a selected group of wards.

The next subject was smoking. This arose from the recently circulated Statement made by the Minister of Health in the House of Commons on January 27th. A meeting of the Chief Officers of the Hospital would soon be considering

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the subject and the group felt they could offer some help. They would meet in a fortnight, invite an independant doctor and the County Adviser on Health Education, and in the meantime, seek the views of as many people as possible. It was also agreed to consider the system of hospital staff retirement gifts and whether long service should be recognised by the Hospital Management Committee in some way.

In response to the Management Committee's request, it was decided to recommend an annual mixed staff conference for staff from all departments. The study group would draw up a three day programme. One of the study group's leaders, together with another member of the group, would run the conference and in this way the technique of group leadership would be experienced by a fair number of people in due course.

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12 UPGRADING HOSPITAL BUILDINGS

(i) THE UPGRADING PROGRAMME AT STANLEY ROYD

S.W. Smith, Group Secretary, Stanley Royd Hospital.

The oldest part of Stanley Royd Hospital was built at the beginning of the 19th Century, being opened in 1818. The hospital today accommodates between 1,800 and 1,900 patients. It was a typical old lunatic asylum built when the function of such institutions was purely custodial.

It has, since the inception of the National Health Service in 1948, been administered in a group of hospitals which includes a large 600 bedded general hospital, Pinderfields General Hospital. These two hospitals are situated adjacent to each other but are run as entirely separate units.

The improvements which have been carried out at Stanley Royd since 1956 fall into two categories. The first are those in the wing of the main building of the hospital accommodating female patients. These have been done as a major capital scheme in five stages, the fifth of which will commence this month and will complete the reconstruction of this part of the hospital. This work has involved the complete gutting of the buildings and re-building inside and will have cost on completion approximately £500,000 including the cost of refurnishings. The construction of the building lent itself to being dealt with in this way as the exterior walls were very sound and well built. The building is three and four stories high. This part of the hospital will accommodate 500 patients. The result is most satisfactory and certainly very much cheaper than completely new buildings. The ward areas are now all served by lifts and are broken down into small sections with glazed partitions for easy observation of patients when necessary, together with adequate lounges, quiet rooms and dining rooms. New bathrooms, toilets, utility rooms, kitchen, Nurses' stations, changing rooms, visitors' rooms etc. have all been provided and the accommodation could easily be used for the nursing of other than psychiatric patients if this was ever required, in fact some of these wards are now used for psychogeriatric cases whose need is as much for physical care as psychiatric treatment. The building has been transformed from a dark, dingy depressing place rather similar in appearance to a prison, to a light, modern attractive hospital.

The other part of the work has been carried out as maintenance expenditure, at a total cost of something approaching £200,000. In this category, work has consisted in some cases mainly of upgrading of sanitary annexes etc., but in others more recently/complete upgrading of a block including new windows, electrical rewiring, new central heating system and complete reorgainisation involving a total expenditure approaching £40,000 on one scheme. In this we have aimed at a standard comparable with the capital scheme.

In the early stages of the maintenance schemes an endeavour was made to try and spread the expenditure over as wide an area of the hospital as possible, but recently we have tended to concentrate on schemes of a higher standard in a smaller area.

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Although there has been considerable expenditure in the past ten years and many parts of the hospital are now of excellent building standards, there is still much to be done but there is no part of the hospital which has not received some attention. Progress is not as fast as we would wish, but we are controlled by the amount of money which we can spend and also by the fact that the treatment of patients has to continue and, therefore, the amount of space which can be liberated for the builders without severely restricting the work of the hospital is limited.

In addition to the upgrading there have been some completely new buildings of various types, including a new Occupational Therapy and Day Centre opened in 1964, and buildings for Industrial Therapy work. The cost of these is not included in the figures which I have quoted.

Time does not permit me to give more details of the work carried out. Dr. Fletcher will describe how he believes the upgrading of buildings has helped the patients and improved their treatment.

(ii) UPGRADING BUILDINGS AND PATIENT CARE

P.F. Fletcher, Physician Superintendent, Stanley Royd Hospital.

The effect on patients of improvements in their structural environment cannot be separated from the beneficial effect of greater freedom, changed staff attitudes, and the use of tranquilisers, but an improved environment is a necessary part of any programme to combat degradation, violence, destructiveness and suicide and to promote good behaviour and social self-reliance. The patients' physical environment must be acceptable to them so that their co-operation in treatment can be gained. Recent admissions expect and accept good conditions and are a lot easier to manage than they used to be when physical conditions were poor but it is in the long stay patients that the effects have been most evident. At first they thought it was wonderland and it was a stimulus for them to take more social interest and concern in their personal appearance. Sitting in a nice lounge they wanted to be nicely dressed. Respect for their surroundings led to increased self-respect and a marked reduction in destructiveness, although there is much more glass, flowers, curtains and carpets about.

After being impressed at first, the patients have come to accept everything and by going out of hospital more often are able to relate hospital conditions to normal conditions, so that carpets and curtains and easy chairs are no longer wonderful, but accepted as a social right, giving them dignity and promoting their social rehabilitation. They feel less like second-class citizens, so that, given freedom, they can cope with normal conditions without feeling inferior or at a disadvantage. The first wards upgraded were envied by other wards and enthusiasm arose to emulate them. Patients' exchange holidays have helped this process of keeping up with the Joneses.

Patients' visitors now find the hospital more pleasant and are coming more often, whereas previously visiting was an unpleasant and off-putting experience. Their interest in and hope for their patients has been renewed.

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An unexpected bonus from structural upgrading has been that a great many contractor s workmen, over a long period, have been interesting their friends and families in the hospital's improved condition, which has helped to remove local prejudice and fear,

Sub-division of wards into small units of thirty to forty patients has enabled much better classification of patients and has provided a higher degree of nursing attention. It has also made it possible to provide each consultant team with a complete set of wards. Single rooms are much prized by ambulant long-stay patients as they afford privacy and a place to keep their possessions properly. Samuel Tuke's design for the original hospital, opened in 1818, provided a single room, not a cell, for most patients. All padded rooms have been taken out so that they would not be used.

The provision of small lounges off the main day areas gives much appreciated peace to patients who want to write a letter, read a book, or just get away from the general noise and the television.

Upgrading of ward kitchens has been standardised to provide, among other things, facilities for boiling eggs and cooking snacks as well as the placing of water geysers to make tea in pots for each table for four, instead of tea urns from the main kitchen. These amenities have encouraged patient and staff attention to the quality of ward service of meals, so that cake stands, water jugs, coloured table cloths etc., have steadily appeared.

Urinals have been provided in sanitary annexes throughout for men and the floors in more chronic sanitary annexes have been found to need impervious and durable materials, for example, terazzo or concrete, which can be swilled down to an open drain. Cork or other floor tiles do not stand up for long to this treatment. Cubicle curtaining round baths and female wash basins have been appreciated. Mirrors have been widely provided and electric shavers provided in male annexes and wards.

We had a big problem with the wide-spread use of chamber pots at night. This was overcome by providing toilets adjacent to dormitories and where the problem was in a block of six single rooms, by converting one side room into a toilet and putting handles on the inside of the side room doors for free access by patients; this has helped the patients greatly to overcome degradation and discomfort at night.

Lifts have been provided for the main building as it is on three and four floors. This makes life easier for the ageing patients and enables them to get out for exercise and fresh air where stairs would have made this impossible for many. Meals are now brought to the wards without having to be manhandled, in containers up staircases. Food hoists are being provided in isolated two-storied blocks which do not have lifts.

Where the architect has not chosen the colour scheme the choice has been left with the ward nursing staff. High gloss paint and light colours predominate but a great deal of wallpaper is used, being less bare and clinical and more home like.

Staff changing rooms have been provided in proximity to all wards - a very important amenity.

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Windows have had special attention, as small windows with many glazing bars contribute greatly to the prison-like appearance of the older hospitals like ours. Large picture windows, especially with flowers on the inner sills, make all the difference to the external appearance of the buildings and patients appreciate the improved view and light and treat the glass with respect being much more inclined to smash small "economical" panes, which used to be standard when patients were not trusted to the extent they are now.

Occupational therapy and industrial therapy accommodation has been progressively extended. It is no good giving patients freedom without organising work for them. There is something wrong with a hospital which has more than a few patients in the ambulant wards during working hours. Getting the maximum number of patients out to work and into the work habit improves their general behaviour and prevents degradation of personal habits. We do not see obvious catatonic schizophrenics now, partly due to tranquilisers but also through stimulating interest and activity. Nor do we see patients sitting in wards in a state of incontinence.

The problem of breaking the airing court habits of large numbers of patients, especially the males, was first dealt with by the provision of adequate accommodation for work but it was found that they drifted back repeatedly, so we took down the railings so that nurses simply had to see that they went to O.T. and ensure that they stayed there until they got into the work habit. Incidentally, when the patients stopped endless shuffling round airing courts the need for shoe repairs fell dramatically. Airing courts have become pleasant unfenced ward gardens.

We first opened and then removed the main gates. We have moved from concern for peripheral security to stop patients absconding, to concern about thieves coming in and burglaring departments. Indeed, we recently had to put bars on the hospital shop windows, having for years been removing the trappings of safe custody from the wards and the hospital generally. Perhaps we have reached a point of social rehabilitation where behaviour of the hospital community is better than that of the outside community.

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13 UPGRADING HOSPITAL BUILDINGS

M.D. Groves, Group Secretary, The Towers Hospital.

When the invitation to originate discussion on this particular topic was received from the Hospital Centre, the first reaction at the hospital was the appreciation of the fact that we had achieved nothing spectacular or novel. In preparing these notes I have been all too conscious that the reader is likely to comment on this lack of anything novel and will probably say "so what" to everything I mention.

However, having completed a five year programme of change, we have already begun to look again at the hospital, to assess whether what we have done is sufficient to meet present day needs; for we feel that critical evaluation and consequent improvement must be a continual process and we have so far only completed the first round. This is why we appreciate the opportunity of exchanging experiences in discussion groups, so that we may learn from others, hear their ideas and of their innovations and apply ourselves to the further task ahead, armed with further knowledge.

It is pertinent to refer to the composition of the group of representatives of the Leicester No. 3 Hospital Management Committee who accepted the King's Fund invitation in June 1966, to discuss common problems in mental hospitals. Our group was not composed of those members and officers who could be spared, happened to be available or felt that they would like to attend. We were members of a seminar group currently participating in discussions which have been inaugurated by the Sheffield Regional Hospital Board on an areas basis to discuss "Management Problems in Hospitals" and the Hospital Management Committee have asked us to act also as a study group and working party and to include in our field of study a second review of the contents of the Ministry of Health Circular HM (64) 45 and use it as the basis for an audit and evaluation of how the hospital, and the service which it gives, measure up to demand and the criteria set out in the Ministry paper. You can appreciate therefore, that we have a very particular interest in discussion relating to HM (64) 45.

The topic of "The Upgrading of Buildings" is dealt with in the concluding paragraphs of this circular. It follows reference to all the other elements essential to the creation of a good and comprehensive psychiatric service. The Ministry gives a reasonfor this, the necessity to define first, the therapeutic needs of the patients. I feel this is significant for when we think about it, the state of the buildings is only the backcloth against which all the other elements stand out.

A surgeon can operate anywhere (they had to do so in wartime) and likewise, a psychiatrist can practice anywhere, but just as a modern well-equipped operating theatre enables a surgeon to practice his skills most effectively, so also the quality of the surroundings in which the psychiatric patient find himself when he has to come into hospital for treatment, is an essential aid to the fully effective practice of psychiatry.

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With out-of-date, dingy accommodation and its resulting drabness, standard of effectiveness can still be achieved, and yet accommodation which is "institutional" (and we can all conjure up the picture and odour of the meaning of that word) cannot but discourage the medical and nursing staff in the performance of their duties and must also make the patient and his or her relatives feel that there is stigma attached to the treatment of mental illness in hospital.

In a psychiatric hospital with its many tensions, a high morale amongst both staff and patients is of fundamental importance and the provision of pleasant surroundings goes a very long way towards creating the environment in which is fostered a "climate" which is conducive to effective treatment. In speaking of the morale of the staff and patients, we must not exclude the morale of the relatives who visit the wards and on whom the quality of the surroundings in which they leave the patient at the end of a visit must have a deep and perhaps lasting effect.

At the Towers Hospital, the period of six years from 1959 onwards has been one of change in many spheres; where necessary the tempo was accelerated, in other directions "evolution" by gradual processes has come about. This paper is restricted, however, to the various aspects of improving old buildings. I have referred to this as a "background" task and this is how we looked upon the upgrading of the old wards at the Towers Hospital - the backcloth against which all the other changes and improvements have been carried out. It was not allowed to dominate the other important facets, it dictated nothing but with its constant periodic movements of ward populations it went on relentlessly, everyone lived with it, accepted it and endured it.

It is perhaps worthwhile reminding ourselves briefly, of the problems which faced us all at the onset of the National Health Service and of those factors which militated against our carrying out, in the years immediately subsequent, desirable improvements which could be "seen" as such. The war had prevented all except the most essential repairs and in the immediate post-war years controls on materials had restricted the "back-log" being overhauled - we "made-do". When finances and materials were available, basic essentials (the replacement of worn-out boilers, electrical rewiring to obviate the very real fire hazard which existed, the extension of heating services and major roof repairs) determined priorities.

Even if money had been available, we all had our overcrowding problems, which precluded the evacuation of wards and restricted upgrading to the limited work which could be carried out, more often than not whilst patients still lived in the wards.

As in most psychiatric hospitals, this was the situation at the Towers Hospital when the Mental Health Act of 1959 came into force, introducing informality of admission and discharge with a resulting decrease in the patient population, which, although not eliminating overcrowding, gave a sufficient degree of manoeuvrability to allow hospitals to think in terms of major upgrading. Plastic surgery, as it were, had become possible instead of the former camouflaging of the blemishes with a covering of cosmetics.

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The Exhibition of 1951 "Britain can make it" brought in its wake a "New Look" to the range of materials and fittings available in the building and engineering field. This and subsequent developments widened the scope for the people engaged in modernisation of old buildings. One only has to think back to the early 50's when the new emulsion paints were perhaps one of the few highlights, to appreciate how the horizons have been stretched.

The situation which faced us at the beginning of 1960 was a hospital population of 956, the recognised statutory accommodation of the standard prevailing at that time being 820. The buildings covered two distinct areas, the original hospital built in 1870 on three floors housing 553 female patients and the nine wards built as a duplication of the hospital in 1903 accommodating 403 male patients.

At the outset the Committee realised when assessing the problem that it was confronted with two distinct problems of differing magnitude. They decided that it was desirable to formulate two programmes, the more modern buildings would be given a face-lift by the maintenance staff. Services and kitchens were to be modernised where this had not already been done and all distasteful aspects illustrative of the pattern of patient care at the time the buildings were erected eliminated. The direct labour force (which was not large) would be augmented by specialist firms for plastering, floor covering and other work which had to be "put out" to contractors. The major task, the old block, was to be placed in the hands of an architect and firms of contractors invited to tender for each phase of the work.

It was imperative, if we were to achieve the target which we had set ourselves, that the two attacks should progress according to the five-year programme we had set.

We realised that it was essential to foster and retain the interest of the staff who were to carry out the work in the direct labour team and to establish the tolerance of nursing staff concering the embargo which we placed on minor day-to-day repairs, which can so easily dissipate the full potential effectiveness of an enthusiastic labour force. The tradesmen were brought into the picture at the earliest possible moment; they knew of the programme and they realised that the time limits were ambitious. The foremen met in my office every Thursday morning with the group engineer and building supervisor, and in thirty to forty-five minutes we ironed out problems, brought to light delaying factors and overcame them, ensured that all materials on order were coming in and began talking about the next phase as soon as possible. Then we looked at the mounting repair tickets and worked out on which days a particular trade could be spared from the major task to tackle repairs in other wards. We had arranged previously that only repairs personally authorised by the head of the department requesting them were carried out immediately. Success was due, I feel, in no small measure to the involvement of the maintenance staff in everything. When they had completed their first ward, their status around the place was enhanced; there was now something which could be seen to have been done, and done very well.

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Owing to restriction on capital works, structural alterations were minimal, but heating, rewiring, lighting, flooring, kitchen repairs and the replacement of old fittings with ones of modern design together with refurnishings were all included.

A brief note on the procedures which we adopted in deciding the alterations and improvement which we would undertake might be of interest. The charge nurse of a ward was asked well in advance to discuss with all the ward staff, including the domestics, the deficiencies of the ward from the functional aspect. They were asked to exclude nothing which they thought worthy of inclusion. These items were discussed on the ward with ward staff by the nursing officers, group secretary, group engineer and building supervisor, the medical staff having been involved in the compilation of the list with the charge nurse. At this stage we explained the reasons why certain ideas could not be implemented. The final pruned lists were given to the nursing, technical and administrative staff, and adopted. No alterations or additions were allowed unless they were well worthy of inclusion. The charge nurses quite often acted as an auxillary clerk of works, being seen ticking off the items on their list as they were completed.

The programme for all the wards have been formulated, these were made known to everyone. When the tradesmen went into a ward the charge nurse of the one which was next in the programme already had his list ready, without being asked to do so.

The old female wards which we were to put in the hands of an architect and building contractors presented a different problem. The male wards at least were all self-contained ward units, whereas on the old female side where the degree of overcrowding was greatest, the architectural defects and lack of essential services in some areas "cross-bedding" had been lived with for many years. In other wards a great number of those who lived by day on the ground or first floors trekked with their belongings to the top floor every night to sleep in one large domitory which possessed no toilet facilities and only limited heating. Ward bathroom accommodation was deficient, but some distance from the wards was the female general bathroom which, at the first opportunity (in 1963) was put out of use and is now a flourishing physiotherapy department. Our plans had to provide for the complete re-division of areas to create self-contained ward units to accommodate where possible a maximum of 32 patients.

Although at this stage we had no overall plan to work to, we started work on the first ward which was to be modernised in this very radical manner. It was useless to attempt to look at the existing structure as a guide but we chose as our first ward one which was already self-contained. We discussed with the architect the standards we wished to incorporate. Medical, nursing, administrative and technical officers looked at the plan which the architect produced. Six copies were made available for study by all medical and nursing staff concerned, a meeting took place with the architect, a further plan was produced then a fortnight was allowed for further study before the plans were submitted to the Committee.

In spite of the fall in population in 1959 and 1960 the wards were still overcrowded and we were faced with the problem of fully vacating a ward for a period of six months and having one continually vacant for a period of five years or so. The purchase of forty folding 'Z' beds, which during the day took up a very small space when not in use, enabled us to use certain day areas as sleeping quarters at night. The building of a new occupational therapy department allowed the old department to be used as a dormitory.

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We had reached the stage where both programmes were now "off" the ground. We planned in detail the next ward to be upgraded so that there would be no delay between the completion of one contract and the commencement of the next and then began to prepare the overall plan so that when modernisation was completed all our work and the many moves which were to take place fitted into the ultimate pattern of things.

In 1959 the medical staff had formed themselves into three clinical teams each with responsibility for a third of the beds of the hospital and this factor played no small part in the pattern of our planning. It was evident that the pattern of function of the hospital in future years should not be dictated by the historical division between the sexes but should take into account the distinct and differing needs of the acute and long stay chronic patients. The geography of the hospital lent itself admirably to the development of the former female wards as an 'acute treatment and medium stay area' and the other side with its more spacious wards on two floors as the 'long stay area'.

The revised standards of accommodation for each patient and the estimated bed needs of future years were factors which had to be taken into account and it is an interesting fact that the estimated number of beds we would require in the 70's was in the region of 610 and the total patient space available according to revised standards was in the region of 600 to 620, even allowing for the classification of patients by sex and type.

A planning brief to provide an acute treatment and long stay rehabilitation side was prepared as a basis for discussion. The acute area would have a male and female admission ward for each team on one floor with supporting medium-stay wards and the new occupational therapy department in close proximity. The long stay side was to be supported by industrial workshops in accommodation made available nearby.

We now knew where we were going and how the hospital would function at the end of the programme. The overall plan was made known to everyone and they would watch the moves in the re-organisation as they took place and be prepared for when they themselves would be involved.

In our planning of these projects it was realised that too often too much time can be spent on elaborate planning and that quite often a third look at something only led to indecision. One can spend a year on planning and produce a result which will still have as many imperfections as would have resulted if plans had been adopted after the second revision. We felt that "time was the essence" and that after the second discussion stage there would be no further amendments but that any worthwhile suggestions would be incorporated in the plans of the next ward. We would learn from experience and put what we learnt into practice and live with our minor mistakes and imperfections.

One of our early and I think major decisions was to avoid fixing for all time the future use to which any specific area could be put. We therefore provided for night lighting everywhere and decided against over-bed lights which would always determine the use of that area as sleeping accommodation. On every L shaped ward we duplicated the toilet facilities on each leg so that we could divide these wards into two if we wished, at a later stage. There was a common ward kitchen at the apex of the two legs. Having cursed our predecessors, we did not want to be cursed ourselves by those who follow us.

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Our yardstick for standards was a simple one, subject to medical advice, we asked "What would be expect if we ourselves became patients?". Our aim was to give every patient a space of his own in a small group of four or six, and as we went along we developed what is now known as "the Towers unit" comprising a divan bed, a wardrobe and locker combined which also acted as room dividers to break sleeping areas into small units. We limited the number of hospital type beds to meet assessed need.

The problems we met were never insuperable and we met no real crises. Certain precautions had to be built in on the acute admissions wards especially those on the two upper floors for we had as basic policy, decided to replace every window with its numerous small panes of glass of various shapes and sizes by modern and to introduce large picture windows wherever we could. We decided to take precautions against impulsive suicide attempts and the possible accident by fitting armoured glass in the large window areas and fixing the opening of those windows which afforded an easy means of egress. We wanted to replace the stable door type of lavatory doors with ordinary type with"vacant" and "engaged" signs and still allow supervision where necessary. We managed to procure door fittings which could be operated by the nurse with a small key, which was not noticeable as it was built into the door closing attachment. We wondered at first about the large areas of glass dividing certain rooms or areas of rooms, but none has yet been smashed, even accidentally; in fact, we now fully realise that the better the standards you introduce the more economical they are in the long run, for they are appreciated and respected.

All too sketchily have I attempted to cover the important aspects of five years of modernisation, the background to all the other improvements which were taking place in so many directions. We had, also in the Group, seven other establishments accommodating nearly 1,000 mentally subnormal patients and our programme had to ensure that all our resources were not concentrated on the psychiatric side of the Group. We had to ensure that these other hospitals reached a comparable state of improvement at the same time.

Looking back I feel certain that we achieved what we did primarily because of the following important factors:-

1. Communications: the involvement of everyone concerned, seeking their opinions, listening to their ideas, acquainting them with the full programme so that moves could be anticipated.

2. Delegation: giving as many people as possible authority to act in their respective fields within the framework of accepted plans.

3. Broad Plan: the setting of accepted basic standards, but allowing flexibility where possible in all other matters.

4. Time: setting seemingly impossible targets, and achieving them. Allowing no major discussions on matters of minor importance and being so implicated in planning the next phase that the one in hand was left entirely to the people responsible for carrying it out.

5. Leadership: taking decisions or ensuring that someone else did.

In conclusion, I would like to say that if a group wish to tackle this type of problem, they will find they need enthusisam, a realistic approach and willingness to invest a lot of time. If they keep everyone in the picture and take people with them in their consultation, they can set a programme calling for a dynamic approach and a strict timetable that after a short while can be left to the people they had involved while they can start looking at the next task to be undertaken.

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DISCUSSION AND CONCLUSION

DISCUSSION

The problems and difficulties of the National Health Service are well-known. They have frequently been described, discussed and theoretically solved. Shortage of money and manpower, old decaying hospital buildings, out-dated equipment, a cumbersome administration and a tripartite structure are some of the usual reasons given for its short comings. In the discussions that followed the papers at the two meetings, these and many other real and imagined obstacles to improvement were mentioned. Some claimed the recommendations in the Ministry of Health circular were completely unrealistic, since they could only be implemented if much more money and staff were made available and the administrative structure of the service radically changed. It was said that a disproportionately small amount of money was spent on mental health and psychiatric patients came off a very poor second best when the resources of the health service were allocated.

The tripartite structure of the service was criticised by many and the discussion clearly showed that in fact more than three divisions existed and too often created artificial problems and barriers. A number of speakers said it was difficult to develop a close relationship with general practitioners and local authority workers. One psychiatrist claimed that few general practitioners showed interest in psychiatry or their local psychiatric services. He had invited the local doctors to his hospital on many occasions but they never came. In some areas the ambulance service was unable or unwilling to provide sufficient transport at the right times to make day hospital care work. When a hospital had a large catchment area which included a number of local authorities and widely scattered general practitioners, all the disadvantages of the tripartite system were accentuated. In some places the same difficulties were experienced in communication and co-operation between different sections of the hospital service as between the hospital, the general practitioner and local authority. Local authorities also had problems with their own sub-divisions which in turn had repercussions on the hospital and its community organisation and the patient.

Many conflicting views were expressed about the place of voluntary organisations and voluntary workers. The staff of some hospitals obviously distrust everyone except professionals whilst others welcomed help whatever the source. The need was mentioned for a full time paid voluntary work organiser in each hospital who would recruit and place voluntary workers in the hospital and liaise with the various community voluntary organisations. None of the hospitals represented had any experience of this type of organisation but the general opinion was that it would be the only satisfactory way to utilise the considerable source of willing if unskilled help available in most communities.

One speaker said that the health service and particularly the mental health service would always be short of money since there was little public pressure on any government to provide more for this public utility. People tended to ignore ill health until they became ill. The shortage of all types of staff was said to be world wide and likely to remain so in the forseeable future.

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The negative comments and explanations why changes could not be made were well countered by positive suggestions in line with the majority of the papers that had been read.

The staff of one hospital described how a programme of upgrading buildings resulted in improved communication and morale within the hospital and an increased understanding of what the hospital was doing by the local community. These changes occurred while there was still material chaos and were not due to the physical improvements per se.

The disturbance and upheaval produced by the work made different grades and types of staff discuss their difficulties together and showed them how problems could be solved when solutions had to be found. The influx of building workers improved the hospitals image in the community because they saw what a mental hospital and psychiatric patients were really like. This corrected their preconceived ideas and fantasies based on popular fictional concepts of madness and in turn they were able to influence their relatives, friends and acquaintances.

A representative of one hospital suggested patients and relatives should be allowed and encouraged to play a more active role in the planning and running of psychiatric services. They were the customers and should at least have some say in what has been done for them. Relatives conferences and patients meetings and committees were not enough. Each hospital should have an advisory panel of patients, relatives and other members of the public who could put their views and ideas to the management under conditions in which they would be given serious consideration and implemented wherever possible.

CONCLUSION

The papers read at the meetings have demonstrated what hospitals can do to improve care of patients in and out of hospitals. There have been examples of what can be done when money is made available and what can be done without either extra money or personnel. The papers from Nayburn Hospital and Moorhaven Hospital are good examples of the latter.

An important feature of the presentations is that they are not the work of experts who have devised some new method of treatment or system of administration but the description by ordinary workers in the various branches of the psychiatric service of what they are doing to improve their services in its day-to-day functioning. Other workers in psychiatry cannot excuse their own short comings by claiming that what has been described is the result of special experimental conditions not applicable to the realities of the normal hospital and community. Lack of money can prevent hospitals upgrading their building and developing new outpatient departments and day hospital facilities but all the other changes and improvements described are possible anywhere provided personnel are appropriately motivated and given freedom to involve themselves in developing new ideas.

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The value of meetings at which people describe what they are doing and discuss mutual problems is difficult to assess but accumulated evidence does support their usefulness. The meetings described here not only brought together representatives from different psychiatric hospitals but also offered an opportunity for cross discipline exchange of views and ideas. Psychiatrists, psychologists, nurses, administrators and social workers were represented. Some who attended learnt something new about their own hospital because of this mixture of staff. Perhaps the range of representation at the meeting should have been extended to include technical and ancillary staff.

The development of an effective psychiatric service depends upon the contributions of workers in many different disciplines and their ability to work together and communicate with each other. Each hospital has to identify their own problems and devise their own solutions, but often these solutions have a more general application. Meetings at which all types of personnel from different hospitals and associated services can informally discuss what they are doing and trying to do must be of value to staff, patients and the community.

It should be possible to arrange regular meetings like the ones that took place at the Hospital Centre in 1966/67 in each Region of the country. If these were organised in different hospitals on each occasion their usefulness would increase because description and discussion would be reinforced by seeing what was being done. Such meetings could play an important part in raising the standard and increasing the effectiveness of all psychiatric services.

IMPROVING THE EFFECTIVENESS OF THE HEALTH SERVICE FOR THE MENTALLY SUBNORMAL

PART II

IMPROVING THE EFFECTIVENESS OF THE HEALTH SERVICE FOR THE MENTALLY SUBNORMAL

Wednesday, 11th October, 1967 and Wednesday, 15th November, 1967

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PART II

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INTRODUCTION

The Ministry of Health circular (H.M. 65 - 104) concerned with hospitals for the subnormal (see Appendix II) deals firstly with various types of patient who may need either hospital or local authority care, and stresses the general aim of enabling the patient to return to the community, whether to live independently or with support. The desirability of close links with various community services for purposes of diagnosis, assessment and counselling is emphasised; and contact with individual members of the community, whether through relatives, social organisations or voluntary helpers, should be encouraged, to broaden the patient's horizon.

After discussing the provision of day hospitals the circular suggests that, within the hospital itself, the aim should be the development of self-confidence, self-reliance and self-respect. Training in educational, vocational and social spheres should be available for all age groups, to promote the fullest possible development of the individual's capacities.

Finally, research and teaching should be encouraged, not only within the hospital but also in conjunction with local authorities, with University Departments and with Medical Research Council centres.

At the two meetings held at the Hospital Centre, thirty-three subnormality hospitals were represented by a wide range of staff.

Speakers were asked to give their experiences in trying to implement the Ministry's recommendations: to describe the outcome of their attempts and, if these had been unsuccessful, to suggest possible reasons for this; and finally, to assess the effect on their hospital.

Most of the papers are included in this report and they have been grouped according to the specific aspect of the Ministry's recommendations which they discuss. The subjects fall into three sections: - research; further education and training; and community links.

One or two of the papers have been enlarged from notes supplied by the speakers, or slightly curtailed for compactness: every effort has been made to preserve the speakers' ideas and presentation of their subject.

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1 RESEARCH

Dr. T.S. Davies, Physician Superintendent, Llanfrechfa Grange Hospital.

When a new hospital for the mentally subnormal was built near Newport in Monmouthshire six years ago, it was done on a very luxurious and lavish scale and no care spared in providing every facility for training and adequate nursing care for the patients at a cost of nearly one million pounds. But I found that no provision had been made for investigation and diagnostic procedures to be carried out at the hospital: in fact, the total equipment provided for this purpose cost very little, consisting of that which might be found in any general practitioner's surgery. This represented the thinking which went on in regard to the scientific investigation of mental subnormality in hospitals when this one was planned ten years ago. When I pointed this out to the Regional Board they quickly saw the point of providing adequate facilities and asked what I thought should be incorporated in the subsequent stages of planning.

At that time much new and existing work was being developed in research laboratories and I thought that it would be a very useful exercise if, firstly, we investigated the feasibility of installing closed circuit television in some of the wards and workshops. This would provide an objective means of observing patients' behaviour, and it would be a useful tool for investigating the response of patients to new drugs and new forms of treatment, without having to rely on the observations of the nurses. (Many at the time were assistant nurses and not highly skilled in observing unusual reactions in patients, such as dystonic reactions following drug therapy). We thought also that it would be useful for case conference work, for psychological studies of autistic children and possibly for observing the relationship between patients and their parents on visiting days.

When the apparatus was installed the nurses became extremely apprehensive and after some discussion it was agreed that the television would not be switched on without first warning them. These fears have proved to be quite groundless and we have never had any objections, either from the nurses or from the patients. The apparatus installed consisted of four cameras, remotely controlled, each capable of panning and tilting, so that patients could be followed about the ward if they were very over-active. There was also a remote control zoom mechanism so that a patient could, in fact, be optically isolated from others in the ward, and observed as necessary.

Since then we have developed two other uses for this apparatus, firstly by the addition of a Video tape recorder whereby films can be made of anything of clinical or academic interest and played back immediately; secondly, we have developed a technique, in its experimental stages at the moment, for linking hospitals together so that doctors in one hospital can present a case or cases to doctors in another hospital, and ask their advice in specialised fields. For instance, we would often like the advice of a Paediatrician in some unusual case, or possibly a surgeon or physician, and this may well obviate the necessity for a specialist coming long distances. He

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may suggest various forms of investigation which may either save him coming or delay his advent until these investigations are available to him. There is no difficulty from a technical point of view of inter-linking hospitals but, at the present time, it is expensive if done by the G.P.O. who, in this instance, asked for £4,000 a year for a land link. It could be done by micro wave at a cost of the same amount, but that would be a once-and-for-all payment. I think the use of television may be a means of bringing together many specialists of different disciplines quickly, and overcome one of the greatest difficulties which medicine and science in general are encountering, in how to inter-connect many specialised forms of knowledge in the shortest possible time.

Secondly:- in view of the great interest which the study of human chromosomes had excited, it was decided to establish a small chromosome laboratory. With the help of the chromosome unit at Penarth a technician was trained, and the first venture was a mass survey of all the patients in the Subnormality Hospitals and also in the Psychiatric Hospitals and Training Centres in Monmouthshire. This proved very successful. We discovered six chromosome anomalies which had not previously been suspected, among them two very uncommon conditions in which the patient had two 'Y' chromosomes.

Thirdly:- a small unit dealing mainly with trace mineral elements was set up to investigate the levels of lead and copper, in view of the interest aroused concerning lead poisoning in children. This unit investigated the lead levels of thirty-two children and found six with very high levels amounting almost to lead poisoning. In these cases the lead was removed and in two cases there was some improvement in intellectual ability. We have also had a grant from a University to establish a small Radio-Isotope laboratory, mainly to investigate Thyroid function using Iodine 131. Over the past three years we have carried out 120 radio uptake studies and found several cases of Thyroid inefficiency.

The work of the Chromosome Laboratory and the Isotope Unit were then cross-correlated and we found that patients with chromosome anomalies had a radio iodine uptake curve which was very flat, suggesting that in chromosome abnormalities Thyroid function may be impaired. This ties up with much work going on concerning auto-immunity.

Fourthly:- we have also carried out a number of small investigations which require no apparatus or money. Research does not depend on vast amounts of either, but much more on the application of new ideas, or the application of the results of fundamental research to field work. For instance, because we have the facilities for doing protein bound iodine studies, when some of the patients were put on the contraceptive pill, we estimated their P.B.I. levels and found that, in all the cases, after a few weeks on the pill the P.B.I. level rose significantly. This shows that the application of investigation in this specialised field can be extended to very much wider fields.

We have also investigated the effect of Circadian rhythms as it effects the sex chromosome bodies or Barr bodies seen in buccal smear surveys, and it seems to me that there is a rhythmic variation in the number seen in the twenty four hours of the day and a variation in the number seen in the twenty eight days of the month and even over the different months of the year. We thought we had detected a difference in the rhythms of certain psychiatric conditions and this work was

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published in the form of a letter which has, as far as I am aware, never been either confirmed or contradicted by other workers.

Another very interesting piece of research which required no apparatus or finance was to investigate the effect of Lysergic Acid Dielethamide (L.S.D.) on the memories of the mentally subnormal as compared with the effects observed in normal subjects.

In conclusion:- my experience of establishing a small research unit has shown that it enhances the public image of hospitals; that the 'fall-out' - to quote an american phrase - from research is to ensure that all the patients are receiving the optimum level of treatment available; that it keeps the outlook of the staff flexible and receptive to new ideas. Research has a stimulating effect on the whole structure of the hospital staff in a field of medicine which is likely to become stagnant; and the enthusiasm engendered by such projects spreads quickly both to the relatives of the patients and to the public in the area in which the hospital is situated.

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2 RESEARCH

Dr. J. Gibson, Physician Superintendent, St. Lawrence's Hospital.

It is generally agreed that mental retardation offers enormous scope for research. One should be prepared to consider research as one of the major activities in all our hospitals. Although it is likely that advances in the subject will continue to come, as some have come in the past, from studies carried out outside subnormality hospitals - in departments, in Institutes of Psychiatry, in University departments of psychiatry, psychology, pathology, biochemistry and sociology; in paediatric and neurological departments in general hospitals; - however, the patients in a hospital for the mentally retarded offer enormous opportunities to those who have the drive and persistence to carry out such research.

In this paper I would like to tell you something of what has been done at St. Lawrence's Hospital in the last fifteen years. Before that time very little systematic research was done, if any at all; occasional papers would appear from the medical and psychological staff, but there was little else.

We have now a research service which I think is possibly the most extensive in any hospital of this kind, certainly in this country, possibly in the world, and even, one might say, in any hospital outside a teaching hospital. Most of the credit for building up this service in the hospital is due to my colleague, Dr. B.W. Richards, who has made it one of his chief activities; and it is largely due to his determination that we have done as much as we can.

The patients in St. Lawrence's Hospital - over 2,000 of them - are predominantly severely or moderately retarded; high-grade patients, for the most part, being sent to other hospitals; the hospital therefore has an enormous amount of clinical material available for investigation. The research departments we have set-up are:-

(1) Biochemistry

(2) Psychology

(3) Cytogenetics

(4) Neuropathology

I have put them in this order as this is the sequence in which they happen to have been established.

Our biochemical service work started in 1957 when Mr. A.T. Rundle, B. Sc., was appointed research biochemist. The first psychological research department attached to us has been run by Dr. Neil O'Connor of the Medical Research Council, Social Psychiatry Research Unit, Maudsley Hospital, now called the Development Psychology Research Unit. Our neuropathology department has been running since 1960 when Dr. P.E. Sylvester joined the staff. Our cytogenetics department was organised by Dr. Richards after the discovery in 1959 of the extra chromosome found in mongolism. Our position now is that we are able to offer a chromosome service to the hospital and to local paediatricians and general practitioners who require these investigations to be carried out.

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Our biochemical research investigations have recently been increased by the addition of Dr. R.G. Westall, formerly of University College Hospital Medical School with a Medical Research Council grant.

We are thus able to examine patients (a) cytogenetically and (b) biochemically in the hope of correlating biochemistry and cytogenetics. Our neuropathological research has enabled us to examine the brains and other tissues of patients after death and to link any changes that have taken place with previously established abnormalities and with the help of the psychological department to psychological difficulties discovered during life.

Papers published in recent years by the staff of the hospital have been on such subjects as chromosomal abnormalities, mongolism, anopthalmia, cerebellar ataxia and hypogonadism, juvenile amaurotic family idiocy, parietal lobe disfunction, discrimination learning in retarded children, endocrinological aspects of mental retardation, serum proteins and serum enzymes in tuberous sclerosis.

The money to carry out these projects has been obtained from various sources:- St. Lawrence's Hospital Management Committee, the South West Metropolitan Regional Hospital Board, the Mental Health Research Fund, the Medical Research Council and by private donations. We have so far been able to adapt existing buildings into laboratories for these services. The staff employed wholly or partly in research are:-

Dr. Richards in the Cytogenetics Laboratory.

Dr. P.E. Sylvester in the Neuropathology Laboratory.

Mr. A.T. Rundle, Principal Biochemist in the Biochemistry Laboratory.

Dr. R.K. Roy, Psychologist.

We have also two chief technicians, Grade 1, and supporting staff. We have also international connections and have had workers attached to our research department from Australia, United States and Poland.

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3 A YEAR'S PROGRESS IN FURTHER EDUCATION

Mr. R.G. Pitman, Chief Male Nurse, Rampton Hospital.

For many years Rampton has been developing its educational programme, and has included the teaching of social competence, to increase the degree of independence of the patient , and to enable them to live as full a life as he can. In the course of carrying out this programme we have in fact catered for the type of realistic situations and the practical application of educational skills mentioned in H.M. (65) 104.

To enable such a programme to be carried out, we have had the collaboration of Teachers, Nurses and Occupations staff.

For some time past, the Head Teacher has stressed the desireability of further expanding the programme of education and social skills, and considered this could best be done by enlisting the aid of the Local Authority's Further Education Schemes.

The Nottinghamshire Education Committee agreed to our proposals, and during the academic year from October, 1966 to July 1967, the North Nottinghamshire College of Further Education undertook to supplement our programme, with a view to providing a wide availability of both active and academic studies for both sexes.

Mr. S. Brackenbury, Head of Educational Institute, organised for our patients eleven additional evening and Saturday morning classes, to supplement our normal programme during that period. The following subjects were covered:-

Art - Crafts
Athletics
Ballroom Dancing
Cookery
Drama
Dressmaking
Folk Dancing
Music
Rural Studies
Social Competence
Technical Drawing

After registration, we found that two hundred and twenty patients had enrolled, with an actual total enrolment of three hundred and seventy-seven, as some wished to take more than one subject. This developed into twenty-eight classes additional to those already existing in the hospital, and the Educational Institute provided sixteen teachers to cover them.

The number of class-hours devoted to these eleven new subjects was over six hundred, and the patients in fact spent some six thousand hours studying at the classes during the academic year.

The new classes were well received by the patients, many of whom were disappointed when told that the programme would finish in July, until the new academic year began in September.

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Although the range of ability in each group was very wide and the standard of work very variable, we concluded by the end of the academic year that, in general, the work of the individual improved as the classes progressed. This was particularly apparent in the Athletics Coaching Class for men when, at the Patients' Annual Sports Meeting, a number of local (hospital) records were broken, including the long and high jumps, the mile and some sprints.

Reviewing the progress of this year of expanded Further Education, and the benefits for those patients who took part, we considered that there is still wide scope for the future of Further Education in the hospital.

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4 CLINICAL EFFECTS AND MANAGEMENT OF MIXING MALE AND FEMALE PATIENTS IN ALL ASPECTS OF HOSPITAL LIFE

Dr. E. Shepherd, Consultant Psychiatrist, Leavesden Hospital.

Our work in subnormality has gradually developed from the puritanical Victorian view, where there was repression of sex, and it was not discussed or allowed to "interfere" with the work of mental hospitals. At the beginning of this century there was a very positive segregation of the sexes in the hope that this would prevent propagation of defectives and gradually eliminate their presence in the community. This was a scientifically invalid argument which was rapidly disproved.

As a first step in implementing that part of Circular HM (65) 104 dealing with integration of the sexes, we found it was both necessary and desirable to commence this with the staff; hitherto they had been as rigidly segregated as the patients. Now the male and female staff have common dining and common room facilities and the Nurses' homes are no longer rigidly for male and female staff. In their work we have also been integrating the nurses. We have for a long time had females working in the male occupational therapy department and we now have female nurses on male wards and the occasional member of the male staff on female wards. The Industrial Training Unit has both male and female staff as have the sheltered workshops. If the Salmon Report is implemented, this will presumably also result in integration of the sexes in the administrative sphere.

From the patients' point of view as regards working conditions, our Industrial Training Unit was first organised as a small Unit with facilities only for male patients, but was later extended and now has both male and female patients working in the same rooms. Patients have always worked together in the Laundry as have staff, although until recently there was some segregation so that they did not work in the same area. We are now planning to merge the Occupational Therapy Departments, which currently, for administrative and other reasons, are quite separate; and it is intended that physically handicapped male and female patients should work in the same Centre. We also have a sheltered workshop for elderly male and female patients. As regards the children, their School has always been "co-educational".

Reviewing the accommodation, a large Villa within the grounds has recently been occupied as a psychogeriatric hostel for the ambulant elderly of both sexes, with separate dormitories for male and female patients but with shared dining and day and bathroom facilities. Needless to say the latter is not used concurrently by members of both sexes! Four wards in a geriatric hospital within the grounds, which were not being used, have been allocated to frail, elderly patients. There is one dormitory for male and two for female patients, with common dining and lounge facilities. Increasingly male children are being cared for in female wards and a recently opened nursery unit will have children of both sexes. It is anticipated that this trend of caring for children under the age of ten years of both sexes in one ward will continue and expand.

For many years the only joint recreational activity was a weekly dance and attendance at Church - although the seating accommodation was separate. The congregation in Church decided that they did not wish to be intermingled and this is, in fact, considered normal and desirable in Wales and in Synagogues. There has been increased expansion of the recreational activities with provision of a recreation centre, many club activities, dances, bingo, sports etc., supervised by a Recreations Officer. Many of the day outings are now for patients of both sexes. For many years one hundred children have gone annually to the seaside together; the only year that they went separately, parents, patients and staff felt the holiday was not so successful.

Much very useful voluntary work is being done by local school children in talking to the patients, playing with the children, taking them for walks etc. and here again, we permit young girls to go to the boys' wards and boys to go to the female wards, depending on which patients they feel they can help most.

5 MIXING THE SEXES IN A VARIETY OF PATIENTS' ACTIVITIES

Mr. R.F. Hughes, Group Secretary, Leavesden Hospital.

Dr. Shepherd spoke of the many activities in which at Leavesden Hospital the traditional practice of keeping male and female patients strictly apart has been abandoned. The activities include occupation and training, education and recreation of all kinds, and, in the cases of the youngest and the oldest, living quarters are shared by male and female patients. In many recreational activities little or no increment of resources was needed to effect the changes, but merely a change of attitude. For example, in sending parties of patients for days out at the seaside any one coach-load can quite easily consist partly of men and partly of women, instead of confining the occupants of any coach to one sex. The same is true of pretty well all recreational activities. We have, however, made one new appointment in the rank of Assistant Chief Male Nurse, so as to focus responsibility for promotion and co-ordination of recreational activities.

As far as "sheltered workshop" activities are concerned (and by this we mean simple industrial work engaged in by patients whose prospects of discharge are little or none, the emphasis being on occupation rather than on training), we have established this in existing accommodation which was under-used, with a negligible amount of new equipment, and with existing resources of staff, except that again we have made one new appointment in the rank of Assistant Matron to promote and control the activity.

Two of the aspects referred to by Dr. Shepherd have involved substantial capital expenditure and accompanying developments of revenue expenditure. They are industrial training and education.

Provision of facilities for industrial training sprang from the recognition by the Hospital Management Committee that opportunities for discharge of patients to self-supporting work outside hospital depended increasingly on the ability of the patients to earn a living in ways different from the traditional ones of domestic or farming or gardening work. The committee applied to the King's Fund for a grant to provide the necessary building, proposing that it should be in the form of two separate workshops, one for men and one for women. The King's Fund was at that time only able to provide half the estimated cost and a start was therefore made on the workshop for men, for whom the need was thought to be the greater. The original plan was a simple sketch made by the Committee's Building Supervisor. The Regional Hospital Board approved a development of revenue expenditure which included provision for a Manager and "supervisors". It was decided to appoint as Manager a man trained in engineering with supervisory experience. The "supervisors" were recruited in the trainer grade under the purview of the Ancillary Staffs Council. The Unit began work in 1959 and was an immediate success. By 1961 the Committee was so firmly convinced of the value of the Unit, and of the necessity of extending its facilities to women patients, that it commissioned an architect to design an extension of the building. The change in attitude towards mixing of the sexes was

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by this time apparent, and the architect's brief included an instruction to plan for men and women patients to work side by side. When the plans were completed, together with a joint report by the Committee and the architect on the objectives of the Unit, a new approach was made to the King's Fund which resulted in a grant of £35,000, believed to be the biggest single grant the Fund has made. Searching enquiries were made, by a small Committee specially appointed by the King's Fund, into the performance of the original Unit, the ideas underlying the proposal to extend it, including the matter of mixing the sexes, and the prospects of the continued value of the extended Unit in the foreseeable future. The Regional Hospital Board approved a new development of revenue expenditure including provision of the necessary additional supervisors, some of whom, of course, are now women. The extension was built without interruption of the existing activites and has been operating successfully since the spring of 1964.

The other substantial capital development referred to was a new school building. Leavesden Hospital was late in the field of school development because it did not admit children until after the Appointed Day. The department was built up gradually from very small beginnings and in make-shift accommodation from 1948 onwards. In 1956 the Hospital Management Committee sent to the Regional Hospital Board a report on future requirements for the care and training of children, and as a result the up-grading of existing children's wards and provision of a new school building were introduced into the Board's capital programme. The School, in the design of which the Committee had a predominating influence, was completed in 1965 at a cost of about £70,000 including much first-class equipment, and was officially opened by Princess Marina in April, 1966. It provides places for 75 children, and has two class-rooms in a separate wing for adult education. The Regional Hospital Board authorised a substantial development of revenue expenditure which made possible an expansion of the staff establishment to include some qualified teachers of Burnham Scale salaries (one of whom is the Principal). The establishment allows for at least one person at a time to be seconded to study for the Diploma of the National Association for Mental Health. Mixing of the sexes in Schools is, of course, no new thing either in or outside hospitals for mental subnormality, and children's classes have always been mixed. From the date of the development described here, however, adult classes have also been mixed.

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6 CO-OPERATION WITH THE LOCAL COMMUNITY AND OTHER APPROPRIATE ORGANISATIONS

Dr. C.E. Williams, Consultant Psychiatrist, Borocourt Hospital

H.M. (65) 104 is an excellent if simple blueprint for the organisation of the hospital services for mental subnormality. However when I read it in 1965 and again recently I could not help feeling that if any hospital existed in this country in which these general aims were not already part of the hospital policy, the senior doctors concerned in those hospitals should be immediately sacked. No doubt there are few, if any, hospitals in which all the aims and aspirations of H.M. (65) 104 are fully achieved, and the purpose of my short communication is to examine some of the ways in which the service provided by my own hospital falls short of the ideals of that Ministry memorandum.

But before proceeding to examine the shortcomings of our service, I want first to outline some very strong links with the community. Co-operation with the Local Authority Services is at a high level. This is made possible because the Medical Officers of Health of three of the five Local Authorities with which my hospital deals are on our Medical Advisory Committee and also on our Management Committee. Two of these medical officers are personal friends of mine and no doubt the other three would be too if they happened to live near enough for us to meet socially. All of the medical officers are young, able men intensely interested in the problems of mental subnormality, and willing and able to integrate their services with the hospital services as far as is possible. There are four consultant psychiatrists on our staff. Each one is responsible for a given local authority area and provides personal liaison with the medical officers, mental welfare officers etc., and runs a clinic at an area general hospital in that local authority area at least once a week. Furthermore, the Child Psychiatry Clinics in Reading are serviced by consultants from Borocourt, and there is a very close liaison with child psychiatrists and also with paediatricians throughout our catchment area. Our consultants are regular visitors to the schools and hostels run by local authorities. One of our consultants shares a joint appointment with a local authority, and there are joint appointments between the local authority and ourselves in psychiatric social work and in speech therapy, while other joint appointments are under consideration.

We are fortunate in having a very active League of Friends who in addition to giving us much financial support, organise many social activities of considerable benefit. Our usefulness to the industrial community is also considerable. One of the philosophies at Borocourt is that subnormal people have a right to employment just as people living in the community have. We do a considerable amount of contract work for local industrial organisations who are fully aware of the high standard and reliability with regard to delivery dates which we are able to offer.

There is a regular bus service to the central buildings of our hospital and our fleet of buses bringing day patients to the hospital is familiar to most people in our immediate environs. Numerous bridle paths and public footpaths cross our hospital grounds and these, together with a large number of visitors of all sorts and disciplines (including those who swell the coffers of the staff social club in attending the weekly dance in our ballroom), means that we are anything but an isolated closed community.

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What are the shortcomings of the service? We are situated in an area in which there is a considerable population explosion. There is thus a severe shortage of beds so that we cannot always offer the service that is needed. An acute family crisis requiring the admission of a patient faces one with a grave dilemma: in the absence of a vacant bed, does one overcrowd by one more, thus creating uncomfortable impersonal conditions on the ward and destroying staff morale, so that good staff leave and join the local authority service? Or does one refuse to admit the urgent case? There is no satisfactory answer to this problem and it is a constant source of headache to us. The only comfort is that one can discuss this with one's appropriate colleague in the local authority service who knows the bed situation in the hospital, and with him on the basis of "one in, one out" come to some compromise which, though not entirely satisfactory to anyone, at any rate makes everyone feel that each one of us is doing the best with the facilities at our command.

There is a gradual increase in the number of local authority hostels and this is more desirable. However much they may seem to be an ideal solution to the numbers of mentally subnormal requiring accommodation, the great snag from the hospital's point of view is that there is no career structure for local authority hostels and very often their best wardens are obtained at the expense of the hospital service. Borocourt is favourably placed in its staffing ratio at the moment but if the local authorities were able to finance the building of hostels and recruited staff from us for the estimated twenty five per cent of our population who could be adequately cared for in hostels, I am wondering if we would be left with sufficient able staff to look after a hospital full of very disturbed or handicapped people. It seems to me pretty essential that salaries and conditions of service in local authority hostels should be the same as in the hospital service, for any differential in favour of the L.A. Services inevitably reduced the quality of the hospital services.

Many problems arise because of the shortage of finance in local authority and hospital services. Thus of sixty four of our day patients, twenty five could equally well be at a local authority training centre. The local authority concerned has already got an excellent record of providing training schools and does not see itself likely to afford a new school in our vicinity for several years to come.

For co-operation with the community services to grow and prosper, it is important that the image of the subnormality hospital in the community should be a good one. I think this image is constantly threatened because of the dual role that the mental subnormality hospital is expected to fulfil. On the one hand, and quite rightly, we are expected to provide the most modern approaches to the care, treatment and rehabilitation of handicapped people and this is well set out in the memorandum. But on the other hand - and this is very rarely mentioned in official publications - the Ministry of Health, the Courts and many psychiatrists expect us to keep out of the community patients who, as para 7 (VI) says "require treatment or training under conditions of security short of those provided at the special hospital".

Now it may be that many hospitals and especially those designed in the earlier part of this century are capable of fulfilling these two roles, in that they are large enough to have wings that are relatively secure, and can provide sufficient in the way of occupation and leisure activity within these wings to make the containment of such patients reasonably humanitarian and therapeutic. Borocourt is a small hospital of some six hundred beds. It has recently been completely rebuilt and offers very reasonable conditions for the patients it is built to serve. But it is in no way suitable from an architectural point of view of containing people requiring conditions of security.

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We take the view that mental subnormality is in no way causally associated with delinquent behaviour and that the attempt to treat delinquency in a mental subnormality hospital setting is to the detriment of the majority of patients in that setting. This is particularly so when the definition of subnormality is so vague that patients in the average or dull average range of intelligence can be brought into the net. A group of such patients in a mental subnormality hospital, apart from consuming enormous proportions of staff time and interest which is then not available to the great body of patients, also produces an attitude of mind in staff which has a deleterious effect on the hospital. It also has unfortunate effects on our relationship with the community who have only to hear of one delinquent escapade to brand all patients in the hospital as dangerous delinquents. In no time at all the good will built up patiently over many years can be destroyed.

There is in our community environment as in any other, a proportion of delinquent people who require psychiatric training and treatment. We are prepared to give such people the opportunities for treatment on an informal basis, but we are not in a position to provide conditions of security for their treatment and in my view should not attempt to do so. I feel that it is very important for the image of mental subnormality in the community, that the ordinary mental defective should be clearly separated from the criminal defective as the Royal Commission clearly differentiated them, and that there should be a few large hospitals giving conditions of security something short of those available at the special hospitals, which could undertake research into the treatment of the mentally dull who are delinquent or criminal.

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7 A VISITING SCHEME FOR PATIENTS' RELATIVES SPONSORED BY THE LEAGUE OF FRIENDS

Mr. J. O'Brien, Clerk and Steward, Rampton Hospital

Rampton Hospital is situated in an isolated part of North Nottinghamshire. It caters in the main for sub-normal patients whose homes are scattered throughout England and Wales. Many patients never receive a visitor and two of the main reasons for this are thought to be the difficulties of the journey, especially from distant areas, and the financial considerations involved. When financial difficulties have been mentioned by relatives, they have been told of the assistance that can be obtained from local and national sources. The isolation of the hospital made it difficult for the hospital officers to interest the local community in these matters since the patients were not from that area and the community itself consisted of people from small nearby villages.

The Minister of Health, who is directly responsible for Rampton and the two other Special Hospitals, asked Sir Albert Martin, Chairman of the Sheffield Regional Hospital Board to try to encourage the local community to form a League of Friends of Rampton Hospital. Sir Albert did this early this year by asking members of the Retford and the Worksop Leagues and certain staff of the hospital to form a Committee. Recruitment campaigns were organised by the newly appointed Chairman of Rampton League of Friends the Rev. Shorland-Ball. At one meeting, Dr. Street, Medical Superintendent, of the hospital, told the gathering of potential members what he thought a League of Friends could do to help the hospital and he also described the types of patient and gave a summary of the work of the hospital. He said that the well-being patients often depended on their receiving visitors regularly.

The League of Friends agreed that one of its first two main objectives should be to sponsor a visiting scheme for patients relatives. Other Leagues of Friends, especially those in the Sheffield Regional Hospital Board area, at the suggestion of Sir Albert Martin were asked to and contributed generously to the start of Rampton's activities.

The staff of the hospital investigated the overall visiting position. This was done by Ward Sisters and Charge Nurses making returns for each ward showing the incidence of visiting individual patients by friends and relatives. These returns showed that nearly half of the patients never received a visitor. The next step was for Ward Staff to carry out a survey by interviewing each patient not visited to find out the reasons for this and to find out also whether, if a visit could be arranged, it would be appreciated. These returns were then analysed by the Chief Male Nurse and in every case, where there seemed the slightest chance of the relative visiting, his name and address was included in a list which amounted to about three hundred. The residences of these relatives were then plotted on a map and it was discovered that most of them were within day return distance of Rampton. The exceptions were the South (below the London Area) the South West, parts of Wales and the extreme North West. At the suggestion of the Chief Male Nurse, it was decided to think in terms of coach trips instead of individual assistance with fares. The London area was selected for a pilot scheme and forty relatives were written to, informed of the scheme and asked if they would take advantage of it if arranged. The relatives of twenty patients responded and on August 5th, 1967, a private coach brought forty relatives to visit twenty patients. The cost to the League, including refreshments on the journey, was fifty pounds.

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A further trip is being arranged for December from the Midland area and the intention is to build up the scheme so that relatives from five main areas of the country are given an opportunity to visit patients twice a year. Similar facilities will be made available for relatives beyond day trip areas and overnight accommodation will be arranged in the Rampton area.

Although at present only patients who have not had visitors are being considered, it may be possible, as the scheme develops, to assist certain relatives who have made the effort to visit despite great financial difficulties. As regards the cost of such a scheme, it is estimated that, when fully developed, it will be five hundred pounds a year, and this will be paid by the League of Friends.

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8 VOLUNTARY WORK IN THE ROYAL EARLSWOOD HOSPITAL GROUP

(1) Mr. L. White, Group Secretary, Royal Earlswood Hospital

A great deal of attention has been given recently to voluntary work in hospitals, and there is in fact an announcement today of a Government Scheme to sponsor voluntary work amongst young people. The Hospital Centre has already held symposiums on this subject, but we decided to introduce it today for the following reasons:-

(a) We believe that little or no mention had been made about voluntary work schemes in subnormal hospitals.

(b) The approach to it is essentially different in subnormal hospitals because, in the eyes of the general public the majority of our patients are not ill.

(c) There is no kudos in it for our voluntary workers, and the type of assistance we need appeals to somewhat different sentiments than the kind of voluntary work done in general and in psychiatric hospitals.

(d) Voluntary work in subnormality must be seen in a climate of extreme shortage of staff, which is much more marked than in any other type of hospital.

(ii) Mrs. D. Cortazzi, Senior Clinical Psychologist, Royal Earlswood Hospital.

One of the general aims in hospitals for the Subnormal and Severely Subnormal should be - according to the Ministry Circular of 1965 - "the development of self-confidence, self-reliance and self-respect". The circular mentions - among the means by which this might be achieved:- further education ... social skills and activities ... contact with the community outside the hospital ... a measure of independence ... and also the creative use of leisure so that the patient may "live as full a life within the Hospital as he can".

We realise that, with our Severely Subnormal patients, Industrial work should not really occupy the whole day, and that we must try to develop every aspect of the personality. Therefore, concentration on education for our adults assumes a larger place in our programme. Sooner or later, this will involve individual attention, and - with the best will in the world - our staff just have not the time for this. So, we are introducing Voluntary Workers to help with simple basic word-recognition; with knowledge of money and telling the time; with using the typewriter as an incentive to better co-ordination and control.

Two of the social skills dealt with by our Voluntary Workers concern personal appearance; a Beautician visits our Female Occupational Therapy weekly to teach the girls skin care and make-up. And a local hairdresser offers a free hair-do to four girls at her shop every Tuesday.

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Since this has involved teaching the girls to travel by bus, and cross roads; to look after their own bus fare; to ask clearly for their destination - this weekly visit has wider implications than just having their hair done. Royal Earlswood Hospital is on the main Brighton Road with heavy, fast traffic, so most of our girls have been rather sheltered, and up to now, only the brightest and most competent have been accustomed to going out on their own.

Then we use Voluntary Help to teach those boys likely to go to work outside the hospital, correct road drill, use of local buses, how to telephone and what to do in an emergency.

One of the great problems in a subnormal Hospital is the use of leisure, and it is fatally easy to provide T.V., films, concerts and dances, and consider the patients well catered for.

As a Consortium, we agreed from the start that this was an area we should concentrate on. We had great plans for developing a Social Club; for evenings of painting and carpentry; country dancing; music; and puppetry. But "leisure skills" is one side of our Voluntary Work that is a dismal failure so far.

The local art school were not able to help - we had envisaged art students visiting us; nor could we find any local musicians with the time to give; another local organisation was not able to help in the construction of an adventure playground; members said they could not face mongol children, it would upset them too much.

Meanwhile, one big achievement in this section is the acquisition of a riding instructress who comes twice weekly, not just for joy rides, but for proper instruction and exercises and lessons on grooming and care of gear. The response, after initial shyness, has been marvellous, and the most unlikely patients are blossoming out.

So far as pure entertainment is concerned, this is in some ways the easiest gap to fill. Many organisations give a great deal of time and money, arranging outings to the sea or up the river; to Christmas pantomimes; film shows and concerts and parties. This has been done for many years, most efficiently.

For several years various organisations have "adopted" patients who have no relations, and they send birthday presents, take the patients shopping or out to tea, or just sit and talk. Community Service Volunteers have worked in our Horsham branch as Nursing Assistants, and the Royal Navy sent groups on a "Venture Exercise" to assist in the conversion of some old farm buildings.

Now we are trying to provide community links with individuals as well as through organisations, and we have volunteers who come once or twice a week to feed some of our more helpless patients. This, whilst obviously helping the nursing staff, is a welcome outside contact and a very personal relationship for chairbound patients.

Other volunteers come to help with weekly letters home. Since this is often a question of spending a long time discovering what the patient wants to say, writing it down very plainly, and getting the patient to copy it word by word or even letter by letter, - it is easy to see that, once again the staff just have not got the time. A voluntary worker here means not only a personal contact with someone from outside, but contact <u>with</u> home and a chat <u>about</u> home, each week. We also find that it teaches the patients to think about other people, about what their parents would like to hear from them instead of the otherwise inevitable: "Dear Mummy, How are you? I am well, Please send sweets".

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Our newest venture in community links is the formation of the first ever Women's Institute in a Subnormal hospital. We have insisted on conforming as much as possible to the normal W.I. pattern, though for the moment the Chairman and Secretary are experienced members from other Institutes, and we also have several helpers from local Institutes each time. The girls pay their subscription and have membership cards and W.I. diaries; they will be visiting other Institutes and taking part in any normal Institute activities.

This, we feel, is really belonging; the community is coming into the hospital and the patients are going into the community. Their activities are normal group activities. They are members and will therefore be expected to assume the responsibilities of membership. If we can achieve this through the W.I. we feel we shall have filled a big gap, because - on the whole - Subnormal and certainly Severely Subnormal patients, get very little encouragement to assume any social responsibility, or to do things for other people.

The organisation of Voluntary Work in Royal Earlswood Hospital itself, is done by a Consortium, which was formed at the request of the Physician Superintendent. We are a group of people already in full-time posts in various parts of the hospital, but we all have a lot of energy and a very strong belief in the possibilities of voluntary work.

We also feel very strongly that we are more effective than one full-time person appointed specifically for the job - at least in our particular hospital, because, firstly there is always one of us around to cope with an emergency or to take over contact with a new volunteer. Secondly, because we have other duties to turn to, we tend to have a relaxed and fresh approach to the voluntary work. The difficulties (which do exist) do not get us down. In the third place, we share the burden, and we find the group acts as a safety valve. Then, it has been our experience that ideas develop very fruitfully and flexibly from constant group discussion. And lastly, between us, we know the ins and outs of the hospital pretty intimately, and we are aware at first hand of the various departmental quirks.

We have had our difficulties during the past year, and some failures. One of our biggest problems has been in trying to use our League of Friends. In our particular case, almost all members are parents of our patients, with all the emotional problems what this inevitably brings. And we are having to accept that whilst they are extremely generous in raising money, organising outings, in giving presents and equipment, in building a centre - we can seldom get them to give us their time.

This has led to a big failure; the organising of a Social Club. Perhaps because we want it in the evening; perhaps because it involves a much closer visitor-patients relationship in a more relaxed atmosphere. We can get generous offers of money for the Club from the League of Friends - but no personal help, apart from a faithful one or two, not even - as I once worked out - for two hours each on one evening per year!

Our second difficulty has been one which surely every big organisation must experience - the problem of personalities and passive resistance. One sometimes feels that our hospital is staffed by centipedes - each member with a hundred toes, all waiting to be trodden on! And of course, almost any new venture could be taken as a personal criticism of someone's work.

I doubt whether there is any answer to this problem, but time.

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Our third difficulty, though not a prominent one, has been one of organisation: lack of sufficient contact on our part with staff or with volunteers.

We had some outbursts after the first lesson on make-up, for instance, because the girls were made to wash it off before tea-time - and this was entirely our fault for not explaining to the ward staff. One volunteer left a note on my desk one day, saying that she had no idea whether she was teaching the right thing, as it was so long since she had been able to discuss it with me. The trouble here was the assumption that such an excellent person needed no moral support!

A fourth problem which has arisen during the year has been the difficulty in persuading staff to give the Voluntary Worker a definite activity or project, rather than letting them "just play with the children" or "take them for walks". One must give the volunteer the security of a framework, at least in the early days. And we now try, wherever possible, to have a definite activity, or preferably a simple project, with record books or charts so that the Voluntary Worker can see exactly what she has to do and what she has achieved.

Many of the difficulties have been due to sheer lack of experience - we have not yet completed our first year as a Consortium; the other problems we are just having to learn to live with.

The effect of this year of organising voluntary work on the hospital: - for the patients the benefits are obvious - there have been a broadening of their activities; much more individual attention; more expeditions outside the hospital as responsible individuals rather than as a sheltered group; more confidence and greater alertness. In other words, more normality and more chance of becoming complete persons, and therefore, happier persons. And, therefore, easier to manage.

From the staff point of view, the effect is less easy to assess. Certainly it has regrettably involved a number of already busy people who are not on the Consortium, in extra work. One hopes this will not always be so, as we become more experienced. We on the Consortium must, I think, face the fact that a good deal of planning and supervising will always be a necessary part of our duties, and the Hospital authorities, that an active Consortium is going to mean a certain amount of friction in the hospital, until we are accepted.

On the positive side, many of our staff who have been in contact with the voluntary activities are themselves developing new ideas. And for those of us on the Consortium, it has certainly widened the scope of our work and has been tremendously stimulating.

Voluntary Workers have come to stay, and the more we get our patients accepted as part of the community, the more we shall need them. What do <u>they</u> get out of it - for this must be a two-way affair?

Most important, I think is the feeling of being needed. So many of our volunteers say after their first visit: "Are you <u>sure</u> you really need me?" It soon becomes obvious to them that - quite apart from the genuine need of the staff for help with certain activities - the patients need someone specially their own to give affection to, belong to. And this relationship is one which nearly all our successful volunteers delight in. Then, Voluntary Work becomes as one person put it -

> "Something to look forward to, something to enjoy -
> and a way of life".

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DISCUSSION

Unfortunately neither of the afternoon discussion sessions was recorded, but full notes were taken of the second meeting. Since it was an extremely lively occasion and resulted in a detailed plan for future inquiry, a summary is included in this report, it is acknowledged however that it does not comprise a balanced account of both sessions.

Vigorous comment from the floor - following the papers from Rampton, St. Lawrence's and Royal Earlswood Hospitals - centered round two provocative issues: the function of the nurse in subnormality and the use of voluntary workers.

The presence of voluntary workers was heatedly attacked by speakers from the floor who felt suspicious of their motives, thought them unreliable, or resented "the plums" beingsnatched from professional nursing staff who would be left - it was said - with drab routine jobs. Their presence might affect recruitment of permanent staff. And there were the legal aspects to be considered.

Seen against the current background of large, understaffed hospitals and overcrowded wards, however, voluntary workers were acceptable to other speakers under certain conditions: if they were doing something for the patients that regular staff could not provide; if they belonged to a recognised organisation; if they had a specific, self-contained job to do; if they were guided and supervised by the staff in the department concerned. It was felt that it should be recognised that no one category of staff, no one person, could possibly contribute all the skills and expertise necessary to the subnormal patients welfare and development. Volunteers were seen, by those who approved, both as a link with the community for patients too long deprived of outside contacts, and as a means of educating the community to accept the subnormal.

Such discussion inevitably involved comments of the function of the nurse in a field where the needs of the patient are often as multiple as the handicaps, and vary from strict nursing care to vocational training; from mothering to education; from the needs of infancy to those of old age. Given full staffing amateur help could be regarded as entirely unnecessary: the nursing staff could and should deal with the patient on a basis of "total care".

Finally, the chairman summarised the fundamental point as the relation of the hospital to the community, and suggested the need for operational research at hospital level. Such research would consider the purpose of a subnormality hospital, the role of the staff and the need for letting the community participate in hospital life. It would assess recruitment, training and supervision of voluntary workers; the place of national organisations; the relationship of volunteers to staff; and, perhaps most important of all, the effect on the patient.

It was essential, in the chairman's opinion, not to hand this over to an outside organisation, but that the hospitals themselves should play an active part in such operational research and become personally involved in the research, planning and organisation.

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DISCUSSION

SUMMARY

Six subnormality hospitals described their experiences in trying to implement the Ministry of Health's recommendations, some two years after publication of the memorandum. Aspects of hospital life covered by the papers were research, education and training, and links with the community. Many - though by no means all - who spoke either from the platform or the floor, admitted to problems arising at some stage from these efforts: problems ranging from lack of finance to lack of adequate buildings; from a hampering admixture of patients needing quite different forms of training to equally hampering difficulties with staff personalities or communication problems. Some expressed fears - real or imagined.

Those who spoke from experience of the effect upon their hospitals of these attempts however, felt it had been beneficial: the public image of the hospital was enhanced, links with the community were stronger; staff were stimulated in a field which, as one speaker commented, "is likely tobecome stagnant"; and patients above all, were getting a better service in diagnosis and treatment, in educational training, and in becoming slowly more accepted as members of the community.

It was evident, however, that one hospital's idea of progress was not necessarily accepted as such by others: an apparently objective use of closed circuit T.V. for instance, was criticised as an infringement of the individual's rights: voluntary workers accepted here were looked on as a threat there; research, the pride of some, was seen through other eyes as too remote from patient care.

It was perhaps this opportunity to hear provocative views, to experience a jolt to complacency, to learn from disagreement, which was the most stimulating aspect of these meetings. From the difficulties and divergencies the needs for future operational research were identified. It is now, as the chairman concluded, up to the hospitals themselves to become personally involved in such projects.

NOTE:

One outcome of these two meetings concerned with improving the effectiveness of the service for the mentally subnormal has been a conference of all organisations involved in this work, held on March 7th, 1968, at the Hospital Centre.

A Working Party was set up as a result of this latter conference to examine suitable areas for further practical study.

APPENDIX 1

Enclosure to H.M. (64) 45

NATIONAL HEALTH SERVICE

IMPROVING THE EFFECTIVENESS OF HOSPITALS FOR THE MENTALLY ILL

1. There are many examples in the history of psychiatry of mental hospitals that were, in their time, outstanding. In most cases, the achievements of these hospitals were the result of the enthusiasm either of one individual, usually the Medical Superintendent, or a group of medical staff, but the standards reached seldom survived their originators. Although there is now abundant literature on the subject of mental hospital reform, and in spite of the leavening function of the Board of Control, it is only during the last 20 years that a more or less uniform pattern of progress has emerged. While this has sprung largely from individual efforts, there are now a substantial number of models that are recognised as such, not only in this country but throughout the world. These hospitals vary considerably in the methods they have used to improve their performance, but the elements making for success are clear enough. But while these progressive hospitals have been advancing, there are many others who have lagged behind, so that the difference between the most and the least progressive is greater now than ever before.

2. The aim of this paper is to set out as briefly as possible the essential elements of a good comprehensive service, to act as a yardstick against which hospital authorities and their staff can assess the standing of their hospitals and plan their improvement. Paragraphs 5 - 26 describe the services to be found at hospitals with good standards. Paragraphs 27 - 45 discuss some obstacles to improvement and possible ways of overcoming them and putting into effect the principles described in the earlier sections. There is inevitably some overlap between the final section and the remainder of the paper.

General Considerations

3. The mental hospital of today is no longer just a centre for the treatment of in-patients, but part of a comprehensive service, of which in-patient care is only one of many components. This represents a fundamental change of function that necessitates not only a corresponding change of attitude of all those who come into contact with the mentally ill, but also one of organisation. It implies a greater confidence in the ability of most patients to be responsible for themselves. It also means that the hospital must work in close conjunction with family doctors, and with local authority and voluntary services, and give help where needed in the creation or development of such services.

4. Properly directed extra-mural activity can reduce the need for in-patient care. Critical examination and, where necessary, reform of the extra-mural services is, therefore, an essential first step in the re-orientation of a psychiatric service.

Extra-mural Services

5. As a general rule, screening as an out-patient, or by domiciliary consultation, is carried out before admission to hospital is decided upon. Pre-admission screening is done by the doctor who will be responsible for the patient if he is accepted for in-patient care, in co-operation with domiciliary nurses and social workers.

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Out-patient clinics are normally held in general hospitals, because they are usually more convenient for the patients. Every member of the medical staff of the psychiatric hospital has regular out-patient experience. The distribution of out-patient clinics and the number of sessions provided will vary with local circumstances; as a rough guide to minimum needs, 9 doctor-sessions per week should be sufficient to serve the new patients from a population of 100,000. These sessions can be provided by one team consisting of a consultant and two junior doctors, but additional sessions will be required for follow-up clinics.

Day Care

6. Many patients can, with advantage, be treated on a day basis, returning to their homes for the night. Two groups of patients are particularly suitable for day care: those who need more intensive individual or group treatment than can be given as an out-patient, but do not require residential care, and those for whom day care is a step towards final discharge after a period of in-patient treatment.

7. Day care is actively organised for treatment or rehabilitation, and care is taken that the day hospital does not degenerate into a club for neurotics or become just a depository for more severely handicapped patients.

8. In practice, it is found that whether the day hospital is a separate building or simply part of the day accommodation of the main hospital, it seldom functions efficiently unless it is situated within a radius of about 5 to 10 miles of the homes of the patients who attend it, unless it is possible to provide a five day hostel for those whose homes are further away. A well sited day hospital in an urban area, with good transport facilities, aims to provide about 50 places for a population of 100,000 although the adequacy of this ratio is dependent upon the development of the services provided by the local authority.

Links with the Community Services

9. The majority of patients seen by hospital psychiatrists come from family doctors, to whom they will ultimately return. In the evaluation of the need for prevention, and in the organisation of after-care, the family doctor has a special opportunity for mobilising the local authority mental health workers. But in all these functions, he needs the close co-operation and advice of the psychiatrist. It is therefore found essential that hospital psychiatrists make it their business to know and keep in touch with the family doctors of the patients under their care. There are many ways in which this can be done: by domiciliary consultation, by encouraging family doctors to visit their patients while in hospital, and certainly to discuss the arrangements for after-care before discharge; by organising case conferences and encouraging clinical assistantships. Apart from personal meetings, the family doctor is always informed of the intention to discharge a patient from in - or out-patient care. He is also provided before the patient's discharge with a short note about treatment and drugs which the patient is receiving and with a summary of the history and recommendations for after-care as soon as possible after the patient is discharged.

10. The same personal contact and understanding has to be fostered between the psychiatrist and hospital staff and the local authority staff particularly the Medical Officer of Health and his team of mental health and welfare workers. There are many ways in which this may be facilitated; examples include arrangements for the Medical Officer of Health to become a member of the Hospital Management Committee or medical advisory committee and for a psychiatric consultant to be a co-opted member of the local authority's mental health sub-committee. Wherever there is a close working relationship between the family doctor, the local authority services and the hospital staff many admissions to hospital are avoided, and the quality of after-care is improved. This kind of liaison is particularly important in dealing with mentally infirm old people, many of whom can remain in their own homes if social and medical support can be provided. In this connection, a close association with the local geriatric service is also essential and, if admission to hospital for medical assessment is needed, it is to a geriatric or to a general medical bed rather than to the psychiatric hospital.

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11. The maintenance of contact with the community during the period in hospital is of the first importance. In addition to visits from those who have a professional interest in their welfare, such as the family doctor and local authority workers, unrestricted visiting of patients by friends and relatives is welcomed. For those who lack home ties, an energetic League of Friends can do much to lessen the risk of institutionalisation by stimulating interest in life outside the hospital. For the same reasons, week-end leave is encouraged and every patient is given access to writing materials, and is urged to use them.

Organisation within the Hospital

12. The success of a psychiatric hospital depends very largely on the attitude of the staff on whose ideas and initiative many of the recent developments depend. The aims of the custodial system, though limited, were positive and easily understood. For its effective administration a hierarchical system, in which the lines of responsibility and communication were clearly defined, was essential. The patient paid for the protection it afforded with the loss of his personal responsibility and independence. While it is now agreed that too many restrictions are positively harmful, many hospitals have not got beyond the symbolic rejection of them that is implied in the unlocking of doors and the abolition of the visible trappings of protection.

13. In order to undo the harm that has been done and to prevent damage in the future considerable changes were needed to promote active treatment and rehabilitation. The ground was prepared for these changes in various ways, including staff meetings, lectures, conferences, study days and visits to hospitals with different ideas and methods. The patterns which have emerged vary but the following points seem to be common factors in good hospital practice; they should not be regarded as goals in themselves, but rather as the logical consequences of changed attitudes, and to this extent, measures of progress.

Basic Needs

14. In order to describe some of the salient characteristics that have been built into the organisation of a good hospital, it is convenient to classify them in terms of the basic needs of any individual patient. Essentially, these needs are no different from those of any other person. Their satisfaction is directed towards the rebuilding of individual self-respect, with a view to a return to independent life outside hospital.

Physical Needs

15. Every patient has the opportunity for privacy, not only for himself but for his personal belongings. This means that lockers, at least, are provided for every patient.

16. Those patients who have clothes of their own have free access to them, and are encouraged to choose what they wish to wear. Complete sets of clothing, marked with the name of the individual, are provided for those who cannot afford to provide their own.

Social Needs

17. Of these, the most important is work. Regular daily occupation is provided except for some aged and bedridden patients. The form of occupation has to be meaningful and useful, and is directed towards increasing the patient's capacity for independent living. A sufficient variety of occupation is made available, so that the patient can choose what he wants to do, and move on to something different as his capacity improves. Part of the value of regular work lies in the opportunities

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for social relations that it affords. Patients' inclinations as to the kind of work and with whom they like to associate are taken into consideration. The same applies to recreation: patients are not dragooned into routine and sometimes childish activities, but encouraged to choose how they will spend their spare time. All patients receive payment for work done in the hospital and those who have no private means are entitled to pocket-money up to 13s. 6d. a week. Saving and spending of money is an important aspect of the retraining of many patients, and no patient is deprived of the right to use money while in hospital. As in normal employment the patient is paid at his place of work.

18. The autocratic and restrictive attitudes of a custodial regime and the system of rewards and punishments which this necessitated have been eliminated. For example, the use of passes for week-end leave and parole cards for patients who are allowed out of their wards has been stopped. Patients are allowed to get up in the morning between 6 and 8.30 a.m. depending on their working hours. The time of going to bed is arranged to suit the patient's age and condition, but is, wherever possible, left for the individual patient to decide.

Psychological Needs

19. It is important for the patient to be recognised as a useful person, who has a part to play in the daily life of the hospital and in his own restoration to normal health. Patients are treated as individuals and equals, not as childish inferiors. The aims of treatment and rehabilitation are promoted by regular staff meetings attended by doctors, social workers, nurses, occupational therapists, Disablement Resettlement Officers and all those who are part of the team.

Internal Organisation

20. The first objective within the hospital has been to ensure that treatment and rehabilitation can proceed in an environment which fosters the development of personal competence. In the past, institutions tended to breed behaviour and attitudes which hindered resettlement. In some of the large institutions uniform, rigid control discouraged individual initiative and led to the development of undue dependency. Such effects have been prevented by various means all of which aim to create a way of life in the hospital as near to ordinary life as the conditions of the patient allows.

21. All patients, especially those who have been in hospital for a long time, are regularly reviewed and classified in terms of the treatment and rehabilitation they need.

22. Most hospitals find it convenient to provide separate wards for those patients requiring intensive treatment. Where symptoms persist, though generally relieved in intensity, a great deal can still be done by various methods of rehabilitation.

23. The starting point of such activity is a detailed assessment of each individual's disabilities. These include not only the residual symptoms and scars left behind by the illness but also its social consequences, such as the loss of home and employment. This assessment can only be satisfactorily made in a hospital setting that resembles life outside as closely as possible. Opportunities for regular work and the satisfaction of social needs are graded to allow the patient to progress from close supervision to self-reliance and independence. A system of regular reviews is found essential to ensure that no patient is retained in hospital who would be better outside.

24. Some large hospitals have found it preferable to divide into sections, each with intensive treatment, rehabilitation and geriatric wards, each section being the responsibility of a consultant and a supporting team of medical, nursing, social workers and other staff. This principle is with advantage extended to cover extra-mural services as well and in this way general practitioners and local authority workers know exactly

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with whom they are dealing. Such sections, geographically linked with the area they serve, should not deal with a population larger than 200,000; otherwise detailed knowledge of local circumstances may be lost. Sometimes it may only be possible to create one such section which would then serve as a model for other to follow.

25. Arrangements under which each consultant is responsible for the full range of psychiatric services do not preclude the appointment of one consultant with special responsibility for organising and developing rehabilitation facilities. This has often been found most useful.

26. Hospitals have found it beneficial to use all the various facilities that the Ministry of Labour provide for the resettlement of the disabled. This involves regular consultations with the Disablement Resettlement Officer about patients who may need his help. Those who have no job to return to may secure placement in open or sheltered employment; others may be advised to attend an Industrial Rehabilitation Unit before doing so. Resettlement is generally more successful if patients are adequately prepared before returning to ordinary work. Apart from what is done by voluntary bodies such as Industrial Therapy Organisations, local authorities have developed workshops in the community, some with sheltered sections helping to prepare patients to become economically self-supporting. (See Cmnd. 1973) Every hospital could encourage such development.

Obstacles to Improvement

27. The methods of overcoming some of the difficulties in adopting the practices set out above are now considered. The extent to which any hospital can improve its function will be governed by a number of factors of which some are modifiable but others need to be circumvented. Of all the obstacles to progress perhaps the most malignant is geographical isolation. For historical and economic reasons the isolated, remote mental hospital is usually also very large. This is partly because land far away from the centres of population was cheap to buy but also because, being isolated, the hospital's therapeutic function was limited and its resident population tended steadily to increase. Though overcrowding and its attendant evils have been accepted as a challenge by some hospitals, others have become resigned to what appears to be a hopeless task. This attitude has in turn made it difficult for such hospitals to recruit doctors and nurses, particularly where communications between the staff and the staff of the general hospital are poor, and a vicious spiral has developed in which more and more patients are admitted, stay longer and receive less attention.

28. Isolated hospitals should make special efforts to improve communications with the communities from which their patients come, both to improve the work of the hospital as a whole and to assist the rehabilitation of individual patients, particularly those who have lost touch with the outside world.

29. Domiciliary and out-patient services, though time consuming, are valuable lines of communication and should be encouraged. Similarly, links with the local authority services are essential for the resettlement of patients after disch arge. It is important to realise that Medical Officers of Health may not always know what services are needed and hospital psychiatrists should be prepared to make suggestions and help in the training of local authority staff to carry them out.

30. Communications may be facilitated by dividing the hospital into self-contained sections each under the control of a consultant with his supporting team. Each section is responsible for a geographical area which ideally should be directly related to local authority boundaries so that there can be no doubt on either side with whom the personal responsibility for individual patients rests. The consultant and his team should make it their business to know the individual family doctors, mental welfare officers and others from whom they receive their patients and who will carry out their after care. They should also be prepared to educate and advise them in mental health matters affecting prevention and after care.

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31. Even though it may not appear possible to reorganise all the work of a hospital in this way, a start should be made on a part that can act as a model. When the advantages of the system are appreciated solutions for changing the remainder will suggest themselves.

32. The re-establishment of contact with the outside world is essential for the rehabilitation of long stay patients and any measure that fosters the desire for an independent, normal life, should be promoted. Frequent visits from relatives and friends should be encouraged and weekend leave arranged whenever possible. Excursions should be organised and no hospital should be without an active League of Friends.

33. Some isolated hospitals have made remarkably successful efforts to overcome the ill effects of their isolation. Their success has usually been mainly due to the enthusiasm of their staff, and this illustrates the paramount inportance of good staff, both medical and nursing. Attention has already been drawn to the vicious spiral where apathy hinders staff recruitment, inadequate staffing hampers active treatment still further, and so on. Thus staffing problems may be a major obstacle to improvement and increases in staff will often be needed if full attention is to be paid to the needs outlined in paragraphs 12 - 26 of the paper. Staff shortages cannot, however, be dealt with overnight, and the best course may be to select one part of the hospital for improvement initially, concentrate staff there, and aim to produce a really active and successful section whose influence will percolate throughout the rest of the hospital and whose reputation will help to encourage new recruitment. The remainder of the hospital can then be dealt with by stages in the same way.

34. The success of the hospital depends greatly on the quality and quantity of its nurses, and progressive hospitals produce and attract good staff. Though the stimulus to activity, without which progress cannot be made, must come from the medical staff, there must be free consultation at all levels between doctors and nurses in the planning and running of all the therapeutic activities of the hospital. In order to make such communication possible a reorganisation of the duty hours of the nursing staff may be necessary. For example, in order to plan the treatment of individual patients or ward groups and keep in touch with their progress, the doctor and nurses concerned should meet at frequent, regular intervals. If the nursing staff is operating a two shift system, the only time when all will be available for meetings is usually around midday and, to make time for it, the takeover period between shifts will usually need to be adjusted.

35. Before embarking upon a new project, such as industrial rehabilitation, it is highly desirable that not only the medical, nursing and other staff who will be responsible for it but also representatives of the Hospital Management Committee should visit such a unit in action in another hospital. Secondment of the staff concerned for a period of two or three weeks is usually necessary in order to understand the medical and administrative complexities of industrial sub-contract work.

36. Shortage of nursing staff is not infrequently put forward as an obstacle to the development of many of the activities described in this paper but much can be done by a re-deployment of the existing staff. If, for example, all those patients who are ambulant and not undergoing intensive treatment are fully occupied, many of the wards can be cleared for most of the day and the nurses occupied in the supervision of working groups. This, in turn, usually means that domestic staff must do the ward work that was formerly done by patients under nursing supervision. Again it may be more convenient for patients to have their main meal in a central canteen rather than re-open the wards for the purpose.

37. The strongest stimulus to the morale of a nurse is the return of the patient to ordinary life and, to this end, the consciousness that discharge from hospital is the immediate aim of treatment must be kept alive. This can best be achieved by frequent conference in which the fitness for discharge of each patient is reviewed during the course of treatment by members of the therapeutic team.

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Structural Obstacles

38. Features of our hospitals that now appear as defects of structure or design are very often due to the change of function from asylum or work-house to hospital. Bad design is often associated with inconvenient siting and for this combination of evils closure is the only rational answer. But there are many structurally obsolete hospitals where wholesale modernisation would be completely unrealistic but which must nevertheless continue to provide a service for many years to come. Expenditure in such circumstances is highly desirable, though it would clearly be undesirable to embark on complete reconstruction.

39. Structural defects that adversely affect the therapeutic function of a hospital are usually of two kinds: essential buildings are lacking, and parts of the existing buildings are unsuitable either because they have become obsolete or because they were built for a purpose that is no longer necessary.

The Lack of Essential Buildings

40. There are three main categories of mental hospital patients whose therapeutic needs can be clearly defined: those needing intensive treatment on a short term basis, those needing rehabilitation either short or long term, and those who require continual care, many of whom will be elderly. While individual members of these three groups may overlap in their needs from time to time the facilities required remain distinct.

41. If only to make the best use of nursing staff, most hospitals now have a section set aside for the intensive investigation and treatment of newly admitted patients. This need can often be more economically met by the conversion of part of the existing structure than by a new building. But even those hospitals that will ultimately be closed should be provided with an admission or intensive treatment unit if they feel the need for one.

42. There are good reasons for thinking that industrial sub-contract work is one of the most effective methods of rehabilitation for a high proportion of long stay patients. Although, as has been said earlier, the detailed organisation of this work is complex, the structural requirements are simple and not costly. In H.M. 58 (57) hospital authorities were strongly advised to set up units for this purpose and some have done so. But there are still many hospitals who have either ignored this advice or have offered this form of rehabilitation to only a fraction of the patients who might benefit from it.

Improvement of Existing Buildings

43. Many of our hospitals contain buildings and indeed essential services which are obsolete and no longer provide a reasonable standard of hygiene and comfort for their patients or tolerable working conditions for their nurses.

44. Much can be done to modify unsatisfactory design by measures short of radical reconstruction. Among them are the partitioning of large wards, the provision of false ceilings, redecoration and the provision of better furniture and lighting. In many hospitals it will be necessary to spend money on basic necessities such as sanitary annexes. In the case of hospitals that will not be needed in, say, fifteen years time, it would seem reasonable to decide what parts are worth preserving until the end and to concentrate on upgrading them. As the number of patients falls, those remaining can be redistributed among the better buildings and the older parts demolished.

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45. In considering what can be done to lessen the structural obstacles to the present day care of the mentally ill in any hospital, it is first necessary to define the therapeutic needs of its patients. It is for this reason that obstacles relating to structure are dealt with last in this paper. For unless all those concerned realise and accept that enabling patients to do without hospital care is the prime function of a hospital, improvements in structure alone will do no good. It will be the function that will determine the structure and it is the modern function of a psychiatric hospital that has to be clearly determined and defined before the structure is altered.

Ministry of Health.

June, 1964

F/M121/1

A P P E N D I X II

H.M. (65) 104

NATIONAL HEALTH SERVICE

IMPROVING THE EFFECTIVENESS OF THE HOSPITAL SERVICE

FOR THE MENTALLY SUBNORMAL

Summary. This memorandum encloses a copy of a paper on Improving the Effectiveness of the Hospital Service for the Mentally Subnormal. Hospital authorities are asked to study this and to introduce any improvements which are necessary.

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1. The attached paper on "Improving the Effectiveness of the Hospital Service for the Mentally Subnormal" has been prepared with the help of a number of psychiatrists and others working in the subnormality services, and in agreement with the Minister's Standing Medical and Mental Health Advisory Committees. It has been endorsed by the Central Health Services Council.

2. The paper describes the functions of the hospital services for the mentally subnormal and stresses the importance of close links with the local authority and voluntary services and with the family doctor. It outlines the facilities which should be available and suggests ways of improving the effectiveness of the services.

3. The Minister recognises the high quality of the services already provided by some hospitals, but asks all Hospital Management Committees controlling hospitals for the mentally subnormal to study the paper and to introduce any improvements that may be necessary. Copies of the paper should be distributed to all members of the Committee and to the Senior medical, nursing and other staff who will be concerned in discussing its contents and in introducing changes.

4. The regional and local mental health liaison committees referred to in paragraph 9(i) of the paper may conveniently cover services for the mentally ill as wellas for the subnormal. It may also be desirable to link them with the planning groups for co-ordinating services for the elderly which were suggested in paragraphs 9 to 12 of the memorandum enclosed with H.M. (65) 77. The Minister does not wish to recommend any fixed pattern, but authorities will no doubt bear in mind that the mentally subnormal, the mentally ill and the elderly are groups which to some extent overlap with each other, and that the provision of a comprehensive service for each of them raises many common problems as well as some which are special to each.

5. The Minister will be considering with Regional Hospital Boards arrangements whereby hospitals which seem to be encountering particular difficulties may be visited and their difficulties discussed.

6. Copies of this memorandum are being sent to local health authorities, Executive Councils and Local Medical Committees, under circular 24/65 and E.C.L. 98/65 copies of which are attached.

Ministry of Health,
Alexander Fleming House,
Elephant and Castle,
London, S.E. 1.

2nd December, 1965
To: Regional Hospital Boards,
Hospital Management Committees,
Boards of Governors.

F/M. 121/03.

APPENDIX II

H.M.(65)104

[illegible] SERVICE

[illegible]NESS OF THE HOSPITAL SERVICE

[illegible] THE MENTALLY SUBNORMAL

Summary. This memorandum encloses a copy of a paper on Improving the Effectiveness of the Hospital Service for the Mentally Subnormal. Hospital [illegible] to study this and to introduce any improvements which are [illegible].

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1. The attached paper on "Improving the Effectiveness of the Hospital Service for the Mentally Subnormal" has been prepared with the help of a [illegible] and others working in the subnormality services, and in agreement with the [illegible] Standing Medical and Mental Health [illegible] Committees. It has been [illegible] the Central Health Services Council.

2. The paper describes the [illegible] hospital service for the mentally subnormal and stresses [illegible] links with the local [illegible] voluntary services and [illegible] should be available and [illegible] the effectiveness [illegible].

3. The Minister [illegible] of the services [illegible] some hospitals, but [illegible] Committees controlling [illegible] for the mentally subnormal [illegible] and to introduce any improvements [illegible] may be necessary. [illegible] be distributed to all [illegible] Committee and to the [illegible] and other staff who [illegible] in discussing its contents and [illegible] changes.

4. The regional and local [illegible] liaison committees referred to in [illegible] 9(i) of the paper may [illegible] for the mentally ill as well as the subnormal. It may also [illegible] them with the planning [illegible] co-ordinating services [illegible] are suggested in paragraphs [illegible] the memorandum enclosed with [illegible]. The Minister does not [illegible] any fixed pattern, [illegible] bear in mind that the [illegible] the mentally [illegible] are groups which to some extent [illegible] each other, and that [illegible] comprehensive service for each [illegible] which are special to each.

5. The [illegible] Hospital Boards [illegible] particular difficulties may be [illegible].

6. Copies of this [illegible] health authorities [illegible] and H.O.L. 96/65 [illegible] of which are attached.

2nd December, 1965

To: Regional Hospital Boards
Hospital Management Committees
Boards of Governors

F/M. 121/65

Enclosure to H.M. (65) 104

NATIONAL HEALTH SERVICE

IMPROVING THE EFFECTIVENESS OF THE HOSPITAL SERVICE FOR THE MENTALLY SUBNORMAL

Summary. This memorandum describes ways of improving the effectiveness of the hospital services for the mentally subnormal. It defines the major groups who may require admission to hospital and the main criteria for discharge. It outlines the facilities which should be available to children and adults in hospital, and extramural services, including outpatient clinics, day hospitals and counselling services. It stresses the importance of links with the local authority and voluntary services and with the family doctor, and ways of achieving these are given.

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1. The Royal Commission on Mental Health recommended that there should be a re-orientation of the mental health services towards community care and away from hospital care except where the special facilities of the hospital service are needed. The aims to be pursued were set out in H.M. (59) 46 and Circular 9/59. Since then hospital authorities have increasingly concentrated on the provision of services for those who need the special facilities of a hospital and local health authorities have developed their services for those who need care in the community. Much progress has been made, although development has been slow in some areas. A reappraisal at this stage of the function of the hospital and of the local health authority services for the mentally subnormal will help to ensure that, as the services develop further, hospital resources are employed in the most effective way. This cannot be achieved unless the plans for the future, whether hospital or local authority, are worked out in co-ordination with the other services concerned, including the voluntary services.

2. The aim of this memorandum is to describe in more detail the functions of the hospital services and of certain elements of the local authority services and to emphasise the need for co-operation between them. It is hoped that it may stimulate discussion and encourage re-thinking about diagnostic problems, and about the treatment and needs of the mentally subnormal person. It is also hoped that it may stimulate research into the evaluation of the services provided. Many of the considerations discussed in the memorandum issued with H.M. (64)45 on "Improving the Effectiveness of Hospitals for the Mentally Ill", particularly those discussed under "Obstacles to Improvement", apply equally to hospitals for the mentally subnormal.

General Considerations

3. The function of a service, whether it is provided by the hospital or local authority, will vary according to the type of person for whom it is intended. The main groups who may require help are:

(i) Children who can benefit from attending junior training centres or comparable centres in hospital.

(ii) Adolescents and adults who require further treatment or social and vocational training specifically designed to increase their degree of independence.

(iii) Others of all ages, including severely subnormal children with physical handicaps, who need comprehensive nursing care and who profit only to a limited extent by attendance at training or industrial centres in or outside hospital.

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Some subnormal adults can be placed in open or sheltered employment, some can live in the community if places in training or industrial centres are available and some will require hospital services indefinitely. The ability to follow employment, or to benefit from attendance at a centre, may depend on the provision of some form of residential accommodation or other services by the local authority.

4. The general aim of hospital care is, wherever possible, to enable the patient to return to life in the community, either independently or with help from the local authority or from other sources.

5. Patients admitted to hospital because they are mentally handicapped generally have emotional, social or physical problems as well. Adequate facilities must be provided for investigating and assessing these problems. These facilities should include the services of social workers and psychologists, and the equipment for investigating sensory defects and other neurological abnormalities. Provision should be made for consultants in paediatrics, neurology and orthopaedics to have regular sessions at hospitals for the subnormal.

6. Admission to a subnormality hospital should be advised only if the special facilities it offers are needed by the patient. Admission will depend not only on the patient's condition but also on social factors and on the degree of development reached by hospital and local authority services. Hospitals should reserve a number of beds for short-term purposes. In the absence of complicating conditions, such as severe physical disability or disturbed behaviour, the severely subnormal patient who has been adequately investigated and treated ought not to be primarily the responsibility of the hospital service for long-term care. Ultimately, when facilities outside hospitals are fully developed, continued hospital care will be necessary only for patients who require special or continuous nursing and for those who, because of unstable behaviour, need the kind of supervision and control provided by a hospital.

Suitability for Admission

7. Mentally handicapped patients who need to be admitted to a hospital for the subnormal generally fall into one or more of the following categories:

(i) Patients requiring constant nursing care.

(ii) Patients for whom special methods of diagnosis are required.

(iii) Patients requiring hospital treatment for a condition other than subnormality who, on account of their behaviour or degree of subnormality cannot be admitted to any other kind of National Health Service Hospital.

(iv) Patients with marked physical disabilities who cannot be cared for at home. (Children with physical disabilities may often be more suitably placed in paediatric units than in hospitals for the subnormal).

(v) Patients who because of disturbed behaviour are unsuitable for outpatient treatment or for care in the community.

(vi) Patients requiring treatment or training under conditions of security short of those provided at the Special Hospitals.

(vii) Patients who normally live at home but require short-term care.

Where local authority provision for care in the community is well developed it will be easier to limit hospital care to those who really need it. For example, elderly subnormal people who have spent all their lives in the community are less likely to need admission to hospital if places in suitable homes for the aged are provided.

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Again, early assessment and an effective counselling service, coupled with the necessary social and medical support, may obviate, or at least reduce, the need for admission.

Readiness for Discharge

8. Discharge of a patient from hospital will be considered when one or more of a number of conditions are satisfied. A determining factor may well be the availability of local authority services, especially where home conditions are unsatisfactory. Among the indications for discharge are:

(i) The completion of the diagnosis and assessment or treatment for which the patient was admitted.

(ii) The completion of a period of short-term care.

(iii) In the case of a child, suitability for a trial at a day or residential school or at a junior training centre.

(iv) In the case of an adolescent or adult, suitability for a trial at an adult training centre.

(v) Stability of behaviour, competence in daily living, or sufficient skill in industrial or other work.

(vi) The availability of employment and suitable lodgings.

(vii) The ability and readiness of relatives to take the patient home.

(viii) The availability of a foster home or other type of community residential placement.

Special attention needs to be given to the preparation for discharge of patients who have been a considerable time in hospital. Ability to function reasonably well in hospital is not the same as ability to function reasonably well outside: patients who are being considered for discharge must be trained to cope with the conditions in which they will live and work after discharge.

Links with the Community

9. Early recognition of subnormality can often be made by medical officers, health visitors and midwives on the staff of the local authority's maternity and child welfare services. Diagnosis may also be established by the family doctor, the specialist in subnormality and the paediatrician. After complete assessment, in which psychological assessment plays an essential part, a mentally-handicapped person and his family should continue to have available to them counselling services from these sources. It is important that there should be close contact between local authority and hospital staffs, not only in the treatment of individual patients, with which the family doctor will also be associated, but in the planning of facilities. The following are examples of ways in which this may be brought about:

(i) Regional and local mental health liaison committees.

(ii) Out-patient clinics for the early diagnosis and treatment of subnormal children and adults. These can with advantage be held in the general hospital by the specialist in subnormality in conjunction with other specialists and with staff of the local health authority.

(iii) Domiciliary consultations, which can be of great value in assessing the environment of the patient and his family.

(iv) Appointment of a specialist in subnormality as a shared appointment between hospital and local authority services. The services of social workers may be shared in the same way.

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(v) Clinical assistantships at hospitals where adequate teaching is availabl for family doctors and local authority medical staff.

(vi) The attendance of psychiatric and other social workers, and nursing staff, at case conferences either in the hospital or in local authority premises, such as training centres and hostels. Mental welfare officers can in this way follow the progress of patients from their area and know when they are to return to the community.

10. Each subnormality hospital or group of units should primarily serve a defined and accessible area, though it should not rigidly refuse to accept suitable patients from outside this area. Contact with the the community life of the area should be promoted in all possible ways. Visits by the patient's personal friends and relatives and by voluntary helpers, and attendance at social clubs run by local authorities and parents' groups, should be encouraged. Social activities outside the hospital, such as expeditions and holidays, may be organised, and permission should be given for visits to shops, cinemas, etc. in the neighbourhood. The quality of the patient's life in hospital and of his contact with life outside the hospital depends greatly on the activities of local voluntary organisations, which can provide the wide range of services set out in H.M. (62) 29.

Day Hospitals for the Severely Subnormal

11. Subnormality hospitals should make day hospital provision for patients who need specialist treatment or constant nursing care, but who can be managed in their homes at night. Such patients will include adults and children with disturbed behaviour or with gross subnormality associated with physical handicap. In the absence of day hospital facilities such patients would qualify for admission as in-patients or their discharge from hospital might be delayed.

12. Though facilities for diagnosis, treatment and rehabilitation should be available, the day hospital need not be on the same site as the parent hospital. It can with advantage be sited within or close to a general hospital, whose facilities, e.g. physical medicine, x-ray, pathology and paediatric departments, it can then share. This not only has direct clinical advantages, especially for the physically handicapped patient, but also helps to bring the geographically isolated subnormality hospital into closer contact with the community it serves.

13. The distinction between those of the subnormal who can benefit from local authority day care and those who require the services of a day hospital is likely to be determined by whether they need social support and training on the one hand or clinical investigation and assessment, specialist treatment or constant nursing on the other. The provision of day hospitals, in addition to out-patient services and the various services provided by local health authorities, should result in a comprehensi service covering a broad range of day care which can be used according to the needs of individual patients and their families.

Organisation within the Hospital

14. The development of self-confidence, self-reliance and self respect is all important, and the extent to which this can be achieved depends on both the internal organisation of the hospital and the attitude of the staff. There should be the minimum of regimentation and the patient's initiative should be continuously encouraged. All patients, adults and children, must have personal marked clothing, including underclothing, which they can regard as their own. They should also be encouraged to use private clothing provided by parents and relatives. Many severely subnormal patients are completely dependent for all their physical needs on nursing care. The tasks involved in feeding, washing, clothing and tending these patients are formidable, but given sufficient staff, adequate space, good equipment and labour-saving devices high standards of care can be achieved and maintained. The aim should be to develop in each patient the maximum social independence of which he is capable, not only to enable him to live as full a life within the hospital as he can, but to prepare him for return to the community wherever this is possible.

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15. Mentally subnormal children need the same sort of stimulus and sensory training as normal children obtain from play, exploration and affectionate care. Many of their problems can be met by modern methods of child care and rearing. Paediatricians, psychologists, nursery nurses, nursery school teachers and others used to dealing with normal children can usefully advise.

16. The most important need for adults is regular work, and some forward-looking hospitals have organised comprehensive training programmes geared to working conditions outside hospital. The creative use of leisure is also of great importance, and social clubs and other forms of group activity should be available in hospital or elsewhere. Local youth clubs can often help, particularly in urban areas.

17. The separation of the sexes has been traditional in subnormality hospitals, but the benefits of mixing, e.g. in workshops and O.T. departments in children's wards and schools, in classes for further education and in social and recreational activities, are beginning to be appreciated. Mixed units and departments catering for both sexes may be staffed by male and female nurses. In the case of children there is therapeutic advantage in having wards staffed by both male and female nurses.

18. A ward should not normally accommodate more than 30 adult patients or 20 children. It may with advantage be subdivided into smaller units. Each patient requires a measure of privacy and at least a locker in which to keep his private possessions, and, in the case of a child, his toys.

19. Each child needs to have toys and possessions of his own. There should always be a large stock of playthings which can be used by all the children on the ward. Simple, solid, play equipment of a semi-permanent or permanent nature should be provided, e.g., swings, climbing frames, chutes, roundabouts, and toy trucks and push carts in which children can sit.

20. Hospitals are finding increasingly that without detriment to their efficient working they can dispense with visiting passes and even with regular visiting days and hours.

Educational, Social and Vocational Training

21. The education and rehabilitation of the patient is the concern of many grades of staff working as a team. Education in this context should aim at developing social competence, manual skills, literacy, the use of numbers, general knowledge and ability to make use of the social services provided by the community. Provision should be made for all patients to spend a part of the day off the ward unless this is contra-indicated for medical reasons.

Children.

22. Less severely disabled children will be catered for in the hospital school. More severely disabled children, incapable of benefiting from the normal activities in the hospital school, will need two rooms - one for those who are reasonably mobile and one for a less active or immobile group. The children with severe behaviour disorder but of higher intelligence, require special educational provision.

23. There must be co-ordination and continuity between the school and the adult education classes and workshops. Lack of continuity creates a gap in the training provided for patients, and, in order to avoid this, training in the last year in the school should be a preparation for the next stage.

24. The cases of children aged 5 and over with an I.Q. of 50-55 plus should be reviewed with a view to having them recognised by the local education authorities as suitable for education at schools provided by them.

Adults.

25. Patients who leave the hospital school will require further training in work habits and skills, such as might be provided in industrial units, hospital services etc.

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The variety of training offered within the hospital should be related to the opportunities for employment in the community. Work assessment units are useful to ensure that patients will always be suitably placed.

26. Further education programmes should be directed towards:

(i) The development of social competence through a variety of realistic social situations, such as the use of public transport, the post office and shops.

(ii) Training in personal hygiene - shaving, make-up and the care of clothing

(iii) Elementary reading, writing and the use of numbers, and the practical applications of these skills, for example, in the completion of forms for savings accounts etc.

Physical education and home management sessions, including such subjects as domestic cookery and laundry, are useful in long-term training schemes. Attendance at local education authority education classes in the community may be arranged or local authority teachers may come into the hospital.

The Elderly

27. Elderly patients, like those of working age, need useful occupation and appreciate opportunities for work and recreation. Very careful assessment will be needed before they can be discharged to local authority hostels. For many the hospital, may have become their home and a move may be both unwise and unkind. Some hospitals arrange to send patients either singly or in groups of 4 - 5 on trial to a local authority home, on the understanding that they will be taken back if they do not settle.

Research

28. Research encourages staff to think about what they are doing and whether there might be better ways of doing it. This in turn raises the level of clinical work. It would be useful for each hospital to have at least one demonstration and staff training ward where new ideas could be introduced. Staff might be encouraged not only to see how many of the very lowest grade of patients could be stimulated to engage in some purposeful activity but also to explore ways of improving contact with parents and relatives.

29. Research within the hospital can usefully be supplemented by studies of other ways of caring for the subnormal and severely subnormal. There is a need for research into the function of hospital nurses in the subnormality field, including the possibility of treatment and follow-up in the community. Controlled trials to compare the effects of different kinds of training or residential care would be of value. In addition to operational research, undertaken jointly with local authorities, hospital authorities should seek opportunities to develop research in the specific fields of psychology, clinical medicine, genetics, pathology and biochemistry. Whenever possible, research should be linked with appropriate units outside the subnormality hospital, e.g., paediatric departments, and University and Medical Research centres.

30. All services for the mentally subnormal provide valuable opportunities for teaching Various professional groups already take advantage of these opportunities, and whenever possible contact with adjacent medical schools, Universities, teacher training schools and other educational centres should be encouraged. Demonstrations and lectures provided by the staff of the hospital to medical undergraduates and post-graduates, psychologists, teachers, health visitors and others will help to raise standards in the hospitals as well as to spread knowledge of this branch of medicine and of its many problems.

Ministry of Health.