PROBLEMS ARISING THROUGH TRANSFER OF PSYCHIATRIC CARE FROM LARGE MENTAL HOSPITALS TO PSYCHIATRIC UNITS IN GENERAL HOSPITALS

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Abstract

A brief review of the historical background of psychiatric treatment in England and Wales, followed by suggested architectural needs for a psychiatric unit in a general hospital. There is a plea for help in designing studies to evaluate the advantages and disadvantages of mental and general hospital milieux.

I would like to discuss the problem of the appropriate environment for the treatment of psychiatric illness. My experience is confined to the situation in England and Wales and my remarks will refer to my personal knowledge. I have no reason to believe that the situation is very different in other countries, although there are minor variations. I think it important to set the problem in context by giving a brief historical account of the background to the present situation.

Historical

In the 18th and early 19th centuries lunatics were dealt with under the provisions of the Criminal, Poor and Vagrancy Laws (Jones 1972). In Victorian England a gradual recognition dawned that these were individuals who required particular consideration because of their handicaps and that it was unreasonable to consider them responsible for their behaviour and their inability to earn a living. County lunatic asylums were built up throughout the 19th century, to house relatively small numbers of patients (Table 1) but there seemed to be little awareness of the size of the problem that awaited them. Although it would be wrong to think that no patients were discharged from these institutions, nevertheless, numbers mounted rapidly since one was dealing with a chronic non-fatal illness. As an example Hanwell Hospital, opened in 1850, doubled its size over the next 15 years. (Table 2). This led to problems of overcrowding which are with us almost to the present day.

During the first part of the 20th century much of the legislation
TABLE 1. The first nine county asylums in England

<table>
<thead>
<tr>
<th>Year</th>
<th>County</th>
<th>Approximate Cost</th>
<th>Accommodation Built for</th>
</tr>
</thead>
<tbody>
<tr>
<td>1811</td>
<td>Nottingham</td>
<td>£21,000</td>
<td>80</td>
</tr>
<tr>
<td>1812</td>
<td>Bedford</td>
<td>£10,000</td>
<td>52</td>
</tr>
<tr>
<td>1814</td>
<td>Norfolk</td>
<td>£35,000</td>
<td>102</td>
</tr>
<tr>
<td>1816</td>
<td>Lancaster</td>
<td>£60,000</td>
<td>170</td>
</tr>
<tr>
<td>1818</td>
<td>Stafford</td>
<td>£36,000</td>
<td>120</td>
</tr>
<tr>
<td>1818</td>
<td>West Riding</td>
<td>£55,000</td>
<td>250</td>
</tr>
<tr>
<td>1820</td>
<td>Cornwall</td>
<td>£15,000</td>
<td>102</td>
</tr>
<tr>
<td>1820</td>
<td>Lincoln</td>
<td>£12,000</td>
<td>50</td>
</tr>
<tr>
<td>1823</td>
<td>Gloucester</td>
<td>£44,000</td>
<td>120</td>
</tr>
</tbody>
</table>

TABLE 2. Expansion of hospital population

<table>
<thead>
<tr>
<th>Year</th>
<th>HANWELL HOSPITAL (Now St. Bernard's, Middlesex)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1831</td>
<td>Built for 300 patients</td>
</tr>
<tr>
<td>1832</td>
<td>Opened 500 &quot;</td>
</tr>
<tr>
<td>1835</td>
<td>570</td>
</tr>
<tr>
<td>1837</td>
<td>(New wings) 900 &quot;</td>
</tr>
<tr>
<td>1847</td>
<td>1000</td>
</tr>
</tbody>
</table>
concerning the lunatic was directed less at caring for the handicapped and more at protecting the sane from illegal and unnecessary incarceration. With the arrival of physical treatments such as shock therapies there came a recognition of the possibility of adequate treatment and the desire for voluntary rather than enforced hospital admission. In England in 1930 the Mental Treatment Act introduced the concept of the voluntary patient. It was now possible for an individual to seek admission to hospital on his own initiative rather than be forced in by a process of certification as insane. At the same time one was seeing the development of out-patient clinics in the general hospitals and to a much lesser extent the provision of specialised units for minor psychiatric conditions.

Immediately after the war came the introduction of the British National Health Service. This brought virtually all the mental hospitals under a central authority, responsible for medical services throughout the country. There was a great increase in the standard of staffing and of money spent on the patients as a result of the National Health Service. An additional factor was the large number of doctors coming back into civilian life after the war; some of these had received psychiatric training to help deal with war neuroses.

A number of separate but interconnected factors began to have their effect on the mental hospital milieu, resulting in changes which expressed themselves in a Mental Health Act passed by Parliament in 1959. Increased staffing, a change in attitudes and the introduction of psycho-pharmacological agents all had the effect of opening up the mental hospitals and the abandonment of locked doors and restrictions for the great majority of patients, and at last a fall in the number of resident patients (Figure 1).

The Mental Health Act set parliamentary seal on the changes which had gradually been taking place. The mental hospital was no longer the only place for the housing of psychiatric patients; they could be admitted to any suitable accommodation in any hospital. While most patients were of informal status there was of necessity need for compulsory detention for the small minority of patients who were unable to accept their need for hospital treatment. To preclude claims of unnecessary compulsion a Mental Health Review Tribunal was set up in each region to hear cases of patients who claimed that they were being unnecessarily detained in hospital. In practice these turned out to be few in number. The stage was now set for the move away from the traditional mental hospital and into the
FIGURE 1. Change in absolute number and rate per thousand of mental hospital population.

The psychiatric unit in the general hospital

Psychiatric units have developed in four main ways. Firstly there is the unit of half a dozen beds as part of a general medical ward. This is just a gesture to the idea of psychiatric beds in the hospital and has very little value for the treatment of the vast majority of conditions. Secondly, there is the psychiatric ward which is adapted from, or designed in association with, a medical or surgical ward. It is very rare to find even with extensive adaptation, that this can function adequately. The needs of the psychiatric patient are so different from those of the person admitted for medical or surgical investigation and treatment that even the physical shape is inadequate and only the most makeshift arrangements can be provided. There have, unfortunately, been a few new hospitals which in conformity with what they consider to
in which gardening can take place are probably useful accessories to the unit. More extensive open air recreation can best be carried out in nearby parks while the town can also provide shopping, cinema, beauty salon and similar facilities rather than relying on segregation of the patient within the hospital community.

Within the building the patient can expect a reasonable degree of space, comfort and privacy, consistent with the demands of his illness. A few psychiatric patients, particularly in the early stages of their illness, need considerable supervision and nursing, while the majority are up and dressed during the day and need to carry out some purposeful activity which is both therapeutic and productive. Not all patients, in fact, need to be in hospital and providing that the hospital is in an urban area a number can live at home at night and spend the day in hospital undergoing any necessary treatment procedures. There is thus need for an Activities Area (Seager, 1973) which functions from first thing in the morning to last thing at night in which congregate patients who spend a relatively small part of the 24 hours in bed either in the hospital ward or in their own home. Patients can transfer from one status to the other according to clinical condition; similarly weekends may be spent either in hospital or at home according to circumstances. The activities area must therefore be large in size, capable of accepting all the in-patients who are fit to be up and about as well as the day patients from the surrounding area. The patients' visitors may also join the group in the evening.

First of all, there are the individual interview offices and larger rooms in which small groups can work. Then there are specialist treatment areas for electrotherapy, abrasions, behaviour therapy, etc. Thirdly, there are rooms devoted to a wide diversity of activities under the general heading of occupational therapy. This would include crafts, heavy woodwork, industrial therapy, domestic rehabilitation, clerical work, music and painting and room for other activities whose scope will depend on local facilities. Finally, there is need for dining space, quite probably on a shift system for so many individuals and also adequate lounges in sufficient number to cater for noisy and quiet activities of varying age groups. Some of the occupational therapy facilities can be used for this purpose.

On the upper floors will be found sleeping accommodation as well as facilities for the more disturbed patients. Accommodation should probably be mainly in the form of single rooms, since these are largely for sleeping purposes. They should be grouped in numbers of approximately 25 - 30, this being the size which
can be cared for by a psychiatric team. In such a unit at any one time there may be three or four patients suffering from some degree of disturbed behaviour, e.g. over-activity, suicidal. These would need supervision in single rooms overlooked by the nursing station. With active treatment it seems unlikely that there will be need for long-term seclusion of disturbed patients. Some psychiatrists favour use of four-bedded rooms for the recently admitted patient so that adequate supervision can be offered.

On such a unit there is also need for a small dining area and sitting room to enable those patients who are unfit to leave the ward to have somewhere to sit during the day while there is also need for a small kitchenette, so that patients and nurses can make suitable refreshments at night.

Certain additional features are necessary from the point of view of the staff. There is some degree of incompatibility between the demands of the patient for privacy and the need for observation and security. Experience suggests that bars, locked doors and similar manifestations of imprisonment lead to more disturbed behaviour rather than reducing it. High staffing levels and a full programme of activities seem to be more satisfactory ways of containing the disturbed individual. For members of a psychiatric team an interview room is just as important a piece of equipment as the operating theatre is to the surgeon. There is, therefore, need for single rooms sufficient to house all possible members of staff and this will include students where teaching is a function of the unit. While it may be possible for each person to have his own office which he can also use as an interview room, it is often more satisfactory to have a central suite of interviewing rooms which are used by all who need to see the patients, arrangements being made to bring in case notes when the room is booked. A proportion of these rooms should have one-way vision screens or closed-circuit television for teaching purposes. A conference room is necessary so that members of the staff can get together in private to discuss problems arising in the unit. This may also house a collection of books and journals for educational purposes. However, an important advantage of a unit in the general hospital is relationship with colleagues in other specialties and it therefore may be more appropriate to have educational facilities at a central teaching unit used by all staff of the hospital. Similarly, staff dining room and lounge should be communal so that there is no segregation of specialties. Another advantage of the general hospital unit is the access to laboratory facilities and advice from other specialists concerning problems that may arise in a psychiatric patient.
Problems

In general one is faced with the problem of substituting relatively small units, near to the home and neighbours for large, often isolated mental hospitals. The former provide many advantages but present environmental problems of structure and design so that they can offer similar facilities to those provided by the much larger mental hospitals, without the disadvantage of stigma and isolation, both medical and social.

Some of the areas for consideration are -

1. Depending on the population area it serves a unit may be quite small in size, perhaps 50 in-patients and 40 day-patients. Segregation according to age, dependency needs and type of illness may, therefore, be difficult. There is a tendency to produce a common environment catering for all needs. In particular the slower pace of psychiatric hospitals tends to be incompatible with that of a general hospital.

2. The situation does not lend itself to specialisation within the general psychiatric framework. It is difficult to provide for a special interest, for example, anorexia nervosa, unless one's colleagues pass on all such cases and in return receive some special interest cases of their own. Similarly, two psychiatrists working alongside each other may have very different views about appropriate treatment and since their patients are in day-to-day contact the idea of a therapeutic community and physical treatment approaches may lead to difficulties both for the patients and the doctors.

3. There is an increase in demands on the psychiatric unit in the general hospital since the physicians discover patients whom they have hitherto discharged as functional, but whom they now discuss with their colleagues over lunch and then refer for investigation and treatment. While in theory this is to the advantage of such patients, in practice it must pose considerable strains on an already stretched service. This in its turn may lead to difficulties in providing some of the more time-consuming treatments such as individual psychotherapy or behaviour therapy.

4. There is need for additional provision for special groups of patients such as the drug-dependent, the security problems referred from the courts, the psycho-geriatric and the adolescent, for example.

5. Finally, there seems no easy scope for the concept of asylum. The care of the patient who is not going to recover completely
from his illness but is going to require supervision and care for the remainder of his days. Either he can remain in the unit and thereby gradually block a number of available beds for the more acute patients or some special provision must be made elsewhere for these handicapped individuals who require a relatively minor degree of medical treatment but who need suitable accommodation and tolerance of their eccentric patterns of activity.

Solutions?

In Britain the Department of Health and Social Services have produced two documents entitled Hospital Services for the Mentally III (HM (T1) 97) and Services for Mental Illness Related to Old Age (HM (T2) T1). These two documents outline a pattern for psychiatric services in England and Wales based on the concept of the unit in the general hospital. There is considerable debate going on concerning the provisions of these documents which are in outline what I have described above. It is suggested that each population centre of some quarter of a million is served by a district general hospital and will provide amongst its other facilities a psychiatric unit consisting of four specialist teams, each catering for the psychiatric illness arising from a population of approximately 60,000. The team would have 30 in-patient beds and an additional 20 day places as part of the main unit. Over the years the mental hospital which formerly looked after the needs of the area would gradually run down since no more patients would be admitted and the long-stay patients would gradually die. In due course residual groups of patients would be moved to alternative accommodation.

Brief outline of the future plans for British psychiatry are producing heated arguments. The questions being asked are, whether such plans are practicable, humane, therapeutic, realistic and acceptable? Fortunately, there will be no overnight transformation because hospitals cost a lot of money and take a long time to build. We have at the moment approximately 100 such units in Britain, of which 10 new ones are large enough to provide adequate facilities for a given population. The question I bring to you is how best to study the new environment and the old as a means of satisfying the variable needs of the psychiatric population (Seager, 1972).

One can set up experimental designs as, for example, did Maslow and Mints (1966) who examined the effect of "beautiful" and "ugly" rooms on their users, while Mints (1966) also looked at the effect on the experimenters. Kasmar and her colleagues (1968) carried out a similar study on patients, measuring the
effects of the environmental surroundings on their mood and on their perception of the psychiatrists. Alternatively, there is the technique of sociometry - measuring the interaction of the patient with his fellows and with the environment (Socmer and Ross, 1958, Proshansky et al., 1970).

There is, of course, no single solution to a situation of this kind but simply a series of compromises which will satisfy the greatest number of demands. I welcome your views and suggestions.

References

Department of Health and Social Security, 1971, Hospital Services for the Mentally Ill. RM (71) 97. London H.M.S.O.

Department of Health and Social Security, 1972, Services for Mental Illness Related to Old Age. RM (72) 71.


269