The Future of Psychiatric Hospitals*

by

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It is the stated policy of the Minister of Health to shut down as many as possible of the large mental hospitals within the next fifteen years, basing the future service on psychiatric units and community care. If psychiatric units in general hospitals are to be the basis of the service, it is vital that there should be a great deal of thought and discussion before it is finally decided how they are to be organised. None of us want to keep the present huge and unwieldly mental hospitals, but we have learnt a lot in them. As treatment of psychiatric disorders has advanced, attitudes towards the mentally ill have changed out of all recognition. It will be a great loss to the future if the experience gained in these hospitals is not used in planning the new psychiatric units. Yet there is a real possibility that this may happen. In the present discussions concerning psychiatric units, some fundamental points are in danger of being overlooked. The concept of the psychiatric hospital as a therapeutic community is generally accepted in theory. Nevertheless, there is a tendency to plan psychiatric units on general rather than on mental hospital lines. This is partly due to the fact that progressive change in the mental hospital is comparatively recent; but there is also a strong tendency to delude ourselves that mental and physical illness are essentially the same. This is not so. When treatment facilities and hospital administration are considered, the differences are far more important than the similarities.

"Therapeutic Community" can be no more than a new name for the old mental hospital or psychiatric unit unless it truly implies revolutionary changes in our concept of treatment and administration. The hospital cannot begin to be a therapeutic community unless the whole life of the patient in hospital is seen as treatment: this includes the emotional atmosphere, the kind of personal relationships that surround him, and the ultimate effect upon him of the administrative structure. Our experience of the therapeutic community as worked out in mental hospital wards and administration, may have more to contribute to planning general hospitals than general hospital experience can offer to the new psychiatric units. Psychiatry no longer needs to adopt an inferior or apologetic attitude towards general medicine or surgery: it should share with

* *This article, whilst the responsibility of its authors, has grown out of innumerable discussions and represents the views of many others at Claybury.*

them what has been painfully learnt about the care of patients as people, and it should plan its own units independently.

The general hospital plan of a ward in which beds are shared by a number of different consultants with different ideas is a great obstacle to the development of a true therapeutic community. Since most psychiatric treatment is still empirical it is both good and inevitable that consultants should have varied approaches to the treatment and management of their patients. It is, however, disastrous to a truly therapeutic atmosphere that any single unit or ward should be divided by conflicting and even opposed points of view. It has already been the experience of some hospitals that a therapeutic community is extremely difficult to develop under such conditions. In planning new units it is, in our view, of the greatest importance that this principle should be borne in mind, and that small comprehensive units, each under the direction of a single consultant, should be set up and linked, if necessary, into a larger whole; thus, divided responsibility can be avoided amongst patients who share a common life in a unit or ward.

We have said that the units should be comprehensive and this needs further discussion. It is being generally assumed that long-stay patients—those in hospital more than two years—will be cared for in separate units, apart both physically and socially from the short- and medium-stay patients. The argument that patients are reluctant to go into mental hospitals because they have to mix with, or see, the long-stay patients is already weakened by the thousands of patients who readily seek admission in spite of this. The argument will disappear altogether in future, when no well run psychiatric unit should any longer produce severely regressed and deteriorated patients. It has been adequately demonstrated that such deterioration was not the inevitable result of chronic mental illness. In our view there is a serious danger of putting the clock back by developing separate long-stay units; these will tend to be relatively neglected by a majority of psychiatrists and the patient's present fear of being moved to a long-stay ward in a mental hospital will be replaced by a worse fear of being moved to "another hospital" where they are all "hopeless cases". The very existence of such units may perhaps encourage their unnecessary use, in the same way that locked wards in mental hospitals tend to be used too readily to solve difficult problems. Such hospitals could only too easily fill up with "hopeless" people and once more we should "need" the large mental hospitals which present policies aim to abolish. It has been shown to be possible in a therapeutic community to develop an atmosphere in which more recent patients can benefit from learning to help and care for those who need longer treatment, and in which the general social mixing can be beneficial to both. It helps those who are long-stay to maintain a better social adjustment and it enables the more recent patients to work

through their phantasies of "madness" and to come to terms with mental illness as a community problem, not something to be hidden in an asylum, mental hospital or long-stay annexe, call it what you will.

For the reasons stated we believe that there is a strong case for establishing small comprehensive psychiatric hospitals of 200 to 300 beds, serving circumscribed areas to facilitate community care. We further consider that such hospitals should be planned on a unit basis, each unit being the responsibility of one consultant only, to ensure an undivided therapeutic administration. Such hospitals could be part of general hospitals but this is not essential since they will be carrying out a task different from that of general medicine and surgery. It would be wrong to assume that by making the psychiatric unit as much like the general hospital as possible, the "stigma" of mental illness would be removed, and the primary purpose, of serving the best interests of the patients, might well be frustrated.

The present attempt to make mental illness and the emotions respectable by pretending that mental and physical illness are the same and require essentially the same kind of treatment and care, is influencing the plans for the training of nurses. A comprehensive training, to include mental and physical nursing, cannot be given in a general hospital with only a short-stay psychiatric unit, nor do we think that the present training of a general nurse is a good basis for psychiatric nursing; the general hospital with its hierarchical structure, orientation towards physical illness and pattern of doing things *to* patients is a poor preparation for nursing in a therapeutic community in which activities take place *with* the patient and doing things *to* him is a comparatively small part of treatment. In many regions it is the policy to base the psychiatric services on the mental hospital; psychiatrists from the mental hospital have, or are to have, appointments at the general hospital psychiatric units, and in some cases the nursing staff of the units come from the mental hospital. In whatever way the liaison between psychiatric unit and mental hospital is arranged it seems important to maintain strong links between them, and the nursing staff should be included in the plans. There is reason to think that some general hospitals will resist any such association and will try to keep their own short-stay units isolated from the mental hospitals.

Nurses in the big mental hospitals are naturally anxious at present because their future is so uncertain, and in some places this anxiety has discouraged, probably temporarily, new applicants to the profession. This anxiety will, we fear, be justified if long-term treatment is to be divorced from short-term and the latter wedded to the general hospital. If, on the other hand, the big mental hospitals are gradually replaced by small comprehensive psychiatric hospitals, the care of the long-stay patient need not relapse into the

institutionalisation from which it has been slowly raised during the past fifteen years, and the long-stay patient and his nurses will not relapse into relative neglect.

These matters require urgent attention; Regional Boards are going ahead with plans for short-stay units in general hospitals: existing wards are being adapted and small or medium sized new units built (20 to 100 beds). 200- or 300-bed comprehensive units will be much more expensive to build and we fear that unless adequate money is set aside for them the psychiatric services may be left in a worse state than they are at present; they may have to make do with the big hospitals for long-stay patients, but without the enthusiasm and hopefulness which exists in many of these hospitals today just because, whatever their shortcomings, they are trying to provide a comprehensive service for their patients and for the community.

"Mental Subnormality - Whose Baby"?

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Firstly, I should make it clear that the use of the word "Baby", in the title of this paper, refers to mental, not chronological, age. In other words, I am not restricting myself only to a consideration of mentally subnormal children. Nevertheless, it has some metaphorical meaning in so far as we are discussing a problem whose unpopular aspects are frequently apt to be bounced on to someone else.

It is an ironical characteristic of this "child" in countries all over the world, that, though actual parentage may be uncertain, there are a large number of hopeful father-figures all anxious to control some aspect of its destiny—educators, administrators, psychologists, social workers, psychiatrists, geneticists, biochemists, paediatricians, hospital authorities, local authorities, etc. It may, therefore, be useful to consider what particular qualifications each of these has to adopt this infant speciality.

The fact that, at least in the higher grade children, scholastic disability seems to be the most pressing problem, suggests that educators and teachers have the most fundamental role to play. It has certainly been demonstrated that, by special teaching methods, in E.S.N. and hospital schools, some degree of mental retardation can be largely overcome, and, with some patients, suitably planned education in their formative years can be the vital factor in the ultimate usefulness of their lives. There are many patients, who, however, because of emotional or physical factors, low grade or age, do not respond to these methods, and there are social, medical, rehabilitation and research problems that would not be dealt with