

# THE ENGLISH OPEN MENTAL HOSPITAL: IMPLICATIONS FOR AMERICAN PSYCHIATRIC SERVICES

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**D**URING the past decade there has been increasing interest on this side of the Atlantic about the British experiment in the organization and administration of psychiatric services. For, while it remains true that present methods cannot cure persons suffering serious psychotic illnesses, the severity of the symptoms and the extent of personal and social disability which result can be reduced considerably by well-established techniques. These techniques include re-educational and psychotherapeutic measures, physical treatments (such as insulin coma and electroshock therapies and drug treatments of anxiety), and social manipulations of the patient's relationship to his environment. However, it has only recently been appreciated that a large proportion of the patient's more distressing and disabling symptoms can be prevented by appropriate conditions of living and treatment. It is this aspect which has been concentrated upon by the more advanced units of England's psychiatric services, and it is these open door mental hospitals and community psychiatric services which we can study with profit.

One of the earliest organizations to perceive this has been the Milbank Memorial Fund which has for the past five years been stimulating the American mental health movement by sponsoring study tours to England, by inviting the directors of England's open mental hospitals to visit their American colleagues, and by holding professional meetings at which the two groups could discuss theoretical considerations and practical applications of this approach to psychotic disability.

Last year I, too, journeyed to England to visit these pace-setting open door hospitals at the Fund's behest and have re-

turned convinced that we have much to learn from their experiences.

What distinguishes these "open door" hospitals?

One of the most striking features is immediately apparent as one enters them: by removing the prison atmosphere that has existed for almost a century, an image of fear was replaced by a feeling of warmth and understanding. This warmth and understanding of the patient and his problems seems to radiate wherever one goes. The bars and bolts and rings of keys, which for over 100 years signaled the asylum as a grim jail, a terminus at oblivion, are gone; they are as startling to the average American as today's general hospitals would have been to our great-grandfathers had they suddenly come across them. For the general hospital of a century ago was looked upon with fear and revulsion, a death house where "epidemic pestilences" made "patients, however extreme their need, dread the very name of hospital, and the most skillful surgeons distrust their own craft." \* Thus one can say that public reaction to the general hospital before Lister's aseptic revolution, and popular reaction to today's locked mental hospitals, are analogous except in degree.

The second striking feature about these open hospitals is the acceptance and appreciation which they evoke in the communities they serve. They are seen as a place of hope, a place where the sick get treatment, a place which helps them recover from their illnesses and assists them to get re-established in the community. In the words of a supervising nurse at one of these trail-blazing services—Mapperley Hospital, Nottingham—"Our biggest problem is to keep the outside population from coming in, not the patients from getting out."

Let us examine some of the more important concepts involved in the administration and operation of the open door hospitals. Last summer, I spent a couple of weeks visiting a number of the most advanced units in England: Mapperley, Littlemore,

\* Sir Thomas Clifford Allbut, M.D., F.R.S., *Lister* in *ENCYCLOPEDIA BRITANNICA*, (XI Edition), Vol. 16, p. 778.

Horton Road, Coney Hill. While they differ in detail from one another (for they are, after all, the creations of their directors), they all hold in common the use of certain broad approaches to patient treatment, which is reducing the number of hospitalized mental illnesses.

I have mentioned the removal of outward symbols of physical restraints: the locks and bars, the straight-jackets and padded cells. This should not imply that the patient may go where he pleases and do as he sees fit. What has been achieved by the staff of these open hospitals is the substitution of an environment in which the patient is considered to be irresponsible and irrational by an environment which views the patient, no matter how ill, to be at least in some degree a rational and responsible human being. Bars and bolts are the visible manifestations of the belief that irrational and irresponsible behavior is the expected norm of those suffering from mental disorders; these manifestations of belief in "madness" apparently elicit "mad" behavior from the patients.

An environment which is organized around contrary beliefs puts an equally heavy psychological pressure on the patient to behave as responsibly and as rationally as he can. And in fact he does. The open hospitals have thus demonstrated that purely psychological measures are as effective in keeping patients in the hospital as are bars, bolts and high walls. In addition they have shown that their approach actively stimulates—rather than destroys—those elements of rational and responsible behavior which are necessary to social existence.

From this new approach to therapy stems a whole series of concomitant activities. First, and as important, is the development of a close working relationship between hospital and community which has already been mentioned. The directors of these hospitals wanted the residents of the communities they served to know what was happening and not to be fearful of what the hospitals were doing. To this end a number of devices have been developed.

At Mapperley, for example, Dr. Duncan Macmillan has

established guided hospital tours for the inhabitants of Nottingham which have been so successful that the city's high schools include it as part of their civics classes, and 16 and 17 year olds now visit the wards in the same manner as they visit the mayor and city council. The effectiveness of this public relations work can be seen in the following exchange which took place between two youngsters standing by Mapperley's main gate watching the destruction of the old brick wall which enclosed the grounds.

"Lumme," said the first. "Look what they're doing to the old looney bin!"

"T'aint a looney bin," corrected the second. "Its an 'orspital."

At Littlemore, the weekly social events at the hospital—such as games, dances, movies, etc.—are open to the community, and the townspeople are encouraged to attend. In addition, the nursing staff has stimulated the formation of a group of volunteers who lend a hand by taking care of patients who are without relatives, or who are lonesome. These volunteers "adopt" a patient, visit him in the hospital and take him out into the community. In this way, not only does the patient feel that somebody cares about him, but the community gets to care about what happens to the patient.

Thus wherever the patient goes he finds a supportive environment, yet one designed at the same time to bring out his abilities. Life on the wards, patient meetings, visitors from the community, visits to them—all constantly impress upon him that he is part of a group from which he can draw strength, and to which he himself can offer something: help for other patients sicker than himself, help for the staff, help in various operations around the hospital, etc. One of the most effective ways that has been found to bring out patient abilities is a meaningful program in occupational therapy.

I believe that one of the reasons for the phenomenal progress that the open door hospitals have had in combatting mental illness is their unique system of occupational therapy which I encountered wherever I went.

Much ingenuity and effort is spent by these hospitals in developing programs which stimulate the interest of patients and prepare them for work when they return to the community. The row of listless patients sitting disconsolate upon benches which is the hallmark of most mental institutions is not to be found here. At Coney Hill, for example, Physician-Superintendent Dr. D. L. Walker has contracted to salvage parts from obsolete telephones for the Post Office, which runs England's telephone system. Patients are paid three cents an hour to dismantle 'phones and sort the components into piles. The program was designed for some 100 chronic patients, many of whom were utterly incapable of caring for themselves before the program started but who now are found to take an interest in what is going on around them. At Littlemore, Dr. Bertram Mandelbrote, the Physician-Superintendent, succeeded in getting a Welsh manufacturer of stuffed animals to organize a quasi assembly line in the hospital rather than build a subsidiary factory in France. Groups of psychotic patients stuff cloth "carcasses" with foam rubber scraps, after which they sew up the mid-sections and put on eyes, noses and tongues. Thirty-six dozen toys are shipped out each week.

Communication between staff and patients is considered to be essential by these open hospitals and is stimulated in a number of ways. The chief male nurse at Littlemore attributes the hospital's success in the past year to the improved system of communication which has been established between patient and staff at all levels. "Formerly, the right hand didn't know what the left hand was doing. This is all changed now. Everyone has a say in what goes on." There are frequent patient meetings to plan improvements usually attended by a member of the staff who serves as recording secretary. Here are the minutes for a meeting which took place during July, 1960.

The garden was the first to be discussed. It was reported that 'casual' labor had produced a good crop of weeds. The 'casual' laborers ignored this. Miss \_\_\_\_\_ asked why the porters had to be given breakfast on this ward: it was most inconvenient

at 7:00 a.m. This was generally agreed upon with great feeling, George ———— demanding to have the door locked to keep them out. Mrs. ———— who comes from the Ashhurst Clinic to help in the ward was voted 'tops.' Our Georgie shouted, 'Yes, worth 20 of these 'ere others.' The meeting was then brought to an abrupt ending by Miss ———— delivering the evening papers, [and] who, seeing a ready-made audience, threw her arms in the air and shouted, 'To be or not to be. . . .'

Whether or not this improves hospital administration, there is no doubt that these meetings help to bring staff and patients closer together and into a better understanding of one another.

So far I have emphasized the work that these open hospitals have been doing within their own grounds. But it has been estimated that at least half of the staff's time and energies are spent in the community since the hospitals consider themselves to be but one unit in a chain of psychiatric services. This chain links together pre- and post-hospital services, including peripheral outpatient clinics, halfway houses, day-care centers, night hospitals, and the community's own local health and social welfare services.

While at Mapperley, I had an excellent opportunity to observe this cooperation at firsthand. I was in with the Medical Superintendent, Dr. Macmillan, when he received a call from the city's chief psychiatric social worker to consult with her on a geriatric case. The three of us went to visit an old man in a dingy, cluttered apartment in the working class district on the edge of Nottingham. It was a pathetic case. He had lost his wife some years before, and now that age and loneliness were taking their toll he was showing signs of mental deterioration. Though one of his married daughters lived next door, she could not spend much time with him, for she had to support her invalid husband. There was a second daughter, but she lived on the other side of town and was able to see him only once a week to do his laundry. Without family attention, he was not able to cope with his infirmities.

I was interested to watch how Dr. Macmillan quickly put

his patient at ease. He spoke quietly, trying to gain the confidence of the oldster, working his way through a succession of seemingly innocuous questions which finally led to the pivotal query which was used to test the old man's memory. "What day of the month is it?" Dr. Macmillan asked without a change of expression. And when the old man looked bewildered and found it impossible to answer the question, we knew the flame inside was beginning to flicker and with that the conversation ended. As we left the house Dr. Macmillan whispered into my ear that the old man would not last more than a couple of months. Should he have to be hospitalized however, the hospital would now be prepared to care for him since it would have a treatment plan ready.

The day care center is another significant social contribution in the development of this chain of psychiatric services and Nuffield House, in Nottingham, is a good example of this type of unit. Five days a week some 60 men and women from all parts of the city are brought to the House in the morning and returned to their homes in the afternoon, in a small bus. Juice in the morning, tea in the afternoon, and a hot lunch are included in a ten cent daily charge. Only one-third of the group are former hospital patients, the rest are merely lonely old people. The House provides a bright atmosphere where older people can talk to persons of their own age and where they can find some light work to occupy themselves: basketry for the men, and knitting and weaving for the women.

Almost equally important benefits are those given the young people by having the oldsters out of the house for a few hours a day—a great help in preventing tensions.

The final, and perhaps the most significant development of these open hospitals, has been their insistence upon and their ability to maintain continuity of patient care along the entire length of this chain of psychiatric services. The importance lies in two different areas. The first is the purely medical innovation of recognizing that there is a necessity for maintaining key parent-staff relationships from the moment a person in trouble is

first seen to the day he is left to lead his own life in the community. The second is the ability to sustain these relationships in the face of divided authority and multiple-service agencies.

The conviction that continuity of care is the heart of the open hospital system is voiced everywhere. Dr. Mandelbrote at Littlemore states: "From first to last, the patient should have the same consultant." At Coney Hill, Dr. Walker contrasts the days in which the patient was almost heedlessly shot out into the community for lack of adequate aftercare services, contrasting them with today's elaborate programs. "The great problem in psychiatry," he notes, "is continuity of care." The importance which the open hospitals place on de-emphasizing their role is therefore logical. They hospitalize the patient only if he fails to respond to domiciliary care, and then make every effort to return him to the community in the shortest possible time.

In line with this it is interesting to see that Littlemore, as part of its program of planned rehabilitation, has classified its patients according to work skills, and that the staff is held responsible for moving patients to a higher level as soon as their condition makes this possible. Five grades are recognized, ranging from patients physically unable to undertake active work, to part or full-time workers with jobs outside the hospital who are but one step removed from discharge. The efficacy of this approach can be seen in the fact that the declining hospital populations have begun to affect the work force upon which these open hospitals depend for a number of their projects—the stuffed-toy contract, for example, or the construction of a new social center.

Indeed, competition for patient labor among the various services of these open hospitals is beginning to bedevil the staff and can be expected to become increasingly 'serious' as the decline in their populations continue.

As filled as it is with promise, there are a number of drawbacks which impede the extension of these trail-blazing open



hospital techniques to the rest of Britain's mental health services.

As was mentioned previously, continuity of patient care has been developed in spite of the split between local health authority, general practitioner and the open hospital; but the difficulties involved in bridging the gap should not be underestimated. For the nationalization of Britain's health services merely confirmed and formalized the previous separation of medical services. Hospitals—both general and mental—are under the jurisdiction of some fourteen regional hospital boards which are subject to the (national) Ministry of Health, but the Medical Officer of Health derives his authority from powers vested in local government. The general practitioner operates in a limbo between the two. That the local health authority (which is legally responsible for patient care in the pre- and post-hospital phases) and the mental institution (which is charged with supplying all phases of hospital services, whether intra or extramurally rendered) have been able to combine their efforts to produce a true community psychiatric service despite the fact that they operate at two different levels of authority is, I believe, the key factor in the success of England's open hospitals.

The integration of pre-care, hospital care and after-care services takes place, therefore, through the efforts of the personnel involved and not because formal administrative structures further such a system. This jurisdictional split is one of the major roadblocks to the rapid spread of the open hospital system in Britain. Dr. Duncan Macmillan makes his position quite clear: "In my opinion, it would be better to have a single administrative authority caring for the mental patient than to divide the responsibility between the local health authority and the Ministry of Health."

In Nottingham, one of Dr. Macmillan's devices for achieving integration of services is to hold weekly conferences of the representatives of the two agencies. Attending these meetings are the hospitals' medical staff and psychiatric social workers,

the city's mental health officer, his assistant and their mental welfare workers. Dr. Macmillan, as the psychiatric adviser to the Mental Health Service of the city of Nottingham, presides. One of the major functions of the conference, apart from specific case work, is to iron out personal problems that might arise. Thus there might be a complaint from the hospital's medical staff that they had been routed out of bed at three o'clock in the morning to examine a patient who did not require hospitalization. Why did the city's mental welfare worker believe hospitalization was necessary? The result is that the psychiatric services in Nottingham are so closely integrated that one can hardly separate the work of the two authorities and say where the one begins and the other leaves off.

Another administrative problem which is hampering the operations of these open hospitals concerns the basis for calculating the salary scales of hospital staff. Under present regulations—drawn up at a time when the implications of the open hospital were not foreseen—the salary of senior personnel is commensurate with their responsibility as measured by a number of variables. Chief of these is size of hospital in terms of the number of its patients, the number of beds, etc. Since the open hospitals are successfully decreasing their hospitalized patient loads, such key staff members as the chief male nurse, the matron, the finance officer, the chief engineer are, in effect, working to cut their own salaries! Dr. Walker has estimated that the present trends at Coney Hill and Horton Road Hospitals will eventually cut the salaries of his two chief male nurses in half. Whether the Ministry will act in time to prevent the open hospitals from losing key personnel remains to be seen. In any case, it seems clear that the national government will have to set up a different basis for rewarding skills, effort and responsibility, or face either a staff rebellion or the consequences of Parkison's Law that "Work expands to occupy time available for its completion."

The magnitude of this decline in the resident population of the open hospital can be seen from the 1959 operating statistics

of Mapperley. When Dr. Macmillan first went there, Mapperley had a complement of 1,300 beds. In 1959, only 940 were in use. Of these 940, 550 beds were used for long-stay patients—those who had been in the hospital for more than a year—while the remaining 390 beds were used to take care of the 1,710 short-term patients (patients who remained in hospital for less than a year). During this year, the hospital discharged 1,745 patients, 1,601 alive, and 144 dead. Dr. Macmillan points out that during the next 20 to 30 years, the 550 beds currently used for long-stay patients will no longer be needed: the patients in them will have died. Thus the hospital, which once required 1,300 beds to serve its community will need only between 400 and 500 beds to do a better job for a more populous district.

Such data as these have caused Britain's General Register Office to lower the official estimates on the future needs for mental hospital beds from the current ratio of 3.4 per 1,000 of population to 1.5 in 1976. This by no means should imply that new construction will cease. On the contrary. Dr. Geoffrey Tooth, Senior Medical Officer in the Ministry of Health, says that current plans call for the development of three different kinds of psychiatric facilities: new short-stay psychiatric units in general hospitals for patients who do not require more than three months hospitalization (about 70 per cent of all annual admissions); new medium-stay rehabilitation units containing between 100 and 200 beds apiece; and finally, replacement or reconstruction of present facilities for the long-term care of patients requiring hospitalization for more than two years (about 4 or 5 per cent of all admissions).

The Ministry realizes clearly that these forecasts are subject to change. "We know we're in the middle of a revolution," Dr. Tooth was careful to point out. "The rate of progress is almost impossible to estimate." All that can presently be said with certainty is that a number of the new short-stay units in general hospitals will be in operation sometime this year. (For example, the Sheffield Regional Hospital Board, under which

Mapperley operates, plans to add twelve such units of 100 beds each to the general hospitals under its jurisdiction).

The freedom of the British Physician-Superintendent to experiment unhindered by higher authority has been contrasted to the disadvantage of his American counterpart, both by British superintendents visiting this country as well as by some of the American mental hospital directors who have toured England's hospitals. Dr. Mandelbrote, for instance, believes that there is a lack of local initiative in America; that American hospital directors will not take responsibility for new programs until ordered to do so from above. He contrasts this with the administrative flexibility which the British superintendent enjoys, since he does pretty much as he pleases within the board policies set forth by the Ministry and Regional Board.

Another criticism voiced of American state mental hospital systems is the heavy burden of administrative duties which is placed on the hospital director. The director has little, if any, time for clinical work because of housekeeping chores; this is in contrast to his British counterpart, who, it is claimed, divides his time equally between the two. (Indeed, Dr. Walker of Coney Hill believes he spends as much time on clinical practice and in consultation as the two senior members of his psychiatric staff who have no administrative responsibility for the operation of the hospital.)

The last major criticism which these English open hospital superintendents voice about American state hospital systems is the size of their individual units. Quite apart from the administrative and organizational problems of attempting to relate the hospital to a very large service district, the British direct heavy criticism at the lack of individual attention given patients in the large hospitals. The very size of these units does not permit the patient to have any close personal contact with the psychiatrist, whose time is spread very thinly over a large number of patients. Indeed, in some hospitals it is possible for a patient not to see a psychiatrist more than once a year. This,

of course, would be impossible in England's small open hospitals, where the patients are organized into small groups which are continuously under active treatment.

Is it possible, from the foregoing observations, to develop a better program of psychiatric services than is now currently found in the United States? I vehemently believe so, for I see vast opportunities in two areas alone—the first administrative, the second legislative.

Administratively, these trail-blazing British open door hospitals have shown that they are likely to reduce the number of institutionalized patients by one-half over the next generation through establishment of a system which focuses efforts on continuity of psychiatric care rendered in a psychologically therapeutic environment. While the originators of this system (such as Dr. Macmillan in Nottingham and Dr. T. P. Rees in Croydon) put their programs into effect slowly for fear of arousing public outcry and censure, such extreme caution has been shown to be unnecessary; Dr. Mandelbrote, after indoctrinating his staff, was able to place Littlemore on an open door footing in a period of six weeks. Since most of our state systems are hierarchically structured, and since our hospital directors are used to playing a more passive role than their British counterparts, it will fall to the commissioners of the various state departments of mental hygiene to initiate the needed administrative reforms. Among these will have to be various experiments aimed at overcoming two major problems occasioned by past American hospital practices—the great size of the units involved and the distant location from centers of population.

However, a number of the defects apparent in America's psychiatric services will require changes in our laws governing the care of the mentally ill. Here again we can learn much from our English cousins. Thus, when we come to reorganize present services so as to achieve continuity of psychiatric care, we can avoid the folly of establishing divided authority. It seems clear to me that we will have to spell out statutorily

the duties and mutual obligations of the three major sources of care—the state mental hospital, the psychiatric unit of the general hospital and the community mental health clinic. This will be no easy task, for each of these services operates within a different jurisdictional framework. In New York State, for example, the state mental hospital is a public institution operating within the jurisdiction of the Department of Mental Hygiene. The psychiatric unit of the general hospital, on the other hand, is a private institution which tends to distinguish itself sharply from the government. In between stands the community mental health clinic which, while locally based and locally operated, has financial ties with and professional standards set by the state. Its professional staff and civilian board members tend to identify more with the voluntary agencies than with government. In the type of patients they will accept, the type of services they will render and the formal relations they establish with other agencies, the clinics are at present more like the psychiatric units of general hospitals than the state's mental hospitals. Enabling legislations will not cause these separate elements to coordinate their activities. However, it can encourage their cooperation on pain of losing state aid.

The English have shown that the disabilities of divided authority can be overcome if a staff has the determination, the enthusiasm and education to coordinate its activities. Such an orientation is the primary component of a successful community psychiatric service and must be pressed for by every means possible.

One statutory innovation which the English incorporated in their 1959 Mental Health Act might well be considered for American import. Early actions had permitted superintendents to "de-designate" some of their beds; that is, since these beds were no longer designated as mental hospital beds, superintendents could admit patients to them without any form of certification. This did away with "voluntary certificates" which were a form of contract between the patient and the hospital. Patients were free to enter and leave the mental

hospital exactly as they would a general hospital and with as little fuss.

In 1959 the new legislation completely removed the legal distinctions between mental hospitals and other types of hospitals. This means that the procedures for admission to all types of hospitals are identical, and that the few patients who need the authority of an involuntary certificate are certified. These certificates are equally useful in sending a patient to any type of hospital, mental or general. The purpose was to avoid the unpleasant and frequently unnecessary formalities of certification and will, it is hoped, be another step in transforming the public image of the mental hospital.

In summary, it is apparent that in some communities the English have devised a pattern of psychiatric care which in a number of respects is an improvement on the patterns currently in use in the United States.

We can learn much from them, both as to elements which might feasibly and profitably be incorporated in our state systems of law and administration as well as to what pitfalls to avoid.

If our mass media are any indication, there is a growing popular interest in mental health programs. This interest should be tapped and guided to spur the development of better psychiatric care for the mentally disordered. Perhaps we, too, are on the threshold of a revolution.