THE CHICHESTER AND DISTRICT PSYCHIATRIC SERVICE

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GRAYLINGWELL HOSPITAL AND WEST SUSSEX

Graylingwell Hospital is a mental hospital which serves the county of West Sussex. It has 1,210 beds (408 male and 802 female). It provides all the psychiatric services for adults in the county; there are no other psychiatric beds nor are there any psychiatric outpatient services other than those run by Graylingwell Hospital. All the medical staff are "whole-time" and no psychiatrist does any private, i.e., fee-paying practice. (A few patients are probably referred to London for private treatment.)

Children under the age of 16 are not normally seen by the hospital psychiatrist. In West Sussex, the psychiatric services for children are run by the Local Public Health Authority independently of the mental hospital. At the present time we are trying to establish closer links with the child guidance services. It is hoped that joint appointments will be made, at any rate at trainee level, thus bridging the gap which at present exists between the adult and the children's services.

The Public Health Authority has also provided the organization for the ascertainment, management, and disposal of mental defectives in the community.[1] The hospital services have been used only when there has been an associated or superadded neurosis or psychosis.

Graylingwell Hospital is situated on the north side of Chichester, about one mile from the center of town. Chichester is in the south-west corner of the county. There is a general hospital outpatient department and a day hospital in Chichester, Worthing (22 miles), and

Horsham (32 miles). Two other outpatient departments in general hospitals are 38 and 8 miles distant from Graylingwell.

The grounds are spacious and well kept and, although the hospital was built in 1895, no boundary wall or fence has been added. There are several entrances and it is possible to leave the hospital grounds at many points. The wards have been "open" for many years, but one male ward of 30 beds is still kept locked. Of the 359 male and 659 female patients in the hospital on December 31, 1964, 337 males and 620 females had been informally admitted. Until April 1964, when it was amalgamated with the general hospitals in Chichester, the hospital was administered as a separate unit with its own budget. Since Dr. Carse retired from the post of Medical Superintendent several years ago, the medical administration has been carried out by a committee composed of senior doctors. The chairman of this committee is elected by them and is responsible for the day-to-day administration. All the medical staff work in the day hospitals, outpatient departments, and in the mental hospital. Domiciliary visits on new patients are carried out only by the senior psychiatrists. The senior medical staff is organized on the "firm" system; each firm is responsible for the patients from one of the three areas into which the county is divided. The Worthing firm has four seniors, the Chichester firm has three, and the Horsham firm has two seniors. Each firm is responsible for its own patients while they are in the hospital, and they also see them for follow-up interview after discharge. There is a great deal of movement of the medical staff in and out of the hospital. They are all available, however, at the hospital on Wednesday afternoons; the senior staff are normally available for interview only on this afternoon. Wednesday evening is devoted to clinical meetings, journal meetings, and visiting speakers. The visiting of patients by relatives is not restricted; there is daily visiting in the admission wards and a good deal of informal visiting at other times throughout the week.

The population of West Sussex is 412,000. It is predominantly a fairly wealthy farming community. The largest town, Worthing, has a population of 80,000 and Chichester has 20,000. The only industrial center is in the heavily populated coastal strip east of Worthing. It is a popular retirement area for professional people and several small holiday resorts bring a big summer influx of population. The population is predominantly wealthy, high social class, and rapidly increasing. It is also an elderly and a rapidly aging population. The 1961 census showed that 14.3 per cent of the males and 20.45 per cent of the females

were aged 65 and over. In England and Wales, 9.4 per cent of the males and 14.4 per cent of the females are in this age group.

Psychiatric practice at Graylingwell, in common with the rest of the country, continued for many of the postwar years the pattern which had been laid down by the Mental Health Act of 1930. This Act introduced voluntary admission to the mental hospital and led to the establishment of the psychiatric outpatient clinic in the general hospital.

The number of admissions rose steadily in the postwar years. Many patients were seen first by the psychiatrist in the outpatient clinic, but the majority of patients came into the mental hospital directly from the family doctor. This could occur without the hospital being aware that it was getting a new patient; for example, in case of an acute illness, the family doctor and the responsible official of the Local Health Authority could complete what was then known as an *urgency order* and send the patient directly to the hospital. More and more patients came in voluntarily; in 1956 the voluntary admission rate to Graylingwell Hospital was 84.5 per cent. The National Health Service Act introduced the idea of the domiciliary visit and more patients were seen at home by a hospital psychiatrist in the first instance. Nevertheless, the question of continued treatment at home rarely arose at this time.

Admissions throughout the country increased steadily during these years. The more acceptable a hospital was to the community it served, the greater the number of admissions. Graylingwell admissions rose from 526 (205 males, 321 females) in 1946 to 1,347 (427 males, 920 females) in 1956. During the same years the hospital's patient census rose from 1,080 (396 males, 684 females) in 1946 to 1,140 (376 males 764 females) in 1956. At this stage overcrowding in the hospital was becoming a problem. In addition, the increase in the number of elderly and senile patients being admitted indicated that this would become a much more serious problem in the near future.

THE WORTHING EXPERIMENT

In May 1956, the South West Metropolitan Regional Hospital Board "approved the setting up of an experimental outpatient service at Graylingwell."[2] The object of what has since been called the Worthing Experiment, which started on January 1, 1957, was "to discover whether the provision of greatly expanded outpatient treatment facil-

ities could reduce the number of patients being admitted to Graylingwell and thereby ultimately overcome the overcrowding which was beginning to cause anxiety".[2] It covered part of the county of West Sussex. No patient living in that area was admitted to Graylingwell until he had first been seen by a psychiatrist in the community and the situation had been fully assessed. During the first year the number of admissions was reduced by 56 per cent for the Worthing area.

TABLE I. ANNUAL ADMISSIONS TO GRAYLINGWELL FROM EACH OF THE THREE AREAS FROM 1956 TO 1962

Year	*Worthing*	*Chichester*	*Horsham*	*Total*	*Rate per 100,000*
1956	645	444	219	1,308	364
1957	284	463	246	993	268
1958	247	228	256	731	191
1959	269	263	227	759	195
1960	295	293	239	827	208
1961	332	329	278	939	227
1962	325	389	311	1,025	245

THE CHICHESTER SCHEME

The success of the scheme in Worthing during 1957 indicated that the introduction of a similar scheme in the Chichester area would result in a significant reduction in the number of admissions from that area. When the Worthing Experiment was seen to have progressed satisfactorily in 1957, we applied its principles on a larger scale in Chichester. We were able to think not only in terms of the effect on admission rates and overcrowding; we wanted also, if possible, to find out how clinical, social, and family considerations might affect the disposal of individual patients.

While the aims of the Worthing Experiment had been to reduce admission rates and overcrowding, our aims in extending this scheme to Chichester were more ambitious. They were:

1. To reduce admissions to a hospital whose admission rate is rising and in which overcrowding is becoming a problem.

2. To reduce institutionalization and recruitment of long-stay patients.

3. To treat the patient in his usual family, occupational, or

social environment, where this seemed appropriate. We expected, other things being equal, this regimen more likely to be successful than routine admission.

4. To select the type of disposition best suited to the needs of the patient and his family. Admission to the mental hospital in the past has often been for custodial reasons or for want of suitable alternatives, rather than on clinical and therapeutic grounds. We now use social and family considerations to help us to decide whether admission, domiciliary, day-hospital or outpatient care is suitable for a particular patient.

5. To explore alternatives to admission for the increasing number of geriatric patients which accompanies the aging of the population in this area and thus to improve services available to old people.

The Chichester psychiatric service was started one year after the Worthing Experiment, on January 1, 1958. It covers the western half of the county with a population of approximately 120,000. This is more rural and has a more scattered population than Worthing. The only towns are Chichester (population, 20,000) and Bognor (population, 28,000).

The staff consisted of three senior psychiatrists assisted by a senior resident and a trainee psychiatrist. In addition to his work in the community, each doctor continued to be responsible for the chronic patients previously under his care. The doctors also retained clinical responsibility for new admissions and continued responsibility after the patient was discharged from the hospital. Thus continuity of care was established. The patient now remains under the care of the same senior psychiatrist throughout his psychiatric treatment, whether this be in the community or in the mental hospital. We find that each senior psychiatrist spends about half of his time in outpatient or day-hospital work and in domiciliary visits; the remaining half is spent on inpatients.

Shortly before the scheme was started the 73 general practitioners in the area were invited to a meeting with the psychiatrists. They were told about the proposed service, informed of its aims, and invited to co-operate. This they agreed to do and they have fully supported us in our endeavors to date. All of them, except one or two newcomers, are known personally by the senior psychiatrist. We are in constant touch with them, not only by correspondence about patients but also

by telephone, and at times we meet at the patients' homes. This is not possible in all cases because of the difficulty in arranging a mutually convenient time. An interesting feature is the increasing frequency with which general practitioners telephone for advice on the management of a patient whom they want to try to treat themselves.

These family doctors play an important part in our service. The majority of patients are referred by them in the first instance and the doctors also often decide whether to refer the patient directly to the outpatient department in the nearby general hospital or to arrange a domiciliary visit or a consultation at the day hospital after discussion with the psychiatrist. Follow-up appointments are usually arranged by the psychiatrist to suit the needs of the individual patient.

The senior psychiatrists are also on the staff of the general hospitals in Chichester. We have no psychiatric beds in these hospitals so patients referred to us by our surgical and medical colleagues are seen either in outpatient departments or on the wards where some inpatients can receive psychiatric treatment during their stay in the general hospital. All patients admitted following a suicidal attempt are referred to us for psychiatric assessment before they are discharged.

Similarly, we rely on the staff of these hospitals for general medical, surgical, and other specialist treatment for patients in the mental hospital. Our general medical and surgical needs are met by a regular weekly session held in the mental hospital by a physician (internist) and a surgeon who are also available for emergency advice and treatment. In the past, all surgical operations were carried out in the operating theater in Graylingwell Hospital; but for some years we have transferred patients requiring operations to the general hospital, so we have closed down our own operating theater.

Patients are also referred to us by probation officers, the courts, and such bodies as Alcoholics Anonymous and the Marriage Guidance Service. We maintain close contact with the probation officers in the area and group discussions are held regularly with them. Regular group meetings are also held with the clergy, and one of the senior psychiatrists on the hospital staff acts as a consultant to the Marriage Guidance Council.

There are private nursing homes in this area that take some not too disturbed senile patients, especially if the psychiatrist agrees to supervise their management and accept responsibility for admission to the mental hospital if they should become too disturbed.

One of the most important aspects of this service is the domiciliary

care of the geriatric patient who often is admitted to the mental hospital because of some acute disturbance, especially if the general practitioner and family feel they cannot cope with the situation. In these cases the initial visit of the psychiatrist is not sufficient; he must be prepared to revisit the next day if necessary and to continue to visit, and also be prepared to admit the patient to the hospital if he does not give the relatives sufficient help. He can organize such community services as are available. The provision of home help and home laundry service, especially when incontinence is marked, may alter the relatives' attitude to the need for hospital admission. In some cases, especially when the patient lives near the hospital or the day hospital, it may be possible to tide the family over a crisis by frequent visits from a senior hospital nurse who can supervise feeding, bathing, and, if necessary, treatment by injection of drugs. During this time the psychiatrist is visiting the home and the relatives know that hospital admission will be arranged if these methods prove inadequate. If the patient goes into the hospital, the same psychiatrist maintains contact with the family. If the situation improves sufficiently, the patient is discharged and follow-up is carried on at home.

One feature of this Chichester service which deserves comment is the establishment of the day hospital, not as a separate unit removed from the mental hospital but as an addition to it. Day patients and inpatients share the same facilities—nursing, occupational therapy, recreation, social life—and also share a common dining room. Most of the inpatients are recently admitted—the majority of them suffering from neurosis, a few from uncomplicated psychosis; their behavior is not disturbed. This is probably not an ideal arrangement because day patients' needs tend to take second place to those of inpatients and there may be a little of the atmosphere of a day hospital. On the average, about 15–20 patients attend daily. Most suffer from neuroses and for various reasons need the support of the day hospital. Some are depressed people who would otherwise be alone at home all day and socially isolated. A few are chronic psychotics who are well enough to be looked after at home but are not capable of holding down a job.

About one-third of the patients seen by us in the Chichester area are regarded as suffering from affective psychosis. Admission to the hospital is usually necessary when the patient is acutely ill. In this condition, he is seen at home in the first instance if he is unable to co-operate in keeping an appointment made for him in the outpatient

department or at the day hospital. Less severely ill patients are usually first seen in the outpatient departments or at the day hospital. Physical methods of treatment, i.e., electroshock therapy (E.S.T.) and antidepressant and tranquilizing drugs are the treatments of choice in these cases. E.S.T. is given to outpatients two mornings a week. Transportation of these patients, to the day hospital and for the return journey home after treatment, is provided by the Local Health Authority.

Patients with neurotic conditions represent about 25 per cent of all referrals. They are usually first seen in the outpatient department or at the day hospital. A small but important group must be seen at home; these are the patients who are housebound because of severe phobic anxiety. Few neurotics are admitted to the hospital. In the Chichester service, individual psychotherapy, drugs to control symptoms, and attempts to alter the social situation, where that is thought to be relevant to the illness, are the chief ways in which help is given to these patients. A few are referred to colleagues for more prolonged individual or group psychotherapy, and an occasional patient is referred to other units specializing in the treatment of neurosis.

We do not encourage self-referral by patients, and anyone seeking an appointment for interview who has not been seen during the previous six months is usually advised to get in touch with his family doctor. The general practitioner can then arrange an appointment if he thinks that it is necessary.

TABLE 2. PLACE OF FIRST CONTACT WITH NEW PATIENTS FROM CHICHESTER AREA IN FIRST YEAR OF SPECIAL SERVICES (1958) AND IN 1964

	Outpatients	*Domiciliary Visit*	*Day Hospital*	*Other*
1958	353	258	207	107
1964	391	287	210	126

During the first year of this service (1958) we saw 925 new patients (345 males, 580 females). In 1964 this figure had increased to 1,026 (382 males, 644 females). The place where the patient was first seen remained fairly constant throughout the years.

THE THIRD REGION

In April 1964 our third day hospital was opened in Horsham. This, with the outpatient department at Crawley, serves the remaining area of our county.

The catchment area is now divided into three separate regions, each with its own community services, day hospital, and medical staff. The senior medical staff are assigned more or less permanently to one specific area. The junior medical staff rotate from one area to another after each year, so they have the opportunity during their training of working with different senior psychiatrists. We have gradually reorganized the hospital into three clinically independent units which correspond to these three geographical regions. The admission wards are shared, but the chronic and geriatric patients are in wards according to the areas in which they lived before coming into the hospital.

This is how the pattern of psychiatric practice has evolved during the past eight years. The patient, unless there are some special circumstances, is seen in the community by a senior psychiatrist who decides his treatment and disposal on clinical and social grounds. The patient continues under the care of this same doctor whether he is treated in the community or admitted to the mental hospital. This pattern is based on the co-operation of the general practitioner. The Public Health Authority is beginning to play a more important role in aftercare through the work of the Mental Welfare Officers. A hostel for mentally handicapped adults is planned for the near future, but there is as yet no provision for other community services, such as sheltered workshops.

REFERENCES

[1] The different responsibilities of local health authorities, regional hospital boards, and hospital management committees are described in more detail in the opening sections of the next paper, "The Plymouth Mental Health Service," by Francis Pilkington (p. 37).

[2] Carse, Joshua, A District Mental Health Service: The Worthing Experiment, *Lancet,* 1, 39–41, January 4, 1958.