

## THE PLYMOUTH MENTAL HEALTH SERVICE

FRANCIS PILKINGTON

"No man is an island," and this is true of the Plymouth Nuffield Clinic. Before saying anything about it, however, I must first remind you of some of the changes that have taken place in the British medical scene over the past three or four decades, and then say something about the Plymouth Mental Health Service as a whole, because any meaningful consideration of the Nuffield Clinic would be impossible if it were studied in isolation.

### THE BRITISH NATIONAL HEALTH SERVICE

The National Health Service Act of 1946 was revolutionary in concept, and it has been as far-reaching in its effects on the nation's psychiatric service as on any of the other branches of medical organization and practice. Under the Act, the Minister of Health acquired nearly every hospital in the country, general as well as mental, which became, for the first time, state hospitals. It is worth mentioning that the Act is in three parts and that the whole service is administered in three parts also: thus there is the hospital service, the general practitioner service, and the Local Authority Service. (In England "Local Authority" is the term used for local government, city and county government as distinct from national government.) This division is the greatest administrative weakness of the Act and it makes co-ordination in the psychiatric field (as in other fields) unnaturally difficult.

The hospital part of the service is administered by some 15 Regional

Hospital Boards in all England and Wales, each Board being responsible for the hospital services of between 2 and 5 million people. Regional Boards delegate the day-to-day management of hospitals to Hospital Management Committees but reserve for themselves the function of over-all planning. In the Plymouth district (population about 265,000) the psychiatric hospital service comes under the ultimate control of the South Western Regional Hospital Board, but the day-to-day management is vested in the Moorhaven Hospital Management Committee. Later I will describe the functions of the Plymouth Local Authority Mental Health Service and how the hospital and Local Authority Services interact, but what I wish to emphasize at this stage is that *the hospital service is a state service over which the Local Authority has no control*. Moreover, it is financed entirely out of central state funds without any charge being levied on the patients.

#### PSYCHIATRIC HOSPITALS BEFORE THE NATIONAL HEALTH SERVICE ACT

But it was entirely different before 1948 (the year when the Health Service Act came into force). Except for a few private establishments all the mental hospitals of England were the property of, and were administered by, the Local Authorities. In fact, they were either city hospitals serving some large town having its own Local Authority, or else county hospitals belonging to a county Local Authority. There was often a considerable difference in character between a county and a city hospital. The county hospital was usually larger and served a widely scattered population: it was often somewhat isolated geographically. (The largest mental hospital in England was a county hospital with 3,000 beds.) The city hospitals were, on the whole, much smaller (and in the case of large cities such as Birmingham were often duplicated). They found it easier, too, to keep in touch with the community they served.

It is important to note, however, that even when all the psychiatric hospitals belonged to the Local Authority they did not come under the control of the Medical Officer of Health and his Public Health Committee but were administered by statutory bodies of the Local Authorities, named Visiting Committees, having as their chief officer the medical superintendent of the hospital. This is relevant in the present context because Medical Officers of Health do not, as a rule, feel very much at ease in a psychiatric hospital setting.

It is true that before 1948 the mental hospitals varied widely in quality and in the service they could give, and that this variation reflected the importance which different Local Authorities attached to the treatment of their mentally ill citizens. Nevertheless, and in spite of the rather circumscribed duties of the Visiting Committees, there were one or two mental hospitals with outstanding medical superintendents, which became the centers of comprehensive psychiatric services in advance of their time. I will cite the City of Portsmouth's mental health service as a famous example.

### MOORHAVEN HOSPITAL 1891-1964

In 1891 the city fathers of Plymouth built Blackadon Asylum with 200 beds to serve a population of approximately 150,000. It was situated in beautiful Devonshire countryside 13 miles from the city. (Previously the mentally ill from Plymouth were sent to an institution 130 miles away!) The asylum was soon overcrowded, and in 1905 six wards were added which made its capacity 400 beds. Its name was changed in 1930 to Plymouth Mental Hospital, and in 1947 the staff themselves were allowed to give it the name "Moorhaven Hospital."

The medical superintendent had one other doctor to assist him until 1928 when a third was added. All the doors were locked, but "mechanical restraint" has been used for only two patients in the history of the hospital: once in 1891 and on two occasions in 1914 when it was needed to prevent interference with a recent eye operation.

It may be postulated that all the doors were locked because all the patients were "certified" insane: they could not discharge themselves so it was unthinkable that they be allowed to run away. In 1930 the passage of the Mental Treatment Act made voluntary admissions legal. This was the crucial turning point in the development of British psychiatry and marked the beginning of the revolution which is not yet over. Voluntary patients were able to discharge themselves and they could complain loudly. The improvement in the service provided in our hospitals started at that time. At Plymouth Mental Hospital the new order was slow to gain momentum, and in 1931 only 7 of 185 admissions were voluntary. *Yet by 1957, 97 per cent of the admissions were voluntary, the highest figure in the whole country.* This striking figure indicates a really satisfactory growth of public confidence, and it is worth while to look for the reasons.

When I arrived at the hospital to be Physician-Superintendent a

couple of years after the end of war the situation was ripe for change. Nearly all the senior officers were ready for retirement on pension, and so it was possible to pick a fresh team. Most of my psychiatric experience had been gained in a university psychiatric institute (the Maudsley Hospital, London) and in the army. I had been brought up to despise mental hospitals and to dislike the alleged autocratic tendencies of medical superintendents. Plymouth, with its quarter of a million population, had been the most heavily bombed city in England. It was backward, somewhat smug and insular, yet forward-looking. It was a well-knit community, but the center of a sparsely populated area. I myself was unashamedly attracted to a backward area remote from London.

I already knew and admired the work of Dr. Thomas Beaton, Medical Superintendent of St. James' Hospital, Portsmouth. The day after I took up my job, he published an article describing the comprehensive mental health service which had been established in Portsmouth, a city the same size as Plymouth and about 100 miles distant. In 1926 an outpatient clinic had been opened in the general hospital there "which dealt with all manner of mental and nervous problems." It was recognized that it was essential to try to educate the man in the street on the nature of mental disorder, its relation to the popular conception of "nerves" and to the problem of the mentally subnormal. To combat the prevailing ignorance and fear, talks were given to various sections of the community (church guilds, Rotary Clubs, etc.) and close contact was made with general medical practitioners. Magistrates courts were given every facility for psychiatric investigation, and a child guidance clinic was set up. Members of the psychiatric staff visited the wards of the general hospital and were called in consultation in private practice. The purely medical side was well supported by a psychiatric social service, operated from a bureau in the city where a complete record of every case dealt with was kept in a card index system.

The whole mental health service of Portsmouth was based on the mental hospital, 75 per cent of whose patients were admitted voluntarily, and the whole situation could be summed up as an attempt to deal with the psychiatric problem as a medicosociological experiment. This was in November 1946. Portsmouth was an inspiration.

### *Relationships With Other Parts of the Community*

As early as 1922 the question of "outpatient work for mental cases" was first raised, and in 1928, "after very long and careful consideration,"

a weekly outpatient clinic was started in Plymouth. This was the first step in community work (only two years behind Portsmouth). In 1945 there were two sessions a week, and progress then went on steadily so that by 1962 there were altogether some 30 doctor sessions a week taking place outside the hospital. These were not all spent in the outpatient department of the Plymouth General Hospital which is confined to adults.

The Plymouth Child Guidance Clinic, which was started by the hospital in 1947 in association with the Education Committee of the City of Plymouth, suffered from a lack of clear administrative policy at ministerial level. The central government department of health, on the one hand, and of education, on the other, were unable to produce a policy which would satisfy both. The Moorhaven Hospital Management Committee was appointed agent of the Regional Hospital Board in 1952, and charged with the responsibility for ensuring, in co-operation with the Plymouth Local Authority, that adequate facilities were provided for children suffering from any form of mental ill health. It was hoped that a small joint Committee of Management of the Child Guidance Service would be formed with the Local Authority. Nothing happened. In 1953 there were 10 medical sessions a week at the clinic, but in 1958 shortage of medical staff caused a reduction to seven.

Since 1948 an important part of the Moorhaven Hospital external psychiatric service has been domiciliary work done at the request of general practitioners. This is a recognized facet of the National Health Service; a general practitioner can ask a hospital consultant to accompany him on a visit to a patient in his own home, provided the patient is unable to attend an outpatient clinic. Such home visits bring the hospital consultant and the family doctor in clinical touch with one another at the patient's bedside. Quite often a home visit prevents a hospital admission. The annual number of domiciliary consultations rose from 118 in 1951 to 232 in 1961.

Clinical consultations on patients in wards of other hospitals have always been undertaken and their number is increasing.

Medicolegal consultations, usually at the request of magistrates or probation officers but sometimes of higher courts, have also been a well-recognized clinical service for many years. Talks have been given to groups of magistrates from time to time, and for the past few years a psychiatrist has held a regular discussion group with the Plymouth probation officers.

In 1958 a Moorhaven Hospital consultant started a weekly seminar with a group of general practitioners. One of these general practitioners has since worked as a part-time clinical assistant in our Department of Psychological Medicine in the general hospital. Over 40 local general practitioners have now participated in the seminar.

Similarly there have been contacts with Local Authority Health Visitors and Local Authority School Medical Officers. Advice has been given to social service agencies, including Marriage Guidance Councils, and Local Authority district (domiciliary) nurses in training are brought into contact with the psychiatric service.

In addition, there is a constant demand for talks to nonmedical organizations of many and diverse kinds—Rotary Clubs, townswomen's guilds, groups of clergy, etc. In 1964 about 80 such talks were given.

Finally, brief mention should be made of the Therapeutic Social Club for outpatients. This was started in 1957 in quite adequate premises in an institution for the blind in Plymouth. The club has always met one evening a week and has been in the hands of one of the senior psychiatrists and the hospital social workers. As time has gone by, the membership has been drawn from discharged inpatients as much as from outpatients.

It can be seen, therefore, that for many years the hospital has gone out into the "community;" in fact, in my view the hospital is part of the community and to regard it in isolation is outdated.

There has been an equally vigorous flow in the reverse direction. Public relations have been studied and fostered throughout my time at the hospital. Voluntary organizations in touch with the hospital have a special opportunity to learn about its work and atmosphere and to enlighten the public. But in the last analysis the day-to-day attitude and approach of the staff of all grades—from the highest to the lowest in responsibility—toward the patients and their visitors is what really counts in securing the confidence of the public. And this surely depends on the morale and sense of purpose of the staff itself. If there is pride in the hospital and understanding of its aims, the resulting high morale will ensure that everyone will give of his best.

Visits to the hospital of groups of people have always been encouraged and these vary from school children to clergy. In a more formal setting the "open days," which have been held every year since 1952, have brought many hundreds of visitors to look around and also hear an address on some mental health topic by an expert of national standing.

The latest significant advance in public relations was begun in 1957 when the Moorhaven Hospital League of Friends was inaugurated. Most of the 360 members are from the immediate neighborhood of the hospital. Personal service rather than money-raising is the keynote.

The purpose of this description of Moorhaven Hospital and its external psychiatric services is to give a picture of the state of development of psychiatry in the Plymouth area immediately prior to the planning and opening of the Plymouth Nuffield Clinic. The hospital service had reached a fairly high degree of sophistication. The medical staff of 12 (five seniors, seven juniors), though too few in number, were progressive in outlook and worked well together. The nursing staff were equally satisfactory and the school of nursing had a national reputation; and we were equally fortunate in our team of psychiatric social workers.

The Physician-Superintendent was responsible for the general medical administration and co-ordination of the work of the hospital. He had a number of patients under his own personal charge but had no clinical responsibility for those patients under the care of his consultant colleagues. There was a medical staff committee that discussed matters of major policy. Importance was always attached to ensuring that whenever possible a patient remained under the care of the same doctor. Treatment was always broad-based: psychological, physical, and occupational and social. Much emphasis was placed on a therapeutic community milieu, but not the kind of therapeutic community developed by Maxwell Jones. Value was put on patients' meetings and patients' committees. The Patients' General Committee, in fact, had some real influence on the administration of the hospital. The hospital was under the management of a competent and liberal-minded Hospital Management Committee which for years had been advised that outpatient and other external psychiatric services were of great importance. Two further points should be noted here: first, the size of the hospital and the population of its catchment area were favorable for the next stage of development; and, second, there was no other psychiatric service in the same area to cause complications.

The Appendix of this paper shows the more important milestones in the history of the Plymouth Mental Health (hospital-centered) Service.

## THE LOCAL AUTHORITY MENTAL HEALTH SERVICE

Some description of the duties of the Local Authority Mental Health Service and the facilities provided is now necessary. In England each Local Authority of the status of County Council or County Borough has a Public Health Committee whose chief officer is termed the Medical Officer of Health (M.O.H.). The Public Health Committee, through its Mental Health Subcommittee, had, up to 1960, two main duties: 1. the ascertainment of subnormal children and the provision and operation of a community service for subnormals, and 2. taking the necessary legal steps to admit persons of unsound mind to a mental hospital. The officers chiefly concerned were an Assistant M.O.H. and a number of Mental Welfare Officers. In Plymouth, as in most other places, this was the full extent of the service until the implementation of the Mental Health Act in 1960.

One of the main principles on which this Act is based is that the emphasis should be shifted, so far as possible, from institutional care to care within the community. This, indeed, is a very large order as it means the development and expansion of the Mental Health Services of Local Authorities to such an extent as to entail in many cases the creation of an almost new service. For instance, it is now laid down that Local Authorities shall have functions with respect to the prevention of mental illness and also in relation to persons who are, or who have been, suffering from mental disorder. The new Act (and certain consequential circulars) goes into the requirements in relation to care and aftercare in considerable detail. The provision of residential accommodation is one of these requirements. Care for patients needing hospital treatment remains, of course, the responsibility of Regional Hospital Boards, but it is now officially the duty of Local Authorities to provide homes or hostels for various categories of persons. These include educationally subnormal and maladjusted young people and also certain patients released from hospital in need of support, and elderly, mentally infirm persons who do not need the full resources of a hospital.

The provision of what are called "training centers" is high on the list of priorities. There are two types of training centers, those for subnormal children and those for adults. In regard to the latter, it is recommended that they should cater to a wide variety of individual needs and should not be limited to subnormal patients.

As regards staff, the employment of a sufficient number of Mental



Welfare Officers (or, as some Local Authorities call them, social workers in mental health) is an extremely important requirement. It is also most desirable that they should undergo a course of training.

The City of Plymouth, like most other Local Authorities, had only a minimal service before the new Act, though in the last few years a junior and an adult training center have been provided. It should be pointed out, too, that not only did the M.O.H. and his committee have no duties or responsibilities with respect to the hospital service but that the converse was equally true: the Physician Superintendent and his Hospital Management Committee had no authority whatever to busy themselves with the Local Authority Mental Health Service. It is true that the central Ministry of Health suggested on more than one occasion that each Local Authority should appoint a part-time consultant adviser on mental health from the staff of the psychiatric hospital serving their area, but Plymouth saw no need for this. There was thus no official liaison at all between the hospital and Local Authority services.

The Moorhaven Hospital psychiatric service has at no time in its history been concerned with either the domiciliary or hospital care of subnormal patients. As far as the domiciliary or community service goes, it has already been pointed out that this had always been in the hands of the Local Authority: hospital treatment was, and is still, provided in a special hospital for subnormals which caters to a wider area than that of Plymouth.

## THE PLYMOUTH NUFFIELD CLINIC

### *The First Steps*

Some 10 years ago my colleagues and I used to discuss from time to time what we would do if we were ever given a sizable grant of money. Our talks often continued into the night, and we were not simply building castles in the air because we knew that the Nuffield Provincial Hospitals Trust would be favorably disposed toward helping us financially, provided we approached the trustees with a scheme they liked.

We considered various projects, but there gradually emerged a consensus that some sort of community mental health center to be provided in the City of Plymouth might satisfy our greatest needs, and early in 1959 we submitted a proposal to the trustees. We were very conscious of the separation of the Local Authority and hospital services, and we felt the time was ripe to try to bridge the gap in our own particular

area, especially in view of the importance the hospital had always attached to outpatient and domiciliary work.

We also suffered from the common problem of psychiatric hospitals, namely, overcrowding and recurrent bed crises. We had hopes that the provision of a day hospital would have the effect of reducing the annual number of admissions and would also accelerate the discharge of patients from the overcrowded wards. Moreover, we believed that for certain patients (particularly those with phobic states and many with senile dementia) a day-hospital setting would be preferable.

The risk of "institutionalization" occurring in our continued treatment (long-stay) patients was a further reason behind our choice. Though the constant need to find beds for new admissions had of necessity led to frequent assessment of all patients with a view to discharge, yet the opportunities for this would be enhanced if we had a day hospital for chronic psychotics. The facilities of a *day* hospital should eventually result in a diminution of the length of inpatient stay for a proportion of patients.

Shortly after the submission of our proposal we were greatly encouraged to learn that the Joint Committee of the Society of Medical Officers of Health and the Royal Medico-Psychological Association in their report of March 1959 recommended the establishment of Mental Health Centers. To quote from their Report:

1. Patients *not resident* in hospital should come under the care of an integrated service working from a special center . . . this could be the center for diagnostic and therapeutic services . . . it could also be the center for a day hospital, patients' clubs and so on. It should be the point at which all concerned with the work can meet, where conferences may be held and guidance and training given.

2. The psychiatrist and his staff from the hospital service should give all possible help and advice to the family doctor and to the Local Authority's staff and should carry out the psychiatric clinical work.

3. The social workers of various categories should pool their efforts as far as possible in each area, working closely with and for both the M.O.H. and the hospital and making contact with the related organizations.

### *The Program*

The proposal submitted to the trustees was that we wished to develop, with their help, a community mental health center. The trustees quickly approved the idea in principle and during the following six months the senior doctors of Moorhaven Hospital worked

up a scheme for a fairly comprehensive center. We were breaking new ground, and there was little to guide us—with one exception. In the city of York a mental health service which co-ordinated the activities of the York psychiatric hospital and the City Mental Health Department had been in operation since 1953. Our own scheme turned out to be a more ambitious one than was possible in York, but one valuable lesson was learned on a visit there, namely, the desirability of having a Joint Committee of Management (with hospital and Local Authority representatives).

In August 1959 the first draft of the scheme was ready and was approved by the Hospital Management Committee and discussed with the Regional Hospital Board and Plymouth Local Authority. The scheme provided for a building with accommodation for an *integrated* social work service for adults, for day hospitals for different categories of psychiatric patients, for therapeutic social clubs, and rooms for individual psychotherapy. In another part of the building there would be a child guidance clinic. It was stated in the draft memorandum that the center would be the focal point of all the community mental health services and a meeting place where various groups of people might come for discussion to help them obtain better insight into the wide range of mental health problems.

The Regional Board did not object to our ideas, but it was soon apparent that the scheme was too unorthodox for the Local Authority. There were two main difficulties: The Local Authority could not see their way to having an *integrated* social work service between themselves and the hospital. This would mean, *inter alia*, joint appointments of social workers which they would be unwilling to operate. We, therefore, agreed to the concept of *co-ordination* rather than *integration* of the social work service. This was the first difficulty, and it was soon resolved. The other main point of disagreement was the Child Guidance Clinic. The Local Authority had grave misgivings about having children and adults under the same roof, even though there would be two completely different sets of accommodation with different entrances from different roads and the two groups would never meet. The Local Authority had difficulty in appreciating that emotionally disturbed children are in fact mental health problems. They feared for the safety of the children and they feared the public would object and not use the Child Guidance Clinic. The psychiatrists, on the other hand, believed that the concept of *family* psychiatry was of great importance. They had come to realize that it was an exception

when only one member of a family needed psychiatric help. If one spoke of the family wheel was faulty, the usual consequence was that other spokes would bend or break or need attention. This was especially true when a child was involved. The psychiatrists felt strongly that a community mental health center should provide a *comprehensive* service and be the focal point of *all* the mental health services in the community and a meeting place for discussion of every kind of mental health problem. Children, therefore, could not be excluded. From the purely practical point of view, moreover, we wished for the greatest ease of communication for the staffs of all parts of the mental health service and we did not wish the staff dealing with children to be left out on a limb. Likewise, we wished for the centralization of documents so far as possible. A final reason for including the children was that we wanted the center to be used by people of various kinds (professional and nonprofessional, e.g., general medical practitioners, probation officers, clergy, schoolteachers, voluntary workers) people who by studying cases showing the early signs of maladjustment and mental ill health, would in the end come to play a part in learning about and teaching preventive psychiatry. So how could children be excluded?

### *The Building*

Nearly a year passed before the matter was finally resolved, to the complete satisfaction of the hospital authorities and—all-important—the Nuffield Trustees who at once (July 1960) most generously gave us 40,000 pounds on the basis of the scheme submitted in August 1959. Detailed planning of the building followed and construction started early in 1962. An imaginative step was then taken by Dr. T. Peirson (Medical Officer of Health, City of Plymouth) and the Plymouth City Council. Not only did they make available for the center a spacious site in the middle of the city, but they also decided to build on part of the same site a new school health and dental clinic and a new maternity and child welfare clinic.

The building was completed in January 1963. The first patients attended a week or two later. The actual cost of the center and its furnishings was a few thousand pounds more than could be afforded out of the grant and, despite the fact that the building itself is the property of the hospital authorities, the extra money needed was provided by the hospital board and Local Authority on a fifty-fifty basis.

Only brief comment on the plan is necessary, but it should first

be noted that the accommodations for adults and children are separated by a single door between the two sections. It was hoped that a day hospital for children could be included, but the idea was reluctantly dropped because of lack of funds. It was also hoped a large house could be acquired adjacent to the site for conversion into a sheltered workshop, but the Local Authority were not prepared to support the scheme.

### *The Staff*

Before describing the service as it has operated since the opening in February 1963, it is appropriate first to discuss the general administrative arrangements under which the Nuffield Clinic is run, and then to comment on the staffing situation in general.

During 1962 a Joint Management Committee of hospital and Local Authority representatives was appointed and held its first meeting in July. The committee consists of six members: Three are hospital representatives and three are from the Plymouth Local Authority. Of the latter, two are from the Health Committee and one from the Education Committee which has a special interest in maladjusted children. The chairmanship changes every year and alternates between hospital and Local Authority members. The Management Committee meets once a quarter. Its powers are limited because many of its decisions have to be approved by the City Council, Hospital Management Committee, or Regional Hospital Board. Indeed, in most respects it is merely an advisory body. Nevertheless, in my opinion a joint committee is essential for the success of a service of this kind. (In passing it may be remarked that one of the committee's first resolutions was to name the center the "Plymouth Nuffield Clinic.")

It may be of interest to mention the principles which govern the financial management of the clinic. By an early decision it was agreed that some items of expenditure should be met entirely by the hospital, others entirely by the Local Authority, still others to be met jointly by the two bodies. For the first year the total cost was about 35,000 pounds and for the year just ended it rose to approximately 39,000 pounds. The increase was due mostly to a planned build-up of staff. The patients themselves pay nothing except a nominal charge for their mid-day meal. Everything else is free, including transportation.

It was difficult to estimate the staff which would be needed for the clinic as a whole. Medical staff, nursing staff, psychiatric social workers, mental welfare officers, psychologists, occupational therapists,

clerks, and domestic staff would all be needed. Most grades of staff were, of course, already "in post" either at Moorhaven Hospital or with the Local Authority, but increases and additions were necessary. The most important and expensive item would be additional medical staff. Without expert direction the clinic would not be worth its cost. It was stated in our original memorandum that the principal doctor should be a consultant psychiatrist and that he should devote some six or seven sessions a week to the clinic, the remainder of his time being spent at Moorhaven Hospital and in the outpatient department of the Plymouth General Hospital. Toward the end of 1962 Dr. Kenneth Weeks, who had been an assistant psychiatrist at Moorhaven Hospital for several years, was made a consultant and medical director-designate of the clinic. He now works there six sessions a week, dividing his time between the adult and children's departments.

In our original plan we considered that two other additional doctors would be necessary: a senior, who should be a consultant child psychiatrist, and a junior psychiatrist in training. Unhappily, the money for the child psychiatrist has not yet been made available, and it was only in January 1965 that the appointment of an extra junior doctor made it possible to increase the total number of doctor-sessions each week.

The principle governing the medical staffing of the clinic is that there should be the fullest possible degree of integration with the other parts of the psychiatric service in the Plymouth area. In fact, each of the 12 doctors on the staff of Moorhaven Hospital does at least one session a week in the Nuffield Clinic. Apart from the medical director's six sessions, one doctor does four sessions, one does three, and the rest average one session a week at the clinic.

Five psychiatric social workers spend a total of about 13 sessions a week in the adult department of the clinic. Here they interview relatives of patients attending the day hospital and also relatives of inpatients at Moorhaven Hospital and outpatients at the general hospital. The rest of their time is spent at Moorhaven Hospital and in home visiting. In the Children's Department there are two full-time psychiatric social workers.

There were four Mental Welfare Officers when the clinic opened in 1963, and early in 1964 a fifth was appointed. The major part of their work is still with subnormal patients in the community, but they are also concerned with making arrangements for the admission of mentally ill patients to hospital, particularly those who have to be

admitted against their will. They are encouraged to keep in touch with these patients when they are in the hospital, and in a proportion of these cases the Mental Welfare Officers undertake the aftercare when they are discharged home. The offices of the psychiatric social workers and the Mental Welfare Officers are adjacent and there are frequent informal contacts as well as joint weekly case conferences.

The nursing staff are supplied by Moorhaven Hospital and are under the administration of the hospital's nursing administrators. There is a charge nurse (male), a deputy sister, a staff nurse (male), an assistant nurse (female), and two student nurses. Three of the staff are, therefore, fully trained. The student nurses are changed every three months.

There is one full-time occupational therapist, and one psychologist who spends about half of his time in the Children's Department and the rest in visiting schools in the city.

### *The Service*

#### 1. Day Hospital

The original intention was to run three small day hospitals and the building was designed with this in mind. In practice, however, there has been no segregation between the different groups of patients attending, but the selection of cases is probably somewhat conditioned by the knowledge that all the patients mingle. The accommodation was designed for an average *daily* attendance of between 50 and 60 patients. At the end of 1963 there were 73 patients on the register, and a year later this had risen to 104. About a quarter of those on the register attend every day. The patients fall into three main groups: psychotic, geriatric, and psychoneurotic, most of them being psychotic, and the fewest psychoneurotic. Patients with *acute* or disturbed psychotic conditions are not accepted, and physical treatments are not given.

In 1963 nearly half of the patients referred and accepted were ex-inpatients from Moorhaven Hospital, about one-third came from the Outpatient Department of the Plymouth General Hospital, and the remainder were community-care patients referred by the psychiatric social workers or Mental Welfare Officers. Their ages ranged from 15 to 86, with an average age of about 50. There were more women than men. No maximum duration of attendances at the day hospital has been fixed. Of the 96 patients discharged during 1963, 40 returned home and 34 were admitted (or readmitted) to Moorhaven Hospital.

Most of the remaining 22 patients failed to attend regularly, and were thus discharged. The day-hospital patients come into close contact with the team of nurses and the occupational therapist, and they have the opportunity of seeing the psychiatrist who referred them. It is fully realized, however, that medical contact has been quite insufficient, and no claim is made that a maximum standard of efficiency has yet been reached. The nursing service is of a high standard, and the nurses and the occupational therapist are responsible for providing the occupational, recreational, educational, and social activities. Shaving and bathing services for geriatric and chronic patients are carried out daily. The social aspect of psychiatric nursing is emphasized and all the nurses have made visits to the patients' homes.

## 2. Social Work Service

This has already been described in the preceding section. During the first 11 months the hospital social workers gave 1,084 interviews at the clinic.

## 3. Individual Psychotherapy for Adults

Until the opening of the Nuffield Clinic all the psychotherapeutic interviews for outpatients were given under poor conditions at the general hospital. Nearly all these have now been transferred to the clinic: there are five doctor-sessions a week.

## 4. "Follow-up" Clinics

This service, which is for "follow-up" work on discharged inpatients, was also transferred from the general hospital. There are four and one-half sessions a week, provided by seven different doctors, some of whom attend only fortnightly.

## 5. Children's Department

It has already proved most valuable to the staff of the Children's Department who operate the Child Guidance Clinic to have close contact with the rest of the service. The number of new referrals increased to a record figure in 1963 and again in 1964. There have been no complications whatever through having adults and children in the same building.

## 6. Educational Service

Since the opening of the clinic a number of different professional groups have met there. Working relationships have been maintained with the probation officers, health visitors, general medical practitioners, voluntary bodies, and others. We also have reason to think



it is becoming known that the Nuffield Clinic is the place to contact in regard to problems of mental health and mental ill health. Spontaneous self-referrals are beginning to take place.

### *Research*

Research has not yet been mentioned. In the original scheme submitted to the Nuffield Trustees we made the point that we considered some useful research could be undertaken with regard to the work of the clinic. The trustees welcomed this suggestion and their grant specifically included a sum of money for this purpose. Briefly, the research project is to evaluate the functioning of the clinic. The broad aim has been to compare the services available in the area served by Moorhaven Hospital *before* the clinic opened with the services operating at the present time. I will leave it to my colleague Dr. Neil Kessel to give an account of the work undertaken.

### CONCLUSIONS

Our original memorandum, so often referred to in this paper, ended with the following paragraph:

Immediate dramatic results from a scheme of this kind are not very likely. As a long-term campaign it is in line with the best psychiatric thought of today, and its success in the following ways could hardly be held in doubt:

- (a) The emphasis on education and "child guidance" would foster the growth of a preventive psychiatry.
- (b) The emphasis on treatment in a community setting would reduce admissions to and accelerate discharges from hospital.
- (c) The intensive co-ordination between Local Authority and hospital service is bound to result in increased efficiency and better value for money.
- (d) The program for opening up communications between general practitioners and the other two parts of the National Health Service should similarly improve the quality of service of all three.

These are long-term aims, and it is too early to say whether or not they will be achieved.

The results of the mammoth head-counting exercise which Dr. Kessel reports may be judged to give some reliable hints of developing trends.

Be that as it may, certain factual statements can be made on the credit side as the result of personal experience. The first is that the gap between hospital and Local Authority is becoming progressively nar-

rower and relationships, which for years had been difficult to establish, are becoming much easier at all staff levels. Second, the success of the Joint Committee of Management has exceeded expectations: no longer is it "their side," "our side," "we" and "they," but simply "us."

But there is a debit side as well. The build-up of staff has been disappointingly slow and has delayed the full operation of the services we intend to offer. The shortage of medical staff has hindered the development of the day hospital work and also that of the Children's Department. The Emergency Psychiatric Service, which we hope to provide for crisis situations of every kind, has had to be restricted to dealing with real emergencies. There is also an acknowledged need for another psychologist and another psychiatric social worker.

Another item on the debit side is the relative lack of participation of voluntary bodies and voluntary workers. However, it should not be assumed that the citizens of Plymouth are not interested. The reason is more on the administrative side: For internal reasons it has been deemed prudent to involve voluntary help slowly. The third debit item to be mentioned takes us back to the early objections raised to the idea of an integrated social work service. If integration had been achieved, the efficiency of the service would certainly be greater.

The developments I have seen since taking office 18 years ago, and have now described, are too recent to be judged in historical perspective. But if we look back to Moorhaven Hospital's first years, when every door was locked and every patient certified insane, when the host of psychoneurotics were not even identified, and when prevention was yet to be even a talking point, it must be admitted that psychiatry has not stood still.

## APPENDIX

### THE PLYMOUTH MENTAL HEALTH (HOSPITAL-CENTERED) SERVICE

#### *Some Milestones*

- 1891 The hospital was opened with 200 beds in six wards under the control of the Plymouth Borough Council. Population served: 155,000. 1.3 beds per 1,000 population.
- 1905 Extension completed, giving 200 additional beds in six new wards. Population served: approximately 200,000.
- 1910 Average number of annual admissions 1891-1910 was 85.
- 1911 1.9 beds.
- 1920 131 patients admitted.
- 1925 Patients were allowed to wear their own clothes.
- 1928 The medical staff was increased to three. A weekly outpatient clinic was started in Plymouth, 114 patients admitted.
- 1930 The "Mental Treatment Act" was passed.
- 1931 2.5 beds.
- 1934 A 50-bed admission unit was opened.
- 1940 179 patients admitted.
- 1947 "Plymouth Mental Hospital" became "Moorhaven Hospital." The medical staff was increased to four.
- 1948 The Hospital was transferred to the Ministry of Health under the National Health Service Act. The first psychiatric social worker was appointed.
- 1950 370 patients admitted.
- 1951 2.9 beds (approx.).
- 1952 The hospital held its first annual Open Day.
- 1953 Medical staff increased to seven. Eleven outpatient sessions a week. 483 patients admitted.
- 1954 A 25-bed psychogeriatric unit was added to the hospital, giving a total of 781 beds.
- 1955 A 44-bed acute psychotic admission unit was opened.

- 1956 The last ward was unlocked, giving an entirely "open-door" hospital. 97 per cent of admissions were voluntary.
- 1957 The Moorhaven Hospital League of Friends was started.
- 1958 Medical staff increased from 9 to 10. 888 patients admitted.
- 1959 Official visiting hours were abolished.
- 1960 The Mental Health Act (1959) came into force; 1,021 patients admitted.
- 1961 2.4 beds.
- 1963 The Plymouth Nuffield Clinic was opened by the Minister of Health on April 26th.
- 1964 Medical Staff increased to 13. Psychiatric social worker staff increased to five. Population served: 265,000. 763 beds, 1,068 admissions, 2.8 beds.