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## Attitudes of Staff and Patients to Psychiatric Admission Wards

### BY A CONSULTANT PSYCHIATRIST

The past 20 years have seen a movement of psychiatric care away from large, isolated institutions and into community orientated services. This change has been facilitated by modern therapeutics; and also by new attitudes to care and rehabilitation of patients, which to operate optimally require contributions to case management by members of a multidisciplinary team.

Yet by 1975—the latest date for which figures are available—73 per cent of the 175,000 psychiatric admissions in England and Wales were still into the large psychiatric hospitals (HMSO, 1977b). In the present economic climate a rapid increase in community-based services is unlikely to be imminent.

Meanwhile, the need to provide links between psychiatric hospitals and the developing community services led to a DHSS directive for mental hospital psychiatric services to become reorganized into 'divisions' serving a district (or part of one) (HMSO, 1975). This has resulted in fundamental changes in organization of admission wards in many large psychiatric hospitals, and a similar pattern is being followed in many general hospital units. Informal and detained patients of all ages, both sexes, all diagnostic categories and all degrees of behaviour disturbance or distress may be admitted together to a 'catchment area ward', there to remain until discharged (or transfer to a long stay ward).

It is difficult to compare the services provided by the large mental hospitals with those provided by the psychiatric units, in relation to their staffing, because of the different types of work undertaken. Mental hospitals generally have large resident populations of long-stay patients, and staff travel elsewhere to out-patient clinics, etc, while units are likely to have day hospitals and out-patients on site, ward referrals, and liaison work. However, in 1975 the majority of large psychiatric hospitals had medical and nurse staffing levels below the national rate, while a few were still below minimum tolerable standards laid down in 1972 (HMSO, 1977a).

Many of the large mental hospitals, especially those distant from cities, are having increasing difficulty in recruiting staff.

In the light of these considerations, the views on certain aspects of admission ward policy were sought from patients treated on admission wards, and from the staff, of a large psychiatric hospital, by means of a survey. Complementary questionnaires were devised, to elicit views of patients and of staff, on the ward environment and facilities; on the wearing of uniform by staff; on care and treatment, including reactions to mixed intake wards, the functioning of the multidisciplinary team including the form of the 'ward round', and the value of group therapy on admission wards. Most

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questions required a 'yes/no' answer, and all questions invited comment. The questionnaires were based on those used by Raphael (1974, 1977) in her surveys of patients in psychiatric hospitals and units, but the scope of inquiry was extended. Questionnaires were returned anonymouly but indicated age and sex; also profession/grade of staff and diagnosis of patients.

The staff survey included all senior nursing staff (22), all doctors (23), occupational therapists (OTs) (10) and social workers (SWs) (10); and a representative sample of trained (166) and learner (39) nurses. The psychologists chose not to take part. Response rates were 100 per cent from OTs, and in round figures 70 per cent doctors, social workers and ward-based trained nursing sta; 50 per cent nurses in training; 30 per cent nursing officers; and 20 per cent enrolled nurses. A total of 159 staff replies were received, from 270 distributed (59 per cent response).

The patients' survey was limited to three admission wards, each admitting all categories of patients except the severely demented. (A locked ward was available for the temporary reception of violent patients during a crisis.) All patients leaving the hospital after a stay of at least five days were asked to complete the questionnaire, until 150 were obtained.

Of the 150 patients, 72 were men and 78 women; ages 18–74, of whom 60 per cent had had a major functional illness.

The conclusions to be drawn from this survey are admittedly limited, by unavoid-able self-selection of responder patients and because the data are derived only from wards operating a particular admission policy. However, within these limitations certain factors emerged as being important to patients and staff. These are discussed below under their various headings. It was apparent from the staff replies that an optimistic treatment philosophy, aiming to restore confidence, self-reliance and a sense of personal identity to patients, was present in the hospital.

(a) *Physical environment*

Comments by staff and patients drew attention to:

1. Need to have adequate numbers of single rooms for patients admitted at night and for disturbed patients.
2. Dormitory sleeping is far from ideal, but if essential then privacy by means of curtains, for dressing, etc, particularly for women, must be provided.
3. Sufficient lockable storage space. Sufficiency of personal belongings and 'space' is important in rehabilitation to independence (Goffman, 1974). Pilfering by disturbed patients is common, and is reduced if patients are able to lock their belongings away safely.
4. Patients need facilities to wash and dry clothing.
5. Television room should be separate from main sitting-room. Also, a quiet area should be available for reading and writing; and privacy is needed for patients to receive visitors (who would welcome a cup of tea after a long journey).

(b) *Wearing of uniform by nurses*

Seventy per cent of patients and 57 per cent of staff liked uniforms. Opinion was divided between those who felt uniforms were reassuring to patients and enbled the confused and disturbed patients to know who was staff; and those who felt uniforms made it more difficult for patients to develop a therapeutic relationship with staff members, suggesting an authoritarian note which was not desirable. However, many patients, and staff, pointed out that ultimately the wearing of uniform should be a personal decision by the nurses, depending on his/her 'style' of working. Thirty-seven per cent of patients said they had difficulty in recognizing members of staff, or knowing what their aprticular job was; and over three-quarters of all staff and patients felt some identifying name-badge was helpful.

(c) *Reactions to mixed sex wards and to behaviourally disturbed patients*

A minority of patients—eight men (11 per cent) and 17 women (22 per cent) declared that they strongly disliked being in mixed sex wards and a larger proportion, especially women, preferred single sex wards. Half of all the patients (35 men and 39 women) had had previous admissions to single sex wards; this made no difference to the preference of the men, but increased the preference of the women for single sex wards. But 35 per cent of the women who had experience of single sex wards preferred them. Asked whether they were at some time worried, upset or frightened by other patients, a positive reply was given by 30 men (42 per cent) and 45 women (58 per cent). Comments suggested that many patients found it particularly difficult to cope with experience of disturbed behaviour in the opposite sex, and the preference of women for single sex wards is probably explained by their greater fear of violence by men, and greater anxiety produced by flagrant sexual behaviour, by men, than is caused by men by such behaviour in women.

Since integration of previously single-sex wards was introduced (two years before the survey), there has been a considerable increase in the numbers of patients of both sexes sent to be nursed in the locked ward over a crisis period of disturbed behaviour; but sexual matters rarely produced difficulties.

The survey showed differences in the attitude to mixed-sex wards between doctors and senior nursing staff on the one hand, and the ward-based nurses on the other. All doctors and six of the seven nursing officers liked mixed sex wards, but only 45 per cent of the ward-based staff did so. There was no such split over the policy of mixing different categories of illness; 55 per cent of all staff liked this, while 31 per cent disliked it. However, a separate facility for the most disturbed was seen as desirable, or even essential, by 85 per cent of the ward staff and doctors.

The staff questionnaire produced a lively debate on the 'pros and cons' of the policy of taking all patients into a catchment area admission ward.

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The arguments and counter-arguments advanced for this policy were:

1. Continuity of care by the same staff, and improved job satisfaction for staff.
2. Having catchment area patients together facilitates co-ordination with community services.
3. Having men and women together improves behaviour and reduces incidence of disturbance. This was not found to be the case in a mixed ward for disburbed patients (Carney & Nolan, 1978); the incidence of violent behaviour increased when the ward was mixed.
4. It is 'normal' and therefore 'therapeutic' for the sexes to live side by side. But what is normal about acute psychosis? Perhaps the dignity of the mentally ill is served by a degree of privacy during acute illness, even more than with physical illness. Return to 'normal' living together may be more appropriate to the later rehabilitation phase.
5. Non-psychotic patients are helped by seeing that disturbed patients can be 'continued'. Yet it is often hard for healthy staff to cope emotionally with disturbed patients; how much more difficult for sick patients!
6. In fact, the limits of tolerance of this situation have caused hospitals to have difficulty in coping with certain types of patients, notably disturbed offenders, for which they have been criticized (B.M.J., 1977, 1979). The DHSS (HMSO, 1975) recognizes the need for a range of facilities to cope with these needs; but in practice this need is not given priority. Reed (1978) in correspondence in The Times, discusses his experience—which others share—of patients in need of treatment who refuse to remain in hospital because of stressful conditions.
7. The disturbed ward becomes known as the 'bad' or 'punishment' ward. Surely it is up to staff to avoid using it in this way.

It is suggested that the more disturbed patients would be best nursed in small single-sex groups. Those less disturbed could appropriately be treated on a mixed sex assessment/rehabilitation area. When settled they could move to the rehabilitation area.

Uniforms might be worn by nurses while working in the 'acute' area, but not in the 'rehabilitation' area.

A district of population 60,000 will require about 30 acute admission beds plus 10 additional day places (HMSO, 1975), needing 8 to 10 nurses per daytime shift. Provided the accommodation were suitably arranged, such a unit might consist of 5 to 6 beds, and day rooms for each sex, for the more disturbed (3 nurses of each sex) plus 20 beds and the day places (4 nurses) for rehabilitation. This type of unit would be small enough to function as an entity in which staff could be deployed as the needs arose in the different areas, continuity of care maintained, and training requirements for staff fulfilled.

This basic scheme would suit a District Psychiatric Unit, and would be adaptable for the admission area of a psychiatric hospital. This would not require more nursing staff than the 'take all-comers' ward, which must be staffed at all times by sufficient nurses of both sexes to cope with all contingencies. In fact fewer night nurses might be needed, since they would not be essential on the rehabilitation ward.

### The needs of patients from minority ethnic groups

A need was expressed by staff for information on the background, culture, beliefs and expectations of patients from immigrant groups; both to help in understanding their psychiatric problems and to assist them to feel less strange and lost in an unfamiliar setting. Recruitment of nurses and/or social workers from the same backgrounds as these patients to the staff of the hospital, was seen as very desirable. Their need for acceptable food was mentioned also, especially for Asian patients, some of whom are vegans.

### (d) Group therapy

All admission wards had some group therapy in addition to other treatment methods. The extent of the groups varied between wards, but there was no difference between these regimes in the proportions of patients who felt the groups to be helpful. Fifty-eight per cent felt the groups helped them to get on better with others and 43 per cent felt the groups had helped them understand more about their own problems; whereas 80 per cent felt they had been helped by talking to members of staff privately.

Comments focused on two points; first the need for selection of patients who are invited to attend the groups, and second, the need for suitable training for group therapists. Patients felt that disturbed members could so disrupt a group that no benefit was obtained by those trying to use the group. Nurses felt that in some patients, group meetings stirred up anxieties which were not dealt with in the group, and might later lend to behaviour disturbances with which the nurses had to cope.

### (e) The Multidisciplinary Team and 'Ward Round'

Apart from day-to-day reviews of progress, medication, etc, between doctors and nurses, the main decisions regarding management of each patient were made at weekly meetings involving all professional disciplines. At such interviews discussion of personal or emotionally charged matters would not normally take place; such issues being best discussed privately with a member of staff. Decisions by the team were conveyed to the patient in the team meeting, especially if the decision was in any way contentious. Failure to do this had sometimes led to episodes of 'acting out' in situations where the staff were unprepared for such behaviour.

Twenty per cent of patients stated that they had not liked being seen in the ward round, mainly because they had not known what was expected of them. So far as the team method of decision making is concerned, only 10 per cent of

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staff did not find it satisfactory. Their objection mainly related to medical co-ordination (or leadership?) of the team, to a persistence of a 'hierarchical pyramid'.

If these views are considered in the light of the next section, on staffing and relationships, it would be fair to conclude that the multidisciplinary team approach is working well but that patients require more explanation of the procedure.

Yet perhaps the criticisms contain some justification. Are consultants, with a small number of sessions in the hospital and heavy commitments elsewhere, always able to fulfil the role required of them? Previously permanent Medical Assistants provided experience and stability; their presence in the mental hospital is missed.

*Patient Care, Staffing Levels, and Staff Relationships*

Seventy-three per cent of patients felt that they had been helped to a considerable extent by admission. The patients were more satisfied with the care received, than were the staff with the levels of care they were able to provide. Only 5 per cent of patients felt they did not get enough care from nurses, while 40 per cent of nurses felt nursing care was inadequate.

There were similar findings in respect of social ward and occupational therapy. The discrepancy between patients' perception of the care received, and staff satisfaction with the level of care they are able to provide could reflect the low expectations of patients from a deprived urban area: or of psychiatric patients in general; or a difference or expectation between social classes; or it could relate to the difficulty staff experience in applying the high standards demanded in training to the realities of work in different settings.

Comments made it clear that the lack of satisfaction among staff with the standards achieved in their work was related to the heavy work loads. But members of each professional group were often unaware that this situation was also a problem for other members of the team, and sometimes individuals were blamed for the shortcomings of their service. Dissatisfaction among professional staff with their own work achievements is a worrying situation. Mental hospital work has 'anti-attractions' for staff. These include the large burden of work with demented and chronic patients, the lack of contact with colleagues in other specialties, and low professional status; and for the younger members, uncertainty about the future of their jobs. If to these are added lack of job satisfaction, then a vicious circle is set up in which staff leave, posts become progressively more difficult to fill as the work-load increases, and requests for increased establishment meet the response 'You can't fill the posts you have'.

Continuity of care is important in good psychiatric practice, where many patients need prolonged support and treatment, inside and outside hospital. This is made more difficult by high staff turnover.

The large psychiatric hospitals will have to provide the greater part of acute in-patient care for some years to come.

Lack of resources need not prevent the testing of changes in practice and organization which might enable existing resources to provide an improved standard of care.

The loyalty and enthusiasm of its staff are an asset which no hospital can afford to lose. If 'job satisfaction' is declining because of staff shortages which cannot be remedied, then perhaps the staff should seriously consider whether they prefer to reduce certain areas of responsibility in order to maintain standards elsewhere; or to continue to offer a more comprehensive service, while acccepting that excellence may have to be sacrificed. Health care, like politics, remains the art of the possible.

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# New Year Honours, 1980

Knight Bachelor: William Henry Trethowan, Professor of Psychiatry, University of Birmingham.

An appreciation will be included in the next issue of the *Bulletin*.