

engrossed in the 'descent of the Manor' from its original owners, the Finch family, onwards.

Historical publications from mental handicap hospitals have not been numerous, and so it is a pleasure to welcome Dr Jancar's *Research at Stoke Park, 1930–1980*, a supplement to the two editions of *Stoke Park Studies*, first collected by R. J. A. Berry in 1933. The scope of the booklet, however, gives the impressive list of research articles and reports which have emanated from the group. There are, besides, chapters on the lives of the founders, the Rev H. N.

Burden and the two Mrs Burdens, and of the two outstanding research directors, R. J. A. Berry and R. M. Norman, a full history of the Stoke Park group of hospitals and of the Burden Institute, and some delightful illustrated notes on the various manor houses dotted around Bristol which constitute the group. As Professor Joan Bicknell says in the Foreword: 'Much that is commonplace now was first discovered at Stoke Park and the Institute . . . and the continuation of the enthusiasm and high standard of work is in no small part due to Dr Jancar's own contribution.'

A Clinical Attachment in Rehabilitation

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Rehabilitation is a subject of topical interest in psychiatry and the Royal College of Psychiatrists has laid down guidelines of practice in its publication *Psychiatric Rehabilitation in the 1980s*. More detailed advice is given in Wing and Morris's (1981) practical manual for people involved in this work. Morgan and Cheadle (1981) make the point that consultants appointed to posts with a special interest in and responsibility for rehabilitation often have no special knowledge of or experience in the field and have to learn as they go along. This was the case with me when I took up my post in March 1978. Having learnt something from colleagues, from my reading and from my own experience, I thought that I needed to look elsewhere and see at first hand what experts in the sphere were doing. I was granted six weeks' study leave in the Spring of 1981 and arranged to spend five weeks at the Maudsley Hospital and a week at Southampton. I also visited Montrose for the Scottish Division's meeting on rehabilitation.

The work of Douglas Bennett, John Wing and others at the Maudsley and Institute of Psychiatry in rehabilitation, social psychiatry and community care is well known and it was most interesting to see things at first hand. The set-up is (or was—see below) based on the Day Hospital which from the outside is an unimpressive and dingy Victorian building. The inside resembles a warren with rooms at many different levels and would seem to be far from ideal. In practice it lends itself quite well to the organization of work for patients in that small working groups are created with high levels of staff-patient interaction. This is a most impressive aspect of the Day Hospital, industrial and clerical work being organized at different levels of difficulty and speed to suit the abilities and needs of each patient at a particular time. Individuals are assessed in great detail by doctors, nurses, social workers, occupational therapists and psychologists and the multidisciplinary approach is seen to work effectively in practice. This involves a considerable amount of time in

assessing patients, pooling information, discussing the abilities, disabilities and needs of each person, planning a programme in considerable detail and monitoring subsequent progress.

Some patients progress from the Day Hospital next door to the Vocational Resettlement Unit (VRU) which is a realistic work environment akin to an Employment Rehabilitation Centre (ERC) on site where the expectations and requirements are more rigorous than those of the Day Hospital. The VRU is not staffed by psychiatric professionals and is special in providing assessment, treatment and long-term sheltered work for a small number all in the same unit under the same roof. A selected few graduate to a nearby sheltered factory (CRA Manufacturing) involved in the production of bathroom, toilet and kitchen fittings. Some people eventually find open employment and others end up attending Local Authority Day Centres.

Most of the patients at the Day Hospital have their own accommodation and a small number have been found housing by the Windsor Walk Housing Association, a charity formed in 1970 by psychiatrists, social workers, solicitors, architects and other interested parties. A few attend from in-patient wards.

I had naively anticipated that Maudsley patients would be less disabled than those from my own mental hospital, but this was hardly the case. A considerable number had severe chronic impairments and a proportion had florid symptoms of illness. Many had multiple handicaps such as physical disability and underlying personality disorder, compounded by social problems as well as mental illness. A large number of patients attended the Day Hospital for depot injections, but I formed the impression that the proportion of patients prescribed oral neuroleptic drugs alone was higher than in my own hospital and that depot preparations were used less frequently.

I was surprised that patients were expected to attend

groups each day, including a large patients and staff group each week. This was at times a tense affair especially on one occasion when a middle-aged white man expressed persecutory delusions about blacks which caused some upset, not least to the coloured patients present. (This was around the time of the riots in nearby Brixton.) While it may be churlish to criticize, I thought that some patients found groups to be too stressful, uncomfortable and anxiety-provoking, and this appeared to lead to relapse in one or two schizophrenic patients during my short visit. It seemed to me that the 'psychotherapeutic approach' was being applied across the board to everybody and that this was to the detriment of a minority. This universally applied blunderbuss treatment was in marked contrast to the stress on work programmes being planned individually for each patient. I felt that a more discriminating selection of patients for psychotherapy and groups might have been more appropriate.

By chance, on my last day in London, I was able to attend a seminar for visiting Canadian administrators at the Institute of Psychiatry on a community psychiatric service which discussed Maudsley Services and how they have developed. It is only since 1970 that the Hospital has had responsibility for a specified catchment area. In the absence of long-stay in-patient wards, novel ideas about provisions for chronic patients have evolved. One of these is the Hospital Hostel (or ward in a house) which accommodates 14 severely disabled new long-stay patients. This unit has a large staff who are highly motivated and enthusiastic. The emphasis is on detailed assessment and planning of care for individual patients with regular monitoring and feedback of progress. At the time of my visit, six of the patients had improved sufficiently in a three-year period to be considered for discharge to a hostel in the community.

Another development, due to open in late 1981, which will take over the functions of the Maudsley Day Hospital, is the District Services Centre. In one building there will be a Day Hospital, rehabilitation facilities and a few in-patient beds providing a community-based service for chronic patients centred around day care. It will be used mainly by long-term heavy contact patients and the aim is to provide continuous personal care for each patient whether they are out-patients, day patients or in-patients.

A surprising omission, I thought, was the lack of a Community Psychiatric Nursing Service. There are several reasons for this: it is in fact possible, at least in theory, for any nurse to go out and visit a patient at home, and this certainly did happen at the Day Hospital. This is fine for a well-staffed hospital with a geographically small catchment area but it would hardly be feasible for a rural hospital with small numbers of staff covering a wide area. On the other hand, the existence of an emergency walk-in clinic gives people ready access to staff for advice, and crises can be dealt with rapidly. This lessens the need for community psychiatric nurses and means that local family doctors are not so involved with psychiatric problems and emergencies.

An outstanding feature of the Maudsley and Institute of Psychiatry is, of course, the academic programme with teaching in a wide variety of interests and topics. I took the opportunity to attend a number of case conferences, lectures and seminars and I was also able to meet many people in the Social Psychiatry Unit who gave freely of their time to discuss things with me. It was like being a medical student again in that I had no clinical responsibilities but I was able to plan what I wanted to do and see. Towards the end I was surprised to find that I was missing direct contact with and responsibility for patients although on my return home it took several weeks to readjust to my own job.

The situation at Southampton was different and probably had more direct relevance for my work. What used to be one large catchment area served by Knowle Hospital is now two areas, one served by Knowle and the other by the Department of Psychiatry at the Royal South Hants Hospital (RSH). Both hospitals have in-patient rehabilitation wards backed up by the day hospitals and a variety of community facilities including sheltered hostels and 17 group homes (six mixed sex). The multidisciplinary approach was again much in evidence, with stress on careful identification of problems and setting up individual programmes of care for patients. A relatives group is held regularly at RSH which was attended by a small number of people when I was there, and they seemed to find it to be of benefit. It was fascinating to compare rehabilitation services in the two areas—one based on traditional mental hospital lines and the other trying to find its way in the setting of a District General Hospital. Difficulties in the latter included the lack of privacy, of recreational facilities and of space in the hospital grounds in comparison with Knowle as well as the lack of paid work for patients. An Industrial Therapy Unit a couple of miles from RSH was just getting off the ground at the time of my visit.

What are my lasting impressions of the attachment? Firstly, rehabilitation works best on a multidisciplinary basis with all disciplines having a significant contribution to make. Much depends on individual personalities as to whether people can co-operate and work together with trust in each other and without feeling threatened by other groups. Secondly, a lot of time and thought need to go into identifying problems and planning treatment in order to achieve good results. Thirdly, we are talking in terms of care rather than cure, and we must appreciate that we are involved in long-term management of patients and be prepared to accept only small improvements in return for hard work over a long period of time. Fourthly, the attitudes of staff are crucial whatever approach to patient care and management is involved. It goes without saying that we need staff who are patient, tolerant, caring, positive, optimistic and enthusiastic, albeit realistic. Finally, the consideration and kindness given by everyone I met and their ready willingness to give of their time in discussion was much appreciated.

Was it worthwhile? Undoubtedly, yes: I learnt a great deal and gained useful ideas. These obviously have to be related

to the facilities and staff in my hospital and I have been stimulated to look critically at our own services and consider how they could be improved.

Would I recommend such an attachment to others? Again, yes: to consultants with a special interest in rehabilitation who have not had much training in the field, I would suggest that they wait until established in post for a while so that they may benefit from their own experience first. The content of such an attachment is open to debate. If I were doing it again I might try to spend time at a larger number of centres for shorter periods of time, but the choice of programme depends on each individual's needs. The

recently appointed Demonstration Centres would be obvious places to visit (Nottingham, Northampton and Netherne as well as the Maudsley).

My thanks go to all the staff at the Maudsley and at Southampton who made my attachment so enjoyable and interesting.

REFERENCES

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Locking up Patients by Themselves

The locking up of psychiatric patients has become a delicate issue, and raises more than questions of consent and of civil liberties. Up to about 20 years ago it was very formally regulated. No patient could be secluded without the authority in writing of the medical superintendent or the responsible consultant, and the hours of starting and finishing seclusion had to be recorded in a special book. Woe betide any nurse or junior doctor who was found to have shut up a patient without higher authority or without record. One of the duties of a ward doctor in a psychiatric hospital was to do surprise checks on single rooms to see if someone was locked in unofficially. This and the other rules with the force of law had been established because of many abuses earlier uncovered.

With the changes in hospital organization in the NHS all these binding regulations were swept away. It is now up to individual hospitals to decide what to do, though the DHSS has recommended that each hospital should have known, established procedure, and the College (*Bulletin*, May 1981;

5, 96) issued a supporting statement that 'it is imperative that doctors should take a primary responsibility for support and guidance of nurses involved in the necessity to use such a facility. Within the NHS therefore, all such actions should continue to be recorded, whether by day or night, and should then be discussed by the appropriate "multidisciplinary team" . . .'

On the other hand, a correspondent writes: 'I suspect the majority of hospitals have no explicit policy, and that where there is one, much variation in the ways of dealing with violent behaviour will be found. For example, some hospitals have protected rooms, others have wards for disturbed patients in which a violent individual can be isolated from the others by means of an armour-plated barrier, and yet others use certain rooms not specifically designed for seclusion . . . on an *ad hoc* basis which would seem unsatisfactory.'

To encourage hospitals to think about this subject and review their policies, we publish below a paper on the subject recently circulated for internal use at the Maudsley.

Procedure for the Seclusion of Patients in the Bethlem Royal and Maudsley Hospitals

Seclusion is containment of a patient alone in a room or other enclosed area from which that patient has no means of egress.

There are two circumstances under which seclusion may be used in the Bethlem Royal and Maudsley:

1. As an emergency procedure to control a potentially dangerous situation;
2. As part of a planned programme of treatment prescribed by the clinical team.

[Of these two circumstances, only the emergency procedure has wider application and is discussed here.]

Institution of seclusion

Authorization to seclude must be obtained from the patient's doctor. The Sister/Charge Nurse or designated deputy at the time may, however, initiate this procedure in cases of grave emergency before calling for help.

At the commencement of seclusion, the Sister/Charge Nurse or designated deputy, will contact the Unit Nursing Officer and the patient's doctor. They will then visit the Unit without delay and see the patient. If the doctor agrees to the continuation of the seclusion, he will sign the Seclusion Book to that effect. If he feels the seclusion should be terminated,