PSYCHIATRIC TREATMENT OUTSIDE MENTAL HOSPITALS.*

By DALTON E. SANDS, M.R.C.P.Ed., D.P.M.,

Deputy Physician Superintendent, Banstead Hospital; Associate Psychiatrist, King's College Hospital.

IN this discussion of psychiatry outside mental hospitals, it is proposed to deal mainly with the field of psychiatry inside general hospitals. The idea of in-patient psychiatric beds in the general hospitals is certainly not new, and was tried out between the last two wars. One of the factors responsible for failure was a lack of effective therapeutics. Thus the comparatively small number of beds available were occupied for periods too long for ordinary general hospital practice, and facilities to ease long-term admission in occupational and social directions were usually lacking. The situation has not substantially changed from that described by Weir Mitchell, who caustically remarked that psychiatrists pleaded for opportunity to treat the early case, but when the plea was granted there was little that could be done. In the last few years advances in both psychological and physical methods have reached a point where certain categories at least of mental illness can be considerably helped by admission to a general hospital psychiatric unit, and be discharged in a period comparable to that usual in general medical wards. A report made in 1943 by the author at Sutton Emergency Hospital, and later, social studies by Brown and Carling, 1945, at the Radcliff Infirmary, Oxford, showed that the six weeks' average stay of the psychiatric in-patients was less than the average for medical patients of a general ward. It was not just a matter of performing a little diagnostic investigation and then transferring the patient elsewhere. In fact less than 8 per cent. of these psychiatric patients were sent to other hospitals. The full figures for a year's admissions are available in the 1943 report.

The in-patient selection field is very wide, and inevitably merges with the mental hospital on one side and the general hospital ward on the other. It has been said, not unreasonably, that mental hospitals are the place for mental illness, and that the innovation discussed trespasses on their clinical inheritance. Writing as one who works in both fields, I do not think this is so great a difficulty as some might believe. Inevitably there must be a little overlapping, but so far as my experience at Sutton was concerned, the majority of those admitted to the psychiatric ward in the general hospital block were not often seen in the mental hospital unless their clinical condition had subsequently altered. One has to remember that except for those who could afford a nursing home, and excepting the very occasional unit provided by a few more far-

* A paper read at a February meeting of the Royal Society of Medicine (Section of Psychiatry).

sighted local authorities and their superintendents, there has so far been no specialized hospital service exclusively available to neuroses and milder forms of psychoses. The provision of voluntary status at mental hospitals covers these types in theory, but only partly in fact. The proportion of voluntary patients varies widely, and naturally it is highest where there is adequate treatment, in hospital units that allow of their being undisturbed by acute cases or depressed by mixing with chronic ones. Until such conditions are universal, one still has to reckon with the public prejudice that tends to make a patient choose the general hospital even if architecturally it is lacking in the amenities of the modern mental hospital admission villa.

The *diagnosis and selection* of patients for a general hospital psychiatric ward cannot be done solely within the usual clinical classification, e.g. some depressions are suitable, others far from it. Looking back over the diagnosis of several hundreds of my patients, it was evident that almost every notable psychotic and neurotic type was represented, from subacute schizophrenia to drug addiction. The factors that really enabled certain obviously psychiatric patients to be cared for in a general ward were one or more of the following: (*a*) A well integrated personality prior to breakdown could retain better social control of symptoms than those less well adjusted; (*b*) the illness was of a type in which prompt treatment could control any features likely to menace the patient or others; (*c*) all patients possessed sufficient insight to know they needed care; and (*d*) the course of the illness in those who were psychotic was of moderate severity. It is such general considerations as those that enable some schizophrenics, certain manic-depressives and so forth to be treated in the open general hospital ward with the neuroses without any special precautions, and even on the top floor of the block.

Some psychiatric types found specially suitable are neuroses in which the struggle to adjust and the tension involved has caused manifest physical deterioration. The patient goes downhill in a vicious spiral of combined psychological and physical traumas. In other cases stress in the home or other environment may be so severe that without removal to hospital recovery would be unlikely or long delayed.

Turning from patients who are solely psychiatric candidates for treatment, there is the large group of psychosomatic cases and others where superficially at least the organic aspect seems predominant. Doubtful cases of cerebral tumour, encephalitis or narcolepsy may be referred for psychiatric attention. The proper investigation of various psychosomatic pains can often be assisted by the backing of general hospital laboratory and radiological facilities. None the less, a vast amount of laboratory and such like investigation could eventually be cut out if the student was taught the characteristic features of psychogenic pain as carefully as the physical pains of pleurisy or renal colic. Diseases such as thyrotoxicosis, peptic ulcer, migraine, asthma, colitis, rheumatism, cerebral trauma, are amongst those subject to greater or lesser degree of emotional aetiology. In some of the above, investigation will make it clear that the whole syndrome is fundamentally neurotic without demonstrable organic lesion, as in the gastric, cardiac, dermatological neuroses; while in others it will be found that emotional complications are aggravating undoubted organic

illness. In the latter we reach a borderline group that so far as selection is concerned are often better treated in an ordinary medical ward.

It is the presence of many better adjusted personalities in this form of work that swells the recovery rate of the physically treated patients compared with results for the average certified mental hospital patient, though on paper they might all look much the same.

Many of the types mentioned are not usually seen in mental hospitals, though they have masqueraded frequently in medical and surgical wards under indefinite or tentative diagnoses. One effect of general hospital psychiatry is merely to grant a frank recognition of the status of such patients. It is clear that the responsibility for selection of patients for admission should be on a senior psychiatrist. The soundness of his out-patient recommendation for the various forms of in-patient status will mainly determine such later complications as premature departure of the mental hospital voluntary patient, or the upsetting of a general hospital unit by noisiness, interference, or suicide, and so on, with possibly subsequent certification in the observation ward.

Where case selection is on these lines, a specimen unit, as it were, of 30 beds will be found to be composed as follows: Rather more than half the patients are neuroses and rather less than half psychotic in type. About half require psychological treatment and investigation, and half some form of physical therapy. At any one time facilities are needed for approximately eight patients on E.C.T., four on insulin comas, another four on modified insulin, two or three on prolonged sleep courses, and very occasionally a leucotomy. Other brief forms of psychotherapy are often needed to complete the treatment of those who have had the physical methods. Such a ward obviously is quite unsuited for patients requiring prolonged psychotherapy or psychoanalysis. If this is indicated, discharge to the out-patients' clinic is arranged. Though only a small proportion of these hospital cases are suitable for analytical technique, there is much that can be done for them psychologically.

The in-patient situation often produces excellent diagnostic information about the patient's personality and its trends, especially after the initial strangeness has worn off, and the patient is more or less being just himself. Assisted by reports from nursing staff, one soon has a better picture in a relatively short time of what kind of a person the patient really is, and many hitherto doubtful features and diagnoses can be settled. When general factors such as these are linked with special methods such as narco-analysis, abreactive techniques, and physical forms of treatment, then the time required for psychotherapy is shortened, and if proper medical staffing allows, it can also be concentrated. Because a majority of patients labour under faulty personal attitudes to occupational, marital, sexual or domestic matters, or because they are subjected to over severe stresses in these fields, it is possible to bring much relief by essentially practical readjustments in these aspects of life, by group therapy, the social club, the resettlement officer of the Ministry of Labour, in addition to the all-important personal interview.

All this is no substitute for such as should properly be subjected to free associative technique. Yet with and without physical treatment, the policy just mentioned led to the recovery of approximately 40 per cent. of civilian

patients, and the improvement of 40 per cent. more in a psychiatric ward on the general side of Sutton Emergency Hospital, after a follow-up of two to twelve months. No group or social club facilities were available at that time.

There are a few practical points in *administration* and *treatment* that are of particular importance for these patients. Even in this type of work the protection of a patient may become an over-riding consideration. The responsibility is the greater since there is no coverage from the mass of regulation and procedure that helps to ensure the safety of the mental hospital case. If general hospitals recognize their own clinical limitations, no such procedure is necessary.

Normally the patient's liability to suicide is settled in the out-patient department or at in-patient consultation in a general ward. By way of illustrating the situation as seen in this type of practice, the records of some 65 general hospital cases who were referred to me from medical wards for psychiatric opinion after attempted suicide in the past fourteen months were re-examined. Of all cases, two-thirds were female, and ages spanned from 16 to 80 years. The majority were between 20 and 40 years of age. In over half, abnormal and unstable previous personalities could be established. Had subsequent interviews been possible, this number would doubtless have been higher. Over half the number used drugs, especially luminal or aspirin as the method, and a fifth employed coal gas. Definite violence was only used by 6 male patients. The most common diagnosis was that of depression, mainly reactive in 21 patients, mainly endogenous in 7; next in frequency were neurotic states, of whom 14 were hysterical and 4 anxious. The remainder were composed of 10 psychopathic personalities, 6 epileptics, 2 schizophrenics, and 1 paranoid psychosis. Male psychotic and psychopathic personalities made the more violent and drastic attempts. All social grades were represented. In nearly a quarter of these cases previous attempts had been made, more especially by hysterias and hysterical psychopaths. Apart from personality defects the main precipitating causes were marital, economic, occupational, and due to organic disease, in that order of incidence.

It is in this type of work that one may sometimes meet the better integrated personalities, who can so minimize symptoms and retain an outward control that attempted or successful suicide is perhaps the first and last visible evidence of breakdown.

More than half the patients were eventually discharged home with or without recommendation for out-patient treatment and various social adjustments. Ten required observation ward care, but others went voluntarily to special hospitals, neuroses centres, nursing homes, etc.

Despite previous consultation, in these days of few beds and long waiting lists, a patient may have altered for better or worse between the time of out-patient interview and admission to hospital. One may have to decide whether to retain or to send to the observation ward a case of good prognosis, though relatively acute, possibly confused, noisy or potentially suicidal. Patients should not be retained in the general hospital unless there is reasonable prospect of controlling symptoms within an hour or so of admission, and unless the diagnosis is sufficiently clear to warrant sacrificing much of the customary

case-taking and investigation. Delay may open the door to suicide, or to manifestations of mental illness detrimental to the progress of other patients. To shut the noisy patient in a side room is no answer, since the idea soon spreads that the ward is becoming a mad-house. If one has to deal with the psychiatric emergency in a general hospital, it is necessary to do as the general hospital does and operate or act on minimum data. For example, prolonged sleep—using quick-acting barbiturates such as sodium amytal, or by electro-convulsive therapy are particularly useful. Narcosis is suited for very acute hysterical and anxious states, and where E.C.T. is not possible, for some agitated depressive and mildly manic conditions. The concentrated use of E.C.T., e.g. one to two fits a day for two days followed by others more spaced out, should settle any affective disorder that is remotely possible for a general hospital. A preliminary course of either of the above can be employed to improve schizophrenic cases temporarily, especially those liable to impulsiveness, while insulin dosage is being built up to coma levels.

It is most important that a good atmosphere or state of morale be maintained, and it is worth remembering that the fundamental attitude of a general hospital psychiatric ward is the reverse of a ward full of certified psychotics. In the latter, acute disturbances may pass almost unnoticed, and even suicidal attempts elicit little reaction. In the former, the neurotic group over-react to and are over-aware of the most modest environmental stimulus. Anyone who has experienced war emergencies in both mental hospitals and neuroses centres will know how great is the difference. Exhibitions of hysterical, agitated, anxious or schizophrenic symptoms should not be allowed to run unchecked. They are apt to spread, with disastrous effect on the progress of other neurotic patients. Occasionally a few will take the view that having seen what nervous illness can really mean, their own complaint must be of little account. They endeavour mentally to pull themselves together and try again. Such talk may be genuine, or it may be a polite rationalization to facilitate their own discharge.

It is suggested that short periods of admission with a steady turnover of patients is the most useful policy. From three to seven weeks is enough for the majority of patients, but this can only be done successfully if those in charge are prepared to use a full range of treatment consistent with the varying needs of their patients. There is no place in this type of work for whole treatment programmes run solely on a particular ideology, psychological or physical. Collections of chronic patients are to be avoided, unless admitted for some limited investigation or to tide them over a difficult phase. One should avoid admitting many cases of hysteria at any one period.

Concerning one's relations with the law, the situation is similar to but not identical with that of any general practitioner treating the psychiatric case. The relieving officer and the observation ward are called on if required. Technically cases that are certifiable may not be retained without the sanction of the Board of Control. Psychiatric patients very greatly appreciated the complete lack of any legal formality or signing of papers on admission or discharge, and it is hoped that this freedom will continue. Administratively I never felt the need of an alteration. Provided one is careful to keep case

selection within the limitations of its own sphere, legal aid should not be necessary and only rarely the assistance of the relieving officer. It follows that administratively as well as therapeutically so much depends on selection and therefore diagnosis in this regime.

In addition the general hospital psychiatrist is usually called to consult in general wards of his own and maybe other hospitals for diagnosis and disposal. In such work the whole field of psychiatry can be covered, and in differential diagnosis no mean part of medicine as well. The range of experience required is considerable. The general psychiatrist, like any general surgeon, requires to keep sufficiently in touch with general medicine, and not only with neurology, to maintain efficiency in his own work.

In conclusion, it is suggested that the use of general hospital beds for psychiatric purposes is a further step to fulfilling the needs of one section of a socially heterogeneous group of illnesses. Probably this type of psychiatry will do much to hasten public acceptance of neuroses and psychoses as forms of illness, and thus ease the stigma which hampers many aspects of the subject. In the long run any relief from public prejudice will help the mental hospitals to cater for a wider in-patient field than the majority do now, especially when these hospitals have been more radically adapted for different grades of mental illness. In the meantime there are many undoubted sufferers from psychiatric illness such as the psychosomatic types, not requiring the more elaborate setting of a mental hospital in which to recover, who will not consent to in-patient treatment unless on equivalent social footing with the medical case. They may be prepared to face the realities of their maladjustments in the confidential atmosphere of the consulting room and in the sympathetic milieu of group therapy, but they are unwilling to advertise the nature of their disorder to a public of limited understanding by being admitted to the mental hospital, even when full treatment is available.

REFERENCES.

SANDS, D. E. (1943), *Brit. Med. J.*, **1**, 628.
BROWN, M., and CARLING, F. C. (1945), *ibid.*, **1**, 478.