Reflections after 30 years of Psychiatric Nursing—Past, Present and Future

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Down through the ages people have become more and more aware of the facts of mental illness. We find this has often been alerted by some reform in legislature, from Connolly at Hanwell and earlier, through subsequent reforms of the 19th century, the Mental Deficiency Act of 1913, the Temporary Patient status and Voluntary Admission in 1930, to our new legislation of today. These changes have naturally affected both lay and medical authorities, and at every stage a hiatus appears between present law and practice, and future trends and plans.

Looking back, legislation and the shift in public attitude to mental illness over more than 50 years has been necessary to achieve the results of today, and dilution and dispersion of the present mental Hospital population will take a great number of years yet; and even with careful planning and an alert awareness of the problems ahead, we shall be very fortunate if we can keep abreast of the needs of our patients.

In the past the brunt of psychiatric care has fallen upon the mental hospitals, and if now the responsibility is being shared with local authorities and community care services, it would be a tragedy if the control and guidance built upon years of experience and research, were to be taken from the parent psychiatric hospital of the area.

Any new means would be welcome that would help to combat an increase of the chronic mental patient in our hospitals, but we must be careful, I think, to avoid dis-service to the community by too hurried planning, too much control by the uninitiated, and "tight purse strings".

The ever increasing numbers of people year by year seeking psychiatric aid, the ever increasing old age population, could "bog us down" again and fill the mental hospitals to overflowing, and we could quite well be back again in the "twenties".

I would like to present rather sketchily an example of the psychiatric service which we provide at Hellingly Hospital for our Catchment Area of East Sussex. They include various sections.

The Long-stay Patient

These are gradually being reclaimed, by means of intensive chemotherapy, work, and group therapy. This programme involves firstly, a rigid segregation of the patient population to facilitate gradual "weaning off" from complete inactivity (called in the past

the demented state) through the stage of earning one's own living outside of hospital, to the happy state of ultimate discharge.

Our pattern at this hospital is aimed at making everyone aware either by suggestion or implication that he or she is employable in some way or another, and that service to the community is paramount. Wards and patients are graded with a set purpose. The nursing staff are made aware of the functions of that particular ward or group of patients, and the response by the nursing staff in promoting the success of these ventures is very gratifying. It is achieved by free discussion and by instilling a feeling of responsibility and team work; a non-regimented and "elastic" approach is encouraged. Nurses are encouraged to treat the patient as an individual and a person.

Patients are categorised very thoroughly as by age, type of illness, length of stay, and compatibility. Each individual passes from group to group as his symptoms are relieved and he begins to realise himself that something is being done.

Commencing with "Remotivation" under constant nursing care and supervision we find distinct changes even in the "lost" schizophrenic: a gradual acceptance of the community and a release from the abject introvert state. This work calls for great patience and flexibility from the nurse and is the most trying of the duties he undertakes. It can be costly in personnel, but has the benefit of passing these patients on to the Industrial Unit from which they once again acquire an entity by the fact of "earning wages" if only within the confines of the hospital at this stage.

Group work under nursing care and supervision is so planned that it is of some value to the community and purposeful in its object. The groups are given a "task"—these are many and varied and include: general working parties, digging of trenches to facilitate telephone cable and electricity cable laying, making car parks, laying paths and roads, making concrete blocks for building within the hospital, foundations to buildings, e.g. Occupational Therapy, Patients' Social Club, Farm and Garden Projects, also outside help to farmers. All these projects are started and completed by the group, thereby ensuring an awareness of the purposefulness of the work.

The nurse plays a big part in the whole of this picture. First by encouragement and by pointing out the usefulness of the work, then stimulating discussion on it, and most important, by reports on the progress of the patients' reactions and approach to life, and a wish to achieve better things.

The patient is again "weaned off" after discussions between medical and nursing staffs. His potentialities are analysed, and he moves on to work in the Industrial Unit, or to work on his own within the hospital community, and is then moved to the "Hostel Ward" for final rehabilitation and resettlement.

In the past year 34 patients have been placed in direct employment outside the hospital, the majority being long-stay cases, some of over 20 years, a very gratifying result when one reflects that previously the sole function of the mental hospital was often only to achieve a discharge into the same environment from which the patient was admitted.

The Problem of the Aged

Medical and nursing staffs in mental hospitals have become acutely aware of the specialised care needed to treat the senile states, and it is hard for the uninitiated to grasp the full impact of confusion and disorientation in the aged. It calls for extra special skills in dealing with this field of psychiatry. Steady progress has been made in relieving the symptoms of senile states, by clinical testing—appropriate drug therapy—vitaminisation, in some cases E.C.T., and a complete therapeutic approach to the whole problem.

The nurse plays a very important part in this team work, and only specialised training in the mental hospital itself can produce the required standard of nursing, and awareness of the problems of the aged.

If one reflects on our entrants from "Old People's Homes" existing at the moment under a Local Authority, one usually finds that the unfortunate old person who has a mild mental abberation has upset the usual routine of the "Home" and so become a problem. Owing to lack of facilities he has to be transferred to the nearest mental hospital for care and treatment. If he recovers a great reluctance is shown to taking the patient back for fear of further breakdowns. So one views with great apprehension the "break up" of mental hospitals and the suggestion of a take-over by the Local Authority of the so-called "Geriatric Units" in mental hospitals.

The Local Authority has in itself an almost unsurmountable problem in dealing with what we might name the "capable aged", who through no fault of their own need community care and we are constantly being informed of this one social problem and the difficulties it presents. Is it wise to add another problem to their burden?

If we reflect on the geriatric states in the psychiatric hospital, we see not only the need of an extra consultant service but also have the corresponding nursing aid to go with it, which is very specialised work. Here is yet another problem. Nurses are understandably reluctant to be "tied down" to just one specific type of patient care, especially one as trying and exacting as geriatric nursing.

Nurses respond to "glamour" perhaps more than any other trade or profession, and "glamour" is far from prominent in this type of nursing care.

As it is, we "get by" in psychiatric hospitals by deployment of nurses into the various aspects of our work and the "interesting" and the more "sordid" types of the professional field are shared, and an over-all experience of psychiatry is gained to the betterment of all concerned.

Domiciliary Nursing Work

With the continued rehabilitation of the "longstay" and the geriatrics, a Nurse Domiciliary Service could be of extreme value in helping to make vital contacts and offer advice and guidance to both ex-patient and relative.

Most patients have had a fairly long stay in hospital, and it is apparent that during their "working out" in the local community they do "lean" on the shelter of the hospital and those that have had care of them.

It has been found that many that return to the community do tend to feel "lost" again, what with experiences of a "new world", public prejudice, tactless approaches; many have lost all previous contacts in society, and find making new friends and contacts a difficulty. This is where I feel the psychiatric nurse can play a great part in comforting and advising, and having had a long contact with the patient, note any changes that may warrant timely intervention, so he may prevent another breakdown, and return to hospital.

As a matter of interest concerning this relationship, we ask a question at one of our meetings, which we hold periodically with the "outside workers", to discuss problems, etc.: "Did they mind the nurse visiting them at their place of work to see how they were getting along", and the unanimous reply was that they welcome it as they felt they could "talk to him", which I think goes to prove their dependency on us.

Nurse domiciliary visiting I feel tends to lend itself more to the rehabilitated and the patient who has spent a fair time in hospital, from a few months to years. The patient in hospital spends most of his time with the nurse, and a great feeling of dependency is experienced, in fact the nurse is his "passport" to practically every daily occurrence, his treatment, the doctor, relatives, weekend leave, social activities, etc. So a camaraderie is built up between nurse and patient, and a great dependence is formed on the part of the patient, and this in itself leads to a trust, and an abstract "father figure" and from my own experiences (thirty years in psychiatry), I feel that if a large number of cases had been visited by their "Old Nurse" after discharge, they would have remained well.

As the "turn over" of patient admission and discharge has increased by leaps and bounds each year, I feel that there is a greater need for this type of work in the community for the trained psychiatric nurse.

As it is a matter of preventive medicine, the local mental welfare officer comes into the picture; but unfortunately all are not psychiatric trained. This is where liaison is of the utmost importance between local authority and the parent mental hospital in seeking advice and help. As the patient undoubtedly comes within some psychiatric orbit, I feel the consultant might well call in the aid of nursing care.

Psychiatric Units in General Hospitals

Here we have to face one unrelenting feature, that of the new admissions. A fair percentage stay for quite a long time before they are well enough to discharge back to the community. So it appears whether we like it or not, facilities for coping with this problem will have to be devised, either by making these units large enough say 3-400 beds, or by the existing mental hospital carrying on as an overflow for the more severe cases.

Take for example the admission rate of our new modern neurosis unit (60 beds only) as compared with the admission rate of the so called "main hospital". After our consultants have contacted somewhere within the region of 3,000 new cases a year in our catchment area, not to mention 3,000 plus follow-ups, we find that approximately *one* per day seeks admission to the new neurosis unit, to *three* per day in the main hospital admission wards, and we must agree that treatment has not advanced so profoundly as to lessen the intake rate of patient admission. Which means that one in four of all patients seeking admission to hospital are being treated in the "short stay unit", the remaining three have to be accommodated elsewhere.

If it is conceived that the psychiatric unit in the general hospital is to receive all the new admissions, it gives one food for thought as to how one is to accommodate such numbers, which runs at present to nearly 1500 patients a year. Come what may, psychiatric aid is being sought more and more each year, and this in itself leads to more "follow-up" care, and day patient treatment.

I would envisage, say, a 60-bedded unit with a day hospital of ten beds attached, and facilities for out-patient treatment or bed numbers related to the needs of the existing clinics operating in the catchment area. But these ideas lead one again to the shortage of the consultant services.

Some cases would inevitably sidetrack these modes of entry by virtue of their disturbing influence on the units, and these would have to be admitted to the parent hospital admission wards for more intensive treatment and stringent observation. The trained psychiatric nursing personnel could cope with some extreme cases in the general hospital unit, but I feel these would be few.

If the unit, however large or small, is to succeed it must have as its foremost policy "that which is best for the patient", which

means expert medical coverage, skilled nursing care, good facilities, nearness to home, and not feeling too far away.

Linked with this the authorities must also give much thought and planning to "cannibalising" the present mental hospitals, not to bulldoze some down indiscriminately and overflow others with the residue of patients, but to pull down *parts* of the existing hospitals and upgrade and modernise the remainder to cope with the entrance from the smaller units in the general hospital. By this we could soften the blow to those who would be unwanted in the short-stay units.

Nurse Training

The versatility of the modern psychiatric nurse can only be acquired if he or she has passed through this complex field.

Down through the years (in the pre-antibiotic era) psychiatric nursing showed a steady pattern, easily absorbed and operated, with the emphasis on custodial care. With advances in psychiatry, a more complex pattern of training has emerged, and to keep apace with these advances the nurse has become more and more a therapist and a vital therapeutic aid to the doctor.

Moving from specialised subject to specialised subject during the course of training, the complete field of psychiatry is covered, and these include work in the "short-stay unit" mild neurosis and hysterias—short-stay psychotics—disturbed new admissions with the accompanying intensive treatments—chemotherapy, electro-plexy, etc.—long-stay wards with its industrial and social rehabilitation schemes of therapy—geriatric and senile states—and the ever-increasing problem of the psychopathic inadequates and the inceptions from the magistrates' courts.

If one logically reviews this vast field, one obviously comes to the conclusion that the complete pattern of training can only be undertaken by the parent mental hospital, with all its "tentacles" stretching out from within its confines to the clinics outside.

This control should be under the supervision of the matron and the chief male nurse of the parent psychiatric hospital training school, who would deploy nursing staff to these smaller units in the general field. The General Nursing Council might well be rather apprehensive of a great number of small units springing up in the areas, owing to their rigid ruling regarding what constitutes a training school, and they would I am sure favour one of a central school of training, where every subject of the syllabus could be expounded.

So in conclusion don't let us regress, but let us approach this new venture with careful and logical planning. It would be disastrous if there were to be a complete split from the present psychiatric hospitals, and if these new proposed units were staffed with half-trained people. In the end only the patient would suffer, and he or she is the complete focus of our work.