Psychiatric Bulletin (1991), **15**, 684–686

Point of view

A psychiatrist *with* beds: evolution and evaluation of socio-therapy on an acute admission ward*

JOHN L. COX, Professor of Psychiatry, School of Postgraduate Medicine, University of Keele, Stoke-on-Trent ST4 7QB

There is a serious flaw in much current thinking about the development of 'community' psychiatry because of the failure to consider the function of admission wards and to resource them adequately. Excessive emphasis is placed on the value of non-hospital psychiatry with an implication that psychiatrists can manage patients adequately *without* beds (see Dean & Gadd, 1990). Although I have not met a consultant who literally believes this to be true, the managerial consequences of this attitude leads to in-patient units being yet further under-resourced, and so becoming more disturbed and having lowered morale. Yet in *Better Services for the Mentally Ill* (HMSO, 1975) the District General Hospital In-patient Unit was regarded as a *main* component of a comprehensive psychiatric service. Clinical experience does suggest that without an effective admission ward the management of patients in the community, including those with intractable mental illness, is unsatisfactory and sometimes totally impossible.

However, the optimum clinical style of these wards is uncertain and the need to establish adequate staffing levels and to agree on bed norms pressing. These considerations must take into account not only 'inflow' and 'outflow' factors but also the morale and efficiency of *the in-patient unit itself* which can determine the duration of admission, the effectiveness of treatment, and also the likelihood of relapse (Hirsch, 1988).

It is therefore unfortunate that at the present time there is a tendency for managers, and some clinicians, to confuse the need to close mental hospital beds, with a disinterest in resourcing adequately in-patient units in district general hospitals and so to believe that, because long stay beds are not required in mental hospitals, beds are not required at all.

This paper reports an attempt to think more creatively about the organisation of an admission ward and in particular the social aspect of in-patient treatment. It is therefore concerned with the 'community in the hospital' as well as with the community 'outside'. Milieu therapy is derived from principles of therapeutic communities and has only been applied occasionally to the admission ward (see Walton, 1971) yet it is likely that some aspects of such socio-therapy (frequent ward meetings, small therapy groups, a weekly staff meeting and democratisation) are as relevant in that setting as in a more long stay neurosis unit. We therefore sought to determine whether sociotherapy was indeed useful on a busy admission ward and to describe aspects of our experience with small and large groups.

**Based on a paper read at the Annual Meeting of the Royal College of Psychiatrists, July 1990.*

The academic unit (Ward 90) City General Hospital

Five years ago a mixed sex admission ward was established which gave particular emphasis to the use of socio-therapeutic techniques especially when combined with behavioural or biomedical treatments.

The ward has 24 beds and there are at least four admissions a week. It was designed 100 years ago for 'idiots and imbeciles' in the workhouse and a new building is planned to open in 1995. However, the ward has a large sitting room which permits all patients and staff to participate in a large ward meeting. The multidisciplinary team includes psychiatric nurses, two consultants, two trainee psychiatrists, two part-time occupational therapists, a social worker, and sessions from an art therapist, psychodramatist, clinical psychologist, and senior registrar.

Ward meetings are held daily, unless there is an inadequate number of staff. They generally have two leaders, one with experience in conducting large groups. The nurses take an active part in their organisation and provide most of the leadership; a consultant also usually participates in one group a week.

Two small groups are held on a Monday morning; a 'talking' group and a more task orientated group led by an occupational therapist. The larger ward meetings last for an hour and usually start with the introduction of new members when it is explained

https://doi.org/10.1192/pb.15.11.684 Published online by Cambridge University Press

that members can talk about their own problems and family difficulties, or about aspects of ward life. The leaders are active and may use diagnostic as well as group therapy skills. They are therefore familiar with psychiatric diagnoses and have knowledge of descriptive psychopathology and the principles of psychiatric management. The therapists must recognise when a depressed patient needs to remain quiet and to know when an intervention is counter-therapeutic or reflects specific psychopathology. Thus good communication between therapists is crucial to the success of the large groups. The principle established by Yalom (1983) of being supportive and flexible in clinical style is important; only rarely is a solely non-directive approach appropriate.

The purpose of such meetings is multifarious and includes monitoring the clinical progress of patients and asking patients for their opinion about improvement in another group member. Ward events such as the admission of a disturbed patient, a 'discharge' against medical advice, a violent incident or a suicidal threat may also be discussed. The meetings are also a forum where the feelings of patients and staff about these events are expressed and understood. Staff members may be perceived as always unhelpful while on other occasions they are idealised. Doctors are commonly stereotyped as prescribing tablets or only attending to physical complaints. The leaders therefore need knowledge about group dynamics and must retain their diagnostic clinical skills. The "before and after" group discussions between therapists is fundamentally important so that peer review and recording the group for report back to the team, as well as for support, can be undertaken.

The theoretical model underpinning this approach to therapy is the bio-psychosocial model of Engel (1980) which uses systems theory to bring together dynamic, social and bio-medical constructs. Each construct is self-contained yet also interacts with another. The book by Yalom (1983) *Inpatient Group Therapy* is a useful guide for a multi-professional team, although the chapters on active group therapy overlap to an extent with present day occupational therapy expertise. Yalom points out the substantial differences between conducting such large therapy groups on an admission ward with mixed patients, and the more traditional analytic out-patient group. Each in-patient group is 'self-contained' as the group members change rapidly and the therapists need to be active and pragmatic in style, and generally to be supportive. It is important for the therapist to know which patients are brought in and those to be possibly excluded, such as the physically ill, or a manic or retarded depressed patient, as well as the patient who did not wish to participate.

In a review of ward environments by Watson & Bouras (1988) it is emphasised that, in addition to the clinical skills of staff, other considerations such as line management responsibilities, staffing levels, training background, duty rotas, and style of leadership of consultants need to be considered. These factors all affect the ward atmosphere and so determine group themes and conductor's morale. There is a need for consultants to provide effective leadership for the multi-professional team, and to take a full part in clinical decisions. The responsibility for patient care remains with the consultant and the ward meeting is an important component of a management strategy.

Such ward meetings encourage altruism as patients learn how to support each other and so gain in self-confidence. Acting out (including violent incidents) is less likely to occur when groups are held regularly. Patients who require 'special observation' can be observed in a group which relieves a nurse temporarily from one to one observation. The meetings give opportunity for the constraints of patients to reduce disturbed behaviour of others, and encourage patients to talk about feelings of despondency or aggression rather than act on them. Such large meetings are usually economical of medical time, as the consultant can rapidly obtain information about a patients' progress and assess the ward atmosphere.

There are, however, disadvantages of ward groups which may restrict time available for individual interviews, and some patients (and staff) find the sharing of information with others difficult. Some groups are stressful because patients can be critical of staff. There is also a possibility that a ward group could be counter-therapeutic; a patient may make an intrusive unempathic comment to another member about a family difficulty or recommend a solution which is inappropriate or even damaging. In these situations the conductor may need to intervene by pointing out that the patient who made this intervention has a particular difficulty which explains the harsh comment. Another responsibility for the leader is to protect a patient from being the scapegoat and from the 'hot seat' – especially if recently admitted. Serious behavioural disturbances in these groups in our experience is rare but staff must intervene if a violent incident is imminent.

The large groups are a useful component of the overall management for many patients, and enable relevant psychodynamic material to be gained which might otherwise have been missed. Our experience suggests that this mode of ward organisation is worthwhile for most patients and leads to a more complete understanding of their psychosocial difficulties. Participation by psychiatrists is important and ensures useful balance between biological and psychological treatments. Patients' self respect is generally enhanced by talking directly to medical and nursing staff who are less protected by their own professional roles.

https://doi.org/10.1192/pb.15.11.684 Published online by Cambridge University Press

Most staff regard such groups as worthwhile and the work satisfaction for nurses is increased. They have a legitimate sociotherapeutic task to counterbalance the need to observe a disturbed patient or to ensure compliance with medication. Adequate supervision is nevertheless vital. A general psychiatrist with an interest in psychotherapy is perhaps best placed to provide this, or another experienced health professional. A psychotherapist may be helpful if a staff problem is insoluble, or if an inexplicable ward crisis occurs. Occupational therapists and social workers are particularly valuable as they may have had training in descriptive psychiatry as well as in case work methods.

We now intend to evaluate the clinical and cost-effectiveness of these groups but in general regard them as beneficial to patients and within 'good practice' of general psychiatry. A feature of working with groups on an admission ward is the constant need for flexibility of clinical style, a readiness to review management goals daily, the ability to discourage some patients from attending while allowing others to leave. The general psychiatrist who works on an acute admission ward which uses large and small groups may need to be a 'Jack of all trades' and also may be advantaged to be a 'master of none'; the optimum approach to general psychiatry includes an ability to move comfortably between different explanatory models and a too rigid interpretation of one could therefore be a disadvantage.

References

DEAN, C. & GADD, E. M. (1990) Home treatment for acute psychiatric illness. *British Medical Journal*, **301**, 1021–1023.

DEPARTMENT OF HEALTH (1975) *Better Service for the Mentally Ill*. HMSO.

ENGEL, G. L. (1980) The clinical application of the biopsychosocial model. *American Journal of Psychiatry*, **137**, 535–544.

HIRSCH, S. R. (1988) *Psychiatric Beds and Resources: factors influencing bed use and service planning*. London: Gaskell (Royal College of Psychiatrists).

WALTON, H. J. (ed.) (1971) *Small Group Psychotherapy*. London: Penguin Books.

WATSON, J. & BOURAS, N. (1988) *Recent Advances in Clinical Psychiatry*. Vol. 6. (ed. K. Granville-Grossman). Edinburgh: Churchill Livingstone.

YALOM, I. D. (1983) *Inpatient Group Psychotherapy*. New York: Basic Books.

Psychiatric Bulletin (1991), **15**, 686–688

People and places

Chelmsford and its aftermath

JOHN ELLARD*

*John Ellard is Chairman of the general psychiatric practice at the Northside Clinic, Sydney, Chairman of the Board of Practice Standards and Chairman of the Clinical Practice Advisory Committee of the Royal Australian and New Zealand College of Psychiatrists and Chariman of the Medical Committee constituted under the Poisons Act of 1966. He is Editor of *Modern Medicine of Australia* and a member of the New South Wales Psychologists Registration Board. He is also Consultant in Psychiatry to the Health Insurance Commission.

In the past he has been Chairman of the Board of Accreditation of the Royal Australian and New Zealand College of Psychiatrists and a Censor of that College for many years. He was Senior Psychiatrist at the Royal North Shore Hospital and Senior Consultant in Psychiatry to the Royal Australian Air Force. He was also Chairman of the Law Foundation of New South Wales and a Commissioner of Corrective Services in that State.

He has published a book and many articles on psychiatry and related topics.

He is a Member of the Order of Australia.

In mid-1963, Dr Harry Richard Bailey admitted a patient to Chelmsford, a small private hospital in a north-western suburb of Sydney. Between then and April 1979 he, and subsequently a handful of associates, treated a large number of patients with deep sedation, often combined with ECT. The patients' diagnoses included schizophrenia, bipolar disorder, alcoholism, and drug addiction; nothing suggests that the diagnosis and the treatment had any particular connection. Records exist for some 1,100 patients, 24 of whom died as a consequence of the treatment; 16 of them were under the age of 50. Others suffered brain damage, convulsions, delirium, pneumonia, hallucinations, cardiac irregularities, abscesses, urinary tract infections, fractures, and other complications.

A committee of 12 psychiatric experts later assembled to examine such documents as existed reported that "almost all patients reviewed were in

https://doi.org/10.1192/pb.15.11.684 Published online by Cambridge University Press