A STUDY OF THE PSYCHIATRIC NURSE AND HIS/HER
ROLE IN THE CARE OF THE MENTALLY SICK

by

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## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Introduction</td>
<td>1</td>
</tr>
<tr>
<td>II Description of working situation</td>
<td>10</td>
</tr>
<tr>
<td>III Type of patient</td>
<td>21</td>
</tr>
<tr>
<td>IV Staffing</td>
<td>26</td>
</tr>
<tr>
<td>V Type of work</td>
<td>33</td>
</tr>
<tr>
<td>VI Working conditions</td>
<td>47</td>
</tr>
<tr>
<td>VII Communication</td>
<td>65</td>
</tr>
<tr>
<td>VIII Recruitment, Selection and Training</td>
<td>71</td>
</tr>
<tr>
<td>IX Health</td>
<td>79</td>
</tr>
<tr>
<td>X Length of Service</td>
<td>80</td>
</tr>
<tr>
<td>XI Morale</td>
<td>81</td>
</tr>
<tr>
<td>XII The main problem</td>
<td>94</td>
</tr>
<tr>
<td>XIII Setting of the problem</td>
<td>110</td>
</tr>
<tr>
<td>XIV Focus of the problem</td>
<td>117</td>
</tr>
<tr>
<td>XV Discussion, recommendations and conclusions</td>
<td>130</td>
</tr>
</tbody>
</table>

### Appendix

| IA The questionnaire                        | 156  |
| IB Form of questionnaire used in survey     | 160  |
| IIA The diaries                             | 166  |
| IIB Guide diary used in survey              | 175  |
| IIIA Participant observation                | 177  |
| IIIA ctd. Example of medicine list          | 209  |
| IIB Ward schedule as used in survey         | 213  |
## Appendix

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>IVA</td>
<td>The interview</td>
<td>216</td>
</tr>
<tr>
<td>IVB</td>
<td>Interview schedule as used in main study</td>
<td>218</td>
</tr>
<tr>
<td>V</td>
<td>Patient characteristics of individual hospitals</td>
<td>221</td>
</tr>
<tr>
<td>VI</td>
<td>Staffing according to hospital</td>
<td>233</td>
</tr>
<tr>
<td>VII</td>
<td>Food</td>
<td>248</td>
</tr>
<tr>
<td>VIII</td>
<td>Training allowance and salaries for mental nurses, 1959.</td>
<td>257</td>
</tr>
<tr>
<td>IX</td>
<td>Categories of ward as supplied by individual hospitals</td>
<td>259</td>
</tr>
</tbody>
</table>

## Bibliography

<table>
<thead>
<tr>
<th>Section</th>
<th></th>
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SECTION I

INTRODUCTION

Since the introduction of the National Health Service in Great Britain (1943), the public has been made increasingly aware of the outstanding burden of mental illness in the community and of its significance. At present, over 50% of our hospital beds are occupied by patients suffering from mental or nervous disorders, and one in every 250 of the population is receiving in-patient psychiatric aid.

That resources, for meeting the demand of so much ill-health, are inadequate is a well-acknowledged fact, though what form this inadequacy takes is perhaps not as fully appreciated. The Nursing Studies Unit (Edinburgh University) having a special interest in nursing personnel, instituted the present survey to determine what were the outstanding problems associated with the provision of nursing care in the mental hospital situation and to assess, where possible, their effect on the quality of that care.

The existence of certain problems, such as low staff/patient ratios, was indicated during discussion with senior members of mental nursing staffs before the study began. Clues to other profitable spheres of investigation were suggested by earlier reports. Dr. C. Blacker in his

1. Neurosis and the Mental Health Services 1946
survey of the mental hospital services placed considerable emphasis on the importance of selection and training of mental nurses whose significance in the psychiatric field, he rated nearly as high as that of the psychiatrist.

The Working Party Report on "The Recruitment and Training of Nurses" (1947) suggested that, for a variety of reasons, mental nursing did not enjoy as much repute as general nursing. The writers went on to say that whilst the mental nurse required special gifts of insight, their investigations showed that "the average intellectual calibre of the nursing staffs in mental hospitals is significantly lower than in other types of hospital". It was thought, too, that discontent and apathy were deeper and more widespread in these hospitals than in the non-mental field, although the sources of discontent were said to be much the same. These aspects were considered sufficiently important to warrant even further investigation, and findings have been incorporated in the ensuing report.

Scope of the present enquiry

In the present survey, an attempt has been made to look at the psychiatric nurse, employed in four local hospitals, both as an individual and as a member of a group which cares for the mentally sick. Where outstanding causes of discontent have emerged, these have been discussed in relation to the nurse's work and her contribution to the patient's recovery. Though not a time and motion study\(^1\) the survey has also considered the functions of the differing grades of nurse, the importance of which, in the general nursing field, was stressed by the Nuffield Report in 1953\(^2\).

\(^1\) The limitations of this method for use in the mental hospital were pointed out in "The Work of the Mental Nurse" University of Manchester 1955.

\(^2\) "The Work of Nurses in Hospital Wards".
The original survey was intended to consider the psychiatric nurse in relation to his/her work in the sphere of the mental hospital generally, i.e. including any out-patient clinics, clubs or home-visiting which might involve the hospital staff. However, none of these extra facilities were provided by the nurses of the four hospitals concerned and so the study became virtually one of the wards alone. It should perhaps be mentioned at this stage that although all the mental hospitals and mental deficiency units in the region of the University were prepared to provide facilities for research, in view of the repetition of problem emerging, it was not considered necessary to study more than one of each "type" of hospital (described in more detail on page 4).

The problem of providing adequate professional preparation for the nurse was, of course, closely linked with the study of her function. Consideration of these points is perhaps especially timely when nurses from other branches of the profession are being encouraged to take up mental nursing, and serious discussions are afoot regarding the provision of an integrated general and mental basic training. The decision as to whether psychiatric nursing is fundamentally different from any other type of good nursing care, is a serious one for policy-makers.

Other factors which, after preliminary investigation, appeared to merit particular attention, included the nurse's relationship with her patients and co-workers; the hospital environment and its effect on patient care, and the part played by equipment in either hampering or facilitating nursing procedures in the wards.

---

1. In some areas experimental courses along these lines are already being conducted e.g. Bangour Hospital, West Lothian.
The anecdotal rather than the "time and motion" approach to the main theme has been employed deliberately in the belief that it is a more useful vehicle for conveying what has been described elsewhere as the "spirit of the work". Additional illustrative data have been included in the Appendices.

May 1957 saw the beginning of the preparation of the survey. By late summer, the South East region of Scotland had been selected as the most suitable area to carry out the study, firstly, because it was easily accessible and secondly, because a high degree of co-operation and interest had been manifested locally.

A pilot study, which commenced in September, 1957, preceded the main enquiry, and the choice of hospital, for this purpose, was influenced by an attempt to avoid interfering with the main survey population. The hospital selected was, in actual fact, atypical in only one or two main respects, the most important being the staff/patient ratio, which was higher than average; social class, the patients being for the most part fee-paying, which resulted in a higher proportion of patients from the upper income groups; and patient status, this hospital having rather more female and voluntary patients than the others. Because so many of the problems were common to all of the hospitals, it was decided to include the pilot study in the final analysis. To avoid identification it has sometimes been necessary to describe the four hospitals together.

The main study commenced at the beginning of 1953 and involved three other hospitals of widely differing situations and traditions. The four hospitals concerned included a town and a country hospital; a large and a small hospital; a fee-paying and a non-fee-paying hospital and hospitals with both "open" and "locked" doors. This wide range enabled the observer
to look at as many variations of institutional care as possible, providing greater opportunity for constructive comparison.

The Hospitals

Two of the four hospitals were situated in the town and two in the country. One of the town hospitals occupied an area near the city centre and lacked the "open spaces" of the other three, but had the advantage of easy access to shops and entertainments. Structurally it was not, on the whole, an attractive building, but alterations were in progress, during the fieldwork, which were expected to improve the general appearance.

The second urban hospital stood on the borders of a town giving the impression of having once been more isolated than at present. It was still surrounded by considerable areas of pleasant parkland and aesthetically, the buildings had considerable charm. At the same time however, its design accentuated problems of intra-hospital communication and administration.

Both the country hospitals had problems of accessibility and transport. One, a relatively attractive and compact building, was situated near a small country town, but was, to some extent, cut off by a very steep hill which was too dangerous for the local buses to negotiate.

The second country hospital was 1½-2 miles from another small town and suffered from the effects of an infrequent bus service. Although special arrangements were made for the transport of visitors from outlying districts on certain days of the week, no specific provision was made for staff. The buildings comprising this hospital tended to "sprawl", making for administrative difficulties, and were a mixture of old and ultra-modern architecture.

Neither of the two country towns mentioned, offered a great deal of
cultural or other entertainment, a fact which was to feature markedly in criticisms made of the position of the hospitals, by their respective staffs.

Personnel covered by enquiry

On viewing the situation, it immediately became obvious that all grades of nursing staff would need to be included (i.e. trained, student and nursing assistant staffs) for the numerical distribution differed from the average general hospital*, in the high proportion of untrained staff involved. Just over 44% of the staff were trained; almost 15% were students, leaving 41% as nursing assistants, a very large number of whom had had no official training at all (See section on staffing, page 29). The total staffs amounted to 687.

Methods of Obtaining Information

The study was carried out by one research worker alone and was intended to be a descriptive survey to highlight both the hidden and the more obvious factors affecting mental hospital life. As full a picture as possible was obtained by employing four separate but complementary research methods, to collect data on educational background, social activity, personality and attitudes to varying aspects of the mental nurse's duties, in addition to details of function.

In each hospital, the study was introduced by a comprehensive and informal talk to a fully representative body of nurses. After the introduction, a period of time was allowed to elapse for the circulation and discussion of this information before the fieldwork commenced.

---

*Of Edinburgh Royal Infirmary 1959, where there were no untrained staff, and only 2.5% state enrolled assistant nurses.
The following methods were used and have been placed here in chronological order to stress the importance with which timing of the stages was regarded.

1. Questionnaire
2. Diaries, kept by student staff
3. Participant observation by the investigator
4. The interviewing of a random sample of all grades of nursing staff (1/4)

Every member of the staff was asked to complete the questionnaire, with the exception of the four matrons and their nurse tutors, on whom it was felt that too great a clerical burden had already been imposed. Whenever it could be arranged, the questionnaire was completed under the personal supervision of the investigator. A high degree of co-operation was obtained 96.3% of the staff completing the form. Of the remaining 3.7%, 1.4% were sick and 2.3% refused to do so. (For exact numbers, see table I.) The questionnaire was concerned with obtaining information about personal background, and with opinions on relatively factual and unemotional subjects. See Appendix I.

During the second stage, students kept diaries (Appendix II) for seven consecutive working days, and with varying degrees of success and interest. The "comment column" developed a therapeutic function as the survey proceeded and a few students availed themselves of the opportunity for commenting, favourably or otherwise, on aspects of mental nursing generally. Some even felt able to express opinions about the survey itself, which made discussion more profitable and "problem-solving".

The third stage consisted of participant observation. Over a period of many months, the investigator observed and performed nursing duties in the 71 wards and departments concerned, by both day and night. This period allowed for the development of some relatively informal relation-
<table>
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<tr>
<th></th>
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<td>17</td>
<td>3</td>
<td>4</td>
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<td>53</td>
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<tr>
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<td>156</td>
<td>57</td>
<td>43</td>
<td>26</td>
<td>247</td>
</tr>
<tr>
<td>Interview (1/4)</td>
<td>33</td>
<td>41</td>
<td>15</td>
<td>13</td>
<td>8</td>
<td>60</td>
</tr>
</tbody>
</table>

Table illustrating:

a) the number of replies to the questionnaire
b) the number of nurses interviewed, by hospital and grade.
ships, stimulated thought and facilitated discussion with members of the associated disciplines, in addition to nurses. See Appendix III.

The final stage took the form of an interview with a random sample of all grades of nursing staff (1/4), most of whom had had some contact with the worker during the previous stages of the survey. To secure the sample, a list of staff was taken and divided according to sex, grade and alphabetical order. From the final list, every fourth person was selected for interview, which was not compulsory and was conducted as informally as possible. If the fourth person were not available for such reasons as sickness, holiday or refusal, the fifth name on the list replaced the original. On one occasion an additional member of staff was interviewed in order that a grade, consisting of less than four nurses, might be represented.

The proportions of staff interviewed were as follows:

<table>
<thead>
<tr>
<th>Type of Staff</th>
<th>% of total Staff</th>
<th>% of random sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trained</td>
<td>44.1%</td>
<td>43.5%</td>
</tr>
<tr>
<td>Student</td>
<td>14.9%</td>
<td>16.5%</td>
</tr>
<tr>
<td>Nursing Assistant</td>
<td>41%</td>
<td>40%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The interview lasted roughly an hour and was concerned with subjects tending to be more emotionally toned than those approached by questionnaire. Only two members of staff whose names appeared on the sample list refused to be interviewed and they gave no reason for their action. One was willing to complete the questionnaire; the second nurse refused this too, but agreed to an informal talk which provided information on some of the more important points. See Appendix IV.
SECTION II

RESULTS

Description of the working situation as related to nursing

The four hospitals were made up of 60 wards, four Nursing Homes, four Occupational Therapy departments, one Recreational Therapy department and two Deep Insulin Units. The Insulin Units functioned five or six days per week and drew their patients from a variety of wards so that they had no fully "resident" population. For this reason they have not been included in the ward analysis (Table II - page 11).

During preparation for the field work, each matron submitted a list of the wards in her own hospital together with a description e.g. "Ward X = Disturbed" "Ward Y = Open - mostly chronic", etc. Due to differences of hospital policy and terminology there were 28 varieties of description supplied\(^\text{X}\) and for administrative purposes it was necessary to classify the wards in a purely arbitrary manner, restricting the classes to seven.

(1) The term "Admission Ward" described provision for predominantly new patients, but in some hospitals these wards also catered for the physically sick, in addition to certain individuals who appeared to adjust more readily in this type of environment. The neuroses were nearly all housed in admission wards.

\(^{X}\)See Appendix IX
**Table II**

<table>
<thead>
<tr>
<th>Hospital Number</th>
<th>Miscellaneous wards</th>
<th>Admission</th>
<th>Disturbed</th>
<th>Geriatric</th>
<th>Physically Sick</th>
<th>Convalescent</th>
<th>Long-Term/ &quot;Workers&quot;</th>
<th>Total Number of wards &amp; Units in hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>4</td>
<td>M. F.</td>
<td>M. F.</td>
<td>M. F.</td>
<td>M. F.</td>
<td>M. F.</td>
<td>M. F.</td>
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<td>II</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>III</td>
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<td>-</td>
<td>16</td>
</tr>
<tr>
<td>TOTAL</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>7</td>
<td>1</td>
<td>3</td>
<td>64</td>
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</tbody>
</table>

*These include wards of specially selected patients for teaching purposes and non-statutory provision*

Table illustrating the distribution of wards according to the survey classification.
The class "Disturbed" covered both acutely and long-term disturbed patients although the latter were predominant. Naturally there was some overlap with the previous group in that "new admissions" were also sometimes "disturbed".

(3) The old, senile, bedridden and some long-term patients were catered for in the "Geriatric" wards which in some instances provided beds for the physically sick too. Generally speaking, these wards were called upon for the greatest amount of bed-side nursing and physical care.

(4) Only one hospital provided specific wards for the "Physically Sick" - (many of whose patients could equally well have been classed "Geriatric"), the remainder being content to allocate beds for this purpose in either Class 1 or Class 3.

(5) The "Convalescent" wards were more difficult to define. In this context they have been taken to mean relatively short-stay wards with some prospects of discharge for the patient, but on occasion it was not easy to distinguish between the "convalescent" and the "long-term" patient.

(6) The "Long-term/Workers" wards provided accommodation principally for the chronic patient whose illness was fairly well controlled, who could possibly do a job on hospital premises under supervision, but whose prognosis was not very encouraging. Because this definition seemed to fit the term "Workers" too, the two groups have been classed together for the sake of convenience.

(7) The "Miscellaneous" wards were made up of a group of units comprising both statutory and non-statutory provision and were impossible to classify in any of the above ways. They numbered seven and concerned two hospitals.
13.

Obviously the "type" of ward listed above could only be considered as a rough guide to the type of patient encountered therein. In some wards it appeared to be specific hospital policy to de-segregate the patients for therapeutic reasons; others achieved the same state apparently by chance, or through a shortage of appropriate accommodation.

It was noteworthy that one hospital subscribed to the policy of "open doors". This meant that none of their patients was kept under lock and key, although naturally some restriction was imposed on the activity of acutely ill persons. The remaining three hospitals had a proportion of "open doors" in addition to a parole system which was graded according to the progress of the patient. It passed through a number of stages from freedom to go out in the company of a nurse or some other responsible person (accompanied parole) to complete freedom to go anywhere alone (full parole). A tendency to introduce more liberty was apparent in two of the other hospitals and greatly influenced the atmosphere of the working situation. At the time of the survey there were 27 "open" wards within the group, patients being distributed as follows:

<table>
<thead>
<tr>
<th>Hospital Number</th>
<th>% of patients nursed in &quot;open&quot; wards (statutory provision)</th>
<th>% of patients nursed in &quot;open&quot; wards (non-statutory provision)</th>
<th>Total % of &quot;open&quot; doors</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>14%</td>
<td>17%</td>
<td>31%</td>
</tr>
<tr>
<td>II</td>
<td>100%</td>
<td>-</td>
<td>100%</td>
</tr>
<tr>
<td>III</td>
<td>32%</td>
<td>-</td>
<td>32%</td>
</tr>
<tr>
<td>IV</td>
<td>28%</td>
<td>6%</td>
<td>34%</td>
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<tr>
<td>TOTAL</td>
<td>40%</td>
<td>4%</td>
<td>44%</td>
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**TABLE III**
The % of patients nursed in the two types of "open door" wards.
Although the Nursing Homes were included in the study, only brief and indirect reference will be made to them in the report. These references will be confined to staffing problems and to the contributions which the observer considered that smaller groups in general, made to patient care. References to specialised departments such as Occupational Therapy will be restricted in the same way so that the main section of the report will be concerned with the 60 ordinary wards observed.

Physical conditions

The physical conditions of the four hospitals varied considerably, not only between hospitals, but between different wards in the same hospital and even between different parts of the same ward. Some of the differences were purely structural e.g. one hospital had been designed to simulate an old country mansion; another presented a typically Georgian facade, while a third was a mixture of old and ultra-modern architecture. Further differences resulted from the furnishings and general arrangement of the ward, which in turn were linked with the financial state of the hospital, the aesthetic taste and ingenuity of the administrators (and sometimes the patients too) and hospital policy with regard to the effect of environment on therapy. Although none of the modernising was accomplished without expenditure, it is worthwhile noting that some of the best results were achieved without major structural alterations. Two extreme examples are described here in detail.

Ward 10 was a small admission unit, accommodating 16 male patients, which had been redecorated and refurnished in modern style. A small alcove had been adapted to provide dining facilities on the ward, in

*From the investigator's personal observation.*
this way differing from the majority of other wards which shared a massive communal dining hall. The tables which were formica-covered and practical as well as attractive, matched the light wood nesting chairs - all Scandinavian-style. The linoleum was a soothing shade of pink, and more neutral carpets and rugs toned with cheery cotton curtains. Leading from the alcove was a room which had been converted into a kitchenette, boasting a modern sink unit, cream enamel gas stove, adequate cupboard space and washable walls. The hot-plates were situated near the dining room which meant that food had the minimum distance to travel before reaching the patient.

In order to destroy the previous institutional appearance of the main ward, ordinary pieces of household furniture had been introduced such as a cupboard with glass doors showing an attractive tea-set. Mantlepieces had been light grained, and paint-work of pastel shades together with gay chintz curtains and brightly coloured mats gave warmth to the room. Sufficient easy and upright chairs were available for the patients (a very important point) and for those from other wards who came to join in social activities such as billiards, for which a table was provided. Flowers gave the room a homely touch and a small electric clock hung on the wall (another important item of furniture when trying to achieve an informal atmosphere).

Sleeping accommodation was provided in two small dormitories (eight beds and five beds) and a three bedded room. Furnishing was adequate, and attractively designed in light oak, with print curtains and screen-covers. Warm coloured linoleum and small mats disguised the bare appearance of the floor and toned with the over-all colour scheme.
A surgery, in the process of being equipped in modern style, and a doctor's consulting room completed the unit. Undoubtedly the small size of the ward made reconstruction a relatively simple procedure, but it was only when compared with the ward next door, which had not been modernised, that the full impact of the change became apparent. Toilet accommodation was adequate.

At the opposite end of the scale came Ward 13, accommodating 75 female patients described as "long-term, less socialised". The different parts of the ward were distributed between three floors, the dormitories and bedrooms being, for the most part, upstairs.

On the ground floor were situated two "parlours" of drab and depressing appearance. The larger room showed a vast expanse of brown woodwork which extended halfway up the wall in characteristic institutional style. The remainder of the paintwork had originally been cream. Seven old settees and upholstered forms lined the walls and provided seating accommodation which was supplemented by four wicker chairs, three antiquated leather arm-chairs and a variety of upright wooden seats. The centrepiece of the room was a large mahogany table decorated with a plant and some flowers. Scattered throughout the room were five pieces of carpet, approximately three feet square in varying stages of decay. The windows were curtained with a heavy, dark material and the fireplace and ancient over-mantle provided perfect examples of Victorian dreariness. A half-hearted attempt to lighten the atmosphere had been made by hanging two or three poster-like pictures on the wall. The frames, which had no glass, accentuated the fact that pictures had not been fully accepted as part of the furnishing of a disturbed ward - a reasonable attitude considering the number and grade of
staff available to encourage "socialisation".

The smaller room had a coal fire and was reputed to house the quieter patients. The colour scheme and furnishing was similar to the first parlour, even to the large polished table and potted plant. Most of the floor was entirely bare.

A dormitory of 15 beds in close proximity, also occupied the ground floor. Each patient had a small wooden box which stood at the end or side of her bed for any private possessions. Only one chair was in evidence and was, of necessity, shared by all the occupants of the room. There were no other furnishings of any description. A few single bedrooms completed the ground floor accommodation.

Situated on the first floor was a dormitory of 29 beds, out of which led ten side-rooms. Three single and two double rooms occupied the same floor and led off a corridor which was separated from the dormitory by the locked ward door. Upstairs again, were eight more single rooms and a double room.

The majority of the single rooms (on all three floors) were decorated in dark colours and their only furniture was a bed and a chamber-pot. A number of these rooms retained their shutters which were put up before 7 p.m., on the days of observation by the investigator, until 7.30 a.m. the next day. This was said to be normal practice. Fifteen patients were locked in their rooms at night and it was one of the Night Superintendent's tasks to unlock the doors and observe these people three times during her period of duty. If they needed help in the interval they knocked on the doors, (some of which had steel linings), and the dormitory nurse then telephoned for the Superintendent to investigate.
The same system was expected to work in connection with the downstairs dormitory and single rooms (which were also locked at night), but which stood an even more remote chance of being heard at that distance. One or two senior members of staff expressed concern over the arrangement but failed to suggest an alternative, in view of the fact that one nursing assistant alone, (supervised by the Night Superintendent) was responsible for the ward by night.

On the top floor, the rooms were slightly more attractive and a few contained chairs and chests of drawers.

Toilet accommodation was variable. On the ground floor the lavatories had been modernised to some extent and consequently possessed half-doors and toilet seats. Wash-basins were also provided, but the communal towels were very dirty and toilet rolls were in short supply. Upstairs the situation was even less satisfactory. The sanitary annexe reeked of urine in spite of valiant assaults made with the disinfectant bottle and scrubbing brush. The toilets had no doors and no seats, and were separated from the sluicing sink by a partition which only extended just beyond the lavatory pan and provided little privacy. Toilet rolls were non-existent.

Wash-hand-basins were only available downstairs, although running water in the sluicing sink did allow for hand-washing if the patient were sufficiently concerned with personal hygiene. There were three baths on the ground floor which, in addition to being used for the patients, did service as sluicing sinks during the day. The reason for this lay in ward routine, in that the night staff, who had access to proper sinks, were unable to find time for sluicing soiled linen. It was consequently left for the day staff to do while supervising patients downstairs, and was therefore performed in the most easily accessible place - the bathroom.
The 75 occupants of this ward ate in a communal dining hall along with 130 or so patients from other wards. They sat at tables for 10 or 12, some of which had been joined together, a fact which contributed markedly to the impersonal and regimented atmosphere. An air of neglect was produced by the odd assortment of chairs, many just bare wood, which lined the tables. Some attempt had been made to brighten the ceiling with light coloured paint but the effect of this was largely destroyed by the brown panelling of the walls. A few of the tables which were formica-topped showed that changes were being attempted, but the scrubbed wooden tops of the remainder drew attention to the institutional setting. Rough wooden floors, half-polished, completed the uninspiring picture.

As one would expect, most of the wards observed, were found to be somewhere between the two extremes. One unit, with ultra-modern day accommodation, provided very mixed sleeping quarters ranging from single rooms tastefully furnished and decorated, to a dark, naked, basement dormitory calculated to depress even the most cheery. Yet another ward, whilst brightly decorated, could not produce a single easy-chair for 27 patients. In reply to an enquiry, the investigator was told that two arm-chairs had been placed in the ward on a previous occasion, but there had been so many fights over their use, that they had had to be removed. The nurse went on to remark that the upright chairs would probably have to go too, because of the danger of their being used as weapons. This would leave only old-fashioned, weighted couches on which to sit.

It can be seen from the above account that material changes were occurring to some extent in all the hospitals studied, even though certain administrators showed considerably more imagination than others.
Yet further progress has been made in each hospital since the end of the fieldwork and the effects of this progress, as well as the trials and tribulations of the staff during a difficult transition period, should not be underestimated. Undoubtedly the physical shortcomings, described here, have been exacerbated by shortage and/or maldistribution of nurses and this aspect will be mentioned in fuller detail later.
SECTION III

Type of patient

Statistics referring to patients were derived from figures submitted by each matron at the beginning of the respective surveys and represented the number of persons under treatment on a particular day.

Status of patients

Four per cent (119) of the total number of patients (2,700) had been admitted under non-statutory provision i.e. without any legal formality at all. Their status was therefore identical to that of any patient entering a general hospital, and they were not classified as either "voluntary" or "certified". Detailed information about this 4% regarding age, sex and length of stay was not available to the investigator and the group has only been included in patient totals in order to facilitate the comparison of "work-loads" between hospitals.

Of the remaining 2,581 patients admitted under statutory provision over 2/3 were certified and just under 1/3 were voluntary. In each category the males were exceeded by females in roughly the same proportion as occurred in the sex ratio of the total hospital population. The figures were as follows:

<table>
<thead>
<tr>
<th>Status</th>
<th>Numbers of statutory patient population</th>
<th>% of statutory pat. pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M.</td>
<td>F.</td>
</tr>
<tr>
<td>Voluntary</td>
<td>359</td>
<td>462</td>
</tr>
<tr>
<td>Certified</td>
<td>799</td>
<td>961</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,158</td>
<td>1,423</td>
</tr>
</tbody>
</table>
Sex of patients

Forty five per cent of the patients concerned in the survey were male, and 55% female, a ratio of 1 : 1.2. The female excess was accounted for mainly by the high proportion of elderly women patients, those over 60 comprising 28% of the hospital population. The significance of this excess, in relation to problems of nursing, cannot be ignored in a situation where male nurses were never employed on female wards.

Age of patients

Diagram I (page 23) illustrates the distribution of patients in the combined hospitals according to age. As may be seen, there were few patients of either sex under the age of 20 but, even so, males exceeded females in a ratio of 3 : 1. The peak of the male hospital population occurred between 40 and 60 years of age, with a slight drop in numbers for the older age groups. The females, however, increased steadily until they reached their maximum at 70 years and over, when they were twice as common as men of that age. The ratio of males to females under the age of 60 was 1 : 0.9 and over 60 years 1 : 1.7.

One serious aspect of the mental hospital problem is perhaps best emphasized by drawing attention to Table IV on page 24.
Diagram I  Showing the distribution of patients in Hospitals I-IV, by age.
TABLE IV

<table>
<thead>
<tr>
<th>Age in years</th>
<th>M.</th>
<th>F.</th>
<th>Cumulative % to nearest round no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>70 &amp; over</td>
<td>194</td>
<td>419</td>
<td>24</td>
</tr>
<tr>
<td>60-69</td>
<td>224</td>
<td>307</td>
<td>45</td>
</tr>
<tr>
<td>50-59</td>
<td>253</td>
<td>293</td>
<td>67</td>
</tr>
<tr>
<td>40-49</td>
<td>254</td>
<td>203</td>
<td>85</td>
</tr>
<tr>
<td>30-39</td>
<td>146</td>
<td>141</td>
<td>96</td>
</tr>
<tr>
<td>20-29</td>
<td>66</td>
<td>50</td>
<td>99</td>
</tr>
<tr>
<td>Under 20</td>
<td>16</td>
<td>5</td>
<td>100</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,158</td>
<td>1,423</td>
<td>100</td>
</tr>
</tbody>
</table>

Distribution of patients by age

From this may be seen that 2/3 of the patients were over 50 years of age, whilst almost 1/4 were over 70. That a high proportion of psychiatric nursing hours was spent with geriatric cases, is a natural corollary. It is noteworthy however, that far from resenting this "non-psychiatric" expenditure of time, the majority of mental nurses appeared quite contented looking after the old and bedfast. Whilst 27 of the 170 nurses interviewed said that they found depressed/withdrawn (i.e. specifically psychiatric) patients "the most difficult to nurse", only five considered geriatric patients so, and a further two mentioned the physically sick or bedridden. Perhaps nursing care of a strictly tangible nature, such as is necessary in connection with physical illness or associated with the feebleness of the elderly, provides more in terms of "work satisfaction" than the often less concrete concept of "psychotherapy".
Length of stay

The figures reproduced below represent a "snapshot picture" of the patient situation as it was at the time of the survey and do not necessarily reflect actual discharge rates within these periods of time.

<table>
<thead>
<tr>
<th>Length of stay in hospital</th>
<th>No. of statutory patients</th>
<th>% of statutory patients</th>
<th>Ratio of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M.</td>
<td>F.</td>
<td>Total</td>
</tr>
<tr>
<td>UNDER 1 year</td>
<td>180</td>
<td>273</td>
<td>453</td>
</tr>
<tr>
<td>1 - 4</td>
<td>232</td>
<td>350</td>
<td>582</td>
</tr>
<tr>
<td>5 - 9</td>
<td>190</td>
<td>219</td>
<td>409</td>
</tr>
<tr>
<td>10 - 19</td>
<td>210</td>
<td>252</td>
<td>462</td>
</tr>
<tr>
<td>20 - 29</td>
<td>190</td>
<td>183</td>
<td>373</td>
</tr>
<tr>
<td>30 yrs. &amp; over</td>
<td>156</td>
<td>141</td>
<td>297</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,158</td>
<td>1,423</td>
<td>2,581</td>
</tr>
</tbody>
</table>

As may be seen, the ratio of females to males was highest in the first two groups of patients i.e. those who had been in hospital under five years. From 5-19 years, the distribution was equal to the proportions of each sex under treatment generally, whilst an almost identical number of males and females had been patients for 20-29 years. In spite of the greater number of elderly female patients present in these hospitals, it was the males who outnumbered the females in the last group, i.e. those who had been in hospital for 30 years and over. Altogether more than 1/4 patients had been in hospital for at least 20 years. Comparisons between hospitals may be seen in Appendix V.
SECTION IV

STAFFING

The staff engaged in nursing the 2,700 patients in the group of four hospitals totalled 637, 96% of whom completed the questionnaire and provided much of the information recorded in this section.

SEX

Of the combined staffs, 32% were male and 68% female, but when considering the sex ratio of 1 : 2.1, it is necessary to point out that whereas all the male staff were full-time, almost half the females were only part-time.

Hierarchy

```
MATRON
   /\                       /\                        /\                        /\
 Deputy Matron (Female)  Deputy Chief Male Nurse  Assistant Chief Male Nurses  Assistant Charge Nurses
   \                     /\                        /\                        /\
  Assistant Matrons     Deputy Ward Sisters      Charge Nurses              Deputy Charge Nurses
   |                     |                         |                          |
  Ward Sisters          Staff Nurses              Staff Nurses
   |                     |                         |                          |
  Deputy Ward Sisters   Students                  Students
       |                                   |                                   |
  Staff Nurses           Nursing Assistants       Nursing Assistants
       |                                   |                                   |
  Students               Orderlies              Orderlies
```
Administration varied slightly from place to place, but in all four hospitals the nursing team (both male and female) was led by a Matron. Two of the hospitals employed deputy chief male nurses whilst all four employed deputy matrons. Coming next in seniority were the assistant matrons and assistant chief male nurses whose function though nominally administrative, tended to be similar to that of departmental sister in a general hospital, in that they had a fair amount to do with the day-to-day running of the wards. Ward sisters (female) and charge nurses (male), both of equal status came next, followed by their deputies respectively. The staff nurse grade represented the most junior of the trained staff, beyond which level there was considerable confusion regarding status. On some wards all students were considered senior to all nursing assistants; on others the opposite was true; in yet a third group, only senior students took precedence over nursing assistants, and so on. The problem was accentuated by the fact that a number of the untrained staff had given many years of service (in one hospital, two were occupying senior positions) whilst roughly half of the students did not even hold their preliminary certificate. From a practical point of view the former were far more "experienced" than the latter, but the tension between the two groups was very marked on occasion, being most forcibly expressed in the student diaries (See Appendix III) and created mainly by resentment over the allocation of duties.

The lowest grade was that of "orderly" but, as these were not strictly nursing staff and were few in number, they were not included in the survey. In one hospital the grade was composed entirely of girls too young to become student nurses (i.e. between 15 years and 17½ years).
Three grades of nurse were represented on these staffs, trained (44%), student (15%), and nursing assistant (41%).

The trained staff numbered 303, 95% of whom filled in the questionnaire. This group was made up of the members of staff who had completed some course in psychiatric nursing with the acquisition of the R.M.N.\(^1\) or R.M.P.A.\(^2\) certificates\(^3\). Of the 283 who replied, 237 had only a mental nursing qualification whilst 36 held both general and mental certificates, and 14 had taken some training such as "fevers". The remaining one offered irrelevant information in error.

At the time of the survey, 30 of the trained staff held administrative posts, 101 were ward sisters/charge nurses, 29 were deputy ward sisters/charge nurses and 123 were staff nurses.

There were 102 students employed in this set of hospitals, 100 of whom completed the questionnaire. The vast majority (83) had had no previous training but, of the remainder, one held the R.G.N.\(^4\) qualification only; five had a general nursing qualification plus some other e.g. Midwifery; five more had no general training but were already on a supplementary register i.e. they held a certificate in a branch of nursing such as "Orthopaedics", and one did not answer the question. They were at varying stages of their training, 42% being still in their first year

---

1. Registered Mental Nurse.
2. Royal Medico-Psychological Association.
3. During the 1939-45 war, the General Nursing Council took over more and more of the examinations in mental nursing and finally assumed full control, after which the certificate of the Royal Medico-Psychological Association ceased to be awarded. Nurses on the R.M.P.A. roll were given the opportunity to transfer to the G.N.C. register up until 1952. It is interesting that 119 nurses completing the questionnaire gave "R.M.P.A." as their sole nursing qualification, indicating that they had never transferred to the current register.
4. Registered General Nurse.
23\%, 2nd year; 32\%, 3rd year and 3\%, 4th year. Normally final examinations were held at the end of the third year, although post-graduate students were allowed to sit after eighteen months or two years (according to hospital policy). The 4th year students were either awaiting the first state examination for which they were eligible to sit, or had failed a previous attempt.

The two outstanding points of difference between mental and other nursing students were firstly the high proportion of male students (57\%) compared with other types of training school where few, if any, males are accepted, and secondly, the wide age-range extending from 17 to 51 years (the oldest student being a grandmother) compared with the usual upper age limit of 35 years (at entry) in other kinds of nursing.

The third grade of nurse was the nursing assistant group comprising 282 personnel, 273 of whom completed the questionnaire. Of those who replied, 5\% were made up of Registered General Nurses whose status was, for the most part, unrecognised; one or two State Enrolled Assistant Nurses in much the same position and a few with irrelevant nursing qualifications, e.g. fever nursing certificate. The vast majority (95\%) presented no evidence of any previous training, and none of the hospitals concerned, provided any organised in-service education for this grade of staff.

Type of Service

It was extremely difficult to assess the true man-power of the hospitals because as many as 32\% of the staff were part-time and working anything from just a few hours per week, up to 40 hours. (At the time of the field-work a 96 hour fortnight was recognised as full-time.)
All the male staff and the whole of the student body were full-time in addition to over half the trained female staff and rather less than half of the nursing assistants. The classification of staff by grade and type of service (male and female combined) may be seen in the following diagram.

**Diagram illustrating the distribution of staff by grade and type of service.**
Staff/patient ratio

The overall staff/patient ratio, at first glance, appeared highly satisfactory with one nurse to less than four patients; but allowing for differences of grade, the existence of part-time, as well as full-time service and distribution of staff between hospitals, the final picture was somewhat modified.

According to grade, and assessing each nurse employed as a full unit, the figures were as follows:

- Trained Staff: 1 : 9
- Students: 1 : 27
- Nursing Assistants: 1 : 10

Type of service however, introduced a major problem. Almost 1/4 of the trained staff were part-time and to count them as "half-units" is probably a generous estimate of their actual contribution. In spite of the many advantages of employing part-time staff, administratively, the exact matching of the needs of the hospital to the hours convenient to nurses with domestic commitments, was virtually impossible and inevitably led to some overlapping.

The student body was entirely full-time and the ratio of 1 : 27 proved a true picture of the situation. A serious problem of student/patient ratios was however associated with the allocation of these nurses to wards, in an attempt to secure a sufficiently wide psychiatric experience for them. The temptation of regarding students as principally "labour", rather than trainees requiring a full professional education, is a dangerous one and can only result in an insecure and inadequately qualified body of trained staff.
Just under half of the nursing assistants were full-time and problems related to the employment of part-time trained staff, applied equally to this group.

An assessment of staff/patient ratios, according to grade, and rating part-time staff as half-units, is recorded below.

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trained Staff</td>
<td>1 : 10</td>
</tr>
<tr>
<td>Students</td>
<td>1 : 27</td>
</tr>
<tr>
<td>Nursing Assistants</td>
<td>1 : 13</td>
</tr>
<tr>
<td>Combined Staff</td>
<td>1 :  5</td>
</tr>
</tbody>
</table>

Distribution of staff by sex once again draws attention to a problem already mentioned. In regarding staff/patient ratios it must be remembered that whereas the male nurses (all full-time), comprising 32% of the staff, were required to look after 43% of the patients plus a proportion of non-statutory patients (a possible 2%), only half of the female staff were giving full-time service. In addition, the male staff had a higher percentage of trained nurses and students, than the females with a consequently lower percentage of unskilled nursing assistants.

(Male trained staff comprised 62% of the total male staff, students 26% and nursing assistants 12%, compared with 36%, 10% and 54% respectively of the female staff.)

The apparent inequality was even further modified by the employment of a certain number of female nurses on male wards in at least two hospitals, whilst nowhere were male nurses found on female wards. Even where the former resulted in a female shortage of staff, it seemed a desirable policy to pursue and there was adequate evidence that the elderly male patients in particular, appreciated the "mothering" and emotional care culturally associated with female nurses. For detailed information regarding the staffing of individual hospitals, see Appendix VI.
AGE

Roughly 93% of the nurses who completed the questionnaire, answered the question on age. It was interesting to note that only one man withheld this information.

Age of trained staff (Total 238)

Diagram II illustrates the distribution of the combined trained staffs. It was startling to discover that only six trained nurses (both sexes) were under 25 years, whilst 73 were 50 years old or more. Translated into practical terms, this means that with a possible retirement age of 55 years, by 1963 (five years after the collection of data), the hospitals face the possibility of a loss of over 27% of their trained staff by retirement alone. Further wastage may be expected amongst the women of child-bearing age (in this context taken as 21-45 years) who represented another 24% of the staff.

Age of students (Total 100)

Data were available for 100 students who filled up the necessary form. Of these, 14 were under 20 years of age (i.e. still adolescent) whilst 15% were over 35 years, which is unusual in other fields of nursing. When considering possibilities of wastage, one has also to take into account the fact that 39% of the student body were females of child-bearing age, a proportion of whom may be expected to desert the field in favour of marriage and family responsibilities. The picture may be seen in more detail in diagram III (page 34).

Age of nursing assistants (Total 273)

Diagram IV illustrates the distribution of nursing assistants by age. Almost a quarter of this grade were 50 years of age and over, whilst only 12 were under 25. The slight drop in numbers which occurred between
TRAINED NURSES

Diagram II  Showing the actual numbers of trained nurses according to age.

STUDENT NURSES

Diagram III  Showing the actual numbers of students according to age.
NURSING ASSISTANTS

Diagram IV  Showing the actual numbers of nursing assistants according to age.

COMBINED STAFF

Diagram V  Showing the ages of the combined staff, expressed as a percentage.
40-45 was entirely accounted for by a reduction in female nursing assistants, the males actually being at their maximum in this age group. It is difficult to suggest any adequate reason for this decrease and it is probably not significant enough to pursue in great detail. However, the following factors may have had some bearing on the pattern. The first might have been a reluctance to employ middle-aged women from the point of view of age alone. In view of the staff shortage, this is unlikely even though employing this age group may entail a certain amount of risk in relation to health. Alternatively the hospitals' financial policy could have affected the intake, in that superannuation can impose a heavy financial burden on any authority employing a member of staff after a break of service which, in many instances, amounted to years. Menopausal symptoms might have been expected to show themselves a little later on, and certainly no similar pattern existed amongst trained female staff, as might have been expected if this were the solution. As with the trained staff however, an increase did occur at 45 years and over and, in the female nursing assistant group, this was very marked.

Age of total staff

The distribution of the combined grades by age may be seen, represented in percentages, in diagram V. Less than one fifth of the staff were under 30 years whilst more than one fifth were 50 years old or more.

In considering the difficulties of an attempted transition from custodial to therapeutic care, the significance of a relatively elderly nursing staff cannot be overlooked. Whereas there may be arguments in favour of the stability and maturity of advancing years, few would deny that adaptability in the nurse, and the capacity for absorbing new theories and techniques are of vital importance at the present stage of
professional evolution. Already the demands made on the psychiatric nurse are heavy. The additional strain and insecurity of unfamiliar methods and differences of approach may not sit easily on the shoulders of nurses with 25 years' or more experience of an entirely different régime. (See section on "communications", page 66)
SECTION V

Type of work carried out by the mental nurse

Nature of illness treated

All four hospitals admitted patients suffering from either the "neuroses" or the "psychoses" in addition to a proportion of mental defectives. The fact that almost 1/4 of the patients were 70 years old or more, ensured a considerable amount of geriatric nursing and, in the ordinary run of events, uncomplicated medical illness occurring in in-patients, was nursed at the same hospital. Three of the four hospitals possessed their own theatres in which varying numbers of operations were performed but more extensive surgery was usually transferred to specialist units.

Diagnosis

Diagnostic tags, such as "defective" or "psychotic" could be applied by most of the nurses to most of the patients, but it was the exception rather than the rule to find a nurse who was fully conversant with the details of her patient's illness. The principle reason for this ignorance was related to the fact that in by far the majority of wards, nursing staff were not allowed access to patient's case notes. Whilst appreciating the need for confidentiality, many of the trained staff and students were irked by the aura of secrecy which surrounded even

simple physical conditions. An illustration of how dangerous this secrecy could sometimes be, has been quoted on page 68. During the interview, 170 nurses asked whether or not they were told the diagnosis\(^1\) of their patients officially. Of these, 100 (almost 59\%) said that they were never told even this much about the people they "nursed". The question was followed up by an attempt to ascertain the opinion of interviewees on whether nurses should have access to case-notes or not. All but 15 were in favour of case-notes being available to at least the charge nurse or ward sister, and some elaborated further by suggesting that it was the duty of senior staff to pass on relevant information to their juniors.

In the main study (119 interviews) the nurses were specifically asked whether they thought full or abbreviated versions of the notes should be made available to nurses. Fifty per cent thought abbreviated versions (i.e. with personal details extracted) would be adequate; 42\% wanted to see the full notes and the remaining 8\% were divided between those who wanted no access at all, those who were doubtful, and those who considered certain senior grades should see the full notes but would restrict junior nurses to edited versions.

Some of the bitterest comments on this policy of secrecy came from staff who had worked in other fields of nursing where, they considered, they had been treated as a more integral part of the therapeutic set-up. One general trained student had the following comments to make on the situation. "In a general hospital, the nurse is the most important member of the hospital team because she is with the patients 24 hours per day. Here this is not so. I don't encourage patients to talk for fear

\[^1\] or where this was not possible, the "pattern" of symptoms.

\[^1\] cf Prof: McKeown's classification of patients according to treatment needs, rather than by diagnosis. Lancet 1959, i, 701.
of saying the opposite to the doctor." She went on to quote an example, "When patients ask if they are going to get well, I say 'Yes' - then discover the doctor has said they will improve, but never get really well". She intimated that this inconsistency shook the confidence of the patients, sometimes with serious results. Continuing to speak of the nurse's lack of knowledge she said, "In no other kind of nursing would you tolerate not knowing what's wrong with the patients". She added, a trifle cynically, "The only thing which makes the ignorance tolerable, is the money". Returning to a problem which evidently caused potentially this sensitive and efficient nurse considerable distress, she spoke of "the embarrassing situation when the patient thinks the nurse knows all about their specific illness" e.g. (the patient might say) "You know my husband hanged himself" - If you say 'No', she shuts up like a clam and loses confidence in the nurse, because obviously the doctor doesn't have it. If (you say) 'Yes', you just land yourself in a pile of trouble." This approach had, she said, resulted in feelings of guilt about "prying" into her patient's affairs. Consequently she avoided the sort of personal relationship which was essential in the achievement of anything more than purely custodial care.

As a result of certain comments made during the pilot study, it was decided to try and ascertain whether medical staff were in the habit of consulting nurses about their patients, or discussing any aspects of patient care with them. When this question was put to the 119 nurses interviewed in the main study, 53% said it never occurred; 18% replied in the affirmative and the remainder (with the exception of two, who made no comment) answered either "sometimes" or "rarely".

1. See "Basic Education of the Professional Nurse" (I.C.N.) p. 9. for definition of ideal relationship between medical and nursing staffs.
It is beyond dispute that those who supported the policy of secrecy, on the grounds of preserving the patient's confidence, were able to present convincing arguments in its favour. There appeared to be some danger, however, in restricting the nurse's knowledge to what she picked up from gossip (which one would expect to flourish in such an atmosphere of mystery), and the sparse information given her by patients themselves, much of which she was in no position to interpret accurately. Thus it may be seen that rightly or wrongly, the nurse in this position was not accorded the full professional status, (with its attendant responsibilities) normally given to her colleagues in other fields of the health service.

**Treatment**

Psychiatric treatment was divided broadly into physical and psychotherapeutic. Physical treatment comprised such techniques as E.C.T.\(\text{II}\), deep or modified Insulin and the use of drugs. Psychotherapy, seriously restricted by the shortage of medical and nursing staff, most frequently took the form of individual interviews, whilst attempts at group therapy were occasionally witnessed. The observer met no patient undergoing a full-scale psychoanalysis during the time the survey was being carried out.

**Other duties**

Apart from her rôle in relation to recognised nursing duties, such as assisting with the treatment mentioned above, the mental nurse appeared to spend a not-inconsiderable period of time on domestic work. Indeed in 50% of the wards no domestic help at all was provided, whilst a few

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\(\text{II}\)Electro-convulsive treatment
others had to be content with part-time assistance. Wherever necessary, sweeping, dusting, polishing and sometimes even scrubbing were divided between patients and nurses. Amongst the older staff, this was frequently accepted as normal routine, with surprisingly few objections. Students, however, caught up in a conflict between the traditional and the forward-looking concepts of mental nursing, showed some resistance to assuming such duties. It is interesting to note that of the 170 nurses interviewed, 69% said they were satisfied with their duties; 20% were dissatisfied, and the remainder had some doubts. When the question of domestic work was specifically pursued, opinions were so diverse that rather than try to summarise them, the investigator has included the full results below. The question was phrased, "Do you think a nurse should ever do domestic work and if so, under what circumstances?"

Replies were as follows:

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes - not specified who</td>
<td>14</td>
</tr>
<tr>
<td>Yes - all grades regularly</td>
<td>45</td>
</tr>
<tr>
<td>Yes - all grades regularly except Charge Nurses/Ward Sisters</td>
<td>3</td>
</tr>
<tr>
<td>Yes - Students and Nursing Assistants regularly</td>
<td>26</td>
</tr>
<tr>
<td>Yes - Students only regularly</td>
<td>1</td>
</tr>
<tr>
<td>Yes - Nursing Assistants only regularly</td>
<td>14</td>
</tr>
<tr>
<td>Yes - all grades in an emergency</td>
<td>17</td>
</tr>
<tr>
<td>Yes - Students and Nursing Assistants in an emergency</td>
<td>1</td>
</tr>
<tr>
<td>Yes - Nursing Assistants only, in an emergency</td>
<td>2</td>
</tr>
<tr>
<td>NO - no nursing grade, ever</td>
<td>40</td>
</tr>
<tr>
<td>Don't know</td>
<td>1</td>
</tr>
<tr>
<td>No answer</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>170</strong></td>
</tr>
</tbody>
</table>

The most outstanding fact emerging is that over 31% of these nurses thought that domestic work was part of the legitimate function of even trained staff whilst a further 10% considered that it should not be beneath their dignity "in an emergency" e.g. when there was no maid on the ward or when immediate action was required in the interests of hygiene. When persuaded to comment on types of domestic work of which
they approved or disapproved: the following opinions were made known. Thirteen were prepared to do specific light work such as dusting and mentioned it spontaneously. Dislikes were even more positively expressed. Forty-three mentioned a specific dislike of floor-scrubbing; 22 of window cleaning; 15 of wall washing; 25 of floor polishing; seven of work entailing ladder climbing and three made no comment. Seven mentioned a specific dislike of one of the following duties, "general carrying and portering"; "washing dishes and doing laundry"; "scrubbing lavatories - it's a wee bit menial!"; "spring cleaning"; "going with the squad emptying dustbins"; "clerical work" and "cleaning fireplaces". Five more were heard to say "We've always done it" or "It never did us any harm".

It is certain that not all the nurses who mentioned specific dislikes were called upon to carry out these duties themselves, but with the exception of one complaint (i.e. emptying dustbins), the writer observed all these types of work being performed by nursing staff at some time or another.

The second main group of duties about which there was some difference of opinion concerned "functions outside the ward" such as working in Occupational Therapy departments, hairdressing units, laundries, gardens or on hospital farms, usually, of course, in association with patients. At the interview, nurses were questioned as to their opinions of extra-ward duties. It was, perhaps, a difficult question to answer, with a distinct subjective bias e.g. the skilled carpenter, who also happened to be a qualified mental nurse saw distinct possibilities in holding classes for interested patients. On the other hand, the female trained nurse was not, on the whole, interested in supervising patients
in the hospital laundry, no matter how therapeutic the occupation was reputed to be. It seemed that at least to some extent 'status' was involved, and this may have been one of the main factors behind the male student's reaction against "cabbage planting" etc., quoted in detail in Appendix IIA page 171.

When this random sample of 170 nursing staff was asked how they felt about nurses supervising the activities of patients outside the wards, 55% stated "It's always part of our duty", indicating full acceptance of extra-ward roles; another 22% considered this supervision part of a nurse's duty but added certain reservations such as, "A nurse should not be expected to work in the laundry" or "It depends on whether the nurse is interested in gardening . . . . " (or whatever it might be). Two nurses thought the Occupational Therapy department should be the sole extra-ward function, whilst 17% considered that the nurse's activity should be strictly confined to the wards. As one trained nurse commented, "If I'd wanted to be a gardener, I'd have been a gardener, but I wanted to nurse".

Again it seemed that nurses with the longest record of service were least disturbed by non-nursing functions.1 The outstanding example met by the observer was the male nurse, almost due for retirement, who told of 13 consecutive years labour in the gardens during which time he became a registered mental nurse without ever working for a single day in the wards of the hospital. Naturally, such extreme instances were rare, and under the revised system of training, could not occur. Far from being distressed by this state of affairs however, it seemed that his main problems had started when, promoted by seniority, he was expected to assume responsibility for a number of treatments with which he was

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1. and consequently the most disturbed by innovations in therapy. Cf. original staff reactions to experiment of Freeman et al, "Chronic Schizophrenia".
totally unfamiliar.

Further discussion of the rôle of the psychiatric nurse will occur later on, but in concluding this section it would, perhaps, be helpful to indicate the main trends in the change of her function. On a purely physical level, advances in medicine have brought in their train greater demands for nursing skill and powers of observation than ever before, and with the opening of operating theatres within mental hospitals, psychiatric nurses have been faced with the need for a high degree of technical efficiency, previously confined almost solely to general hospitals. Psychiatrically, the mental nurse has been called upon to change fundamental attitudes to patient-care and the transition can never be easy. Tranquillisers have certainly made patients more accessible to psychotherapy; they have controlled, to a large extent, aggressive and bizarre behaviour and as a result they have placed on her shoulders an ever increasing responsibility to persevere in attempts to achieve a therapeutic relationship. In such an atmosphere, teamwork becomes not only desirable but essential.

The unlocking of doors, whilst relaxing general ward tension, has undoubtedly multiplied the responsibilities of the nurse towards her patients. The spiritual, intellectual and social aspects of their personalities, which at one time it might have been possible to ignore, are beginning to take their rightful place in treating the patient as a "whole person". With increased understanding of patient needs, has also come the charge to meet those needs as adequately as possible.

Finally, it cannot be denied that whilst division of labour, in the form of the introduction of psychiatric social workers and occupational

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therapists, has lightened her responsibilities to some extent, it is with the mental nurse that the ultimate success of therapy lies, often achieved through her skill and ability to co-ordinate and utilise the specialist contributions of the parallel disciplines. Without adequate knowledge of her patients she cannot hope to fulfil her true function efficiently.
SECTION VI

Working conditions

The physical environment of the mental nurse has already been described, to some extent, in an earlier section. To summarise briefly, it was pointed out that although varying degrees of painting and furnishing were occurring everywhere, many of the wards still presented a bare, bleak and sombre appearance which could not be expected to assist the mental health of either patient or staff:

Ward planning (Working conditions continued)

Aesthetic susceptibilities apart, it was discouraging to see that in some newly planned wards there appeared to have been little regard for practical nursing details. In one ward of very modern design, inhabited by a large number of elderly and feeble patients, it was impossible to get a wheelchair into the bathroom, and the lifting of patients into the bath was also hampered by shortage of space. In another ward, again catering for geriatric cases, ventilation proved a problem in that the windows were designed to open both at the top and bottom at the same time and in one movement. The sudden gale which invaded the room, whilst excellent for airing empty premises, was wholly unsuitable for a ward occupied by frail and "draught-conscious" old ladies. Unable to control the incoming air, the unequal struggle inevitably ended by

the majority of the windows being shut, and the effect of this action in a ward afflicted with a high degree of incontinence, can be left to the imagination.

Large areas of window space, pleasant as they may have been, also brought their problem. In one or two wards adequate privacy was secured for the patients by the hanging of white plastic venetian blinds. During a period of observation these were being washed (by nursing staff) and enquiries were made as to how long the task normally took. A senior member of staff gave an estimate of twelve hours per week!

The staff of some wards were hampered by ill-placed cupboards and equipment. In one or two wards, drug cupboards were situated on the ward corridor so that traffic to and from made administration of medicines difficult. In other wards the steriliser was located in a room which did service as assistant matron's office and doctor's consulting room. Because of the general inconvenience, as well as the undesirability of a steam-sodden atmosphere here, equipment was boiled in a bucket over the gas in the kitchen. It cannot be denied, of course, that even special sterilising rooms brought some difficulties in their train. The steriliser of one ward was out of action because, situated as it was in an inconspicuous annexe, no-one had noticed it boiling dry.

A shortage of storage space produced other peculiar problems. In one ward the patient's crockery was stacked in a cupboard in the bathroom where, incidentally, the nurses took their mid-morning break. On another, the observer saw margarine, cereals, eggs and even jugs of milk stored on the floor of a wash-room adjoining the toilet. Fortunately the latter did not seem to be used at all for its intended purpose.

Passing from storage problems, the lack of everyday amenities was a great hindrance to the socialisation of patients and must undoubtedly have led to the lowering of standards of hygiene in nursing staff. An outstanding example occurred in a ward where the "kitchen" had no running water. In order to wash up, every bowlful had to be carried from the sanitary annexe nearby and taken back again to empty. On yet another ward, the washing up was done in the wash-hand-basins of the bathroom itself.

Occasionally lack of staff facilities led to misuse of those provided for patients. In one hospital, where progress had recognised the rights of its patients to a degree of privacy, cubicles had been erected and curtained off within easy reach of the baths. Faced with the dilemma of leaving her bicycle outside as a temptation to patients, or parking it in a cubicle, the nurse chose the latter course and effectively put a quarter of the accommodation out of action.

Unintelligent planning, often exacerbated by overcrowding, produced inconvenient and even sometimes dangerous situations. On one occasion patients had been carefully segregated into the "incontinent" and "those who were capable of looking after their own toilet". They were placed in different sections of the ward, each equipped with a sluice room and accessories, and separated by the administrative offices and sitting rooms. In all this careful planning, the incontinent patients had been placed at the end furthest from the point at which the laundry van was able to call. Consequently all wet and soiled linen traversed three quarters of the ward before it could finally be disposed of.
Elsewhere, what had originally been designed as a patients' sitting room, had been converted into a small ward for tuberculous cases. In spite of the nature of the unit, not one wash-hand-basin had been installed. Up-patients were forced to walk the length of the main ward before reaching the toilet accommodation whilst the bed-pans and urinals of the more ill patients followed the same route. Crockery and cutlery passed through the main ward, up a corridor and into the sluice where, in the interests of "hygiene", they were washed separately.

Of course, not all wards were examples of poor physical surroundings. One of the better planned wards has already been described in detail, and even in the worst, plans were usually afoot to improve at least the colour schemes. Defects of working conditions were not however confined to the structural aspects of the wards.

_Distribution of staff (Working conditions continued)_

The numerical distribution of staff has already been dealt with in some detail but undoubtedly the practical implications require further mention in relation to the working conditions of the mental nurse. The ratio of one trained nurse to ten patients may not sound too disturbing until allowance is made for night duty, days off, holidays and sickness. Immediately it becomes obvious that a great deal of responsibility for the care of patients, must of necessity, have been left in the hands of student and untrained staff. This was particularly true at night when nursing assistants, depending to a large extent on the help of patients to accomplish their quota of work, were sometimes in charge of as many as 80-90 patients, a large proportion of whom might require active nursing care. In quite a number of wards, nurses, feeling that some form
of repayment was due the patient helpers, would bring in food of varying kinds, which was generally much appreciated. Others offered cigarettes or tobacco in return for services rendered. By day, the nurses were only a trifle less dependent on such labour. In some wards, patients carried a good share of the domestic burden whilst in others, even administrative responsibility was delegated. The investigator observed one patient busily at work amongst the linen stocks and she was told, by the staff, of another, who jangling a larger bunch of keys than even the trained nurses, was responsible for allocating the ward supplies of bread, tea and sugar. In a ward of yet another hospital, two trained nurses were in charge of 70 male patients by day. They admitted freely that they would never have been able to cope without the assistance of a few reliable "chronics". As it was, the younger nurse was already disheartened and discouraged by the standards which the staff shortage had forced him to accept. Perhaps in some kind of self-defence, a proportion of the nurses had become blind to the needs of their patients and, in spite of low staff/patient ratios, had taken refuge in routine domestic tasks.

Thinking along the lines of shortage of staff, the observer commented on the high degree of cleaning done by nurses in one unit. The charge nurse, in reply, said, "How else could they fill their time in, but by doing the domestic work?" Yet, nearby stood a patient with a malignant disease of the ear which badly needed cleansing and dressing. A group of senile old gentlemen sat requiring to have their noses wiped, their trousers buttoned and their ties straightened, while some of the more active walked up and down the ward displaying large holes in the heels of their socks and rents in their shirt fronts. With such obvious physical needs, is it unrealistic to suppose that they might have physio
logical needs too? Whilst the reader may appreciate the demoralising effect on the staff of fighting against such odds, and whilst he may be prepared to face the fact that two nurses are but "a drop in the ocean", it is necessary to realise that the fight against an apathetic approach to conditions in individual wards must always precede large scale reform and must inevitably contribute to its success.

**Hours of work (Working conditions continued)**

In only one of the four hospitals was a shift system operating, which meant that in three hospitals, nurses came on duty at 7 a.m. (or earlier, as in one hospital) and were not off again until 3 p.m. Long as the day was, boredom and frustration often made it seem longer, and mental and physical fatigue tended to reduce nursing to the level of mere custodial care. Some of the comments made by students have been quoted in the section on "Diaries", to be found in Appendix II.

Once more, it was the younger staff who rebelled most against the long working hours. One nurse, aged 19 years, who had already made a name for himself in amateur athletics, had been forced to abandon all thought of further participation because of the length of his working day, which prevented him from getting regular practice. In another hospital the investigator spoke to a sensitive and conscientious student in his early twenties, (of whom the matron thought highly) and asked him if he were settling down on his new ward. To her consternation, he replied with great distress and mopping his brow, "I just don't know. Really I just don't know. I'm told I'm on the worst ward and things are easier elsewhere. When I came I got to exhaustion point. Now I'm just dreadfully tired all the time."
All of the nurses who were interviewed were asked about their satisfaction with the length of working day. Twenty-five were doing a long day and were satisfied; 31 working the same number of hours, were not. Twenty-nine working the shift system (eight hours) were satisfied basically, although one or two suggested that a week of morning shifts followed by a week of afternoon shifts would have been preferable to the daily switch which occurred. Eight of these 29 objected, however, to the three "long days" worked per fortnight, two of which were at alternate weekends to relieve the opposite shift, and one in the middle of the week, in order to make up the 48 hour quota required. Thirteen working the shift were entirely dissatisfied and some of the senior staff amongst these objected principally on the grounds that the existence of a sister or charge nurse on each of the day shifts, tended to disrupt continuity of administration. Thirteen were working a full-time night duty, (which in all instances lasted between ten and twelve hours) but 11 of them were satisfied. Of the three who worked a split shift, two were dissatisfied. Fifty-five others were working part-time and were not so intimately concerned with hours (although a few mentioned that they might have been able to work full-time, had a shift system been operating). One gave no answer to the question.

When the subject of hours was raised in informal conversation, it was not uncommon to hear members of the older generation expressing sympathy for their younger colleagues. Some, whilst personally preferring a longer period of duty, with its consequent longer breaks, thought it was too much to ask of new staff, particularly if straight from school. A typical comment would be, "I prefer the long day. I've done it all my life and I'm used to it, but you can't expect the young folk of today
to work these hours. They can get other jobs with free evenings, Saturdays and Sundays off, and more pay."

On a busy ward, one sometimes heard cries of distress from even the older generation. One sister of middle age, attempting to cope with a large group of disturbed patients said, "Sometimes by eight o'clock, your head is going round." She went on to explain that, although the staff had voted in favour of a shift system, there were too few nurses to implement it. In one hospital, a young male student with a wife and two children told the observer how, in addition to reducing his salary by almost half, mental nursing necessitated his rising at 5.30 a.m. and not returning home until 9.10 p.m. The strain had already begun to tell and, as might be expected, within a few months he had left. A female colleague, facing much the same problem revealed how some of the other nurses "worked out their own salvation". After a meal, scheduled to take half an hour, she retired with her friends to a sitting room where they relaxed for another 15 minutes, unofficially. With complete frankness she told how, on learning of the writer's visit to the ward, she had been tempted to return to duty at the proper time. On further contemplation she had decided to act honestly and explain that without such "subsidised off-duty", for her, to keep going would be virtually impossible.

Staff facilities (Working conditions continued)

Staff facilities were variable, depending sometimes on the age of the building, sometimes on the amount of money available for alterations and sometimes on an appreciation of the nurse's difficulties by the administrators. Defects ranged from minor inconveniences such as having nowhere to hang outdoor clothes or to park bicycles, to the more serious
such as the lack of a kitchen (sometimes even the lack of a gas-ring) or the existence of inadequate staff toilet accommodation. The placing of telephones was also often open to criticism in that their very lack of privacy proved a source of embarrassment to nurses. In passing, it may be noted that on very few of the wards was there direct contact with outside callers, the majority of replies to patient enquiries having to be transmitted through an operator.

Inadequate provision of office space led to situations like the one witnessed in a fairly busy ward. Here, the sister was forced to write her report on a bed or chair in the midst of all the bustle and activity, and surrounded by noisy and occasionally inquisitive patients.

Overcrowding (working conditions continued)

The shortage of office space was indubitably closely related to general overcrowding which further increased the nurse's difficulties. One of the most outstanding examples of practical problems caused by insufficient space was noted on a ward for physically sick and geriatric cases. As each meal-time approached, a sort of "general post" commenced with the nurses pushing the beds together at one end of the ward, re-arranging the position of others, transferring dining and serving tables from remote parts of the unit and erecting them in whatever space they had managed to produce by this time. Apart from the nursing problems of such situations, the environment for patients, herded together in such close proximity, was only a trifle better than that of the bathroom where certain patients on another ward took their meals, in an attempt to overcome a similar difficulty.

Overcrowding in dormitories, as well as being generally undesirable from a health point of view, tended to encourage the lowering of stand-
ards of nursing. Properly set back trolleys were bulky pieces of equipment to manoeuvre in a restricted area and it was often difficult to find sufficient space to lay down even a back tray. The closeness of beds proved a temptation to nurses to strip bed-clothes from one patient on to the bed of the next, with all the dangers of cross-infection. Alternatively, beds were sometimes stripped on to the floor, for shortage of space and consequently of furniture, often meant that a chair was not readily to hand.

Ward changes (Working conditions continued)

Policy with regard to the movement of nurses within the hospital, appeared to be very flexible and both extremes (ranging from "no ward changes" in the past three years, to almost "daily changes") were sometimes experienced by different grades of nurse on the same staff. The situation resulting, was fraught with dangers of an equally extreme nature. Of the 661 nurses who completed the questionnaire, almost 1/5 had not changed their ward at all during the previous three years. The main dangers in this state of affairs were over-familiarity with both routine and patients, leading to rigidity, apathy, boredom, lack of initiative and finally either resignation or despair, according to the personality of the nurse. The least critical comment which might be made, is that it was not conducive to stimulation. In order to put the argument in perspective it is necessary, at the same time, to note that a degree of stability in a mental hospital staff, is eminently desirable. It allows for a more thorough knowledge of the patient; it makes for continuity of treatment and it furnishes security for the sick person, providing staff/patient relationships are satisfactory.
A further 1/5 of the staff were not concerned by the question because they were either high administrative staff, unattached to a specific ward, or students whose movement should have been largely motivated by training requirements. (In actual fact it was possible to find students whose practical experience had been very inadequate, like the young girl who, having trained for a year at the time of the survey, had only worked on the one ward.)

Seventeen per cent reported nine or more changes in the past three years, a large proportion of these either describing themselves as "relief nurses" or intimating that changes occurred almost daily. Such frequent changing was not generally popular. Quite a few nurses commented spontaneously on the lack of interest they felt in their work, as a result of the constant movement; others were upset by the insecurity resulting from not knowing where they would find themselves, and yet others objected to being constantly moved to relieve on heavy wards.

One nursing assistant, complaining of backache and general fatigue, attributed it to the fact that the day of observation was her third consecutive day of lifting heavy geriatric cases in and out of the bath. She went on to comment that she had seen virtually no other aspect of patient care at all during this period, but had been sent from ward to ward for the express and sole purpose of bathing patients. A further almost 20% of the nursing personnel were unable to answer the question, often because they could not remember the moves which had occurred.

Of the remaining staff, just under 20% had made 1–4 changes in the previous three years whilst 5% had made between five and eight changes.

Without more detailed research it is impossible to assert dogmatically the optimum point in time at which nurses should change wards.

It is suggested however, that in order to meet the needs of both staff and patients a regular changeover should occur every few months, with perhaps only a section of the nurses moving at one and the same time. With such a change in policy, it should no longer be possible to cite even one instance of a nurse who had been employed on the same ward for over 30 years. To quote an example: before retirement, one male nurse was heard to say that although he was still physically capable of carrying on, his family were beginning to notice a change in his personality - a certain quick-temperedness which had not been apparent before. After 30 years of continuous contact with the same disturbed ward it seems amazing that he should escape with so minor a disability. Apart from damage to individual personalities, which must always be regarded as of great importance, it is very unlikely that nurses "stagnating in the same pool" for a quarter of a century or longer, will be enthusiastic supporters of research and experimentation within their field of work. Professional progress becomes blocked by nothing more than apathy and over-familiarity with traditional routines. Such an approach cannot but affect the status of the profession, virtually reducing it to nothing more than a "lay occupation", in spite of the valiant efforts of altruistic and devoted pioneers who constantly strive for something better.

Special problems of working conditions by night

Although many of the working conditions already described applied equally to both day and night duty, certain aspects emerged more clearly during the period of night observation than at any other time.

Loneliness

In 59% (i.e. 27) of the wards under supervision by night, the nurse

1. Cf. opinion of Freeman et al Op. Cit. p.105, that the nurses "should not be liable for sudden transfer to other wards and activities".
was on duty alone, although in three instances this was slightly modified — one was sent a relief during the peak working period; the night sister was "based" on the ward of a second and a third was occasionally visited by a trained nurse who was responsible for a nominal supervision of the nursing assistant's work. The loneliness of the nurse was accentuated by the widespread nature of the wards in some hospitals, and in certain members of staff, fear was closely related to this physical isolation. On occasion it was a vital part of the night superintendent's duty to keep those "manning the outposts" happy and content, and this was done by an extra minute or two of conversation with them during the round, a few words of encouragement or perhaps joining them in a cup of tea. The most acute period of loneliness tended to occur after the patients had settled for the night, and it was usually at this time that any "footsteps", "tappings at the window" and other mysterious happenings — often products of an over-stimulated imagination — were reputed to occur. Fear was not lessened by the economy-motivated switching off of corridor lights which, though they were certainly not essential from a practical point of view, gave a degree of reassurance to the more timid. There is no doubt that loneliness also accounted to a large extent for the very warm welcome, which the observer experienced on most wards, during the periods of night observation and interviewing.

**Ward temperature**

One of the more serious discomforts experienced by staff at night was the ward temperature. In spite of the check of thermometers carried out in at least two hospitals, many of the wards were uncomfortably cold to sit in and, in the absence of capes, nurses were reduced to wearing a strange assortment of multi-coloured cardigans and sweaters. Among the
untrained staff it was not uncommon to see the fight against cold carried to the lengths of wearing fur-lined bedroom slippers on duty, which, quite apart from being unhygienic, accentuated the assistants' lay approach to their work. On one or two occasions, the investigator was told of rime actually being visible on the top blanket of patients' beds during periods of intense frost, but the introduction of central heating was undoubtedly contributing to the solution of the problem and such extreme cases were never witnessed by the writer herself.

Ventilation, already mentioned in connection with day duty, was, if anything, worse by night; the problem being exacerbated by overcrowding, the unhygienic habits of mentally disturbed patients and again, the fight against cold. In some of the older wards, the combined effect was nauseating, and it was difficult to understand how the odour could pass apparently unnoticed.

Food

On some wards the nurses attempted to overcome the effects of cold by providing hot drinks for both patients and themselves. This drew the attention of the observer to two facts: firstly that in many of the wards there were no facilities for heating food or drink, (some nurses were forced to bring thermos flasks on duty), and secondly, in a high proportion of wards, even those in which gas-rings were provided, the nurses were expected to supply their own dry tea, sugar, butter, bread and even milk. Not only did they do this for personal snacks, but many brought food for the patients too, either to act as a sedative or as a reward for help given during the peak periods of work. Complaints regarding feeding generally, were frequently discussed by night. In one hospital the investigator was told of the long-term ward nurse who was so distressed at the short-
age that, when staff suppers were over, she would take a tray down to collect any surplus food which she then distributed amongst her patients. A second nurse, overhearing and confirming the story, added, "The chronic patients only just get enough food to keep them going. They could never do a day's work on it".

It is perhaps appropriate to record here, the opinions of the 119 staff who were interviewed on the subject of food generally (i.e. for staff and patients). See Appendix IV, Question 34. Whilst 14% made no comment on any aspect of patient food (though some of them did on staff food), just over 52% said they were satisfied with food provided for patients and 24% stated that they thought their feeding arrangements satisfactory. Thirty-one per cent were, however, dissatisfied enough to comment on either the type or the amount of food supplied to patients and 32% complained of unsatisfactory feeding arrangements for them e.g. the way meals were served, or the type of dining room facility provided.

Because complaints, too frequently justified, were also heard from the lips of patients, (See Appendix VII), it was unusually refreshing to hear the favourable criticism of a patient on one of the more fortunate wards. Following a glowing account of the week's menu, she concluded by informing the worker that she was, in her own phraseology, "putting on the beef". In the same hospital, staff testified spontaneously to the improved behaviour of disturbed patients as food increased.

As far as could be ascertained, in only one hospital had any systematic investigation of diet been carried out, although, as in the last hospital mentioned, the importance of food was coming to be realised in all hospitals. On the discovery of certain deficiencies and shortcomings, specific action was being taken to ensure that patients received adequate
quantities of protein, fat and carbohydrate to provide a reasonably balanced diet.

With regard to staff food, 22% of those interviewed made no comment, partly because most were non-resident (only 16% of the nursing staff were resident) and were not wholly dependent on the hospital for food, and partly because in many cases they were concentrating too hard on putting forward complaints about the food and feeding arrangements for patients. Forty-two per cent stated that they were satisfied with staff food and 21% with feeding arrangements. On the other hand 31% intimated that they were dissatisfied with the food itself, complaints being mostly concerned with quality rather than quantity: lack of variety proved another frequent criticism. Nineteen per cent commented on their dissatisfaction with staff feeding arrangements and 4% felt they could make no useful contribution.

In spite of the criticism of staff food by day, it was on the whole a vast improvement on that which was served by night. The problem was no easy one for the hospital because the number of staff who actually ate a full meal in the middle of the night, was not large. Hence, it was uneconomical, even if possible, to secure the services of a night chef, and in only one hospital was this attempted and without much success.

Furthermore, the shortage of staff necessitated the staggering of meals, and relieving for the main meal, on wards where only one nurse

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^Because of the form which the question took, not everyone commented on each aspect of the subject, e.g., some only commented on food, ignoring feeding arrangements; others confined their comments to staff food or that of patients. In view of this fact it was interesting to note that almost 1/3 of the staff commented unfavourably on patient food.
was on duty, might start as early as 11 p.m. and continue till after 3 a.m. In one hospital, the sole official break was of 25 minutes duration, which hardly allowed the more distantly situated nurses to get to the main building and back, let alone eat a meal in the time. It was more common then, to find her taking the opportunity of chatting to the relieving nurse - the only contact with her colleagues for the night.

Where more than one nurse was on duty they would either relieve each other for food or, more commonly, prepare something on the ward. In one ward with a very heavy night routine, to save staggering meal times, supper was eaten in the ward itself and was constantly interrupted by calls for help to the toilet, the activities of deluded or restless patients and the investigation of unexplained noises. Under these circumstances it is not surprising that 7% of the nurses interviewed preferred day duty, because of the digestive upset which night duty brought in its train.

**Miscellaneous problems of night duty**

Because of the nature of their illness, it was necessary to maintain adequate observation of patients by night and this necessity presented serious practical difficulties in some instances. In certain wards the nurse actually sat amongst the patients in cold, ill-ventilated and overcrowded dormitories, whilst others occupied dutyrooms which did not always give a view of the ward. The extreme example of this was the unit housing over 30 moderately disturbed patients, none of whom could be seen by the nurse on duty without doing a round of dormitories.

**Sleep**

The importance of sleep was emphasized during the interview stage of the survey when 1/5 of the nurses concerned, stated that they preferred day duty because of their inability to obtain adequate rest by day.

1. The importance of taking meals away from the wards is stressed in *Report of Nursing Committee, Belfast 1960* p.93.
Apart from the fact that reversing the long-established habit of sleeping by night comes hard to many people, there is the additional problem that the rest of the world is awake and living its life just when quiet would be most appreciated. In the Nurses' Home of one hospital, to obtain enough sleep was especially difficult. No separate accommodation was provided for resident night staff who were consequently scattered all over the building. A considerable amount of traffic passed through the Home during the day, rising to a peak at meal times and, finally, the building was made indescribably noisy by an apparent absence of any kind of sound proofing at all.

Naturally non-resident staff also had their problems ranging from the occasional interruption of sleep by tradespeople to the more regular reduction arising out of heavy domestic responsibilities.

Relationships

To conclude on a more hopeful note, the observer was constantly being made aware of the good relationships which tended to exist between senior and junior night staff. In one hospital, she heard reports of practical help given to harassed nursing assistants by their night superintendent. In another, married staff returning to duty after a break of many years were having their self-confidence restored by the kindly encouragement of a senior nurse. In a third, esteem and loyalty of the highest degree were afforded the supervisor who noticed when her nurses became over-tired or strained and who arranged for their transfer to a less exacting ward. As in every field, the importance of human relations cannot be overstressed, and it is probable that good relationships in conjunction with a real vocation for nursing the mentally sick, enabled some of the staff to carry on against apparently overwhelming odds.
SECTION VII

Communication

That communication was of first importance, and that lack of it could actually retard the patient's progress, emerged very clearly from the survey. Over and over again it became apparent that nurses often did not comprehend what lay behind a certain mode of treatment and were consequently both less willing and less able to cooperate. Their ignorance of vital parts of case histories was, of course, closely related to their not being allowed access to patients' notes, as well as to deficiencies of verbal communication. Examples of the misunderstanding which resulted were legion.

In one hospital a permissive attitude to patient aggression was encouraged by the medical staff but not appreciated by the nurses. On numerous occasions, and from all parts of the building, the investigator heard accounts of a particular patient who had broken crockery or smashed windows or otherwise been destructive, but whose doctor had done nothing to prevent this conduct. One of the nurses reported, "After 43 hours of this behaviour she (i.e. the patient) was sufficiently sedated to sleep, whereupon along came a doctor and woke her up to take her to the office for a chat .... " That the story had spread so far from its ward of origin gives some indication of the importance attributed to it, by the staff concerned.
An alteration in the type of discipline meted out, caused resentment elsewhere. One male nurse said, "In the army, if a patient smashed up goods etc., he was placed in seclusion and given physical punishment. We never had any of this (indicating a noisy patient). You could hear a pin drop at night. Here, if they put their hand through a window, they're given a plate of trifle. It just encourages bad behaviour when the other patients see it".

Nurses in yet another hospital did not understand what lay behind an experimental approach to alcoholics. A senior member of staff reported some instructions which she had obtained from a doctor, regarding the reception to be given to one such patient on his return from a drinking bout. According to her account, its principal features comprised the administration of tea, associated with a kindly greeting and the withholding of any condemnation. With a sigh of desperation containing a wealth of meaning she said, "I've been nursing mental patients for almost as long as he (the doctor) has been alive". Although this nurse could be relied on to carry out the letter of the law, it must have been obvious to all, including the patient, that the spirit was sadly missing. In such circumstances, was the treatment being given a fair trial?

Stray comments on patients or therapy were often very revealing too. One nursing assistant made frequent reference to "dopey" patients and spoke of their few personal belongings as the "rubbish in their lockers". At the opposite extreme from this unimaginative and insensitive approach, was the trained nurse who wanted to prevent all her patients from meeting the general public so that they would not be stared at or mocked. Both attitudes could undoubtedly have been modified by a little more psychiatric education.

1. For further example of misunderstanding of policy see Appendix IIA p.172.
Occasionally, lack of communication led to nurses viewing the mental hospital situation as something of a battlefield, with the patients as the prize over which medical and nursing staffs fought. Unlike most battles the prize sometimes joined in the fight too, allying itself to one or other side against the "opponent". To illustrate this last point an incident, which was many times discussed among the staff, may be quoted. Miss X, unable to sleep, was prescribed a large quantity of sedative each night. After one or two private discussions with the doctor, about the contents of which the nurses knew nothing, a further dose was prescribed should the patient wake during the night. In the course of her duties a nurse discovered that if Miss X did not waken spontaneously for her "repeat dose", she got her neighbour to call her in the early hours of the morning. This was reported to the doctor who then, it was stated, told Miss X - in order to alleviate her anxiety - that the time of her "repeat dose" could be brought forward if necessary. In response to this, the patient was said to either refuse to go to bed until she had been given the second dose or, having gone to bed, to deliberately keep herself awake until "zero hour". Once again the doctor was informed, and the result was instructions to the effect that as the patient appeared to be worried about missing her sedative, even if she were asleep, she must be wakened for it by the nurses. Whether the approach of the doctor was correct or incorrect is of no consequence in this context. The vital point is, that faced with a situation at least superficially illogical and contrary to nursing principles, and for which no reasonable explanation had been given, the nurses revolted. The action was interpreted as a threat to their authority, and the team-work relationship, so often the essence of successful psychiatric help, was immediately disrupted, leaving

the nurses antagonistic to both doctor and patient.

On one or two outstanding occasions, nurses were kept in ignorance of the physical conditions from which their patients suffered, as well as the psychiatric. Danger to both patients and staff resulted, and how serious that danger could be, is illustrated by the following examples. A student told of the difficulty the staff had had in inducing a patient to eat. Under the impression that his reluctance was of psychiatric origin, the nurses had persistently placed food in his mouth and in other ways tried to encourage an appetite for it. Following two or three days of unsuccessful attempts, the patient was fed by tube and intravenous drip. According to the account of the incident, the diagnosis was revealed by chance - a paralysis (of physical origin) affecting the muscles of swallowing, which subsequently responded to treatment. With some evidence of guilt and distress the student ran mentally over the perils of trying to feed a paralysed patient by ordinary methods. It had obviously made a deep impression upon him.

The second example illustrates the unnecessary risks run by nurses because of ignorance of the facts. In another hospital, a nurse related how she had been ordered to insert medicated vaginal pessaries, but her instructions had included a clause to the effect that if the patient proved recalcitrant, it was better not to pursue the matter. No indication was given as to why the pessaries had been prescribed, but the "optional clause" aroused her interest, and after some enquiry she discovered that the patient was suffering from gonorrhoea. In neither of the instances quoted were the case notes available to the nursing staff, and they were, therefore, dependent on what they were told verbally or in the report. Experiences as emotionally traumatic as these can hardly
be expected to encourage the self-confidence and eagerness to assume responsibility, which are normally associated with professional status. In place of these attributes are bred anxiety, fear and distrust, — perhaps to be replaced later in the nurse's career by apathy or even the "aggression", which one overwrought and untrained member of staff mentioned as the sole quality desirable in a mental nurse.

In addition to poor doctor/nurse relationships, staff relations, existing between senior and more junior nurses, were also frequently afflicted with the same problem of communication. In none of the four hospitals was there, for example, a regular office hour during which members of the nursing staff could consult the matron without prior appointment. Only 3% of the nurses interviewed (all of senior grade) stated that they were permitted direct access to her office, whilst 68% explained that it was necessary to request an interview through a more senior member of staff who frequently required to know the reason for the request. Twelve per cent thought it necessary to apply in writing for such a meeting and another 3% thought a telephone call should precede it. The remainder had never had cause to make contact with the matron and were unaware of the procedure. Informal meetings seemed to occur most easily during ward rounds and indeed in three of the hospitals, the matrons were seen to deliberately seek such contact with all grades of nursing staff. Whilst appreciating these gestures of friendliness, certain nurses expressed a desire to be able to talk to their "employer" with both less formality and more privacy than the traditional means of access demanded. Although the institution of an "office hour" might prove time consuming, the findings of this study suggest that dividends in terms of staff relations and general release of tension would be very worthwhile securing.

1. The degree of formality depended on the matron herself, and on the expectations of staff. Consequently, some rounds were more formal than others.
Tensions within the ward itself and occurring between the nurses, doctors and therapists might equally well be resolved by ward meetings referred to in the section on "training".

and
"Group training in Elizabeth Maitland Unit". Shackleton & Pool. Nursing Mirror 16th October, 1959, where the value of discussion groups, to both staff and patients, is recorded.
SECTION VIII

Recruitment and Selection

In theory, the selection of students for the mental field was more rigid than in practice. At each hospital the prospective nurse was personally interviewed; he/she was expected to produce two references, if possible one relating to academic ability\(^1\); one hospital carried out a routine intelligence test although this was not interpreted by a qualified psychologist and two other hospitals administered a test if "in doubt" or once the student entered the Preliminary Training School. The remaining hospital relied on the tutor's judgment. Two hospitals specifically mentioned that an application form had to be completed and one hospital took the student on a conducted tour of the wards and also to the training school. Only one hospital stated that they actually carried out their own medical examination but another mentioned the necessity for a doctor's certificate of fitness. The lowest age of entry was given as 17\(^{1}\) years in one hospital; 17 years nine months in another and 18 years in the remaining two; whilst all gave 35 as the normal upper age limit. "Orderlies" were however accepted at a considerably younger age in at least one hospital, and the upper age limit was not always adhered to rigidly if possible candidates presented themselves. It was evident that in practice the acute shortage of staff sometimes forced the

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\(^1\) At present there is no minimum educational standard of entry.
hand of the selecting matron to accept candidates of a lower standard than was considered ideal. Amongst these people one would expect to find a high degree of wastage. In all four hospitals, selection of other grades of staff followed much the same pattern, with the exception of the assessment of intelligence.

In every hospital the observer was told of the difficulties of attracting and recruiting sufficient numbers of staff with both the intelligence and personality required to perform the work satisfactorily. This was indeed borne out by statistics. Of the combined staff, more than half had left school at 14 years or less, whilst 80% had left by the age of 15. Only 3% had continued studying until 18 years or more and amongst these could be found a proportion of "atypical" mental nurses made up of foreign men and women who, whilst holding professional qualifications granted by overseas colleges or universities, were unable to follow the career of their choice in this country. The figures were further boosted by the replies of temporary nursing assistants, some of whom were university students on vacation work. The situation was not much better when trained staff alone were considered. Fifty-two per cent had left school by the age of 14 and 77% by 15 years. Less than 3% had continued to the age of 18 and the majority of these were found among the most junior grade of trained nurse. Amongst the students, 72% had left school by the age of 15 years whilst only 4% had continued schooling till 18 and not all of this latter group intended staying in mental nursing.

In reply to the question concerning leaving certificates, only 3% of the entire staff were able to quote success in any of the following examinations:— Matriculation, General Certificate of Education (ordinary or advanced level), Senior Leaving/Higher Leaving Certificates or their
foreign equivalents. Two members of the permanent staff held degrees, (one foreign) and of these two nurses, one has since died and the other retired from the field in order to emigrate. A few (1%) stated that they held domestic science qualifications of some kind; a further 2% reported a commercial training and 1% held some diploma or certificate other than nursing.

Although it was difficult to analyse replies to the question on previous types of employment, certain trends emerged very clearly. Only five of the combined staff had been employed in work which has been classified by the Registrar General as "professional" or "intermediate" i.e. social class I or II. The most popular appeal had been made by occupations (in social class III) such as mining, clerical, armed forces, shop assistants and "other". Semi-skilled work (social class IV), especially agricultural, had also provided a fairly wide appeal whilst considerably fewer were employed in entirely unskilled work. Nearly 6% of the staff did not answer this question and a further 27% stated that they had never before been employed.

From replies to the previous question, an assessment has been made of the numbers of types of employment in which the staff had been engaged before taking up nursing. Again 1/3 of the nurses had had no prior employment, but 10% had tried either three or four different types of work, sometimes entailing an even greater number of actual posts. One may justifiably assume that with these people at least, "vocation" was not the principal motive behind their choice of profession.

Closely associated with the question on previous types of employment was the nurse's age when he/she first started in the mental field. It was interesting to note that whilst 57% had started in their present occupa-
tion before the age of 25 (some as young as 15 years), 11% had not done so before the age of 40 years, 1% actually being over 50 when taking up this work for the first time.

The assessment of social class, as determined by father's occupation, was hindered to some extent by a certain reluctance to divulge this information (9.5% did not answer the question). By far the greatest number (44% of fathers of the staff) appeared to have been employed in social class III occupations, such as clerical, foremen/supervisors or some kind of skilled manual work. Only 1.5% reported fathers in professional occupations but a substantial proportion of these nurses (23%) were apparently the off-spring of "intermediate" or social class II homes.

The personalities of the staff have to some extent been revealed in their reactions to situations described in foregoing sections, but it is perhaps appropriate to include here some of the qualities which the nurses themselves considered necessary to do this job satisfactorily. Of the 170 interviewed almost 35% (59) mentioned the necessity for "patience" whilst nearly 25% (42) mentioned the need for an "equable temper". Vocation, kindness/sympathy/consideration and emotional stability came next, in that order. Sixteen of the staff thought no specific qualities were required, whilst those qualities least often mentioned were calmness (4), physical strength/health (6), firmness (6), tolerance (7), self-control (7) and trustworthiness/honesty/integrity (8). When the same nurses were asked whether anything they had learned in their work had proved of value to them personally, "understanding and coping with people" headed the list (35%) whilst about half this number mentioned patience, tolerance and insight/ability to cope with personal problems. It was interesting that nearly 12% (20) could mention no specific points of value.
Now and again the interviewer came across members of staff who appeared maladjusted and whose replies to such questions revealed a degree of emotional upset. One elderly trained nurse recounting what he thought had proved of value personally said, "The longer I stay here, the less I care or worry about outside. My brother died one month ago and it did not affect me at all - it was like being at someone else's funeral". Another said, "The job makes you hard-hearted. You wouldn't lose any sleep over a man with his throat cut, although you'd do your best".

Naturally there were others (a larger proportion of nurses) who claimed a greater degree of mental health since taking up this work. Many specifically mentioned that it helped them to "get life in perspective", "to count their blessings" and to understand their fellow men.

Training

The instruction of students in each hospital was geared to meet the requirements laid down by the General Nursing Council for Scotland.

The plan of training envisaged the student's first twelve weeks being spent in the Preliminary Training School, engaged in theory, after which ward experience would follow. In actual fact, owing to the dearth of candidates presenting, most of the students had spent a not inconsiderable period of "waiting time" on the wards before enough people could be recruited to make a theoretical training session worthwhile. After the original period in the classroom each hospital offered students a "block" of four to six weeks' study in both second and third years, plus a variable number of "study days" for revision purposes before examinations.

A somewhat limited operating theatre experience was provided by three of the four hospitals and concerned only a small proportion of their students. Undoubtedly a degree of anxiety existed in connection with this
specific duty, illustrated by the requests of nurses made both at interview and in informal discussion, for more instruction in theatre techniques. The fourth hospital performed no surgery at all and these students, together with the majority from the remaining three hospitals, were deprived of a valuable period of training in aseptic techniques - an aspect of nursing which was peculiarly difficult to encourage on the wards, under the poor physical conditions already described.

Facilities for private study were also limited, students being allowed access to the classroom for this purpose in one hospital, and possessing two study rooms in the Nurses' Home of a second. Each group of students was allowed to borrow text-books from a small professional library.

Three of the four hospitals provided some occupational therapy experience for at least a proportion of their students, and nurses in all four hospitals were expected to participate in the social activities of patients, which in two hospitals were frequently arranged by the patients themselves. In only one hospital were students employed in gardening, farming or outdoor work and complaints reaching the investigator suggested that even here, the duties were not considered "professional" by the people concerned.

In two hospitals, the allocation of students to wards - (a vital aspect of training) depended entirely on the matron; in another it was the result of consultation between matron and tutor, and in the fourth hospital no specific policy was recorded. In connection with ward experience it was discovered that in two hospitals only adverse reports on progress were discussed with the student; in a third, reports were only dealt with as they arose in informal discussion whilst the fourth hospital provided written reports solely on the classroom progress of
students, so that no record of practical ability existed at all.

To provide students (particularly female) with sufficient experience of the wards by night, posed another problem for administrators. A large number of the female night staff (most of whom had domestic responsibilities) were only prepared to work two or three nights per week and for personal reasons could not undertake day duty. To have transferred them from night duty would have meant accepting their resignations, which the hospitals could not afford to do, and so inevitably there developed an almost static female night staff in at least two of the hospitals. As a result none of the female students in these two hospitals had done any night duty at all although all second and third year male students in each hospital had done at least one period and often more.

Less formal education of the nurse existed in very small measure. Case conferences, conducted by medical staff on the wards, were held in only one hospital at the time of the survey and, unfortunately, on the day on which it was arranged for the observer to attend, the conference was cancelled. Tutorials and case studies carried out by students were an acknowledged part of one other hospital's training programme.

A general shortage of nursing staff made clinical instruction virtually impossible on many wards, and it did not appear to be a regular feature of any of the four hospitals. A ward discussion of cases was only witnessed on one occasion (and restricted to senior nursing staff), and this was by way of an experiment introduced by a newly appointed member of the medical staff. The tensions which so obviously existed between different grades of nurses were almost certainly due to uneasiness caused by an ill-defined rôle, inability to appreciate the contribution which could be made by each member of staff to the welfare of the patient, and

ignorance of the aim and purpose of therapy as related to individual patients. It is probable that most of these tensions could have been resolved had ward discussions been held with the medical staff and all grades of nurse, to verbalise their common goal and the part which each member of the team was expected to play in achieving that goal. From the point of view of training, not only would anxieties decrease through discussion (thus facilitating learning) but contact with doctors and senior nurses would provide opportunity for application of theory to practice, and motivate the student to greater observation and interest in the patient.

Procedure committees, which aimed at securing uniformity of practice in classroom and wards, existed in three of the four hospitals but much of their value was lost in that equipment (e.g. sterilisers) and other necessary provision, such as wash-hand-basins, were not available for use on the average ward.

The senior students of two hospitals were given the option of a little domiciliary visiting in their final year, but the opportunity was not universally exploited owing to the nurse's feeling of inadequacy in coping with this strange situation, for which some felt insufficiently prepared.

In none of the hospitals were nurses given experience in out-patient clinics or child guidance work, and facilities such as day hospitals and out-patient social clubs were available nowhere within this group.

Case assignment existed in a modified form on some wards where a nurse (either trained or nursing assistant, but rarely student) accompanied a group of patients to work in the gardens or grounds of the hospital. A more intimate relationship with patients was, however, achieved in the two deep Insulin Units where the small groups of patients

concerned, were the responsibility of the same staff for six of the seven days each week.

The writing of case histories by nurses occurred sporadically but was deprived of much of its motivation by the lack of interest exhibited by the ward doctor and other associated disciplines. On one ward however, it was specifically mentioned that the medical officer had found the nurses' notes of considerable value in assessing the progress of patients over a period of time. Having seen the fruits of their labours put to some practical use, the nurses had been encouraged to continue recording their observations, with the achievement of mutual benefit.

At the time of the survey there was no organised in-service training for nursing assistants operating anywhere. Refresher courses and study days for trained staff were, however, gaining favour in the region generally and a greater degree of inter-hospital contact was occurring.

In none of the hospitals were both tutor and matron entirely satisfied with existing educational programmes and comments ranged from complaints against the "unrealistic approach of the mental nursing syllabus", to requests for a "comprehensive mental and general nursing training".

**SECTION IX**

**Health**

The sickness absence among these mental nurses was low; 39% of the staff recording no absence from work through illness during the previous three years (or since being employed if less than three years). Five per cent did not answer the question at all and it is probable that most of these too, had no sickness absence, although some with a relatively

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1. For advantages of individual care see "Case assignment in a mental hospital" Tyson. *Nursing Mirror* 6th June, 1958.
high incidence of sickness may have been unwilling to record it. A further 31% had averaged a week or less per year during the three years, leaving approximately 1/4 of the staff distributed between "four weeks" and "over 99 weeks" (one nurse).

"Infectious" diseases, affecting 26% of the staff, headed the list of illnesses mentioned, influenzal infections being responsible for the vast majority. Other respiratory diseases had affected 12% of the nurses, with orthopaedic (just over 6%) and gastro-intestinal disease (5%) occurring next in order of morbidity.

In addition to acute illnesses, there was of course a degree of chronic illness which was not reflected exactly in sickness absence figures e.g. among nurses suffering from relatively mild heart conditions or from peptic ulcers. Although it is impossible to assess accurately how great a handicap such a victim suffers, the reduction in efficiency cannot be ignored altogether when assessing the relationship of health (associated with other factors) to quality of patient care.

SECTION X

Length of Service

In spite of the complaints about poor working conditions and professional frustrations which the mental nurses voiced during the survey, it was interesting to note that they were not, on the whole, given to frequent changes of hospital. From the 35% to whom this question applied (exclusive of the 15% student population), 22% had given between five and ten years' service in the same hospital, whilst 36% had given over ten years' (3% having given 30 years' or more). Reasons for the lack of
mobility can only be suggested, but it is probable that promotion (by seniority) played an important part in influencing the male staff to stay. To this might be added the traditional fear of unemployment which undoubtedly existed amongst some of the older staff and which was possibly due to their experiences during the pre-war years of economic depression.

Desirable as a degree of stability may be within a psychiatric unit, the lack of movement from hospital to hospital was almost certainly responsible for the slowness with which new ideas and attitudes had spread and was consequently to be deplored. The problem was further exacerbated by difficulties in securing housing which also influenced decisions to move or remain static.

SECTION XI

Morale (or efficiency)

From the preceding passages it must already be obvious that morale, indicating efficiency, was seriously affected by the conditions already described.

A low standard of asepsis proved one of the most outstanding problems with regard to physical care, and arose principally out of a shortage of equipment (e.g. sterilisers), a lowering of professional standards (often for want of adequate supervision) or just lack of knowledge.

Examples of poor aseptic technique were legion; responsibility for allowing such conditions to persist was equally divided between medical and nursing staffs, e.g. on none of the wards, where E.C.T. was performed.

1. Whilst poor morale and poor efficiency are not necessarily co-existent, they frequently have common determinants, (See 'Group Dynamics' Ed: Cartwright & Zander p.625) and, as occurs here, may be closely related.
were anaesthetic masks routinely sterilised between patients: a doctor's request for this to be done would have remedied the situation immediately. Another example will illustrate this joint responsibility and its significance. It has been quoted in some detail because it is regarded, by the writer, as of extreme importance. On one of the wards of a somewhat old building, a lumbar puncture was observed. One or two bowls and receivers had been boiled over the gas in the kitchen where the trolley had been assembled. When preparation was complete, the equipment was wheeled through to the ward. Masks were not worn for either setting the trolley or carrying out the procedure itself. The doctor scrubbed up in a china bowl of warm water on which, ere long, appeared an unavoidable layer of scum. As the surface of the trolley had not been prepared aseptically, it soon became obvious that only one receiver on the top, containing the lumbar puncture needles, was in fact "sterile" and with this piece of equipment the doctor attempted to work. Scattered around the receiver was a selection of bottles and unsterile containers lying side by side with adhesive tape and a pair of scissors, just removed from the pocket of a nurse. The syringes, which had been autoclaved, were found at the last minute, to have no needles.

Operating a pair of Cheatles forceps, the trained nurse assisting, handed the doctor the swabs from the drum, one by one. Iodine, (which had to be fetched), was poured straight out of the bottle and on to the swab. When the first injection of local anaesthetic had been given it was found that no sterile surface existed anywhere on which to lay down the syringe. After a number of similar incidents, the procedure terminated with a nurse attempting to pass to the doctor (by hand) a receiver full of "sterile" water, (heavily loaded with deposit from the kettle).
The patient recovered without incident.

It has already been seen that standards of general hygiene were frequently associated with working conditions and the quantity or quality of equipment available to the nurse. Inadequate supplies of toilet commodities led to the use of "communal" towels and face-cloths, and in some wards it was the practice of the staff to use the same piece of surgical lint to wash the soiled backs of a number of incontinent patients. Lack of equipment was not however always the cause of low standards, for it was not unusual to see the same water used for treating the backs of more than one patient. Insufficient supervision also played its part—particularly with relation to surgical dressings where faults of technique were difficult to correct in the absence of adequate skilled oversight. A second contributor to decreased efficiency was misunderstanding of function, often associated with poor teamwork and poor communication. In one ward, a patient recovering from a burns accident was charted for four hourly recording of blood pressure. The nurse, a conscientious and skilled man, perceived that sleep was of first importance to the patient at this stage of convalescence, and omitted to waken him for the procedure at 2 a.m. Having had no opportunity to discuss this omission with the medical staff, and possibly afraid of the consequences of his action, he recorded a fictitious blood pressure to the satisfaction of all concerned. It is probable that discussion with the medical staff would have led to the same course being adopted legitimately, but such discussion did not take place.

On many occasions the observer met examples of sensible modification of ward routine, but too frequently the nursing staff felt compelled
to apologise for their action. On one ward a nurse, seated at the bedside of a patient and absorbed in conversation with him, sprang guiltily to his feet when conscious of the writer's presence. Another found it necessary to explain in detail why a young active schizophrenic should be allowed to stay up later at night than other older or more deteriorated patients.

At the opposite end of the scale were the nurses who, again misunderstanding their function, imposed unnecessary restrictions on activity. In one ward, an intelligent, if disturbed, male patient told of his inability to conform to certain standards of behaviour, such as only rising from the table when given the signal to do so. Following several other minor breaches of discipline, which had been reported, he was moved to a second ward where there was virtually no one capable of sustaining a normal conversation for more than a few seconds. There was no doubt in his mind that this move was directly associated with his previous behaviour, and he had interpreted this as punishment for rebellion against regimentation. With tears in his eyes the patient explained that he had been admitted to hospital following an attack on his wife, with whom he was now reconciled. In an effort to make some reparation for the wrong he had done her, he had started to weave a length of cloth which could be used to make her some article of clothing. However, the cessation of occupational therapy had accompanied his transfer of ward, and now he felt there was nothing that he could do to illustrate the sincerity of his affection. The observer is not competent to assess whether the patient was right or wrong in his assumptions concerning treatment, but it was obvious that such an

emotional reaction demanded highly skilled and sensitive handling on the part of the nurses concerned. An equal amount of sensitivity was required in dealing with foreign patients who were not only mentally disturbed but under the additional stress of needing to express themselves in a language other than their mother tongue.

In certain wards it appeared that "conformity" was the criterion by which the patient's progress was assessed, those who achieved the greatest degree being adjudged "good". Thus regimentation was sometimes carried to absurd lengths - the most extreme example being a ward where at a call, "polishers", a team of six male patients appeared complete with tins of wax and heavy duster-covered mops. In perfect time they swung their "bumpers" to and fro, advancing steadily down the ward, completing their task with the precision of robots. That they were reasonably content, some even happy, was indisputable but of the ultimate therapeutic value or purpose of the task, there was little indication.

The exclusion of the nurse from the team usually implied that her rôle was frequently misunderstood by others as well as herself. The dearth of professional information concerning patients and the lack of guidance, led to a blocking of the nurse/patient relationship. Whilst it was considered "right" for the nurse to mark clothes, polish floors, even in extreme cases "plant cabbages", little practical assistance was forthcoming when she was faced with a patient anxious to discuss his motivation for suicide, or another whose aggressive tendencies threatened to disrupt the ward's peace. She had already discovered for herself that while a pat on the arm might temporarily comfort a patient, it contributed little to the solution of his fundamental problems.

1. from either medical or senior nursing staff.
Many of the same factors contributed to unprofessional behaviour and the existence of "lay" attitudes to the work. Inadequate preparation of the nurse was sometimes responsible too. In one hospital, a senior member of staff was distressed to hear what she considered irreverent and callous mirth from two nurses escorting a patient to the mortuary. This attitude may well have been unconsciously encouraged by economy measures, which resulted in some wards supplying no shrouds for the last offices. In another hospital, a student related unconcernedly how he had laid up the appropriate trolley in anticipation of a patient's death, and how the last offices had been performed as soon as that state was confirmed. Several nurses had found this lack of a reverent approach towards death, induced by a shortage of necessary equipment and time, a distressing feature of mental hospital life.

Thoughtlessness was another cause of unprofessional behaviour. Because many of the patients were senile or too deteriorated to appreciate privacy, treatment was sometimes carried out without screens. This applied particularly to dressing or undressing patients, some of whom did not make matters easier by their general restlessness and tendency to roam during the operation. Indicating that it was time for bed by a semi-humorous thumbing movement, in the direction of the stairs, was again behaviour to which many patients had not been used, before admission.

Shortage of staff produced other peculiar situations such as the wards for which patients were virtually responsible. This might entail supervising the activities of other patients, making their beds, attending to their backs and ensuring that nothing went wrong. Where a nurse
was on duty alone and in charge of widespread units, such delegation of responsibility was inevitable. To a lesser degree, the authority afforded nursing assistants by night was in some ways comparable, in that they, as untrained staff, were on occasion, responsible for acutely disturbed patients.

From time to time the investigator came across routines which were apparently carried out only because they were traditional. The strangest of these was "blocking the bed" and was only observed on one ward, though it was said to exist elsewhere. The procedure entailed making all the beds up in a type of operation pack, first thing in the morning. During the day, the pack was left on the bottom of the bed over a sheet, which was pulled very taut. Later on, the beds had to be re-made in the normal way. On another ward the lunch table was routinely set at 8 a.m., in spite of the fact that patients were forced to use the same area of space as a sitting room.

Very often, of course, both nurses and patients were the victims of circumstances. Shortage of trained staff in one hospital made mass sessions of E.C.T. inevitable. The technical procedure was highly efficient, but the herding of patients in such close proximity gave the observer the feeling that all individuality had had to be sunk for the sake of expediency. Although each patient was screened before the administration of the "shock", it was still possible for patients awaiting treatment to witness the various stages of unconsciousness experienced by those who had already received it. The effect of "mass production" was further heightened by measures taken to ensure that each patient received the right amount of pre-medication.*

*For more detailed discussion of procedures related to drugs see Appendix IIIA.
Standing together in the middle of the ward, the patients waited for their names to be called and, in order, slipped into the next vacant bed in preparation for their injection. Syringes, which had been prepared in the same order, then lay ready for use when the anaesthetist appeared.

Considerable anxiety was generated by the need to lock patients in remote single rooms or other sleeping accommodation by night. Inability to leave large dormitories of patients for whom she was responsible, often prevented the nurse from doing regular rounds of single wards, which then became the duty of the night superintendent. Thus, theoretically, in the event of sudden illness or fire, discovery would be postponed until this routine inspection occurred. It was amazing how few such incidents were met with in practice.

Supervision of patients' meals depended on a variety of factors, not least the number of staff available to serve food and encourage socialised behaviour at these times. Some of the problems have already been described in detail, but attention should be drawn to situations occurring in the first instance, through a breakdown in communication such as the following:

In one ward, patients awaiting E.C.T. were given premedication, consisting of Sodium Amytal grs. iii and Atropine gr. 1/150th at 9.15 a.m., following breakfast (one slice of bread and a cup of tea) at 7.30 a.m. It was not until 12.30 p.m. that the doctor arrived to carry out the treatment, by which time the effect of sedation had worn off and the patients had been unnecessarily starved for three or four hours. This, however, was not the end of the story, for lunch was served at 1 p.m. Three alternatives presented themselves:—

1) patients could miss their
lunch altogether, in which case they would get no food until evening, 2) they could be taken in a dazed and unfit condition to the "halls" where they would probably require feeding or 3) food could be brought back to the ward for them, but in view of the lack of facilities of any kind to keep it hot, this course was not popular. A little discussion between doctors and nurses would probably have meant earlier treatment, earlier recovery and the abolition of a great deal of discomfort and even anxiety for the patient.

In many wards use of the nurse's initiative in difficult situations could only arouse the greatest admiration. One ward, housing a large number of old folk, was faced with the problem of keeping them warm and, at the same time, postponing the processes of physical and mental deterioration. The ward sister hit upon the idea of working a "shift system" among the patients. Early in the morning the nurses began to get up a proportion of elderly patients, who sat by the fire for two or three hours and were then got back into bed. Meanwhile, a few more would be helped from bed and would enjoy a period of warmth and company. As the sister explained, in order to look after the patients' purely physical needs, the nurses were forced to return the first "shift" to bed at 2.30 p.m. In winter, the work was made even heavier by the introduction of daily hot baths, for those patients most likely to succumb to the cold weather.

During the period of observation, it was noted that extreme concern for the physical welfare of the patient was frequently associated with anxiety, resulting from inadequate instruction regarding nursing care. Sometimes the incident was a relatively trivial one, such as the occasion when the observer was asked to read a thermometer for the nursing
assistant in charge of a ward by night. On other occasions it was far more serious: in one ward the student in charge made two unsuccessful attempts to give an injection, after which a request was made to the observer for instruction. Elsewhere, advice was sought as to whether or not a patient who had collapsed required the services of a doctor.

This same lack of instruction and supervision led to errors in routine nursing of the patient. In one hospital, surgical spirit was being applied to an open bedsore, and in spite of the patient's complaints, because it was the accepted mode of treatment for unbroken skin. Elsewhere a patient, who had been diagnosed "coronary thrombosis", was allowed up to the toilet, even though his condition had obviously deteriorated since the doctor had allowed this concession. In another hospital, an elderly patient with a recently fractured femur was being nursed flat on his back, in spite of marked evidence suggesting the onset of hypostatic pneumonia. In yet another hospital, anxiety regarding surgical technique allowed the nurse in charge of a ward to leave a "daily" dressing for two days, until the return of her second in charge (who had more confidence), rather than risk doing the wrong thing in her absence.

During the interview, over 50% of the staff who voiced an opinion, thought their preparation for the work had been inadequate. Nursing assistants were particularly persistent in their requests for instruction in physical procedures, such as how to lift patients, whilst more senior staff expressed anxiety on subjects like "legal aspects of mental nursing", and their ignorance of the psychiatric and physical states of their patients. One trained nurse said "Many a time a patient has dis-
charged himself because, not seeing the case notes, the nurse didn't know what the patient was getting at. Concerning the physical aspect, another trained nurse said, "You're not told enough about the patients. You could have a man dying in the ward and not know what he's dying of. Your only guide is the drugs he's on."

**Fear of dismissal**, though it should not be overemphasized, was undoubtedly present in the mental hospital field. A number of factors may have contributed to this, such as the insecure background of some of the older staff (e.g. those employed during the economic depression of the twenties and thirties); the increase in litigation of recent years, and anxiety arising out of an obvious change in role from custodial to therapeutic care. Fears of this nature were illustrated principally during informal discussion with the observer, but were also reflected in the need for repeated reassurance concerning the confidentiality of the questionnaire, and the reluctance of many to express their views in writing. As the survey proceeded (without evidence of "victimisation"), so it became more fruitful, but even in conversation a certain amount of fear existed. One nurse who provided many extra comforts for the patients out of her own pocket, and was genuinely concerned with their welfare, hinted on several occasions at the serious mismanagement of ward affairs. After a conversation in which she had said, "It's not necessary to bully the patients; they work without it", the observer tried to pursue the subject. In reply she was told, "You (i.e. "one") can't say anything without having proof." (i.e. a witness). "If you made any complaint, you would go - things would be made too uncomfortable for you." A student, elsewhere, who confessed to witnessing much
the same treatment of patients, informed the observer that he, too, had been afraid to report the incidents because of the consequences. He wondered if his word would be taken against that of a certificated nurse, or whether an additional witness of the events would be required.

A second student, who had been accused of unnecessarily rough handling of patients, related with considerable emotion, the ensuing disciplinary interview. He maintained that had he known the nature of the patient's illness and his expected reactions, his own defensive behaviour might have taken a different course. Another nurse, complaining of lack of instruction about management of disturbed patients said, "You're not taught how to restrain patients. It's just sense. You're told never to hit patients, or attempt to break up a fight alone - but sometimes you have to hit in self-defence. There's trouble if you mark a patient."

It must not be assumed from the foregoing passages that rough handling of patients was a common feature of life in these wards. Although exasperated nurses occasionally lost their delicacy of touch, only one outstanding example of manhandling was witnessed. The observer, entering the ward at the beginning of her spell of duty, too late to witness the preceding events, was in time to see a nurse jump on the back of a patient and bring him to the floor. On enquiry she was told that the patient (an epileptic) had been "setting about" the nurse, and "you have to show who's the boss". The nurse added that that type of behaviour was common on the ward, and certainly he appeared little disturbed by it.

The necessity (if necessity it were), to act in this manner might well have been behind some of the fears of litigation and dismissal.

A trained nurse of some intelligence, conceding the existence of this fear of dismissal among the older staff, suggested that their appar-

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1. Cf. accusations of Paul Warr "Brother Lunatic"
ent obsessional interest in domestic work was merely a reflection of anxiety. If the ward were superficially "clean and tidy", few enquiries would be made about the more intangible aspects of psychiatric nursing. As well as adding to their feeling of security, the activity itself was "anxiety-allaying". In conclusion of his argument he said, "While you're polishing, you can't think - and that's the idea!"
SECTION XII

The main problem

It is obvious from the foregoing description that too little nursing attention of both a psychological and physical nature was available, in these four hospitals, to achieve the complete transition from custodial to therapeutic patient care. Although the problem itself may be so evident, its solution is not as easily achieved. In an attempt to find an answer, the administrator may face the decision between improving working conditions generally - in order to attract more nurses of the required calibre - or alternatively following a policy of more careful staff selection (particularly at student level) in the hope that with the consequent rise in status, a more active part will be taken by the profession, in the care of the mentally sick.

But the difficulties of the administrator are by no means over, for the problem may present itself in different guise as applied to different members of her existing nursing staff; e.g. on page 39 a description was given of a student nurse, who though possessing all the required qualities of sensitivity, technical efficiency and reliability, was herself unhappy and dissatisfied with her restricted rôle. At the opposite end of the scale was the nurse, who content to offer only physical care, was afraid lest greater demands be made upon her. Commenting on her ignorance of
the patients' diagnoses, her whole attitude was epitomised in the words, "This does not interest me. With the trouble I have at home, I don't want to know any more (about the patients)." Kind as she was to her patients, this nurse's contribution to their welfare was restricted to a purely superficial level which made the minimum demand on her own resources. It is obvious then that, during this period of transition, there is bound to be at least one group of dissatisfied nurses. Which aspect should be tackled first in reform?

Because psychiatry is so essentially a field where teamwork is required, inadequate nursing care must inevitably have repercussions on the medical staff. The discontented and frustrated nurse will transmit her tensions to her patients with unfortunate consequences whilst the nurse, content with only superficial care, can never hope to achieve a truly therapeutic relationship. Where there is no agreed goal in therapy for both doctor and nurse, the former may find that not only has the latter contributed nothing of importance in what is known as "the other 23 hours", but has in fact nullified the effect of the original "one hour" spent with the psychiatrist.

In addition to the problem as viewed by nurse and doctor, there exists the same problem as seen by the community, and which can only be assessed in terms of human suffering. Inadequate nursing care means retarded recovery with longer separation from relatives and friends; an increased fear of mental hospitals and misunderstanding of their function; a greater reluctance to seek psychiatric help in time of need and a general repudiation of the themes of current propaganda.

One factor emerges as indisputable - if the nurse is not contributing as fully as possible to the recovery of her patients, she has failed to fulfil her function.

When examining the possible approaches to reform, mentioned above, it soon becomes evident that there are strong links between the two, and that improvement in either working conditions or staff selection would almost certainly affect the other in some way. In this section both material used earlier and additional data will serve to illustrate the argument.

Although only 55% of the staff concerned were employed in town hospitals, 76% of those interviewed preferred a town site to work in, all things being equal, (some being dubious, however, of the desirability of such a position from the patient's point of view). The siting of these hospitals in town might then be expected to attract more nurses even though, at the same time, the administrator be faced with the problem of competition for labour from commerce and industry. An important point to be considered is, of course, whether the nurse who always requires the ready-made amusement of town to employ her leisure, is more desirable than the young person with a capacity for self-amusement. It would seem that a healthy balance of the two is perhaps required. Encouragement of enterprising activity within the hospital itself would, nevertheless, be difficult to achieve without a nucleus of intelligent and enthusiastic nurses supporting such a policy.

In contemplating reform inside the hospital itself, an attempt might be made to improve physical surroundings by altering the colour of paintwork, providing curtains and replacing antiquated furniture with that of contemporary style, such as has been done in some of the wards described.
The assumption here is that the psychological uplift would be sufficient to improve the quality of work of the existing staff, and encourage the entry of new candidates. There is certainly no doubt that practical measures of reform such as the fitting of doors to toilets, the supplying of adequate clothing to patients and the improvement of food are all vitally important, but even more important is the nurse/patient relationship which encourages the degree of socialisation necessary to make use of these toilet doors; the relationship which senses the need of patients to possess their own individual clothing, and the relationship which appreciates the significance and symbolism of food and feeding arrangements\(^\text{*}\) to the mental patient, as well as their intrinsic value. At this point in time, selection of staff becomes of first importance: it becomes essential to recruit those who maintain high standards of behaviour in themselves and are unwilling to lower those standards to conform to what is so often accepted as "normal" in the environment of a mental hospital. Nowhere should "depersonalisation" of the patient be allowed to result from lack of individual attention.

Provision of staff facilities such as duty rooms, changing accommodation and bicycle sheds, whilst not expected, of themselves, to attract more nurses, would at least contribute to a more contented staff and leave no excuse for misuse of existing facilities. Much the same applied to improvement of conditions by night. Additional heating and the supply of regulation capes would remove the necessity for wearing fluffy bedroom slippers and multi-coloured cardigans on duty. Increased numbers of night staff (if necessary, of the assistant grade) would relieve some of the patients of nursing responsibilities, and the companionship thus supplied to the existing staff, might well be expected to increase efficiency, by decreas-

\(^\text{*}\)See Appendix VII page 248. For a more detailed description of food and feeding arrangements.
ing the fear and loneliness which, at present, so frequently surrounds the solitary rôle of night nurse. The overall effect would be a rise in morale and a consequent heightening of awareness of status, which of itself could bear more fruit.

The position with regard to reform of nursing duties is, perhaps, slightly different. At present, little discussion is held with medical staff or other disciplines about treatment (only 13% of the nurses having regular contact with doctors). Teamwork is therefore a rare phenomenon, though very much appreciated where it does occur. In defence of those who supported the exclusion of the nurse from the team, during the survey, it must be recalled that only a very low proportion of the nursing staff had had more than the barest minimum of secondary education (30% having left school by the age of 15). On the other hand, the findings of Stanton and Schwarz suggest that even nursing aides had something to contribute in discussion, and were worthy of access to limited information to assist their efficient functioning. Once again, to solve this problem, not only has the situation itself to be changed, but selection of staff also becomes important, as a means of providing nurses of the right intellectual and moral calibre to carry the additional responsibility of active participation in therapy. A nucleus of suitable and enthusiastic people is already in the field. Here and there they were being exploited but, for the most part, their fund of intimate knowledge of the patient, culled during the "other 23 hours", was seldom put to practical use.

The difficult problem of what constitutes a nurse's rightful duty, has already been referred to earlier in the text. It will be recalled that

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*The Mental Hospital, Chapter 9.*
almost 1/3 of the staffs concerned, considered that domestic work was an acceptable part of even the trained nurse's duties. Over half of the wards never had domestic help of any kind, and housework was traditionally performed by nurses and patients. Such a situation must always be potentially dangerous. Nurses may use cleaning and polishing as a way of evading more demanding responsibilities. An example of this approach was quoted earlier, occurring in the nurse who, surrounded by over 70 patients requiring physical as well as psychiatric care, wondered how the nurses would pass their time without these routine domestic chores. Perhaps the mental nurses' content with "bumper-swinging" may be associated with the need to find an outlet for the anxiety and tension which from time to time occurs and which they attempt to relieve by physical activity. Maybe, as the trained male nurse remarked, it merely "stops you thinking".

That domestic work may be valuable, is clearly illustrated by Freeman et al in "Chronic Schizophrenia". A limited amount of cleaning, performed with a specific motive - that of encouraging the patient to identify with the nurse - may open up the way for further therapeutic measures. Utilised in this manner, to achieve practical results is not only commendable but desirable. Too often, however, this motive was missing and co-operative or team effort, with both nurse and patient was rarely encountered in the four hospitals studied. It would seem then, that domestic work as a means to an end, may be regarded as a legitimate function of at least the less skilled nursing grades, but as an end in itself, should find no place in their duties. Where this policy supervenes, the second potential danger - namely exploitation of the patient - is less likely to occur.

Which then is to be reformed first? Should mental nursing be stripped of its irrelevant tasks or should the emphasis be placed on recruiting only

1. the rhythmic movement of long-handled, manually operated floor polishers.
those clear-sighted enough to appreciate the difference between psychiatrically orientated and non-orientated work. Again the answer is that both are necessary. One point which, however, should not be ignored is that if the nurse is deprived of tension-relieving tasks such as polishing and cleaning, provision must be made for other more productive outlets. What could be better than the ward discussion group, which, in addition to allaying anxiety and encouraging insight, could be used for informal psychiatric education which could only bring greater benefit to the patient?

Training presents another sphere in which changes might well be contemplated. In none of the four hospitals was a comprehensive general and mental training envisaged, and yet under existing regulations both general and mental nurses in Scotland are required to sit the same preliminary examination. The nursing experience which, in practice, the student gained during training, has been shown to be inadequate, a fact of which they themselves were only too aware and which did much to lower morale and sap self-confidence. This then seems one aspect of mental hospital life where conditions must be changed before improvement can occur. The attraction of suitable candidates to the profession cannot be expected, where even these conscious and justified needs are remaining unmet. The frustration and disillusionment of a sensitive and intelligent student (quoted on Page 40), at the age of 26, is both alarming and a warning of what may be expected if work satisfaction is reduced to its minimum, and if training does not fit the nurse for the role which she should be fulfilling. Already the young nurses of today are feeling insecure; it is small wonder then that their seniors, threatened by fear of a complete professional metamorphosis, take refuge in obsessional cleaning and polishing.

Promotion is perhaps a subject which up till this point has received

1. Cf. "The Give and Take in Hospitals", Burling, Lents & Wilson, p.102 where the professional "embarrassment" of the older nurse is described.
scant attention. Most administrators subscribed (in theory at least) to the view that promotion should occur only after full consideration of experience, qualifications, moral and intellectual suitability for the vacant post, and general personality. In practice this was not always possible. Problems of female promotion were entirely different from those of the male staff. The high degree of wastage through marriage and family responsibility, as well as the cutting down of working hours for the same reasons, meant that few full-time females were available for up-grading. Undesirable as the practice was thought to be, promotion for them almost inevitably occurred within a few months of state registration.

For the male, promotion did not come so easily. Domestic responsibility made no difference to working hours (all male staff being full-time). In addition, the married male, as distinct from the single female, (which groups, promotion most nearly concerned) had little incentive to change his hospital once training was completed. Out of this immobility of the labour force, arose the generally accepted (if unofficial) conviction that promotion should depend on seniority, although occasionally an exception might be created in the case of a doubly-trained male nurse. In practice, seniority appeared to be the ultimate criterion of selection for up-grading, although some administrators believed that the more official criteria came into play in allocating the newly promoted nurse to a specific ward or duty.

It was interesting to note that 54% of the staff (just over half of both the male and the female staffs) were satisfied with the existing promotion policy. Some of them added comments to their reply intimating that seniority was the only "fair" way of selecting people for higher posts, and with the use of the word "fair", attention is drawn to the fact that

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1. Holding both general and mental nursing qualifications.
the amount of pension which a man draws on retirement, is dependent to a large extent, on the position he holds at the end of his career. "Unfairness" can have long-lasting effects!

Among those who considered promotion unfair or unsatisfactory, relatively few thought it so on account of the criterion of seniority. One man considered his Trade Union activity had caused him to be passed over; a few objected specifically to the quicker promotion of doubly-trained men, whilst one or two had personal grudges or complaints concerning favouritism, victimisation and the like. Several particularly mentioned the rapid promotion which came to female nurses, emphasising that "You can't put old heads on young shoulders" but realising too, that with the existing staff shortage, many such appointments were unavoidable.

Once again it is impossible to ignore the strong link between reform of promotion policy, and the need for adequate staff selection. If, as one male said, "Any nurse who has passed the examination should be equally capable of taking a ward", then indeed selection, at student level, becomes a duty of the greatest significance with far-reaching consequences.

The opinion has been voiced that with regard to technical efficiency, reform needs to be swift and drastic. In the description which has gone before, it has been seen that the breakdown in efficiency was in fact related to other factors: shortage of equipment; acceptance of low professional standards; misunderstanding of function; lack of communication and inadequate preparation (both formal and informal) for assuming the optimum rôle. Morale was further reduced by the consequent lack of self-confidence and professional poise which only comes from being "on top of one's job". (One nursing assistant, when reprimanded for a thoughtless action is reported to have replied in all seriousness, "I could have managed them (the patients)
if they'd been a herd of cows; if sheep I could have penned them in, but I can't manage these.

To separate the two aspects of reform is well nigh impossible. A nucleus of conscientious nurses, with high professional principles, is essential wherever it is attempted to raise standards, but how great the pressure may be to content themselves with a lesser degree of care, can be illustrated from the comments of a young and effective male staff nurse. "We have a lot of domestic duties which take time that should be devoted to patients. By the time the domestic work is done, you feel tired and even short-tempered with patients, .... . The way food is served is atrocious .... many of them (the patients) are not treated as human beings at all. They're just mental patients (who are) threatened with Ward X - if they don't do as they're told." It is not surprising to learn that a few months later, this same young man, fearful of the process of deterioration, left to take up "further nursing duties" elsewhere. Obviously the battle does not end with selection of good nurses. There remains the responsibility to provide the sort of physical and emotional environment conducive to the healing of the mentally sick.

The suggestion, that psychiatric advice be made available to staff, has already been put forward. From time to time anxiety and tension may be exacerbated by happenings on the wards and the general nature of the work. Many nurses are ashamed of these reactions and loth to discuss them with colleagues. Discussion with some experienced person, removed from the nursing hierarchy and with whom only a professional relationship is acknowledged, might do much to encourage robust mental health. What is perhaps more important, is that an assessment of the candidate's personality be made before breakdown is threatened, or serious crises supervene.
Few people enter any profession from purely altruistic motives, but it is certain that the more blatant "misfits" could be eliminated at a very early stage with the minimum of hurt to both nurse and patient. Physical health, since the advent of the National Health Service, has been principally the concern of private general practitioners, and only in the event of extreme and neglected ill-health does it become in any sense the responsibility of the employing hospital.

The standard of food varied considerably from hospital to hospital. Like the provision of staff facilities, it is perhaps more important in maintaining a happy and contented group of nurses than in actively encouraging fresh recruits. It is worthwhile remembering, however, that food, with its capacity for attracting displaced emotions from other spheres, may be an exceptionally good barometer of emotional health and well-being. Discontented and unhappy nurses, like other dissatisfied people, look for a disproportionate degree of satisfaction from food. As a result, critical faculties are sharpened and complaints may increase. It is equally foolish to ignore the fact that the argument can work inversely – a contented, well-fed staff may be more prepared psychologically to extend the care and attention needed by so many withdrawn and depressed patients. From the foregoing argument, it is easy to see that improved material conditions (in this instance, food) may vitally affect the general morale and efficiency of the hospital.

Only one of the four hospitals was working a shift system, whilst the remaining three worked differing versions of the "long day" (See Page 52). It is almost certain that 13 hour spells of duty were responsible for discouraging some of the younger potential mental nurses, although the older group of staff seemed inured to these marathons. Perhaps, again,

1. Research on selection techniques is at present taking place in the Nursing Studies Unit of the University of Edinburgh.
this was related to a differing conception of the rôle of psychiatric nurse. Concentrated mental effort for such a number of hours, three or four days per week, either makes excessive demands on the stamina of the conscientious nurse or, where full attention is not given to the job in hand, encourages the taking-on of other part-time employment in the so-called "off-duty" period, both of which states are equally undesirable in work of this nature. The nurse with the professional approach, soon appreciates where her duties lie - but as yet there is only a nucleus with a truly professional outlook on mental nursing. We have seen, at the same time, that some of the responsible ward sisters preferred a longer working period than the accepted "shift", in order to achieve continuity of administration. What then will solve the problem? With isolated mental hospitals, the "split shift" for all grades of staff, proves no solution, yet the 13 hour day has been seen to extend beyond the bounds of usefulness. It seems then, that some form of shift system is inevitable and that it must compare with other types of employment providing a 24 hour service to the public. There would, however, seem to be no reason why administrators should be bound to these rigid hours of duty. The ward sister, in complete control of her ward, might be willing, even eager, to modify her off-duty hours compatible with "full control" and comparable to those worked by her colleagues in general hospitals. Alternatively it might be possible for her to modify the shift operating, according to her commitments and responsibility, working from perhaps 3 a.m.-5 p.m. one day; 10 a.m.-6 p.m. the second; 8 a.m.-3 p.m. the third and so on. With a degree of flexibility and initiative the problem would not seem to be insuperable.

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2. The provision of two or more hours off-duty in the middle of the day.
1. Cf. the recommendations of the Report of Nursing Committee Belfast, 1960, for a three shift system.
Since the completion of the fieldwork in 1953, salary scales of each grade of mental nurse have been increased. (For present scales see Appendix VIII Page 257.) In addition to the straightforward increase for trained female staff, additional yearly increments until 1961 will achieve the state of equal pay. It was interesting that even in 1953, 56% of the staff were entirely satisfied with existing rates of pay, and only 16% expressed dissatisfaction with salary scales for mental nursing generally. The remainder confined their complaints to specific grades, the most vocal groups being young male students attempting to support a family on a training allowance (with no extra sum for dependants), and newly qualified male staff nurses who considered that seven years, with little prospect of promotion in the meantime, was too long a period before attaining the maximum salary for the grade.

Whilst the appeal of higher salaries was responsible for the loss of certain members of these grades to industry actually during the survey, and whilst they undoubtedly provided a counter-attraction to recruitment, discontent, on the whole, was less apparent in this sphere than in the spheres of "nursing duties" and relationships. In spite of the fact that equal pay was not operating, 70% of the women interviewed were satisfied with their wages, but only 23% of the men. Certain instances of real financial hardship came to light both in the survey and in the follow-up, some of which resulted in the resignation of the person concerned, (usually a male student) or his taking on a part-time job in his off-duty. Employment thus engaged in, included casual agricultural jobs such as hay-making and potato picking; labouring e.g. with bricklayers, and the making of articles for sale, such as lampshades or rugs. Whereas many of the senior staff felt that such casual labour was incompatible with professional status,
reform could not be seriously pursued when the additional money was essential to tide a man over the "lean years". As yet it is too early to assess whether reform of material conditions - in this instance wages - has helped to achieve the financial independence which was desired, or whether it has had any effect on recruitment. It would seem however, that the danger of attracting the "wrong" people by an increase in salary is no more of a problem than already exists today. The answer inevitably lies in selection.

Investigation of the subject of discipline yielded somewhat unexpected results. Unlike the general hospitals studied by the Nuffield Provincial Hospitals Trust, no-one, during the interview, complained that ward discipline was too strict, although just under 9% thought it variable. Whilst 49% were satisfied with discipline as it was, 40% on the other hand, were concerned at the laxity which existed, showing that in the striving for improved status, a goodly proportion of the nurses were both willing and eager to adopt the sterner discipline and more exacting ethics consistent with professional standards of behaviour. To impose reforms of discipline may be possible in certain limited spheres e.g. restricting smoking to official break-times, but at a more subtle level it is virtually impossible. True etiquette, like other everyday courtesy, springs from a respect for the intrinsic worth of the individual and appreciation of his contribution to the community, which depend ultimately on the type


2. cf. Nuffield Provincial Hospitals Trust 1953 -
   5.1% thought discipline too strict
   53.6% were satisfied
   30.4% considered it too lax

(These figures, whilst applying to female interviews only, were thought by the Nuffield team to reflect the opinions of both sexes.)
of people involved in such relationships. Where active teamwork exists, this respect is fostered naturally and will grow without forcing any issues. Where, on the other hand, rôles are ill-defined and appreciation of function between grades is non-existent, only a false facade of respect can be maintained, which is good neither for morale nor for relationships generally. Again we are forced to acknowledge that staff selection, particularly at student level, is the factor on which the solution principally hinges. When administrators begin to view students as the potential leaders of the future, the criteria for selection immediately become sterner, and both personality and intellectual ability become at least equally as important as the availability of a pair of hands.

Personal discipline provided, on the whole, few problems. Sixty five per cent of the staff reported that their private lives were never affected by any hospital discipline of any kind, and a further twenty per cent only commented specifically on ward discipline, the assumption being that the subject of personal discipline aroused no strong feelings within them. The complaints of the remainder came mainly from staff resident in Nurses' Homes. Some were trivial but others, like that of a young staff nurse, were demanding of more attention. He complained that after 11.30 p.m. the doors of the Nurses' Home were locked, and admission for latecomers was gained by seeking out the appropriate "authority". Whilst satisfied with this arrangement, he, like others, objected strongly to being locked in a building from which there was no egress other than through a window or by the fire escape. As he explained, in the event of illness or other emergency, the male section of the Home was not even in telephone contact with the rest of the world. It was indeed strange to find nurses more concerned with getting out than get-
ting in! Equally strange, to the outside world, must appear the necessity to lock up fully grown men who are also qualified nurses. Although this point of discipline could easily be rectified by providing the trained staff and older students with keys, the solution of the main problem depends on the type of staff employed. There comes a point in every normal person's life when responsibility for his actions and behaviour must depend on himself. If a man is considered mature enough to hold the emotional well-being of his patients in his hands, it is reasonable to assume that he can also run his own life. Certainly, in no other profession are outside sanctions expected to re-inforce a man's personal self-discipline.
SECTION XIII

Setting of the problem

In the preceding passages, an attempt has been made to show how reform depends both on attracting more people to the profession by improving working conditions, and on selecting more carefully those who are to train for the mental nursing field. Emerging clearly from the descriptive sections is the tendency for a "lay" outlook to pervade the environment, and there are very real reasons why this should be so, associated with the profession's close link with the lay community. In addition, inadequate financial resources of the hospitals have imposed physical working conditions such as would have long ago proved intolerable, in other branches of nursing. The existence of sometimes appallingly low staff/patient ratios has produced a lowering of the standards of physical, as well as psychiatric care. Overcrowding has resulted in the acceptance as "normal" of undesirable - even anti-social - types of behaviour among patients, with a tendency to encourage most people to conform to the lower rather than the higher levels of conduct. The indiscriminate application of the term "nurse" to untrained staff, some of whom do not comply with professional standards of ethics, has done little to encourage recruitment or improve the status of mental nursing as such. To add to her distress, the psychiatric nurse, with no clearly defined rôle of her own, has been forced to become a "stand-in" for all and
sundry, ranging from medical officer to laundress or porter, and throughout it all she has not, for the most part, been considered worthy of being told even the barest details of the patients she has been "nursing".

What has been the effect of these conditions on the nurse and her rôle? It may perhaps be summed up in a loss of "vocation" for the work and the infiltration of a "lay" attitude towards the care of patients. Of the nurses interviewed, almost 2/3 indicated, by their replies to certain questions, that morale was low e.g. 54% were of the opinion that mental nursing was not regarded as a profession in the same way as other branches of nursing, and a further 10% had serious doubts of its status. Another illustration of attitudes towards nursing in the psychiatric field occurred in the question on rank order, (Appendix I question34), where 1/5 of the total staff considered mental nursing of lower status than general nursing, and where a further 24% were unable, or refused, to assess their relative standing in the community. It was interesting that in this same question, the person awarded the highest rank most frequently, was the psychiatrist, followed next by the general practitioner, whilst lowest rank went most often to the ward cleaner followed next, at some distance by the bank manager.

A good proportion of the 7% who did not answer the question, remained silent on the grounds that, "All men are equal" whilst most of the remainder did not understand the question or were afraid of its implications.

The "popularity" of the medical profession was interesting in view of the complaints lodged by nurses regarding lack of co-operation in patient care. It may well have been that the aura of secrecy surrounding certain aspects of the psychiatrist's function e.g. interviewing, endowed him with "magical properties" or alternatively, it may have been entirely due to his established position in the hospital hierarchy. The mental nurse had
a great respect too, for the general practitioner, whose status also ranks high amongst the lay community. The low rating of the bank manager is perhaps too complex to pursue in this context but, in passing, it may be pointed out that certain conditions existing in the profession ensured that contact between nurse and bank manager was minimal, e.g. payment of salary was made in cash rather than by cheque, and in some instances weekly, rather than by the month. This resemblance between the nurse and the non-professional worker may have at least contributed to the low placing of one who is generally accorded a fairly high status in the community at large.

Some of this group's identification with the general community may be explained in terms of social background. It has already been shown that only 1\% of the staff came from professional homes (social class I), and of these a proportion were temporary staff e.g. university students working in their vacations. On the other hand, the fathers of 61\% of the staff had been engaged in work ranging from clerical or skilled manual - including service as foremen and in other supervisory capacities - (social class III) to completely unskilled manual work (social class V). A further 9\% did not answer the question. It is not then entirely unexpected that certain unprofessional standards of behaviour such as "thumbing" patients up the stairs, or tossing them toast by hand, or using the same washing water for more than one person, should be met with on certain wards. Nevertheless, it is unfortunate that professional education has been inadequate to achieve a modification of these tendencies - or better still their replacement by a more professional code of behaviour. It would seem that in the psychiatric field particularly - where so much stress is now being placed on rehabilitation and re-education - the example on which the patient so often patterns his own behaviour, should be the best available. It is also important that
in a field where staff shortage necessitates untrained nurses being in charge of wards, selection of even the lowest grade should not be undertaken without due thought for the consequences.

Residence and kinship, two more factors which were closely related in this context, tended to reinforce the link between mental hospital and lay community. During the period of maximum unemployment earlier in the century, it was common practice for hospitals to impose a "radius ban" on staff. This ensured that recruitment of nurses was restricted to those coming from outside a certain radius (e.g. 40 miles in one hospital), thus reducing the ties of staff with the immediate environment, to a minimum. In these four hospitals during the survey however, 67% of the staff lived within five miles of their hospital and, particularly in the country areas, had strong links (both of blood and socially) with the outside community. With the rescission of the radius ban, fresh problems of discipline inevitably developed. Respecting the confidence of the patient assumed greater importance, for the temptation to discuss with one's neighbour the illness of patient X - a mutual acquaintance - immediately became greater. Mental nurses, no longer living in the self-contained community of the hospital, sought their amusement outside too. Desirable as this was, it is easy for conversation to degenerate into gossip, particularly in an atmosphere where "guessing the patient's diagnosis" and "speculating on his prognosis" is a current feature of the rôle of the mental nurse.

The provision of varying numbers of hospital houses encouraged male nurses to settle around the immediate area and in turn, their relatives have been encouraged to take up the same type of work. It is not now uncommon to find complete families employed in nursing duties in the same hospital wards (a factor which can affect discipline), and over 1/3 of the staff
stated that they had relatives who had been, or were engaged in mental nursing, illustrating how strong was the kinship tie within the profession.

Reasons for choice of a specific hospital to work in, again closely linked with residence and kinship, showed quite a marked tendency to regard the hospital from a lay standpoint. Only 2% had selected a hospital for its reputation as a training school, whilst 44% had done so to join relatives or friends. A quarter of those interviewed had chosen a hospital "near home" and in the case of 9%, unemployment had played some part in influencing their decision to assume mental nursing duties.

From a physical or material point of view, the wards have already been described in some detail. It has been seen that although redecoration and modernisation were occurring in all hospitals, working conditions in certain wards were still very poor. In every hospital, the observer was told the same sad story of financial restrictions, and limitations placed on plans for improvement and, in one hospital, during the survey itself, a cut of £2,000 per annum in expenditure was imposed. Even where the staff were sufficiently stimulated to seek to improve their working environment, their efforts often brought forth little fruit for purely financial reasons. In a phase of depressed frustration, one young psychiatrist, who was fighting a battle to obtain more occupational therapy materials, remarked that "X hospital cannot even afford to buy what many others could afford to waste".

A significant difference between conditions in general and mental hospitals, was illustrated by the existence of the trade union movement in the industrial sense. Membership of the union (usually the Confederation of Health Service Employees) was encouraged by a number of factors, the
most interesting being fear of dismissal and fear of litigation as well as the exclusion\(^1\) of a high proportion of the mental nursing staff from membership of the Royal College of Nursing, the largest professional organisation associated with nursing. There is little doubt that their exclusion from membership has caused some of these nurses to give allegiance to the unions, whilst others have reacted by seeking to form yet another professional organisation for psychiatric nurses alone. That they should feel ill-used in this matter is understandable, particularly when it is seen that, as students, they are **encouraged** to join the Student Nurses’ Association (an affiliated body of the Royal College of Nursing) yet, on qualifying, are denied the privilege of full membership afforded general trained nurses. It must be admitted however, that not all psychiatric nurses joined trade unions in protest against professional discrimination. Some, identifying with workers in industry and on the land, saw nothing strange in linking themselves with non-professional employees of the National Health Service, even though one would expect the professional and the lay focus of their problems to be somewhat different. In the present survey, 37%\(^2\) of the staff stated that they belonged to a trade union, whilst a further 7% claimed membership of either a hospital social club or a trade union, but did not specify which. The degree of interest in patients and their relatives, shown by a proportion of these members

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1. Those excluded from membership by the College were all the mental trained staff not holding a general nursing certificate as well, and all the male trained staff, whatever their qualifications.

2. Actual membership may have been higher but some nurses admitted fear of victimisation and may not have revealed their allegiance in writing.
was clearly illustrated by the altruistic reforms for which they were responsible e.g. clearer sign posting to wards, the securing of more diverse leisure occupations for patients, and the obtaining of more adequate payment for patient labour. Others, however, regarded the union principally as an "insurance" against dismissal or litigation, of which there appeared to be a very real fear. But, whatever one may feel about the presence of trade unions in mental hospitals there can be little doubt that, in the opinion of her nursing colleagues, the psychiatric nurse's involvement in union activities has done little to improve her professional status.
SECTION XIV

The focus of the problem

The focus of the problem then, would seem to be in the factors affecting recruitment and selection of staff, rather than in rapid turnover, for, as may be seen in the following table, undue mobility of the labour force presented few problems in these four mental hospitals.

<table>
<thead>
<tr>
<th>Length of service in hospital</th>
<th>Hospital I %</th>
<th>II %</th>
<th>III %</th>
<th>IV %</th>
<th>I - IV %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year</td>
<td>8</td>
<td>17</td>
<td>15</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>1 yr. less than 5</td>
<td>17</td>
<td>19</td>
<td>14</td>
<td>27</td>
<td>19</td>
</tr>
<tr>
<td>5 less than 10</td>
<td>29</td>
<td>25</td>
<td>23</td>
<td>25</td>
<td>26</td>
</tr>
<tr>
<td>10 less than 15</td>
<td>17</td>
<td>19</td>
<td>19</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>15 less than 20</td>
<td>11</td>
<td>6</td>
<td>6</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>20-29</td>
<td>13</td>
<td>6</td>
<td>11</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>30 yrs. &amp; over</td>
<td>3</td>
<td>8</td>
<td>5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>No answer</td>
<td>1</td>
<td>-</td>
<td>6</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>% with more than 5 years' service</td>
<td>73%</td>
<td>64%</td>
<td>64%</td>
<td>67%</td>
<td>69%</td>
</tr>
</tbody>
</table>

TABLE V
Distribution of staff according to length of service.
It is interesting to note that well over 2/3 of the staff had given more than five years' service in the same hospital, whilst 15% had given over 20 years', and it is suggested that the policy of promotion by seniority alone, which these figures reflect, may even have led to a stagnation of thought and action. To illustrate this point, the reader is referred back, once again, to page 66 where an older member of staff was having difficulty in accepting a new approach to the treatment of alcoholism. Whilst undoubtedly some of her attitudes resulted from an ill-defined rôle (even at a senior level), in this instance, as in others, lack of movement from hospital to hospital, and area to area, also played a part.

In passing, it should be pointed out that the low percentage of newly employed staff occurring particularly in hospitals I and IV, and quoted in table V, is not entirely due to poor recruitment in the previous twelve months. It illustrates, in addition, a point made by several of the senior staff themselves; namely that shortage of money prevented them from employing a proportion of even suitable candidates now presenting.

But as the writer mentioned earlier, the main problem stemmed from inadequate selection of staff. The effect on technical competence has already been illustrated to some extent:—lack of ordinary day-to-day hygiene; inaccurate reporting and recording of the condition of patients, and misunderstanding of function, with resultant custodial rather than therapeutic care. Medical staff were responsible for drawing attention to other examples of inefficiency, such as the development of abscesses through contaminated injection needles; the danger to epileptic patients from the use of soft feather pillows supplied by inexperienced nurses, and problems arising out of the promotion of unsuitable persons to positions of authority.
The most serious professional effect of low technical competence was the loss of status with the other related professions, particularly the medical staff. The lack of communication occurring between the two groups, led to even greater technical inefficiency and misunderstanding, and was in turn responsible for a further decline of confidence in nursing staff. Gradually the problem assumed the shape of a vicious circle from which even the best and most competent nurses were to suffer the effects.

It is not surprising then, in view of the resultant lowering of status, that self-assessment was also low, and this was reinforced by two major factors; firstly the social and educational origin of a high proportion of the staff and secondly, the experience of working in an ill-defined occupation. In spite of the increasing amount of general nursing occurring in mental hospitals, only 5% of the staff had any training in that field. The attitude of some nurses was illustrated by the man who informed the observer that, now the trade union had decreed "that general training is not necessary for senior posts, there is no point in doing it". Moreover, the difficulties of acquiring additional certificates must not be underestimated in a population where 30% had left school by the age of 15 years, and where few had had effective studying habits inculcated at an early age.

The confusion existing over what comprised the nurse's function, was responsible for a further loss in status and in self-regard. As several of the nurses said, "When the patients see you with dirty hands and aprons, on your knees cleaning out the fire-place, they just think of you as servants and treat you as such". There was even evidence that some nurses

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As one sister said, "We don't want to know personal details - just the illness, what to expect in behaviour and line of treatment. We could be more use to the doctors then".
regarded themselves as nothing more, and were prepared to spend most of each day in duties which proved anything but satisfying to those interested in psychiatry and its practical application in the care of patients. Job satisfaction then, also plays its part and depends to a large extent on what the nurse expects to get from her work, and whether in reality this is forthcoming. There is little doubt that those with the highest concept of the terms "medicine" and "nursing", were the most disappointed by the actual harsh facts of reality, and the more distressed by the obvious status of those employed in occupational therapy and social work departments.

A lack of identification with truly medical purposes could be seen to obtrude from time to time, and once again, this was closely linked with the lay background of certain nurses. Illustrations occurred in the tendency to attach blame to a patient for his behaviour rather than looking for a cause and attempting to cure it. In an earlier section, a nurse was quoted on how patients were sent to Ward X if they did not "conform". The lay attitude was further illustrated by the day-to-day connotation of the word "neurotic" rather than use of the word with its medical interpretation. As a result, one frequently heard comments that neurotics were just in "to dodge responsibility" - or "you don't know how much of the illness is genuine and how much imaginary" or they were "too pampered". This was particularly astonishing in view of the obvious handicaps under which certain patients were placed by their illness e.g. fear of being left alone, or even of stepping outside their own front doors.

Perhaps associated with the nurse's ill-defined rôle and lay attitudes, was the subject of overtime and payment for it. At the time of the survey a 96 hour fortnight was officially operating, but nurses were frequently
requested to work additional time escorting patients to parties and cinema evenings, engaged in extra-ward duties or even just filling the routine gap. Of the people interviewed, 44% said that they were never required to work overtime, but 13% stated that in their case it was compulsory, whilst 41% had some choice in the matter. (The remainder made no comment.) Repayment was sometimes made in time, sometimes in money, but there was a tendency for the latter to die out, and in this, the outlook was becoming more like other professions.

It seems then that a close relationship existed between the nurse's social origin, her lay/professional attitudes and her ability to identify with medical purposes; those coming from "professional" backgrounds appearing to find the identification less difficult than those from lay backgrounds. Where this identification was easily achieved, mutual trust existed between nurses and doctors, leading to a complete reversal of the vicious circle previously mentioned. Psychiatrists, appreciating the sensitivity and understanding of these nurses, gave them more information about their patients, thus further stimulating their interest and ability to give even better service. The result was high morale, high self-assessment and an apparent all-round increase in efficiency and effective teamwork, as illustrated by one or two outstanding wards in the survey. Occasionally, of course, low technical efficiency and high morale (in a lay sense) occurred together, one example being the nurse, already quoted, who described her patients' personal belongings as "the rubbish in their lockers". In this instance, she was happy in her work for three reasons: firstly, her lack of sensitivity to her patients' needs; secondly, the absence of colleagues with a higher standard of efficiency with whom to compare, (she worked alone), and thirdly, her own unprofessional concept
of what nursing entailed.

The main problem, although a function of selection, can be defined almost entirely in terms of morale and efficiency and, as already suggested, these depend essentially on staff relationships and communication. What can the doctor do to increase efficiency? First of all it is necessary that he maintain his own professional standards, for much is taught by example. It is unlikely that the nurse seeing the doctor anaesthetising all the patients with the same uncleansed anaesthetic mask, will be over particular in ensuring that airways are regularly sterilised between patients. In these days of concern over infection in hospital, it should be easier too, for him to press his claims for a minimum standard of hygiene e.g. in the provision of wash-hand-basins in treatment rooms.

Secondly a determined attempt must be made to bridge the gap between medical and nursing staffs in these hospitals, whereby a two-way flow of information could be established. (See references to discussion groups page 73, and communications page 40.) Not only might this result in arousing more interest on the part of the nurse in her patients, but would allow her to pass on information to which she has daily, unhindered access in the course of her normal duty. It is worthwhile noting too, the importance of applied psychology in doctor/nurse as well as doctor/patient relationships. A considerable amount of hostility was engendered by the tendency of specific psychiatrists to "forget" to say "good morning" to their nursing staffs, or acknowledge their presence in any other way. Nursing their hurt feelings and resentment, the staff were, in return, likely to "forget" to share with the psychiatrist, their latest observations on patients - a state of affairs which not only worsened staff relations but threatened to delay the patient's return to normal society.
On the other hand, where psychiatrists appreciated the value of extra effort spent on cultivating a relaxed atmosphere among the nurses, spontaneous tribute was frequently paid to the doctors concerned, and the seeds of teamwork were already sown.

The deficiencies in staff relations were by no means confined to doctor/nurse situations. Efficiency was sometimes reduced by lack of communication between nurse and nurse. In one hospital a small quantity of Nembutal—enough to provide sedation for about six hours—was left out for the use of a night nurse in charge of a disturbed patient. At 9.15 p.m. the round was done by the night superintendent who enquired whether the drug had been given. Explaining that the patient only slept for a limited time, the night nurse attempted to delay administration of the Nembutal until the ward settled for the night. Her explanation was met only by an authoritarian insistence that she give it immediately. After the departure of the sister, the nurse related how night after night this same procedure had occurred and how, just as frequently, the patient wakened at 3 a.m., when she disturbed the slumbers of her fellow patients by her hyper-activity. It seemed only common sense to the person in charge of the case to delay administration, in the hope that awakening would also be delayed. If the night superintendent had any valid reason for disallowing this request, she had certainly not bothered to pass it on to her exasperated but intelligent junior colleague.

A further cause of poor nurse/nurse relations resulting in low efficiency sprang from confusion of status roles. Within these mental hospitals, there was found to be a traditional acceptance of the idea that all grades of staff should be expected to perform the same duties. This was partly illustrated by the replies to the question on domestic work, when 31% of
the nurses considered it the legitimate function of even trained nurses. At the opposite end of the scale, further conflict existed over duties performed by junior staff. In one hospital, unknown to the senior administrators, even ward orderlies took round the medicines whilst third year students constantly found themselves burdened with clearing away crockery and preparing food. The existence of such ill-defined roles was the cause of some heated comment in the student diaries. A nursing assistant also verbalised her feelings when she said, "In 'general' (i.e., general nursing), you start as a junior and work your way through the general bed-pan stage to more responsibility. Here, no matter what grade you are, you do the same .... No young girl will do it now - and I don't blame them". (sic) Another trained nurse put it a trifle more succinctly - "In mental, they think they're all Jock Tamson's bairns". The use of Christian names on duty, between nurse and nurse, and even patient and nurse gives yet more credence to this statement.

Finally, before greater efficiency can be expected, there is the necessity to introduce consistency of nursing behaviour in comparable circumstances. To give an example, in each hospital studied, the observer was told that it was a hospital ruling that observation ward patients were never left alone. During the day, this worked fairly well with nurses being relieved at regular periods for both off-duty and to allow them to take "up-patients" to the toilet or bathroom. By night, the staff shortage made it impossible for such rules to be kept. Frequently the nurse was faced with a serious dilemma; should she accompany one disturbed patient to and from the toilet, leaving the remainder unattended, or should she allow the individual to go alone? Providing no relief was available, she would be breaking a hospital rule either way, and this inevitable
rule-breaking would tend to relax her attitude to other rules concerning patient care. Thus would start a gradual undermining of authority and morale, resulting in a decline in efficiency in other fields of work. Consistency of policy is essential and cannot be attained without good intra-nursing relationships. It would seem reasonable to assume that if a patient can be safely left alone in the evening or early morning when staff are short, she can be equally safely left at other times in the day, but discussion of points such as these rarely occurred.

Staff relations with the therapists and social workers were variable, tending to improve as contact increased. There was, however, evidence of inter-professional jealousy exhibited, particularly on the wards where therapists were provided with more information regarding the patients, than the nurses. In some instances it was common for the nurse to secure most of her factual information about the illnesses she was "treating", from the somewhat scanty reports sent to therapy departments. Tensions were further exacerbated by the employment of nursing staff within the specialised units. In one hospital, nurses were used principally to escort patients to and from their therapy sessions, after which they tidied up generally, including sweeping the floor. In another hospital, the nurse (an assistant), was the only member of the department staff who was excluded from the weekly meeting with the doctors. All of these factors, whilst perhaps relatively trivial in themselves, indicated the attitude of those with established professional status towards those who were still fighting to attain it. It is perhaps surprising that relationships were often as good as they were; undoubtedly they could have been better had the nurse's rôle been more clearly defined in relation to occupational therapy and the patient. In one hospital, the problem was largely overcome
by the therapists using part of their time to impart their skills to the nurses, who in turn were able to give more concentrated attention to individual patients.

From the foregoing paragraphs, it may be seen that in general, morale, within these four hospitals, was low. It is suggested that self-assessed morale, in conjunction with other factors, such as the existence of an ill-defined occupation, was closely related to the degree of efficiency manifested. What, then, is poor morale in the context of a mental hospital and how is it related to self-assessed morale? Poor morale occurs where lay attitudes take precedence over professional ethics, resulting in a lowering of efficiency which, in turn, retards the progress of the patient.

How can low self-assessed morale affect working efficiency? The answer is, principally by satisfaction occurring at a lower than professional level, e.g. 69% of the staff were satisfied with mental nursing as it stands today, including all the domestic chores. Thus, motivation to anything more satisfying is missing. On the other hand, an example of a dissatisfied mental nurse was quoted on page 40; a person whose efficiency was high but who wanted to know more about her patients in order to remedy the shortcomings of her function, of which she was readily aware.

To pursue another indication of low, self-assessed morale; between 1/2 and 2/3 of the staff interviewed, considered that mental nursing was not regarded as a profession in the same way as other branches of nursing; whilst 1/5 of the total staff, without equivocation, considered mental nursing of lower status than general nursing. It is not difficult to understand the effect of such low self-regard on the standard of work produced. If the nurse does not regard herself as the equal of her colleagues in other branches of nursing and if, in addition, she is not expected to act like them, it is
but a short step to serving food without adequate care\(^1\); or paying too little attention to hygiene\(^2\) or treating potent drugs as if they were nothing more than coloured sweets\(^3\).

Naturally, not all lay attitudes were of themselves harmful. There was much evidence of spontaneous kindliness and thoughtfulness e.g. amongst the nurses who, out of their own money, bought food or tobacco for patients, or who took them out in off-duty time. But in modern psychiatry is kindliness enough? The answer is without doubt a negative one. If the reader needs further illustrations to support the reply, his attention is drawn to the motherly, old nursing assistant standing helplessly by a patient in an epileptic fit; or alternatively to the potential suicide who is awaiting an opportunity to unburden herself to a staff who admit freely that they know nothing of her history, and have no idea how they will cope when the situation arises; or again to the neurotic whose distress is intensified by being dubbed spineless, imaginative or pampered.

How great then is conscious dissatisfaction? In some circles the answer is encouraging, particularly amongst the young, the newly-trained and the student groups. Individuals in each hospital showed too, that a nucleus of professional people existed everywhere, ready to put into practice suggested reform. Amongst other groups, dissatisfaction was not so high. "We have always done it" was a phrase heard on many occasions when some function was queried. Examples of satisfaction with lay tasks have already been given, such as the senior male nurse who for the first eighteen years of his mental "nursing" experience worked, without a break, in the gardens; or the charge nurse who didn't know how the nurses would spend their time if domestic duties were removed.
Some of the nurses, of course, got satisfaction out of the domestic work itself. Even where it was not strictly essential, senior staff were found industriously sweeping the floors and dusting the furniture, the familiar domestic ritual apparently providing intrinsic work satisfaction and happiness. Perhaps the male nurse who worked for over 30 consecutive years on the same ward, doing the same tasks, fell into this category for, as we have seen\(^1\), he escaped with apparently only relatively minor damage to personality. Other nurses, however, faced with conflict between traditional and forward-looking concepts of mental nursing, sometimes took refuge in "bumper-swinging"\(^2\) as an anxiety-allaying ritual. In the absence of discussion groups or other provision for relieving tension, some such rhythmic or soothing duty was inevitable. Domestic work was the obvious choice of those orientated to a lay rather than professional way of problem-solving. As the male trained nurse said earlier on, "While you're polishing, you can't think - and that's the idea".

In concluding the assessment of the focus of the problem, it is essential to stress once again the importance of recruitment and selection of staff. The effects of employing large numbers of nurses in responsible positions, with lay attitudes towards their duties, can only end in a further reduction of professional status for mental nurses generally, and, what is even more important, inadequate care of the patient. That working conditions are poor, cannot be denied. It is indeed thought-provoking that in a 20th century British hospital, under the National Health Service a nurse should be able to say with perfect truth, "You wouldn't be allowed to have

\(^1\) Page 53

\(^2\) Polishing the floor with a manually operated, long-handled polisher.
such sparse equipment as that in a factory. It is equally startling to find "disturbed" wards without basic equipment for attending to cuts and injuries. The question is immediately posed, "Would candidates coming from a professional background, or alternatively, those who had been given the chance of an adequate professional education (and been able to benefit from it) be willing to accept such intolerable deficiencies and shortcomings?" Without doubt there is a place, and a very large one, for the kindly, motherly woman who only wants to "look after people" but her place is not at the head of a team, nor in sole charge of acutely ill patients. For these positions, nurses must be carefully selected, irrespective of length of service or any factors other than efficiency and suitability of personality. From this point it is only logical to pursue the argument a step further and advocate a more careful selection of students, who must be the leaders of the future. And how can these desirable candidates be attracted? Firstly by improving the standards of nursing for those already within the field (which entails in particular the co-operation of medical staffs); and secondly by raising the standard of entry to one comparable with other professions. It is not suggested that the transition period will be easy, but these are problems which must be tackled immediately if patients are to receive adequate nursing care and if mental nursing is to achieve the status which it should rightfully occupy.


Discussion, recommendations and conclusions

"There is no simple formula in which to describe the work of the mental nurse ...." These are words quoted from the Manchester Mental Nursing Survey\(^1\); words which are amply borne out by the present study. In this study however, an attempt has been made to look at the mental nurse as a person; to observe his/her work in the wards of four Scottish mental hospitals and to assess the importance of certain problems which hindered the provision of adequate nursing care. It cannot be denied that considerable inefficiency existed, and the writer has tried to show that all the instances quoted of poor relationships, poor morale and poor communication, although primarily nursing problems, had an important bearing on patient care\(^2\).

The general discussion and recommendations will follow the headings of the main text, but an attempt will be made at the end to extract the principal conclusions, and indicate a rational framework into which they may fit.

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\(^1\) "The Work of the Mental Nurse" Manchester University, 1955.

\(^2\) cf. Teaching of T. G. Muller in "The Nature and Direction of Psychiatric Nursing".
1. The Working Situation

Attention is drawn to the wide variation of working environment provided for the nurse, and to conditions which virtually forced a lowering of professional standards, namely dark depressing wards, overcrowding and the related shortage of furniture; absence of vital facilities such as wash-hand-basins and inadequate toilet provision.

Far from providing a therapeutic environment, these conditions were responsible for retarding the progress of some patients, in that they encouraged eating and living habits far below those desirable in re-socialisation programmes. The effect on nursing staff was equally disastrous for, exposed to the daily sight of mass feeding and communal living of this type, the nurses found the incentive to improve the situation steadily decreased and, as some said, it was being replaced by apathy. Asepsis suffered too, for many of the wards were ill-equipped for either hand-washing or sterilisation of instruments. A number of these problems, it seemed, could be overcome by the introduction of a central supply, which would be responsible for both the provision and the sterilisation of equipment required for ward use, and would relieve these wards of the necessity of "making-do" with buckets and fish-kettles on gas-rings.

Attractive décor, the psychological effect of which may be very difficult to measure, was nevertheless genuinely appreciated by nursing staff, who were keen to display any improvements which had occurred.

1. See Brown & Fowler "Psychodynamic Nursing" p.80 for discussion of the effects of the "static" environment on patients.

2. See The Use of Colour in Hospitals Newcastle Regional Hospital Board, 1955.

Certainly the nurses (and patients) were stimulated to take more interest in the care of these newly decorated wards, a factor which in itself, sometimes encouraged a greater interest in the work generally. For this reason it is suggested that pleasant ward surroundings have some bearing on the provision of satisfactory patient care.

2. Type of patient

The size of the patient population over the age of 70 years (almost 25%) is worthy of particular consideration, in view of the difficulty in securing trained personnel to staff the wards. Although the majority of nurses, trained and untrained alike, were perfectly content to care for the principally physical needs of the older patient, it seemed that this arrangement was unnecessarily extravagant of psychiatric skilled labour. The very existence of such contentment demands a reconsideration of the mental nurse’s duties, for at present, she is far happier fulfilling a function not strictly her own, than caring for those more accurately described as mentally sick.

A possible solution for the care of the bed-ridden might lie in fuller recognition of the status of the general trained nurse and the state enrolled assistant nurse in the mental hospital, both of which grades are normally only recognised as nursing assistants. Such a step would possibly act as an incentive to general nurses to join mental hospital staffs — thus providing a pool of labour adequately skilled to care for this group of patients.

1. cf. nurses' professional satisfaction quoted by:
   b. MacLean in "Mental nurse in Dungarees" Nursing Mirror, 12th June, 1959.

where nurses were actively involved in therapy.

2. cf Belknap's comments on the "dumping" in hospital of all those for whom the community does not otherwise provide. State Mental Hospital
With regard to the care of the many old, long-term patients who merely require "parental" supervision\(^1\), the provision of Cottage Homes run by unqualified "house parents" might be entirely satisfactory, releasing even more trained staff for the care of those acutely ill, and those whose prognosis is good. These small family size groups\(^2\) would be easier to look after physically than large cumbersome wards, and by their very composition of mixed age groups and ability, might encourage the mutual help and social support which is only possible on a limited scale under the present system.

An additional advantage of smaller groups would be that many of the factors reinforcing the patient's depersonalisation, such as mass feeding, communal sleeping, sharing of clothing and toilet requisites and the removal of personal belongings\(^3\), would be likely to disappear spontaneously, resulting in a probable improvement in their condition and consequently a further reduction in the need for skilled nursing care. Where nursing care was still needed however, the Cottage Home system could be so modified that instead of untrained "parent" figures, qualified nurses, offering the same type of intimate care, would be in charge.

3. Type of nurse

Status was found to be of very great importance in the eyes of the mental nurse, and for this reason a recommendation is made, that consideration be given to the relative positions of all three grades of staff. Tension was perhaps greatest between the student and the nursing

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1. Cf. articles of Garratt, Lowie & McKeown British Journals of Preventive & Social Medicine, October, 1957 and January, 1958, in which they reveal that 64\% of the patients they studied made no demands on nursing services at all.
3. For the importance of this aspect see Freeman et al. Op. Cit. p.115. also "Open Doors" leading article, B.M.J., 8th November. 1958.
assistant, arising most frequently out of the allocation of such status-giving duties as administration of medicines and injections. But confusion of role generally, created a great deal of dissatisfaction and frustration, to which further reference will be made.

The sex distribution of staff in these four hospitals showed that more male candidates appeared to be presenting for training, than female. The significance of this trend is perhaps best appreciated when it is noted 1) that patient figures showed an excess of females over males, and 2) that male nurses were never employed on female wards in any of the hospitals studied. The situation is even more serious than it appears on first glance, in that wastage from marriage and home responsibilities is likely to be much higher amongst the female staff than the male.

Two alternatives for coping with this situation are suggested; firstly the employment of a proportion of male nurses on female wards. Scope for this, however, is limited and, in addition, candidates for such posts would need to be extremely carefully selected. The second alternative is the recruitment of more female students, some approaches to which have been discussed in Section XII. It is probable too, that greater use could be made of middle-aged women, with grown-up families and a residual desire to "look after people", for either full training, or work on the wards as nursing assistants. Certainly married women, both trained and untrained, are already used to a greater extent in mental hospitals than in other types of hospital, but their wider employment is restricted by lack of finance.

The implications of the age distribution of staff are startling. There were very few young trained nurses in any of the hospitals, whilst at the other end of the scale, 27% of the staff of the four hospitals will be due for retirement by 1963. Recruitment for these hospitals has thus become a matter of some urgency. As an inducement to candidates of suitable ability and personality to take up mental nursing it is suggested, once again, that the subject of work satisfaction be given special consideration.

Figures of the distribution of staff by grade, implied that no shortage of trained staff existed in these four hospitals, and it was only when the wards were seen functioning that their "scarcity" was fully appreciated. It is not however, suggested that the establishment of the trained grade be increased, but rather that they be relieved of all extraneous duties, such as caring for the chronic sick and performing domestic work. Simultaneously, it would seem a wise policy to select candidates for training much more carefully than in the past, relying on reforms within the profession to attract a sufficient number of able students.

It is thought that the status satisfaction (and to some extent morale) of the mental nurse is seriously lowered by the existence, within the "profession", of a large body of completely untrained personnel, with lay attitudes towards their function, who are known, if not legally\(^1\) at least to the general public as "nurse". A possible solution might lie in the provision of compulsory in-service training in basic nursing

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1. Although use of the title "nurse" was legally restricted by the Nurses Act, 1943, its recruiting appeal is thought to be greater than the titles "ward orderly" or "domestic worker".
and elementary psychology, for all who are to be allowed to use the title of "nursing assistant", or alternatively, in the abolition of this grade and the full recognition of the State Enrolled Assistant Nurse in the mental hospital. If this latter suggestion were adopted, it would mean the regrading as ward orderlies or domestic workers, of all nursing assistants not prepared to take the S.E.A.M. training of two years, thus avoiding the inherent dangers of "over-dilution". This necessarily has wider implications than merely the improvement of self-esteem in the mental nurse, however, since interest in professional status, though a legitimate professional concern, cannot by itself be sufficient ground for changes in public policy. It is interesting to note that the necessity for training of some kind was not only observed by the investigator, but requested by members of the nursing assistant staff themselves.

4. Type of work carried out by the mental nurse

Reference has already been made to the necessity for defining the duties of each grade of nurse, particularly with regard to students and nursing assistants. Even within the grades however, a need was felt by the nurses themselves to progress from less responsible to more responsible work as they became more senior, and it was a cause of great complaint that seniority brought little alteration in the nature of their duties. This cause of unrest may have lain at the root of their insistence on promotion by seniority, rather than by merit, a step which ensured that length of service was at least rewarded by increase in "status", if not in work satisfaction. The implications of this policy are discussed.

1. of at same time, plan for assisting promising "aides" to become professional nurses. "A co-operative plan for bettering care to the mentally ill", Schmidt & Gordon. Nursing Outlook, September 1958
In most of the wards observed, it was evident that even the trained nurse was not considered a full member of the therapeutic team. From the data collected it has been seen that, generally speaking, the nurses knew very little about their patients, and examples were cited where the health, even the lives of patients were endangered by the withholding of vital information. It is suggested that with more careful selection of staff for training, as recommended earlier, "edited" case-notes could safely be made available to all trained staff and final year students. These nurses in turn could then be responsible for passing on to the junior grades, the information necessary for the efficient running of the ward.

Because it is recognised that there must be no breach of confidence in the doctor/patient relationship, a suggestion is made that the "editing" consist of the exclusion of confidential and irrelevant material from the case-histories, and the inclusion of a summary of the patient's progress. From this point, it should be possible to encourage the nurses to supplement the records with their own observations, which might themselves prove of value to the psychiatrist in charge of the case. As always, the success of such an experiment would depend to a large extent on the relationship between medical and nursing staffs and the degree to which they would be capable of working together, but it is thought that any time expended by the doctor in the preparation of these summaries would be more than compensated for, in the greater efficiency and involve-

1. Cf. views of Greenblatt et al, Op. Cit. p.72, where access to case-notes is recommended for all grades of staff.
ment of the nursing personnel.

It was interesting to find that, in spite of a "shortage" of nurses, much of the time of each grade appeared to be spent on non-nursing (particularly domestic) duties within these hospitals. The main cause lay in the confusion which existed between the role of the skilled, professional psychiatric nurse, and that of the untrained nursing assistant, part of whose time might appropriately be spent in this way. At the time of the survey, it was common to hear the existing system rationalised as "work therapy for the patients", thus providing a legitimate excuse for the employment of qualified mental nurses in domestic work. Yet the circumstances under which these tasks were usually performed, e.g. nurses and patients working apart from each other, and even the nature of the tasks, e.g. rhythmic swinging of a "bumper", suggested that "expediency" and "apathy" rather than "therapy" supervened. Once again, the situation calls for reconsideration of the function of individual grades of staff, both for the sake of efficiency, and in order to protect the status of the fully professional nurse.

The suggestion, even by trained nurses, that routine domestic duties discouraged thinking and proved anxiety-relieving, seemed to indicate that their own needs were being inadequately met. It was inevitable that tensions should arise in a situation where the very illnesses of the patients were likely to stir up personal anxiety in the staff, and where, in

1. Importance of nurses working with patients stressed in "Bridging the Gap" Edited by Tredgold p.152.
2. Cf. the approach at Belmont hospital where a "domestic" group, composed of nurses and patients, existed for its specific therapeutic purpose. (Reported in Nursing Mirror, 8th February, 1957.)
3. See Expert Committee on psychiatric nursing (W.H.O. report 105) for recognition of the significance of these tensions and explanation of their existence.

\[ *\] cf. Barton's theory regarding value of "real-life"situation therapy rather than work that merely benefits the hospital. In monastic"
addition, the nurses knew so little about their patients that their behaviour was often unpredictable. It only seemed unfortunate that the principal outlet for the nursing staff lay in domestic work rather than in discussion with each other and/or the psychiatrists - a step which might have been expected to lead to a solution of the problem, more profitable to staff and patients alike.\(^1\)

Reluctance to think, (again possibly an attempt to avoid anxiety), appeared to be an important factor in producing apathy, which in turn was responsible for the perpetuation of traditional routines, for which rational explanations were difficult to find. One such example was the copying out of the entire medicine list daily, which occurred on a great many wards, irrespective of whether there were any changes or not - a procedure which only increased the possibility of error with each copy.

The change in function of the mental nurse, resulting from advances in psychiatry generally, has brought with it many problems, most serious of which is the lack of sufficient numbers of nursing personnel with suitable educational qualifications and personality to assume the additional responsibility. The ultimate means of attracting these candidates may lie in the provision of a comprehensive basic training\(^2\) but, meantime, it would seem that action must be taken to ensure that those already within the psychiatric field are given adequate opportunity for professional satisfaction.

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2. See page 146.
5. Working conditions

Ward planning emerged as a very important factor when considering working conditions, and it was unfortunate that even in the most modern additions and alterations to wards, insufficient attention had been paid to practical nursing details. It is thought that some of the fundamental errors might have been avoided had sufficient discussion occurred between nursing and planning personnel. The absence of washing facilities was particularly regrettable in an environment where resocialisation of the patient plays so large a part, and where such education is, of necessity, carried out principally by example.

Another factor demanding consideration, was the degree to which nursing staff were forced to rely on patients for assistance, a situation full of potential dangers. In addition to the two obvious dangers of bribery and exploitation of patient labour, there is a further risk, that the allocation of patients to specific wards might be decided more on domestic than on medical grounds. Criteria for assessing a patient's progress could also assume a lay appearance, the "satisfactory" patients automatically being those most willing to "conform" by helping with domestic or nursing chores. Whilst the therapeutic value of work cannot be ignored, it is suggested that when nurses are dependent on patient labour in any sphere, the objectivity of their judgment is seriously reduced. This could apply equally to their assessment of "progress", and to their calculation of the optimum amount of time which a patient should spend in this type of therapy.

Hours of work was a subject over which a variety of opinions were expressed, but from the observations made in this survey, it is suggested that the 13 hour day was far too long a period to provide intensive and

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efficient patient care. In addition to producing fatigue and its dangerous concomitants, the long day imposed real hardship on some nurses, with both emotional and physical repercussions. It is thought too that, attractive as the consequent off-duty period may have been to older staff, it was not sufficient incentive to attract new and younger candidates to the profession.

Overcrowding created a great deal of extra physical work for the nurses, and was responsible for a tendency to lower professional standards with consequent risk of cross-infection among patients and reduction in every-day hygiene. From the patient's standpoint, such an extreme form of communal living provided neither a good imitation of normal life for the long-term patient, nor a satisfactory stepping stone to discharge for the more fortunate. For these reasons, overcrowding and its effects would seem to merit more attention.

The optimum amount of time which a nurse should spend on one ward, is a subject which requires further study, but judging from the comments of the nursing staff concerned with this survey, the daily moving of staff is a policy to be discouraged. Frequent movement seems to rob the work of much of its interest, in that it becomes difficult for the nurse to follow the patients' progress; it tends, at the same time, to reduce the feeling of responsibility which she, herself unsettled, feels towards her patients. The importance of the effect of staff stability on patients, has been stressed by Freeman et al in their book "Chronic Schizophrenia", in which they state without hesitation that the nurse

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"should not be liable for sudden transfer to other wards and departments". Night duty produced a number of difficulties specifically its own, whilst others were more obvious by night, than by day. Physical isolation from colleagues, with resultant loneliness and fear, presented a major problem. In some wards, relief for meals was difficult to achieve where one nurse was on duty alone; in others, the provision of adequate nursing care was virtually impossible without the assistance of patients. Thus, for more than one reason, it seemed desirable that a second nurse be provided on these wards. It is suggested that the requisite staff might be supplied from 1) those replaced by house-parents in the Cottage Home Scheme; 2) a redistribution of those relieved of domestic and other extraneous duties and; if necessary, 3) an increased establishment.

Heating, ventilation, food and noise were additional problems considered important enough to be described in some detail in the text. It is thought that the main hindrance to their solution was false financial economy. Whilst this subject may be outside the terms of reference of the present study, attention is drawn to the lowering of morale and efficiency which stemmed from these conditions of work.

6. Communication

It may be seen, from Section VII of the main text, that a great deal of room for improvement lay in the sphere of communications. Nurses had little or no access to case-notes, and were frequently not even told of changes of policy in relation to patient care. The aura of secrecy seemed to surround the physical, equally as much as the psychiatric conditions, and was responsible for the development of situations which were highly dangerous to both staff and patients. Misunderstandings which
arose, further worsened relations between medical and nursing personnel. It is thought that many of these misunderstandings could have been avoided by the introduction of informal staff meetings, with their opportunity for discussing hospital policy and grievances.

Intra-professional relations also suffered from inadequate communications, senior nursing staff not always appreciating the need for regular contact with more junior nurses. Particular attention is drawn to the complicated procedure necessary before matron and nurse could meet. The introduction of a daily "office hour", during which time the matron would be available without prior appointment, might be expected to serve a two-fold purpose. Firstly, it would meet an expressed need of the staff for more contact of a less formal nature, with the matron; secondly, it would allow the matron to keep a more sensitive finger on the pulse of the hospital, resulting in her greater awareness of the areas of conflict and tension.

7. Recruitment, selection and training

Whilst recruitment to the mental field may be regarded as a matter of some urgency, it is strongly suggested that improvement in status depends, to a large extent, on more careful selection of students. The data collected has shown that the educational standard of the majority of the staff was low. Even though this did not necessarily reflect low intelligence, it explained the difficulties which faced many nurses, both in passing examinations, and in attaining full professional adjustment. In a sphere of work where the nurse needs to be continually alert

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1. Cf. also expressed need of nurses for formal contact (e.g. in ward rounds) when praise for work well done is sought. "The give and take in hospitals; Burling, Lents, & Wilson p.102.
2. Further examples quoted in Appendix 11 A.
to follow up psychiatric "clues", and where increased numbers of drugs and technical procedures demand a high standard of intelligence, intellectual ability, particularly amongst students and trained staff, cannot be ignored.

Personality too, appears to be of considerable importance. Sensitivity, understanding, emotional stability and a genuine desire to contribute towards the recovery of the patient, may all be regarded as essential qualities of the mental nurse, whilst the need for moral integrity is easily appreciated, in a situation where patients are often incapable of safe-guarding their rights. Whereas it is appreciated that selection techniques may still be in their infancy, the writer suggests that it is mainly by their greater use and more scientific development, (together with a simultaneous improvement in working conditions), that sufficient candidates of the right calibre will become available for training. The existence of a large "lay" element on the staff of the mental hospitals, merely accentuates the desirability of a professionally trained staff.

Although it is outside the scope of this study to comment in detail on the common training syllabus followed, it is obvious from the data collected, that there was considerable variation in the training facilities provided by each hospital. In spite of the increase in surgery

1. The Report of Nursing Committee, Belfast 1960, suggests the introduction of a standard entrance examination for candidates who hold no Senior or Junior Grammar School Certificate.
4. Approved by the General Nursing Council for Scotland.
within the mental hospitals, operating room experience, for many students, was non-existent — a fact which gave rise to a great deal of anxiety amongst them. At the time of the survey, occupational therapy experience was similarly restricted, but it is understood that this is now being rectified. For the most part, students were not employed on duties outside the wards, (such as gardening or laundry supervision), but attention is drawn to the diversity of opinion expressed, concerning the responsibility of nurses for such extra-ward activities. The criterion for deciding the issue might well be the value of their contribution in such circumstances, estimation of which could only be attempted by a "properly formulated controlled experiment".

Allocation of students to wards was theoretically determined by their professional and educational requirements, but it is perhaps worth commenting that, under the present system, where students are considered a part of the labour force, the needs of the wards sometimes take precedence. That many of the students had never been on night duty, illustrates the point. It is suggested that the main danger of this policy is the production of only semi-trained nurses, without the confidence or poise dependent on breadth of experience. The solution, (though likely to produce temporary hardship), would appear to lie in the introduction of full student status, as a result of which these nurses would be considered supernumerary to the wards. Once the securing of an adequate professional education (rather than patient care) becomes the acknowledged and primary aim of the student, it is likely that the training period could be considerably reduced. A further reduction

1. a situation which exists throughout hospital nursing generally.
2. Like the Manchester report op. cit., this survey suggested little relationship between formal training and the more skilled aspects of the work of the trained nurse.
might be achieved by the removal of domestic and other extraneous duties from their day-to-day work.

The introduction of teaching by informal methods, i.e. case conferences and discussion, appeared to be a progressive step, and support for this approach may be found in the work of Freeman et al., quoted earlier. With the more careful selection of trained staff, it is suggested that clinical instruction might well play a larger part in the role of the ward sister or charge nurse. Once again however, removal of extraneous duties must be relied on to provide the necessary time, whilst redistribution of nurses, as previously discussed, might increase ward staffing and make such a situation feasible.

Experimental approaches to training (e.g. the addition, to the normal curriculum, of domiciliary visiting) are to be commended, in that any attempt to assist the nurse to see her patient as an individual, must, of necessity, broaden her professional outlook generally.

It may be inferred that, as medical science advances, it will become more and more difficult to split patients into complete entities of "mentally sick" and "physically sick". For this reason, it is suggested that the time is ripe for the introduction of a fully comprehensive basic training, providing experience in each of the main branches of nursing. This would necessitate the interchange of staffs between

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1. "Chronic Schizophrenia"
2. That they have both types of needs, is made explicit in "Comparisons between Medical and Surgical Nurses", Lentz & Michaels. Nursing Research, Autumn 1959.
3. The policy of interchange is strongly supported by the Report of Nursing Committee, Belfast, 1960. p.75.

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hospitals linked by the scheme, and might help to break down some of the prejudice and stigma still attaching to mental nursing. In parenthesis, it might provide a partial solution to the mental hospital staffing problem, by stimulating a permanent interest in psychiatry amongst those seconded from other branches of the profession. Certainly, the interchange of physical and psychiatric skills could bring nothing but benefit to patients, in each kind of hospital.

The need for some type of nursing education for untrained staff, has already been discussed in relation to protection of the legal title "nurse". The prime object of such training would, however, be more efficient patient care. In Section XI, instances were quoted where, through misunderstanding of mental illness, nurses added to, rather than alleviated the misery of their patients. On other occasions, considerable anxiety was displayed by nurses who were expected to carry out physical procedures, without prior instruction. It is suggested that both types of situation could be avoided, by the provision of some in-service training, designed to assist the orientation\(^1\) of new staff, to the procedures of the psychiatric hospital.

3. Health

The sickness records of the nurses of these four hospitals were interesting, in that they appeared to indicate a good standard of physical health. However, before valid conclusions could be drawn with regard to morbidity, further investigation would be required into the amount of chronic ill-health (not necessitating absence from work).

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9. Length of service

The pattern emerging from the figures quoted in the main text, suggest that once employed in a mental hospital, staff tended to remain static. The policy of "promotion by seniority" appeared to have induced some of this immobility, which in turn may have been responsible for the nurses' tendency to cling to traditional routine, rather than welcoming new approaches to therapy.

It is suggested that a more satisfactory way of appointing staff might be by open competition following advertisement of each senior vacancy¹. In this way, appointments could be made on merit, rather than by seniority and, equally important, the circulation of new ideas would be encouraged by the greater movement of staff from hospital to hospital. In passing, it is perhaps worth mentioning that difficulties in securing housing in a new area, were thought to discourage mobility.

10. Morale and efficiency

As Katz² has said, "Morale is not a strictly unitary concept .... it consists of a number of dimensions". For this reason it is most easily studied with reference to other data, becoming in the process a sort of "portmanteau" for such states of mind as anxiety, confusion, lack of confidence and disconsolateness (or alternatively, their antonyms).

In this context, efficiency proved so good an index of morale³ that the terms became almost interchangeable, although, as one would expect, there were instances of "low morale and high efficiency"⁴, as well as "high morale and low efficiency"⁵. Some of the factors which appeared most

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1. Supported by findings of Nursing Committee, Belfast 1960.
3. See work of Viteles, M. S. "Motivation and morale in Industry" p.287
5. p.121
important in influencing morale and affecting efficiency are summarised below.

Shortage of equipment, without doubt, contributed seriously to the lowering of professional standards, but it appeared to be the attitudes of both doctors and nurses that were responsible for perpetuation of most of the errors of technique. Others occurred as a result of inadequate skilled supervision on the wards, due to the shortage or misuse of staff.

A further decrease in efficiency arose out of misunderstanding of function, which was in turn, a reflection of poor communication and consequently poor teamwork. In some wards, excessive traditional routine and regimentation were frequently observed, but it was encouraging to note that in others, there were genuine attempts by nursing staff, to introduce a more permissive régime. A further step forward will have been taken when these nurses no longer feel compelled to apologise for the relaxation of unnecessary discipline.

The intrusion of lay attitudes towards patient care, mentioned in connection with the need for increased professional education, also had a bearing on morale. Some nursing assistants were very conscious of their lack of knowledge and lay background, even though others, oblivious of their shortcomings, were quite content with things as they stood. Their unprofessional approach\(^1\) was usually evident in day-to-day attitudes to patients\(^2\) and their illnesses, but appeared most incongruous when associated with such events as death. The tendency for patients

\(1\) Cf. Parsons, The Social System, where he studies the medical profession in relation to this same concept of "professional" behaviour.

\(2\) e.g. "thumbing" them to bed.
to participate in basic nursing duties such as washing, bed-making and "back-rubbing", caused a further encroachment of lay attitudes, which was hard to eliminate. In parenthesis, it is perhaps difficult to comprehend how sufficient time could be found for nurses to carry out domestic duties, when it was apparently necessary for them to delegate nursing duties to patients.

Attention is drawn to the conditions under which some patients were housed, particularly by night, and to the risks of fire or sudden illness concomitant. There is much evidence to suggest that the daily observation of patients living in such surroundings and under such conditions, tended to produce a "defensive apathy" in the nursing staff, which in turn, led to perpetuation of undesirable situations.

At times efficiency was reduced by administrative problems, often of themselves trivial, such as the relative arrangement of meal and treatment times; but it is essential to stress at this point, that on other occasions, and in spite of formidable difficulties of this nature, nurses were able to offer their patients care of a very high quality.

The insecurity of the mental nurse, revealed in a variety of ways, appeared to stem from a) the challenge of a changing role; b) fear of litigation (which has increased of late), and in some instances, c) anxiety regarding unemployment - a reflection of the "depression years" of which so many of the staff had personal experience. But whatever the cause, this insecurity was responsible for a great deal of both inefficiency and "covering up".
Summary and conclusions

The most significant fact which emerged from the study of these four mental hospitals, was that patients were receiving inadequate nursing care of both a psychological and physical nature. The technical inefficiency responsible for this lack of care, stemmed principally from the serious confusion which existed between the role of the trained psychiatric nurse\(^1\), and that of the less skilled grades. Maldistribution of jobs (and labels\(^2\)), as one might expect, resulted in the insecurity and incompetence which is commonly associated with "unstructured" situations in any sphere. It fast becomes evident that, if patients are to receive therapeutic rather than mere custodial care, and if mental nursing is to become truly professional, some distinction must be drawn between the "technical" skills offered by the qualified nurse\(^3\), (which go beyond the layman's "kindness" and "sympathy",) and the more rudimentary contribution of the nursing assistant\(^4\). As a direct result of the too common refusal to recognise and act on this distinction in the mental hospital\(^5\), there has developed a dangerous situation in which everyone working on a psychiatric ward, expects to be classed as a nursing grade, irrespective of training or function. From this, it is but a short step

1. The student, as a potential trained nurse, must also be concerned in the distribution of jobs. Cf. current dissatisfaction of students, described in Appendix IIA.

2. For reference to misuse of term "nurse" see page 135.

3. Cf. Teaching of C. Towle in Common Human Needs, where she draws attention to the risks attendant on the intrusion of lay attitudes into the work of the social worker.


5. Whilst the Manchester Survey, Op. Cit., acknowledged the distinction between "technical" and "basic" nursing in the mental hospital, no specific recommendation was made with regard to the allocation of these duties.
to the birth of the stereotype of the "typical mental nurse". Paradoxically, the administrators who thought to increase recruitment by granting the status of the label "nurse" to those whose duties might well be principally domestic, have in fact been responsible for producing a most effective deterrent.

Poor staff relations and poor communications, in themselves responsible for a great deal of inefficiency, dangerous practice and low morale, were undoubtedly exacerbated by the confusion surrounding the function (and status) of the qualified psychiatric nurse. Dubious of her capabilities and potential skills and thinking of her still in terms of the "typical mental nurse", medical staff have been slow to include her in the therapeutic team, and have continued to regard her as a mere custodian. Frustration, lack of stimulation and traditional patterns of familiar routine have threatened to reduce even the most promising to a state of apathy and boredom, and consequently have had serious repercussions on patient care. The fact that some staff may not be emotionally or intellectually suited to assume responsibility consistent with therapeutic care, draws attention once more to the need for distinguishing between the duties of the skilled nurse and those of the semi-skilled, and also to the desirability of more careful recruitment, selection and training.

It appears from the survey that recruitment to mental nursing in these four hospitals was influenced more by "lay" attitudes, such as "wanting to work near home", than "professional" reasons like consideration of "the medical reputation of the hospital". At the same time, selection, the value of which was acknowledged in theory, rarely occurred in practice, and little recognition was given to the necessity for dis-

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criminating between those candidates wishing to become trained nurses, and those more suitable for the less skilled grades. This merely accentuates the need for making explicit the respective functions of each group of staff, for whilst custodial care and even domestic duties may be considered the legitimate concern of the ward-orderly-type of personnel, they are highly extravagant of skilled nursing hours.

In addition to the points mentioned, this study suggests that a comprehensive basic training, the logical conclusion to the acknowledgement of the patient as a whole person, is long overdue. Its value lies not only in providing a broader preparation for the potential trained nurse — leading to better patient care — but it also offers increased opportunity for stimulating students from other branches of the profession who may never have considered the possibility of psychiatric nursing as a career.

1. In the light of the present study, it is disturbing to learn that in the memoranda prepared by the Ministry of Health and the General Nursing Council, (The Nurses (Amendment) Rules, Approval Instrument 1960), mental nurses have been omitted from the list of those who, from July 1962, will require a minimum educational standard of entry. It seems that the professional "apartheid", practised in relation to membership of the Royal College of Nursing (See p.115), is being extended to even more fundamental concerns.

2. It is not suggested that the "ward orderly type of personnel" requires no skill. She too needs training and orientation, and indeed has a vital function in the mental hospital, but the main concern of this study lies with those working within the mental health team.

3. See page 146.

4. It might also help to solve the problems of "apartheid" referred to earlier.
That this report makes, on the whole, depressing reading cannot be denied. It is a harsh picture of technical inefficiency - stemming from confusion of jobs and low morale, and intimately related to poor staff relations and communication. It is a picture overshadowed too, by reports of inadequate financial resources, poor working conditions, and a shortage of facilities and equipment, sometimes severe enough to daunt even the most courageous heart. Yet its harshness is softened by instances of good nursing and genuine concern for the welfare of the patient; by evidence of conscious dissatisfaction with the present régime (particularly amongst the younger nurses); and by the existence within each hospital, of a nucleus of medical and nursing staff, working hand in hand to achieve the transition from custodial to therapeutic patient care. The perpetuation of their efforts and ideals depends, once again, on the recruitment and selection of personnel whose motivation is equally strong. Whilst the transition may not be easily achieved, it is believed that rewards, in terms of job satisfaction and increased efficiency are well worth striving to attain.

But, as I have indicated, the first step in improving the standard of nursing care for mental patients, lies in drawing a clearer distinction between the minimally qualified ward-orderly-type of personnel, affording only rudimentary physical care, and the fully trained mental nurse, skilled in psychiatric techniques. In the past, the confusion of activity of these two groups (both under the loosely used label "nurse") has created

1. It is suggested that more careful selection should be accompanied by a simultaneous improvement in working conditions (See Section XII.)

2. It is interesting that Bellnap considers poor financial support a symptom, rather than a cause of mental hospital problems. "Human Problems of a State Mental Hospital"
a stereotype of psychiatric nursing which has been accepted both by mental hospital staffs and the general public. The time has come to destroy this image, and replace it by one more consistent with contemporary legislation\(^1\) and policy. Where to draw the dividing line between the two types of duty is no easy problem, but nevertheless an urgent one,\(^2\) the solution of which may demand a well conducted experimental enquiry.\(^2\) And there are many other questions too, to which answers are urgently required. Even now, very little is known about what comprises good nursing care in the psychiatric field; or how it may be given; or which type of nursing is most successful in which situation; or to what extent the response of the patient to treatment is affected by nursing attitudes.

Since then, there are so many avenues in which improvement may be pursued, it is essential to have a rational basis for new policies. It is therefore important at this stage, not merely to repeat documentation of poor conditions, but to discover what alternative procedures in selection and training are superior in differing circumstances. From that position, the concept of improved patient care should become less of an ideal, and more of a reality, to the mutual benefit of both patient and nurse.

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2. The dividing line would probably need to be differently placed from that suggested by the Nuffield Report on general hospitals Op. Cit.

3. See Bellnap's comments on the "vital distinction between the standards of the professional and the custodial situation on the wards". p.215. "Human Problems of a State Mental Hospital".
APPENDIX
APPENDIX IA

THE QUESTIONNAIRE

The questionnaire was the instrument by which all personal information, regarding staff, became accessible to the investigator. The following table gives some idea of the very high degree of co-operation experienced in each hospital.

<table>
<thead>
<tr>
<th>Hospital Number</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>I-IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade:</td>
<td>% of grade</td>
<td>% of grade</td>
<td>% of grade</td>
<td>% of grade</td>
<td>% of grade</td>
</tr>
<tr>
<td>Trained</td>
<td>96</td>
<td>97</td>
<td>94</td>
<td>93</td>
<td>95</td>
</tr>
<tr>
<td>Student</td>
<td>100</td>
<td>94</td>
<td>100</td>
<td>97</td>
<td>93</td>
</tr>
<tr>
<td>Nursing Assistant</td>
<td>96</td>
<td>97</td>
<td>96</td>
<td>100</td>
<td>97</td>
</tr>
<tr>
<td>Combined grades</td>
<td>97</td>
<td>96</td>
<td>96</td>
<td>96</td>
<td>96</td>
</tr>
</tbody>
</table>

The form was normally completed by groups of eight or ten staff at a time, under the personal supervision of the observer. These group sessions were made possible by the efforts of administrative staff who released a certain number of nurses, for this purpose, at regular intervals. The arrangement worked well, and ensured that replies were relatively spontaneous and that all forms were returned, whether completed or not.

The personal administration of the questionnaires had certain other advantages too. Firstly, it enabled the investigator to make an initial contact with most of the staff; secondly, she was able to interpret the survey in
greater detail to a higher proportion of staff than had attended the introductory talk, and thirdly, the informal atmosphere of small groups encouraged questions, comments, and criticism which had not been forthcoming previously.

As the table shows, over 96% of the nurses were willing to co-operate in providing the required details. Of the remaining 3.7%, 1.4% were sick and therefore not available, and 2.3% refused to participate. Reasons for refusal ranged from a suspicion that the survey was being carried out by one or other political party, to "fear of a nursing examination". Incidentally the last factor also worked inversely, and a few of the untrained staff attended the session in the hope that at the end, they would be awarded some kind of qualification. One or two nurses who refused to fill in the form, appeared so emotionally disturbed by the suggestion that it was considered unwise to pursue the reasons for their refusal.

Although final statistical results were much the same from hospital to hospital, the atmosphere at these sessions varied considerably, and there were, of course, further variations from group to group.

In one hospital (open doors), no-one refused either questionnaire or interview, and there was little evidence of hostility or tension at the sessions. At a second hospital, aggression and lack of co-operation were much more obvious. Eight nurses refused to complete the form and of these, four were holding senior positions at the time. Two suggestions to account for this were made in general discussion: the first interpreted it as a blow against even higher authority, with whom the investigator might have been identified; the second recalled a survey carried out several years ago, of which nothing had been heard since, and which had produced a certain cynicism in the staff concerned.
In all hospitals there were certain members of staff who, while outwardly conforming, expressed aggression in a variety of "concealed" ways. Some "forgot" to attend sessions (which were not compulsory); some were late for appointments; some made facetious or destructive comment of the survey content, and from time to time, finger strumming, toe-tapping and sighing revealed the existing irritation and tension.

At one hospital, in spite of overt support, practical co-operation was difficult to secure. Tables and chairs disappeared overnight, so that written sessions started with a kind of "hunt the thimble". Messages were lost, delayed or distorted en route, all of which greatly increased the administrative burden of the survey. It is possible that inefficiency and lack of liaison accounted for some of the difficulties, but it is unlikely that they were responsible for all.

It was perhaps to be expected that a certain amount of resentment should exist everywhere, in connection with certain questions. Those which aroused most hostility concerned social class, and in particular, occupation of parents, the nurse's previous employment and a request to place certain professions and jobs of work in order of status. The question aimed at assessing professional morale (at all levels) in relation to other callings in the community at large. In spite of repeated reassurance, a proportion of the staff persisted in regarding it as either an intelligence test, or a measure of their political leanings and were consequently loath to complete it. A few were content to accord all men equal status, whilst the rank order of others, was to say the least, a trifle incongruous. The low position so frequently accorded members of professions usually accepted as of high social status, (e.g. bank managers and graduate school teachers) suggested that, although it had
been stressed that the question referred to the "community at large", in addition to other factors, discussed in the main text, it was still being interpreted as the "mental hospital community".

In assessing responsibility for aggression, there were numerous factors which could not be estimated statistically, but which nevertheless appeared to play an important part. Among these were the size of hospital (associated with staff relations and atmosphere), geographical location (associated with regional temperament) and even the stage of the survey (associated with how much information had spread from other hospitals and whether or not it had been distorted). A great deal too, depended on the interest and co-operation of the administrative staff generally, on whom fell the burden of keeping the ward adequately staffed throughout Stage I of the survey.

The questionnaires themselves were unsigned, by request of the investigator, but a separate sheet of paper with numbers corresponding to those on the questionnaires was circulated and staff were requested to fill in their name opposite the appropriate number. This "key", accessible only to the writer, was used for administrative purposes and to relate the questionnaire information to that of the interview.
APPENDIX 1 B

TRAINED STAFF

(CONFIDENTIAL)

QUESTIONNAIRE

(as completed by one group of staff during the survey.)

1. Number.

2. Sex  
   a) Male  
   b) Female

3. Are you  
   a) single  
   b) married  
   c) widowed  
   d) divorced  
   e) separated

4. If you are, or have been married, were you married –  
   a) before mental training
   b) during mental training
   c) since mental training

5. Have you any children or dependents?  
   a) Yes
   b) No

If so, please give sex and age of these.

6. Are you working  
   a) part-time
   b) full-time

7. a) Are you  
   i) resident
   ii) non-resident

b) If you are non-resident, is your house hospital property?  
   i) Yes
   ii) No

   c) If you are non-resident, do you  
      i) live at home
      ii) live in lodgings with meals provided
      iii) cater for yourself

8. If you are non-resident, how do you travel to work?  
   i) walk
   ii) bus
   iii) train
   iv) car
   v) bicycle
   vi) motor-cycle
9. Approximately how far away do you live, in miles?

10. How long does it take you (total travelling time) to and from work each day?

11. What is your age  
   a) now
   b) when you began nursing at all
   c) when you began mental nursing

12. How long have you worked in this hospital?

13. Please give details of nursing training(s) in chronological order, with names and dates of qualification, and place of training.

<table>
<thead>
<tr>
<th>Order of training</th>
<th>Training Hosp. &amp; Place</th>
<th>Qualification</th>
<th>Year of gained Qualification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. Position now held.

15. Which school did you attend last? (Please give name of town and county in which it was situated.)

16. How old were you when you left school?

17. a) Were you awarded any leaving certificates?
    
    i) Yes
    ii) No

    b) If you were, give the full name of the certificate(s) and the subjects for which they were awarded e.g. Scottish Higher Leaving Certificate in -

    1. English
    3. History

    c) Have you any other educational qualifications? If so, please name them.

18. When did you first want to take up mental nursing?
19. Why did you want to do this work?
   a) for promotion
   b) for security
   c) for more money
   d) for interest in this type of work
   e) for religious reasons
   f) for other reasons (Please name them).

20. Have you at any stage considered giving up mental nursing?
   i) Yes
   ii) No

   If so, why?

21. a) Did you undertake any other employment prior to nursing?
      i) Yes
      ii) No

      b) If so, give details with approximate dates.

      | Type of work | From | To |
      |--------------|------|----|
      | 1.           |      |    |
      | 2.           |      |    |
      | 3.           |      |    |
      | 4.           |      |    |

22. Occupation of father.

23. Occupation of mother.
   (N.B. As far as possible state the exact work done, e.g. foreman engineer in heavy engineering workshop or staff nurse in mental hospital.)

24. Are there any nurses in the family, other than mental nurses?
   i) Yes
   ii) No

   If so, what relation, and what kind of nurse?

25. Are there any mental nurses in the family?
   i) Yes
   ii) No

   If so, what relation?
26. Are there any doctors in the family?
   i) Yes
   ii) No
         Please underline

If so, what relation and in what branch of medicine are they engaged?

27. Have you been off sick during the past three years?
   i) Yes
   ii) No
         Please underline

        Approx. date   Type of illness   Time off duty

1.  
2.  
3.  
4.  

28. a) Have you been on night duty in this hospital during the past three years (or since qualifying, if less than three years)?
   i) Yes
   ii) No
         Please underline

b) If so, how many times?

        Approx. date of beginning   For how long

1.  
2.  
3.  
4.  

29. a) Do you prefer –

       a) day duty
       b) night duty
       c) no preference

         Please underline

b) If your answer is a) or b), why?

30. Name your three favourite leisure time occupations in order of preference.

1.  
2.  
3.  

31. How much of your off-duty time do you spend within hospital surroundings? (including the Nurses' Social Club, Nurses' Home, etc.)

   a) more than half
   b) about half
   c) less than half

32. How many times have you changed your ward in the past three years (or since qualifying, if less than three years)?

33. a) Do you prefer to nurse a) neurotic patients Please underline
    b) psychotic patients

    b) Why?

34. How do you consider the following should be placed in order of status?

   a) Physiotherapist
   b) Psychiatrist
   c) Student mental nurse
   d) R.G.N. only
   e) Ward sister, R.M.N., R.G.N.
   f) Psychiatric social worker
   g) Matron
   h) Bank manager
   i) Student general nurse
   j) R.M.N. only
   k) Chaplain
   l) General practitioner
   m) Ward cleaner
   n) Nursing assistant
   o) Occupational therapist
   p) Graduate school teacher

Mark the position that you consider the highest (1), second highest (2), and so on. Where you think more than one person should hold equal position, mark them with the same number.

35. Do you have access to a fictional library within the hospital?

   a) i) Yes
      ii) No
      iii) Do not know

   b) Do you have access to a professional library within the hospital?

      i) Yes
      ii) No
      iii) Do not know
36. Do you belong to a) a professional organisation?
   i) Yes
   ii) No  
   Please underline

   b) a trade union?
   i) Yes
   ii) No

37. Do you ever take patients off-duty with you e.g. shopping or to the pictures?
   i) Yes
   ii) No  
   Please underline

   If so, where.

38. Have you any suggestions for recruiting further staff to the profession?

39. Have you any other points which you would like to mention concerning anything to do with mental hospital life?
APPENDIX II A

THE DIARIES

The students were asked to keep diaries for seven consecutive working days and to record events under the following headings:

1) the time
2) task
3) reason for doing it
4) diagnosis of patient
5) whether any conversation took place
6) if so, what topic was discussed
7) whether any other staff or patients were involved
8) comments

A guide diary was available for each student, indicating how entries should be made.

The main purpose of the diary was to familiarise the investigator with individual ward routines, and allow for comparison of both these routines and student duties in different parts of the hospital. Secondly, it aimed at discovering how much the students knew, or were allowed to know, about the patients and their illness, and for this reason they were asked details of procedure and diagnosis. Attitudes to patients were often revealed in topics of conversation, and interesting sidelights on morale and staff relations emerged from the comment column. After a day or two, this column developed a therapeutic function, draining off quite a lot of aggression regarding the survey, as well as general feelings of discontent.
Some of the diaries were very well kept, and proved particularly valuable in assessing the student's opinion of his own rôle, as well as his relations with both other grades of staff and patients. Others were not so good, and provided nothing more than a catalogue of times and well worn phrases. Grammar was often poor and the mis-spelling of such every day words as "supper" (super), "dining" (dinning) and "holidays" (hollidays) occurred quite frequently.

The "time" column was not sufficiently accurate to assess exactly how much of the day was spent on individual duties, but it was obvious that cleaning, polishing and running errands featured markedly in some ward procedures. In the "reason" column, most tasks were recorded as "routine" but occasionally hospital policy was revealed in these comments e.g. Task - "Patient taken to X Hospital" - Reason "Patient must be accompanied by a nurse."

The "diagnosis" section was very poorly completed, often because the nurses were unaware of what was the matter with the patient. Some had not bothered to try and find out; others had made unsuccessful attempts, whilst one in apparent desperation recorded, "I'm not meant to know".

Conversation naturally depended to some extent on the condition of the patient and the type of illness, e.g. as one would expect, no deep discussion was recorded on the diary of the student who described most of his patients as "aunts". It was encouraging however, to read of the occasional efforts of other people to explain treatment and offer reassurance, and one felt that these students were at least attempting therapy rather than affording purely custodial care.

The column dealing with "other members of staff or patients involved in the procedure", was very poorly completed, and rarely revealed whether the other participant(s) were in a teaching relationship, being taught,
assisting, being consulted or just observing, although this was specifically requested.

The comment column was perhaps the most valuable of all and remarks fell into three main categories: 1) individual and personal comments/complaints 2) those related to work 3) those concerning the survey.

The first group usually sprang from specific incidents, e.g. in one diary the following entry was made, "Interview with M/O - Psychiatrist. I requested this interview so that one or two of my complaints may be thrashed out, but on leaving his office I was in a more confused state than when I went in. All questions put to him was (sic) evaded. Refused to give information. Apart from my own complaints, the friction between medical and nursing staff is terrific".

Another comment which came from a male student referred to long hours. Following numerous recordings of "Nil" in the conversation column, he wrote, "Reason for no conversation is that after working six days at 13 hours, I don't feel like talking". The same attitude was reflected in the comments of other students, one of whom wrote "No matter how keen one may be, it is impossible to remain interested for 13½ hours per day, seven days per week, as worked here. Patients suffer in the end. After a day's work the time left leaves no time for a student to study and enjoy any degree of social life whatsoever. Studying is an effort after a day's work and I for one, find it most hard to put my mind to books in the time left before bedtime. If these hours are not changed very soon, I will not stay in nursing if and when I pass the final examination." This has been quoted at length because it was the comment of a promising and popular student nurse.

Occasionally a student recorded a positive comment, and after a discussion on drugs, during which the nurse had received instruction from the
ward sister, she wrote, "Glad to be in this branch of the profession, where such advancement is being made."

Comments related to work were diverse and referred to such matters as nursing conditions, patients' food, equipment, duties and relationships. One nurse made a plea for a greater variety of styles in patients' coats, as well as for less institutionalised dining facilities. A second, made an exhaustive list of faulty equipment on her ward - criticism of which was entirely justified. A third student nurse drew attention to the confusion of rôle which occurred, and following nearly three hours of preparing, serving and clearing away meals wrote, "I must admit although I did help with the maids' work, I did it with some resentment - my reason being most of the day the ward orderly was allowed to do the work I should have been doing, e.g. giving out the sedatives .... . When 5 p.m. came round and the ward orderly was off-duty, I was of use to the ward sister." She added a trifle irately, "The orderly has been here longer than I!!!", the implication being that length of service was all important in the situation. This nurse's complaint was also justified, for she was an intelligent final year student who, only a month or two later, would be expected to shoulder a great deal of responsibility for which she had been inadequately prepared. A later comment summarised the situation, "As a 3rd year student nurse I feel I do not get sufficient responsibilities to keep me thoroughly interested in my work. Only when there is no other possible person do we get responsibilities - then it is in charge of the ward. The following day we can be reduced to a junior watching an orderly do our work. I feel very strongly about this matter." Criticisms of this nature were made by several people.

A substantial number of complaints concerned the lack of information
available to nurses, regarding diagnosis and treatment, as well as history of patients. One nurse recorded, "Case Presentation (very interesting and informative). What's the good of discussing only one patient in the whole hospital. If they can tell us all about one patient, why not tell us a little about all of them?" A post-graduate student wrote, "(I) find that the older nurses do not want to know any more about the patients than they do already. They feel that there's no need for the nurse to know anything about the patient. They would prefer to fulfil the rôle of personal servant." Such apathy and lack of interest may well have been an important factor in the secrecy surrounding the nature of a patient's illness, but other factors, not least that of confidentiality, also played a part.

On occasion the secrecy caused extreme embarrassment for the nurse, and even danger to the patient. An intelligent student made the following entry, after accompanying a patient to a general hospital. "I was given X-ray forms and a letter from S.M.O. stating what treatment Mrs. X was on etc. The patient was very drowsy when we reached ——— which appeared to be due to a sedative. No-one told me what she had in the way of this. I did know she had Pethedine 50 mgms. I.M. at 8.30 a.m. but that was all. I had never seen the patient before .... . All sister was told was that she had faulty habits and that she was a voluntary patient. I will refuse to take any more patients to another hospital unless I have full particulars."

The nature of duties appeared to irritate at times and a male student made the following entry: Task - "Drawing lines on report books - Oh for books with lines! It would certainly save time." A second student complained that he was sent to clean the dormitories during vacation time, while temporary orderlies, (often medical students of course), carried out
nursing duties. A 3rd year student recorded, "Had I known before starting what a large percentage of work here is routine and uninteresting, I would never have started. A ward orderly is much better off, with a larger pay, shorter hours and weekends off. I find it impossible to be interested in this kind of work for 13½ hours a day, so I am afraid the patients and hospital suffer in the long run."

Yet another frequently complained about his work in the gardens, "This is sometimes a dirty job and no protective clothing is supplied .... This is not a job for a student nurse but for a farmer. No nurse is interested in planting cabbages or sorting out rotten turnip pits."

Vacation students and their employment were a serious bone of contention in one hospital, and the following report of circumstances did much to reveal staff attitudes and relations. This is a quotation from a student's diary, written during a time when university students and other temporary staff were employed. "In this ward there are usually two student nurses. However, lately we have had to put up with two orderlies who have little idea and no interest in ward work. This has naturally put more work on regular staff. These orderlies are on vacation from university and their sole interest is their pay envelopes, and I consider it to be grossly unfair to put them in a ward where so much nursing is required."

Further discontent and aggression showed itself in a later comment. "Being a senior student, I normally don't have to do this job, (washing and dressing helpless patients), and I usually spend this part of the day preparing trolleys etc. However, the junior students from this ward have been removed to make room for medical students on vacation, who are quite incapable of doing the job required." A later comment referred to "excessive pampering of patients, by psychiatrists" and the "preferential treatment" afforded
"about 50% of the patients in this ward".

From these comments, three main points emerge; first and most serious, the student's attitude to the patients, closely connected with his attitude to his own rôle. It is evident that he considers washing and dressing patients, with all its opportunity for personal contact and therapy, too lowly a task for a senior student. This in itself is a disturbing thought. Secondly, the comments reveal a serious breakdown in communication. The reference to "pampering the patients" was occasioned by the introduction of a more permissive attitude of the psychiatrist towards the bathing habits of new admissions. No longer was the whole ward required to attend a communal session at the same time on the same day, but the more responsible patients were allowed a certain amount of liberty in this matter. It seems that no attempt had been made to explain the change of policy to the staff, and so it had been interpreted by this nurse, and others, as a deliberate attempt to deprive them of their authority. When only four of the twenty-eight patients appeared in the communal bathroom at the routine time, the nurse felt he had lost face with the rest of the group - a fact which did not make for the happiest of inter-personal relations. The third point was a legitimate complaint raised by several students, namely the allocation of staff to different parts of the hospital. In the ordinary course of events it was difficult to ensure that students had adequate, supervised experience in all types of wards and there was some competition for the relatively few bed-ward vacancies. Where temporary staff were employed, it was sometimes a problem to know where they would best fit in for so short a period, and bed wards frequently provided the most suitable solution. However, this action caused considerable discontent amongst the students who considered that lay people were depriving them of their "rights".
Again a breakdown in communication had occurred, resulting in neither administration nor staff being aware of the opinions or problems of the other group. A little discussion, re-arrangement of duties and even an attempt to refocus the nurse’s attention on the true function of the mental nurse, would have gone a long way towards ironing out difficulties and establishing a contented student body.

Relationships of all kinds were illustrated in the diaries. One student strongly criticised the fact that a senior member of staff was "dressed down" by a doctor, in his presence. Another wrote, "Doctors try to do too much at one time. This causes panic amongst nursing staff." Friction was evident too between the different grades of nursing staff. Nursing assistants and orderlies came in for most of the criticism - usually when they carried out duties regarded by students as being within their particular province. One nurse, however, made the following entry, "Bad atmosphere in ward. Student nurses seen with resentment by older staff." Once more this referred to the allocation of duties by the senior staff of the ward who, in some instances, it appeared, felt threatened by the greater technical knowledge of their juniors.

Staff/patient relationships were often good, but the following comments were certainly thought-provoking. A first year student wrote "Patients very helpful, they will polish the floor willingly." (A criterion perhaps, for judging patients?) Another wrote, somewhat aggressively, "Patients treat this place like a holiday camp and not as a hospital. In the other wards, the staff are superior officers but in here, they are inferior." - indeed a strange idea of nurse/patient inter-action.

The third category of remark concerned the survey itself, and these comments were both favourable and unfavourable. Resentment took several forms.
Though no-one refused to complete the diary in so many words, some just failed to return the sheet; one or two, with insufficient courage to do this, sent in blank forms in sealed envelopes; some made scanty or commonplace comment; others were mildly aggressive like the student who wrote, "Some how I don't know what good this will do anyone .... Tomorrow will be my last half day of this and I must say I will be glad as this gets a little boring." On the other hand a student who had made extensive recordings (and incidentally, had obviously spent a lot of time on domestic work) ended with "Good luck in your investigation".

After completion, the student sealed his/her diary in an envelope and brought or sent it to the investigator. Many signed their forms and added the number of the ward to which they referred, so that the diaries, in this respect, differed from the anonymous questionnaires. Seventy-six were completed in all.
<table>
<thead>
<tr>
<th>TIME</th>
<th>TASK</th>
<th>REASON</th>
<th>DIAGNOSIS OF PATIENT(S)</th>
<th>ANY CONVERSATION WITH PATIENT(S)</th>
<th>TOPIC DISCUSSED</th>
<th>ANY OTHER MEMBER OF STAFF/PATIENTS INVOLVED</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 - 7.15</td>
<td>Bedmaking (6 beds)</td>
<td>Routine</td>
<td>Neurotics</td>
<td>Yes</td>
<td>1. how slept</td>
<td>3rd year student (A)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td>2. treatment</td>
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<td></td>
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<td>3. breakfast</td>
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<td>4.</td>
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<td>6.</td>
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<tr>
<td>7.15-30</td>
<td>Giving out patients' breakfast</td>
<td>Routine</td>
<td>Neurotics</td>
<td>Yes</td>
<td>Choice of food</td>
<td>2 patients: Ward Orderly (A)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Patients complained of bad night because Mrs. S. had a nightmare</td>
<td></td>
</tr>
<tr>
<td>7.30-45</td>
<td>Fed patient</td>
<td>Paralysed</td>
<td>Hysteria</td>
<td>Yes</td>
<td>Film seen by patients last night</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>7.45-8</td>
<td>Fed patient</td>
<td>Won't eat unless fed</td>
<td>Schizophrenia</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8-8.15</td>
<td>Collect dishes</td>
<td>Routine</td>
<td>Neurotics</td>
<td>No</td>
<td></td>
<td>Ward Orderly &amp; Nursing Asst. (A)</td>
<td></td>
</tr>
<tr>
<td>8.15-30</td>
<td>Sweep ward</td>
<td>Teach 2 patients</td>
<td>Neurasthenia</td>
<td>Yes</td>
<td>1. work &amp; method</td>
<td>Patients more skilled than yesterday</td>
<td></td>
</tr>
<tr>
<td></td>
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<td>2. treatment</td>
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<td></td>
<td></td>
<td></td>
<td>Yes. 2 Patients (A.T.)</td>
<td>Patient rather confused. Taught to divert her attention</td>
<td></td>
</tr>
<tr>
<td>8.30-9</td>
<td>Bed Bath Demonstration Teaching</td>
<td>Faulty</td>
<td>Senile</td>
<td>Yes</td>
<td>1. heat of water</td>
<td>Clinical Tutor (T)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. new talcum powder</td>
<td></td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>3. visitors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TIME</td>
<td>TASK</td>
<td>REASON</td>
<td>DIAGNOSIS OF PATIENT(S)</td>
<td>ANY CONVERSATION WITH PATIENT(S)</td>
<td>TOPIC DISCUSSED</td>
<td>ANY OTHER MEMBER OF STAFF/PATIENTS INVOLVED</td>
<td>COMMENTS</td>
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</tr>
<tr>
<td>9.30-10</td>
<td>Coffee</td>
<td>Break</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-10.15</td>
<td>Poultice to arm</td>
<td>Boil</td>
<td>Obsessional neurosis</td>
<td>Yes</td>
<td>1. Reassured</td>
<td>Staff Nurse (T)</td>
<td>Patient has had series of boils. Told about care of skin.</td>
</tr>
<tr>
<td>11.45-12</td>
<td>Helping patient with knitting</td>
<td>Dropped a stitch</td>
<td>Depression</td>
<td>Yes</td>
<td>1. Knitting patterns 2. child for whom garment destined</td>
<td>Occupational Therapist (G)</td>
<td>Patient still not very interested in present occupational therapy. Would prefer sewing.</td>
</tr>
<tr>
<td>12-12.45</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
APPENDIX IIIA

Participant Observation

The term, as used in this context, meant that observation of nursing techniques and a sharing in the more routine duties, occurred concurrently. This third stage, carried out by the investigator in the 71 wards and departments of all four hospitals, and lasting many months, covered both day and night duty. The time spent in each unit varied from a few hours to a few days, depending on the nature of the ward and how profitable the observations proved.

Its placing was deliberately contrived to follow the initial contact of the questionnaire, and to precede the most intimate of the research relationships which occurred in the interview. The first aim of this stage was to get to know the staff as individuals, and to establish the sort of relationship which would encourage them to express themselves and verbalise their problems. In the informal talks which were inevitable, the investigator was able to correct false impressions regarding the survey, and to involve individual members of staff in the matters which so vitally concerned them. Many of the conversations occurred over meals, and in every hospital the observer established the right to eat with whichever section of the staff she chose, day by day. This did much to break down the impression that she was identifying with any specific grade.
The second purpose of participant observation was to witness the nature of duties performed in mental hospitals, the time they took, the manner and skill with which they were carried out, and equally important, the outstanding problems associated with psychiatric nursing. These last included such things as length of duty period, shortage of staff, strains associated with specific wards and calls made upon the resources of the nurse.

The third reason for employing this technique was in order to bring the investigator into direct contact with both patients, and disciplines other than nursing. Many of the discussions with medical staff, social workers, occupational therapists and patients too, stimulated thought both in the writer and in the staff themselves.

Before the observation started, much time and consideration was given to the subject of uniform for the observer. It was finally decided that the best solution lay in a navy-blue nylon coat with hospital buckle, which identified the wearer as a nurse, but not as belonging to any specific grade. It was, in addition, easily laundered and incidentally proved pathetically fascinating to many long-term patients, to whom nylon was still something of a novelty. No cap was worn.

In order that the survey should not be regarded as mere "spying", it was policy at first to reveal research plans for several weeks ahead. This, however, proved impractical in that it almost always resulted in the presentation of a false picture, e.g. sometimes the staff were reinforced from other wards, or specific nurses were on duty as a reception committee; or again, the linen would all be changed and the ward spruced up, under the impression that the observer's sole interest was the quality of hygiene existing. Finally a compromise was acted upon, namely that the investigator
herself, telephoned the appropriate ward on the evening preceding her visit. This allowed insufficient time for major changes of off-duty or routine, yet ensured that the relationship between staff and observer remained unharmed.

**Day Duty**

In three of the four hospitals, the "long day" was operating, i.e. the nurses were on duty for 13 hours or so, with breaks of varying lengths for meals. The remaining hospital worked a three-shift system.

Observation of the wards working the "long day" produced several problems. It was essential that the investigator should experience the full period of duty, both to witness the demands made on the nurses during the day, and the effects of those demands manifested by 8 p.m. The 13 hour day, however, was found to be far too long for efficient observation and concentrated attention, so that once again compromise became necessary.

In each of the three hospitals concerned, the observer worked one or two long days, but for the remainder of the time, an eight or nine hour shift, covering varying parts of the day, was found to be more productive in the long run. Where the shift system operated, much the same method was employed to enable her to meet staff of both day shifts.

**Night Duty**

In many ways, night duty presented fewer problems than the day. All hospitals worked a 10/12 hour night, which fell quite naturally into three distinct sections. There were two "peak" periods; the first, entailing the supervision of patients before and whilst going to bed at night, ended about 11 p.m.; the second, consisting of getting them up and supervising dressing procedures in the morning, commenced at varying times, according to the ward. The third period, the interim, was usually quiet in most places, although certain geriatric wards had little respite.
Each night on duty, the investigator used the peak periods for observing nocturnal ward routines. The middle section of the night, (roughly 11.30 p.m. - 4.30 a.m.), was used either to accompany the night superintendents on rounds of the hospital, or to talk to nurses whose names had presented for interview, and who were on night duty at the time of the survey.

Relationships tended to be exceptionally good by night, possibly because many of the staff were normally on duty alone, and welcomed anything which broke the monotonous vigil. Increased periods of observation were also found to be possible during the night, due to decreased staff (and consequent decreased activity), and a reduction in the demands made of the observer by patients.

**Technique Employed**

In the "pilot" hospital, the investigator employed free recording, i.e. she noted down each event or observation as she became aware of it. When this first study was complete, the information was sorted according to headings which had emerged as important. From these, a ward schedule (See Appendix IIIE) was devised which the writer completed in every subsequent ward. The advantages of such a schedule included:

1) Early focusing of the observer's attention on important factors.
2) Provision of material which could be compared from ward to ward.
3) Economy of time and greater accuracy in assessing data gathered.

Details of the observation schedule were supplemented by informal discussion with members of the ward staff, and more formally, with the nurse in charge. Recordings were made at the time of observation, and it was interesting that the majority of the staff appeared to be in no way perturbed by this routine.
"Participation" was limited, for the most part, to tasks in which the writer was able to assist a member of staff, e.g. bed-making. From performing these tasks, specific problems came to be appreciated, such as the degree of overcrowding which necessitated moving four other beds, before the corner one could be made; or work dissatisfaction resulting from inadequate or unsuitable supplies of linen. From time to time, a nurse (usually a student or nursing assistant, temporarily in charge of a ward) would seek instruction from the observer in some specialised technique, e.g. how to give an injection or apply a dressing. Once or twice, she was actually left in charge of the ward for a limited time, but these were rare occasions, and presumably only arose because of her professional training. The principal significance of the incidents lay in her acceptance as a member of the staff.

Observation of two types of ward by day

Criteria for adjudging a ward "good" or "poor" were difficult to establish, but in this description, emphasis has been placed on staff/patient relationships, atmosphere and the quality of therapeutic care enjoyed, rather than on purely physical surroundings, important as they were.

The first ward housed over 80 female patients who, up until three months before the survey, had earned a reputation for being one of the most difficult groups to control. With the unlocking of the ward doors, the transition period had commenced in respect of both patient care and décor.

Physically, the ward was far from perfect. The sleeping accommodation was for the most part, bare, desolate and depressing. Even the dormitories, which had been redecorated, were devoid of furniture, and single rooms resembled those described in the main text. For basic equipment, the
sitting room was in only a slightly better position but, in spite of this, the combined efforts of staff and patients had achieved a cheery and homely appearance.

It was evident that great pains had been taken with flower arrangement and tastefully filled vases were situated at vantage points. (Incidentally, many of the flowers had been brought in by the nurses themselves.) Somewhat dreary walls had been lightened by attractive travel posters, framed and hung by patients. Multi-coloured cushion covers were being embroidered by others, under the supervision of nurses and occupational therapists, and coal fires burned brightly in the old-fashioned grates.

**Routine on the day of observation**

Day duty commenced at 7.30 a.m. when the dormitory patients, dressed and with their beds made, came downstairs. Single ward patients, and those who slept on the ground floor, were also gathered together in the day accommodation for washing and/or general toilet supervision. Those who could be responsible for personal belongings had their own face flannels and towels, which many of them carried all day, for want of somewhere to store them. Those who were not capable of looking after toilet equipment were washed and dried on communal provision. The staff (one trained nurse and three nursing assistants) were all engaged in this task until 8 a.m., when breakfast was served.

At the rallying cry of "Hall-time, Ladies", the 80-odd patients gathered together for their journey to the dining accommodation shared by two other large wards. Some, for the sake of safety, carried their entire possessions in holdalls, which literally accompanied them everywhere.

They were seated at tables for 10 or 12, the general effect of which was uninspiring. Breakfast was better than usual, and started with corn-
flakes, followed by a kipper and bread and margarine. The food was served from aluminium "baths" and containers, whilst the tea circulated in copper kettles, which gave it a grey and unappetising appearance.

The encouragement of socially acceptable behaviour at meals was difficult to achieve because of the nature of the patients' illnesses, the ratio of staff to patients, and the absence of such necessities as knives. Undoubtedly a degree of segregation would have led to opportunity for improvement in both the least, and the better socialised groups.

After breakfast (about 3.30 a.m.), several patients went off to work in the laundry, sewing room and other parts of the hospital, administration of medicines having preceded the meal. It was at this stage that quality of care became especially noticeable. Doctor and ward sister had worked in close co-operation to try to match the personalities of supervisors and patients, and to ensure that the majority worked in the happiest departments of the hospital. Hours of duty were checked, and where they exceeded an acceptable number, the victim was unobtrusively withdrawn for regular periods of off-duty. Payment of patients often appeared illogical and haphazard to the staff, who considered that it frequently bore no relation to quantity or quality of labour. They continued, however, to draw attention to those people who, like one reliable patient, regularly performed a responsible job of work, for 5-6 hours per day, in return for 2/6d. per week pocket money.

With the departure of these "workers", the nursing assistants and some of the more able patients commenced the domestic work. There was so much more activity here, than on some of the other wards, that cleaning fell naturally into perspective and was finished by 10.30 a.m. or a little after. The main criticism was, that although teamwork existed, it tended to be exclusively between nurses or between patients, rather than between the two
groups combined.

From 9 a.m. onwards, those who had completed their domestic chores seated themselves by the fires, with some kind of handicraft. Many were employed in making basic ward equipment such as cushion covers; others, less skilled, knitted dish-cloths or simple garments. Where a patient showed specific talent e.g. in embroidery, she was encouraged to exhibit in outside shows, and prizes had been won in local art displays. In passing, it was interesting to see the esprit de corps which emerged in moments of crisis, e.g. when one patient experienced an epileptic fit, two or three others immediately flew into action; one to fetch a nurse, one to clear the settee of its other occupants, and another two, to place the patient flat. Within a matter of seconds, life resumed its normal tenor.

At 10 a.m., about half the ward, (those who were not out working, but who were nevertheless hungry) went to the "Halls" for a cup of tea and a piece of bread and butter. On their return to the ward, a group of patients were taken for a walk in the grounds by the nurses. Recreational therapy also played a part, but owing to the restricted size of the department, the number of patients who could participate was limited. Activity included games, dancing and rhythmic movement. On the observation day, one nurse was very gratified to report that an intensely withdrawn patient had, for the first time, caught a ball, after three days of throwing it in her direction without success. For those who could not go to recreational therapy sessions, a borrowed gramophone encouraged movement and provided entertainment, and it was planned that certain ward funds should be spent on a second-hand model, for the sole use of this group of patients.

Organised occupational therapy commenced at 11.45 a.m. Although this entailed a further change of scenery, unfortunately, there was little change in the nature of employment. Discussion with staff suggested that

lack of materials and personnel was largely responsible.

Before lunch, medicines were given out from a cupboard situated in a corner of the sitting room. The list was extensive and took some time to administer. Drugs were given direct from bottles on the shelves, to eliminate the risk of patients helping themselves from a medicine trolley. No running water was available nearby to wash the medicine measures, and indeed, on more than one occasion they were not washed between patients at all. Certainly, many were skilled in swallowing drugs without water, and for that reason, and because the staff knew the patients so well on this ward, the tablets were not routinely crushed, as in many other units.

At 12.45 p.m., the patients gathered for their meal which was again eaten in the "Halls". On this occasion it was particularly poor, consisting of a plate of soup, followed by meat roll and potatoes only. There was no dessert except for a minute quantity of milk pudding, sent up for the old people. The staff agreed that it was a grossly inadequate lunch for even elderly patients, and especially poor for those who were working. Complaints were registered with the catering officer and physician superintendent, who did a round at a very opportune moment.

On their return to the ward, a variety of occupations were pursued including unchaperoned walks, sunbathing (to a limited degree because of drug reactions) and ball games. The staff recounted how, when the doors were first opened, the patients were loth to venture forth and took little initiative in exploiting their freedom. By the time the survey started, they were just beginning to appreciate it and make independent expeditions, but none had ever strayed too far, or caused a disturbance of any kind.\footnote{of "Freedom for Patients in Mental Hospitals", The American Journal of Nursing, March 1958}

The atmosphere of the ward itself, notwithstanding its physical and even technical shortcomings, was excellent and seemed to be directly asso-
associated with staff attitudes towards their rôle. Patients were known and cared for as individuals, in spite of demands made on a very small staff by a very large number of mentally disturbed people. This same emotional warmth spread and affected the behaviour of patients amongst themselves, resulting in such situations as the middle aged woman who assumed responsibility for an epileptic child; the young who ran errands for the older; and the less disturbed who "adopted" and protected defectives, to their mutual benefit. Apart from the purely physical and emotional aspects, real attempts were also being made to meet spiritual needs, by encouraging the chaplains and personal ministers to visit; socially, entertainments were planned and games demanding teamwork and co-operation were organised. Finally, in the intellectual sphere, individual attention was devoted to securing suitable reading material for those who were not content with the usual run of romantic novel. Patients were emerging as whole persons.

At 3 p.m., the period of observation was concluded.

Observation of the second ward

The second example, unlike the last unit described, housed only 27 male patients at the time of the survey, all of whom were disturbed individuals.

Physically, the ward was in a good state of repair and had recently been decorated in contemporary pastel shades, but furnishing was inadequate and outmoded (particularly seating facilities) and the contrast between these two aspects produced a somewhat incongruous effect. Dormitory and other sleeping accommodation contained only beds and toilet buckets, whilst the lavatories lacked any kind of privacy, a fact which must have seriously hampered any attempts at resocialisation. The outstanding problem however, was shortage of space, which led to one of the nurses describing the pati-
patients as "like a lot of caged animals", when weather or circumstances kept them indoors.

Routine

Observation on this ward commenced at 2 p.m. The investigator's entry was unnoticed at first, for by pure chance, in knocking the wooden panel of the door, she had given the "staff signal", which normally indicated that the visitor was not an "official".

It was an extremely hot day and the patients, who had just had lunch, were waiting to be allowed out for exercise. Some stood at the door; a few lounged against the walls, but most had crowded into the tiny sitting room and had seated themselves on hard chairs or benches (there were no easy-chairs). After a while it became apparent that nursing help from other wards was not to be forthcoming, which meant that no outing would be possible. (The ward staff consisted of one charge nurse, one staff nurse and a student, at least one of whom would be needed to stay with bed patients.) An explanation of the circumstances was not given to the waiting patients but, in any case, by this time they had already lost interest.

As the afternoon progressed, a proportion of the patients continued to lounge (changing only the wall or their position), whilst the remainder and the nurses watched television and smoked.

Tea time saw the commencement of real activity. Tables, which had been stacked in the bathroom since lunch, were carried through and laid for the meal, to be eaten in the "all-purpose" sitting room. Two of the patients, whose feeding habits were even less acceptable than average, ate their meal on a table over the bath, and one remained standing throughout.
The meal, which consisted of bacon and fried bread, bread and margarine and tea, was delivered to the ward by a porter and squad of patients. Tea, which had been made in the central kitchen and later transferred to teapots on the ward, was of the characteristic grey hue. The only piece of cutlery allowed per person, was one dessert spoon, and the meal, served at 5.30–6 p.m., was the last that night, for most patients.

In the three quarters of an hour employed in preparing, serving and eating the meal, four fights developed between patients. One nurse in particular, was expert at separating the combatants with a minimum of physical restraint, and real tact was evidenced in settling, as far as possible, the original disputes. The observer however, was left with the impression that sheer overcrowding was the major factor contributing to the general unrest of the ward.

Following tea, the medicines were administered from a cupboard in the charge nurse’s office, and this duty was performed by a staff nurse. Twenty-two of the twenty-seven patients were on regular doses of tranquillisers or sedation of some kind, whilst two or three more needed drugs from time to time. Once again medicine measures were not washed between patients.

Towards the end of the round, a patient was given a routine dose of paraldehyde (a hypnotic). Each dose was dispensed individually, in small bottles, which were returned to the pharmacy every morning, and a day’s supply was sent at a time. When the dose had been poured out, the bottle, containing a few minims of the drug, was filled with water and handed to a mentally deficient patient, who had been haunting the nurse since the medicine round began. In one gulp the bottle was empty, and the patient, now beaming, handed it back to be replaced in the dispensary basket.
After the writer had observed this occurrence twice, she commented, to which the staff nurse replied, "That'll keep him happy. When this patient is bad, he really is bad and we keep him on an even keel this way." Although the obnoxious smell and taste of paraldehyde is thought to discourage addiction, nurses could often quote examples of the strange acquired taste developed by long-term patients. Once it has been developed, the constant and wearing demand for "just a wee sip" must prove a great temptation to any over-tired or over-wrought nurse.

With the conclusion of the medicine round, general activity went into reverse, and the tables were cleared and re-stacked in the bathroom. The room was swept after the meal, by both nurses and patients, and then the "bumpers" (polishers) came into operation again.

When the room had been set to rights, the television was switched off and the radio on. Volume and programme were controlled centrally, and were geared to the needs of the large widespread wards. The effect of so much deafening noise in such a confined area was nerve-racking, quite apart from the fact that it completely drowned the ringing of the telephone.

There was no evidence of constructive activity anywhere in the ward, although a half finished stool rested, by itself, on top of a cupboard in the staff room. The nurses informed the observer that since an accident, in which one patient used a needle as a weapon against another, the owner had not been allowed to continue his therapy. They explained that only two patients attempted occupational therapy on the ward in any case, and one other went to the department itself.

During the evening, the charge nurse was observed speaking to one or two patients, but the staff were working a 13 hour day and, on the whole, seemed happy to let life drift by with as little effort as possible.
When the ward was fairly settled, at about 7 p.m., a trained nurse remembered that he had a dressing to renew. It was a burn caused by a patient secreting a box of matches inside his shirt, and accidentally firing the entire number. The burn was severe and extended from shoulder to elbow. After the patient had removed his shirt, he stood beside a table in the sitting room (the other patients were not very interested), and waited to have it dressed. The nurse appeared with a pair of forceps, (the private property of another nurse), a pair of scissors and a roll of gauze, none of which was sterile. Without washing his hands, and whilst smoking a cigarette, he prepared the gauze on the unsterile surface of a meal table, and after extracting a piece of tulle gras from a tin, applied it to the area.

Soon after this it was time for the staff "break", at which they consumed tea and toast (officially). When it was over, the remains (six or seven pieces of toast and some half cold tea), were given to a group of patients waiting expectantly outside! The slices of toast were "dealt" to them like playing cards from a pack, and came straight from the fingers of a trained nurse.

At 7.40 p.m., preparation for the night began. Patients undressed, and their clothes were tied in bundles (secured by the coat sleeves), removed from the dormitory, and placed in a cupboard. When the shelves were full, or if the cupboard were too far away, the bundles were stored on the office floor.

Downstairs, patients who had spent the day in bed, were escorted upstairs to other rooms where they could be more easily observed by the night staff. Fresh patients immediately took possession of their original rooms. Although the observer did not witness the change of bed linen, she
was assured that this had been done between patients. The room, mattress and blankets, however, had not even had a brief airing before the night inhabitants took over. Finally, after two patients had swept and tidied the day accommodation, following the departure of the rest, the downstairs bedrooms were shuttered and locked for the night, and the last nurse joined his colleagues upstairs.

Most of the patients were in bed by this time, but one patient who had been restless and excitable, suddenly returned to his room, and peace reigned again. On enquiry, the writer was told that the nurses "save the ends of their cigarettes for the patients" (who promptly re-roll the tobacco in toilet or any other paper). The nurse continued, "It's amazing what it'll do" (i.e. tobacco). A patient, who came from another ward to help, was given a piece of fresh tobacco roughly \( \frac{1}{2} '' \times 1 \frac{1}{2} '' \), which caused him great delight, and was obviously regarded as a munificent gesture.

Generally speaking, the staff/patient relationship on the ward was good, even though individual approaches sometimes lacked "polish". The observer was told that, in a ward like this, "trouble has to be nipped in the bud", a policy which might have accounted for a certain brusqueness evident at times. Even so, a rough kindliness was co-existent, illustrated perhaps, by the use of a nickname or a pat on the shoulder.

The most disturbing feature of the ward was apathy, shown in each aspect of patient care. Examples have already been quoted in relation to physical care; emotionally the apathy was evidenced in a lack of personal contact with the individual, (apart from those who received a share of staff attention as a direct result of their anti-social behaviour). In the intellectual sphere, the observer was told that only one patient was allowed to visit the hospital library, whilst three out of twenty-
seven attempted occupational therapy of some kind. The amount of enthusiasm with which it had been pursued, was illustrated earlier in this section.

As far as spiritual care was concerned, the charge nurse told the investigator that, in the previous six months, he had only seen a chaplain on the ward once. He thought it possible that he might have been off duty for some of the visits, but it was unlikely that this would happen every time. He had never witnessed the visit of a private minister.

Socially, only three patients had parole which allowed them to attend hospital activities generally, whilst eight or nine went to the hospital cinema show, and about four to dances and concerts on the premises. Television was the main form of recreation, to the exclusion of most physical activity which would have demanded a greater number of nursing personnel, but would have paid dividends in an easing of both staff and patient tension.

When the observer approached the subject of intra-hospital contact, she was told that quite literally no co-operation existed with any discipline other than the medical staff, represented by the ward doctor, whose interest was strictly limited. Unlike the last ward described, there was virtually no evidence of mutual help between patients either, possibly because they were too little socialised.

Opportunity for discussion with the staff arose from time to time throughout the afternoon and evening, and it seemed that pointers towards the reasons for apathy emerged quite clearly. Relations with senior nursing and medical staff were strained and, as a result, discussion of problems was not easy. Fear of "victimisation" (which emerged on many occasions) characteristically appeared again, taking the form of complaints against too frequent periods of night duty; withholding of promotion, even alloca-
tion to a "difficult" ward, and jealousy of doubly trained colleagues, (i.e., those who were both general and mental trained). Resentment against the senior staff, who criticised ward routine, was expressed in the comment, "She should be here and have a day of it when they (the patients) can't get out all day. We've had enough by 8 p.m." That the staff were aware of tension, was illustrated by the young student who, when referring to physical fear, admitted that he was "shaking at times".

The older nurses on this ward had earned a reputation in their younger days, for organising social activities with the patients. It was particularly disturbing then, to hear one say that he was now "weary in well doing". He continued, "In this kind of work neither the staff nor the patients are appreciative of what you do."

A specific complaint about lack of equipment, concerned the "burns" case mentioned earlier. The accident had happened at night, and the investigator was told how the nurse on duty had had to run to a "sick" ward some distance away, to fetch a dressing. He added, "You wouldn't be allowed to have such sparse equipment as that in a factory".

During the period of observation, the staff virtually chain-smoked and gave the impression of being past even a pretence at professional appearances. The entire attitude of the ward was summed up by one of the trained staff who said, "We all start out with high ideals but get fed up with beating our heads against a brick wall." Observation was completed at 8.30 p.m.

Night Duty

As the writer explained in an earlier section, longer periods of observation were possible by night than by day, and these commenced at 7.30 p.m. or thereabout, and concluded at roughly 8 a.m. the following day.
In view of the similarity of routine in most wards, it has not been considered worthwhile to describe a series of "typical nights", but an attempt will be made to draw attention to certain aspects of patient care which emerged as important from the survey of all four hospitals by night.

The attention of the observer was drawn to clothing at an early stage in the proceedings. Whereas in many wards a large proportion of the patients were already undressed when the night staff came on duty, most nurses had to supervise at least a few patients preparing for bed. It was while this was in progress that certain shortages became apparent. In most of the long-term female wards, there was a dearth of foundation garments which, together with the general tendency of such patients to obesity, must have contributed substantially to their loss of pride in appearance. In the absence of suspenders, stockings were anchored with string which, in addition to being ineffective, accentuated the slovenly and unkempt impression already created. The substantial nature of the stockings usually ensured that they were in a good state of repair, but differences in colour were not always considered important. Inadequate supervision at night on some wards, resulted in patients sleeping in their day clothes, which in one or two extreme cases included even shoes.

On the long-term male wards, the principal shortage was underwear, particularly pants, and in some wards vests as well. In one hospital, patients were said to be easily identified in town by their typical "institution" shirts, and this fact was brought to the writer's notice by members of the nursing staff themselves.

Where hospital policy and finances permitted, cupboard space and lockers were provided to store patients' clothes, but too frequently these were not available. As he undressed, the patient would bundle his clothes
inside his jacket, tying the sleeves to secure the package, which would then be placed on a chair (or the floor) at his bedside, or removed to some nearby storeroom. In the morning it would be retrieved, usually by a "reliable" patient who was better acquainted with the individual bundles than the nurses, and the owner would attire himself in the creased contents.

On long-term wards, dressing-gowns and slippers were not generally used by night, and on one ward in particular, the staff apologised to the writer for the appearance of patients at the door, without even a night-shirt. The re-socialisation of such patients with the existing staff/patient ratio, (sometimes one nurse to 50-30 patients), was virtually impossible.

Shortage of linen by night was more pronounced than by day, firstly, because of a tendency for the day staff to allocate a strictly limited quantity for the use of night nurses, and secondly, because borrowing was more difficult to achieve when the nurse was alone and unable to leave her ward. In one ward, the observer witnessed that only six sheets and three night-gowns had been left out for 25 bed-ridden patients, some of whom needed changing two or three times in the night. An appeal, made to colleagues at supper time by the harassed nurse, produced one or two more. In a few wards, the shortage of sheets was so acute that they were often laundered on the ward, and put to dry in the bathrooms and sluices. The situation was aggravated on some wards by the use of draw sheets to dry patients, (in the absence of bath towels).

It is essential to point out at this stage that conditions as quoted above, refer to some long-term/chronic wards, and not to admission wards or neurosis units where, for the most part, patients were encouraged to wear their own clothes, and were nursed in reasonably well-equipped departments.
In one such ward, the approach to patients was heartening. A nursing assistant was in charge who, though untrained, seemed able to draw the best out of her patients as if by instinct. Routine was restricted to a minimum, and the fact that the patients appreciated the atmosphere, was illustrated by the way they rallied round to help their less fortunate patient-friends and incidentally, the nurse. Around 9 p.m. they helped themselves to a warm drink, after which they collected their sedatives and prepared for bed. One patient, a trained nurse, did considerable fetching and carrying for patients confined to bed, helped with washing-up medicine measures, and even surreptitiously slipped a spoon into the fingers of the nurse who was administering tablets by hand. A pride in personal appearance was deliberately fostered, and at 10 p.m. almost every bed was occupied by someone applying face cream, curling hair or generally preparing for the next day.

Emotional care, as evidenced by the nurse towards her patients, was reflected in their attitude to each other. One young girl, rather homesick and emotionally labile, was calmed on several occasions by the warm and friendly interest of more stable patients, who were merely emulating the successful approach so often witnessed and experienced during the acute stages of their own illness.

It was significant that in this admission ward, and on others, both acute and long-term, where less rigid discipline existed, the nurses found it necessary to apologise to the observer for what they evidently considered a departure from the "letter of the law".

Drugs and their handling, emerged as another important feature of mental hospital life. Each hospital had its own routine by night; in some wards a supply of medicines was left out by the day staff; in others, nurses were dependent on delivery by the night superintendent or a "patrol nurse".
(not always trained); in yet others, the nurses had access to drug cupboards on the wards.

Problems associated with the storage and administration of drugs were manifold and ranged from the trivial to the really serious. Where drugs were left out by the day staff, the process often entailed a considerable amount of work, e.g. in one or two wards, the drugs were actually removed from their enclosing capsules and emptied into envelope-like folded papers. These were marked with the name of the drug and dosage, and stored in a box which was made available to the night nurse. The paper wrappers were kept from night to night, until they disintegrated. Where, as in these wards, the sedative list was a long one, the extra stage before administration was time-consuming, pointless and even dangerous. In wards where delivery of drugs depended on a "patrol nurse", the situation was often highly unsatisfactory. Sedative drugs, in tablet and capsule form, would be checked and placed in a tin box or some other container, labelled with the ward number. On arrival at the ward, the nurse was sometimes expected to know the identity of drugs by their shape or colour e.g. seconal were reddish-pink capsules. Most of the drugs were distinctive, but occasionally there was difficulty where only the size of the tablet distinguished it from another. The number of tablets supplied would then provide the solution. On one occasion, the observer saw capsules extracted from the supply of the patrol nurse and counted into the hand of the staff nurse, who stored them in his waistcoat pocket until they were required. Another nurse, on duty alone in a disturbed ward, carried the bottles of paraldehyde in his jacket. He explained that there was no locking cupboard in the ward, and the office was too far away to be of any value. (He added, in passing, that he could not even hear the office phone ringing from the dormitory.)
The tendency towards paraldehyde addiction was even more noticeable by night than by day. The doses, made up individually, were frequently administered straight from the bottle, to patients who savoured each mouthful to the full. In one ward, where an attempt was being made to substitute another drug, the patient padded gently but persistently up and down the ward until she gained her own way, and was given an illegal dose. The odd minim or two, topped up with water, was sometimes adequate to pacify the long-term patient with a taste for paraldehyde, but the situation facing any nurse, particularly the young and inexperienced, was certainly no easy one.

Laxatives, though perhaps producing no dangerous problems, were responsible for considerable discomfort and distress arising out of unwise or thoughtless administration. In some wards, it was policy to ensure adequate bowel action by means of a routine laxative to the whole ward. Following one such medicine round, the two nurses and the writer, observing that night on a geriatric ward, spent a large proportion of their time changing soiled beds and attending to the hygiene of patients affected in this way. In another ward, a patient sat for 2½ hours on a commode. When enquiries were made of a kindly nurse, why this should be necessary he replied, "It saves him messing the bed".

Minor discomfort, which could have been avoided, was sometimes caused by inconveniently situated medicine cupboards. On one ward, a patient was complaining of flatulence and endeavouring to make herself vomit by poking her finger down her throat. Carminatives were kept in the drug cupboard downstairs and, but for the presence of the observer (who minded the ward in the nurse's absence), could not have been procured until the night superintendent's visit two hours later. On wards where inexperienced nursing
assistants were in charge, even routine injections and some sedatives by mouth had to await the arrival of a senior nurse before they could be given.

The standards of hygiene associated with medicine rounds have already been mentioned and include such points as the "communal" medicine measure, the drinking of medicines from the bottles, the wiping of patients' mouths with the tea-cloth used for drying medicine glasses, unsterile procedures in the giving of injections and unnecessary handling of pills and tablets. It must be remembered, however, that the length of medicine lists was often overwhelming whilst the number of trained staff in no way corresponded. To illustrate the size of the problem, an example of one such list has been included. (See end of Appendix IIIA) This ward was staffed during the day by one trained nurse, a pre-P.T.S. student, one university student (acting as a nursing assistant) and a ward orderly aged 15 years. A relief assistant looked in from time to time. The number of patients involved was 72, nearly 1/3 of whom were bedridden and needing a great deal of basic nursing care, whilst a large proportion of the remainder needed toilet assistance and/or help with feeding. By night there were just two nursing assistants.

But of all the problems associated with drugs, both by day and night, the most serious concerned arrangements for dealing with D.D.A. poisons. Provision of storage space and safeguards for such drugs varied tremendously from ward to ward and hospital to hospital. At one end of the scale, their supervision was entirely satisfactory. Locked cupboards within locked cupboards were provided for all medicines controlled by the Dangerous Drugs Act. Keys were entrusted only to trained staff, and adequate records of administration and checking were maintained. In some wards the procedure was carried even further, and a list was kept of literally every
tablet or dose of medicine administered - even to the most trivial. In passing, it may be stated that the necessity of keeping these oft-time lengthy and complicated records engendered a considerable amount of ill-will. On many wards the staff did not appreciate the underlying purpose of such a rule, and it had become merely a pointless and time-consuming routine, often delegated to a junior member of staff, and signed, without checking, by a senior nurse. In some wards the lists required the daily signature of a medical officer, a procedure presumably introduced to safeguard both nursing staff and patients.

Apart from the wards where a separate record was kept for each medicine round, (as described above), some wards were required to re-write their medicine lists daily, irrespective of whether there was any change or not. It seems possible that the risk of error creeping in, would increase with each copy. It is certain that the point of this unpopular task, (if any), was not understood by the nurses performing it.

At the opposite end of the scale, a certain laxity existed. Storage of medicines was sometimes haphazard. In one ward, the medicine cupboard was part of a converted wardrobe, the bottom of which stored equipment, and the next compartment, everything from patients' private food such as biscuits and sweets, to the ward's supply of linen and floor wax. Fortunately, on this ward there were no Schedule I or II poisons involved.

In other wards, particularly by night, keys to cupboards containing dangerous drugs were freely accessible to all. In two or three wards, the one key opened every cupboard and drawer in the duty-room, and when needed one night, was found after some search, lying in an office drawer. Sometimes the D.D.A. cupboard had a separate key which hung inside the medicine cupboard; on other occasions it was entrusted to the care of
nurses as junior as a pre-P.T.S. student, who was able to show the observer the complete stock of drugs.

The administration of dangerous drugs had decreased considerably after the introduction of the tranquillizers which meant that D.D.A. record books, designed some years ago and no longer entirely satisfactory, were still being used up. Many of them did not require the signature of the nurse checking the drug; others required only a doctor's signature to the effect that the drug had been prescribed, and this could be appended when convenient. In most instances the nurse preferred a colleague to check the drug for her own peace of mind, but often there was no written evidence that this had in fact been done.

An interesting point which might be quoted in concluding this section on drugs, concerns the soothing effect of substances, other than medicinal, administered by mouth. One nurse spoke of his ability to substitute cigarettes for sedatives, whilst many achieved a state of calm in patients much more effectively by means of food, suggesting that a later meal might contribute to the solution of the problem of heavy night sedation.

Following the tucking up of patients in bed and the administering of sedatives, the next happening, chronologically, was the visit of the Night Superintendent. The observer was permitted to accompany the senior night staff on many rounds of the hospitals, and the most outstanding feature of these tours was the conscientiousness of these supervisors, associated with a high degree of anxiety. It is, perhaps, not always appreciated how great a responsibility senior nurses shoulder at night, especially in hospitals where a large proportion of the staff are untrained.

Anxiety was manifested in a number of ways. One supervisor addressed each patient by name on the first round at night, and the last in the morning.
Before passing on, she waited for a reply. A second supervisor sought reassurance from the observer, regarding the mental condition of a patient who appeared more disturbed than usual. Her anxiety was increased by the fact that the patient slept in an unobserved and locked dormitory. A third superintendent insisted on switching on the lights at each round, to convince herself that the patients were all present and well. This was not popular in wards where patients were easily wakened.

Most of the anxiety was very well founded. On two occasions "convalescent" patients required transfer to observed wards during the night. Fear of finding patients ill or harmed, missing or even dead was expressed on numerous occasions, and the fear of fire breaking out in locked or overcrowded rooms, seemed a very real one. On one occasion when the observer sought information from a nurse as to whether he was able to hear anything of his patients downstairs, the reply came, "Oh no - we don't hear much here unless the toilet window is open". The possibility of their needing help during the night had apparently not occurred to him.

A more personal type of anxiety was sometimes manifested in connection with the widespread nature of the hospitals. In two hospitals particularly, night rounds entailed lengthy walks from ward to ward, through the grounds. The same sort of anxiety was shown in some instances, by nurses on duty alone in remote wards. It may have accounted for some of the stories of unexplained noises at night, and reports of the presence of mysterious, unauthorised persons in hospital buildings and grounds. Certainly the loneliness of such positions was a factor which could not be ignored.

Another feature of night rounds was noise. Fortunately, most of the patients seemed conditioned to the frequent and loud turning of keys in squeaky doors, and the tramp of noisy shoes on creaking floor boards, but
complaints were occasionally lodged by sleepless patients, or more often, by the staff.

Etiquette, if anything, was a little more closely observed by night than by day, but there were one or two exceptions, e.g. an increase in the amount of smoking on duty was noted by night, particularly on the female wards, where it was a relatively rare occurrence during the day. A second point worthy of note concerned the behaviour of male staff in the presence of senior nurses, both male and female. Whereas the majority showed adequate courtesy towards the opposite sex, on one or two wards male nurses remained seated during the round of the female night superintendent. Where the supervisor was himself male, the atmosphere was usually even more free and easy, illustrated by the use of Christian names and other similarly informal behaviour. The lack of etiquette shown to females, may well have been one manifestation of the resentment so frequently expressed by male staff towards women administrators, and is interesting when viewed from this angle. Occurring between men, it was much more indicative of the "hail-fellow-well-met" approach, which appeared to be distinctly cultivated between some male administrators and their more junior staff.

Following the official round, the ward normally settled for the night and the nurses were able to partake of a little light refreshment. Sometimes this was provided from a central depot, and carried to those members of staff without facilities for making their own, but where there was more than one nurse to a ward, the tea or coffee could usually be made on the spot. Much kindliness was evidenced during these breaks, when nurses would hand out tit-bits of cake or biscuits, provided at their own expense, to
restless patients. Unfortunately, now and then the social graces were missing, as on the occasion when a patient who persisted in singing, was quietened with a piece of toast which somewhat unprofessionally, even if good-humouredly, was tossed to him.

Night time often provided the best opportunity for observing really efficient psychiatric nursing, particularly in acute wards. In one such ward, an excellent piece of psychotherapy was witnessed in connection with a young and obstreperous adolescent. The interview terminated with a spontaneous apology from the patient, and with the nurse tucking her gently into her bed. On other occasions reassurance was offered, or a bed made comfortable, or perhaps a problem discussed, and in a more relaxed state of mind, the patient would fall asleep.

Following the tea-break, the routine *raising of patients*, principally those with a tendency towards incontinence, took place. In geriatric or long-term units this was a marathon, as in the ward where the nurse was in charge of 37 patients, distributed through three or four dormitories. The problems were emphasized by the use of heavy, antique commodes which had to be carried from bed to bed, and were both noisy and demanding of considerable physical effort on the part of the nurse. Some of the busier wards finished one toilet round only in time to begin another.

Where no further activity occurred until morning, as was the case in most wards, the nurses were free to keep awake in whatever manner they chose. During rounds of the hospital, it was interesting to note that relatively few carried out any active occupation, although one enterprising young man was working for his General Certificate of Education; another made lamp shades, and two or three played chess. Only a little
reading, apart from the newspapers, appeared to be done, and this probably accounted to some extent for the degree of smoking which occurred in an attempt to ward off sleep.

The hour at which patients were called in the morning depended partly on the amount of attention which they required, partly on the ward routine e.g. whether it was the responsibility of night or day staff to make beds, and partly on tradition. One admission ward had introduced a sensible modification of routine by stripping and turning mattresses at night, so that patients stayed up later in the evening, and could sleep till 7 a.m. next morning, when they merely tidied their beds*. In contrast to the late-rising wards, another admission ward commenced work at 4.45 a.m., putting on the main lights at 5 a.m. When the observer asked what was the next duty after tidying beds, she was told, "We usually do temperatures, but there aren't any at present so there's nothing to do until 5.30 a.m., when we have a cup of tea". At 5.30 a.m., the tea was duly made, and the break lasted till 6 a.m. when one of the nurses retired to finish her report, which had been started earlier. At 6 a.m., the observer was told that as the staff were not allowed to get patients up too early, they would not be called until 6.45 a.m., but the main lights were still left on to interrupt the sleep of several patients). Even

* Incidentally the difficulties experienced in bed-making were such as could only be fully appreciated by active participation. In one ward beds were so close together that they had to be pulled to the centre of the floor before they could be made; in another, two or three required moving before the corner one could be reached; in yet others, the size, quantity and quality of bed-linen provided the most outstanding problems. A shortage of chairs also contributed towards lowering the standard of nursing and hygiene by necessitating the stripping of bed-clothes on to either the floor or the next door bed.
allowing for unexpected happenings, they had been disturbed at least 1\(\frac{1}{2}\) hours before they needed to get up.

Several nurses, on long-term wards, complained about the necessity of dressing old people before the day staff came on duty. Some were got out of bed as early as 5.30 a.m., just to sit around in chairs for the rest of the day. In explanation, one conscientious nurse said that this was often done to avoid rushing the old folk themselves, and also to avoid leaving all the heavy cases for the day staff.

The problems of calling disturbed patients too early were witnessed on frequent occasions. On certain wards there were no chairs to sit on, and the patients rested on the floor until called to go downstairs. Tem-pers were easily frayed at this time in the morning, and congestion in a confined space tended to aggravate the situation. Disputes were not unusual under these circumstances, and required a great deal of skilful handling to avoid mishaps. Posturing and grimacing were common sights too, where bored patients stood around with nothing to do, and on wards where patients were wakened early before physical treatments such as E.C.T., the lengthy waiting period tended to exacerbate the general ward anxiety and tension.

Of course, there were patients whose background or illness made them virtually impossible to keep in bed. Examples of such patients included the old lady who rose at 4.30 each morning "to milk the cows"; the ex-nurse, who in her obsessional attempts to run the ward "as it should be run", rose at 3 a.m. to organise the toilet arrangements; and the male patient whose anxiety-relieving polishing commenced like clockwork at 5 a.m. That many of these early risers helped the staff cannot be denied, but on occasion they also afforded a source of embarrassment and annoyance, like the man who regularly "crashed" about the ward at 4.30 a.m., dusting.
The degree of assistance given by patients to the nursing staff was especially noticeable in the early morning, and particularly on busy long-term or geriatric wards. On one such ward, the observer spoke to a patient who was up and helping at 4 a.m. He pointed out that as he was always in bed by 7.30 p.m., he had had his full quota of sleep by 3.30 a.m. and was ready to rise. He added that he liked working for other patients, and it stopped him "getting irritable and bad-tempered and using vile language".

Where patients were employed in carrying out strictly nursing duties, both supervision and example were often seriously lacking. To quote an outstanding instance, an untrained nurse was seen to wash several patients with the same water and flannel, to dry their faces and backs (one of which was soiled) on a communal towel, and finally to use it for wiping her own hands before proceeding to the next task. Such low standards of hygiene were quickly adopted by the patient-helpers, and occasionally transferred to other duties. One patient, engaged in distributing breakfast trays, interrupted his task to empty urinals, later returning to the original duty without washing his hands.

Following the routine dressing and supervising of patients in the morning, it was normal for the report to be completed. In many instances it was composed of a list of drugs administered, and their degree of effectiveness. On some wards a line sufficed such as, "All patients slept well". More personal observations were not often recorded, and this gave the impression that either their value was not fully appreciated, or their purpose not fully understood. This lack of understanding was illustrated by such entries as "E.T.C. given", for "E.C.T. given". When the same error

*Electro-convulsive treatment.*
occurred persistently, one was forced to conclude that the report writer did not know for what the initials stood, even though this was a common physical procedure.

Night duty in every hospital drew attention to difficulties and deficiencies which, in the welter of activity and distractions, were not so obvious by day. The most important of these came under the headings of "communications" and "working conditions", both of which have been dealt with in detail elsewhere. It is therefore sufficient to say here that lack of communication, particularly between medical and nursing staffs, existed to an astonishing degree (See page 68) whilst working conditions were often highly unsatisfactory. When assessing the efficiency and competence of the psychiatric nurse, no judgment can be passed without first considering the inevitable effects of these two outstanding problems.

The period of duty usually ended at 3 a.m., but in some wards, the shift was completed by the nursing staff at 6.15 a.m.
## SAMPLE MEDICINE LIST

<table>
<thead>
<tr>
<th>Patient No.</th>
<th>Drug</th>
<th>Dosage</th>
<th>When Administered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Miltown</td>
<td>tab. I</td>
<td>T.I.D.</td>
</tr>
<tr>
<td></td>
<td>Carbrital</td>
<td>tabs. II</td>
<td>P.R.N.</td>
</tr>
<tr>
<td>2</td>
<td>Epanutin &amp; Phenobarbitone Special Mist.</td>
<td>caps. I</td>
<td>B.D.</td>
</tr>
<tr>
<td>3</td>
<td>Phenobarbitone</td>
<td>gr. I</td>
<td>T.I.D.</td>
</tr>
<tr>
<td></td>
<td>Mysoline</td>
<td>tab. I</td>
<td>T.I.D.</td>
</tr>
<tr>
<td></td>
<td>Chloral</td>
<td>gr. x</td>
<td>T.I.D.</td>
</tr>
<tr>
<td>4</td>
<td>Serpasil</td>
<td>0.25 mg.</td>
<td>T.I.D.</td>
</tr>
<tr>
<td></td>
<td>Omnivite</td>
<td>tab. I</td>
<td>T.I.D.</td>
</tr>
<tr>
<td>5</td>
<td>Largactil</td>
<td>50 mg.</td>
<td>T.I.D.</td>
</tr>
<tr>
<td></td>
<td>Sodium Amytal</td>
<td>gr. I</td>
<td>T.I.D.</td>
</tr>
<tr>
<td>6</td>
<td>Monodral</td>
<td>caps. 0.5</td>
<td>T.I.D.</td>
</tr>
<tr>
<td></td>
<td>Pipanol</td>
<td>tabs. II</td>
<td>T.I.D.</td>
</tr>
<tr>
<td>7</td>
<td>Sparine</td>
<td>50 mg.</td>
<td>T.I.D.</td>
</tr>
<tr>
<td></td>
<td>Omnivite</td>
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<td>Mercloran</td>
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<td>When Administered</td>
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<td>Hydrochloridi</td>
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<tr>
<td>43</td>
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<td>Drug</td>
<td>Dosage</td>
<td>When Administered</td>
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<td>Q.I.D.</td>
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<td>nocte</td>
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<td>Serpasil</td>
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WARD SCHEDULE

1. Name or number of ward.  
   (As completed during observation period)
2. Type of ward.
3. Sex of patients.
4. Number of patients.
5. Number and grade of staff.
6. Situated on which floor.
7. Any special features of situation (e.g. separate Villa).
8. General appearance (e.g. iron bedsteads, interior decoration).
10. Sluices.
11. Arrangements for disposal of soiled linen.
12. Recreational facilities on the ward (e.g. Radio).
13. Existence of any staff facilities (e.g. separate toilet, duty room).
15. Comments on ward equipment.
   a) Technical equipment (Injection trays, amount of equipment).
   b) Basic nursing equipment (bed-pans, wash-bowls).
   c) Linen.
   d) Cutlery.
   e) Arrangements for personal belongings (lockers, wardrobes).
16. Feeding Arrangements
   a) Number to dining rooms.
   b) On ward but able to feed self.
   c) Requiring help with feeding.
   d) Requiring full feeding.

Comments.
17. Arrangements for transporting food; and by whom.
18. Devices for keeping hot, serving, etc.
19. a) Number of patients able to dress unaided.
   b) Number of patients able to dress with assistance.
   c) Number of patients needing complete dressing.
   d) Number of patients who do not get up at all.

Comments.

20. a) Number of patients who can wash themselves unaided.
    b) Number of patients who can wash with assistance.
    c) Number of patients who need full washing.

Comments.

21. a) Number of patients to toilet unaided.
    b) Number of patients to toilet with assistance or reminder.
    c) Number of patients using commodes.
    d) Number of patients entirely bedfast, but continent.
    e) Number of incontinent patients.

Comments.

22. Administration of Medicines and Drugs.

   a) By whom.
   b) Any checking.
   c) Storage arrangements.
   d) Bowel check and administration of aperients.

23. Temperatures.

   a) If ever taken.
   b) In what circumstances.
   c) By whom.

24. Physical technical procedures.

   a) Type of procedure.
   b) Carried out by whom.
   c) Any other discipline concerned.

Comments.


   a) E.C.T. administration.
   b) Insulin
      ii) Modified.
   c) Drugs.
   d) Surgery.

Comments.
26. **General psychiatric care.**

Attempts to meet the following types of needs:

i) Emotional.

ii) Intellectual.

iii) Spiritual.

iv) Social.

Comments (Concerning attempts made, working with other disciplines, patients assisting each other, co-operative efforts.)

27. **Doctor’s rounds.**

   a) Accompanied by whom.

   b) Purpose.

   c) Frequency of routine checks.

28. **Relatives.**

   a) Dealt with by telephone.

   b) Dealt with by direct contact.

29. **Comments on communication and relationships.**

30. **General comments on staffing, such as numbers for tasks to be done,**

    efficiency, attitudes, intelligence.

31. **Administrative duties and ward organisation.**

    a) Any contact with other departments of hospital.

    b) Any allocation of work to staff and by whom.

    c) Amount of clerical work involved.

32. **General ward routines (and treatments).**

33. **Nurses’ comments (regarding the hospital set-up or staffing)**

34. **Stresses and particular problems (of this ward).**

35. **Miscellaneous.**
The Interview

The interview was timed to come at the end of the survey in each hospital, when the investigator was known to most of the staff, and when much of the original suspicion and apprehension had died down.

Topics discussed were more personal, and tended to elicit more emotional response than those covered by questionnaire. After the pilot study, the schedule was revised and a copy of the final plan may be seen on page 218.

Length of interview naturally varied from person to person, and ranged from fifteen minutes with an uncommunicative student, to over three hours with a loquacious charge nurse. As one would expect, the variation in time depended, to some extent, on the environment. On average, where the writer interviewed a nurse on her own ward and by night, the length of the interview tended to be greater than by day, when time was more restricted, and when part of this time had to be used by the nurse for travelling to the interview room. One factor which appeared to account for the extended night interviews, was that many nurses were on duty alone and welcomed the existence of anything which helped to pass the time. In addition, the familiar environment and absence of noise made for a greater degree of relaxation than was usually possible by day. Normally an hour was allowed for each interview.
Although a strict sequence of question and answer was followed (for purposes of comparison), the interviewer endeavoured to be so familiar with the order, that references to the schedule were reduced to a minimum and an atmosphere of informal conversation was cultivated. Replies were recorded in the presence of the interviewee and as far as possible, verbatim. It was interesting to note that very few nurses appeared perturbed by this procedure, and on only three occasions was the writer asked to withhold specific pieces of information. For the most part, they seemed pleased that their comments were considered sufficiently valuable to warrant reporting. The pause resulting from verbatim recording was found to be useful to both parties in that it gave time to marshall ideas and express "second thoughts".

Nurses from each grade were represented proportionally by the method explained in the main text. Most appeared to enjoy what they referred to as their "wee chat", and quite a large number expressed gratitude for the opportunity of discussing their work and problems. Many considered the interview had been therapeutic in effect, like the nurse who said, "This talk has done me more good than eleven years of working here". From this and other similar comments, the investigator was led to speculate on the possible advantages of employing a personnel officer, one of whose tasks might be just to sit and listen intelligently.

The number of nurses interviewed totalled 170, made up of 74 trained staff, 23 students and 63 nursing assistants.

SCHEDULED INTERVIEW

1. Number. (Revised form of questions asked during the interview)
2. Sex.
3. Grade.
4. Type of ward.
5. What made you choose this hospital to work in?
6. Do you think there are any special advantages or disadvantages in the position of the hospital, from both staff and patients' point of view?
7. Do you think that the average person outside, regards this hospital as they would an ordinary hospital? (i.e. General)
8. Have you any opinions on the furnishings, decorations, or general appearance of the hospital?
9. Have you any opinions on toilet accommodation, or any other equipment at all?
10. Are you resident or non-resident?
   A. For resident only
      a) Are you satisfied with the accommodation and facilities provided for you?
      b) If not, why not?
   B. For non-resident only
      a) What arrangements have you made for living out?
      b) Do you consider this an ideal arrangement?
      c) If not, what stops you from making different arrangements?
11. a) Are you satisfied with your duties on the wards?
    b) Do you think a nurse should ever do domestic work?
    c) If so, under what circumstances?
12. How do you feel about nurses supervising the activities of patients outside the wards, e.g. in the gardens? Do you consider this a nurse's function?
13. a) Have you ever taken part in a Case Conference?  
   b) If so, have you any comment to make on their value?  
   c) Do you think they should be confined to any special grade of staff,  
      or be open to all?  

14. a) Are you told the diagnosis of your patients officially?  
   b) Do you think the case notes of the patients should be seen by the  
      nursing staff?  
   c) If so, do you think they should see the full notes or an abbreviated  
      version?  

15. a) For Trained Staff only  
      Do the psychiatrists ever consult you about the treatment of the  
      patients?  
   b) For Students and Untrained Staff  
      Do you ever have an opportunity to discuss any of the patients  
      with the psychiatrist?  

16. a) Which type of patient do you find most difficult to nurse?  (i.e.  
      exhibiting what symptoms?)  
   b) Do you prefer nursing neurotic/psychotic patients?  
   c) Why?  

17. Many people with whom I have spoken say that they are, or have been  
    afraid to work in a mental hospital.  
   a) Have you ever experienced any fear?  
   b) Under what circumstances?  
   c) What did you do about it?  (i.e. to overcome it)  

18. a) Have you ever found any part of your work upsetting?  
   b) Can you remember what upset you?  
   c) Did you take any action as a result?  

19. Do you think that anything you have learned while working in a mental  
    hospital has proved of value in your private life?  (i.e. dealing  
    with difficult tradespeople or solving your own personal problems).  

20. Do you think that any special qualities of character or qualifications  
    are necessary to do this type of work?  

21. a) Do you think that mental nursing is regarded as a profession, in  
      the same way as General?  
   b) If not, what do you think is the difference?
22. a) Do you prefer day or night duty?
   b) Why?

23. If you were starting mental nursing all over again, what would you consider the most important things about your introduction to the ward?

24. How do you feel about discipline
   a) on the wards
   b) regarding your personal life?

25. Is there any situation which you have met while doing this work, which you would like to have been taught something more about, before having to cope?

26. Trained staff only
   Do you think promotion is fairly arranged?

27. Are you satisfied with working this number of hours, as they are, or would you prefer to see some other arrangement?

28. A. How far ahead do you know a) your holidays
   b) your off-duty

   B. Does this seem reasonable to you?

29. a) Do you ever have to work overtime?
   b) Is it compulsory or voluntary?
   c) Is it repaid in time or money?

30. a) Do you ever take patients off-duty with you?
   b) If so, where?

31. a) How do you secure an appointment with Matron?
   b) Is this an easy procedure?
   c) Are there any routine reasons for visiting her office? e.g. broken equipment.

32. Are you satisfied with the way in which you are informed of matters which concern you? (e.g. Ward changes or anything which affects the running of the hospital).

33. What do you think of wage scales in mental hospitals?

34. How do you feel about food and feeding arrangements, both on and off duty (day and night, and for both staff and patients)?
35. a) Do you ever have to work with any of the other disciplines such as occupational therapists, medical staff, social workers, etc.?
    b) Is this easy?

36. a) Do you think that spiritual help is necessary for patients in mental hospitals?
    b) Do you think it is of any value to staff doing this kind of work?
    c) What do you think of the existing arrangements for spiritual help?

37. For those who have completed over ten years' service

   How do you think that mental nursing today compares with the profession before the N.H.S.?

38. a) If you were to start your career all over again, would you still do mental nursing?
    b) If not, why not?
    c) If so, why?

39. a) Do you think there is a happy atmosphere in this hospital or not?
    b) Is it possible to pin-point what is responsible for it, or is it just chance?
APPENDIX V

Patient characteristics of individual hospitals

Status of patients

Table VI gives in detail the number of patients in each hospital and their distribution by status and sex. That considerable variation in the proportion of voluntary and certified patients existed, is more clearly illustrated in the following figures.

<table>
<thead>
<tr>
<th>Hospital No.</th>
<th>% Voluntary</th>
<th>% Certified</th>
<th>Vol. : Cert.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>57</td>
<td>43</td>
<td>1 : 0.8</td>
</tr>
<tr>
<td>II</td>
<td>39</td>
<td>61</td>
<td>1 : 1.6</td>
</tr>
<tr>
<td>III</td>
<td>17</td>
<td>83</td>
<td>1 : 4.9</td>
</tr>
<tr>
<td>IV</td>
<td>37</td>
<td>63</td>
<td>1 : 1.7</td>
</tr>
<tr>
<td>I - IV</td>
<td>32</td>
<td>68</td>
<td>1 : 2.1</td>
</tr>
</tbody>
</table>

Hospital I (urban and fee-paying) had a far higher proportion of voluntary patients than any of the remaining three, and was the only hospital with more voluntary than certified patients.

Hospital III (rural) at the opposite end of the scale, had only 1/5 patients with voluntary status, whilst 83% were certified. Between the two came Hospitals II (rural) and IV (urban) with roughly 2/5 voluntary patients in each instance.
## TABLE VI

<table>
<thead>
<tr>
<th>Hospital Number</th>
<th>No. I (420 patients)</th>
<th>No. II (457 patients)</th>
<th>No. III (1,069 patients)</th>
<th>No. IV (754 patients)</th>
<th>Combined Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% statutory pat. pop.</td>
<td>% statutory pat. pop.</td>
<td>% statutory pat. pop.</td>
<td>% statutory pat. pop.</td>
<td></td>
</tr>
<tr>
<td>SEX</td>
<td>M.</td>
<td>F.</td>
<td>Total</td>
<td>M.</td>
<td>F.</td>
</tr>
<tr>
<td>Voluntary</td>
<td>72</td>
<td>125</td>
<td>197</td>
<td>32</td>
<td>97</td>
</tr>
<tr>
<td>Certified</td>
<td>54</td>
<td>96</td>
<td>150</td>
<td>117</td>
<td>161</td>
</tr>
<tr>
<td>TOTAL</td>
<td>126</td>
<td>221</td>
<td>347</td>
<td>199</td>
<td>258</td>
</tr>
</tbody>
</table>

*These totals are exclusive of patients admitted to non-statutory provision.

The status of mental hospital patients (statutory provision).
Speculation on the cause of such wide variation, does not come within the present terms of reference, but undoubtedly an interesting field lies open for further research here. It is possible that income group, associated with social class and education, may have been related to these figures. Alternatively it may have been primarily a question of hospital policy, or even regional situation.

Sex

Once again Hospital I was somewhat atypical in the sex distribution of patients. Figures for the individual hospitals were as follows:

<table>
<thead>
<tr>
<th>Hospital No.</th>
<th>% M.</th>
<th>% F.</th>
<th>Ratio M. : F.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>36</td>
<td>64</td>
<td>1 : 1.8</td>
</tr>
<tr>
<td>II</td>
<td>43</td>
<td>57</td>
<td>1 : 1.3</td>
</tr>
<tr>
<td>III</td>
<td>48</td>
<td>52</td>
<td>1 : 1.1</td>
</tr>
<tr>
<td>IV</td>
<td>45</td>
<td>55</td>
<td>1 : 1.2</td>
</tr>
<tr>
<td>I - IV</td>
<td>45</td>
<td>55</td>
<td>1 : 1.2</td>
</tr>
</tbody>
</table>

Hospital I had a much higher proportion of female patients than any of the others, even though a female excess was evident in each hospital. Hospital IV reproduced exactly the sex ratio for the entire group, whilst Hospital III came nearest to achieving equal numbers of males and females.
The ratio of males to females, in both voluntary and certified patients, has been tabulated below.

<table>
<thead>
<tr>
<th>Hospital No</th>
<th>Voluntary</th>
<th>Certified</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M. F.</td>
<td>M. F.</td>
</tr>
<tr>
<td>I</td>
<td>1 : 1.7</td>
<td>1 : 1.3</td>
</tr>
<tr>
<td>II</td>
<td>1 : 1.2</td>
<td>1 : 1.3</td>
</tr>
<tr>
<td>III</td>
<td>1 : 1.1</td>
<td>1 : 1.1</td>
</tr>
<tr>
<td>IV</td>
<td>1 : 1.2</td>
<td>1 : 1.3</td>
</tr>
<tr>
<td>I - IV</td>
<td>1 : 1.3</td>
<td>1 : 1.2</td>
</tr>
</tbody>
</table>

As one would expect from the foregoing paragraphs, in each class (i.e. voluntary and certified) the proportion of females was considerably higher in Hospital I, than in the remaining three hospitals, whose figures were roughly comparable both between classes and between hospitals. The overall sex ratio for each hospital, as quoted earlier in this section, was of course reflected in the above figures.

Age of patients

A look at the four hospitals separately showed up some variation in the age/sex pattern. Table VII gives percentages in detail, which are illustrated in diagrams VI to IX (pp.226-227).

Once again Hospital I produced certain distinctive features; half of its patients were women over the age of 50, whilst 53% of the combined hospital population were over the age of 60. Although no hospital had many patients under 20 years, Hospital I was again unusual in that it had no female patients in that age group at all, and only 0.5% of the hospital population were women under 30. The male pattern was also atypical in
<table>
<thead>
<tr>
<th>Hospital Number</th>
<th>No. I (420 patients)</th>
<th>No. II (457 patients)</th>
<th>No. III (1,069 patients)</th>
<th>No. IV (703 patients)</th>
<th>Combined Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEX</td>
<td>M.</td>
<td>F.</td>
<td>Total %</td>
<td>M.</td>
<td>F.</td>
</tr>
<tr>
<td>AGE (in years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNDER 20</td>
<td>0.2</td>
<td>-</td>
<td>0.3</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>20-29</td>
<td>2</td>
<td>0.5</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30-39</td>
<td>4</td>
<td>6</td>
<td>10</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>40-49</td>
<td>5</td>
<td>7</td>
<td>12</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>50-59</td>
<td>7</td>
<td>15</td>
<td>23</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>60-69</td>
<td>8</td>
<td>15</td>
<td>23</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>70 &amp; over</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>TOTAL %</td>
<td>36</td>
<td>64</td>
<td>100</td>
<td>43</td>
<td>57</td>
</tr>
</tbody>
</table>

Table illustrating Age/Sex distribution of patients expressed as a percentage of the individual hospital population (to the nearest round number).
Diagram showing the distribution of patients in Hospital I, by age.

DIAGRAM VI

Diagram showing the distribution of patients in Hospital II, by age.

DIAGRAM VII
Diagram showing the distribution of patients in Hospital IV, by age.

Diagram showing the distribution of patients in Hospital III, by age.
that the figures rose steadily from 0.2% under 20 years of age, to the peak of 10% at 70 years and over (cf. peak age for the group, occurring between 40 and 60 years). As in each hospital, females aged 70 and over, were twice as common as males of the same age.

It is very likely that the fee-paying principle of the hospital accounted, at least to some extent, for the unusual age/sex distribution particularly in association with the younger age groups. The professional element at least, if not those of private income, would be more likely to consider private treatment after the age of 30 than before, because of the greater likelihood of financial establishment occurring in middle age or later.

Hospital II (rural), like all the hospitals, had fewer females than males under the age of 20, and the pattern up to the age of 60 years was similar to that of the combined hospitals, with the males increasing markedly between 40 and 60 years. In spite of a further atypical increase at 70 and over, the ratio of males to females in this group was still 1 : 2.

Hospital III (rural) was interesting in that it had fewer old people than any hospital in the group. Up to the age of 50, the pattern was similar to that of the combined hospitals after which, on the male side, the numbers dropped steadily from 12% to 6% at age 70 and over. On the female side the pattern compared with the group until the age of 60, when unlike any other hospital, the figures dropped, to rise again at 70 and over. As elsewhere the females outnumbered the males by more than 2 : 1 in the oldest age group.

Hospital IV was distinctive in that up to the age of 60, the sexes were roughly equal in number and that the males did not start to decrease until after the age of 70 years. The females continued to increase, once more typically reaching their peak at 70 years and over, when again they were equal to more than double the males of this age group.
The following figures summarise the sex ratio of patients according to age and hospital.

<table>
<thead>
<tr>
<th>Hospital No.</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>I - IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEX</td>
<td>M. F.</td>
<td>M. F.</td>
<td>M. F.</td>
<td>M. F.</td>
<td>M. F.</td>
</tr>
<tr>
<td>Patients under 60</td>
<td>1 : 1.5</td>
<td>1 : 1.1</td>
<td>1 : 0.8</td>
<td>1 : 1</td>
<td>1 : 0.9</td>
</tr>
<tr>
<td>Patients 60+</td>
<td>1 : 2</td>
<td>1 : 1.8</td>
<td>1 : 1.7</td>
<td>1 : 1.6</td>
<td>1 : 1.7</td>
</tr>
</tbody>
</table>

As may be seen, under the age of 60 years, females exceeded males in only one hospital, but over 60 years, this was the case in every hospital and to a significant extent in Hospital I.

Length of Stay

Table VIII is made up of figures supplied by officials at the beginning of the survey of each hospital, and refers to the length of time which patients had already spent in hospital when the study commenced. It is summarised below.

<table>
<thead>
<tr>
<th>% of hospital population to nearest whole number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital No.</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>In hospital Under 1 year</td>
</tr>
<tr>
<td>1- 4 years</td>
</tr>
<tr>
<td>5- 9 years</td>
</tr>
<tr>
<td>10-19 years</td>
</tr>
<tr>
<td>20-29 years</td>
</tr>
<tr>
<td>30 yrs. &amp; over</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
<tr>
<td>Hospital Number</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>SEX</td>
</tr>
<tr>
<td>In hospital</td>
</tr>
<tr>
<td>UNDER 1 yr.</td>
</tr>
<tr>
<td>1- 4</td>
</tr>
<tr>
<td>5- 9</td>
</tr>
<tr>
<td>10-19</td>
</tr>
<tr>
<td>20-29</td>
</tr>
<tr>
<td>30 years &amp; over</td>
</tr>
<tr>
<td>TOTAL</td>
</tr>
</tbody>
</table>

Patient length of stay, by hospital and sex (% to nearest whole number).
Almost 1/4 of Hospital I's patients had been in hospital less than one year, and over 1/2 (53%) had had a stay of less than five years. Compared with the remaining three hospitals, this was high, for in Hospitals II, III & IV, the proportion of patients hospitalised for less than five years, was 46%, 38% and 34% respectively. At the opposite end of the scale, Hospital I had only 13% of patients who had been in hospital over 20 years, whilst the remainder had 26%, 23% and 23% respectively. Again it is possible that the fee-paying principle had affected the duration of stay, which in turn would have been reflected in the above figures.

The sex ratio, according to length of stay and hospital is shown in the following table:

<table>
<thead>
<tr>
<th>Hospital No.</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>I - IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>In hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1 year</td>
<td>M. F.</td>
<td>M. F.</td>
<td>M. F.</td>
<td>M. F.</td>
<td>M. F.</td>
</tr>
<tr>
<td>1-4</td>
<td>1 : 2.3</td>
<td>1 : 1.8</td>
<td>1 : 1.6</td>
<td>1 : 0.9</td>
<td>1 : 1.5</td>
</tr>
<tr>
<td>5-9</td>
<td>1 : 2.3</td>
<td>1 : 1.4</td>
<td>1 : 1.3</td>
<td>1 : 1.6</td>
<td>1 : 1.5</td>
</tr>
<tr>
<td>10-19</td>
<td>1 : 1.4</td>
<td>1 : 1.1</td>
<td>1 : 0.9</td>
<td>1 : 1.3</td>
<td>1 : 1.2</td>
</tr>
<tr>
<td>20-29</td>
<td>1 : 1.6</td>
<td>1 : 1.9</td>
<td>1 : 0.9</td>
<td>1 : 1.3</td>
<td>1 : 1.2</td>
</tr>
<tr>
<td>30 yrs. &amp; over</td>
<td>1 : 0.6</td>
<td>1 : 0.8</td>
<td>1 : 1.2</td>
<td>1 : 0.8</td>
<td>1 : 0.9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1 : 1.8</td>
<td>1 : 1.3</td>
<td>1 : 1.1</td>
<td>1 : 1.2</td>
<td>1 : 1.2</td>
</tr>
</tbody>
</table>

Hospital IV was the only unit to have fewer females than males who had been in hospital less than one year, whilst Hospital I had a far higher proportion of females in this group, than either of the remaining two.

Of those patients who had been in hospital 30 years or longer, Hospital III
was atypical in its preponderance of women, whilst Hospital I had the lowest proportion of female patients in this group, of any of the four hospitals, in spite of its larger number of elderly women under treatment.

Summary of patient state

The most outstanding feature of the patient state statistically, was the high proportion of people over the age of 60, at that time, in the four mental hospitals. This was closely associated with a preponderance of female patients generally, who were however, more marked in the upper age groups and especially evident in Hospital I.

Certification of patients was apparently much more common in Hospital III than elsewhere, whilst at the same time this hospital had rather fewer elderly patients than the remaining three units.

Hospital I appeared to have a higher percentage of relatively short-term patients (i.e. those who had been in hospital under five years) than the rest of the group, but without more research it is impossible to determine whether this was the result of the fee-paying principle, the much higher staff/patient ratio, (see section on staffing) or any of the other factors mentioned in previous sections, such as education or social class of the patients concerned.
Staffing according to hospital

The total staff for the group (687 nurses), was distributed between the four hospitals in such a manner as to provide considerable variation in problems of personnel. Diagram X illustrates the situation as it was at the time of the survey. The outstanding point emerging is that Hospital I, with 30% of the combined staffs, was nursing only 16% of the combined patients, whilst Hospital II, with only 12% of the staff, was in fact nursing 17% of the patients. As may be seen in the later section on "type of service", the position was even more extreme than appeared at first sight, in that a higher proportion of Hospital I's staff were giving full-time service. Hospitals III (33% staff) and IV (25% staff) were nursing 40% and 28% of the patients respectively.

It is perhaps appropriate at this stage to recall the administrative arrangements for Hospital I, which account to some extent for the higher ratio of staff to patients. The hospital unit was composed of a main hospital and four nursing homes and, as one would expect, it was the latter which were most highly extravagant of staff. At this period, 62 nurses (38 full-time and 26 part-time) were employed in caring for 73 non-statutory patients; 22 were full-time trained nurses; 10 part-time trained and the remainder were nursing assistants equally divided between
Diagram illustrating the percentage of patients nursed in each hospital (to the nearest whole number).

Diagram illustrating the percentage of staff working in each hospital (to the nearest whole number).
full and part-time. Thus within Hospital I itself, almost 30% of the staff were nursing 17% of the patients.

Problems of staffing the main building were further exacerbated by its structure, which made economical use of staff extraordinarily difficult. The nursing of patients in single rooms and L or T-shaped wards, together with ill-positioned toilet accommodation and its consequent problems, made a high proportion of nurses essential for adequate supervision.

Sex of staff

Hospital I, as may be seen in Diagram XI, had by far the fewest male staff (18%), balanced to some extent by the lowest proportion of male patients too. The shortage of male staff was partially remedied here by the employment of female nurses on male wards when necessary.

Hospital II was interesting in that proportions of male and female staff were exactly reproduced in the patient statistics. The conclusions one might be tempted to draw are misleading however, because of the small number of female staff engaged in full-time service. As male nurses were not allocated to female wards, the "surplus" could not be spread, resulting in a serious staff shortage on the female side of the hospital.

Hospital III showed exactly the same proportion of male and female staff as Hospital II, but with a much higher percentage of full-time female nurses, the female shortage was less obvious. A further modification of distribution occurred through the patient statistics, this hospital having a greater percentage of male patients than anywhere else in the group.

Hospital IV reproduced the exact proportions of male and female patients as was average for the group, and almost exactly the staff distribution by sex too. Again the apparent female excess was modified by the
Diagrams illustrating distribution of staff by sex and type of service, according to hospital.

Diagrams illustrating distribution of patients by sex, according to hospital.
fact that well over half the staff concerned were part-time only. The remainder of the "surplus" was utilised on male wards.

Grade of staff and type of service

It has already been shown that considerable variation in the overall numbers of staff existed between the four hospitals concerned in this survey. The balance of staff was still further affected by the distribution of nurses according to grade, and by the number of hours they worked per week. (See diagram XII, page 238.)

In Hospital I could be found 28% of the total trained staff (for 16% patients), which equalled just over 2/5 of Hospital I's individual staff. Of these trained staff, 3/4 were full-time, which would make for a stable core of nurses who could be fully available to take part in therapeutic projects. The proportion of male trained staff was low, as mentioned earlier (see Table IX, page 239).

The students comprised just over 1/3 of the individual staff, and atypically, the females exceeded the males (by two). All were, of course, full-time, whilst the nursing assistants were equally divided between full and part-time. Sixty-seven per cent of this entire hospital staff were engaged in full-time duties.

Hospital II claimed only 11% of the total trained staff (for 17% patients) which again equalled 2/5 of the hospital's individual staff. The percentage of female trained staff was relatively low (see Table IX, p. 239), and of these, only just over 1/3 were full-time. In addition to the "excess" of male trained staff, the proportion of male students far exceeded the females, in a ratio of 7 : 1\[sup]6\]. Finally, whereas in every hospital female part-time nursing assistants exceeded the full-time, in Hospital II, only two of the female nursing assistants were full-time.

\[sup]6\]The ratio applies to actual numbers, rather than percentages as used in Table IX.
 Diagrams illustrating the proportions of staff in each hospital according to grade and full/part-time status. (Information provided by hospital officials.)
### Table IX

<table>
<thead>
<tr>
<th>Hospital Number</th>
<th>Sex</th>
<th>F.T.</th>
<th>P.T.</th>
<th>Combined</th>
<th>F.T.</th>
<th>P.T.</th>
<th>Combined</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>M.</td>
<td>9</td>
<td>-</td>
<td>9</td>
<td>6</td>
<td>3</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>F.</td>
<td>22</td>
<td>10</td>
<td>32</td>
<td>7</td>
<td>19</td>
<td>23</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>31</td>
<td>10</td>
<td>41</td>
<td>13</td>
<td>22</td>
<td>23</td>
<td>100</td>
</tr>
<tr>
<td>II</td>
<td>M.</td>
<td>22</td>
<td>-</td>
<td>22</td>
<td>17</td>
<td>4</td>
<td>-</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>F.</td>
<td>7</td>
<td>12</td>
<td>19</td>
<td>2</td>
<td>2</td>
<td>33</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>29</td>
<td>12</td>
<td>41</td>
<td>20</td>
<td>6</td>
<td>33</td>
<td>100</td>
</tr>
<tr>
<td>III</td>
<td>M.</td>
<td>32</td>
<td>-</td>
<td>32</td>
<td>6</td>
<td>4</td>
<td>-</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>F.</td>
<td>10</td>
<td>4</td>
<td>14</td>
<td>6</td>
<td>18</td>
<td>19</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>42</td>
<td>4</td>
<td>46</td>
<td>12</td>
<td>22</td>
<td>19</td>
<td>100</td>
</tr>
<tr>
<td>IV</td>
<td>M.</td>
<td>17</td>
<td>-</td>
<td>17</td>
<td>9</td>
<td>4</td>
<td>-</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>F.</td>
<td>11</td>
<td>19</td>
<td>30</td>
<td>8</td>
<td>12</td>
<td>19</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>23</td>
<td>19</td>
<td>47</td>
<td>18</td>
<td>16</td>
<td>19</td>
<td>100</td>
</tr>
<tr>
<td>I–IV</td>
<td>M.</td>
<td>20</td>
<td>-</td>
<td>20</td>
<td>8</td>
<td>4</td>
<td>-</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>F.</td>
<td>14</td>
<td>10</td>
<td>24</td>
<td>7</td>
<td>15</td>
<td>22</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>34</td>
<td>10</td>
<td>44</td>
<td>15</td>
<td>19</td>
<td>22</td>
<td>100</td>
</tr>
</tbody>
</table>

Table showing the distribution of staff in percentages, by sex, grade and type of service within the hospital.

(Corrected to the nearest whole number.)
whilst 27^1 were part-time. The staffing situation here was therefore rather more serious than in the remaining three hospitals, only 55% of the total staff of this hospital being full-time.

Hospital III with the highest proportion of full-time staff (76%), also boasted the highest percentage of trained staff (35% of the group total). These figures were associated with a high number of male trained but relatively few female trained nurses (See Table IX). The shortage was however compensated to some extent by the fact that 5/7 of the female staff were full-time, which may have been related to the existence of a shift system. There was an equal number of male and female students who represented a slightly lower proportion of the staff than their counterparts elsewhere. Again unlike other hospitals, full-time nursing assistants (combined male and female) exceeded the part-time.

Like Hospital I, Hospital IV showed a lower than average percentage of male trained staff but was distinctive in that its greatest number of trained staff was amongst the part-time females. Male students exceeded females (by two) and in the nursing assistant grade there were rather fewer females, both full and part-time, than was average for the group. The full-time staff for this hospital comprised 62% of the combined grades.

**Staff/Patient Ratios**

To summarise what has gone before, it is perhaps wise to record the situation in terms of staff/patient ratios, part-time staff being assessed as "half-units". The following figures show comparison by hospital.

<table>
<thead>
<tr>
<th>Hospital Number</th>
<th>Trained</th>
<th>Student</th>
<th>Nursing Assistant</th>
<th>Combined staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>1 : 6</td>
<td>1 : 15</td>
<td>1 : 6</td>
<td>1 : 2.4</td>
</tr>
<tr>
<td>II</td>
<td>1 : 16</td>
<td>1 : 29</td>
<td>1 : 24</td>
<td>1 : 7.1</td>
</tr>
<tr>
<td>III</td>
<td>1 : 11</td>
<td>1 : 33</td>
<td>1 : 15</td>
<td>1 : 5.3</td>
</tr>
<tr>
<td>IV</td>
<td>1 : 12</td>
<td>1 : 25</td>
<td>1 : 17</td>
<td>1 : 5.4</td>
</tr>
<tr>
<td>Group average</td>
<td>1 : 10</td>
<td>1 : 21</td>
<td>1 : 13</td>
<td>1 : 4.6</td>
</tr>
</tbody>
</table>

^1 actual numbers, as distinct from percentages used in Table IX.
That Hospital I had by far the most staff emerges very clearly when the figures are tabulated in this form. The staff/patient ratio for combined staff was nearly twice as high as the group average and the proportion of trained staff to patients indicated a marked numerical superiority over any of the remaining three hospitals.

To refer back to Table VIII, it may be recalled that Hospital I showed that at the time of the survey, \( \frac{53}{25} \) of the patients had been in hospital less than five years, compared with rather smaller percentages in the other three units. In addition, proportionately fewer of Hospital I's patients appeared in the group of people who had already been in hospital 20 years or more. In order not to exaggerate the significance of these figures, it must be recalled that Hospital I's patient population was largely "atypical" as described in detail elsewhere, nevertheless further research might reveal whether any positive correlation exists between numbers of trained staff and length of patient stay.

Hospital III was the second most favourably placed for staff generally, with an overall ratio of 1:5.3 patients but a particularly low proportion of students. When compared with patient length of stay (at the time of the survey), the most striking fact was the very high proportion of patients who had been in hospital 20-29 years; a number exceeding that of any other hospital. The drop in numbers which occurred in the last group (i.e., those in hospital 30 years or more) may have been related to the smaller number of old people in the 70+ age group of Hospital III.

These figures only apply to patients admitted under statutory provision. A high proportion of the non-statutory group would also come into this category.
Hospital IV was below the average for each grade, producing an overall ratio of 1 : 5.4, much the same as Hospital III. The main difference between the two hospitals however, lay in the distribution of staff by grade, Hospital IV having a much higher ratio of students associated with fewer trained and assistant staff.

Looking once more at patient length of stay, it was obvious that of all the hospitals, Hospital IV had the fewest patients who had (in 1953) been in-patients less than five years, but again the true figures would be increased by the inclusion of non-statutory patients. At the other end of the scale, it recorded the highest number of patients who had been hospitalised for 30 years or more.

By far the worst staffed unit, however, was Hospital II. Attention has already been drawn to the acute female shortage and the table on page 240 shows that the overall ratio was much lower than anywhere else; 1 : 7.1 compared with the average of 1 : 4.6. The picture was even more startling when ratios for individual grades were assessed. Only one trained nurse was available for 16 patients, one student for 29 patients and one nursing assistant for 24 patients. With so few staff it is surprising to find that 46% of the patients had been in less than five years even though more than 1/4 had been hospitalised for 20 years or longer.

It is perhaps relevant at this stage to mention that the hospital had been operating an "open-door" policy for several years.

Age of staff by hospital

Hospital I employed 82 trained staff who completed the questionnaire and from all but four of whom details of age were obtained. Only 16 (i.e. 1/5) were found to be under the age of 40 years, leaving 80% over that age.

1. A proportion of Hospital IV's patients were admitted under non-statutory provision and were consequently not included in the statistics.
The largest cluster of students occurred in the 25–29 age group whilst 73% of the nursing assistants were aged 40 years or more. The following table gives the figures in detail.

### HOSPITAL I

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Trained</th>
<th>Student</th>
<th>Nursing Assistant</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>20–24</td>
<td>-</td>
<td>3</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>25–29</td>
<td>5</td>
<td>12</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>30–34</td>
<td>4</td>
<td>4</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>35–39</td>
<td>7</td>
<td>1</td>
<td>13</td>
<td>21</td>
</tr>
<tr>
<td>40–44</td>
<td>15</td>
<td>1</td>
<td>14</td>
<td>30</td>
</tr>
<tr>
<td>45–49</td>
<td>21</td>
<td>-</td>
<td>22</td>
<td>43</td>
</tr>
<tr>
<td>50–54</td>
<td>16</td>
<td>-</td>
<td>20</td>
<td>36</td>
</tr>
<tr>
<td>55 &amp; over</td>
<td>10</td>
<td>-</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>No answer</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>32</td>
<td>28</td>
<td>92</td>
<td>202</td>
</tr>
</tbody>
</table>

Thus 30% of the combined staff were 50 years or older and facing retirement within a year or two, 12% having actually passed their 55th birthday. The hospital was however in a more favourable position, with regard to staff, than the remaining three.
Hospital II employed only 33 trained staff, who completed the questionnaire, 67% of whom were 40 years or more. Student numbers were very small indeed and included only one female. Of the 31 nursing assistants, 55% were 40 years or older.

Detailed figures were as follows:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Trained</th>
<th>Student</th>
<th>Nursing Assistant</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td></td>
<td>3</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>20-24</td>
<td>1</td>
<td>6</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>25-29</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>30-34</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>35-39</td>
<td>3</td>
<td>3</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>40-44</td>
<td>4</td>
<td>-</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>45-49</td>
<td>10</td>
<td>-</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>50-54</td>
<td>5</td>
<td>-</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>55 &amp; over</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>33</td>
<td>15</td>
<td>31</td>
<td>79</td>
</tr>
</tbody>
</table>

In this hospital only 16% were facing retirement within a short period of time, but the staff was very small and staff/patient ratios were much lower than anywhere else.
There were 99 completed questionnaires from the trained staff of Hospital III, 64% of whom were 40 years or older. The largest group of students occurred between 20 and 24 years of age and the highest proportion of students under 20 years anywhere, was found in this hospital. Strangely enough the oldest student recorded in any hospital (aged 51 years) was also training here. Well over half the nursing assistants (53%) exceeded 40 years of age.

Detailed figures were as follows:

<table>
<thead>
<tr>
<th></th>
<th>Trained</th>
<th>Student</th>
<th>Nursing Assistant</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>-</td>
<td>7</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>20-24</td>
<td>4</td>
<td>10</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>25-29</td>
<td>5</td>
<td>-</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>30-34</td>
<td>6</td>
<td>5</td>
<td>12</td>
<td>23</td>
</tr>
<tr>
<td>35-39</td>
<td>21</td>
<td>3</td>
<td>16</td>
<td>40</td>
</tr>
<tr>
<td>40-44</td>
<td>20</td>
<td>1</td>
<td>11</td>
<td>32</td>
</tr>
<tr>
<td>45-49</td>
<td>17</td>
<td>1</td>
<td>14</td>
<td>32</td>
</tr>
<tr>
<td>50-54</td>
<td>-</td>
<td>1</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>55 &amp; over</td>
<td>6</td>
<td>-</td>
<td>13</td>
<td>19</td>
</tr>
<tr>
<td>No answer</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>99</td>
<td>28</td>
<td>90</td>
<td>217</td>
</tr>
</tbody>
</table>

Thus 22% of the combined grades were 50 years or more and facing possible retirement.
Hospital IV employed 74 trained nurses who were prepared to reveal details of age, and of these 69% were 40 years of age or more. The largest group of students occurred again between 20 and 24 years and, like Hospital III, 53% of the nursing assistants were 40 years or older. Detailed figures were as follows:

**HOSPITAL IV**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Trained</th>
<th>Student</th>
<th>Nursing Assistant</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 20</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>20-24</td>
<td>1</td>
<td>11</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>25-29</td>
<td>5</td>
<td>8</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>30-34</td>
<td>3</td>
<td>4</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>35-39</td>
<td>14</td>
<td>3</td>
<td>14</td>
<td>31</td>
</tr>
<tr>
<td>40-44</td>
<td>16</td>
<td>-</td>
<td>10</td>
<td>26</td>
</tr>
<tr>
<td>45-49</td>
<td>17</td>
<td>1</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td>50-54</td>
<td>8</td>
<td>-</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>55 &amp; over</td>
<td>10</td>
<td>-</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>No answer</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>74</td>
<td>29</td>
<td>60</td>
<td>163</td>
</tr>
</tbody>
</table>

In this hospital 17% of the staff were 50 years old or more and facing retirement in the near future.

To summarise briefly, it may be seen that in each hospital a fairly high proportion of staff exceeded 50 years of age, the most serious situation occurring in Hospital I where 3/10 were concerned but where, fortunately, the highest staff/patient ratio existed. The position in Hospitals II and IV (one rural and one urban) were least seriously threatened by retirement, but their advantage was modified by having the least staff to begin with. The figures quoted above make no allowance for marriage
or other possible causes of wastage but are perhaps sufficient to illustrate the ageing nature of the nursing population with its attendant problems.
APPENDIX VII

Food

The subject of food, whilst important to almost everyone, tends to assume outstanding dimensions in hospitals, for obvious reasons. In this way, the four mental hospitals involved in the survey, proved no exceptions.

The physical environment has already been described; sometimes 200-300 patients ate together in a vast, impersonal dining hall; elsewhere they were seated at tables by their bedsides; on a few wards adequate and attractive facilities were available whilst on others, occasionally a board over the bath did service as a dining table. It must be remembered too, that an equally wide variety of patient needed to be catered for. Some, with neurotic illnesses, had impeccable table manners and shrank from contact with those who had not. Some were depressed and required coaxing to eat; some, perhaps engaged in manual labour, were less fastidious whilst others absorbed in psychotic phantasies, hardly noticed that their food was disappearing on to the plates of their companions at table. Finally, there were some, who, because of a physical disability such as Parkinson's disease, or chorea, or severe epilepsy, were better fed on their own.

Cutlery

An oft-quoted feature of traditional mental hospital life was the counting of knives and forks at each meal. Changes in therapy and outlook toward the patient, in addition to a staff shortage, have modified
this feature to some extent. A proportion of patients have been adjudged responsible enough to be trusted with cutlery. On small wards, others have been allowed it under supervision, but a large number were still being provided with only one, or perhaps two dessert spoons for the entire meal. With relatively small numbers of staff to supervise large numbers of patients, this was hardly avoidable at the time of the survey.

Crockery

In most instances crockery was made of thick white china, but in one hospital a plastic material was being tried out. Unfortunately, although breakages had been reduced and the appearance of tables improved by the innovation, complaints were being received from patients about both the taste of food thus served, and about the tendency of the cups to become discoloured by tea.

Service

Whereas each hospital had its individual problems in connection with the service of food, they all shared one in common—the difficulty of producing a really hot meal for each patient.

Distribution to wards

In one hospital, the design of the main building, in addition to the provision of separate villa-type accommodation for patients, made the use of heated trolleys impossible. As a result food either had to be cooked on the premises, or carried by hand from the central kitchen. This was not a popular task with nursing staff, who were sometimes called upon to perform it.

In a second hospital, it was possible to use trolleys, but these were of an open variety, which again needed to be fetched by either patients or nurses, from the central kitchen.
In a third hospital, which also had a number of separate buildings but fewer stairs than the first hospital mentioned, food was delivered to individual wards or distribution kitchens by a porter, in charge of "a squad" of patients. Sometimes the food appeared in thermos containers; sometimes in large milk churns and sometimes in "bath-like" serving dishes, fully exposed to the air. The wards nearest the distribution kitchens were expected to arrange their own transport, and this usually took the form of a patient wheeling an ordinary open trolley.

The fourth hospital was able to use heated trolleys for a proportion of the wards but, once they had left the central kitchen, there was nowhere on the individual wards where they could be plugged in again. Upstairs wards were excluded from benefit by the size of the lift, which was not large enough to accommodate their bulkiness.

Service to communal "halls"

The "halls" were commonly found near to a distribution kitchen so that the transfer of food was a relatively simple process. Service to individual patients was not so easy. In each hospital, as much as possible was prepared before meal times began, and this entailed a very early start where numbers were large. In one hospital, nurses and domestic staff were responsible for laying the tables, putting out the bread and preparing for service of the meal; in the remaining three, patients did most of the preparation, sometimes supervised by nursing staff.

The summons to food came in various ways, ranging from the ringing of a bell in one hospital, to reliance on the call, "Hall-time" in the individual wards of another.

Following the summons, it was usual for the patients to seat themselves in their accustomed positions without further prompting; where this was
accomplished without a hitch, it was often considered a commendable achievement, second only to getting them to rise together, by a clap of the hands, at the end of the meal.

The food was normally served with conventional implements, from containers resembling small baths. Where patients assisted with this procedure however, close supervision was required to ensure that the "fingers were made before forks" philosophy was not put into practice. One patient in particular, objected strongly to receiving his sausage and potato literally from the hands of another; he was also justifiably concerned about the standards of hygiene in connection with washing up, and was responsible for drawing the observer's attention to the need for adequate supervision of patients performing this task.

In most of the "feeding units", the meal was distributed from the end of each individual table. A nurse might however, be responsible for the supervision of several tables at the same time, and this was often difficult. On one unit, accommodating 150 patients, the nurse was seen to offer second helpings, which were eagerly sought after. Some patients kept their eyes on their plates to ensure that the contents were not stolen in transit; others solved the problem by clenching the remains of their first helping in their hands - perhaps a portion of fish - and passing only the empty plate. A deterioration in table manners could only be expected where shortage of staff, and sometimes of food co-existed.

On a second unit, while patients queued outside a locked door, the first course was served before their entry, and was consequently barely luke-warm by the time they were seated. The second course lay cooling on the service hatch, whilst the tea, made in a central kitchen, transported in a milk churn and finally poured out of copper kettles, presented anything
but an appetising appearance.

With such mass distribution of food amongst mentally sick patients, it was often very difficult to observe the niceties of a meal table. Drinking water was not usually provided, and the odd patient, to whom this mattered a lot, might be seen on his way to the dining hall with a jam jar of water. Condiments were another luxury which, though possible to control in smaller units, provided more problems in the larger. Faced with such formidable numbers of patients, it is small wonder that the nurse occasionally slipped up in her allocation of special diets. If the patient concerned were sufficiently in contact with reality, he might be able to help with this situation; if he were not, the man on a fat-free diet might be found sitting in the corner, feasting on a fried egg.

Times of meals

Times of meals varied only slightly from hospital to hospital. All served breakfast in the region of 8 a.m., with lunch about 1 p.m. In one hospital with rather smaller wards than the others, a mid-morning egg flip or tasty snack was prepared by the nurses, for those of capricious appetite. Naturally, some of the "raw materials" for these culinary exploits were provided by the patients themselves or their relatives. In the remaining hospitals, there appeared to be no consistent policy. Some sisters hoarded buns or biscuits from the previous night's supper and produced them mid-morning; others spent special amenity funds on provisions; certain patients were supplied with thick slices of bread and margarine, and "anaemic"-looking tea in return for services rendered; others were taken to the "halls" where a drink and perhaps a slice of toast were officially supplied. Not only did arrangements vary between hospitals, but also between wards, and a lot seemed to depend on the ingenuity and initiative of the nurse in charge.
After midday, arrangements varied even more. One hospital, which had scientifically examined the amount of food provided for patients, had introduced an extra meal as a result of their findings. Afternoon tea was served at 3.45 p.m., with high tea at 7 p.m. In this, the patients were better off than the resident staff, whose last set meal was at 5 p.m. or 5.30 p.m.

In a second hospital, tea was served at 3 p.m. with supper at 6 p.m. Shortage of domestic staff made a later meal difficult to contemplate, but the feeling was that the last three meals of the day came too rapidly one after the other, followed by a consequent 1/4 hour break till breakfast.

The third hospital served high tea to the bed wards at 4.45 p.m., with a snack consisting of something like cocoa and a bun at 7 p.m. On the other wards, high tea at 6 p.m. was the last meal for the day.

At the fourth hospital, the last meal was officially served at 5 p.m. or 5.30 p.m., but on some wards tea or cocoa was available, if fetched from the central kitchen.

Diet

A good, balanced diet was often difficult to secure for many reasons, not least of all financial, but lack of imagination also played its part.

Breakfast in two of the hospitals consisted largely of carbohydrate - porridge and bread - with tea, margarine and sometimes marmalade to complete the meal. In one of these hospitals, a protein course was provided for breakfast regularly once per week, and occasionally more often. On one ward, where tapioca pudding was served to those on light diet at breakfast time, it was interesting to note that although the staff commented spontaneously on this unconventional approach, they were apparently used to the situation. It must be recorded too, that none of the patients was
heard to complain.

Lunch was a three course meal in three of the hospitals, and variable in the fourth, where usually either soup or a dessert was served, but rarely both, except on certain bed wards. The quality of food also appeared to be somewhat poorer here, on average, than in the remaining three. On one occasion, in a ward where most of the patients were "workers", a lunch of soup, meat roll and potatoes was served. Even the catering officer could not account for the absence of vegetables. No dessert was generally available, but a very small quantity of milk pudding was divided, by the ward sister, amongst the old folk. A cup of tea completed the meal.

Naturally, sometimes the fault lay in the cooking. In another hospital, a main meal of an egg, sausage and potatoes was served. Two men employed on heavy manual labour complained that the sausage was not cooked and, in any case, this was not an adequate meal for hard-working men. They also complained that 13 hours was too long a period to go without food at night. One of them remarked that he was afraid to approach the chef direct, - "They would row us for complaining. If we complain to the attendants, they tell the kitchen and nothing is done".

In contrast to the patients who sought a more filling meal, were those who were unable to cope with what was provided. It was not unusual to see toothless old people fighting a losing battle with a plate of fried fish or, even more serious, as was observed in a third hospital, a patient just recovering from a severe attack of pneumonia, faced with a formidable plate of meat pie which would have challenged the most robust digestion.

Waste

Waste of food, occurring in all four hospitals, was accounted for by a variety of reasons. Firstly, the food was sometimes inedible. As one
patient was heard to say, "(one) sweet they serve is no more than dry bread soaked in custard, and often the milk pudding is just made with water".
Whether the diagnosis was accurate or not is irrelevant; the fact remains that the patients did not eat it. Secondly, occasionally quantities of food—particularly semi-solid foods like custard and gravy—were grossly over-estimated, and it was said to be difficult to use the surplus on its return to the kitchen. Thirdly and most serious of all, surplus food was often contaminated by patients, and unfortunately, sometimes by nurses too.

It occurred in this way. After a meal had been served, there might be as much as half a container of porridge or custard or soup left unused. As the plates were collected in for washing, it was not unusual for them to be scraped into the container, instead of on to a spare dish of some kind. On the least careful wards, double wastage occurred, in that bread, left over from the first course, was sometimes returned to the kitchen floating on top of the surplus custard from the second course. Shortage of staff and apathy once again ensured that re-socialisation in spheres such as this, was a long and fruitless battle.

However, in spite of the many difficulties and obstacles in the way of good feeding, one hospital had achieved a great deal. A serious attempt to provide variety in diet was relieving at least some of the monotony of institutional routine, whilst the provision of "extras" like glasses of milk at lunch time, showed an imagination and appreciation of the patient as an individual, which ought at all times to be encouraged.

It is perhaps unfortunate, that in none of the hospitals was a qualified dietitian employed in spite of the need, illustrated by the number of instances of anorexia, obesity and physical illness requiring special diet, now encountered within the walls of psychiatric wards. There can
be no doubt that her services, in an environment where food is often the principal high-light of the day, would make a vast impact on conditions as they are at present.
# APPENDIX VIII

## MENTAL NURSING STUDENTS, 1959

<table>
<thead>
<tr>
<th></th>
<th>Cash Allowance</th>
<th>Emoluments</th>
<th>GENERAL Nursing Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 18 on entry</td>
<td>335</td>
<td>130</td>
<td>-</td>
</tr>
<tr>
<td>Age 19 on entry</td>
<td>350</td>
<td>130</td>
<td>-</td>
</tr>
<tr>
<td>Age 20 on entry</td>
<td>370</td>
<td>130</td>
<td>-</td>
</tr>
<tr>
<td>21 or more 1st year</td>
<td>430</td>
<td>153</td>
<td>235</td>
</tr>
<tr>
<td>2nd year</td>
<td>450</td>
<td>158</td>
<td>300</td>
</tr>
<tr>
<td>3rd year</td>
<td>470</td>
<td>158</td>
<td>320</td>
</tr>
</tbody>
</table>

Cash payment of £40 on passing preliminary examination (General Nurses £5)

Cash payment of £50 on passing final examination (General Nurses — Nil)

There were no dependants' allowances for mental nursing students.

Students over 21 were charged £49 per annum for meals on duty, and use and laundering of uniform.

continued overleaf.
### Trained Nursing Staff, 1959

<table>
<thead>
<tr>
<th>Position</th>
<th>Emoluments</th>
<th>GENERAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Sister</td>
<td>670-850</td>
<td>205</td>
</tr>
<tr>
<td></td>
<td>25(6) 30(1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>+ stages to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>equal pay</td>
<td></td>
</tr>
<tr>
<td>Charge Nurse</td>
<td>675-850</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25(7)</td>
<td></td>
</tr>
<tr>
<td>Female Staff Nurse</td>
<td>545-675</td>
<td>180</td>
</tr>
<tr>
<td></td>
<td>20(5) 25(1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>+ stages to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>equal pay</td>
<td></td>
</tr>
<tr>
<td>Male Staff Nurse</td>
<td>550-675</td>
<td>180</td>
</tr>
<tr>
<td></td>
<td>20(5) 25(1)</td>
<td></td>
</tr>
<tr>
<td>Nursing Assistants over 21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Assistant (Female)</td>
<td>425-550</td>
<td>160</td>
</tr>
<tr>
<td></td>
<td>20(6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>+ stages to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>equal pay</td>
<td></td>
</tr>
<tr>
<td>Nursing Assistant (Male)</td>
<td>430-550</td>
<td>160</td>
</tr>
<tr>
<td></td>
<td>20(6)</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX IX

Categories of ward as supplied by individual hospitals

1. Admission
2. Acute admission
3. Quiet admission
4. Disturbed
5. Acutely disturbed and others
6. Long-term disturbed
7. Long-term disturbed and unreliable
8. Long-term, less socialised
9. Long-term, less co-operative
10. Observation
11. Acute psychotics
12. Psychotics
13. Geriatric
14. Physically ill
15. Convalescent
16. Semi-convalescent and long-term at a good level
17. Convalescent and well socialised
18. Convalescent and farm colony
19. Short-term
20. Long-term
21. Continued treatment
22. Long-term quiet
23. Long-term quiet and less socialised
24. Mixed long-term
25. Open ward - mostly chronic
26. Open ward - mixed
27. Retired hospital working patients and others
28. Mostly working patients
BIBLIOGRAPHY

Altschul, Annie "Aids to Psychiatric Nursing", London 1957

Archer, P. "All Doors are Open All Day", Nursing Mirror, 3rd May, 1957.


Blair, D. "Music as a Therapeutic Agent", Nursing Mirror, 23rd May, 1953.

Bowe, A. B. "Beyond Procedures - Incidental Teaching", Nursing Outlook, November, 1953.


Bredenburg, V. C. "Nursing Service Research; Experimental Studies with the Nursing Service Team", Philadelphia, 1951.

British Medical Journal (General article) "Mental Hospitals of the Future", 9th April, 1960.

British Medical Journal (Leading article) "Patients in Mental Hospitals" (2nd August, 1958)

British Medical Journal (Leading article) "Open Doors", 3th November, 1953.

Brocklehurst, P. D. "Do The Hospitals Want Older Recruits?", Nursing Mirror, 5th April, 1957.


Charatan, F. B. "Psychological Aspects of Bodily Disease", Nursing Mirror, 28th June, 1957.


De Boosere, Deodatus "Psychiatric Clinic in Belgium" (New Unit at Ghent) Nursing Mirror, 21st February, 1958.


Greenblatt, H., York, R. H., and Brown, E. L. "From Custodial to Therapeutic Patient Care in Mental Hospitals - explorations in Social Treatment", New York, 1957.

Hird, N. G. "Socio-therapy - Resocialisation of Chronic Mental Patients by Reciprocal Inter-action", Nursing Mirror, 6th February, 1959.

H.M.S.O. Mental Health Act, 1959.


Izzard, W. "A Study of Therapeutic Meetings in a Neuroses Hospital", Nursing Mirror, 7th December, 1956.


Lembo, B. "Admission of Mother and Child at Moorhaven", Nursing Mirror, 5th June, 1959.


Lancet (Leading article) "The Right Background", 2nd August, 1953.


Lentz, E. M., and Michaels, R. G. "Comparisons between Medical and Nursing Research, Autumn, 1959. Surgical Nurses"

Liverpool University Social Science Department "Deva Hospital", Unpublished, 1954.

Loe, P. "Mental Health and Psychiatric Nursing", Nursing Mirror, 14th June, 1957.

MacCallan, D. R. "Ideals in Mental Nursing", Nursing Mirror, 12th October, 1956.


MacLean, A. "Reorganisation of a Mental Hospital", Nursing Mirror, 31st January, 1958.

MacLean, E. E. "Mental Nurse in Dungarees", Nursing Mirror, 12th June, 1959.


Manchester Regional Hospital Board and University "The Work of the Mental Nurse", Manchester, 1955.


Ministry of Health and General Nursing Council Memoranda
"The Nurses (Amendment) Rules Approval Instrument",
Presented to Parliament, April, 1960.

Muller, T. G. "The Nature and Direction of Psychiatric Nursing"; the Dynamics of Human Relationships in Nursing,

National Association for Mental Health Conference on "The Needs of the Mentally Sick",

National Association for Mental Health "The Practical Application of Research and Experiment to the Mental Health Field", London, 1953.

National Association for Mental Health "Mental Health and Personal Responsibility",
Newcastle Regional Hospital Board "The Use of Colour in Hospitals", 1955.

Northern Ireland Hospital Authority "Report on Nursing Committee",
Belfast, 1960.

New York, 1957.

Nuffield Provincial Hospitals Trust "The Work of Nurses in Hospital Wards",
London, 1953.

Nursing Mirror (Anon.) "Mixed Staffing in Mental Hospital Wards",


Oppenheim, A. N. "The Function and Training of Mental Nurses",


Royal College of Nursing (Report) "A Comprehensive Mental Nursing Service".


Schmidt, M. S., and Gordon, J. Berkeley "A Co-operative Plan for Bettering Nursing Outlook, September, 1958. Care to the Mentally Ill".

Schwartz, M. S., and Shockley, E. L. "The Nurse and the Mental Patient": A Study in Interpersonal Relations,


Tyson, J. "Case Assignment in a Mental Hospital", Nursing Mirror, 6-13th June, 1958.


Wright, R. A. "Re-establishing the Ex-Mental Patient in his Own Social Nursing Mirror, 28th August, 1959.