PSYCHIATRY IN GENERAL HOSPITALS—DEVELOPMENTS AND PROSPECTS*

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Among the many recent developments in psychiatry there are a few basic currents that are running strongly—so strongly that, like a mighty river, they are changing the entire look of the land—forming new channels and altering the topography of the psychiatric world.

I mention just a few landmarks on the latest psychiatric map—the introduction of the new psychotropic drugs; the 'open door' policy of mental hospitals; the new British Mental Health Act of 1959; the Amsterdam community psychiatry plan; the swing to the community and the first day-hospitals in Canada and England in the early 1950's. All these have altered the look of psychiatry and it will never be the same again.

New Currents

The major currents are as follows:

Perhaps the most important of all is the shift of the centre of gravity of psychiatric services towards the community so that hospitals which have rendered sterling services for so many years have ceased to be the main or only available resource.

Another important current of the psychiatric flood is the diversification of services. There are many forms of mental illness and different patient needs. For so many cases there are so many cures, and today we realize it matters where, as well as how, the patient is treated, e.g. behaviourally-disturbed and very violent or impulsive cases need some form of restraining accommodation; the chronic deteriorated psychotic requires a sheltered non-stressful haven for the rest of his life; geriatric patients need special accommodation including infirmary care; psychopaths and other personality disorders as well as the criminally insane need special treatment institutions; neurotics, early psychotics, and those with psychosomatic conditions often do best in psychiatric departments of general hospitals, and still other patients of all diagnostic categories do best without benefit of hospitalization, i.e. under treatment in the community.

One of the major developments of recent years is psychiatric services associated with general hospitals. Before World War II there were no inpatient psychiatric beds, and outpatient and consultative facilities existed only in a few general hospitals on a small scale. Today, psychiatric facilities in general hospitals are a major resource in countries leading the field, such as Britain and the USA. In Britain for instance, accelerated by the introduction of the Mental Health Act of 1959, the responsibility for treatment of the psychiatric sick is increasingly being transferred to these hospitals, and the Ministry of Health is actively expanding and setting up new psychiatric units of 100 - 200 beds in general hospitals throughout the country. On the other hand, it is now their official government policy that mental hospitals are to be reduced in size, some are to be closed, and there is a plan to shut down 75,000 mental-hospital beds within 15 years. In Canada too, within 1 year (1955 - 56) the number of cases admitted to psychiatric departments in general hospitals increased from 6,800 to 11,000 while those admitted to mental hospitals decreased from 32,000 to 30,000. This is a fairly general trend in psychiatry.

*From an address given at the First South African National Conference on Mental Health, Cape Town, October 1963.

THE ORGANIZATION OF PSYCHIATRY IN THE GENERAL HOSPITAL

How should psychiatry in general hospitals be organized? Much progress has already been made and we, in South Africa, are not altogether lagging behind. I will illustrate the general scheme of things from our own experience in establishing a comprehensive scheme at Groote Schuur Hospital during the last 18 months. This will be described in some detail, to serve as an indication of what is necessary and what can be achieved. Although what suits one situation may not suit another, the facilities that are described are susceptible to considerable adaptation to meet local needs.

The basic tenets are that you must work from your material, i.e. the numbers and types of psychiatric patients presenting for treatment; and from this it follows that diversity and flexibility of facilities are essential to meet differing patient needs. The best way to satisfy all demands is to set up a department or section of psychiatry in the hospital consisting of several parts with specific functions which work interdependently as a comprehensive whole. These sections are detailed below, in the sequence that they are usually encountered by the public.

The Emergency Unit

Many of the problems that arise in any community as a result of mental disorder or emotional stress come straight to the casualty department of the general hospital. These are usually urgent cases and come to light because of disordered behaviour, i.e. attempted suicide, uncontrolled, impulsive or violent behaviour as a result of schizophrenia, delirium tremens or other toxic factors, confusional psychoses from brain disease or toxins, etc. The public and the medical profession, especially general practitioners, look to the general hospital for *immediate* help (even if it is only assistance in getting the case certified and admitted to a mental hospital); but in many casualty departments these cases are regarded as a nuisance and not within the proper sphere of the casualty officers who, it must be acknowledged, are not trained to deal with them and do not often have proper facilities and outlets available. They feel that they are 'stuck' with them and become frustrated and impatient. The provision of a good service for these patients is entirely dependent on having adequate machinery available: in effect, an emergency walk-in clinic for mentally or emotionally disturbed people, in the same way as we have a casualty department for medical and surgical emergencies. To give an idea of the extent of the service, at a busy general hospital such as Groote Schuur Hospital, from 150 - 200 such cases are seen monthly, a psychiatric registrar being kept occupied for several hours a day in the casualty department, dealing with up to 7 - 8 cases. The emergency service is most effective and economical because acute crises can be dealt with there and then and often subside with brief intervention so that the patient can be sent home in the care of relatives. Sometimes an appointment for the next psychiatric outpatient clinic is necessary, and others again need certification and transfer to a mental hospital.

Some patients are not ill enough to be certified but not well enough to be sent home, e.g. where the diagnosis is in doubt, or they need investigation and observation; or where the condition is obviously only temporary and will clear up in a day or two, as in alcoholics after excessive drinking. For this purpose a few emergency beds must be available, and such patients are

accommodated in the casualty emergency ward under the care of psychiatrists for up to 48 hours or even longer. Emergency psychiatric beds are a great help and all fairly large general hospitals should have them; in fact the Committee on Psychological Medicine of the Royal College of Physicians has said unequivocally in their 1961 Report that a general hospital of 1,200 beds should have *at least* 20 beds set aside for these purposes. The emergency patients are always there—it is only necessary to tackle them with a plan and purposeness—to give them the attention that they really need, and so to diminish subsequent inpatient treatment.

The Outpatient Service

The outpatient service must be capable of coping with a large turnover of patients and with many and disparate patient needs. Most psychiatric patients require special treatment and adequate outlets, otherwise they overfill and impair the working of the outpatient department. There are enormous numbers to be dealt with. To give an idea, there were 11,221 outpatient attendances dealt with by the Department of Psychiatry of Groote Schuur Hospital during 1963, and 12,151 at the psychiatric outpatient department of the Johannesburg General Hospital (including Tara Hospital) for the year April 1962 - March 1963. With the drift of psychiatric cases to general hospitals, outpatient attendances increase yearly and make great demands on the limited numbers of psychiatrists that are available, since treatment takes *time* and only *skilled attention* will do.

The chronic cases present a special problem. Psychiatrists in general hospitals find themselves dealing with the detritus of all other outpatient departments in the form of chronic neurotics, irretrievable personality disorders, entrenched psychosomatic illnesses which have been bandied about in other outpatient departments for years, chronic 'hospital birds', drug addicts, inadequate personalities, etc. These are the chronically sick of psychiatry, and of medicine too; patients who resist cure but still come for regular attention. Often they are social rather than medical problems, and can usually be recognized by their thick folders, their many referrals to various specialists, and their dozens of prescriptions for tonics. In the end they are usually passed on to the houseman to deal with and he, poor chap, struggling with problems that have already floored his seniors, merely repeats the prescriptions and tells the patient to come back in a month. They tend to fill psychiatry outpatient departments 'from the bottom up', since the more acute and recoverable cases get better and are discharged.

The needs of this group of cases must not be ignored. For their own comfort and satisfaction, and also because they constitute a large proportion of the outpatient load, they should be purposefully dealt with. The first step is to recognize that they constitute a special problem; the next is to provide a separate clinic, and at Groote Schuur Hospital we have recently set up a supportive clinic which is conducted by our most senior and experienced psychiatrists. Useless medication is reduced, patients are given supportive and group psychotherapy, and attempts are made to diminish hospital dependence. Many patients are discharged who have been hanging on without benefit for years, and are offered alternative and more appropriate help through social agencies; or else transferred to the care of the psychiatric community service. Effective dispersal techniques are still being explored, but of one thing I am sure—it is a real economy to devote concentrated and energetic efforts to these chronic patients who absorb an incalculable amount of time and a considerable slice of the hospital's drug bill.

The Short-term Inpatient Unit

The short-term inpatient unit is for patients who need to be in hospital for investigation or short-term treatment. From 25 - 30 beds for a 1,000-bedded general hospital seem to be about adequate, provided that other psychiatric services are available, as dealt with in this paper. The psychiatric inpatient unit caters for a particular group of patients, i.e. mainly cases of depression, acute anxiety states, and other neurotic ailments, psychosomatic illnesses such as asthma, peptic ulcer, anorexia nervosa, etc. and a wide variety of personality disorders and early psychoses. Few of these cases need stay more than a couple of months, and many for much less than that.

The inpatient unit is the heart of the general hospital psychiatric service, and the main centre for research and teaching. I shall not go into its organization here except to say that it is an *active, short-term, intensive* treatment centre, and that a 'therapeutic community' type of organization does extremely well. It is not necessary to retain a strong hospital atmosphere or 'clinical' look, i.e. shiny stainless steel furniture, hospital beds, etc., as the majority of the patients are up and about in their ordinary clothes all day. Hence they need day-room accommodation in the ward, and much group and occupational therapy. There is no reason why the psychiatric wards should not be decorated in attractive fabrics, colours and furniture, to look more like a comfortable and pleasant home than a white, sterile and shiny hospital (which qualities have little place in psychiatry anyway).

The Day-Hospital

The day-hospital facilities are for the type of patient who does not need full hospitalization or who needs transitional care in an active and less sheltered environment. On the one hand, it is an expanded and more intensive form of outpatient treatment, and on the other, a substitute for inpatient care. Experience has shown that all the types of psychiatric illness normally dealt with by inpatient units, and many that are treated in mental hospitals, can now be dealt with in the day hospital, i.e. short-term acute cases as well as long-term patients such as recovered or quiescent schizophrenics. A day-hospital for psychiatric cases has recently been established at Groote Schuur Hospital, Cape Town, and is proving a most valuable asset.

Most of the usual psychiatric treatments are done there, e.g. ECT, psychotherapy, behaviour therapy, and in addition it is an excellent place for systematic after-care. The great advantage is that patients can be treated in the context of their normal environments and are thus subject to all the socializing and controlling influences of society.

The day hospital can also be used at night to treat patients who for various reasons, e.g. having to earn a living or look after a household and children during the day, can only come for treatment in the evenings.

The Community Service

Once the facilities mentioned above have been established, a community service becomes highly desirable—it acts as the oil which allows the other wheels to turn harmoniously. This was first started in South Africa at Tara Hospital, and more recently at Groote Schuur Hospital, where the community service consists of 2 full-time highly trained psychiatric nurses under medical direction. They work with patients from the outpatient department, inpatient unit, day hospital and alcoholic unit (William Slater Hospital), and do pre- and post-admission visiting, attend to a wide variety of emergency calls, e.g. to suicidal bids, alcoholic 'benders', etc. They also work in the supportive clinic, and generally cooperate most closely with psychiatrists and social workers. They are the outlying 'rovers' of the team—psychiatric women-of-all-work who do a many-sided, previously neglected job and thereby raise the effectiveness of the entire psychiatric service to an extent that has to be experienced to be fully appreciated. Many patients who would otherwise have had to be hospitalized can now be dealt with in the community, and others can be discharged much earlier under supervision of the community nurse.

I have described the basic elements of a comprehensive psychiatric department in a big general hospital. Other facilities may well be added, e.g. a special children's clinic, a geriatric unit, and an adolescent section exist at Tara Hospital; and Groote Schuur Hospital has a specialized alcoholism-treatment centre under the control of the Department of Psychiatry (William Slater Hospital) as well as a clinic for the treatment of emotional disturbances in children.

THE SWING OF PSYCHIATRY TO THE GENERAL HOSPITAL

It is important to examine why psychiatry has swung to general hospitals. One reason is that the medical profession and the public now understand that many psychological disturbances, e.g. neuroses or psychosomatic illnesses can be effectively treated in an open general hospital. Another reason is that general hospitals are easily reached and people are in any case accustomed to going there for help for medical illness. The more the news gets around that mental disorder is an illness, the more people come.

Apart from the fact that people *like* to come there for their psychological and mental ills, there are of course good medical and psychiatric reasons why psychiatry should be centred in a general hospital. For one thing, it leavens and revitalizes other branches of medicine. Psychiatry is a medical science, but somewhere along the road it became, to some extent, estranged from medicine. Perhaps this was because of the unfortunate phase where mind and body were regarded as separate entities, this idea being reinforced because psychiatrists for the most part worked remotely from other doctors. All this is entirely ameliorated by having psychiatrists in general hospitals, where they come to be appreciated as useful and contributing members of a team, and are in an excellent position to translate the advances and conceptions of psychiatry to their medical colleagues. This is especially important, as many doctors practising today have only the old vision of psychiatry and are largely unaware of the great changes in attitude and treatment that have occurred in recent years. This is because in their student days, say 20 or 30 years ago, psychiatry was largely an undeveloped subject. Psychiatrists, therefore, apart from being clinicians, are also the carriers and interpreters of the knowledge of modern psychology, e.g. the insights of Freud, Pavlov, Jung, and the behavioural sciences. Without their influence the rest of medicine is the poorer; and of course, the process works in reverse, for without active and continuous contact with physicians, surgeons, general practitioners, etc., psychiatrists become poorer doctors themselves. Today, the psychiatry ward is as necessary and intrinsic a part of the general hospital as the orthopaedic ward or the ENT department.

Perhaps the most important role for psychiatry in general hospitals though, is teaching medical students how ubiquitous a part of medicine the mind really is. Teaching in psychiatry used to deal mostly with the major mental disorders in mental hospitals, but today, in keeping with the recognition that general practice, and in fact all branches of medicine, are laden with patients showing *minor* emotional and psychological disturbances, it is these which receive increasing attention in the undergraduate medical curriculum. Students are still taught about the psychoses—this is essential—but courses of instruction are now grounded in normal psychology, human relations and psychodynamics, and place emphasis on the less serious but no less crippling psychological and emotional disturbances of everyday practice. Above all, students see psychiatry in the context of the rest of medicine.

For all these reasons psychiatry in general hospitals gives a better understanding of what psychiatry is and can do. It is the trail-blazer for a new public image of mental illness from which all, the public and the profession, benefit.

TYPE OF ILLNESS DEALT WITH IN GENERAL HOSPITALS

We now consider the type of psychiatric cases dealt with as inpatients in general hospitals, since these influence the form and characteristics of the service that is provided. Patients are dealt with under certain clearly defined groups —the neuroses, e.g. anxiety states, hysteria and obsessional neurosis; the depressions, early psychosis, personality disorders, mild adjustment reactions and transient emotional disturbances; and psychosomatic conditions such as ulcerative colitis, asthma, duodenal ulcers, anorexia nervosa, etc., comprising the bulk of the cases.

It is interesting to note that there is a general difference in the composition of the diagnostic categories dealt with in comparison with that of mental hospitals where the largest proportion of patients suffer from a psychosis of some type, usually owing to constitutional and organic causes (such as schizophrenia, arteriosclerosis, senility, etc.). Most other varieties of mental illness are of course treated in mental hospitals as well, but the proportion is small relative to the total number of cases dealt with. In Table I a clearer indication of these differences is given. (Figures are taken from a survey of cases admitted to Tara Hospital, a general-hospital-type psychiatric unit, in 1957 - 1958, and from the 1961 Report of the Commissioner of Mental Health, which deals with mental hospitals in South Africa. The latter are the most recent available figures.)

TABLE I. DIFFERENCES IN TYPES OF MENTAL PATIENTS DEALT WITH IN A GENERAL AND IN MENTAL HOSPITALS

	Tara	*Mental hospitals*
Psychotic depression	17·9%	3%
Psychoneurotic conditions	51·8%	0·3%
Organic brain syndrome	1·7%	17 %
Schizophrenia	9·75%	53 %

From Table I it will be seen that the general hospitals are serving an important section of the mentally ill in South Africa who are normally dealt with only in limited numbers in mental hospitals.

The type of cases dealt with gives rise to several of the characteristic features of general hospital psychiatry, e.g. patients tend to have a relatively short inpatient stay of about 3 - 4 weeks, and few are in hospital for longer than 3 months. The turnover of cases is therefore rapid, so that each bed is used on an average from 4 to 8 times a year. Other features are that these patients usually require many investigations both psychological and biological; and treatment, although short-term, tends to be very time-consuming and requires generous staffing as it commonly includes psychotherapy, which can absorb several hours per week per patient. In addition, although many patients stay only a few weeks as inpatients, the majority continue on discharge as outpatients with psychotherapy or other forms of treatment. To meet these demands the case load for both medical and nursing personnel tends to be low in terms of established beds, but is very heavy in terms of the total number of patients dealt with. Bed establish-

ments do not therefore reflect the actual situation. In fact, the vast majority of patients being dealt with in general hospitals never even get into bed, since they are treated as day-patients, outpatients or domiciliary patients (all of whom take just as much valuable time of the psychiatrists).

GENERAL HOSPITAL PSYCHIATRY IN THE TOTAL PICTURE

Contemporary Psychiatry

Contemporary psychiatry is a many-sided discipline with a large body of knowledge, many effective methods of treatment, and a complex organization of personnel, institutions and hospitals. Mental illness, too, presents many faces, appears in many places, and talks with many voices. Because of these facts a diversity of facilities is essential, and no one organization, neither a general hospital, mental hospital, or other service, can have monopolistic rights in discharging the responsibility for treatment.

The general hospital. As I have shown, general-hospital psychiatry is here to stay and must expand—a living demonstration that mental illness can be dealt with in precisely the same organizational, administrative and professional framework as physical illness. *It must be emphasized once again that mental illness is a medical illness,* the mental patient is a medical patient, and psychiatry should, to a considerable extent, be integrated in general hospitals with the physical and personnel resources of the rest of medicine.

The mental hospital, in its turn, provides an irreplaceable service for large numbers of patients who cannot, and should not, be dealt with elsewhere. There the necessary experience, organization and facilities exist for particular types of patients, and I wish to pay tribute here to the commendable efforts of the present Commissioner of Mental Health and his dedicated staff who, supported by the authorities, have rendered such excellent services for the public over many years. They are coping with an overload of patients, staff shortages, and inadequate accommodation that has accumulated over a long period. Furthermore, they have the full burden of large numbers of chronic psychiatric patients, and they must be given the funds, staff, and conditions to convert this psychiatric deadweight from being 'the burden of the chronic' to 'the challenge of the chronic'. However much the mental hospitals develop and change in the future—and many welcome developments have already taken place in the last few years—the fact remains that their main load still is, and must continue to lie towards these chronic patients. They are a slow-moving population who expand to occupy all available beds, and absorb the limited numbers of trained staff available. Taken as a whole they constitute a drag on the therapeutic machinery of the mental hospital.

There is, however, a vastly more optimistic attitude about these patients at present which has spread from Britain, Europe and the USA where, owing to the psychotropic drugs and new rehabilitative and re-socializing methods, many are being successfully treated. This is a new vision of therapy for the chronically ill, a peep into the future where old solutions to old problems are no longer applicable. It is now realized that the mere provision of more low-cost places for board and lodging and limited care for the chronic mentally ill merely multiplies the existing problems. This is all that is required for certain patients, but is not enough to enable the large numbers, who could possibly benefit from active rehabilitation, to return to the community. Psychiatry is in fact jumping with good ideas for the so-called 'hopeless cases' these days, and the challenge of the chronic patient can be met by such techniques as industrial therapy, open hospitals, village treatment of psychotics, day-hospitals and hostel accommodation, remotivation techniques, community services, sheltered employment, and other rehabilitative measures.

This is not to say that mental hospitals should deal exclusively with the chronically mentally ill. They must be active treatment centres dealing with *all sorts* of acute psychiatric disorders too, and it is a source of satisfaction that active outpatient clinics and short-stay therapy units are being developed in certain mental hospitals in South Africa. This will do a great deal to alter the public image of mental illness. However, one must keep a sense of proportion in these matters. It is very difficult to bend the mental hospitals to all uses—the patient population, the staffing, and the sheer physical structure (their size, situation and buildings) will not always allow it; and in any case, as I have shown, mental illness must be treated in multiple venues in the 'new look' psychiatry of the 1960's. This trend will undoubtedly continue.

THE SHORTAGE OF STAFF

There are many great problems that press for solution in dealing with mental illness in South Africa. All cannot be solved at once, and forward movement is obviously a question of priorities. Our most urgent needs are for staff, facilities and funds, and of these, staff is the greatest. I should like to sound a note of warning. *We must expand and improve services, but we must also beware of taking on more than we can encompass immediately without adequate staff;* services which cannot be manned can easily arise out of good intentions. For this reason (and various Expert Committees of the WHO state quite explicitly), training of personnel has to have priority over organization of services. It is easy to dream up schemes to cope with the present emergency and future expansion. Buildings are easy to put up but nothing can be done without psychiatrists, nurses, social workers, psychologists, occupational therapists, and other types of trained personnel in large numbers. These are difficult to come by and take years to train; and when we have them, we must see to it that we keep them. This is largely a matter of conditions of service, incentives, salaries, and the realization that there is valuable and interesting work to be done. We lose too many trained men from our psychiatric services, and the reasons for this need investigating.

Psychiatrists everywhere are heavily over-burdened and trying to stem a heavy tide. It is only because those in private practice and in general hospitals are pitching in together with their colleagues in mental hospitals that we are able to deal with the vast amount of illness that is our common charge. There is not enough to go round anywhere, however, and what we need above all is *urgent attention at top level to training*—a crash programme for all types of psychiatric staff of all races. Today we are busily selling psychiatry to the public; more people buy, but we have so few assistants in the shop! In conclusion, I appeal urgently for training and yet more training as that is the immediate essential.