A survey of ward behaviour of long stay Psychiatric patients

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This survey was done in Hospital Bahagia, a custodial institution for the mentally ill in West Malaysia. Built in 1910, the hospital now serves a catchment area of 16,360 sq. miles with a population of over 5 million (Annual General Report, Hospital Bahagia, 1971).

At the time of study, there were about 4000 inpatients, 1740 of whom were designated as longstay and nursed in a separate section of the hospital – equivalent to the "back wards" described by Barton (1959). Although the hospital has kept apace with clinical developments in psychiatry, with consequent improvement in diagnosis and drug treatment of patients, it has remained essentially custodial in its ward management of patients.

In an attempt to study some of the adverse effects of custodial care on longstay patients, the following survey was done.

Two assumptions are held:–

(1) A chronic patients' ward behavior is related to the degree of restrictiveness of the wards i.e. he/she will behave in a more socially acceptable manner in a less restrictive ward.

(2) The degree of ward restrictiveness is related to the ratio of patients to nursing staff, i.e. overcrowded short staffed wards, dependent almost solely on attendants for patient care, will be most restrictive.

Method and Materials

(i) A total of nine wards in Hospital Bahagia with a combined population of 261 chronic patients, were selected for this study. Chronic patients were defined as those who had been in hospital two years or more, with less than one month's parole (leave from hospital) in that time.

(ii) The following data were obtained from the clinical notes of each patient:– age, sex, race, number of admissions to Hospital Bahagia, diagnosis, current medication, length of inpatient stay (to the nearest year), and frequency of recorded visitors.

(iii) The wards selected were:–

Female 1st Class F1
Female 2nd Class F2
Male 1st Class M1
Two Male 2nd Class wards .....M2a and M2b

These wards are for fee-paying patients, irrespective of their length of stay in hospital.

One of a complex of 8 Female A wards FA1
Two of a complex of 12 Male A wards .....MA6 and MA7.

These wards are for long stay non-fee-paying patients, who have little or no prospect of discharge.

One of the hospital's 14 Farms ..... Farm 5

The majority of the patients who live and work in the farms are selected by nurses and attendants from the Male A (longstay) wards.

(iv) The degree of restrictiveness of each ward was rated on a Ward Restrictiveness Scale (See Appendix I). This Scale is a modification of that used by Wing and Brown (1970) in their comparative study of three British mental Hospitals. The 11

items in Section A are concerned directly with restrictions on the movement of patients, such as the locking of ward doors, being permitted to leave the ward unaccompanied, and the use of seclusion rooms. The remaining 18 items (Section B) are concerned with general rules and routines, e.g. restrictions on the use of bathroom, regulations concerning personal clothing, access to the ward pantry, etc..

The Sister or Senior Hospital Assistant together with the Staff Nurse or Hospital Assistant and the wards' charge (head) attendant were interviewed together on one occasion. A week later, additional information was obtained from the night duty attendant.

The scores of sections A and B are combined. A score of 29 indicates maximum restrictiveness. The lower the score, the more permissive the ward.

Some problems were encountered in scoring which were related to the number of patients in a ward who were affected by the restriction. For example, wards F1, FA1 and MA6 had no patients possessing matches (scoring as restrictive on this item B), yet the number of patients having matches in the other wards (scoring as non-restrictive on this item) was less than three per ward. In another instance, wards F1, F2, M1, M2a and M2b combined to have a weekly complaints meeting with their ward staff. This meeting, conducted in English, was mainly attended by English speaking patients. Though these wards score as non-restrictive on item 15, less than half the patients were in fact free to make complaints.

(v) Patients' behavior were rated on a Ward Behavior Scale (See Appendix II). This is a three point scale (0–2) scoring on 10 items of ward behavior. The maximum score is 20 for the most deteriorated behavior, and 0 for the most acceptable, which is considered normal. This scale is only concerned with ward behavior, not diagnosis.

Each patient was interviewed by the doctor i/c in the presence of a nurse, the occupational therapist and charge attendant. Of necessity, much of the information on the patients' ward behavior was obtained from the charge attendant. Since wards MA6 and MA7 were not accustomed to making detailed observation of patients' behavior, their data was accepted with this reservation in mind.

Results

(i) Characteristics of the patient sample

At the 1972 census of the total patient population of Hospital Bahagia, the majority of patients were in the 31–40 age group. In this sample, the majority of female patients were in the 40–59 age group, while the majority of male patients, excluding the farms, were in the 30–49 age group. In the farms, patients were older, in the 50–59 age group. This probably reflects selection policy, since only those patients thought by attendants and nurses to be non-aggressive, are sent to live on the farms. In this sample there were 164 males and 97 female, a ratio of 1.9 to 1, which corresponds to the ratio of males to females for the total hospital population.

The majority of patients (73%) were first admissions, and 75% of the patients were diagnosed as Schizophrenics. In the 1972 census 64% of the total patient population of Hospital Bahagia, Ulu Kinta were diagnosed as Schizophrenic.

The majority of patients receiving drug therapy were on phenothiazines. All fee paying patients received drugs, while on the other wards in our sample 63% were on no drug therapy.

90% of the patients had been in hospital 5 years or more (range 2 – 35 years).

Only 12 patients in our sample were visited more than 6 times in the preceding year by their relatives, and of these 10 were fee paying patients. 70% received no visitors at all in the preceding two years.

The Sister in charge of F1 and F2 was also responsible for one third class ward. Altogether she had 97 patients. F1 had 16 patients of whom 2(12%) were chronic and included in this study. F2 had 33 patients of whom 15(46%) were chronic. The 97 patients had one staff nurse and one shift duty trained assistant nurse.

The Hospital Assistant incharge of male fee paying wards M1, M2a and M2b had 71 patients. He was assisted by one trained Junior Hospital Assistant. In M1, with 13 patients, 5(38%) were long stay. The results of wards M2a and M2b were so similar and the numbers in the sample so small that hereafter these two wards will be referred to as one – M2. 14 patients (30%) of M2 were long stay. In a ward of acute and chronic patients with inadequate staffing, it is likely the staff attention available for chronic patients will be limited.

(ii) The ward staff situation (See Table I)

TABLE I

	FEMALE			MALE					
	FEE PAYING		NON–PAYING	PAYING			NON–PAYING		
	F 1	F 2	F A 1	M 1	M 2a	M 2b	M A5	M A7	Farm 5
No. of Sisters or Senior Hospital Assistants	1* (responsibility over 97 pateints)		1* (responsibility over 640 pts.)	–			1* (responsibility over 711 pts.)		1* (responsibility over 398 pts.
No. of Staff Nurses or Hospital Assistants	1		2	1 (responsibility over 71 pts.)			2		1
No. of Assistant Nurses or Junior Hospital Assistants	1 – 2 (on shift)		4 (shift)	1			2		2
No. of Pupil Assistant Nurses or Junior Hospital Assistants	6		7	1			2		–
No. of Charge Male Attd. or Female Attendants per ward	1	1	1	1	1	1	1	1	1
No. of shift Male Attd. or Female Attendants per ward	1	1	1	1	1	1	1	1	1
No. of patients/ward	16	33	80	13	29	29	59	62	29
No. of Chronic patients per ward	2	15	79	5	3	14	58	58	26

* Psychiatric Trained

TABLE 2 WARD RESTRICTIVENESS SCALE

	FEMALE			MALE					
	Fee paying		Free	Fee paying			Free		
	F 1	F 2	F A1	M 1	aM2	bM2	MA6	MA7	Farm 5
Score Section A	6	9	7	4	7	7	10	8	7
Score Section B	5	10	15	10	12	10	17	14	14
Total Score	11	19	22	14	19	17	27	22	21
Total No. of patients/Senior Nurse	97		640	71			711		387
Total No. of patients in ward	16	33	80	13	29	29	59	62	29
No. of patients in study	2	15	79	5	3	14	59	61	26

On the 8 FA Wards (with a total of 640 long stay non-fee paying patients) the patient/senior nurse ratio is 6.4 times that of F1 and F2. .

On the 12 MA wards (711 long stay patients) the patient/senior nurse ratio is 10 times that of M1 and M2.

(In practice, on all wards, staff/patient interaction is very little, and actual patient care is relegated to the attendants. Student nurses are temporary, and on account of the shortage of teaching staff, they have inadequate clinical supervision in the wards and they tend to look to the attendants for guidance in the "control" of patients.)

(iii) Results of Ward Restrictiveness Scale

To the casual visitor to Hospital Bahagia the fee paying wards may seem vastly superior to those free long stay wards. However, the scoring on the Ward Restrictiveness Scale demonstrates the basic similarity of all the wards. (See Table 2).

All wards in the Hospital are built round a quadrangle. Internal ward doors are locked at certain times of the day, usually at times of counting patients, when attendants change shift duty. The only exceptions are the male and female first class wards where the number of patients is small. All female patients are unable to leave the ward section unless accompanied by a staff member. In practice, the wards being so short staffed, this means some patients may never leave the ward section. A minority of male patients may leave their wards, unaccompanied. These patients are selected by the nursing staff.

Bathing 'line ups' are the usual practice, with little or no privacy. For 15 months prior to this survey, F1 and F2 patients had been encouraged to wear their own clothing. On all other wards hospital uniform is compulsory. With the exception of F1, all hair washing and all shaving is done by the staff.

In most wards patients do not have their own bed allocated to them, and there is no encouragement to keep personal possessions. On wards that do have pantrys, only attendants have access. Those wards which have newspapers, the papers are removed for safe keeping after 4.00 pm so the time they are available for patients to read is limited. Since it was the practice to lock all except F1, M1 and FA1 patients in their wards after the evening meal, only selected patients can view T.V.

No senior staff were on duty on these wards after 4.00 pm. The nursing staff spoke very frankly and freely about their difficulties in the preceding 15 months in attempting to provide a less restrictive ward environment under the present staff conditions of Hospital Bahagia.

The difference in scores between F1, M1 and F2, are mainly in less restriction of movement.

Differences between second class wards and the

TABLE 3 WARD BEHAVIOR SCALE

	FEMALE			MALE				
	Fee paying		Free	Fee paying		Free		
	F 1	F 2	F A1	M 1	M 2	MA6	MA7	Farm 5
Average Score	–	7	7	–	7	8	8	4.5
No. of *workers per ward	1	2	20	–	1	4	16	15
Average Score of *workers	2	4.5	4.35	–	6	6	5	4

*"workers" = those patients scored as being capable of doing useful work without supervision.

free wards are small, and reflect amenities, e.g. newspapers, a complaints meeting, and (on the female ward) personal clothing. That MA6 should score 27, while MA7 scores 22 is extremely interesting when the geography of these wards in the male long stay section is considered. MA6 with the highest score is furthest from Hospital Assistant's office, while MA7 is adjacent to it.

(iv) Results of Ward Behavior Scale (See Table 3)

Excepting Farm 5, the total average scores of patients were similar for all wards. Those patients scoring 0 on item 6 – i.e. able to work well without supervision in the ward or farm – form an interesting group which hereafter will be referred to as the "workers".

In no case did a worker score above the average score for his ward, even allowing for the (–2) points he gains on account of the fact that he can work without supervision. Moreover all the workers except two had speech. Of the two one was a deaf mute who was able to communicate in meaningful sign language. One patient in 3 of the total sample was mute.

On Farm 5, 60% of the patients worked well without supervision, and only 3 (12%) were unable to work at all. Yet, inpatient stay had been longer, and the age group was older on the farm.

In FA1, 21% of patients could do "cottage industry" type work in the occupational therapy department, where an occupational therapist had been assigned for the past two years.

Only one patient in F1 and F2 could do such work. There were then no such projects available. The Occupational Therapist for F1 and F2 had only been assigned to these wards six months ago. Emphasis was laid on social and group activities. In the total patient sample, 74% had no spontaneous interest, while in F1 and F2 only 59% were thought quite incapable of showing any interest in leisure activities.

For 15 months prior to the survey, efforts had been made by the nursing staff of F1 and F2 and the 3rd class long stay wards of which FA1 was a part, to provide a less restrictive ward atmosphere.

In comparing items in the ward behavior scale the percentage of patients with habitual (score 2) socially unacceptable behavior was significantly higher on the 3rd class wards than on the others. Incontinence, stripping, gribbing food from others did not occur habitually on F1 and F2. But it did occur some of the time (score 1) and to the same extent (11% of patients) as in FA1. 36% of patients on the FA1 are mute, as compared with 11.8% on F1 and F2.

Incidentally, during the 18 months prior to this survey, 2 long stay mute patients from FA wards were transferred to F2, and they regained speech.

Since 63% of the sample were receiving no medication, it is not valid to discuss whether or not cooperation with treatment influenced the scores.

Since 70% of the sample received no visitors at all in the last 2 years, it is not valid to discuss whether or not receiving regular visits influenced the ward behavior scores.

DISCUSSION

The early enthusiasm for the effects of drugs on the long-stay patients in mental hospitals (Krammer and Pollack 1958: Brill and Patton 1959) has been tempered by more recent findings which emphasize the importance of the hospital environment (Shepherd, Goodman and Watts 1961, Odegard 1964). These workers found that when they analysed rates from hospitals before and after the introduction on phenothiazines, the discharge rates *fell after* the introduction of drugs. Wing and Brown (1970) in comparing three mental hospitals in England concluded that there were differences in the clinical and social states of the chronic schizophrenics in the three hospitals, and though they could not relate these differences to the medication prescribed, they were significantly related to the degree of social change and improvement in the hospitals environment.

15 months ago, the author felt that although Hospital Bahagia was not ready to adopt an "open door" policy, it should be possible to increase the personal freedom and responsibility of patients within the locked ward. Attempts were made to provide this on all the wards in the sample, but especially on the fee paying wards. Assessment on the modified ward restrictiveness scale after 15 months showed that all wards scored disappointingly high and there was also very little interward difference. However, the highest scores were on the non-fee paying longstay wards and farms, where the patient/senior nurse ratio was the highest.

What are the possible reasons for this? An understimulating environment can lead to extreme social withdrawal (Wing 1970) in psychotic patients. It is difficult to communicate with a withdrawn patient. In Hospital Bahagia, Ulu Kinta the difficulties are compounded by language problems. Long stay Chinese and Indian patients are often able to speak only their mother tongue. Moreover, with the impossibly high patient/staff ratio, patient care is relegated to attendants, who are already overburdened with custody of ward equipment and ward cleanliness, and they tend to apply the same methods to the custody and cleanliness of patients, e.g. the counting of patients and crockery at each change of attendant shift, the bathing of all patients in a line-up at set times of the day.

It is worrying that student nurses, inadequately supervised in their ward training because of staff shortage, look to the attendants for their models in "controlling" patients.

This study has demonstrated that patients who work are not mute and have lower than average ward behavior scores independent of the ward restrictiveness score.

In our present nursing staff shortage, it may be economically more feasible and just as effective to set up industrial workshops within the hospital ground, staffed by trained (non-medical) personnel from outside factories to teach and supervise patients in paid work.

Moreover, if some patients were attending these workshops daily, the number of patients left on the wards would be reduced, and the nursing staff would have less patients to deal with.

Psychiatrists in countries with community care programmes available differ widely as to whether handicapped long stay patients still in need of care should be looked after by their relatives. (Catterson, Benett Freudenburg 1963). In Malaysia the only available after care is that of relatives, supported by outpatient clinics. In our sample of 261 patients, only 12 were visited more than 6 times a year and 70% had no visitors at all in the last 2 years. Relatives need to be actively involved in the rehabilitation of patients in the early stages if they are to accept them back into their homes, which, at present in Malaysia is the only alternative to life long institutionalisation.

SUMMARY

(i) 9 wards in Hospital Bahagia, with a total of 261 patients were assessed using a Ward Restrictiveness and a Ward Behavior Scale.

(ii) The degree of restriction was high on all wards, but highest in those with the greatest patient/senior staff ratio.

(iii) Habitual socially unacceptable behavior was much less evident in working patients.

(iv) The implications of some of the findings are discussed.

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APPENDIX I

Items of Ward Restrictiveness Scale

A. Movement

(1) Time outside door locked.
(2) Time/times (internal) ward door locked.
(3) Time/times bathroom and toilet door locked.
(4) Time patients went to bed.
(5) If and when patients were locked out of the internal ward.
(6) If and when patients were required to inform nurse when leaving the ward.
(7) Whether free to visit the canteen with permission.
(8) Whether free to visit shop in T.R. with permission.
(9) Whether there was a railed 'airing court' attached to the ward.
(10) Entries in 'seclusion book' in the last month.
(11) Whether patients were kept waiting to be counted.

B. Other restrictions

(1) Access to bed in the day.
(2) Access to bathroom.
(3) Whether nurse (or member of staff) was present whenever the patient bathed.
(4) Whether patients were allowed to do their own laundry.
(5) Whether hair of patients was washed by nursing staff.
(6) Whether beds were made by nurses or a few ward workers.
(7) Whether patients were allowed more than one article of hospital clothing at a time (e.g. sarong).
(8) Whether patients had ready access to their own private clothing.
(9) Whether patients could change into their private clothing without permission.
(10) Whether they had free choice of the amount of rice at meal times.
(11) Whether patients were free to switch on and control the T.V.
(12) Whether patients were allowed to use the ward kitchen for minor tasks - e.g. help themselves to fridge water, (make a drink).
(13) Whether patients were free to smoke at any time outside of dormitory.
(14) Whether a patient could possess matches.
(15) Whether there was normal means of making complaints e.g. ward meetings.
(16) Whether current newspapers were supplied.
(17) Whether patients could lock the toilet door.
(18) Whether baths were screened from other patients.

WARD BEHAVIOR SCALE

		Score
ITEM 1. INCONTINENCE (OF URINE)	1. Most of the time 2. Occasionally, or use drain 3. Absent	2 1 0
ITEM 2. STRIPPING OR EXPOSING	1. Most of the time 2. Occasionally 3. None	2 1 0
ITEM 3. EATING HABITS	1. Good – normal 2. Fair – messy 3. Poor – messy and grabs from others	0 1 2
ITEM 4. PICA	1. Eats edible rubbish 2. Eats inedible rubbish 3. No pica	1 2 0
ITEM 5. COMMUNICATION	1. Normal 2. Irrational 3. Complete withdrawal, no communication	0 1 2
ITEM 6. WORK – IN WARD	1. Good, without permission 2. Good with supervision 3. Cannot work	0 1 2
ITEM 7. WORK – IN O.T. (OR FARM WORK)	1. Good, without supervision 2. Good with supervision 3. Cannot work	0 1 2
ITEM 8. BEHAVIOR (VERBAL OR NON VERBAL)	1. Aggressive – more than 5 times/month 2. Aggressive – less than 5 times/month 3. Non Aggressive	2 1 0
ITEM 9. LEISURE INTERESTS	1. Shows no interest in anything 2. Shows very little interest, but can be persuaded to watch T.V. or read papers. 3. Normal spontaneous interests	2 1 0
ITEM 10. MEDICATION	1. Cooperative 2. Needs supervision 3. Uncooperative	0 1 2