Ward Meetings in a Security Hospital

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Summary: The content of ward meetings in a security hospital is described. The development of the group is traced, and some conclusions are drawn about the detrimental and anti-therapeutic effects of chronic hospitalization in a high security setting.

The Central Mental Hospital, Dundrum, is the only security hospital in the Irish Republic. Like similar institutions elsewhere, it cares for psychotics, neurotics, epileptics, organics, subnormals and personality disordered who are detained at the Government's pleasure, on a ministerial order (Department of Justice), or on a Section 207 order (Mental Treatment Act, 1945). With the exception of patients transferred from the prison service doing a determinate sentence, who must be released when their sentences expire, most of the traffic is into rather than out of the hospital. Although the admission process can be cumbersome, *e.g.*, a 207 order, nevertheless it is easier to gain admission to Dundrum than it is to get out. We find it particularly difficult and frustrating to place patients who no longer require, or who perhaps never did require, a high security setting in general psychiatric hospitals throughout the country. That holds even when the patient was transferred to us from a general psychiatric hospital in the first place. So a high proportion of our patients have been with us for a long time. With 19th century buildings, the environment seems harsh; and, with meaningful occupation for only 60 per cent of the patients, life in the hospital for many inmates is boring and repetitive. New units and workshops will be open in two years to solve some of the problems. Interestingly, the organization feels much better than it looks, and one can only attribute that to the humane and caring staff-patient relationships. Also, with only 110 patients, its size seems almost ideal. It is possible for all of the staff to know each other, and all of the patients' crises are anticipated and averted.

One section of Dundrum has a particularly stable population. The older patient tends to gravitate there; those with physical illnesses also, and those who are less well able to fend for themselves in more competitive wards. The main room is dormitory, dayroom, T.V. room-dining room combined; and, while it sounds like bedlam, it is, in fact, well organized, and one would feel, the best room in the whole hospital. A year ago I started regular ward meetings in this male unit. They take place every Monday morning, lasting 45 minutes. A short staff meeting follows. Obviously there is nothing unique about ward meetings in general and they are customary in psychiatric hospitals world wide; but I feel that something happened in this setting that deserves recording. The meetings were held in the main room already

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described. The most common diagnosis in the room was schizophrenia, and the most common crime leading to admission was murder. Patients were told that the meeting was a discussion platform where the open expression of feelings and opinions would be sought and encouraged.

The opening meetings were pretty slow affairs dominated by one patient who repeatedly inquired about his release. His rather chronic illness had failed to respond to diverse treatment attempts, but he retained an admirable and healthy core that clung to the possibility of release; this, in a way, saved him from institutionalization.

It quickly became apparent that the patients knew very little about each other despite having spent years living together. When challenged with "tell us what you know about – ?" one patient who was not psychotic demonstrated the point by quickly running out of details. In fact, most of the patients lived in lonely and private psychological as well as physical cells. The staff remembered vividly one developing relationship between two patients that was terminated by an inquiry from one that the other judged much too personal and invasive. What relationships existed on the ward survived on superficiality. It does not stretch any analytic mind to conclude that the majority of these patients felt considerable guilt and greatly reduced self esteem which demanded secretiveness and preserved isolation. Encouragement to open up with revelations about self or enquiries about the feelings of others were greeted with remarks like "Ah! that's too personal." Anonymity was preserved at whatever cost.

A striking number of patients remained chronically psychotic with delusional systems untouched by drugs and drug combinations. Group members who were psychotic had no difficulty in recognizing illness in others, *e.g.*, "the trouble with ––– is that he just talks out all his thoughts," but seldom did the insight become personal. Since the percentage seems higher than one would expect, it is possible that prolonged high security hospitalization promotes illness or at least discourages remission in illnesses like schizophrenia. The prolonged periods spent alone in individual cells can hardly be therapeutic when one considers the disruption that experimental isolation causes in normal volunteers, and prolonged detention must induce feelings of helplessness and pessimistic apathy that are unlikely to contribute to recovery from illness. If this observation and causal hypothesis is correct, it places an enormous burden of responsibility on all of us to insure that chronically detained patients are at least surrounded with physical comforts, work, social opportunities, and that as many doors as possible within the institutions remain unlocked, allowing visual and verbal contact and stimulus.

As time passed, more and more patients contributed to the meetings, and hostility towards the meetings, where it existed, reduced. In early meetings one patient used to sit with his back to the meeting, but later he became more involved and indeed helpful to his fellow patients. Despite the fact that several patients had committed serious crimes, these were seldom discussed, and, if introduced, the description of events leading up to arrest was more likely to come from a psychotic patient. An occasional sexual remark or joke was more often greeted with disdain rather than mirth, emphasizing again how some subjects were taboo. Our male and female patients are separated most of the time, and with the exception of doctors and occupational

therapists no female staff member works on the male side of the hospital For the male patients there is little opportunity to see or talk to females. Sexual feelings and needs must be buried.

Something else began to happen with the leaders' involvement on the ward. Other doctors with patients in the group began to get feedback on their patients from the author, and new treatment approaches were attempted on some patients with this group input prompting an earlier or more urgent look at exacerbations of illness. As a side effect, patients in the group got more attention from their own individual doctors. Focussing on this, one unit helped us to realize the problem of having chronically ill patients under the care of rotating registrars. Chronic illness, almost by definition, is low key, seldom claiming attention, and chronic patients can easily end up with a series of short term doctors, none of whom get sufficiently involved in the individual's illness to challenge it or change it. This happens also in general psychiatric settings and may contribute to chronicity or non-resolution of illness. Where possible I feel a long term patient should be looked after by, as it were, a long term doctor, that is usually a member of the senior staff. Another side effect attributable to the group was an earlier focussing of the wards' physical needs. The author got involved in some requests to the administration for ward improvements, and these were responded to in a way that suggested medical requests carry some weight. Repetitive involvement on a ward ultimately encourages interest in all aspects of ward life; that, of course, includes maintenance.

As with prison populations, comparison between patients and how they were treated differently caused some resentments. Conventional prisoners serving life sentences tended to feel that they should all be treated equally; those who failed to get privileges or parole often reminded one that others have done shorter sentences for similar crimes and they wondered why this should be so. Our patient group discussed this topic more than once. The resentment when a fellow patient got released after a short period was certainly felt by some, and better for all that it was expressed.

The deaths of three patients in the hospital had quite a marked effect on the group. The first patient stayed on the ward and attended all the meetings in silence. He died in his 60's from a coronary four days after he had been transferred to the I.C.U. of the local general hospital. He got an injection to relieve the chest pain that ushered in his illness, and somehow or other the injection was seen to have caused his death. This type of paranoid interpretation is understandable in a security hospital setting and almost certainly derives from the helplessness and loneliness that a lot of our patients feel. Literally, they feel that the hospital system overpowers them, removing obvious freedoms and rights and substituting rigorous security and degrees of authority where the patient feels distinctly disadvantaged. The second death happened elsewhere in the hospital; the patient was much younger, suffering a minor form of epilepsy. The P.M. findings were compatible with asphyxia following a fit during sleep. The hospital rumor system suggested that he had been badly beaten up before his death. This in fact was untrue and unsupported by any factual evidence. The third man to die was another patient on the ward who died in his 80's from chronic respiratory disease. A fellow patient suggested that the physiotherapy he was

receiving caused his death. Again the paranoid interpretations were explored in the group, and I am sure a lot of new delusions were averted. As time passed, more topics were aired; with no organizational backlash to criticism of the hospital system, more patients felt confident to challenge staff attitudes and responses. Indeed, staff learned how to take these open criticisms on the chin, as it were, and sift out the valid from the paranoid, responding to both differently. Information flowed in both directions, staff to patients as well as patients to staff.

During the period under review, some of the ward patients went on outings to the countryside. Two separate doctors accompanying the patients on these trips reported independently to the author that patient behavior outside the hospital was much more normal than it ever seemed within the hospital. One of the group patients, sitting on the bus beside a doctor, talked very sensibly for an hour about his life become coming into the hospital; this same patient seemed quite disorganized in the group. What these observations suggest, at least, is that many patients have the potential for more normal and therefore less ill behavior and that this emergence is not encouraged by chronic security care.

In conclusion, the meetings have started to chip away at excessive personal privacy and secrecy with the basic assumption that, at the right pace, no harm will be caused or felt. As a side effect, more frequent treatment attempts flow into the ward to challenge the chronicity of illness that seems to gather in such places. Some improvement in the physical environment has been achieved. The expression of concern for others is beginning to emerge. Paranoid responses are nipped in the bud with the exchange of honest information replacing hospital rumor. Rumor tends to be rampant where communication is poor, and our ward meetings handle rumor rather than allowing it to distort reality. It is hoped that the patient group will feel new freedoms within the institution to replace the rather basic freedom that they have lost by being there.