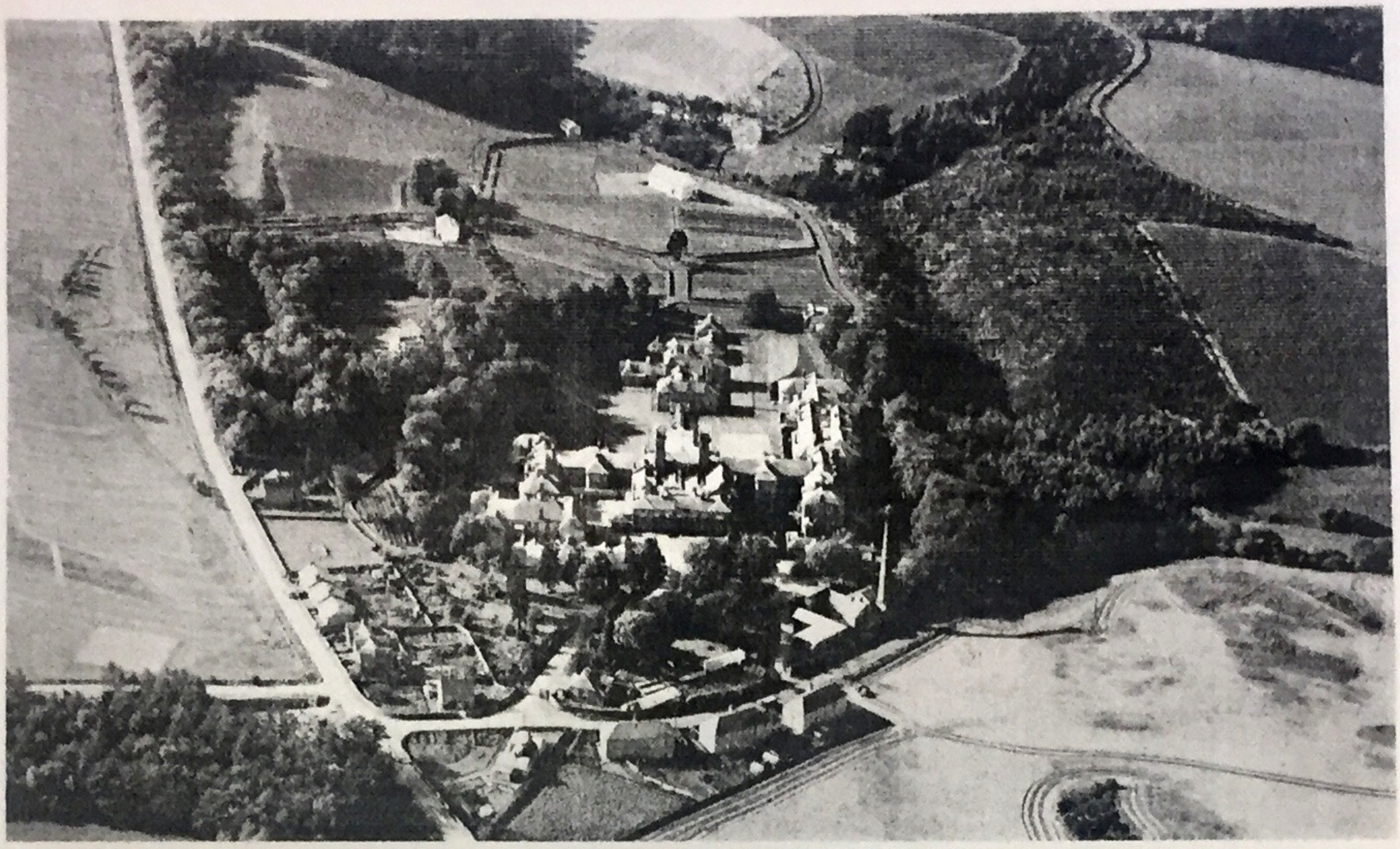


Dingleton Hospital's Therapeutic Community

J. K. W. MORRICE, M.D., D.P.M.
Deputy Physician Superintendent
Dingleton Hospital
Melrose, Scotland

HISTORICAL firsts can rarely be claimed with confidence, and their importance is often exaggerated. But for what it is worth, Dingleton Hospital in Scotland is distinguished on two counts. It was the first psychiatric hospital in Scotland to be completely open, and it was the first to organize its total structure as a therapeutic community.

Originally called the Roxburgh District Asylum, the institution accepted its first patients in 1872. The buildings have been enlarged and modernized, and in recent years money has been spent to rebuild and brighten the wards and to provide increased social facilities. The hospital has the advantages of being small (just over 400 beds) and of being located in a pleasant countryside on the slopes of the Eildon Hills, 38 miles south of Edinburgh and about 25 miles north of the English border. It provides psychiatric services for a population of about 100,000.

G. M. Bell, M.D., who became physician superintendent in 1945, pioneered the open-door policy, and by 1949 the hospital had no locked wards. In 1962 Maxwell Jones, M.D., after several years in the United States, succeeded Dr. Bell and, sowing on fertile ground, used his unrivaled experience to encourage the rapid growth of a therapeutic community.

It will be of interest to American readers that over the past few years Dingleton's evolution into a therapeutic community has been assisted by visitors from the United States who have spent time with us. These colleagues have included several social workers, a ward nurse, and two third-year psychiatric residents. Coming to learn from us, they themselves made significant contributions to our programs. At present we are fortunate in having as one of our three senior staff psychiatrists Paul R. Polak, M.D., from the Fort Logan Mental Health Center, Denver, Colorado, a hospital widely known for its advanced therapeutic community ideas and practice. Although the cultural patterns of the Scottish Borders are ob-

Dingleton Hospital is situated in the rolling green countryside of southeastern Scotland, 25 miles north of the English border. Dingleton pioneered the open hospital and therapeutic community concepts in Scotland; increasingly the hospital is extending its programs into the communities that surround it as well.

viously different from those of North America, we do have a great deal in common and much to learn from one another.

The hospital, which is part of the Border community and the focus of mental health services in the area, is becoming, we believe, an increasingly important psychiatric center in Scotland, and what we are doing and planning may interest American readers. This paper complements a report written by Herman B. Snow, M.D., which was published in this journal in September 1965. Dr. Snow, with other American Psychiatric Association members, visited us and several other Scottish hospitals in the summer of 1965, during a joint meeting of the Royal Medico-Psychological Association and the APA in Edinburgh.

For administrative purposes, Dingleton comes under the South-Eastern Regional Hospital Board of Scotland, whose offices are in Edinburgh, the capital city. The hospital also has a local board of management, whose members are drawn from its catchment area and who in a real sense govern its affairs as representatives of the population it serves. The hospital's medical staff members are employed full time by the National Health Service and do not engage in private practice. None of the hospital patients pay fees. They all receive allowances from national insurance or public funds to care for their dependents and to provide pocket money for themselves.

THE National Health Service Act of 1947 and the Scotland Mental Health Act of 1960 provided a foundation for liberal practices in patient care. Although recurrent financial difficulties have slowed down and upset plans for building and staffing hospitals in Britain, a great deal of attention has been paid to the needs of the psychiatric services. Local authorities, who are responsible for running the affairs of towns and counties, have been asked to prepare plans for the care of former mental hospital patients in their areas. Increasing emphasis is being laid on coordinating all mental health services in each community. The use of day centers, hostels, and halfway houses is a result of cooperation between local authorities and hospital centers; at present there is energetic discussion about coordinating the roles of social workers, welfare officers, nurses, and family physicians in the community care of the mentally ill.

It is against this background of social and legislative change that Dingleton Hospital should be viewed. It is a therapeutic community in the sense that we make every effort to use the therapeutic potential of staff and patients. Within the limits of our resources we are trying to apply the same principles outside the hospital, involving families, volunteer workers, local authorities, and other community groups.

Dingleton admits every type of psychiatric patient. Every appropriate form of treatment is used, including drugs, electroshock therapy, and individual psychotherapy. But the main emphasis is on group methods and milieu therapy.

THE social organization of the hospital is democratic; we stress open communication channels and, where appropriate, give staff and patients full opportunities to share in decision making. The physician superintendent, the matron, and the group secretary[1] of the hospital meet regularly to deal with practical administrative matters. This meeting is open to any staff member who wishes to raise an issue. Problems that deal more directly with patient care and treatment are considered by the senior staff committee (SSC), which meets four times a week and is made up of doctors, senior nurses, social workers, the group secretary, and several others. When decisions must be made that involve the hospital as a whole, the SSC makes recommendations to the board of management, which carries the ultimate responsibility. Various other committees function on a permanent, semipermanent, or *ad hoc* basis to deal with such matters as nursing problems, work therapy, and social activities. Some are staff committees and others include both patients and staff.

As in any therapeutic community, the ward group is the keystone of the treatment program. In the acute admission wards the community meeting takes place daily; in short-stay wards, the emphasis is on verbal communication. In other wards the group may meet less frequently or take a different form; mentally subnormal or geriatric patients, for instance, may respond better to a work group or a recreation group.

Nowadays it is unnecessary to emphasize that a group of patients living together in a ward will demonstrate in their day-to-day behavior the problems and difficulties that led to their admission. In

[1] In British hospitals, the group secretary is the equivalent of a nonmedical manager; he is responsible to the board of management for the day-to-day operation of the physical plant; he is also responsible for all financial matters.

A group of newly admitted patients chat with nurses in a lounge of the acute admission ward, which is the newest part of the hospital. The Dingleton program stresses a democratic social organization in which patients and personnel work closely together and have an opportunity to share in operational decisions.

ward meetings, where patients, nurses, psychiatrist, and sometimes also social worker and work therapist sit down together for an hour, such matters and the feelings surrounding them come to light. Patients in ward groups vary in their willingness to examine their behavior and emotions; the same group varies considerably from time to time. Many variables act and interact to make the group situation a constant challenge to the skills and experience of the therapists.

The difficulties of the staff and their perceptions of the interactions and interrelationships in the ward meeting are discussed in the review that takes place immediately after each ward meeting. The review is an important learning experience for staff, without which their skills in sociotherapy would fail to grow.

At Dingleton activities are not confined to the ward; we encourage patients to participate fully in the work of the hospital. The work therapy program is headed by a rehabilitation officer, who maintains a close relationship with the nursing staff. The program includes a graduated-pay incentive scheme and the placement of patients in outside employment. Dr. Snow in his paper commented on the two patient groups called Pots and Pans. The Pots are patient occupational therapists, who work under the supervision of a trained occupational therapist in a program for geriatric patients. This venture has completely changed the concept and function of the occupational therapy department. There no longer is pressure to produce a large number of well-made articles for sale. Instead there is a mutually helpful interaction among patients of differing abilities so that the more able help the less able. The Pans are patient assistant nurses, who, under the supervision of a registered nurse, give bed care to incapacitated and physically frail patients.

Other patients in the work therapy program have jobs in the canteen, the laundry, and the dining hall. Some 10 men patients, under the supervision of a nurse, perform heavy polishing and cleaning chores, mainly in long-stay wards.

The canteen, which serves both staff and patients, is part of the hospital social center. It is run by patients under the supervision of the staff and provides a meeting place and focal point for the social life of the hospital.

AN ACTIVITY THERAPY program operates within the framework of the work therapy department. Heading this is a young woman trained both as a psychiatric nurse and as an occupational therapist. She encourages patients to join her in planning and carrying out entertainment or recreation activities, particularly after working hours. Volunteer helpers and social organizations working in this program find comfortable and meaningful roles. Through their contributions patients are encouraged to make contact with the surrounding community, finding new friendships and renewing old interests.

Each work therapy group meets regularly with the leader or work therapist to discuss difficulties that have arisen during the working day. In this way the work situation is exploited not for the economic convenience of the hospital but as a direct contribu-

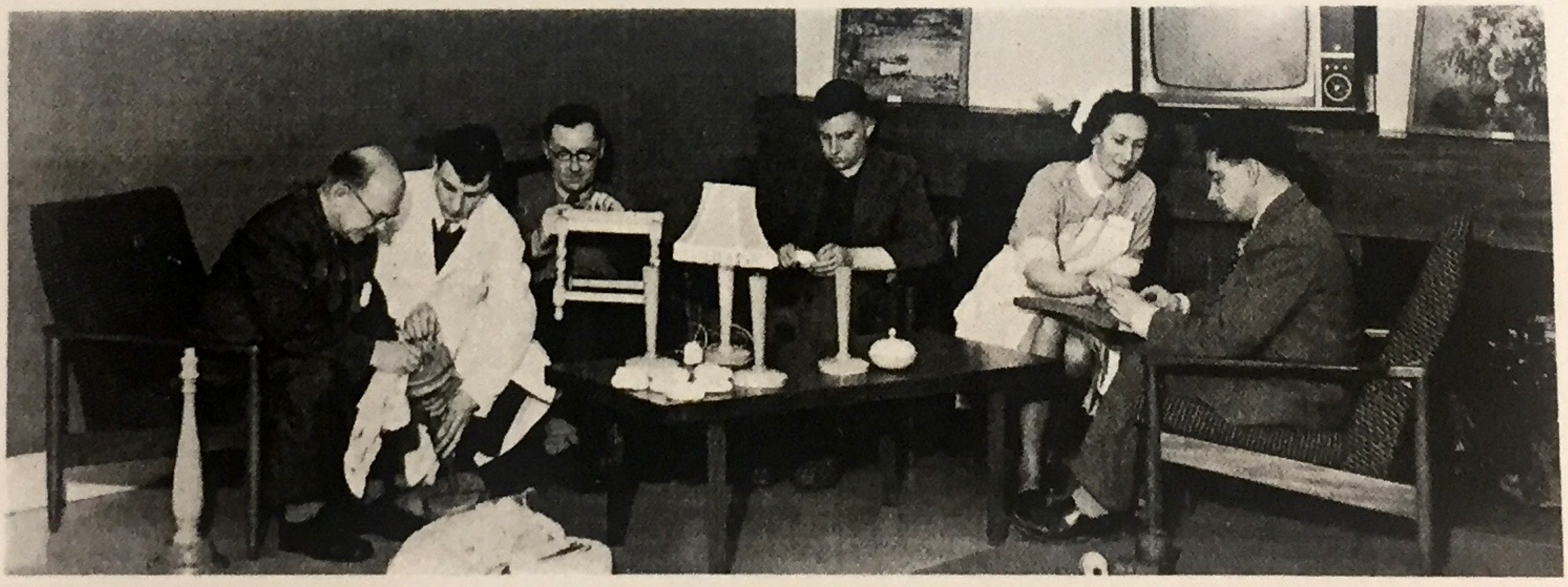
tion to the treatment and rehabilitation of the patients. The needs of the work therapists for training and support are not forgotten, either. Each therapist also meets regularly with a ward group, and the work situation and the ward situation merge increasingly as interacting opportunities for therapy. The psychiatrist and ward nurse are involved in the events of the work program; the work therapist is aware of the broad issues current in the life of the ward. As a more formal teaching measure, work therapists meet with one of the psychiatrists in a weekly training seminar.

Our program extends beyond structuring the hospital's social organization in an effort to make the patients' daily experience stimulating, meaningful, and therapeutic to them. Like most other psychiatric hospitals, Dingleton has breached the containing wall and has become actively engaged with society outside. If we believe that an individual's mental health depends to a significant extent upon his family, his neighborhood, his work situation, and other community factors, then these matters must concern us. The modern psychiatrist cannot avoid involving himself in the general social and cultural evolution. In helping with the rehabilitation and aftercare of his patients, he meets employers, health officers, housing authorities, magistrates, and educators. He may conduct social education programs in schools, correctional agencies, religious bodies, and local industries, and in return be educated himself. If he seeks to develop a program for positive mental health—in other words, preventive psychiatry—he cannot avoid entanglements with community affairs. Social psychiatry in action may well require a breakdown of professional barriers, a renunciation of pedestals and ivory towers, and a willingness to enter the hurly-burly of life outside the hospital walls.

Recently a local architect asked one of our staff members for help in planning new blocks of flats and homes for old people. The psychiatrist, flattered at first, was soon embarrassed to discover that his answers were inadequate. Yet housing conditions are an important element in mental health. Here is an obvious need for greater collaboration and careful research.

A group in the Scottish Borders, taking its cue from British social psychiatrists who have set up an organization called "Forum," has recently been formed to help in such community situations. It is hoped that this body, composed of local people of status and power who are also able to co-opt experts when they are needed, will provide the machinery to influence public opinion and exert pressure to advance various types of worthwhile projects for the community.

This plan may raise the familiar accusation that psychiatry is once again trespassing beyond its rightful territory. It is true that there have been occasions in the past when psychiatrists have invited censure and even made themselves ridiculous by making claims that were shown to be pretentious. We must be chary of shouldering burdens we have no real skill in handling. We should not risk spreading ourselves too widely to the neglect of our primary task of treating the mentally ill. But in these challenging times, a psychiatrist in a hospital like Dingleton cannot avoid the conviction that he must be involved in relationships far removed from his desk and his couch. The therapeutic community has extended its boundaries. •



Personnel are engaged with patients in projects both on and off the wards at Dingleton. Here staff members assist with occupational therapy on a ward for long-term patients. Work therapy is also stressed.

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