those things that for a long time have been taken for granted may quite easily and quickly fall to pieces. Too often people appreciate what they have only when they lose it.

New contract

The new contract resembles the old one in most respects. One difference is that the health service now has some influence on the size of a doctor's practice, and on where he is allowed to practise. There has been a high output of medical graduates in recent years, which has led to a considerable increase in the number of general practitioners. So it has been necessary to regulate the distribution of doctors so that desirable areas do not become overpopulated while unattractive parts of the country have too few doctors.

Another difference is the introduction of separate payment by the health service for family planning advice. In the past patients have had to pay for such advice themselves, unless they chose to visit a public family planning clinic—most patients preferred to see their own doctors for advice, even if they had to pay. In return, many doctors chose to give the advice as part of ordinary medical care, and without charging anything. When advice was sought about the pill it was especially difficult to overlook the fact that the advice (and the follow-up) was nothing less than large-scale long-term drug treatment given to essentially healthy women. Family planning, however, has now been officially accepted as a normal part of medical care to which people have a right. One reason for this change in attitude has undoubtedly been the somewhat alarming rise in legal abortions since the introduction of a liberal abortion Act a few years ago. We hope

that the new arrangement will result in fewer induced abortions.

Who, in the end, won the dispute between the GPs and the Health Service? Perhaps good old-fashioned common sense.

New Act

On 1 April a new Act was promulgated which provides for improved public assistance to everybody with social or medico-social difficulties. The Danish Health Service now resembles the British system with a synthesis of medical care and social services brought together under one roof, but administered locally. For the individual doctor the new arrangement means a much greater degree of formalised co-operation with the social services. For the patient it may well be an important step forward: it will no longer be necessary to rush round from one office to another to sort out the different aspects of what the welfare services have to offer.

But there are still some doubts abroad. As always, good intentions may not work in practice, and some doctors feel that it may simply give them more work, for it is hard to see how their usual work load could diminish. Some patients, too, may feel overwhelmed by this new superstructure and the apparently greater State control over the individual. Ultimately it is the patients' verdict of the new system that matters most. They are the consumers for whose benefit a system exists.

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Contemporary Themes

Experiment in managing sociopathic behaviour disorders

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British Medical Journal, 1976, **2**, 1056-1059

Summary

A ward catering for both sexes admitted patients with aggressive, suicidal, or otherwise disturbed behaviour for observation and treatment until decisions could be made about their long-term needs. Patients were referred from the police, special hospitals, and the courts and some were transferred from other wards in the hospital. A third of the first 100 patients were admitted for forensic reasons. Twelve inmates were discharged to long-term accommodation for disturbed patients. The ward was

intended to provide fairly short-term accommodation, though no time limits were set, and it was run as a medium secure unit. The ward was run by 16-18 nurses with support from medical teams, occupational therapists, and clinical psychologists. It has secured its status as a special unit within the hospital and will continue with the active support of the hospital staff.

Introduction

The confusion that has arisen in the mental health services has resulted in a reduction of facilities for patients with sociopathic behaviour disorders to below the basic requirements. This has led to increasing overcrowding in the special hospitals, inappropriate prison committals, vagrancy, and lack of treatment. It has been suggested¹ that psychiatric hospitals are losing the skills needed to look after really difficult patients. Bowden² pointed out that the complete absence of suitable facilities in 40% of the mental hospitals within one region, coupled with the planned inability of district general hospital units to deal with disturbed patients, has resulted in the concentration of the

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problem in the large mental hospitals, which are poorly equipped for the task. This pattern may be the natural sequence of the advance in psychiatric techniques available for the other types of patient, so the position might be acceptable if the large mental hospital had a specific department that carried kudos as well as responsibility. Such a concept led to the opening of a short-term sociopathic ward in the Royal Edinburgh Hospital (900 beds) in December 1974.

The unit

The term sociopathic ward was adopted to indicate that patients with all types of disturbed behaviour would be considered for admission. In the setting of a psychiatric hospital we expected that the need for admission would be mainly from psychopathic personality disorders and schizophrenic types of sickness. When the short-term sociopathic ward for both sexes was opened the difficult long-term non-geriatric patients in the hospital were reorganised into two small wards of 17 and 18 beds for men and women, respectively.

Statistics on the hospital's night emergency service for the city showed that 80% of patients admitted as emergencies at night are discharged by the end of a month. Many have recurrent social and behavioural problems, and their diversion to a special ward is justifiable, but we regarded it as an important principle that emergency patients should not normally have the sociopathic ward as their first experience of psychiatric hospital admission. We therefore proposed that patients would be admitted to the ward if they were: (a) referred from court or prison, unless special arrangements were made for quiet nonabsconding patients elsewhere in the hospital; (b) admitted as emergencies with known sociopathic behaviour—for example, psychopathic personality disorders with social or psychiatric complications; (c) admitted as emergencies with behavioural disorders that made admission to other wards dangerous or unreasonable by the extent to which they would disrupt treatment regimens.³

The medical responsibility for the patients remained with the 11 clinical teams with sector or other general psychiatric duties who admitted them. Two registrars, who had other duties, were available to deal with day-to-day problems and a consultant (JWA) took a special interest in the general running and community of the ward. No specific length of stay was laid down, but the short-term responsibility of the unit was emphasised.

We analysed our experience with the first 100 patients admitted to the unit.

Findings

The first patient was admitted on 5 December 1974 and the 100th eight months later, on 8 August 1975.

SEX, AGE, AND MARITAL STATUS

Seventy-six men and 24 women were admitted, a ratio that conformed to penal rather than psychiatric expectations. Their ages ranged from 11½ to 74. Patients aged 20 to 40 predominated (total 66), but there were nine troublesome teenagers.

Only 19 of the 100 patients were married (13 men, six women). Fourteen women were single and four were separated or divorced. A notable feature was the large number of single men (51) together with 12 separated or divorced men. This reflected the diagnostic predominance of schizophrenia and personality disorders found in the group.

LEGAL STATUS

The Mental Health (Scotland) Act 1960 has four provisions for compulsory detention in hospital. Section 31 is the emergency seven-day compulsory admission on medical authority with the agreement of relatives or a social worker acting as mental health officer, which may be followed by compulsory treatment under section 24. The Criminal Procedures (Scotland) Act 1975 has replaced the other Mental Health Act provisions by identical clauses: sections 25 and 330 (section 54 of the Mental Health Act) provide for remand in hospital for observation and a psychiatric report: sections 174-178 (sections 55-63 of the Mental Health Act) provide for hospital treatment with or without restriction on discharge.

On a ward with a continuous intake of disturbed, aggressive, and psychopathic patients we contained and treated over half of them without resort to compulsion. Of the 44 compulsory admissions 26 were emergency detentions; eight patients were admitted for examination and report, and 10 were admitted for treatment. Of the 10 admitted for treatment six were under a court order, three had been transferred from the state hospital, and one was on probation. The small number of patients remanded from court for a psychiatric report was disappointing in view of the ward's expected medicolegal function. These admissions comprised 4% of all the procurator fiscal's referrals during the period.

REASONS FOR ADMISSION

Thirty-seven patients were admitted from other wards in the hospital for suicidal risk, attacks on staff or other patients, smash-ups, hypomania, persistent absconding, etc. Emergencies elsewhere, which led to the admission of 31 patients, tended to be overdoses or other actions with serious suicidal intent, acute psychotic episodes, and hysterical states. Twenty-three patients were admitted because of criminal behaviour: breach of the peace, assault, fire-raising, etc. Three patients were sent from the state hospital for rehabilitation, and the remaining six were admitted for various other reasons.

WHERE PATIENTS COME FROM

Thirty-one patients were transferred from other wards and six were admitted from the outpatient department. Fifteen came from other hospitals. Eighteen people were received from the police, five directly and 13 after being seen in the cells by the duty psychiatrist. They had all behaved in public in a way that suggested mental disorder. Thirteen were ultimately diagnosed as psychotic and five as having personality disorders. The existence of a secure unit probably led to these patients being diverted to hospital after examination by the psychiatrist rather than being held in prison.

A further 14 patients were transferred from the courts or prison for examination and report or for treatment. As might be expected in patients admitted for diagnostic reasons, there was a higher proportion with personality disorders in this group. No restrictions on discharge were imposed in this series.

Three patients were transferred from the Carstairs State Hospital to start their rehabilitation programme. Eight patients were sent by a general practitioner or came from their homes.

DIAGNOSIS

Psychopathic personality disorder was the primary diagnosis in 29 patients and a secondary diagnosis in 20 others. Alcoholism was the primary diagnosis in nine and secondary diagnosis in eight. Of 52 psychotics 25 were schizophrenic (table I).

TABLE I—Primary diagnosis in 100 patients

Diagnosis	No of patients	Diagnosis	No of patients
Psychosis:	52	Personality disorder	29
Schizophrenia	25	Alcohol-related condition	9
Affective psychosis	15	Drug dependence	4
Paranoid state	7	Neurosis and sexual deviation	3
Associated with physical condition	5	Mental retardation	3

WHERE THEY WENT

Ninety-two patients were discharged or became sufficiently settled to be transferred or returned to other wards in the hospital, including the longer-term disturbed wards (table II). Only 12 were readmitted to the sociopathic ward during the eight-month survey period. Those whose destination on discharge was designated as not known were of no fixed abode and determined to maintain that way of life. It did not necessarily exclude them from follow-up. Some attended the "moderate clinic."

TABLE II—*Destination after discharge*

Destination	No of patients	Destination	No of patients
Long-term disturbed wards	11	Hostel facilities	10
Carstairs State Hospital	1	Prison	6
Other wards in Royal Edinburgh Hospital	47	Home	13
Other hospitals	7	No fixed abode	3
		Still on ward	2

LENGTH OF STAY

Experience on the new ward confirmed the expected early discharge of most patients (table III). At one end of the scale 40 patients left in under a week, but 25 stayed longer than 28 days and a few proved difficult to discharge. One manipulative woman managed to prolong her stay for six months.

TABLE III—*Length of stay in sociopathic ward*

Stay	≤24 h	Days				Months					Still on ward
		2-6	1-13	20	27	1-2	3	4	6	≥6	
No of patients	4	36	17	10	8	10	8	2	2	1	2

Discussion

The sociopathic ward is an upgraded long-stay ward that can accommodate 19 patients in various sex ratios but is usually laid out to provide for 11 men and eight women. We established that maximum security was neither attainable nor desirable and a medium secure environment became the objective. Unbreakable glass was fitted in the nurses' station, and reinforced glass was provided in all the lower windows. The argument prevailed that to impose or incorporate the expectation of violence through the physical surroundings was perhaps to invite destructive acting-out, which we hoped eventually to be the exception rather than the rule. A room was fitted for recreational facilities rather than used for seven additional beds.

Some nursing staff saw the opening of this ward as retrogressive and simply an unwelcome return to keys and custodial care. Despite this fear we recruited 16-18 nurses, comprising three charge nurses, five staff nurses, and three enrolled nurses; the remainder were senior students and nursing assistants. The male-female ratio among the nurses was usually 1.5:1. Most of the staff were aged under 30. The ward operates with about five nurses per day shift and two or three nurses at night.

WARD POLICIES AND TREATMENT PROGRAMME

The ward policies grew out of considerable discussion between nursing and medical staff. We invited and received contributions from the patients, who are encouraged to maintain as much responsibility as they can tolerate or are willing to accept. For example, there is an evening dish-washing rota and they are responsible for making beds, keeping rooms tidy, etc.

The part-time occupational therapist directs a broadly based programme which includes resocialisation, social skill education, active and passive recreation, sociodrama, pottery, music and movement, etc. These activities take place within and outside the ward. Advice from the clinical psychology staff is available.

The admission policy aims at maintaining a balanced patient: staff population, so patients are not automatically admitted just because a bed is empty. This has proved to be a realistic and workable policy, and it has contributed towards the existence of an enthusiastic staff. There is a fine line between staff survival and staff growth, and unless this is borne in mind treatment aim can become incidental.

It is essential to establish realistic relationships and lines of communication with other staff within the hospital. Nursing

staff visit patients on other wards and have discussions with the nurses who will take them back, to explain the experience gained. The ward senior nursing staff also act in a consultative capacity, providing advice to other wards on the management of particular patients, but a general policing role for the hospital is avoided.

STAFF MEETINGS AND WARD MANAGEMENT

Two community meetings a day, where here-and-now issues are explored, have proved to be a necessary part of the ward programme. Attendance is compulsory for all patients irrespective of occupational commitments within the hospital. Participating in such meetings can provoke anxiety in staff, so daily supervision is conducted by the nursing officer. The same procedure may follow any major disturbance, and nursing staff in particular are able to admit openly to feeling ineffective or anxious without fear of ridicule. Community meetings appear more effective when staff accomplish in their meetings what patients are expected to accomplish in theirs—that is, inner control until a structured opportunity is provided to express frustration, insecurities, etc. This serves both to relieve the nurses' tensions, which are aroused by such difficult work, and to help personal growth and provide the consequent satisfactions.

Apart from holding a long daily review to which other hospital teams are invited to send representatives, the staff have developed sufficiently to make constructive use of a weekly multiprofessional meeting. At such a meeting policy is defined and modified and the most effective and realistic ways of sharing treatment and management decisions are sought. Often exaggerated fears can be spread about the violence of particular patients. Examining and working through some of these feelings is undoubtedly difficult and time consuming. Nevertheless, it is an integral part of the primary task of attempting to treat these disturbed patients effectively and maturely.

The attachment of two trainee psychiatrists to the ward, in which they spend 80% of their working day, ensures adequate support for the nurses. They act on behalf of the teams responsible for the patient. The placement is regarded as excellent training in the rotational training scheme for psychiatrists.

OBJECTIVES MET AND UNMET NEEDS

The objective of accepting all the requests for forensic psychiatric services was met. We also largely accomplished our aim of moving disturbed patients from the other wards, although not all were moved. Every patient who creates a disturbance is not necessarily transferred, especially if the patient's difficult behaviour is likely to be of short duration. On the other hand, the transferring teams can continue their care. This helps to prevent the sociopathic ward being regarded as a "dump" for the unwanted. This arrangement is maintained for patients transferred from the smaller outlying hospitals but tends to fail with the services for adolescents. Adolescent patients with personality problems are often under the care of regional social work departments, which are less sensitive to the hospital's administrative problems. We found it impossible to respond to demands from these services except to a limited extent. This was made more difficult by Sunday newspaper articles suggesting that adolescent girls with hysterical personalities were put in moral danger by proximity to male patients. Though the dangers were in fact reversed, the situation did put serious strain on the nurses. The psychotic adolescent is more simply managed. Crises in subnormal patients tend to be socially determined and manageable. The obvious defective patient with physical stigmata is no more (or less) welcomed than in other parts of the hospital.

The objective of obtaining special unit status for the sociopathic ward was largely accomplished. A referendum to the medical staff and senior nurses in the hospital resulted in a whole-hearted recommendation to continue, the discordant vote

suggested a Henderson Hospital type of treatment unit⁴ rather than failure of the present service.

The danger that the ward might fail to achieve the number of discharges necessary to maintain vacancies was often considered, as the nursing staff were only rarely able to cope with more than 15 patients. One temptation is to try to force a time limit on the individual patient's stay in the sociopathic ward, but the benefits of continued treatment in several cases have altered the ultimate prognosis. We agree with Rockstro⁵ that some patients are neglected by being denied compulsory detention for treatment by excessively permissive philosophies.

"BUTLERISM" AND THE LOCKED WARD

Overcrowding of the special (state) hospitals and estrangement of the mental hospital has been minimised in Scotland because the law here does not recognise "psychopathic disorder" as a category for compulsory admission for treatment. Fairly adequate state hospital provision in Scotland, not overtaxed in recent years, has further reduced the tension in the mental hospitals' struggle for existence. Admission for observation and report is available to the courts, and the Procurator Fiscal was advised that special facilities were available. The functioning of these legal provisions in Scotland has been described by Binns *et al*⁶ and Woodside.⁷

Regional security units fit in with the concept of a mental health service that is inevitably fragmented by separation of its acute short-term, disturbed, long-term, and other components. This system, which is the equivalent of extending the state hospital type of management to the regions, has the objective of reducing admissions to state hospitals and providing a base for forensic psychiatric services. The Butler Report⁸ envisaged a simultaneous upgrading of the prison system by providing within it special treatment units for the management and rehabilitation of psychopaths, usually of a different type from the patients we have described.

Scott⁹ forecasted that forensic services will resemble other autonomous units and become selective about their intake. As the Butler units are to be associated with a pay differential for difficult and dangerous work, disputes regarding the proper placement of non-forensic patients may well take place. Furthermore, if their main traffic is with forensic patients then patients who commit no legal offence (and their relatives) could reasonably object to transfer to an establishment with such a stigma. The regional secure units will also be located at distances which will be inconvenient for much of the population serviced. The demand for accommodation for disturbed patients outside the

Butler units is, therefore, likely to continue and the provision of units of the type we have described may be needed.

Conclusions

The experiment of having disturbed men and women of all ages, social backgrounds, and psychiatric conditions—some with forensic status, some bright, and others dull in intellect—has been successful. We expected some complaints from patients and relatives, but these were few and generally directed at unspecialised features of the service or items that could be reasonably excused rather than at basic organisation. Having men and women together does not ensure good behaviour, but it provides some stimulus towards better manners and allows the opportunity for a wider range of relationships.

In our experience 16-18 nurses with adequate support from medical teams, occupational therapists, and clinical psychologists can provide suitable short-term care, treatment, and management for the sociopathic disorders referred from our population of 500 000. Back-up support from long-term disturbed wards was required for 11 patients and from the state hospital for one. The unit requires a regimen based on therapeutic community principles and it needs the status and privileges accorded to other specialised services.

The equivalent of one whole-time and one half-time trainee psychiatrist was deemed to be necessary plus one-and-a-half hours of consultant support in addition to the liaison with the responsible teams. This is an estimate of the staffing required in view of the warning from the Department of Health and Social Security¹⁰ about setting up wards for disturbed patients without adequate resources.

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When assessing the vision of men employed as inspectors on aeroengine work we have been testing the long-distance vision with the Snellen's chart at a distance of 6 m and the near vision with the test types. Is this sufficient or should we give them further tests on the Mavis machine to ensure that we are not missing any cases of latent ocular muscle imbalance?

It is always difficult to advise on visual testing without detailed knowledge of the visual task. Testing near and distance visual acuity will not detect simple hypermetropia or muscle imbalance, but unless the visual task demands long periods of close work this may not be important. If there is much close work people with hypermetropia or muscle imbalance are more likely to complain of eyestrain. Many people with a muscle imbalance do not suffer any particular inconvenience, and it would be wasteful to reject a person for employment because they failed an arbitrary test of muscle imbalance.

Have there been any recent advances in the treatment of Paget's disease?

Recent advances in the treatment of Paget's disease are based on the substance known as calcitonin that is synthesised and secreted by the parafollicular cells of the thyroid gland in mammalian species and by

the ultimobranchial gland of birds and fish. Its physiological functions are still not completely understood, but one function appears to relate to control of calcium and phosphate metabolism by acting as a fine control of, and antagonist to, the actions of parathyroid hormone on bone. At pharmacological doses calcitonin inhibits skeletal resorption, primarily that resulting from osteoclastic activity. The controls are based on the fact that the serum alkaline phosphatase is raised in Paget's disease, and the urinary hydroxyproline is increased. These two are the effects of osteoclastic activity in the bone. Under treatment with calcitonin—and the one most popular now is salmon calcitonin¹ as opposed to human or porcine calcitonin—salmon calcitonin is given for at least six months, initially daily in the region of 100 MRC units subcutaneously or intramuscularly, until the pain settles and the indices in the serum and the urine have decreased; then 500 MRC units can be given three times a week. After six months if the patient is completely free of pain the treatment is stopped, and, although the alkaline phosphatase may rise quickly, the increased secretion of hydroxyproline does not rise as quickly. It would appear in most cases that even if these indices might return to their pretreatment level patients have been known to stay free of symptoms for up to a year or longer.

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