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Community Psychiatry*

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Much confusion has resulted in recent years from the use of the word "community" to mean merely "outside hospital". Community psychiatry is not just extramural work or a means of avoiding hospitalization. A community mental health service is a comprehensive psychiatric service of care and treatment for a defined population, including full hospital facilities (Freeman, 1963). The hospital is in fact part of the community, and provides one of its services. The size of population base that can most efficiently support a comprehensive service is probably between 150,000 and 200,000 in urban areas, judging by experience in Lancashire (Smith, 1965). This is large enough to contain all the basic services that are needed, and small enough to allow all key professional workers to remain in constant face-to-face contact. Within its defined area, the service must have continuous and final responsibility, whatever the clinical state of individual patients. It must offer a continuous spectrum of integrated services, from full-time, permanent care in an institution on the one hand, to occasional support for a patient or family at home on the other. Since the demand for services is potentially infinite, an essentially ideological choice must be made in assessing priorities for the resources that exist. I believe that if we try to act primarily on the basis of human needs within the total community, the first call on these resources must be for the three great problems of schizophrenia, subnormality and old age. Concentration on psychotherapy would make it more likely that these greater social needs remained unmet, and it may well be that any large-scale treatment of neurosis or personality problems would have to be outside psychiatric—or even medical—channels (Ryle, 1967).

Certain basic processes seem to have led to the emergence of community psychiatry. Firstly, advances in treatment methods have made it possible to make use of general hospitals, family doctors, social agencies and other extra-hospital facilities in the management of severe psychiatric illness. Secondly, there have been changes in the pattern of illness, as it presents for treatment. The altered population structure causes enormous problems of chronic diseases in the older age-groups, whilst rising standards of living and education, together with improvements in the services offered, result in much greater numbers of clients for psychiatry. The development of comprehensive community mental health services can accommodate this broadening of clientele and can prevent the division of psychiatrists themselves into groups of differing status. Thirdly, there has been a greater awareness and knowledge of therapeutic forces, stemming partly from the progress of social and ego psychology and partly from more pragmatic developments, such as therapeutic communities and industrial rehabilitation. In the future, community psychiatry will have to pay as much attention to these factors as to the purely clinical aspects of diagnosis and treatment. Fourthly, general social changes, such as decline in family size and geographical dispersal from rehousing, call for a genuinely comprehensive service and for an integrated approach to treatment and care. This is particularly so since the trend to shorter hospital stay means that there may be little difference between the needs of some patients in hospital and others living outside.

In considering actual developments towards creating comprehensive community services, we inevitably come up against the tripartite structure of the National Health Service. On the whole, earlier services were developed outwards from hospitals, as in the Worthing Experiment, where the local authority's part consisted of little more than its minimum statutory functions. In

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some areas, such as York, Croydon and Oldham, the local authority was an active partner in hospital-centred developments (Freeman, 1960). In Salford and in the London Borough of Newham, it has been the initiator of progress. But on the whole the controlling influence and status has remained within the hospital service, where it has often failed to provide the necessary lead. Further, some of its earlier efforts now seem to have been based on rather naïve propositions, such as measuring success by reduction of the number of admissions, without taking into account whether patients and their families were better or worse off as a result.

Under present conditions, over the course of a severe psychiatric illness, a patient is likely to spend more time outside hospital than inside. Therefore, to a large extent, the degree and frequency of hospitalization will depend on the efficiency of extra-hospital services. In fact, it has become wrong to think of many psychiatric patients as being "ill" when they are in hospital and "well" when they are at home. On this account, the focus of influence should shift more to services centred in the community, and hospital concepts should play a smaller part in the total management of patients. For this to happen, it would obviously be helpful if our health services were not divided administratively into three. But until the majority of local health authorities are brought up to the standard that the progressive ones have achieved already the growth of community psychiatry must remain sporadic, since hospitals cannot provide a comprehensive service by themselves.

Nevertheless, a great deal can be achieved within the existing administrative structure, and this is illustrated by our experience in Salford (Freeman and Mountney, 1966, 1967). Up to 1961, psychiatric patients in the area were served by four separate agencies—mental hospital, general hospital, local health authority and general practitioners. Each operated to a large extent in a watertight compartment, while communications between them were difficult and formally structured. This situation was altered by two new appointments. Firstly, a trained psychiatric social worker became senior mental welfare officer; without a professional social worker in this position, it would have been almost impossible to attract suitable social work staff, especially in a rather uncongenial industrial area, such as Salford. Secondly, an additional consultant psychiatrist was appointed jointly to the two general hospitals in the city, to the nearby mental hospital (which served it and other areas) and to the local authority health department.

The first objective was to improve the continuity of care. Within the mental hospital, it was agreed that all patients admitted from the Salford area were to be automatically assigned to the new consultant (unless the admission had been arranged by one of his colleagues). In practice, after a short time, the great majority of cases were first being assessed outside—in an out-patient clinic or at their home—or else the case had been discussed by the consultant with the general practitioner or mental welfare officer concerned. In this way, once the patient had been referred to any psychiatric agency, there could be continuous responsibility by the same professional team, with free communications between the different services involved. Secondly, whereas Salford patients had been scattered throughout all the wards of the mental hospital, progress began towards the creation of a self-contained unit, to form one element in a comprehensive community service. So far, an open admission unit of 41 beds for both sexes has been created, but further progress is held up by lack of funds. A clinical "firm" has been constituted, with a registrar and clinical assistant, and a second consultant psychiatrist is now working within the total service, replacing a consultant who was attached only to the general hospitals and has now retired. There have also been two joint appointments of psychiatric social workers—one between the local authority and the mental hospital and the other between the local authority and the two general hospitals.

In many other ways, the various services are now interlocking, and we hope that the result will be a common sense of identity and purpose. For instance, an assistant medical officer of health holds a weekly discussion meeting with patients in the general hospital psychiatric ward. Patients from the mental hospital go out one evening each week to a social club in the city,

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organized by the health department. A weekly case discussion at the health department is attended by all social workers and by hospital medical staff. Patients from the general hospital ward can go to a nearby local authority day centre in the afternoons for occupational and social therapy. All follow-up work from the mental hospital is done at the general hospital clinics, and mental welfare officers visit the patients' homes if any fail to attend. Some general practitioners are now involved in community health teams, which include a health visitor, district nurse and mental welfare officer. Cases may be referred from these teams to the hospital service, and the consultant psychiatrists have started to meet some of the teams on a regular basis.

To attempt to cope with the vulnerable, recurrent cases of schizophrenia, many of whom will not co-operate in regular oral medication or attendance at out-patient clinics, we have been treating the majority of these during the past year or so with long-acting fluphenazine enanthate by regular injection. This not only ensures that such patients have at least a certain amount of medication, but also means that they are supervised more frequently and systematically than before. The district nursing service has been of tremendous help here, and as a result has become more closely linked with the mental health service in general.

These measures add to a considerable degree of progress, but each step makes us more conscious of the next one that is still to be taken. We have not yet been able to involve our hospital nurses in extramural work. We lack adequate rehabilitation facilities for the chronically disabled, both in hospital and outside community. We lack an organized ladder of sheltered accommodation for domestic resettlement, and we have neither group homes nor supervised lodgings. It should be possible to offer patients all the facilities for active rehabilitation outside hospital, but at the moment several vital parts in the process are missing.

But there are two even more significant areas in which we are conscious of the need for change. The first concerns age-groups. If a comprehensive service means anything, it is one that serves the whole age-range of the population. In fact, our psychiatric services today—good as they are in relation to most other countries—are geared to the needs of young or middle-aged adults. At both ends of the life-cycle, provision becomes completely inadequate. As far as the elderly are concerned, the only way a community service can plan for their needs is to consider psychogeriatric, geriatric and local authority Part III accommodation together, and to separate this clearly from beds for psychiatric illness. Problems arise here, not only from the division of responsibility between hospitals and local authorities, but also within many local authorities themselves, between their health and welfare departments. An essential element in any comprehensive service will be a screening facility, to select for treatment old people who are mentally ill. We hope to have such a short-stay assessment unit, run jointly by psychiatrists and geriatricians, within our general hospital group in the fairly near future.

The other age-group which is under-privileged for psychiatric care is that of the young. Apart from the overall lack of professional resources, most services for children are not in any way integrated with a wider network of mental health facilities. (The one remarkable exception is the mental health service developed in the Borough of Newham around the child guidance clinic and other local authority facilities (Kahn, 1967).) This situation presents a tremendous handicap to the development of community psychiatry, which is concerned very much with the family, rather than merely with the clinical state of a single person. So far, we have only been able to take a few small steps towards the integration of child psychiatry into the wider service for Salford.

The final area where we particularly see the need for change is in relation to staff training and appointments. Post-graduate education in psychiatry has up to now been almost totally deficient in its community aspects, and has wasted the opportunities of in-service experience in areas which are creating comprehensive services. Furthermore, an integrated service must in the long run surely have a unified staff, with all professional appointments made jointly by the different authorities involved. It would be perfectly possible to do so within the existing

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administrative structure, but there is very little awareness yet of this need among hospital authorities or medical teaching centres. Progress towards arrangements of this kind would be of tremendous value in the development of community psychiatry.

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