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Reading about...

Community Psychiatry

The definition of community psychiatry is, of course, a central issue in any personal choice of books or articles about this field. The topic may be interpreted as the study of the provision of psychiatric and related services for the optimal care of the whole community or population. Alternatively, the concept may be confined to all services except hospital residential care, or even to more restrictive definitions. My preference is to adopt the wider definition on the basis of *Gestalt* theory applied to organisations. That is to say, non-hospital care may have characteristics of its own, but it will also have characteristics which result from its inclusion in the whole programme of psychiatric and social care available. Hence, community psychiatry is only understandable in the context of all forms of care. The interaction of the clinical and organisational roles in community psychiatry is probably more important for good patient care than in any other clinical specialty. In reading about this topic, therefore, a balance has to be struck between clinical psychology and psychiatry and their related skills on the one hand and an understanding of management and its skills on the other..

Historical antecedents of community psychiatry

The historical context provides the best setting for an understanding of the arguments and pressures for non-hospital care. Jones (1972) eloquently described the clinical, social, and political context of those factors or forces which were to move the focus of care away from the hospital residential setting: the development of the major tranquillisers in 1952; the introduction of 'open door' and rehabilitation policies; and legislative change, culminating in the Mental Health Act of 1959. These factors were not independent of each other and, in addition, depended on gradual changes in public attitudes. Jones also summarised and discussed some of the negative factors in large psychiatric hospitals which were to push favourable public opinion away from these institutions.

The most irreverent, readable, and plausible attack on the processes of total institutions, of which the psychiatric hospital was considered to be one among many, was the work of the American sociologist Erving Goffman (1961). His description of the processes experienced by inmates of total institutions led to the concepts of role stripping, block treatment, rigidity of routine, social distance, and depersonalisation (in this context meaning the lack of opportunity to have privacy and personal possessions). Regrettably, in many circles it became accepted that hospital residential care was synonymous with institutionalisation. Paradoxically, it was careful scientific research in hospitals in the 1960s which was to identify the important elements of social therapy and rehabilitation necessary to combat institutionalism, particularly in schizophrenia (Wing & Brown, 1970).

Establishing the need for community psychiatric care

The classical approach to planning a service for a community is to establish the need for the service through appropriate epidemiological studies. A clear yet succinct account of the findings of epidemiological studies of the frequency and type of psychiatric conditions is given by Goldberg & Huxley (1980). The logical approach of these authors is to consider psychiatric case finding at various levels: population surveys, general practice surveys, and hospital contacts. Surveys based on whole populations, or representative samples thereof, range from the relatively unstandardised psychiatric diagnosis approach of Hagnell (1966) to those surveys essentially based on symptom reporting, for example the Midtown Manhattan Survey (Srole *et al*, 1962) and the Stirling County Study (Leighton *et al*, 1963). The very high rates of symptom reporting in the latter studies underline the importance of the diagnostic approach if sensible estimates of prevalence are to be made.

At the general practice level, the important work on consultation rates by type of psychiatric morbidity can be found in Shepherd & Clare (1981), although Goldberg & Blackwell's work (1970) on the sensitivity of GPs in detecting psychiatric morbidity is vitally important for explaining the variation

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between practices. The final level of case identification concerns psychiatric morbidity treated by psychiatrists in specialist settings, for which psychiatric case registers are the prime evaluation instrument (Wing & Hailey, 1972). Nevertheless, it is a moot point whether studies of need can produce accurate estimates of the size and type of psychiatric service required. Studies of the frequency of psychiatric disorder, particularly at specialist level, are biased by many factors, most notably the availability of resources and manpower. Even case identification at the level of population surveys requires judgement about the threshold at which intervention should take place – hence the necessity for evaluation in the form of effectiveness and efficiency studies.

Evaluation

By and large, the drive towards non-hospital residential care has been fuelled by theories, processes, and professional concerns rather than by the careful definition of specified clinical and social outcome criteria and their evaluation. For example, no definitive randomised controlled trial has been carried out to compare care with a District General Hospital psychiatric unit as the base with that provided from a traditional single-specialty psychiatric hospital. However, some contributions relevant to community psychiatry are genuinely helpful in practice. An important example is the work on expressed emotion as a factor in the relapse rate of schizophrenia, and the subsequent controlled trial of social intervention (Leff *et al*, 1985; Leff & Vaughn, 1985). In addition, Paykel *et al* (1982) have shown in a controlled trial that neurotic patients requiring follow-up are treated just as effectively in terms of symptoms, social adjustment, and family burden by home support from community psychiatric nurses as by routine psychiatric out-patient care. Generally, however, with the exception of drug prescribing, it can be argued that there is relatively little empirical guidance about what is actually done by whom in community teams and the precise skills exhibited by the various professionals.

Policies

Successive governments have been committed to the concept of community psychiatric care, although, if quality of care is an issue, it will be expensive and not necessarily less so than hospital residential care. To read all the government guidance is a daunting task, but important DHSS policies on mental illness are admirably summarised in the appendix of Wilkinson & Freeman's edited report (1986) of the proceedings of a conference on planning mental health services.

The most thoughtful and incisive analysis of recent policies and practice in community psychiatry was made by the late Professor F. M. Martin (1984). Martin's approach was to examine community care with respect to each professional group. Within each group a 'product champion' was sought, that is, a committed innovator to promote energetically the idea of community care. Martin's analysis led him to conclude that each profession involved in community psychiatric care had failed to provide the caring profession's equivalent of the entrepreneur. The essence of the 'product champion' is that he is willing to take risks for the idea of community psychiatric care. Risks are required since Martin also identified the dearth of high quality research in this field. For me, Martin's book is the 'desert island' choice in community psychiatry.

Finally, for those innovators who are committed to community psychiatry, complex organisational change is often required to put ideas into effect. The psychiatrist has to give as much attention to his power and influence in promoting organisational change as he does to the understanding and management of individual patients. For example, community care professionals must be adept at recognising issues such as the readiness and capability for change as well as the possible resistances. In addition, he must be sensitive to his own styles of influence. Handy (1981) and Kolb *et al* (1984) describe approaches that concentrate on human behaviour in organisations; they will be helpful and of interest to psychiatrists.

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