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Emergency Psychiatry

By J. K. W. MORRICE

In the United States considerable emphasis is at present being placed upon emergency psychiatric services. This is part of a national drive to provide a high level of care for the total population and not just those who can afford the services of private psychiatrists. Investigations have been conducted in various centres in the U.S.A., and subsequent discussion and documentation (e.g. 5) suggest that emergency care is best given by a centre which also provides full in-patient and out-patient services. This echoes and reinforces the recommendations of the "Community Mental Health Centers Act", which promises Federal matching funds to American states setting up community mental health centres, provided the services are comprehensive. The term "comprehensive" is defined in some detail, and comprises in-patient and out-patient services, partial hospitalization (e.g. day-care), emergency services for 24 hours in the day, and consultation and educational services to professional personnel and to the community at large.

Americans themselves suggest that the importance being given to emergency services is due to the stigma still attaching to the mentally ill in that country. Mentally disturbed individuals are still looked upon as dangerous and consequently often locked up in jails. It is understandable, therefore, that a society accustomed to the expulsion of such people to secure and often remote institutions needs reassurance in order to accept them in local treatment programmes. The *quid pro quo*—the safeguard and the persuasion—is the emergency service, which provides a mechanism whereby the socially disruptive patient is handled promptly and effectively.

What is an Emergency?

It seems difficult to arrive at a clear, short definition of a psychiatric emergency. Most people who try end up with a paraphrase such as "any situation which compels a person to seek *immediate* psychiatric treatment, or which impels his family, friends, or an official agency to seek such treatment for him" (9). Ungerleider (17) states concisely that all patients whose condition warrants prompt psychiatric attention for whatever reason are designated emergencies. This recommends itself as a working definition, because it is the experience of emergency psychiatric services that almost all who present themselves for treatment do indeed have psychiatric problems, although not all are in need of immediate care. In effect, therefore, an emergency psychiatric service opens a door for anyone in the community who is emotionally disturbed and who asks to be helped at once. It is not limited to those who are dangerous to themselves or to others, for an individual's distress cannot be equated with his nuisance value. Nevertheless, it is generally the threat of assault, damage, or suicide that leads to public intervention and the recognition of an emergency. This suggests that most psychiatric emergencies are social emergencies, although, of course, the converse is not true.

In Britain we congratulate ourselves on having provided comprehensive mental health care for the whole population. Emergency services, in the main, are part and parcel of the daily work of the mental hospital or clinic. But the enthusiastic planning of our American colleagues suggests that we should look again at the adequacy of our provisions. This may be forced on us by concern over the so-called "dangerous patient", and the threat posed by his falling through the mesh strung between law enforcement agencies and psychiatric services. A reappraisal is further recommended by our dawning awareness of the great mental health needs of the community at large.

The Doctor's Changing Role

For a long time past doctors felt satisfied that,

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within the limits of their knowledge, they were meeting the medical needs of society. Nowadays there is much less assurance on the doctor's part about his own role and what constitutes the community's legitimate demands upon him. The British National Health Service and recent liberal mental health legislation give an opportunity for high-level health care; yet many doctors seem frustrated and unfulfilled, while surveys uncover large numbers of the population whose disorders go untreated. It seems that for every case of diabetes, anaemia, or depression that reaches a physician there are several, sometimes many, people in the community suffering from these disorders and receiving care that is inadequate; and often care comes too late (11). In the mental health field it is clear that only a minority of those with signs and symptoms of psychiatric disorder come to the attention of a psychiatrist or enter a psychiatric hospital (16). In the past, psychiatrists, overburdened with patient loads, and often isolated from colleagues and the general public, were content to accept this fact. They felt they already had too much to do and possessed inadequate tools to perform even the tasks at hand.

More recently, psychiatrists have reconsidered their roles and reviewed their assumptions about what they do and where they do it. Accepting the insights made available by the investigations of social scientists, many psychiatrists questioned the appropriateness of the medical model in dealing with the emotionally ill, both inside and outside hospital. This led them to evolve therapeutic communities, which are primarily concerned with creating social situations that make therapy part of the everyday life of institutions. Now, therapeutic communities are extending their boundaries, concepts, and practices to embrace society outside hospital. After all, if mental health and mental illness are products of living in groups which experience satisfactions or difficulties in such situations as being neighbours, being married, bringing up children, finding suitable housing, employment or recreation, or in growing old, then these matters—and others like them—are of inevitable concern to mental health workers. The attention of the latter is being diverted from the intrapsychic conflicts of the individual patient to consideration of problems of an interpersonal or social kind.

The proposition now offered is that most psychiatric patients fall ill and are admitted to hospital because of a crisis or series of crises in their relations with family, employer, or other significant persons. If this is the case, then psychiatry is faced with the tremendous challenge of intervening effectively in social crises, both as a preventive measure and as a method of treatment.

This means the abandonment of the formal role the psychiatrist has been accustomed to play. Instead, he must often leave the structured office situation for the uncertainties of interaction with families in their own homes, working alongside general practitioners, health visitors, general hospital doctors and nurses, clergy, and community agencies of many kinds. This step is inevitable if problems, such as are involved in bereavement, loss of employment, accidents leading to disablement or disfigurement, divorce, and clashes with the law, are to be met therapeutically and effectively.

Such a development arises logically from therapeutic community principles; and much that has been learned in social psychiatric practice in hospital is applicable to the outside community. But when he steps outside hospital, a psychiatrist is quickly made aware of the great unmet needs and wants of the general population in its striving for health and happiness. On the one hand there is a tendency to be overwhelmed by the extent and nature of this sea of problems, and, on the other there is a temptation to respond by shouldering tasks and responsibilities for which one is unprepared. The clinician entering community mental health may need, as Caplan (2) suggests, a new professional identity; he must define a manageable area of the field and also a new frame of reference. Yet the clinician familiar with therapeutic community practice is already comfortable in the role of helping people to help themselves. He possesses a working knowledge of consultation, confrontation and social action; and he accepts in his daily work the therapeutic potential of non-professionals. The further the problems of community psychiatry and emergency psy-

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chiatry are pursued, the clearer it becomes that the non-professional holds the key. The role of the doctor must inevitably become in large part that of support and consultation rather than direct service to the patient.

Social Crises

The hypothesis is offered that much mental illness is the result of unresolved social crisis situations, and that many individuals seeking admission to psychiatric hospitals do so, not simply because of signs and symptoms of mental disorder, but because their behaviour can no longer be tolerated by the society in which they live. This proposition is supported by several studies (3, 6, 12). In a recent investigation, Polak (15) assessed consecutive admissions to a male ward at Dingleton Hospital, Melrose, Scotland. He found that of 55 patients subjected to detailed analysis 60 per cent. were admitted primarily as a result of social factors. The point was also made that the problems leading to the crisis of admission were often familiar difficulties that everyone may meet; but these patients did not meet them in a healthy fashion. The crises were not satisfactorily resolved. Resources in the patient himself, his family, and his community were insufficient. One crisis led to the next until the individual was eventually consigned to hospital.

Investigation of Referrals at Fort Logan

Adopting Polak's criteria, an investigation was conducted of 50 referrals made over a two weeks period to Fort Logan Mental Health Center, Denver, U.S.A. Use was made of the written data available and also of the judgment of an experienced intake worker to whom the referrals had been directed. On this basis the present writer attempted to assess whether social factors or the individual's psychiatric symptoms were the primary reason for referral. In 56 per cent. of cases social factors were thought to be primary. Table I gives a profile of the unresolved crises judged to be present in the total referrals. A patient may have experienced more than one significant crisis situation, and this is shown in the Table; percentages therefore total more than 100 per cent. In general, this investigation supports Polak's findings and goes some way to confirm the importance of social factors in a population, both male and female, in an American as compared with a Scottish culture.

TABLE I

Unresolved Crises leading to Referral

Type of Crisis	Number of Cases	Percentage
Marital and Family ..	13	26
Antisocial Behaviour leading to police intervention ..	13	26
Conflict with Parents ..	11	22
Medical illness in Patient ..	6	12
Work crisis	5	10
Financial difficulties.. ..	4	8
Pregnancy	2	4
Bereavement	1	2
Mental illness in Friend ..	1	2

It should be noted that the present series comprises 50 *referrals*, of whom 25 were admitted to the Fort Logan programme, 16 admitted elsewhere, and 9 not admitted at all. Thirteen of the 23 males and 15 of the 27 females were judged to be in social crisis, so in this sample there is no significant difference between the sexes.

Since subjects were referrals and not admissions, there was not always sufficient information upon which to base a firm opinion. However, it seems a matter of considerable difficulty, even with ample data, to separate psychiatric symptoms from social forces. A result of this difficulty is evident in Table I, where the large category, named antisocial behaviour and classed as social crisis situations, stems nevertheless to a significant extent from personality disorder, delusional ideas, and dependency on drugs or alcohol.

Moreover, in an illness like schizophrenia (into which category 16 of this series fall) the distinction between psychiatric symptoms and social forces may be meaningless. The established schizophrenic is suffering not so much from an illness as following a way of life, one characterized by preoccupation with inner fantasy, misinterpretation of outer reality, and consequently many possible disturbances of behaviour. Whatever comes first in the schizophrenic process, the disturbed ego or the clucking relatives, the forces that bring the patient to medical attention

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are compounded of both. And both need to be treated.

False Dichotomy

It may be said, therefore, that the dichotomy into social and psychiatric is false and puts an unwarranted interpretation upon the facts. The two categories are often so closely interdependent that to separate them is to do injury to the total concept of psychiatric illness. The only justification for such a division is its usefulness in treatment.

This is a forceful argument in the present stage of psychiatric development. It seems necessary to emphasize social forces at the expense of individual psychopathology in order to re-orientate ourselves to deal more effectively with the legitimate mental health needs of our society.

In the therapeutic community of the psychiatric hospital, emphasis is laid upon a patient's interactions with other patients and nursing staff and upon his learning new patterns of behaviour. His relationship with the psychiatrist and the development of insight into his own psychopathology is relatively neglected. In the same way, in the outside community, it is expedient in dealing with the emotionally ill to be less concerned with intrapsychic forces and more concerned with social ones. This does not mean that we ignore the former, devalue our knowledge of individual psychology, or neglect valuable treatment methods. It does mean that in many cases a more useful concept in treatment is provided by the social model rather than the medical one. This seems to be particularly true of emergency psychiatric services. The patient in crisis may respond more readily to a social prescription that involves changes in the family as well as in the patient himself.

Crisis Intervention

Caplan's work (1) has focused attention not only on the need for intervention in social crisis but also on the advantages consequent upon *early* intervention. He defines crisis as a state provoked when "a person faces an obstacle to important life goals that is for a time insurmountable through the utilization of customary methods of problem-solving". A period of disorganization ensues which signifies both danger and opportunity—danger of descent into mental disorder or, on the other hand, opportunity for successful treatment, in the sense that prompt short-term intervention may halt the evolution of a full-blown disorder and avoid the necessity for prolonged care.

Experience teaches the truth of these observations. A disturbed individual and his family are not only readier to co-operate when in a crisis, but their psychological and social resources are also more easily mobilized. Jacobson and his colleagues (7, 8) have described their practice at the Benjamin Rush Center in Los Angeles. This is one example of a walk-in clinic which offers prompt treatment for adults, without hospital beds of its own, and with a schedule that sets a top limit of six visits by a patient. From their early experience these authors make the following comments.

People who come to the Center are clearly in need of psychiatric help. About two-thirds show psychoneurotic and personality disorders; almost one-fifth are psychotic; and one-sixth demonstrate "transient situational disorders". While over 70 per cent. of patients appear at the Center in response to a recent crisis situation, many of them have long-standing problems.

Eighty-five per cent. of the people coming to the Clinic receive treatment. One-quarter of patients see the therapist once only. On this point the authors comment: "It is one of the tasks of the therapist during the first visit to make a treatment plan and to attempt to implement it. Even patients who have only one visit are under certain circumstances considered treated. Therapeutic intent is present from the start in a conscious and systematic way, with no formal separation of treatment and diagnosis, and each hour is considered as if it may be the last treatment opportunity."

The therapist focuses from the start on the patient's failure to cope in the here-and-now rather than on any long-standing pathology. The minimum goal is to restore the patient's functioning to the level which existed before the crisis. The maximum goal is for improvement in total functioning. Since time is at a premium, both commitment and urgency are developed in reaching the stated goal.

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The Center's disposition figures are similar to those of others, including traditional out-patient clinics. Approximately one-third are referred for further treatment, one-third withdraw from therapy, and one-quarter complete their treatment at the Center and are discharged. While unwilling to commit themselves without longer term follow-up, the authors consider that two-thirds of patients respond satisfactorily.

Avoidance of Hospitalization

A great deal of the present interest in emergency and community psychiatry arises from a desire to keep patients out of hospital. There is much to be said for this on the grounds that admission to a psychiatric hospital may be destructive of a person's self-esteem and may make all the harder his return to family and community. At the same time, it is disadvantageous to emphasize the side-effects and dangers to the exclusion of the benefits of hospitalization. It is difficult for many psychiatrists to accept the current suggestion that mental illnesses do not really exist and that psychiatric hospitals are an unfortunate carry-over from an evil past. While welcoming the change of climate that allows more and more patients to be treated in the community, they remain convinced that use of an in-patient milieu is often a necessary part of treatment and may even be specific for some disorders.

Those who reformulate mental illness as merely a social disorder and its treatment as social intervention are simple-minded and unduly parsimonious of disease concepts. They are swinging too far from the rigid and admittedly outmoded practices of some schools of psychiatry and run the risk of devaluing and neglecting much of our knowledge regarding the complex subtleties of mental disease and its treatment. Nevertheless, it is equally a reality that hospitalization is often regressive and does not cure, and that care in the community gives happier results.

It is plain, however, that the avoidance of hospitalization of sick people and their effective treatment in the community means the marshalling of resources in a different fashion from that traditionally practised. An early model was provided by Querido in the 1930's in Amsterdam when he evolved a versatile complex of community-based psychiatric services, including 24-hour emergency care. The Fort Logan Mental Health Center is a more recent example; it serves metropolitan Denver—a population of just under one million—with less than 200 occupied beds. Fort Logan utilizes a flexible and wide-ranging programme, including transitional forms of treatment in order to avoid prolonged hospitalization (Kraft, 10). As already suggested in such a programme the professional is faced with new roles and techniques; the non-professional has the opportunity for more direct treatment functions; and community agencies are encouraged and supported in accepting responsibility for the sick and deviant in their midst.

"Brief psychotherapy", said Fenichel, "is the child of bitter practical necessity." But this implies that prolonged therapy is better. This may not be true. Some studies, indeed, suggest the opposite (e.g. 13)—that the shorter time a patient is under treatment the better he is likely to function afterwards. Whatever the truth, the matching of supply with demand causes concern in both Britain and America. It would be extremely helpful to have a thorough inquiry into methods and results, such as Freeman's (4) consideration of psychoanalytical psychotherapy in the N.H.S. in Britain and the study of Crisis Family Therapy being conducted in the U.S.A. by Pittman and his colleagues (14).

Community Needs and Resources

It is regrettable that available information gives an incomplete picture both of mental health needs and of treatment resources. But, however deployment is made, the contribution of emergency psychiatric services is a vital element in the plan of providing prompt and effective treatment. Integration is a key concept. If continuity of patient care is to occur against a background of comprehensive services, then close collaboration is necessary. For example, crisis intervention and community psychiatry programmes must go hand-in-hand. Direct treatment services, rehabilitation, and preventive psychiatry must forge close links with each other.

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What the practice of crisis intervention teaches is that many patients can be treated successfully without hospitalization by prompt attention to their problems in a way that has been more acceptable in the past to social workers than to psychiatrists. Emphasis is placed on dealing with present social crisis. Attention is focused on enabling the patient—with the help of family, friends, and other neighbourhood resources—to overcome immediate difficulties. Any treatment modality may be used, and much is possible by vigorous intervention to prevent symptoms settling into a chronic mould. Such brief methods do not set out to effect basic changes in personality or family pattern. If these occur they come as bonuses. This is the kind of treatment many patients wish for themselves. It makes sense to them, and they can give full co-operation in mobilizing resources around them.

The community's mental health needs cannot be matched with *professional* resources. For example, the provision of effective alternatives to hospitalization demands a high level of skilled staffing which few centres can provide. Consequently patients are admitted to hospital beds as a second-best alternative to the active social and psychological support that would have kept them at home. The answer lies in the fuller and more enthusiastic use of non-professionals, and of professionals who are at present untrained in mental health. This includes nurses both in and out of hospital, welfare workers, school teachers, clergy, family doctors and so on. All communities have resources that lie dormant, and stimulation is needed to bring them into use. This means that the psychiatrist and his colleagues will spend much time in indirect services, such as consultation and education, to those who are dealing directly with patients or who are preventing people becoming patients.

Psychiatric illness, in all its protean manifestations, is patterned by society. It might be said that mental disorder is how some people are affected by others. It follows that psychiatry must be involved with the social as well as the intrapsychic condition of the patient. So, just as it has proved to be a necessary function of therapy inside hospital, attention to community structure outside hospital becomes an inescapable task.

Summary

Psychiatric hospitals are providing an increasingly wide range of services, and at the same time evolving new concepts regarding their treatment roles and practices. The present revolution in American psychiatry, it is suggested, has lessons for Britain at this period of its development. Not least is the emphasis on emergency services.

Social factors as precipitants of a patient's admission to hospital are examined with reference to both Britain and the U.S.A. It is concluded that methods of crisis intervention have much to offer in dealing with the mental health needs of a community, and may often provide an alternative to hospitalization. Such a development in treatment demands a fresh deployment of resources and a changing role for the psychiatrist.

Emergency psychiatry and community psychiatric services go hand-in-hand and derive naturally from therapeutic community ideals.

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