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Annotation

The Hive System
A Model for a Psychiatric Service

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Psychiatry has an advantage over other medical disciplines in that its skills are ones that can be practised in almost any setting. Although this is a truism it is worth repeating as psychiatry is still strongly associated with hospital treatment in the public mind. This view is endorsed by the activities of most psychiatrists, who spend their working lives in psychiatric hospitals or in extensions of them such as out-patient clinics or day hospitals. The reasons for this are at least partly historical. The great mental hospital building programme of the 19th century was planned deliberately to set up hospitals in isolated areas away from the centre of the community they served (Scull, 1979). Many countries are still left with this legacy of mental quarantine and find it difficult to overcome its geographical handicaps. Although it is appreciated that more patients can be treated successfully outside hospital it is often easier to follow the maxim, "if in doubt don't keep them out" and admit patients who seem to need further assessment. This is understandable whilst most personnel are based within the hospital and is certainly easier than setting up alternative systems of care away from the hospital base.

Over the past 40 years the disadvantages of a psychiatric service based on hospital care have become apparent both from the ease with which successful management can be achieved outside hospital and from increasing awareness of the negative effects of institutional care (Barton, 1959; Goffman, 1961). In the United States these fears stimulated the development of community mental health centres (CMHC's) and led some to believe that the State hospitals could be superseded. Similar optimism was expressed in this country over the opening of psychiatric units in district general hospitals (Little, Kear Colwell & Lloyd, 1973). This optimism was misplaced; old psychiatric hospitals are hardy perennials and will continue to be needed for many years, particularly for long stay patients (Bewley *et al,* 1975).

One of the many reasons why the attempt to achieve satisfactory comprehensive psychiatric care in the United States has failed stems as much from the neglect of the State hospitals as from any defects in the organisation of community services. Such hospitals have been perceived as out-dated anachronisms that need replacement rather than reform, and their importance as the cornerstone of care for the seriously ill and underprivileged has been underestimated. It was therefore unrealistic to expect that State hospitals would close once facilities for community care improved. Unfortunately, the CMHC's were viewed inevitably as competitors by the State hospital rather than partners in a comprehensive psychiatric service. Although in principle they are a major advance on traditional systems of psychiatric care (Jones, 1979) in practice they have fallen far short of expectation. They are unduly selective, failing in particular to serve the chronically ill and the elderly, are isolated from the mainstream of psychiatry and therefore unpopular with psychiatrists, and ineffective, both in reducing admissions to State hospitals and implementing the preventive psychiatry programmes that were envisaged when they were set up (Fink & Weinstein, 1979; Winslow, 1979; Clare, 1980; Mollica, 1980; Donovan, 1982).

It is reassuring that these dashed hopes have not led planners of mental health services to abandon community initiatives and to fall back on the old hospitals as the only satisfactory means of providing comprehensive psychiatric care. Any psychiatric service that can provide adequate care close to the community which it serves is more likely to be sensitive to the needs of that community (DHSS, 1975). Psychiatry, more than other medical disciplines, has to be aware of patients' socioeconomic circumstances if treatment is to be realistic and appropriate. The typical large psychiatric hospital responsible for a population that includes a kaleidoscopic mixture of wealth and poverty, town and country, old and new industries, and great variation in population of young and old, may fail to see its many colours and too often plumps for a uniform grey.

The advantages and disadvantages of psychiatry based in the hospital and the community are summarised (Table). In order to combine their advantages much better integration of services is necessary. As the hospital is the only service that can provide an adequate number of beds for those who have serious mental illness it is right for it to be

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TABLE

Comparison of hospital and community based psychiatric services

Hospital base		*Community base*	
Advantages	*Disadvantages*	*Advantages*	*Disadvantages*
Easier administrative structure	Poor accessibility for many patients	Easy accessibility	Difficult to co-ordinate service
Good range of professional expertise	Delay in referral due to "filter system"	Early contact with patients	Fragmentation of professional expertise
Many beds	Poor knowledge of community structure	Sensitive to needs of community	Inability to provide comprehensive range of services
	Relative concentration of resources within hospital	Liaison with community services leads to better continuity of care	

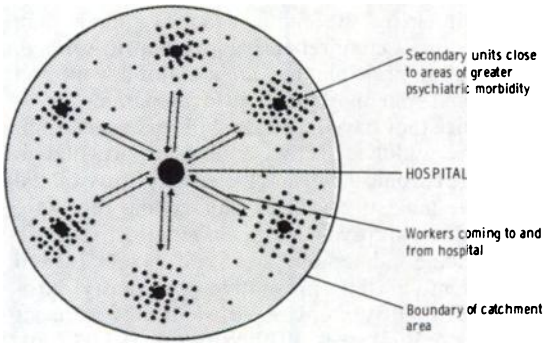


FIG. The hive system of psychiatric care.

the administrative centre of the service. Community psychiatry should not be regarded as a separate branch of the subject as this will only enhance the dichotomy between it and hospital psychiatry. What is needed is a system of psychiatric care that integrates community psychiatry with the hospital base so that true comprehensive care can evolve. A satisfactory way of achieving this is represented by the hive system.

The hive system

The hive system is so named because it bears a close parallel with the activities of the honey bee. A good apiarist places his hive near to the middle of its floral catchment area so that its worker bees have easy access to all flowers in the area. Some parts of the area have greater floral intensity than others and need more frequent visits. The sites of greater density vary with the seasons and there is a need for regular communication between the workers to identify the productive areas as soon as possible. It has been shown elegantly by the late Karl von Frisch (1967) that this is achieved in bee society through the language of dance in the hive. The system is remarkably effective in communicating the distance and direction of the flowers to be visited. The subsequent harvesting of flowers in the area leads both to a productive hive and healthy plant growth, as cross pollination is achieved and ecological balance maintained.

A good psychiatric service uses the same principles. The hospital base should be sited within easy reach of all parts of a well-defined catchment area, as if it is built away from the population that it serves or has no defined geographical area it is less likely to offer a satisfactory service. At worst, it becomes so inward-looking that it exists primarily for itself and its staff rather than the patients under its care. The so-called "special hospitals" that have no defined catchment area sometimes include this type of mentality (DHSS, 1980) and their malfunctioning has led to the argument that such hospitals should be closed because they do not serve the purpose of therapeutic institutions (*Lancet*, 1980).

It is also preferable for the hospital to have sub-units of care close to the areas of greater psychiatric morbidity. These may be day hospitals, community clinics or mental health centres, but not new large in-patients units. A new hospital base needs a separate catchment area that should not overlap with the parent hospital, otherwise the two-tier (two-hive) arrangement will lead to the decay of one member. All sub-units need to be co-ordinated with the main hospital because if they become autonomous there is a danger that they will cease to be aware of the needs of the service, often, for example, introducing selection procedures for patients that restrict numbers unduly although making the work of the staff easier. It is a well-known fact that (sometimes formulated as Jarvis's law) that the amount of use made by an unrestricted service by patients is inversely proportional to the distance they live from that service. This explains

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why a locally based service leads to greater referral rates than a service that has referrals scattered over a much larger area (Tyrer, Seivewright & Wollerton, 1984). Psychiatric sub-units situated in areas of greater psychiatric morbidity may not only detect psychiatric illness earlier but could help to prevent relapse in patients who normally show poor compliance with conventional out-patient management.

The quality of the psychiatric service provided by the hospital depends on its staffing and its links with other caring resources in its catchment area. These links can only be established satisfactorily if hospital workers leave their base and explore their catchment area, define its specific psychiatric needs and the local resources available to deal with them. Back in the central hive these needs can be discussed and resources deployed appropriately. The good psychiatric worker, like the bee, spends much of the day serving in the community but has regular contact with the base hospital so that his work is never carried on in isolation. These links also allow all forms of care to be available to the worker, from simple counselling in the home to emergency hospital admission.

It might be thought that the praises of community psychiatry have been sung so long and loud that this is indeed the pattern of present day psychiatry. Unfortunately, it is rare, as few psychiatric professionals work both in the hospital and community along these lines. The nearest equivalent to the psychiatric worker bee is the community psychiatric nurse, who often has some hospital responsibilities but is based mainly in the community. But the number of community nurses is still abysmally low; they have no recognised career structure and very little voice in the organisation of nursing services. They also have limited training for the work they are supposed to do, for nursing teaching is so hospital-bound that it has little of value to draw on in preparing nurses for community work. So the newly appointed community psychiatric nurse has a satisfying and progressive title but it is no better qualified than Arthur Miller's salesman, "a man way out there in the blue, riding on a smile and a shoeshine, and when the world stops smiling back, it's an earthquake". It is to the credit of the community psychiatric nurses that despite the tremors of their early experience they are still able to achieve at least as much as conventional psychiatric out-patient treatment (Paykel *et al,* 1982).

By contrast, the medical members of the psychiatric team, who should be leading by example, have one of the worst records of community activity and look suspiciously like the drones of the psychiatric hive. Although most psychiatrists see at least some patients in out-patient clinics these are held mostly in other hospital settings that are divorced from the community and the agencies serving it. The rarity of genuine liaison is illustrated ironically by the title "liaison psychiatry" to mark the only regular consultation achieved, that with other hospital doctors. The only time that the average psychiatrist is expected to provide a service in the community is when he is asked to carry out a domiciliary visit, and for this enterprise he is rewarded separately, presumably as it is beyond the normal call of duty.

Community psychiatrists are now being appointed in some areas but there is a danger that a divide will develop between them and hospital psychiatrists, one group developing a special knowledge of severe psychiatric illness and the other regarded as responsible for a "softer" population with different problems. It is this separation of responsibility that has led to criticisms of CMHC's and lowered their status in the United States. Hospital and community care have no need to remain separate. In the hive system the psychiatrist is required to travel out with his fellow professionals and have regular contacts with general practitioners and other workers in primary care. He can still carry out his hospital duties and the balance of his work is altogether more satisfying (Tyrer, 1984).

Advantages and benefits of the hive system

The maintenance of a central co-ordinating centre and administrative base is essential to a good psychiatric service. The base hospital should be large enough for specialised services such as those for mothers and babies, adolescents and children. It must also have sufficient depth of expertise and informed interchange so that the feelings of professional isolation prevalent at CMHC's is avoided.

At the same time easy accessibility and early contact with patients can be achieved. In this country we have the advantage of a comprehensive system of primary care that is second to none but, apart from a few exceptions, links between psychiatric and primary care services have been very few. In the hive system links with all the actual and potential psychiatric services in the catchment area are developed to make a structure that offers the best service to the patients. Flexibility is needed, but although the structure of the hive may vary from place to place it still follows the general principles of comprehensive care and continuity of service. In some rural areas this may best be achieved by expanding community psychiatric nursing services, such as at Dingleton Hospital in the Scottish

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borders, where a hive-based system has operated for many years. Psychogeriatric patients are much less mobile than young ones and with this population a domiciliary psychiatric service is often essential. If this service allows for treatment as well as assessment it releases blocked hospital beds and allows them to be used more effectively (Godber, 1978). For younger patients psychiatric clinics in primary care offer early contact in a setting which is more convenient to the patient and is preferred as it is free from the stigma of psychiatric hospitals (Tyrer, 1984). The CMHC may also be an important component of the system if it works closely with the hospital services, and a British equivalent has flourished for several years in the London borough of Lewisham because of its good integration with the parent hospital (Bouras & Brough, 1982). Another variant that could be accommodated within the hive system is the crisis intervention service (Querido, 1968; Scott, 1980) but although this is excellent for treating mental illness of acute onset it is far less appropriate for chronic or relapsing illness. If crisis intervention is to be employed it should be one limb of the service rather than the whole body.

Quite apart from the benefits to the patient, the hive system is more satisfying for the psychiatric services. Hospitals that have no community links are like casualty clearing stations close to a battleground about which they know little. The emergencies are admitted, patched up and discharged, only to return to the front and be readmitted again with injuries shortly afterwards. When it is realised that the battle in the community can be influenced favourably by psychiatric intervention morale is improved at all levels.

The productivity of the hive system is difficult to measure. Unlike the apiarist, who can measure productivity in weight of honey, the hospital planner has to rely on indirect evidence of increased effectiveness. Nevertheless, one consequence that is almost universal is a reduction in the importance of the hospital base. This allows staff to be redeployed for community work without the need for additional resources (Tyrer, Seivewright & Wollerton, 1984). If the system requires new staff to be employed for community work with no change in the pattern of in-patient activities it is not operating satisfactorily. The reduction in hospital beds can be substantial. For example, in Nottingham the development of better community and rehabilitation services has led to a reduction of 24.3% in bed occupancy at Mapperley Hospital between 1978 and 1982, compared with a small increase of 5.04% in hospital bed occupancy in other psychiatric hospitals in the County of Nottinghamshire.

Professor Kathleen Jones has recently summarised the key problem of mental health care as Scull's dilemma, named after Andrew Scull, who has lucidly exposed the inadequacies of both the older institutional and newer forms of attempted community care, so the clinician is criticised no matter which option he chooses. The hive system of patient care offers a solution to Scull's dilemma, as it integrates hospital and community services in a way that still follows Schumacher's maxim "Small is beautiful", while retaining central co-ordination. It is based on the triad of mobility, flexibility and contiguity of psychiatric services and has been shown to work. It only remains for all of us to get buzzing.

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