COMMUNITY PSYCHIATRY

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The APIT (1) report and that of the DHSS-sponsored conference (2) on the provision of a district psychiatric service are both concerned with a hospital-based psychiatric sickness service. Nowhere can one find any clear statement on the possibility or even desirability of a comprehensive community care service. We could define such a service as providing individualized, comprehensive, continuous, efficient, effective and flexible care, including the identification and treatment of psychiatric disorder, the avoidance or reduction of secondary and tertiary disability with integration or reintegration of the individual into the community, and the provision of appropriate support to his family during this process. There are some who would argue that even this as yet unattained goal is insufficient, and community care must also embrace primary prevention programmes and the alleviation of distress or disability not due to illness.

However defined, the care of the psychiatrically disturbed cannot be left to a single professional group, nor can illness or distress be fragmented into separate components each to be dealt with by an appropriate professional. The Royal (Macmillian) Commission of 1924–6 stressed the view that mental and physical illness are inseparable and reinforced the medical concept of mental illness. Surely we do not require another Commission to assert that medicine in general and psychiatry in particular cannot be separated from their social content.

The failure to achieve community care has often been attributed to the arbitrary division between hospital and community, the separation between hospital, public health and welfare services and the general practitioner services—indeed between anything which separated aspects of total care for the individual patient. We now see some prospect of a reduction of artificial barriers within the health service, but at a time when the social services have been consolidated in independent local authority departments without clear channels for communication or consultation.

Failure to develop community care is not merely a matter of administrative ineptness, for within the psychiatric service there are tremendous self-perpetuating pressures towards the maintenance of a hospital-based service. If we consider the time-table of the average consultant, as depicted by Professor Russell (1), it is clear that he has little time to invest outside the hospital, and the volume of identifiable psychiatric illness in the community (3) is such that improved psychiatric education and more comprehensive medical and social care will increase the rate of referral to already overextended psychiatric clinics. Under pressure of time the hospital is a convenient base involving minimal travelling, and the admission of the patient allows time for further observation to clarify difficult conditions, provides a safety net lest other physical or psychiatric symptoms have been missed, and makes the patient available when the consultant chooses, usually after junior medical staff and other professionals have made time-consuming examinations and observations. Admission in emergency often means that the problem can be placed in cold storage and may even go away.

Within the hospital and over a long period it is possible to develop a working multidisciplinary team, but liaison by telephone or letter with G.P.'s, hospital colleagues, social service departments, health visitors, probation officers, voluntary social agencies and the like is extremely time-consuming, and even with defined catchment areas it is difficult if not impossible to develop a direct working relationship with every key worker in an area. Confinement within the hospital involves a further self-perpetuating factor—once across the threshold an individual becomes a patient who must be registered, recorded and examined, with neglect in any area of examination or history-taking carrying a possible charge of professional negligence, so that time is once more absorbed.

Social service departments, on the other hand, appear to be compulsively recreating the bureaucratic mistakes of medicine, for like the health service the social service has become a sickness service. Help is provided to individuals in trouble, and once the emergency (I avoid the word crisis, for crisis theory seems to have little influence on practice) is passed they may be left to fend for themselves. In an attempt to answer every knock on the multiplicity of doors which still remain, area officers are often unable to carry long-term cases except at a very superficial level, and even families with children at risk may be neglected. It is pressure of demand and scarcity of resources rather than perversity which produces this state of affairs, but the situation is even more complicated in some areas where there are differences of philosophy between the social worker and psychiatric services. The patient whose social worker is eager to reduce his dependence on drugs and on the hospital is likely to reappear, often in another hospital, as an emergency. Some patients with defect states are

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deprived of places in hostels because they cannot contribute to the therapeutic community or in day centres because they are not motivated to move on to more productive work. In many areas the dispersal of mental health teams is keenly felt, and the failure to appreciate that social work with the mentally ill calls for special knowledge and experience is deeply resented.

One development in the social service departments which differs from the health service is the fact that the administrators have been largely recruited from the ranks of the practitioners. The unwieldy bureaucratic structure of the larger departments, and the multiplicity of small ones have created senior posts which have creamed off many of the best practitioners. This certainly compounds the present difficulties, but it is difficult to predict the long-term effect, for many attribute the current ills of medicine to the disappearance of the medical administrator.

The psychiatric services are increasingly occupied with the needs of neurotic or personality-disordered individuals many of whom require time and informed concern rather than specialized psychiatric skills. With some groups of persons it seems likely that identification as patient and attempts at 'treatment' may worsen or prolong what is normally a self-limiting state. Our social services, too, are experiencing heavy demands from individuals and families with chronic or recurring problems. The inadequacy of both psychiatric and social services affects most seriously those least able to find alternative help, the chronic patients whose social breakdown is due to intractable psychosis or personality disorder. Between 1960 and 1969 the hospitals gave up 24,000 beds (4), but although this may be due to a triumph of modern treatment one wonders whether it is not largely a failure to provide asylum. Local authority hostels provide just over 2,000 places of extremely variable quality (5) whilst approximately 27,000 men and 2,000 women (in 1965) were living in common lodging houses, hostels and shelters and at least 1,000 people were sleeping rough (5).

The prison population doubled from 20,000 in 1950 to 40,000 in 1970 (7) whilst the number of men remanded for medical reports increased from 5,000 in 1960 to 12,500 in 1970 (8), and the numbers continue to rise. Asylum in a community-linked hospital may yet prove a more humane and possibly less expensive form of care for many of these individuals.

With currently available resources and utilizing current treatment models I do not believe that we can provide adequate psychiatric or social care. We must either specify more limited objectives than those unspecified but implicit in current practice or we must radically alter our current patterns of practice. It may be necessary to accept that professional care givers cannot be the primary care agents and must instead develop screening techniques to detect those requiring specific types of skilled care and methods of supervising or sustaining volunteers or other less skilled primary agents. Organizations such as the Telephone Samaritans have demonstrated their ability to provide both crisis intervention and continuing support and may indeed have had more success in these fields than formal services. To achieve community care we must involve the community in caring.

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