Correspondence

NHS Health Advisory Service special project on services for disturbed adolescents

DEAR SIRS

I believe your readers will be interested to know that the NHS Health Advisory Service is mounting a special project on services for disturbed adolescents. The background to the project is that existing provision has been found by the Health Advisory Service (and others) to be uneven, fragmented and sometimes grossly deficient. A recurring feature has been poor communication and co-ordination between the various agencies and considerable professional isolation of individual services.

During the first half of 1985, a series of special multidisciplinary visits will be conducted throughout England by the Health Advisory Service to assess existing services provided by health and local authorities. A seminar on the subject will be held and the project will culminate in the issue of a guidance document for the use of individual authorities, on the lines of the very successful *Rising Tide*.

I would be grateful if you would draw the attention of your readers to the project. More importantly, I would like them to be aware that the multidisciplinary steering committee formed to oversee the exercise would like to receive the views of interested individuals or groups on existing services; examples of 'good practice'; and on the way in which better services might be achieved in the future.

I shall be very grateful for your help. All correspondence should be directed to: Dr Peter Horrocks, Director, NHS Health Advisory Service, Sutherland House, 29–37 Brighton Road, Sutton, Surrey SM2 5AN.

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The continuing saga of community psychiatric care

DEAR SIRS

As one who is a community psychiatrist of many years' standing, I would like to join the current and resurgent wave of enthusiasm about the psychiatric care and management of the mentally ill in the community.

We described and discussed already in the mid-1960s the possible roles and functions of a community psychiatrist, then a new concept and not universally accepted, as well as the establishment and function of a Community Psychiatric Nursing Service.

Papers were published on how we saw the shift of psychiatric management from hospitals to the community, a move considered inevitable in times to come and now slowly taking shape.

However, until comparatively recently we were told by authorities there were not many community psychiatrists in existence and the few voices that did speak out made little impact on the powers that be to develop the areas of community psychiatric management, rehabilitation and care. Furthermore, the large cost involved was often quoted as the reason for the tardy development which did take place. Indeed, community psychiatric care is not a cheap option and should not merely be considered when money needs to be saved.

At present the contemplated closures of some of the large psychiatric hospitals have given a new impetus to the establishment of psychiatric facilities and services outside hospital. It is somewhat unfortunate that mainly due to these closures the urgent need for community psychiatric services has become highlighted. We have consistently maintained that a large number of psychiatric disabilities have always been in the community and required help and support, many of whom either came only temporarily in contact with the hospital services or not at all.

Let us hope authorities will pursue the path of expanding these community psychiatric facilities, and services and government will be more willing to make available the necessary finances.

Locally we were more fortunate in the gradual development of various services for the mentally disordered outside hospital. I would like to describe very briefly some of our more innovative services, if only to stimulate responses from your readers.

We have had in operation for some years an Assessment and Rehabilitation Team Service in which various professional disciplines from Health, the Local Authority, the Department of Employment and Voluntary Agencies have come together to help the mentally ill. This service has been divided into two sections, one deals with the assessments and is led by the community psychiatrist, the other is work placement orientated and is conducted by a senior social worker. Cross membership between the two sections was considered essential from the very beginning.

We considered of great importance direct contacts with employers and the latter in turn were encouraged to approach the team whenever they had any difficulties with any of their previously mentally ill employees. The consent of the individual involved was, of course, always sought first and was rarely, if ever, refused.

Such two-way communications and easy access to advice were thought to have kept a number of people in employment who otherwise would have been dismissed, whilst some employers given that kind of professional assistance, were prepared to accept someone they would not have otherwise considered for employment. Strictest ethical codes and confidentiality were observed at all times.

It is well known that occupation in its widest sense is not only ego strengthening to the patient but may act prophylactically by preventing recurrences of mental illnesses or at least postponing or ameliorating them in quite a number of

cases, provided appropriate supervision is maintained throughout the process.

We try to manage patients in their own environment, even in their homes, wherever possible.

The involvement of relatives has always been one of our prime considerations, either by holding regular group discussions or allowing them free contact to us on any of their problems relating to their mentally disabled relative.

A more recent development has been the formation of an interdisciplinary working group to give advice and make recommendations on 'Innovative Services for the Mentally Ill' in the community.

Most recently we concerned ourselves with the establishment of mental health centres where various professional disciplines from Health and Social Services join to provide some of the management, rehabilitation and resettlement of mentally affected persons in day or residential environments.

There are many more better known activities and functions undertaken by our community psychiatric services which need not be enumerated here.

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(See also Dr Freeman's article on pages 29–32.)

DEAR SIRS

I am apprehensive that recent developments to close many mental hospitals and the increasing bias towards community care may weaken the ability of the Mental Health Services to take appropriate steps to care for the patient with a mental illness.

A recent example will suffice to show that the resources of two hospitals and a possible third were necessary to cope with a crisis within one family. The family consists of mother, father, two sons and a daughter. One of the sons is severely mentally handicapped, the other son is suffering from a psychiatric disorder which resulted in a hospital admission under a court order. It is more than likely that he may be admitted to a State Hospital. The parents had not spoken to each other for some years and lived in different parts of the same house. The severely mentally handicapped son had been a hospital in-patient for about ten years because of severe feeding difficulties but with prolonged nursing care and medical help he had gradually gained weight and had reached a normal height and weight ratio.

About one year ago his mother began to exhibit early signs of a psychiatric disorder which resulted in her accusing the hospital staff of injecting her son with drugs to make him fat. She took him home and refused to return him to the hospital. He lived with his mother in a single room in the parental home. She refused to accept any help from the community services. His mother's condition deteriorated and recently her behaviour became so disturbed that she had to be admitted to the local psychiatric hospital for treatment, leaving only the patient's unmarried sister, who was six months' pregnant. His father would not offer any help. The boy was admitted to the local mental handicap hospital where he was found to be emaciated and suffering from severe iron deficiency anaemia with a haemoglobin of 4.2 gm per cent. He will require a great deal of skilled nursing and medical attention to return him to his previously robust good health.

This is an example that illustrates the need for the retention of core units of sufficient size so that they can meet the demands of society when the current mode of community care, however good, cannot do so.

I feel that it is a very good idea to care for people nearer their homes in the community, but there must be a core unit which can be relied upon to offer support and relief to the families, neighbours and society in cases of crisis.

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How to treat when neither 'mad nor bad'?

DEAR SIRS

The recent decision of the Mental Health Review Tribunal to release a patient detained under Section 3 of the 1983 Mental Health Act has prompted me to seek the views of other College members on the treatment of those who are neither 'mad nor bad'. This patient, and a number of others with similar difficulties known to me, would be regarded by psychoanalytically orientated psychiatrists as suffering from borderline personality disorder. This diagnosis, which can only be arrived at by close inspection of the personal relationships of the patient, comprises a chronic instability of personality, manifested by an angry attitude to others, relationships which oscillate between idealization and denigration, transient loss of reality testing under stress, and an extraordinary capacity to split groups of staff into warring factions.

Such people fail to respond to conventional medical treatment, and yet are clearly not sociopathic. They almost invariably cause a major management problem with episodic violence and chaotic personal relationships. Frequently the capacity to control their management is the only therapeutic tool at our disposal. In the case of this particular man, it will be quite pointless readmitting him to hospital since we cannot treat his condition without compulsory powers, and in terms of the Act he is not ill.

My concerns are twofold:

(1) If he and others like him are to be treated in hospital, they will go to prison when, quite clearly, not responsible for their actions.

(2) Why do we insist on subscribing to an obsolete system of classification, which makes no allowance for the people we actually see, many of whom, like him, fall between two stools.

Comments, please!

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