Brit. J. Psychiat. (1978), **132**, 209–20

Review Article

Community Psychiatry

By DOUGLAS BENNETT

Introduction

Community psychiatry is not solely the outcome of the collective wisdom of psychiatrists and professionals working in mental health. It is one facet of the response of government and of the people to changes in society and changing views on the position of the individual in that society, be he well adjusted, deviant, disadvantaged or mentally ill. The view most obviously relevant to the future care of the mentally ill was expressed in the Webbs' minority report to the Royal Commission on the Poor Law. They insisted on the State's responsibility to secure a national minimum of civilized life open to all citizens of both sexes and all classes. Their idea received further impetus when the shared dangers and experiences of the Second World War drew people in our society closer together. By the end of that war it was widely accepted that it was the proper function of government to ward off stress, not only among the poor but among all classes of society. This was realized when Beveridge's plan led, after the war, to a series of enactments establishing what we know as the Welfare State. Its egalitarian philosophy of 'bread for all before cake for anybody' and the establishment of the National Health Service had a considerable effect on the care of the mentally ill. Other social changes have influenced the care of the mentally ill less directly: earlier marriage, changes in family size, the raising of the school-leaving age, shorter working hours and longer life expectancy. Psychiatry, too, has changed. It is now accepted that society itself plays a part in the genesis of mental illness. This has led to questioning of the distinction between sanity and insanity; and, more recently, to questioning by existentialist philosophers of the value of psychiatry. Even those physical treatments which have been subsequently discredited, as well as those which did ameliorate the symptoms of mental illness, played their part in dispelling public and professional doubts about the value of psychiatric treatment.

Contemplating these changes, it is impossible to estimate the particular contribution of any one of them to the alteration in services for the psychiatrically disordered. Their effects are illustrated when the differences between community psychiatry in Britain and the United States are related to their contrasting systems of health and welfare provision. In Britain the general practitioner, the first medical contact for most psychiatric patients, treats a large proportion of the minor psychiatric disorders. He only refers to the psychiatrist about one in twenty of the patients whom he recognizes as suffering from a psychiatric disorder (Shepherd *et al*, 1966). Thus the non-psychotic disorders have only been partly assimilated into specialized psychiatry. Although these conditions are treated in the community, psychiatrists rarely see them and do not usually discuss their care in terms of community psychiatry (Cooper, 1966). In the United States community psychiatry has focused on the care of neurotic patients. This probably reflects a dearth of family doctors, the absence of a National Health Service or the economic supports of a comprehensive welfare system. But these factors alone do not explain the pattern of community care. While the nature of treatment offered varies according to whether it is publicly or privately financed, the overall organization of service must reflect other aspects of the social system (Goldberg, 1971). Financial considera-

https://doi.org/10.1192/S0007125000283256 Published online by Cambridge University Press

tions do not explain why, in Britain, the word 'community' refers to the care of psychotic patients other than in the mental hospital, while in the United States it is thought not only to represent the preference for locally, rather than federally, funded care but is equated with ideas of community organization and plans for radical social change (Cumming, E., 1968).

In Britain there is a growing concern about primary community psychiatry as practised by general practitioners, in terms of its relation both to the specialized psychiatric services and to the training which general practitioners require if they are to give the psychiatric care which is needed (Morrice, 1976). It is thought that the high prevalence of minor psychiatric disorders points to a need for better primary care rather than for more specialist psychiatrists (Brook and Cooper, 1975). For adult patients there are advantages in generalist care; it provides continuity, its approach to mental illness is holistic, it avoids unnecessary 'labelling' and stigma, it bridges the specialties and so prevents fragmentation of care. Finally, it protects the patient from the excesses or narrow-mindedness of specialized technocracy (Titmuss, 1965; WHO, 1973).

The Mental Hospital and Community Psychiatry

Whatever the reasons, community psychiatry in Britain is concerned principally with chronically ill or disabled psychotic patients who cannot perform adequately in a major life role. The story of community psychiatry for the psychotic patient begins with changes in the mental hospital. The establishment of public asylums became compulsory in 1845 and over the next hundred years their expansion was uninterrupted (Isaacs, 1977). But in the 1920's, patients with GPI requiring medical and laboratory facilities were admitted to general hospitals without certification, while later experiments with 'trial leave' for mental hospital patients showed that psychiatric patients could safely be treated without legal restraint. The Mental Treatment Act of 1930 not only made voluntary treatment possible for many more patients, but provided funds for the establishment of out-patient clinics. The Mental Health Act 1959 made it possible for the mentally disordered to be admitted 'informally', except where there was a positive refusal on a patient's part. As a result the number of 'certified' patients fell dramatically in a few years and the number of admissions to mental hospitals rose. Hospital patients who were not compulsorily detained had a say in the timing of their own discharge. Psychiatrists, faced with rising admission rates, anxious to reduce overcrowding, conscious of a lack of staff, did not oppose patients' requests for discharge. Readmission rates increased and psychiatrists rationalized this development by suggesting that periods of life in society, even if interspersed with hospital residence, were more beneficial than a long hospital stay. From the middle 1950's the new pharmacotherapies played their part too. However, they had less effect on patients in hospitals where therapeutic optimism and organizational change had preceded their use (Ødegaard, 1964).

The Royal Commission on the Law relating to Mental Illness and Mental Deficiency set the seal on these changes in 1957 when it recommended a change in emphasis from hospital care to community care. It said that 'in relation to almost all forms of mental disorder, there is increasing medical emphasis on forms of treatment and training and social services which can be given without bringing patients into hospitals as in-patients, or which make it possible to discharge them from hospital sooner than was usual in the past' (Royal Commission, 1957).

Community psychiatry as an extension of the hospital

Before this, mental hospitals had begun to extend their clinical services into the community, first with out-patient facilities and later with day hospitals and domiciliary visits by psychiatrists (Freeman, 1962). The services were medically orientated and the specialist staff were based on the mental hospital. The contact with local authorities was often limited to a discussion on the admission of severely disturbed patients with Duly Authorized Officers or requests for the supervision of discharged cases or help in finding employment (May and Gregory, 1963). Such services were most often found in County Boroughs, where the hospital

https://doi.org/10.1192/S0007125000283256 Published online by Cambridge University Press

physician superintendent was able to re-establish a co-operative relationship with the staff in the borough mental health service, of which he had been a member before it had been divested of responsibility for its mental hospital by the National Health Service Act in 1948. The hospital's catchment area was coterminous with the borough boundary. This pattern of services in Croydon, Nottingham, Portsmouth, Plymouth and York was admired and copied (Macmillan, 1956; Carse *et al*, 1958). These 'extended' or 'transplanted' hospital services sought to show that by integrating the resources of the hospital and the local authority serving the same population they could provide effective and continuous care for the mentally ill patients of the district (May, 1965). However, when Brown *et al* (1966) studied the clinical condition and outcome of care over a period of five years for a group of patients with schizophrenia admitted to such a service in 1956, they found that the results were no better than those of a traditional mental hospital service. Although the patients in the County Borough service had more contact with community services, this did not reduce clinical morbidity or strengthen family cohesion. This was not surprising, for there was no real change in practice. Services were still influenced by medical and institutional ideologies; staff and patient roles and attitudes were unchanged. Some hostels, too, were criticized as being little more than transplanted hospital wards whose institutional practices were little changed (Apté, 1967). It would be as wrong to suggest that former patients were not helped by these services as that patients were not helped by mental hospitals. But it is questionable how much better they were. For like the mental hospital these provisions afforded only specialized, segregated care for the mentally ill, who often retained their sick role.

A Comprehensive Psychiatric Service

At the same time as the mental hospitals were extending their clinical services outside their walls, other changes were taking place. The Mental Health Act removed legal barriers to the treatment of the mentally ill patient under order in general hospitals, and opened the way to the provision of psychiatric services in a medical context. In 1960 the Chief Medical Officer, Sir George Godber, suggested that 'if the opportunity for bringing psychiatry fully into the general pattern of medicine which now presents itself is grasped, the new attitudes created both within the profession and the public mind will do more for mental health than any other single measure' (DHSS, 1960). The Ministry of Health encouraged the further development of psychiatric out-patient, day-patient and in-patient services in general hospitals, but still thought that a substantial part of hospital psychiatry would be undertaken in the traditional mental hospital. Later it decided (DHSS, 1971) that improvements in treatment and care made it possible to replace the large separate mental hospitals with a service based on District General Hospital psychiatric units. These hospital facilities, together with the family doctor and social services would provide comprehensive psychiatric care to a defined district. There was a growing recognition that the mental hospital had catered largely for the psychotic, and that such patients accounted only for a small proportion of those suffering from psychiatric morbidity. Thus there has been an increasing awareness of the needs of the elderly mentally infirm, the emotionally disturbed adolescent, the drug addict, the chronic alcoholic and the psychopathic offender, as well as of the needs of those who are socially adrift in society without employment, home or family ties and who constitute a burden on the economy and the public conscience (Hill, 1969). While some needed hospital services and a few required hospital admission, the majority could be helped by community services.

Changes were taking place, too, in social work. In 1951, there were only eight full-time psychiatric social workers employed by all local health authorities and these had only increased to twenty-six by 1959 (Titmuss, 1963). While, in 1958, local authorities had some sort of service for the supervision of the mentally retarded and the care of old people, none seemed to make any provision for the psychotic discharged from hospital (Harris, 1958). Even in 1962, of a hundred patients with schizophrenia

https://doi.org/10.1192/S0007125000283256 Published online by Cambridge University Press

discharged from mental hospitals in the London area, only four were visited by a social worker in the follow-up year (Parkes *et al*, 1962). Since that time there has been a vast expansion in the training and recruitment of social workers. Social work has been reorganized and social workers, who had been divided into a number of groups concerned either with mental health, probation, child care, the physically ill or the aged, have recognized that human need could not be categorized in such an arbitrary fashion. They decided to give up their former specialist associations and training and, with the exception of the probation officers, to integrate these into one profession with a generic training which would provide a unified family service (Command 3703, 1968). When this was ratified by the Government in the Social Services Act of 1970, social workers took charge of their own Social Service Departments under the local authorities (Bennett and Wing, L., 1972).

These social services, not always well received by psychiatrists, together with District General Hospital psychiatric units, as well as extramural activities developed by mental hospitals, provide the foundations for a locally based and comprehensive service (Brothwood, 1973; DHSS, 1974; Command 6233, 1975). The policy has been widely discussed and its feasibility questioned by those who fear that it could lead to a two-tier service, and that suitably trained staff will not be avilable in sufficient numbers to deal with all new problems with which psychiatrists and social workers are being asked to cope (Cawley and McLachlan, 1973; Birley, 1973; Russell, 1973). Little concern is expressed that the service is still centred on the hospital; in part because community social services, hard pressed by the needs of children and other clients, have only made limited provision for the mentally disordered. They, too, lack resources. Thus in March 1974, 31 local authorities had no residential accommodation for the mentally ill, and 63 had no day facilities (Command 6233, 1975). There are particular fears about the transition period when the care of the patients is being moved to the general hospital units. There are reasonable doubts, too, about the capacity of these units to cope with patients who are demented, difficult, dangerous or chronic. Certainly at the present time, while the patient with psychoneurosis has a one in three chance of being admitted to a general hospital, the chances of a patient with dementia are only one in ten (Isaacs, 1977). Since 75 per cent of adult psychiatric admissions still go to the mental hospital, these hospitals must remain the convenient and time-saving work location for most staff for some time to come.

Belief in the value for the mentally ill of maintaining their normal home and community ties had led some psychiatrists to equate progress in community care with the prevention of hospital admission rather than with the amelioration of psychiatric illness (de la Torre, 1973). This rightly led to critical questioning of the Government's planned reduction of psychiatric hospital beds which seemed to be based on an acceptance of rather doubtful data from a few services (Tooth and Brooke, 1961; Baker, 1969; Oldham, 1969). The assumptions underlying the community approach have not yet been fully tested; but neither have those underlying the established mental hospital approach. So it is reasonable to question with Wing, and Hailey (1972) whether 'the disadvantages apparently inherent in the mental hospital system will not be inherent in any system which replaces it'. There is always a danger that this Government policy, which is an overall national strategy, may be applied too rigidly and take too little account of local and regional differences. There is little evidence that the advantages of piecemeal change within the overall strategy, properly monitored and evaluated, have been considered (Cumming, J., 1974). Yet there are still large areas of ignorance and uncertainty in such radical planning and hence a continuing need for limited experiment. In spite of these criticisms, change continues. There is increasing emphasis on day treatment and care. Social service facilities are being built up, staff recruited and trained and the balance of resources shifted from health services to social services.

A Polarization of Views on Community Psychiatry

These profound alterations in the care of the mentally ill not only influence the allocation of

https://doi.org/10.1192/S0007125000283256 Published online by Cambridge University Press

resources but also alter the existing roles, responsibilities and training of the professional groups involved. As it has become more apparent that this change will inevitably take place, the debate about its nature and extent has become more emotional. The issues have been oversimplified or distorted, and important facts have been overlooked or suppressed or phrased in dichotomous terms (NIMH, 1976). Thus community care has been seen, not as complementary to hospital psychiatry, but as its opposite. Such polarized views do 'not mean that each problem only has two facets, but simply that public action can best be mobilized, a denominator most easily struck, when there are only two sides. The most common formula is the "for and against" statement' (Davis, 1949). An account of a meeting of the Association of Psychiatrists in Training (APIT), on 'Community Psychiatry: Vision or Mirage?' vividly represents the emotional climate and oversimplifications of the current debate (Clare, 1972). Hawks (1975), as he considers the current absence of evidence for the effectiveness of community-based services, expresses less emotionally this polarization of views in the particular assumptions about community care which he chooses to examine. For example, it is assumed that the community is therapeutic and really cares, although no source is quoted for this assumption. As a result the possibility that the community could care is not discussed. Vague general abstractions such as 'mental illness', 'mental patient', and 'hospital' are freely used in discussion. It is rarely suggested that, in the rational treatment of an individual, the nature of his illness, his particular community environment or that of the hospital or ward where he is treated should be considered.

In the United States, the argument has been complicated by the belief of some psychiatrists that they were competent to determine and achieve a form of community organization which would provide mental health and prevent mental illness (Levenson and Brown, 1968; Yolles, 1969). Such views, not replicated in Britain, drew pungent criticism from others (Dunham, 1965; Mechanic, 1966; Kubie, 1968). But in both Britain and the United States, the most public, most general and most oversimplified clash has been between the supposed horrors of mental hospital life for the mentally ill on the one hand, and the supposed horrors which they face in the community on the other. English newspapers have reported how deceased patients were exhumed at Farleigh Hospital to substantiate charges of neglect, while at Whittingham Hospital patients were said to have been tormented, cheated of food, sometimes denied water and robbed (Wilson, 1972). These stories are countered in New York by accusations that many of the owners of the city's proprietary homes caused 'callous humiliation and fear among released patients. In those buildings . . . the patients sit side by side in absolute silence. Their eyes are glazed, their minds turned inwards' (Schumach, 1974). The anxieties aroused by the possibility of change in the locus of psychiatric care are less frequently mentioned. Yet mental hospital staff have anxieties about their future careers (Stotland and Kobler, 1965), politicians fear that the closure of mental hospitals might affect the equilibrium and happiness of their constituents (Greenblatt and Glazier, 1975), and urban residents are scared that property values will fall if patients are rehoused in their locality (Wolpert, 1975). Professional fears about status seem to underly anxieties about confidential information being passed to social workers (Jones, 1969). One report has even asserted that the Social Services Act has removed any hope of providing unified services relating to mental health (Tripartite Committee, 1972). The same report dichotomizes good communication between doctors, nurses and former Duly Authorized Officers from bad communications with social workers; overlooking evidence to the contrary (Miles *et al*, 1961; Lawson, 1966).

More Moderate Views

Bachrach believes that in the United States there has been some tempering of these polarized stances (NIMH, 1976). In the United Kingdom, with the growing recognition that the mental hospital is still the predominant provider of psychiatric in-patient care, there is a decreasing tendency to indulge in polemics (Isaacs, 1977). There is an increasing willingness to consider the need for a continuum of services

https://doi.org/10.1192/S0007125000283256 Published online by Cambridge University Press

which are comprehensive rather than alternative to each other. Wing (1975) sums up the situation when he says that 'the quality of life lived by the patient is the final criterion by which services must be judged. A good hospital is better than a poor hostel or a poor family environment. A good family environment is better than a poor hospital or a poor hostel . . . Universal denunciation of any one type of setting is likely to be harmful, since it is clearly not based on rational principles of assessment, treatment or care.' If services to patients are to be improved, rational discussion is essential. The deficiencies which exist in most services have to be recognized and the absence of resources admitted. It has to be accepted that the hospital is part of the community and retains an important place in a district-based psychiatric service (Command 3703, 1968). Few community psychiatric services have been evaluated. But we do know that, if they have not proved more helpful to the patient than the mental hospital, they have not been less helpful. It has to be admitted that in some instances families have suffered distress and inconvenience in the absence of adequately thought out support from psychiatric and social services (Brown *et al*, 1966; Sainsbury, 1973). Such deficiencies can be used as an argument for better community services or for a return to mental hospital care. Yet the same obstacles, in terms of manpower and shortage of economic resources, which hinder the development of a district service, impede the improvement and adequate staffing of mental hospitals. Mental hospitals, too, have certain disadvantages for patients. For once a person has been admitted he is subjected to social influences which have little to do with his psychiatric complaint. His discharge is related less to his mental state than the number of visitors he receives, the patient and staff interaction and the staff-patient ratio (Langsley *et al*, 1973). Once having been admitted a person is more likely to be readmitted regardless of his presenting symptoms, if the family and social resources are inadequate (Erikson, 1957; 1962). It is not illogical, therefore, to try to tackle a person's difficulties in the first instance in the place where they occur, rather than expose him to risks of stigma, the patient role and institutionalization. Hospital admission will be necessary for some, but it should not be the first resort. It can be argued that the present plans have other merits. First, they establish the principle of district responsibility, which means that in a geographical area it is possible to identify who is responsible for providing services to the patient. The services are accessible to the local population and their varied, flexible and often non-segregated care is usually more acceptable to patients and their families.

Social Psychiatry in Community Psychiatry

Whatever the champions of mental hospital care or community care may say, both methods seem to have advantages and disadvantages in seeking to help the patient and ameliorate his pathology. If any progress is to be made, we have to be able to employ the available facilities and services to decrease or contain disease, disability or distress for the patient, his family and the community at large. Care and treatment undertaken at home is not necessarily preferable to that undertaken in hospital. Instead, each environment must be assessed and its merits judged according to the effect it is likely to have on a particular individual's clinical condition and behaviour, while bearing in mind the effect that he, in his turn, will have on those with whom he lives and works. This requires an understanding of the interaction of social and clinical events, which is the content of social psychiatry; as well as other information from psychology and the other behavioural sciences (Wing, 1971).

Then, according to Sabshin (1966), it is possible to reformulate community psychiatry as a use of the techniques, methods and theories of social psychiatry, as well as those of the other behavioural sciences, to investigate and treat the mental health needs of a functionally or geographically defined population over a significant period of time. According to this formulation, community psychiatry is concerned with the mental health needs not only of the individual patient but of the district population; not only of those who are defined as sick, but those who may be contributing to that sickness

https://doi.org/10.1192/S0007125000283256 Published online by Cambridge University Press

and whose health or well-being may, in turn, be put at risk. This approach affords a way of working with patients which takes account of their clinical condition, the expectations and stresses to which they are exposed, and the social supports on which they may count. It provides no dogmatic statement about *where* the patients should be treated or by *whom*. What matters is *how* they are treated.

Community Psychiatric Treatment

The nature of community psychiatric treatment is poorly understood. Thus the pressing, but separate, treatment needs of neurotic and psychotic patients have been all but obscured in yet another polarized debate which contrasts the supposedly limited 'first-aid' treatment by reassurance and the prescription of medication for 'community' patients with the benefits of 'skilled' psychotherapy for neurotics (Cawley and McLachlan, 1973). A reasonable concern for the treatment needs of neurotic patients is presented in a way which distorts and devalues community psychiatric treatment. The differences between the two situations are overlooked. In community psychiatric treatment, the psychiatrist is a member of a team and has to share responsibility, over time, for the care of patients whom he does not select—except by residence in a defined district—who may be co-operative and treatable, but may just as likely be poorly endowed and unable to co-operate in, or respond to, treatment. In psychotherapy the psychiatrist more often works in private with patients selected for their suitability and desire for treatment; patients who are 'his' alone. Community psychiatrists, too, are at fault. Preoccupied with the logistics of providing service alternatives to the mental hospital and of mobilizing adequate resources for this, they have failed to describe adequately the aims and methods of a community approach.

If community psychiatric treatment is to be effective, it must be grounded in the application of those theories and findings of social psychiatry which show the clinician how social factors cause, precipitate, exacerbate, minimize or prevent manifestations of psychiatric illness and how, in turn, psychiatric illness affects society. There is much useful and relevant information about the social determinants of the patient's present mental state and the course of the disease in schizophrenia, whether the patient is residing in hospital (Wing, 1962; Wing and Brown, 1970) or in the family (Brown, 1959; Brown *et al*, 1962, 1972; Vaughn and Leff, 1976). Other studies have explored the effects of schizophrenia and other forms of mental illness and mental retardation in the family (Tizard and Grad, 1961; Rutter, 1966; Grad and Sainsbury, 1968; Hoenig and Hamilton, 1969; Hirsch and Leff, 1975) as well as the social determinants of the family's ability to cope with its disabled member (Susser, 1965). There is new knowledge of the social precipitants of psychotic disorders (Brown and Birley, 1970) as well as of those social factors which render some patients more or less vulnerable (Brown *et al*, 1975). These influences and effects are more readily appreciated and more easily evaluated in a day hospital, a realistic work setting or in conjoint family meetings than in a ward or clinic (Bennett, 1972, 1975; Bennett *et al*, 1976).

The next stage is the formulation of individually centred methods of treatment involving environmental changes which emphasize method rather than technique. It is possible to be eclectic in the use of soundly based psychological, sociological and social psychiatric knowledge, provided that the effects of this intervention are vigorously evaluated (Shepherd, G., 1977). To do this requires staff with the skill to observe the patient's functioning in various social situations and to relate these observations to the patient's mental state and adaptive ability. In doing this they must be sensitive to their own feelings as well as those of their colleagues and appreciate how these feelings influence their own actions, as well as the response of patients and their families (Bennett *et al*, 1976).

Since many psychiatrists and other staff still fail to think of the hospital as part of the community, it must be emphasized that this 'community approach' must be followed for patients, whether they are living in the hospital or outside it. For what happens to the patient in his family and in society will determine whether he needs hospital care. Similarly, how he adapts

https://doi.org/10.1192/S0007125000283256 Published online by Cambridge University Press

at home and at work will be determined, in part, by what has been done for him in hospital. This is true for all psychiatric patients, but it applies with greater force for those severely disabled patients who may lack families, homes or jobs. For them the obstacle to a reasonably comfortable and happy life is their desocialization and their loss of adaptive capacity because of illness or disability. If they are to function in society, desocialization must be prevented or reversed and adaptive capacity maintained or developed (Bennett, 1975). This cannot be achieved by the oversimple expedient of avoiding or shortening hospital admission. Socialization is largely a matter of meeting society's expectations in the performance of the roles of adult life; a capacity which may be lost as easily in the patient's own home as in a mental hospital. Nor is such socialized behaviour acquired, once for all, in childhood or reacquired in rehabilitation. Life does not stand still; roles are constantly changing and a person has to struggle continuously to maintain his position in society. In this struggle he is aided by family and friends.

In rehabilitation, a psychiatrically disabled person can be helped to acquire the social and instrumental skills, the emotional control and the motivation needed for the performance of roles in society (Wing, 1963; Mechanic, 1975; Bennett, 1975). But once this has been done the former patient has to find and perform 'real' roles in society, with the support of other people, if he is not to become desocialized again. All patients can be rehabilitated to a greater or lesser extent and helped to make better use of their skills in spite of their handicaps; but not all can be resettled in the community. Those who cannot be resettled remain in hospital as long-stay patients. With improvements in treatment and rehabilitation the numbers of 'new' long-stay patients are only a fraction—less than a quarter—of the 'old' long-stay who previously accumulated in mental hospitals (Hailey, 1973, 1974). Over half of these 'new' long-stay patients suffer from senile dementia.

Support and Shelter

It is often suggested that such long-stay patients and many with similar disabilities who are coping poorly in the community really require 'asylum' (Annotation, 1973; Cawley, 1973). According to the *Oxford English Dictionary*, an asylum is 'a benevolent institution affording some kind of shelter and support to the afflicted'. Mental hospitals are not only hospitals but hotels, reformatories, dustbins, and asylums (Watson, 1969). As asylums they provide not only treatment and rehabilitation but also shelter and support (Edwalds, 1964). Now shelter is a roof over one's head and the means of paying for it. Support is the human assistance which sustains and maintains people in their roles, encouraging them to success and protecting them from failure. People get support from various groups to which they belong and from a network of kin and friends. Long-stay hospital patients and severely disabled community patients not only have difficulty in making close relationships with others; their behaviour has often alienated them from their families and friends. They are not able to make new relationships easily or use the available supportive services effectively. The presence of former chronic and still disabled patients in society, who are living impoverished lives in degrading conditions, is often the outcome of their discharge from hospital by doctors who, satisfied with their clinical condition, have overlooked these social difficulties (Tidmarsh *et al*, 1972). It is then suggested that mental hospitals should be retained to provide asylum, or that more specialist psychiatric hostels should be built. Support can be infantilizing, can increase dependency, can limit self-expression and constrict individual development. It often took this form in the mental hospital. So when support and shelter are needed it is better, where possible, that they should be separated and not combined in some 'total institution', however benevolent, in the community or elsewhere (Goffman, 1961). While it recommends the separation of housing and support, the recent White Paper (Command 6233, 1975) fails to recognize the need for well-organized and aggressive supporting services if disabled community patients are not to be lost to care or end up in difficulty (Mechanic, 1975). It only recommends 'limited support' or 'minimal support', from social services alone.

https://doi.org/10.1192/S0007125000283256 Published online by Cambridge University Press

Many seriously disabled patients, if properly prepared, can live in bedsitting rooms or flats provided by the Housing Department and can there develop their own life styles. In day centres, at work or elsewhere they can often build up a limited supportive network of friends and acquaintances (Birley, 1974). These patients also need psychiatric support.

Psychiatric services traditionally provide consultation, but support is not always forthcoming. Psychiatrists and other hospital staff like to feel that they have done their job and that their former patient is now discharged. They cling to the myth, recently challenged by Bergmann (1977), that community care will reduce the number of their psychiatric patients. New methods of community treatment do contain disease and disability and help to reduce distress, but they do not eliminate the need for care or support from the psychiatric services themselves. While the needs of the 'new' and 'old' long-stay hospital patients have been identified, little attention has been given to the needs of the 'seriously disabled community psychiatric patients'. Their care requires little in the way of buildings; only the willingness of the social services and the specialist psychiatric team to work together in meeting their particular needs, enough time to do this, and an ability to co-ordinate these activities with those of other services which make up the community support system (Turner, 1977). Hospital services have sought to meet patients' need for psychiatric support by employing district psychiatric nurses. This is a step in the right direction. But it has its limitations; for while the nurse has an important part to play in the community services, the independent district psychiatric nurse cannot offer continuity of care. Continuity breaks down if it depends on one person, whether a psychiatrist, psychiatric social worker or community nurse, both because of the mobility of professional workers and because a single repository of personal help is often absent when that help is most urgently needed (Watson *et al*, 1970). But continuing personal care can be provided on a ward at any time; during the day, in the evening, and for the whole weekend. Of course this demands a geographically accessible hospital, but more importantly, staff who will make the service available at any time. The nurses are in the front rank of such a service because the organization of their duties enables them to be available throughout the whole twenty-four hours. As members of a team they can call on the services of other team members (Watson *et al*, 1970). It is often better for former patients to come to the ward than to be visited in their homes, thus lessening their social isolation. They can also receive help with their laundry or bathing as well as the occasional meal and their medication. Patients who fail to attend may have to be sought out, but those who need this are very few in number. Present in-patients, seeing that they can put their trust in such a supportive service are more willing to risk discharge from hospital.

Secondly, there is an urgent need on the part of both social and psychiatric services to preserve the patient's family and social supports which are only too easily lost or diminished as a result of hospital admission. These assets, invaluable to the patient, are often invisible to hospital psychiatrists. If lost, they have to be replaced by continuing 'asylum' or other expensive forms of professional assistance. It is an essential part of community psychiatry to work with the family and others who are our partners in caring for, and supporting, the community psychiatric patient (Vickers, 1967; Bennett *et al*, 1976).

Organization

There is a need to organize and co-ordinate the network of people and resources available from health, social services, voluntary agencies and families. In Mechanic's view this requires a shift from the traditional bureaucratic hospital procedures to more 'organic' organizational concepts. It requires the abandonment of rigid professional role structures and responsibilities. Instead, professionals 'must be on the scene their ears to the ground, away from the usual insulation, security and lack of realism of the professional office' (Mechanic, 1975). Care can only be integrated if the professional staff are prepared to work in this way and themselves become the facilitators, co-ordinators and integrators of the system. One cannot transplant

https://doi.org/10.1192/S0007125000283256 Published online by Cambridge University Press

or adapt the classical models of organization to the provision of services at the community level. The goals are too many, too varied and too intangible; the techniques are not clearly specified or are uncertain, the environment is unpredictable and changeable. There is a good case for the use of an 'organic' system of management in hospital, but its employment is essential in community psychiatry (Bennett *et al*, 1976).

Finally, there is the need to instil and maintain the commitment and motivation of staff. Mechanic (1975) discusses this difficulty at length and concludes that the only possible solution is to allow participating staff to make changes from time to time so that they are more committed to, and enthusiastic about, a service in which they have some stake.

Conclusion

Community psychiatry has many facets. It stems from society's response to social changes which have altered the position of the individual in society. In Britain it began as an attempt to provide treatment for psychiatric patients outside the mental hospital. Now the term is used to cover a national plan to provide district-based, hospital-centred, services in which general hospital units and statutory or voluntary social services complement each other. Emotional and rational discussion of the logistics and the merits and demerits of this scheme has diverted psychiatrists' attention from more important clinical and organizational considerations. Community psychiatry should aim to employ the available resources and develop others to contain disease, disability and distress for the patient, his family and the community at large. It can only do this if psychiatric and social service provisions are co-ordinated and managed on 'organic' organizational lines. Professional staff have to understand that, whatever the genetic, biological or psychodynamic characteristics of psychiatric disorder, they can be exacerbated or contained by the manner in which patients are defined and managed, as well as by the social climate of treatment (Mechanic, 1975). What can be achieved does not depend solely on manpower and capital investment. A service can employ adequate numbers of trained staff, but if they do not consult and co-operate in the assessment of the patient's clinical and social situation or in the formulation of goals for treatment, rehabilitation or support of the individual and his family, their expensive skills will be wasted.

References

ANNOTATION (1973) Back to the bin. *Lancet*, *i*, 527–8.

APTÉ, R. (1967) The local authority hostel as a transitional institution. In *New Aspects of the Mental Health Services* (eds H. Freeman and J. Farndale), pp 667–77. London: Pergamon Press.

BAKER, A. A. (1969) Psychiatric illness in a district general hospital. *Lancet*, *i*, 1090–2.

BENNETT, D. H. (1972) Principles underlying a new rehabilitation workshop. In *Evaluating a Community Psychiatric Service: The Camberwell Register 1964–71* (eds J. K. Wing and A. M. Hailey), pp 275–82. London: Oxford University Press.

—— (1975) Techniques of industrial therapy, ergotherapy and recreative methods. Chapter in *Psychiatrie der Gegenwart: Forschung und Praxis*, **3**, 743–78 (eds K. P. Kisker, J.-E. Meyer, C. Müller and E. Strömgren). Berlin: Springer-Verlag.

—— FOX, C., JOWELL, T. & SKYNNER, A. C. R. (1976) Towards a family approach in a psychiatric day hospital. *British Journal of Psychiatry*, **129**, 73–81.

—— & WING, L. (1972) Social work services. In *Evaluating a Community Psychiatric Service; The Camberwell Register 1964–71* (eds J. K. Wing and A. M. Hailey), pp 309–16. London: Oxford University Press.

BERGMANN, K. (1977) Letter. *British Journal of Psychiatry*, **130**, 522.

BIRLEY, J. L. T. (1973) The ghost in the machine. In *Policy for Action* (eds R. Cawley and G. McLachlan), pp 103–9. London: Oxford University Press.

—— (1974) A housing association for psychiatric patients. *Psychiatric Quarterly*, **48**, 568–71.

BROOK, P. & COOPER, B. (1975) Community mental health care: primary team and specialist services. *Journal of the Royal College of General Practitioners*, **25**, 93–110.

BROTHWOOD, J. (1973) The development of national policy. In *Policy for Action* (eds R. Cawley and G. McLachlan), pp 11–31. London: Oxford University Press.

BROWN, G. W. (1959) Experiences of discharged chronic schizophrenic mental hospital patients in various types of living groups. *Milbank Memoral Fund Quarterly*, **37**, 105–31.

—— BHROLCHÁIN, M. N. & HARRIS, T. (1975) Social class and psychiatric disturbance among women in an urban population. *Sociology*, **9**, 225–54.

—— & BIRLEY, J. L. T. (1970) Social precipitants of severe psychiatric disorders. Chapter in *Psychiatric Epidemiology* (eds E. H. Hare and J. K. Wing), pp 321–5. London: Oxford University Press.

—— —— & WING, J. K. (1972) Influence of family life on the course of schizophrenic disorders: a replication. *British Journal of Psychiatry*, **121**, 241–58.

https://doi.org/10.1192/S0007125000283256 Published online by Cambridge University Press

Brown, G. W., Bone, M., Dalison, D. & Wing, J. K. (1966) *Schizophrenia and Social Care*. London: Oxford University Press.

—— Monck, E. M., Carstairs, G. M. & Wing, J. K. (1962) Influence of family life on the course of schizophrenic illness. *British Journal of Preventive and Social Medicine*, **16**, 55–68.

Carse, J., Panton, N. E. & Watt, A. (1958) A district mental health service: the Worthing experiment. *Lancet*, *i*, 39–41.

Cawley, R. (1973) Postscript. In *Policy for Action* (eds R. Cawley and G. McLachlan), pp 179–87. London: Oxford University Press.

—— & McLachlan, G. (eds) (1973) *Policy for Action. A Symposium on the Planning of a Comprehensive District Psychiatric Service*. London: Oxford University Press.

Clare, A. W. (ed.) (1972) Community psychiatry: vision or mirage? Association of Psychiatrists in Training. Proceedings Symposium, November 1972.

Cooper, B. (1966) Psychiatric disorder in hospital and general practice. *Social Psychiatry*, **1**, 7–10.

Cumming, E. (1968) Community psychiatry in a divided labor. In *Social Psychiatry* (eds H. Zubin and F. Freyhan), pp 100–13. New York: Grune & Stratton.

Cumming, J. (1974) Elements of a comprehensive psychiatric service. *Psychiatric Quarterly*, **48**, 475–82.

Davis, K. (1949) *Human Society*. New York: Macmillan.

de la Torre, J. (1973) Discussion of Lipsius' 'Judgments of alternatives to hospitalization'. *American Journal of Psychiatry*, **130**, 895–6.

Department of Health and Social Security (1960) Annual Report of Chief Medical Officer, Command 1550. London: HMSO.

—— (1971) *Hospital Services for the Mentally Ill*. Hospital Memo 97. London: HMSO.

—— (1974) *Providing a Comprehensive District Psychiatric Service for the Adult Mentally Ill*. DHSS Reports on Health and Social Subjects No. 8. London: HMSO.

—— (1975) *Better Services for the Mentally Ill*. Command 6233. London: HMSO.

Dunham, H. W. (1965) Community psychiatry; the newest therapeutic bandwagon. *International Journal of Psychiatry*, **1**, 553–66.

Edwalds, R. M. (1964) Functions of the State mental hospital as a social institution. *Mental Hygiene*, **48**, 666–71.

Erikson, K. T. (1957) Patient role and social uncertainty—a dilemma of the mentally ill. *Psychiatry*, **20**, 263–74.

—— (1962) Notes on the sociology of deviance. *Social Problems*, **9**, 307–14.

Freeman, H. L. (1962) The Portsmouth mental health service 1926–1952. *Medical Officer*, **107**, 149–51.

Goffman, E. (1961) *Asylums: Essays on the Social Situation of Mental Patients and other Inmates*. New York: Anchor Books, Doubleday.

Goldberg, D. (1971) The scope and limits of community psychiatry. In *The Role of Drugs in Community Psychiatry. Modern Problems Pharmacopsychiatry*, **6**, pp 5–25 (ed. C. Shagass). Karger-Basel.

Grad, J. & Sainsbury, P. (1968) The effects that patients have on their families in a community care and a control psychiatric service; a two-year follow-up. *British Journal of Psychiatry*, **114**, 265–8.

Greenblatt, M. & Glazier, E. (1975) The phasing out of mental hospitals in the United States. *American Journal of Psychiatry*, **132**, 1135–40.

Hailey, A. M. (1973) The chronic mental hospital population: a six-year follow-up study. *British Journal of Preventive and Social Medicine*, **27**, pp 255–60.

—— (1974) The new chronic psychiatric population. *British Journal of Preventive and Social Medicine*, **28**, 180–6.

Harris, A. (1958) General adult psychiatric services outside the mental hospital. *Hospital and Health Management*, **21**, 405–7.

Hawks, D. (1975) Community care: an analysis of assumptions. *British Journal of Psychiatry*, **127**, 276–85.

Hill, D. (1969) *Psychiatry in Medicine*. London: Nuffield Provincial Hospitals Trust.

Hirsch, S. R. & Leff, J. P. (1975) *Abnormalities in Parents of Schizophrenics*. London: Oxford University Press.

Hoenig, H. & Hamilton, M. W. (1969) *The Desegregation of the Mentally Ill*. London: Routledge & Kegan Paul.

Isaacs, A. D. (1977) The psychiatric hospital model. Paper read at CIBA Foundation Symposium on 'Concepts of Community Psychiatry'.

Jones, R. H. (1971) *The Doctor and the Social Services*. London: Athlone Press.

Kubie, L. S. (1968) Pitfalls of community psychiatry. *Archives of General Psychiatry*, **18**, 257–66.

Langsley, D. G., Odland, T. M., Barter, J. T. & Moorhead, D. (1973) Who goes to the mental hospital now? Proceedings of American Psychiatric Association.

Lawson, A. R. L. (1966) *The Recognition of Mental Illness in London*. Maudsley Monograph. London: Oxford University Press.

Levenson, A. I. & Brown, B. S. (1968) Social implications of the community mental health center concept. *Proceedings of American Psychopathology Association*, **57**, 117–27.

Macmillan, D. (1956) An integrated mental health service. *Lancet*, *ii*, 1094–5.

May, A. R. (1965) Principles underlying community care. Chapter 13 in *Psychiatric Hospital Care* (ed. H. Freeman). London: Balliere, Tindall & Cassell.

—— & Gregory, E. (1963) An experiment in district psychiatry. *Public Health*, **78**, 19–25.

Mechanic, D. (1966) Community psychiatry: some sociological perspectives and implications. In *Community Psychiatry* (eds L. M. Roberts, S. L. Halleck and M. B. Loeb), pp 201–22. Madison: University of Wisconsin Press.

—— (1975) Alternatives to mental hospital treatment: a sociological perspective. Paper presented at Conference on Alternatives to Mental Hospital Treatment, Madison. (To be published.)

Miles, H. L., Loudon, J. B. & Rawnsley, K. (1961) Attitudes and practice of Mental Welfare Officers. *Public Health*, **76**, 32–47.

https://doi.org/10.1192/S0007125000283256 Published online by Cambridge University Press

MORRICE, J. K. W. (1976) *Crisis Intervention: Studies in Community Care*. Oxford: Pergamon Press.

NATIONAL INSTITUTE OF MENTAL HEALTH (1976) *Deinstitutionalization: an Analytical Review and Sociological Perspective*. DHEW Publication No. (ADM) 76-351. Washington.

ØDEGAARD, Ø. (1964) Pattern of discharge from Norwegian psychiatric hospitals before and after the introduction of the psychotropic drug. *American Journal of Psychiatry*, **120**, 772–8.

OLDHAM, A. J. (1969) Community psychiatry in London: a three-year analysis. *British Journal of Psychiatry*, **115**, 465–74.

PARKES, C. M., BROWN, G. W. & MONCK, E. M. (1962) The general practitioner and the schizophrenic patient. *British Medical Journal*, *i*, 972–6.

REPORT OF THE COMMITTEE ON LOCAL AUTHORITY AND ALLIED PERSONAL SOCIAL SERVICES (1968) Command 3703. London: HMSO.

ROYAL COMMISSION ON THE LAW RELATING TO MENTAL ILLNESS AND MENTAL DEFICIENCY (1957) Command 169. London: HMSO.

RUSSELL, G. F. M. (1973) Will there be enough psychiatrists to run the psychiatric service based on district general hospitals? In *Policy for Action* (eds R. Cawley and G. McLachlan), pp 111–16. London: Oxford University Press.

RUTTER, M. (1966) *Children of Sick Parents*. Maudsley Monograph. London: Oxford University Press.

SABSHIN, M. (1966) Theoretical models in community and social psychiatry. In *Community Psychiatry* (eds L. M. Roberts, S. L. Halleck and M. B. Loeb), pp 15–30. Madison: University of Wisconsin Press.

SAINSBURY, P. (1973) A comparative evaluation of a comprehensive community psychiatric service. In *Policy for Action* (eds R. Cawley and G. McLachlan), pp 129–43. London: Oxford University Press.

SCHUMACH, M. (1974) Proprietary homes called Snake Pits. *New York Times*, 5.8.74.

SHEPHERD, G. (1977) The environment and the individual. Paper presented at Netherne Hospital Postgraduate Medical Centre. (Mimeo.)

SHEPHERD, M., COOPER, B., BROWN, A. C. & KALTON, G. W. (1966) *Psychiatric Illness in General Practice*. London: Oxford University Press.

STOTLAND, E. & KOBLER, A. L. (1965) *Life and Death of a Mental Hospital*. Seattle: University of Washington Press.

SUSSER, M. W. (1965) Rationale for the community care of mental disorder. *Hospital Care*, **3**, 52–9.

TIDMARSH, D., WOOD, S. & WING, J. K. (1972) *Camberwell Reception Centre. Summary of the Research Findings and Recommendations*. London: DHSS.

TITMUSS, R. M. (1963) Community care—fact or fiction: In *Trends in the Mental Health Services* (eds H. Freeman and J. Farndale), pp 221–5. London: Pergamon Press.

—— (1965) Role of the family doctor today in the context of Britian's social services. *Lancet*, *i*, 1–4.

TIZARD, J. & GRAD, J. C. (1961) *The Mentally Handicapped and Their Families: a Social Survey*. Maudsley Monograph. Oxford University Press.

TOOTH, G. C. & BROOKE, E. M. (1961) Trends in the mental hospital population and their effect on future planning. *Lancet*, *i*, 710–13.

TRIPARTITE COMMITTEE (1972) *The Mental Health Service after Unification*.

TURNER, J. C. (1977) Comprehensive community support systems for adults with seriously disabling mental health problems *Psychosocial Rehabilitation Journal*, **1**. In press.

VAUGHN, C. & LEFF, J. P. (1976) The influence of family and social factors on the course of psychiatric illness. *British Journal of Psychiatry*, **129**, 125–37.

VICKERS, G. (1967) Community medicine. *Lancet*, *i*, 944–7.

WATSON, J. P. (1969) Hotel, asylum or reformatory; the functions of the mental hospital in the community. Lecture 152: Guild of Pastoral Psychology.

—— BENNETT, D. H. & ISAACS, A. D. (1970) Psychiatric units in general hospitals. *Lancet*, *i*, 511–14.

WILSON, D. (1972) Mental health scandal: the guilty ones. *The Observer*, 20.2.72.

WING, J. K. (1962) Institutionalism in mental hospitals. *British Journal of Social and Clinical Psychology*, **1**, 38–51.

—— (1963) Rehabilitation of psychiatric patients. *British Journal of Psychiatry*, **109**, 635–41.

—— (1971) Social psychiatry. *British Journal of Hospital Medicine*, **5**, 53–6.

—— (1975) Planning and evaluating services for chronically handicapped psychiatric patients in the UK. Paper presented at Conference on 'Alternatives to Mental Hospital Treatment'. Madison. (To be published.)

—— & BROWN, G. W. (1970) *Institutionalism and Schizophrenia*. London: Cambridge University Press.

—— & HAILEY, A. M. (eds) (1972) *Evaluating a Community Psychiatric Service: the Camberwell Register 1964–1971*. London: Oxford University Press.

WOLPERT, J. (1975) Service facility representation in urban communities. (Mimeo.) Princeton, N.J.: School of Architecture and Urban Planning.

WORLD HEALTH ORGANIZATION (1973) Regional Office for Europe. *Psychiatry and Primary Medical Care*. EURO 5427 I, Copenhagen.

YOLLES, S. F. (1969) Past, present and 1980: trend projections. Chapter in *Progress in Community Mental Health*, **1** (eds L. Bellak and H. H. Barten), pp 3–23. New York: Grune & Stratton.

Douglas Bennett, M.D., F.R.C.Psych., *Consultant Psychiatrist, The Bethlem Royal and the Maudsley Hospital, Denmark Hill, SE5 8AZ*

(*Received 28 June 1977*)

https://doi.org/10.1192/S0007125000283256 Published online by Cambridge University Press