CURRENT VIEWS

Community Care: A Historical Comment from the United Kingdom

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In the United Kingdom, as elsewhere, national policies are dictating that mental health services should be increasingly provided 'in the community', which generally implies 'other than in hospital'. Experience suggests that the implementation in practice of such policies may produce very varied effects; the purpose of this note is to explore this from a British perspective which may illustrate generally applicable principles.

Forty Years Ago

The term 'community care' first appeared in the British postwar literature in the title of the classic paper by TP Rees (1957) "Back to moral treatment and community care". This title drew attention to Rees's contention that the principles of moral treatment made possible and should underpin the continuing care of the mentally ill outside hospitals. Rees urged that continuing care should be sustained by the relationships between individual patients and individual staff members (particularly nurses) established in the hospital and continued after discharge. In effect the nurse would 'follow the patient into the community'.

The establishment of staff-patient relationships with potentially therapeutic properties was a key principle of the moral treatment arrangements developed in the early nineteenth century by the Tukes and their successors (see for example Tuke 1813, Connolly 1860, Bucknill and Tuke 1879). In contrast with the dehumanising systems observable in the public institutions of the day, they thought it essential to treat the patient with respect, as competent to the extent that their illness allowed them to function normally, and as people who should have as much liberty and as little restraint as again, that their illness allowed.

In contemporary community care arrangements, staff-patient relationships are often not mentioned at all, let alone given primacy as therapeutic agents. Planners and bureaucrats seem to prefer administrative criteria, typically the patient's address or age, as the basis for allocating services. In Britain this usually means that if a patient moves address, then their care has to be transferred to another clinician or clinical team, even if this means breaking staff-patient relationships of great personal importance.

Rees's paper was a rallying cry to enthusiastic psychiatrists seeking release from the therapeutic nihilism dominant before the second world war. He saw that service changes which benefit patients must involve enthusiastic clini-

cians. Administrators and managers must facilitate the work of clinicians; experience shows that all too often they may tend to stifle clinical enthusiasm.

More Recently

In UK, the 1960s saw the development of psychiatric units in general hospitals, furthering the re-integration of psychiatry within the rest of Medicine (Hill 1970). As with Rees and 'Community Care', the protagonists of District General Hospital (DGH) psychiatry were enthusiastic and claimed the future. Some said that everyone from a defined patch needing inpatient care could be treated in the DGH, while others were more cautious and pointed to the need for 'back-up' mental hospital beds for some patients. The possibility that mental hospitals might not be needed had appeal for politicians and others aware of the considerable resource associated with the large asylums.

Concurrently, another set of enthusiasts were expounding the therapeutic potential of the large psychiatric hospital. One leader in this field was David Clark, the Superintendent of Fulbourn Hospital, Cambridge, who worked to establish a therapeutic environment throughout the hospital (Clark 1964). Chiefly he did this by using the power entailed in the office of superintendent, to make administrative changes. In doing this he was applying the concepts of the 'therapeutic community' developed by Maxwell Jones (1968) which in turn drew upon principles of moral treatment. Therapeutic communities emphasised non-medical aspects of care, notably the very great potential impact of the social environment, and regarded the patient as an active participant in their treatment program ; the DGH approach used more medically-dominant methods.

The work of Clark and others drew attention to the therapeutic potential of the large asylum. At the same time, reports appeared of adverse effects on patients of bad mental hospitals (e.g. Brown et al 1966) ; and as the 1970s progressed there were reports of abuses in large hospitals. Reports of hospital scandals seemed to support the views of those advocating mental hospital closure even when fueled by economic considerations. However, it must be remembered that reports of bad practice in mental hospital almost invariably emerge from poorly staffed and under resourced institutions. The Tukes were quite clear (Tuke 1813) that moral treatment was impossible without enough staff, since staff-patient relationships were the mainstay of therapeutic success and could not be done with too few staff in relation to patient numbers. The therapeutic potential of a well-resourced and well-staffed hospital was never subjected to controlled evaluation. The message for today is that there must be sufficient staff numbers to allow the establishment of the patient-staff relations which are essential for adequate patient care in hospital or in the community.

As the 1970s passed, and DGH units developed while mental hospitals waited uneasily for the implementation of emerging redevelopment plans, interest increased in the psychosocial morbidity of the general population and of individuals attending general practitioners and other primary care staff. Also, the presence of psychiatric units in general hospitals tended to increase the referral to psychiatric staff of medical patients without medical diseases, usually with unexplained physical symptoms. By 1980 the British psychiatric scene could be represented as a field with four corners: the DGH unit ; the mental hospital ; the DGH itself ; and primary care.

Since 1980

Since the early 1980s the mental health scene in Britain has been dominated by the Manager. General management principles and practices were introduced into the National Health Service after a Government-commissioned report in 1983. After that, and until about 1988, various attempts were made to enable doctors and managers to work together, with some success and some degree of excitement about new possibilities. However, another set of changes, this time to introduce principles derived from business and commerce into healthcare, were made in 1988. These changes are derived entirely from Government ideology. They include the separation of purchaser from provider of healthcare, the introduction of an internal market in the health service, and the creation of administrative bodies called 'NHS Trusts'. The effects of these changes cannot yet be calculated. Nevertheless it is difficult to resist the conclusion that their primary aim is to control public health expenditure. The principles of moral treatment, focusing on the therapeutic primacy of staff-patient relationships, can only suffer if fiscal imperatives take precedence over clinical ones

References

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

Bucknill J.C., Tuke D.H. (1879): A Manual of Psychological Medicine, Fourth Edition. London, Churchill

Clark D.H. (1964): Administrative Therapy, London, Tavistock

Connolly J (1964): Recollections of the varieties of insanity. Parts I-VI. The Medical Times and Gazette, Volume 1 for 1860, pp 6-8;111-114 ; 212-214; 336-338 ; 442-444 ; 544-546

Hill D. (1970): Psychiatry in Medicine. Retrospect and Prospect, London, Nuffield Provincial Hospitals' Trust

Jones M. (1968): Social Psychiatry in Practice. The Idea of the Therapeutic Community. London, Penguin Books

Rees T.P. (1957): Back to moral treatment and community care. Journal of Mental Science, 103, 303-313

Tuke S. (1813): Description of The Retreat

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Epilepsy

Stopping treatment in Controlled Patient:

The longer the history of active epilepsy, the less safe is withdrawal of medication. Withdrawal should be considered only after two or more seizure free years in patinets with a long previous history of epilepsy, but in patients with a very short histroy (say of only one or two seizures) withdrawal after six months of freedom from attacks might be considered.

If a patients has partial seizures, symptomatic epilepsy, mental handicap, neurlogical signs or other evidence of cerebral damage, the risk of withdrawal are much higher, and in most cases, treatment should be continued for many years even if the seizures are controlled.

Withdrawal should be carried-out very slowly in staged decrements.
Only one drug at a time should be withdrawal.
The risks of recurrence should be clearly explained to the patient, and the possible medical and social implication made explicit. There may be serious domestic consequences and effects on employment or driving, and these should be considered before the decision to withdraw medication is made.

Ciba Geigy