THE ROCK CARLING FELLOWSHIP

1969

PSYCHIATRY IN MEDICINE

RETROSPECT AND PROSPECT

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The Rock Carling Fellowship
was founded as an annual memorial
to the late Sir Ernest Rock Carling,
for many years a Governing Trustee
of the Nuffield Provincial Hospitals Trust
and Chairman of the Trust's Medical
Advisory Committee.

Each holder of the fellowship
will seek to review in a monograph
the state of knowledge and activity
in one of the fields in which Sir Ernest
had been particularly interested and which
is within the purposes of the Trust.
The arrangements provide that the
monograph will be introduced by a
public lecture to be given at a
recognized medical teaching centre
in the United Kingdom.

PREFACE

The honour of being elected by the Trustees to the Rock Carling Fellowship for 1969 is one I deeply appreciate. I regret that I am surely the first Fellow who did not know Sir Ernest Rock Carling personally. When Mr Gordon McLachlan told me of the Trustees' decision and invited me to suggest a title for my monograph, I was filled with doubt and hesitation. It would, of course, have to be on a topic related to psychiatry. I knew of Sir Ernest's reputation as a great surgeon, as a man who had left a mark on medical education and as a distinguished medical administrator, but I did not realize the depth and breadth of his interests, which have been embodied in the terms of reference of the annual Fellowship which commemorates him. Having looked at these, I had no difficulty.

I have chosen the title of *Psychiatry in Medicine* firstly to point to the fact that the clinical practice of the subject was for several centuries outside medicine, and secondly to emphasize that it is now very much a part of it. I have during my own professional lifetime witnessed the process of integration. It is this, the various aspects and consequences of it that I have tried to describe. There are several themes which are separately developed, but I hope that this book will be read not as a series of short and unrelated essays, but that some degree of cohesion will be apparent.

The rapid development of psychiatric services within the NHS far outstripped any comparable development of psychiatric education in the medical schools and teaching hospitals. As the facilities in the NHS became greater, it became evident that the concept of mental disorder had been too narrowly defined and vocational training for the specialty inadequate. The resources in financial and human terms to meet the demand for psychiatric care are now also seen to be inadequate, and the gaps in training of those who have to provide care are wide and serious. I do not share the view of some whose work has only been in academic

centres, that those of us who have spent our professional lives in them should not concern ourselves with the problems of patient care in the community. I think on the other hand that we have a special responsibility to see that education is fashioned to meet the requirements of all those who will have to practise medicine, wherever it is practised.

Among the injunctions given by the Trustees to the Rock Carling Fellow is that, having chosen a particular field to survey, he should be free to speculate about its future and that such speculation should include practical possibilities and ideas which might lead to progress. It is easy to identify problems and areas where knowledge or skill, facilities or training are deficient. It is much more difficult to suggest how deficiencies might be remedied. Nevertheless I have tried to follow the injunction. What I have to offer will be found in the final chapters of this monograph.

DENIS HILL

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ACKNOWLEDGEMENTS

In the preparation of this monograph I have drawn extensively upon the work of many friends and colleagues. For historical data I am particularly indebted to the writings of Dr Richard Hunter, Sir Aubrey Lewis, Dr Denis Leigh, Professor Thomas McKeown and Dr Alexander Walk; for data on attempted suicide to the work of Dr H. J. S. Matthew and Professor Neil Kessel, and that on morbidity surveys to Dr Michael Rutter and Professor Michael Shepherd, who kindly allowed me to reproduce data from his book on general practice. The studies referred to in chapter 7 have been largely the work of Dr Griffith Edwards and his colleagues. To Dr John Wing of the MRC Social Psychiatry Unit I am particularly grateful for allowing me access to the detailed work of the Camberwell Psychiatric Register. Among the many colleagues who have influenced my thinking either by discussion or by their writings I must mention Dr Douglas Bennett, Dr John Brotherston, Dr Philip Connell, Professor Arthur Crisp, Miss Margaret Eden, Dr Douglas Hubble, Dr Brian Kirman, Dr Felix Post, Miss Eileen Skellern, Dr Henry Walton, Dr Heinz Wolff, and my wife, Dr Lorna Wheelan. Nevertheless, I must of course take responsibility for the views which I have expressed.

At the Ministry of Health (as it then was) I was fortunate for some years both in the Mental Health Advisory Committee and from informal meetings with Dr Geoffrey Tooth and Dr Anthony May to learn about the state of hospital and community psychiatry, and their relationships with the rest of medicine. My knowledge was greatly expanded by participation at many meetings and symposia on these subjects which brought me into contact with colleagues working in the field and, although I am sure that not all will agree with the views I have expressed, I am grateful to them for this part of my education. I am particularly grateful to Dr K. F. Weeks and Dr J. T. Downham who gave me their unstinted help in reviewing the work of the psychiatric services which they have developed.

I have to thank many colleagues who have enlarged my understanding of medical education, especially those with whom I have worked on the Education Committee of the General Medical Council, and particularly its President, Lord Cohen. Through many meetings and discussions I have had the opportunity to take advantage of an unrivalled continuing education in this field.

Above all I wish to record my great indebtedness to my colleague, Dr J. P. Watson who at all stages in the preparation of this work, collected, analysed and reviewed a great deal of data; without his help and the benefits of his lively, enthusiastic and critical mind, the manuscript would not have been ready to meet the publisher's date, and it would have contained more errors and inconsistencies than it actually does. Finally my thanks go to my secretary, Miss Pamela Richards who typed the manuscript and enabled me only just in time to meet the obligations of the Fellowship.

I

Historical introduction

The nineteenth century witnessed the end of the gross cruelty to the mentally disordered which had continued since medieval times in all countries. 'Moral treatment' was the first form of psychotherapy, and at first was resisted by the medical profession. In mid century the large asylums were built, not in the towns or cities, but in the country. This had adverse consequences for the future. The mentally ill, like many other classes of patient remained a deprived group, neglected by medicine. The teaching hospitals had excluded the mentally ill. The geographical and ideological isolation of psychiatry from medicine continued until the creation of the National Health Service in 1948. After the Mental Treatment Act of 1930, the movement of psychiatry from asylum-care began; but the real stimulus and opportunity only came after 1948. The Hospital Plan which defines the concept of the District General Hospital with psychiatric units in them, marked a serious step towards the reintegration of psychiatry in medicine.

The year after Waterloo was a significant one in the history of psychiatry in England. In 1816 John Haslam (1764–1844) and his chief Thomas Monro (1759–1833) were dismissed from their posts as apothecary and physician to Bethlem. The Board of Governors' decision was taken as a consequence of a public outcry against gross malpractices discovered at Bethlem by a select committee of the House of Commons. There is no evidence that either of them was cruel, insensitive or ill-disposed towards his patients. In fact the writings of Haslam suggest the contrary and when Monro was displaced, his son was appointed in his place and he himself in his turn was later to be the object of severely adverse comment (1). This son, Edward Thomas Monro, was like his father a respected physician among physicians, and both were Fellows of the Royal College of Physicians. Edward refused to resign; he was the fourth Monro to hold the post at

Bethlem and when he retired the family tradition, which had extended over four generations and 126 years, ended. Haslam was a sincere and dedicated scientist, the first to give a clinical and neuropathological description of GPI and his name in the annals of psychiatric progress is secure; yet he died in poverty.

Haslam and Monro were victims of the new attitudes to the poor, the chronic sick and the mentally ill which divided the old world from the new. The French revolution was the watershed. When Edward Wakefield MP and some friends visited Bethlem in 1814 they were appalled by the conditions they found. Wakefield commissioned on the spot an etching of William Norris, who had been confined on a straw palliasse for ten years in a sitting position, manacled to the wall.

In one of the cells on the lower gallery we saw William Norris; he stated himself to be 55 years of age, and that he had been confined about 14 years; that in consequence of attempting to defend himself from what he conceived the improper treatment of his keeper, he was fastened by a long chain, which passed through a partition, enabled the keeper by going into the next cell, to draw him close to the wall at pleasure; but to prevent this, Norris muffled the chain with straw so as to hinder its passing through the wall; that he afterwards was confined in the manner we saw him, namely, a stout iron ring was riveted round his neck, from which a short chain passed through a ring made to slide upwards and downwards on an upright massive iron bar, more than six feet high, inserted into the wall. Round his body a strong iron bar about two inches wide was riveted; on each side of the bar was a circular projection; which being fashioned to and enclosing each of his arms, pinioned them close to his sides. This waist bar was secured by two similar bars which, passing over his shoulders, were riveted to the waist bar both before and behind. The iron ring round his neck was connected to the bars on his shoulders, by a double link. From each of these bars another short chain passed to the ring on the upright iron bar. We were informed he was enabled to raise himself, so as to stand against the wall, on the pillow of his bed in the trough in which he lay. But it is impossible for him to advance from the wall in which the iron bar is soldered, on account of the shortness of his chains, which were only twelve inches long. It was I conceive equally out of his power to repose in any other position than on his back, the projections

which on each side of the waist bar enclosed his arms, rendering it impossible for him to lie on his side, even if the length of the chains from his neck and shoulders would permit it. His right leg was chained into the trough; in which he had remained thus encaged and chained more than twelve years (1).

In the inquiry which followed his attitude towards mental illness was clearly stated and with no sense of self-criticism or doubt by Monro, who when asked about his objections to chains and fetters as a mode of restraint said 'They are fit only for pauper lunatics; if a gentleman was put in irons he would not like it. I am not accustomed to gentlemen in irons; I never saw anything of the kind; it is a thing so totally abhorrent to my feelings that I never considered it necessary to put a gentleman in irons.' He had never done so in the private house which he kept for about forty fee-paying patients. It was not necessary to use physical restraint because he had as many servants as he had patients. He admitted that in Bethlem at this time for 122 patients there were only five attendants.

There was nothing surprising in all this. Indeed the practice of providing entirely different forms of treatment for the rich and the poor had been continued for centuries, throughout the whole of the Christian era. In ancient Rome, slaves who became mentally ill were flogged, starved and restrained in chains. Indeed the chronic undesirables or psychopaths were put to death. On the other hand the Roman citizen could expect sedation with opium, entertainment, music, good food and a quiet environment. Historians of psychiatry tell us little about the treatment of the well-to-do during the medieval period and that which followed the Renaissance. No doubt many sick people were hidden away and looked after by their relatives. The insane poor were either neglected and left to roam the country or treated as criminals. The medieval church had identified mental illness with witchcraft and heresy. For three centuries after the publication of the *Malleus Mallificarum* (The Hammer of the Witches) in 1487, countless thousands of the mentally ill in Europe, including women and children, were burnt to death. The last 'witch' was executed in Germany in 1775 and in Switzerland in 1782. Matters were better, but only a little better in the

England which followed the Reformation. In 1736 the laws against witchcraft had been repealed, twenty years after a woman and her nine-year-old daughter had been hanged in Huntingdon for selling their souls to the Devil. In the eighteenth century Bethlem had been used as a zoo for the public. In 1770 when John Haslam was a boy of 6, £400 had been collected from visitors' pennies. Twenty-five years later when Haslam was appointed to Bethlem, the French revolution was in full flood and Philippe Pinel had just persuaded the Commune in Paris to allow him to unshackle and release the wretched patients in the Bicêtre. The last decade of the eighteenth century, despite its horrors, was a period of great advance of the human spirit. 1796 was also the year when William Tuke opened the Retreat at York for the humane treatment of the mentally ill. The object was to provide a family environment. The patients were regarded as guests, not 'inmates'; chains and manacles were forbidden. The Tuke family were Quakers and the first two generations were laymen. Indeed it seemed to William Tuke that doctors were not required. In 1813 his grandson wrote: 'The experience of the Retreat if it should contribute in some degree to the improvement, will not add much to the honour or extent of medical science. I regret that it will be the business of the present chapter to relate the pharmaceutic means which have failed rather than to record those which have succeeded' (1). The 'moral treatment' of the insane at the Retreat caused a profound impression both nationally and internationally. William Tuke at the age of 83 gave evidence before the Parliamentary Commission whose report led to the dismissal of Haslam and Thomas Monro from Bethlem in 1816.

The first half of the nineteenth century witnessed a profound change in the attitude of society to the socially deprived, the exploited, and to the many classes of afflicted persons, including the mentally ill. For the first time the sentiment of humanity was now a great force in politics. Slavery was abolished at the cost of £20 million to the British taxpayer; factory legislation stopped the abuse of child labour and although England remained, as Disraeli said later, divided into two nations—the rich and the poor—the great movement towards reform slowly effected

changes in many aspects of national life. The enlarged sympathy with children, wrote G. M. Trevelyan (2), was one of the chief contributions made by the Victorian English to real civilization.

The tragedy of John Haslam, whose intelligence was undoubtedly of the highest, whose scholarship outshone that of all his contemporaries and who introduced to psychiatry the methods of observation of the clinical scientist, can be regarded as a prophetic warning to a profession that has always resisted change. By hindsight we can see that despite his scholarship and his science he was a man out of step with the new century, blinded by prejudice. Until his time the chief characteristic of the insane had seemed to be their 'fury'—their inexplicable violence and aggressive behaviour. Regarded for centuries as evidence of demoniacal possession, by the time of Haslam many saw this as being the direct consequence of an endogenous process affecting the nervous system, the result of unknown disease. The main method of psychiatric management was therefore aimed at reducing and controlling this aggressiveness and the use of chains, fetters and manacles were logical consequences of this belief. To reduce the 'fury' of the insane, bleeding, purging and gross physical restraint and deprivation of normal human amenities were pitilessly applied. The 'Darwin' chair, invented by the great biologist's grandfather, Erasmus, caused the insane to be rotated 'until blood oozed from their mouths, ears and noses. Castration and starvation cures were also employed' (3). It was in revolt against this concept of mental disease, this view of human personality and the meaning of illness, that 'moral treatment' was introduced. But Haslam and many less distinguished than him would have none of it. 'Because of the current state of affairs,' wrote Ackernecht, 'treatment of the insane was largely in the hands of chief warders of the institutions and not in those of the physicians. Among these chief warders were many intelligent and humane individuals who discovered, often before the doctors did, that psychotherapy was more effective than the usual methods of purgation and blood-letting.' It was not the last time in the history of medicine that great advances in the care of the sick were to be introduced, not by the medical profession, but by informed and humane laymen.

To the end of his life Haslam maintained an attitude of arrogance and contempt for the Tukes and Pinel. He did not understand the humane basis of moral treatment but rather believed that those who practised it were able to induce in the insane a fear which controlled their fury. Writing of one such practitioner of non-restraint, Dr Willis, 'it is said that sweetness and affability seem to dwell upon his countenance; but his character changes the moment that he looks on a patient: the whole of his features suddenly assume a different aspect, which enforces respect and attention from the insane. His penetrating eye appears to search into their hearts, and arrest their thoughts as they arise. Thus he establishes a dominion which is afterwards employed as a principal agent of cure' (4). With a characteristic lunge at Pinel, who believed the English to have special gifts for the moral treatment of the mentally ill, Haslam wrote: 'if any influence were to be gained over maniacal patients by assumed importance, protracted staring or a mimicry of fierceness, I verily believe that such pantomime would be much better performed in Paris than in London'.

During the years after the victory over the French, England despite her great wealth suffered a grave economic depression. This affected the social classes of the population differentially—the rich becoming richer, the poor, poorer. Unemployment and extreme poverty spread through the working classes both in town and country. In 1816 when Haslam was displaced, 'a savage anger, unknown in England since the civil war, spread through the labouring classes' (5). Riots followed which were met by the authorities with savage reprisal. The distress and destitution of a large section of the people went on for years and the paupers became a national problem. Civil war and anarchy at times seemed imminent. Yet at the same time from among the educated middle classes the spirit of reform, based upon understanding of human needs, was kept alive and grew. Yet the new Poor Laws of 1834, enacted to relieve the problems of poverty and the paupers, were so cruel and so oppressive that their implementation in many areas was impossible. They created the distinction between the 'deserving and the undeserving poor'—a distinction which was to last for at least until the end of the century. It was

a distinction which was to make the work of the first medical social workers (the 'almoners') so embarrassing and so difficult. It was ridiculed with salutary wit by Bernard Shaw in *Pygmalion* even in 1912. The 'undeserving poor' by the conditions laid down found the relief and aid offered them so distasteful and cruel that there was every incentive to avoid the help for which the Poor Law made provision. In the Poor Law institutions—the workhouses—administered by the local Boards of Guardians, were many of the mentally ill who were paupers.

By 1841 the asylum building programme, initiated by the 1808 Act, had made a start. At this time according to Walk and Walker (6) fifteen English counties had complied. Many of them were at first small (Nottingham 170, Gloucester 250 beds) but some, like Hanwell with over 900 beds, were regarded even at the time as much too large. This was not to prevent the later building of giant asylums with 2,000–3,000 beds. The finance for these developments came partly from the local councils and partly from private subscriptions. The asylums at the start, therefore, had two classes of patient, the paupers who were rates supported and the fee-paying patients. The latter necessarily were given the best accommodation and the different conditions developed for these two classes soon gave rise to criticism. An example described by Walk and Walker (6) was the new Gloucester asylum of which the original architect was John Nash. The main centrepiece of the building is a magnificent regency crescent, which was reserved for the 'opulent' patients, while the 'pauper' wing projected back from the centre of the curve. This section of the building 'was divided longitudinally by a wall separating male and female wards so that the single rooms on each side were back to back and received no daylight or ventilation except indirectly from windows on the narrow gallery running in front of their doors'. The design was such as to favour the interests of the attendants rather than those of the patients.

The county asylums were administered by the county authorities, at that time the justices of the peace, and it was a misfortune that after 1834 when the new Poor Law was enacted the large workhouses where many destitute persons were to be placed came under the control of the local Boards of Guardians.

Thereafter until 1867 these two types of institution went their separate ways. 'The problem', wrote McKeown (7), 'which had plagued reformers for two centuries was to relieve distress without encouraging idleness, and the legislation reflected anxiety about souls as well as bodies. The Poor Law Amendment Act of 1834 was unquestionably concerned with souls, for its object was to end domiciliary aid to able-bodied paupers by making admission to an institution where they could be put to work a condition of public assistance.' But of course they not only admitted the destitute but also the sick. In 1867 Parliament authorized the building of infirmaries for the destitute, and these came in London to be controlled by the Metropolitan Asylums Board. Thus for many years there was an unsatisfactory division of responsibility for the mentally ill between asylum and workhouse, administered by different people with different resources, with different aims and with different attitudes to those under their care.

In 1859 there were approximately 17,500 patients classified as paupers in county asylums or under contract in licensed houses (private institutions). But these were only some 54 per cent of all pauper patients. About 7,000 were in workhouses and a further 8,000 patients were living 'with friends or elsewhere'.

Thus, wrote Dr Alexander Walk (8) reviewing the progress of 100 years, a tripartite classification could be observed—foreshadowing the situation of responsibility which was in the future to be shared by hospital boards, local authority residential homes and community care.

The disadvantages of the system of separate responsibility were most severe, of course, for the patients. Everything was done to save the taxpayer money and the workhouses were very cheap. Although the Poor Law Commissioners had pointed out to the Boards of Guardians that the 'first object ought to be cure by proper medical treatment, which could only be obtained in a well regulated asylum' and that to retain a curable lunatic in a workhouse was highly objectionable, nevertheless there was reluctance to transfer patients to a more costly form of treatment. Walk (8) has pointed out, moreover, that the Guardians took advantage of a misrepresentation of the law which had stated that

it was prohibited to detain a *dangerous* lunatic in a workhouse for more than fourteen days, assuming that it was therefore legal to detain those not dangerous. This practice continued to defeat the reformist movement in the treatment of the mentally ill and 'the shadow of the workhouse hung over the sufferer from mental disorder almost as much as it did over the physically sick and infirm'.

The policy aimed at keeping the 'less deserving' mentally ill out of mental hospitals was reinforced by the Lunacy Act of 1890 by which only those who were certified could be admitted. This continued until the act of 1930 which allowed mental hospitals to admit voluntary patients. But even this was resisted, the fear being that the hospitals would be overwhelmed by requests for admission. The London County Council, which administered about 30,000 mental hospital beds decided that those who wished for admission should first be screened by the medical staff of the Maudsley Hospital, to ensure that treatment was necessary.

THE DEVELOPMENT OF HOSPITALS

The first hospitals were almshouses provided by the monasteries for the shelter of the aged, the destitute, the chronic sick and the severely handicapped. McKeown (7) states that there were about 700 of them in England before the Reformation, but few survived the suppression of the monasteries, although Bethlem was an exception. By 1700 there were less than a dozen hospitals in the whole country and most were in London. The voluntary hospital system which developed throughout the eighteenth and nineteenth centuries and which was to form the physical basis for the future teaching hospital was founded by rich laymen, or by Royal Charter. The hospitals derived their money from endowments, voluntary subscriptions and donations. They were governed by the people who had contributed most and these people could determine admission policy. Very soon admissions were also influenced by the medical staff who gave their services free. At first there was no intention to exclude any class of patients, but as they existed to relieve the suffering of the poor, only the poor went to them. Very soon restriction on admission began. St Thomas's, for example, in the seventeenth century

only admitted cases expected to be curable and others followed suit (9). By the mid-nineteenth century children and obstetric cases had been excluded and admission was largely restricted to short-term illnesses. In this policy the medical staff played a large part, for the policy was said to be good for teaching purposes and to make the best use of the beds. Special hospitals developed in the last century for conditions for which voluntary donations could easily be obtained and for many specialities of medicine this was the case: e.g. neurology, eyes, chest diseases and obstetrics.

Three big classes of patient did not attract charity and numerically they were very large—the chronic sick, the infectious and the mentally ill. Because the voluntary hospitals, which had become the pride of the rich citizens who had supported and administered them and the source of pride and status of the doctors who worked and taught in them, refused to accept so many classes of sick people, it was necessary that other institutions should be created. The Poor Law workhouses were terrible places and in 1867 Parliament authorized the building of separate infirmaries that were designed as true hospitals and later became the municipal hospitals which were set up in every city and large town throughout the country. These were administered by the local county and borough council authorities and were paid for out of the local rates. An interesting thing happened. As their medical care and standards improved, they began to emulate the voluntary hospitals and to start the restrictive practice of limiting admission to acute cases and to accept patients above the pauper class. Thus the chronic disabled and infirm, and the destitute elderly were passed down the line from the voluntary hospital to the municipal infirmary and finally to the workhouse (7). In these places were also to be found many mentally subnormal persons, many mentally ill, those with venereal disease and many classes of the chronic sick. Before 1700 few mentally ill patients entered any kind of institution. In the eighteenth century mentally ill patients were excluded from the voluntary hospitals, but a few private asylums had been started. After 1808 the building of county asylums was first permitted and later enforced by Act of Parliament and into these places the mentally

ill who were paupers were admitted. The mental hospitals therefore developed separately from the Poor Law infirmaries and it was not until 1889 that these asylums were transferred to the new county and county borough councils who remained responsible for them and for the municipal general hospitals until 1948.

The stigma of insanity, the fear of the mentally ill, the distaste with which the subject was viewed not only by the lay public but also by the medical profession, the chronicity of many forms of mental disorder, the lack of any effective treatment and the large number of persons afflicted which meant large expenditures of money to care for these patients had certain consequences when the first mental hospitals were built in the mid-nineteenth century. It seemed that the asylums had to be very large and many of them came to have 3,000 beds. They therefore had to be built on land which was cheap, that is, not in towns or cities but in rural areas. Money that could be provided was small in comparison with needs and this meant overcrowding, very poor buildings, inadequate diet, clothing and amenities for patients. It was very difficult to get away from the centuries-old belief that the 'mad are ipso facto bad'. They had been treated as criminals, indeed worse than criminals, for so long. This meant that there was not only geographical but also ideological isolation of the mentally ill and those who cared for them, the doctors and nurses. The effect on medical education and on the development of psychiatry as a medical scientific subject was profound, and this went on well into the present century. It was not until 1930 that a patient could be admitted to a municipal mental hospital except committed as a certified patient. When medicine became a university subject, the medical schools and their associated teaching hospitals were built in the main cities and in fact the old voluntary hospitals became the teaching hospitals. Thus the places where medicine was taught and where it was developed as a scientific subject were in the main cities, and the places where the mentally ill were cared for were outside these cities often at distances of twenty or thirty miles. There was little or no contact between the two so that even after the First World War education in psychiatry had hardly developed.

THE NATIONAL HEALTH SERVICE

Those who had the task of creating and shaping the National Health Service before 1948 found themselves with three main divisions of medical activity in the country. There was first the hospital service. Under the Act all hospitals in the country, not only the voluntary hospitals but also all the municipal hospitals—both the general and the mental—became the property of the State. Secondly, there were the local authority health and welfare services which had been administered by the county councils and county borough councils throughout the country and with the coming of the Act these authorities had lost their hospitals. Lastly there were, of course, the very large numbers of general practitioners, and these too entered into contract to provide services for the communities in which they lived. Since all hospitals became the property of the State, the mental hospitals had equality of status before the law with all other hospitals and equal rights to their share of the financial cake. Psychiatric patients for the first time in history were to be treated like all other patients and with them the chronic sick, the geriatric and the chronically disabled. The NHS was greeted with enthusiasm by the underprivileged sections of medicine. The local authorities on the other hand had lost their hospitals and with them much of their status and prestige in the general field of medicine. They became aware, however, of the enormous responsibilities and opportunities which now lay open to them for the care of the elderly, the mentally ill and the other chronically disabled patients who remained in the community. They retained their original functions in the field of public health, the prevention and control of epidemic disease and child welfare.

In 1948 the Ministry of Health inherited a very large number of hospitals, some large, some small; but all were old buildings unsuited to modern medicine and many were dilapidated and urgently in need of repair. Nevertheless the hospitals could be classified into three groups. There were first the voluntary hospitals, both general and special, which in the university towns were the teaching hospitals and these, of course, had the largest prestige and status. Secondly there were the municipal general

hospitals and thirdly, having the lowest status of all, the municipal mental hospitals outside the main centres of population. A process of refurbishing and repair was set in motion and large sums of money were spent on the mental hospitals. In the first ten years about £40 million was spent on mental hospitals alone. At this time the old mental hospitals had carried on their work behind their walls and behind their closed doors. A new spirit found expression in the open-door policy which now, of course, has been accepted throughout the western world. After 1948 there was a great wave of enthusiasm in the mental hospitals; standards were raised, establishments were increased and despite great recruitment difficulties of doctors, nurses and social workers, there was a steady increase of staff. In a ten-year period the increase of doctors in psychiatry was more than 60 per cent. Psychiatrists moved out from their hospitals, started out-patient clinics in general hospitals and started day hospitals, and the idea of a community mental health service began. The duration of stay in the psychiatric hospitals progressively fell, the patients were got home as soon as possible, and many patients who formerly would have been treated in hospital were treated at home, in day hospitals and as out-patients. This movement was greatly assisted by three things. The first was the discovery of the phenothiazine drugs in 1954, which shortened the period of acute psychosis to a few days or weeks and alleviated the symptoms of chronic psychosis enabling rehabilitation. The second was the anti-depressant drugs whose appearance came a few years later. The third was the Mental Health Act of 1959 which made it possible for *any* hospital to accept any psychiatric patient whether informally or under compulsory powers. Thus the legal distinction between mental or psychiatric hospitals and all other hospitals was finally abolished. There was no longer any excuse except lack of facilities for general hospitals and in particular teaching hospitals to restrict the admission of psychiatric patients.

The tripartite nature of the NHS had been accepted from the start; it was an inevitable consequence of the historical development of medical services in the country. Nothing in fact could be done about it. Nevertheless some degree of decentralization of authority and of administration was made. The country was

divided up into fifteen regional hospital board areas. London and the country around was served by four metropolitan boards. Nevertheless the teaching hospitals were given independent status and were not made the responsibility of the regional boards in whose area they were situated. The twenty-six undergraduate teaching hospitals in the United Kingdom and the few special post-graduate teaching hospitals were each provided with an independent Board of Governors answerable to the MOH direct. From the start, therefore, the teaching hospitals remained separate and were given separate status from the other hospitals in the NHS. This has had serious consequences for the development of community medicine as a whole and for psychiatry in particular. The psychiatric departments in the university teaching hospitals at the time when the NHS began were either very weak or non-existent. They have developed over the last twenty years at a very great rate, so that now nearly all university hospitals have active departments of psychiatry. Nevertheless these departments of psychiatry, like the teaching hospitals in which they are situated, have until quite recent years played no role in the development of community medical services. During this period in which the idea of community mental health services was developed, the initiative and the practical application have come from psychiatrists working in the old mental hospitals. They established contact with the communities in which they were situated and with the general hospitals in their region. As a result new units, both in-patient and out-patient, have been set up all over the country in general hospitals. Collaboration, however, between those working in the large psychiatric hospitals and in the community services which they promoted, was at first negligible or non-existent with the new departments of psychiatry in the teaching hospitals in the neighbouring cities, and particularly in London. Thus it can be said that in a sense the ideological and geographical isolation which separated the main work of psychiatry from the growing points of medicine, which we would normally associate with university activity, has until quite recently continued.

The idea that the university teaching hospital should no longer remain isolated from the community in which it is situated, but

should attempt to serve the major medical needs of that community, has at last been accepted. As far as London is concerned there are, however, great difficulties. In London there are twelve undergraduate teaching hospitals which educate and train nearly half the medical students of Britain. They are for the most part situated in the central area of the metropolis, an area which is quite atypical of any community from a medical point of view. In the past many of the patients entering these teaching hospitals have been sent from all over the country because of the rarity and peculiarity of a particular medical condition, or because they required the type of special investigation or treatment which was only available in a teaching hospital. The unsolved problems about the organization of medical care and treatment in the metropolis, and the role which the dozen undergraduate teaching hospitals should play in this, were, no doubt, among the reasons why the Government set up the Royal Commission on Medical Education.

THE HOSPITAL PLAN

The heritage of large numbers of very old hospital buildings for mental patients, many of them containing as many as 3,000 beds, was a great drawback to the development of psychiatry in the country. Nevertheless the development of community care, the advent of psychiatric units in general hospitals, the provision of day hospitals and the effects of the new attitudes to mental illness which had been so greatly helped by the development of psychotropic drugs, gave rise to the idea that in time some if not many of these large hospitals could be closed. In 1961 Tooth and Brooke (43), summarizing these trends, anticipated that there would be a decline in the need for psychiatric hospital beds which at that time were 3·3 per thousand of the population. It was anticipated that the number would fall by 1975 to 1·8 beds per thousand of the population. This would mean that many of the ward-blocks in these old hospitals could be closed and no doubt some of the hospitals themselves could be pulled down. It was therefore decided that no new psychiatric hospitals should be built, but that wherever a need for greater provision of psychiatric beds was evident, these beds should be built as units in general hospitals

within the cities and towns. As an example, after 1948 the Manchester Regional Board set up psychiatric units in general hospitals in its region. These units varied in size from 68 to 250 beds. They served populations varying from 120,000 to a quarter of a million people. These units were said to be truly comprehensive for all types of patients.

The success of the psychiatric units set up in the Manchester region in general hospitals has been acclaimed, and will be considered further in chapter 5. It was anticipated that small units of 60 or 100 beds would very soon silt up with chronic patients, particularly chronic schizophrenics and elderly people. It was thought that it would be necessary for them to keep close relations with the large mental hospitals of their region and that very soon unless these units were to become blocked that they would have to transfer many patients to the larger hospital. But this has not occurred.

In 1962 the Government published the Hospital Plan setting out the aims and expectations for the ensuing fifteen-year period. This plan gave the first clear account of the concept of the District General Hospital, a large hospital serving the needs of a given population. At first it was thought that the district general hospital should have about 800 beds which would enable it to serve all the acute medical and surgical needs of a population of 150,000. In this hospital there were to be units for general medicine and surgery, for pediatrics, for obstetrics, for geriatrics, an isolation unit for infectious diseases and finally a substantial psychiatric unit having about 60–80 beds. The concept of the district general hospital has grown and it is now envisaged that it will be considerably larger and as a consequence will serve a larger population and the separate units in it will therefore be necessarily larger. In such a hospital there will be a wide range of facilities required for diagnosis assessment and treatment. It is anticipated that the standards in such hospitals will be high and that the distinction between them and the teaching hospitals, which they should closely resemble in many features, will gradually disappear. District general hospitals may well play an important part in the future in postgraduate education, not only for hospital doctors but also for GPs. Already a few

new District General Hospitals have been built in areas where the hospital service is inadequate. In other areas general hospitals have been altered to meet the new plan and in some, groups of hospitals have been put together to fulfil the concept of the District General Hospital. Since there is a very large number of small and isolated hospitals, it may happen that in the future many of these small hospitals in the smaller towns will disappear. In the future one can anticipate that a plan will develop in which all the acute medical needs of the population will be served by a system of designated large District General Hospitals distributed throughout the country. The inclusion of psychiatric units in all these hospitals will have very beneficial consequences for the subject. This means reintegration of psychiatry in medicine —a process which many have worked for but which has not been possible for several centuries.

2

The development of psychiatric education: some historical aspects

Changes in both undergraduate and postgraduate medical education have been retarded by the concept that at graduation the medical product is the 'complete doctor'—'the safe general practitioner'. The concept was introduced by the Medical Act of 1886, and is still the legal requirement. The Goodenough Committee accepted it but the Todd Commission implicitly did not. Postgraduate education and vocational training for all branches of medicine is now accepted. For historical reasons psychiatry until the last decade has played a minor role in undergraduate education; postgraduate education, except in a few centres, has hardly existed. The academic development of psychiatry was retarded for many years because of the isolation of the subject. The recent creation of university departments in most medical schools should change the prospect. The role of a few outstanding individuals, the Universities, the Royal Colleges, and the Royal Medico-Psychological Association in initiating change is examined.

Postgraduate vocational training and education for a particular career in medicine is not a very new idea in Britain. The Goodenough Committee (10), working on the Government's decision to create a National Health Service after the war, paid great attention to it, but remarked that the number of beds in special departments of general teaching hospitals was so few, that they would have to confine their efforts to undergraduates. They looked to the special hospitals to provide postgraduate education, and in London recommended the organization of postgraduate institutes attached to specialty teaching hospitals—an idea which was to be realized in the British Postgraduate Medical Federation. They did not propose, however, that such institutes should be restricted to London. The Royal Commission on Medical Education

(11) paid even greater attention to postgraduate vocational training —recommending it for all doctors—and while they advised a great increase in the output of doctors from the undergraduate medical schools, suggested the reintegration of the postgraduate institutes with the undergraduate schools. It is feared in many quarters that if this advice is followed the developments in the postgraduate field which have only recently established themselves will be wrecked.

The Medical Act of 1858 which established the General Medical Council was designed to bring some order and co-ordination of the standards of undergraduate medical training in Britain. The Act of 1886 set forth the requirement that the qualifying examination for doctors should be in medicine, surgery and midwifery and that the required standard 'shall be such as to guarantee the possession of knowledge and skill requisite for the efficient practice of medicine, surgery and midwifery'. Thus the law which is still yet not amended, makes it clear that the object of undergraduate medical education is to produce the 'complete' doctor, equipped to practise any branch of medicine, to perform any sort of operation, to meet the needs of any sort of patient. The ideal and purpose was to produce the 'safe general practitioner'. In the context of modern medicine we know that this makes little sense. In the first four decades of the present century great efforts were made to bring medical education more closely under the umbrella of the universities and to set up professorial departments at least in the major subjects of medicine and surgery. The Goodenough Committee did not foresee in 1944 what had become apparent to all by the time the Royal Commission reported in 1968, that vocational training would be needed for all doctors, and suggested that the undergraduate curriculum should have a definite bias towards the needs of the future general practitioner. The first to challenge this view was a committee of the British Medical Association which provided a report on *The Training of a Doctor* in 1948 (12), and Lord Cohen who was its chairman was later to write that his committee held that

general practice is a special form of practice which must be founded on general basic principles and appropriate *postgraduate study*. In the

committee's view the undergraduate medical course should be primarily concerned with the training in those basic principles of medicine which are the necessary foundation for all forms of medical practice (13).

This concept the GMC was fully to accept in its 1967 recommendations as to the undergraduate curriculum, the title of which was changed to 'Basic Medical Education'. Only in the last two years have responsible educational bodies accepted this principle.

Postgraduate training for most branches of medicine has been usually acquired, with the exception of certain facilities, in London, by apprenticeship to specialists working in teaching hospitals. Until after the Second World War many subjects, including psychiatry, general practice and social medicine were excluded, specialists in these subjects having at most a nominal attachment to their hospitals, or such teaching as they did was aimed at undergraduates. For many subjects including psychiatry, participation in undergraduate courses was minimal and for several reasons. The curriculum had become grossly congested. As each new branch of medicine and surgery developed it added its quota of clinical teaching to what was conceived necessary for the 'safe general practitioner'. New knowledge in physiology, biochemistry and pathology had to be included in the clinical part of the curriculum. The representatives of each subject clung fiercely to their share of the student's time and despite anxiety and remonstration by responsible bodies nothing could be done to lighten the increasing load on the medical student. There was little response to the advice of the GMC (1957) 'to instruct less and to educate more'. The battle for the student's time rather than his mind went on the whole to the teachers of the subjects which over the years had been most strongly entrenched in the teaching hospital scene—those with beds. In this psychiatry was poorly placed. Finally the Medical Acts in defining that 'the qualifying examination' for the fully registered medical practitioner was to be in medicine, surgery and obstetrics, left it open to the medical hierarchies in the Faculties of Medicine and in the Royal Colleges to determine what the meaning of, for example,

'medicine' was. The pressure, as far as London was concerned, instigated by the Haldane Commission (1913) to bring medical education firmly into the hands of the university and to make a 'single portal of entry' to medicine (14), conflicted with the long established right of the Royal Colleges to provide conjoint diplomas as a 'portal of entry' for the practitioner. This delicate but in past times closely contested debate, was reopened once again in 1944 by the Goodenough Committee who saw in London 'a constant competition between the university on the one hand and the English Conjoint Board and the Society of Apothecaries on the other'.

At this time only 5 per cent of male medical students, reading for a university degree, and trained in the schools of the university of London, took the university degree as their first qualification—and only 45 per cent ever did so. Why, the Committee asked, should those bodies which conduct examinations but have no teaching responsibilities 'realize a considerable surplus from examination fees'? Why should the clinical courses of instruction provided by the medical schools and aimed at the attainment of a university degree, be continually disarranged and fragmented or worse still tailored to meet the needs of students who wished to take various parts of the Conjoint examination? Further, if large public funds were to be provided in the future for the training of medical students, should not the surplus obtained from examination fees be applied directly to the costs of the student's training? The trouble was that the university never provided adequate funds for the teaching of medicine.

The Goodenough recommendations did not significantly alter the situation in London. Evidently the fight for the control of university medicine in London had still to be won within the faculty of medicine itself. The problem of divided loyalties among the teachers of medicine is a problem which few care to face in all its implications. The solution may be found in the future if the Royal Colleges who clearly have a tremendous opportunity and role in postgraduate vocational training accept this as their particular responsibility and hand back to the universities the responsibility which clearly belongs to them for basic medical education.

But this issue is by no means decided. The Royal Commission on Medical Education (1968) noted that over 500 candidates annually from British medical schools were awarded non-university qualifications, but that less than 5 per cent (only 235) had to rely solely upon such qualifications for admission to the Medical Register (11). Nevertheless the Commission thought that, with a few exceptions, 'medical students at British universities should not be allowed to enter for a non-university qualifying examination until they have completed their medical degree course'.

In the years between the two world wars, successful consultant practice depended upon an appointment in a teaching hospital where a consultant gave his time and his teaching free. Most of his time was spent in his private practice upon which his livelihood depended. But his prestige, his status in the profession depended upon his hospital appointments and these were greatly coveted. Through them he was able to advance his subject, influence medical policy and become known and respected as a (or the) leading exponent of his particular specialty to generations of students who would in the future supply him with patients. It was vital to him that he should protect and if possible expand his share not only of the hospital facilities for the treatment of patients, but also his share of the students' time. The right to control of beds was a sign of appointment to the senior staff and many junior consultants had to wait in the wings for years to obtain this privilege, acting as physicians to out-patients, assistant physicians and so forth. Once he had acquired this favoured status and a number of beds allocated by the medical committee of his peers, the consultant protected his right to retain them and fought with a dogged tenacity for each one against the inroads which new specialties and new aspirants tried to make. For years psychiatrists came low in the pecking order, suffered from the humorous, but always firm rejection by their colleagues. But they and psychiatry had been caught up in a vicious circle which no one in the profession could break. The Goodenough Committee while assuming that everyone would agree (which they did not) that psychiatry should occupy an important place in medical thought and practice, asked the question: 'why has the

provision of training in psychiatry failed to keep pace' with this need? They thought the contributory causes were as follows.

(i). The mental hospitals and their medical staffs have been almost completely isolated from the general hospital service and there have been very few posts for psychiatrists in the teaching hospitals.

(ii). As a result there has been a discouragement to the recruitment of the ablest practitioners to this branch of medicine. There has also been a lack of stimulus to those who have specialized in it to acquire that measure of experience in general medicine that is usually obtained by men in other branches of medicine before they embark on studies and posts peculiar to their specialty.

(iii). Hence psychiatrists as a class have tended to lack prestige in the medical profession possessed by other practitioners of consultant status. There are notable individual exceptions.

(iv). Owing to the limited opportunities for work in the teaching hospitals, most of those psychiatrists who did not wish to confine their interest to the psychoses and to work in mental hospitals have been compelled to give their services to clinics separate from, and independent of, the medical schools and teaching hospitals. Many of these clinics met a real need and have provided useful courses of training, but their detachment from the main body of medical education and practice has deprived their staffs of that contact with other branches of medicine which is necessary for progress and the preservation of a true perspective and has weakened their influence on the development of medical education.

This was all very discouraging. Psychiatrists lacked prestige, status and opportunities in teaching hospitals because of the isolation of the subject. Those who did not wish to study psychoses and work in mental hospitals, worked in clinics so divorced from medical science that they had no influence on medical education in the schools. Psychiatrists were not well enough educated first as doctors, then as psychiatrists, and there were very few who could teach their subject. In any case 'accurate knowledge . . . is still of modest dimension'.

I think the Goodenough Committee[1] had the knowledge and

1. It is of interest that only three psychiatrists gave evidence before the Goodenough Committee. While the Association of Royal Mental Hospitals in Scotland and the Institute of Psycho-Analysis gave written evidence, the Royal Medico-Psychological Association gave neither written nor oral evidence.

the awareness to have set in motion the changes that were necessary to alter all this. They clearly had the diagnosis but when it came to treatment, they faltered and their prescription was the wrong one. They supported the idea of large postgraduate training centres in London (at the Maudsley) and in Edinburgh, but they were in any case already in existence. Nevertheless the Good-enough Committee certainly recommended their expansion and development. No doubt the Committee believed that it was impossible or unwise to attempt to provide adequate undergraduate education in psychiatry because the teachers did not exist, and it was necessary first to provide these teachers. Although the Committee understood the needs of undergraduate education in psychiatry, the prescription was almost a repeat of what had been attempted before. They recommended that the main clinical teaching should be in the out-patient department, where there should be supervised case-taking, and practical demonstrations not necessarily given by psychiatrists, although reciprocally psychiatry should have the freedom to teach in the general wards of other consultants. There should be a *few demonstrations* in a mental observation ward, at a mental hospital and at a mental deficiency institution. Nowhere is there the suggestion that there should be a psychiatric department with in-patient beds, or clinical clerking in the subject. It was left to the UGC, backed by an MRC that deplored the failure to develop psychiatric research in the medical schools to press for changes fifteen years later. But let us turn aside from the events of the last quarter of a century and before considering the present scene, look at those influences from which ultimately change was to be brought about.

SOME PIONEERS

The first psychiatrist to be given formally the right to accept pupils (1753) and to teach, certainly in England, perhaps in the world, was William Battie (1703–76). He was a distinguished physician of his day who became President of the Royal College of Physicians, was Harveian Orator in 1746 and for many years was a governor of Bethlem. He had appointed John Haslam's predecessor as the first Resident Apothecary and he had helped to found in 1751 St Luke's Hospital, 'another hospitall for

Lunaticks', in Moorfields near to the old Bethlem. Hunter and Macalpine (1) write of him that as the first physician of repute with a scientific background (he was an FRS) and a distinguished social position, he had made insanity his whole time work and raised the 'mad business' to a respectable medical specialty. He began to publish his observations on the insane—a thing his neighbours at Bethlem had never done. There was a good deal of enmity between Battie and the Monro of the day at Bethlem. St Luke's and Bethlem went their own ways and two centuries later in 1948 the former foundation became the psychiatric in-patient unit of the Middlesex Hospital, while the latter became joined to the Maudsley Hospital. Each therefore maintained their teaching hospital status. There is little evidence that Battie's clinical teaching had much influence; nearly a century later in 1843, the Governors of St Luke's tried to renew the teaching and a course of clinical lectures was given annually to selected pupils who could attend them free of charge (15).

THE ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION

In 1841 an association of the Medical Officers of Lunatic Asylums was formed, with a membership of 44. They were the first psychiatrists in the new asylums which had been built by the local authorities on a nation-wide basis. This was the association which was to become the Medico-Psychological Association later to be given a Royal Charter. It has had over the 128 years since its creation a sustained and growing effect not only on the standards of psychiatric practice in Britain, but also upon the educational development of the subject. Increasingly, by reasons of its meetings and the quality of its journal (the *British Journal of Psychiatry*, formerly the *Journal of Mental Science*), it has provided the major forum for scientific debate in the country. From the beginning it has operated as a learned society.

In the third year of the Association's life (1843), John Conolly was its Chairman. The Association had dedicated itself to improve treatment, to gain knowledge of insanity and to study 'medical and moral treatment'. But Conolly, within four months of appointment to Hanwell Asylum in 1839 when there were 800 patients, had removed all forms of physical restraint, then in

general use in all the asylums. His example gradually spread. The superintendents, while paying little attention to the Tukes at the Retreat in York, or even to Pinel, listened to Conolly who came from a different background. As a young man he had established a fine reputation as a writer on medico-social issues and as a physician. He had helped Sir Charles Hastings to form the association which was to become the BMA. He attended the first meeting at Worcester and gave the anniversary address in Birmingham at the third meeting in 1834. He had had the distinction of being the first Professor of Medicine (1827–31) in the newly formed University of London (University College), but at this time there was no University Hospital for teaching, only an out-patient clinic, and 'internal strife fostered by an autocratic warden, refusal of the Managers to pay a living wage so that Professors were forced into private practice against Conolly's principle that they concentrate on teaching and research' (16), all this was too much for him and he resigned. Later he devoted himself entirely to psychiatry. He was not only very critical of contemporary methods of physical restraint, which largely through his influence came to be abolished, but also of the attitudes of the medical profession to psychiatry. He believed that only by clinical teaching of the subject could the matter be put right. He wrote what has been re-echoed and restated again and again through the century since his death.

> They (medical men) have sought for, and imagined, a strong and definable boundary between sanity and insanity, which has not only been imaginary and arbitrarily placed, but, by being supposed to separate all who were of unsound mind from the rest of man, has unfortunately been considered a justification of certain measures against the portion condemned which, in the case of the majority were unnecessary and afflicting.

To remedy this evil he suggested that doctors should be taught to be as familiar with disorders of the mind as with other disorders and that to this end each lunatic asylum should become a clinical school in which medical students might prepare themselves for their future duties (1).

At Hanwell, clinical teaching started in 1842. After physical restraints had been removed and 'all violent and irritating methods

of control', the student 'could contemplate disorders of the mind in their simplicity', the patients being 'presented to observation as subjects of study and reflection, and not as criminals'. Bethlem followed suit in 1848 and the hospital was open for clinical instruction, lectures were given, the courses lasting four months and held twice a year. Thus by 1848 there were three hospitals in London—St Luke's, Hanwell, and Bethlem—where postgraduate instruction could be obtained, and in Edinburgh Alexander Morrison had given courses of lectures in psychiatry for twenty years. For many years after 1864 when the Professor of Medicine, Laycock, espoused psychiatric teaching, Edinburgh acquired and sustained the reputation of being the leading teaching centre in Britain.

The opportunities for the RMPA to provide psychiatric education have always been very limited, although after 1886 it provided a Certificate in Psychological Medicine for doctors who had had three months' clinical experience in mental disorders or who had attended a course of lectures on the subject and who had followed the practice of a mental hospital where there was some clinical teaching. The examination which continued for over fifty years consisted of written, oral and practical parts. When the DPMs provided by the universities and the Royal Colleges were introduced after 1910, the importance of the certificate of the RMPA which was never great became much less, but the introduction of DPMs came about largely as the result of the pressure brought upon the universities and colleges by the RMPA. The first to respond were the Royal College of Physicians of London and the University of Edinburgh.

ROYAL COLLEGES OF PHYSICIANS

While universities gradually accepted an increasing responsibility not only for providing medical degrees, but also for providing medical education and clinical instruction which led to their first degrees, they have never held it to be part of their business, except in a few subjects, to involve themselves in postgraduate education. This has always been the prerogative of the Royal Colleges, whose membership and other specialty diplomas were given after an appropriate theoretical and practical examination, preparation for which involved the student in a necessary period of postgraduate

study, which in the case of the specialty diplomas was usually prescribed. In the case of psychiatry the conjoint DPMs of London and Edinburgh served an invaluable purpose for several decades and the majority of psychiatrists took one or other of them as they still do.

However, it has never been a function of the Royal Colleges themselves to provide clinical training or educational courses for those sitting their examinations. Royal Colleges were, in the first instance, set up not for an educational purpose, but to protect the public from quacks, and to maintain standards of practice within the profession. To this end they were given the power to grant licences to doctors to practise. As far as undergraduate training was concerned, the Royal Colleges became licensing and examining bodies, not educational bodies—and insofar as their involvement in the postgraduate field was concerned they continued to operate on these principles.

For the majority of postgraduates who aspired to a career as a consultant hospital doctor in general medicine, surgery or obstetrics or in one of the specialties nearly allied to the major subjects, there were for several decades opportunities to serve apprenticeships in a junior capacity in one of the teaching general hospitals. Education and vocational training insofar as it was provided, depended upon whether the aspirant to consultant rank could acquire a post in a teaching hospital. If he could do this, then he could obtain the benefits of the relevant basic science departments in the associated medical school. But this, of course, was again dependent upon whether the specialty which the postgraduate wished to study was represented as a clinical service or department in the teaching hospital itself. If this was not the case, and as has already been pointed out, many specialties including psychiatry had already been excluded from the teaching hospital scene, the postgraduate had little or no opportunity for obtaining supervised instruction of any kind. Before the Maudsley Hospital started courses of lectures and lecture/demonstrations, which young psychiatrists in the London mental hospitals were given leave to attend, very few of those taking the conjoint DPM in London had received any formal education in psychiatry. The limit of responsibility accepted by the Royal Colleges was to prescribe

conditions of entry to their examinations, to indicate in which hospitals or departments appropriate clinical training could be obtained, and to maintain the general standard of their examinations.

UNIVERSITY PARTICIPATION

The idea that training to be a doctor was a university responsibility came very slowly. The teaching hospitals and the universities had had different roots, were often geographically apart and pursued different objectives. The former existed for the pursuit of knowledge and scholarship, the aim being to produce scholars and teachers; the latter to produce a vocational product, a doctor who had mastered the healing art. Medical science had to be developed which would bridge the gap. Only after the First World War were professorial units in the main subjects of medicine, surgery and midwifery set up in a few London medical schools and the majority were to do so, some reluctantly, after the Second World War. Training for medicine throughout the last half of the nineteenth and the first decades of the twentieth century had been largely by an apprenticeship, which followed a general survey of the sciences on which medicine was held to depend—chemistry, physics, geology and mineralogy, but the main emphasis was a rigorous training in topographic anatomy. Later some sciences were dropped and in their place others were introduced—physiology and comparative anatomy, zoology and biochemistry, pathology and pharmacology. Only very gradually did knowledge of these sciences appear to have any relevance or to make any impact on the student's mind during the period of his clinical training, which remained strictly vocational in character. The medical schools, and the scientists who were its teachers of the 'pre-clinical' period, and the teaching hospitals and the clinicians who looked after the sick and taught the students how to do so, were in most cases men of different casts of mind. They had different allegiances and were governed by different institutions. The problem of how to bring them together, so that each should influence the other, so that the discoveries and methods of thought of the scientist and the needs of clinical medicine should be common to both—of how to produce a *true medical science*—has been the preoccupation of medical educators of the last fifty years.

Psychiatry as a clinical or academic subject was largely excluded from the debates and the changes in the medical scene which witnessed the gradual absorption of medicine as a university activity. There were a few to represent the subject, but their voices were not heard. The enormous load on society of its chronic sick and disabled, either physically or mentally, had made little or no impact upon the teachers of medicine in the teaching hospitals, even less on the physical and biological scientists in the Faculties of Medicine. Only after 1948, when the State became responsible for the health and welfare of the entire community did these things gradually impinge not only upon the public but also upon the medical and scientific conscience.

The psychiatrists in the asylums writing in their journal, and the successive presidents of their association in their annual addresses continued to press that better provision should be made for the training in the specialty and that the universities should take part. The GMC in 1893 proclaimed that mental disorders should be a part of every medical student's education. This later led to visits by students to mental hospitals and to demonstrations of the chronic insane, often a derisory and frivolous experience for them. Formal courses of lectures in the medical schools were also introduced. But the GMC neither at that time, nor later, suggested that the subject should be included in the final examination, and until recent times psychiatry was, of course, omitted. The impact of the subject on most medical students was negligible —indeed it tended to confirm the view of their medical teachers that the psychiatric patient and the subject of psychiatry were hardly part of medicine.

In 1910 the efforts of the RMPA were successful. Following a letter written by the President, Mercier, to all the universities, Royal Colleges and other licensing bodies pointing out the evils of neglect of psychiatry, and the urgent need for postgraduate teaching in the subject, a limited response was at last obtained. From this grew the university and college diplomas in psychological medicine which were in the first instance provided by the RCP of London and the University Department at Edinburgh. The outline of the subjects which were to be taught was laid down, and it is a striking fact that these actual subjects have changed very

little during the intervening fifty-five years. It was suggested that the subject should be divided into those which should be compulsory and those which should be optional. In the first group were included anatomy, physiology and pathology of the nervous system; psychology normal and morbid, and clinical pathology, clinical neurology and clinical psychiatry. The optional subjects included experimental psychology, biochemistry, bacteriology, comparative anatomy, physiology of the nervous system and eugenics. This was in 1910. By 1912 five universities, Manchester, Leeds, Edinburgh, Cambridge, and Durham had instituted diplomas in psychological medicine. At this time several universities, including London, allowed candidates to sit their MD degree examinations in psychiatry but no university provided any special instruction or training with the exception of Edinburgh (17). From 1885 when the RMPA initiated its certificate, until after the Second World War, there was dissatisfaction felt by most leading psychiatrists in the country about the quality of psychiatric training and of the poor quality and meagre entry to the ranks of the subject from among those graduating from medical schools. Most believed that if the universities were to provide a thorough postgraduate training for the subject, and moreover if undergraduate training included a sufficiency of psychiatric knowledge the situation might change, but none did. Moreover no one had yet grasped what psychiatry was really about. It was only after the First World War and no doubt largely as the result of experiences obtained during it, that some began to understand that the training of the psychiatrist and his education should include the study and treatment of neurotic as well as psychotic illnesses. Certainly until 1930 the psychiatrist's job had been to look after the insane and little else.

But the impulse to change which this new awareness gave, misfired in practice. After the First World War out-patient departments of psychological medicine began to appear in the undergraduate teaching hospitals, particularly in London. By 1930 they were headed by men whose experience and interest were for the most part largely in the field of the psychoneuroses and their private practices consisted largely of neurotic patients. They owed their appointments to the interest which neurologists took in the

neuroses. Thus it came about that the psychiatrists in our teaching hospitals, and as I have said these were mainly in London, were for the most part psychodynamically oriented psychiatrists. They called themselves medical psychologists and their appointments were appropriately named. Their practice was mainly in out-patients and their concern was with the psychoneuroses. Psychotic patients who naturally turned up occasionally could not be treated, so arrangements for transfer were developed between the teaching hospitals in London and the large mental hospitals which were run by the municipal authorities, and which were situated twenty or thirty miles away on the periphery of London; such patients were not seen again. Occasionally a psychiatrist working in a municipal mental hospital was given a clinical assistant post in one of the teaching hospitals, but this was by no means the rule. Thus it can be seen that the type of psychiatry, the interest in the subject and the practice of it which was carried out in the teaching hospitals bore very little relation to the type of practice and experience of those who worked in the mental hospitals. The study and treatment of neurotic patients on the one hand and of psychotic patients on the other became separated by an apparently unbridgeable gulf. Before the Second World War it would have seemed to the observer that there were in Britain two types of hospital psychiatry, that carried out and taught in our teaching hospitals, and therefore that which influenced our undergraduate students (psychological medicine), and that practised in the large mental hospitals (psychiatry).

Before the Second World War there was no official body other than the RMPA which felt itself responsible for postgraduate training in psychiatry, although the Maudsley Hospital had been created and already had made a profound impact, and had been accepted by London University as a medical school. Those educational bodies who were concerned with the undergraduate curriculum came to believe that all that was necessary for psychiatry was for students to attend out-patients in their teaching hospitals where the study and treatment of neurosis could be observed. Thus it seemed that in the years between the wars the aims that were set out in 1885, to stimulate the universities into taking psychiatry under their wing, to provide instruction, study, and

opportunities for research commensurate with other branches of medicine had failed, with one very significant exception. Indeed some universities who had previously provided a DPM ceased to do so during these years . This was no doubt due to the fact that in most medical faculties there was no one interested or concerned with psychiatry and the clinical practice of the subject was not carried out except in a limited way in teaching hospitals. Yet if we look at the development of postgraduate medical education in the country as a whole we can see that the position of psychiatry was not unique. Indeed no formal postgraduate education or vocational training had yet been developed. Psychiatry was only unique in the sense that it was isolated from the rest of medicine. Yet for psychiatry there were already powerful influences at work. 'In each generation', wrote Lewis (18) in his Maudsley Lecture, 'there are men of rare gifts, severe in self-criticism, with strong and consistent purpose, who in psychiatry as in other fields, accomplish much good and leave behind them a lasting memorial.' Such a man was Henry Maudsley.

THE MAUDSLEY HOSPITAL

In my examinations at the London University I was fairly successful having gained a Scholarship and Gold Medal in surgery and three more Gold Medals; altogether therefore I possessed ten gold medals, which in the end I parted with to Dents the clockmakers for a gold watch which I leave behind me to tick when my heart shall cease to tick. At the end of my studentship the difficulty was to know what to do . . .

It remains only for me to say that in my old age, I induced the London County Council by a contribution of £30,000 to build a hospital for the early treatment of mental disease. The cost of getting the thing done, after the Council had accepted the proposal, was I may say, a greater burden than the money [Henry Maudsley writing at the age of seventy-two].[1]

Henry Maudsley (1835–1918) spent a short period when young, working in several asylums, notably Cheadle Royal, but most of his life was spent in private practice in London where he achieved a considerable reputation. His life bridges the period between the

1. Unpublished document in Maudsley Hospital Archives.

emergence of psychiatry into the moral treatment period, to the modern era of the subject's development as a scientific specialty. Lewis (18) emphasizes that he was influenced by others, notably by John Conolly whose daughter he married, that schools for psychiatric instruction were greatly needed and further that voluntary treatment for the mentally ill, free from all legal forms, should be made available so that treatment at an early stage could be initiated. In the Maudsley Hospital which he endowed he was able posthumously to realize both these aims. The hospital was opened, only for voluntary (informal) patients in 1923, five years after his death. It was the first of its kind in Britain where voluntary patients, supported by the municipal authority, could be admitted. His second objective that the hospital should be a university school, where early treatment, research and post-graduate training were to be carried out, and which Maudsley made a condition of his bequest, was also realized.

Maudsley grew up in a period of intense intellectual activity, not only in the sciences, but also in the arts and in letters. He equipped himself with the new knowledge, and became as did others in various branches of medicine, a typical Victorian philosopher-clinician. Yet his writings created a profound impression and he was perhaps the first English psychiatrist, after John Haslam, to acquire a European reputation. Psychiatry in the mid-nineteenth century was making significant advances on the Continent. It was essentially the 'syndrome' period of medicine, and on the Continent particularly in France and Germany, psychiatry could claim its share. Griesinger (1817–68) had established the first university psychiatric clinic in Berlin in 1865, and later Kraepelin's clinic at Munich was to serve Maudsley as a model of what he would like to see in London.

In Maudsley's plan to create a university hospital for psychiatry he was greatly helped by Frederick Mott, a student of his who had been appointed pathologist to the LCC mental hospitals. The building at Denmark Hill was finished by 1915 and although Mott began research and laboratory work, the hospital was used throughout the war and for some years afterwards for military patients. It was finally opened in 1923 to serve the purposes for which it was created. It became a medical school of the university

in 1924 and in the same year Bethlem Royal Hospital was given similar recognition. In 1948 the two hospitals were amalgamated. They then ceased to be schools of the university, and the Joint Hospital became the hospital associated with the Institute of Psychiatry, one of the constituent institutes of the British Postgraduate Medical Federation. In this association the 'relation of the Institute to the Hospital to which it is attached should be the same as that between an undergraduate medical school and its parent teaching hospital' (10).

UNIVERSITY DEPARTMENTS OF PSYCHIATRY

Before the Second World War, university departments of psychiatry had been created only at Edinburgh and at the Maudsley Hospital. In London as has been described, the teaching hospitals had in many instances started out-patient departments, and made a very limited contribution to undergraduate education—none in the postgraduate field. Only at the York Clinic at Guy's Hospital, founded by a benevolent donor, did a teaching hospital have any psychiatric beds. After the war the scene was to change radically. Since then all provincial medical schools in the United Kingdom have created professorial departments—the last being Oxford in 1968. The twelve medical schools of London in this respect lagged behind, no doubt through lack of space and the necessary financial resources. Encouraged by the UGC, however, since 1960, professorial units have been created at the Middlesex, St George's, St Bartholomew's, and the London Hospital. Thus at the present time psychiatry is represented by university departments in all the established medical schools of Britain, with the exception of Cambridge and eight of the London schools. No doubt others will follow.

The task confronting the first generation of those working in these new departments has been an arduous one. The majority of these departments are still in an active phase of development and are preoccupied with the many problems of undergraduate education, the need to provide a full clinical service for their parent hospitals, to obtain the necessary financial resources to staff their units, to create the necessary space and to develop research. Having too few beds in the teaching hospitals they have

often formed a direct liaison and entered into partnership with the local psychiatric hospitals of their regions—to the mutual benefit of both. Their responsibilities towards postgraduate education and training, while well recognized, could at first be only a limited one. Now in many departments in the provinces, postgraduate education has been developed for the registrars working not only in the departments themselves, but also in the psychiatric hospitals of the region. Many of these departments have too few graduate staff—a situation creating difficulty for them when they are asked to provide teaching not only for psychiatrists and non-medical personnel working in the psychiatric field, but also for students in other faculties of their universities.

In London only six schools have psychiatric beds in the main teaching hospitals—with a mean of seventeen beds. All the London schools use beds in associated general hospitals—a mean of forty-nine such beds per school (19). The community responsibility of the London departments has hitherto been minimal or non-existent, and their working relationship with local authority services haphazard. The type of psychiatric practice carried out in these schools is therefore rather different from that in the provincial departments where integration within the community services has been a realizable goal which was aimed at from the beginning.

3

Psychiatric hospital services (England and Wales) 1949–1968

It has become apparent that what constitutes 'mental illness' or 'mental disease' has been a concept too narrowly defined. The mental health services were at first organized on the basis of making provision for the psychotic and the mentally subnormal. They have gradually been extended, but finance and manpower shortage will inevitably limit further expansion. The work of psychiatrists has enormously increased and extended in the range and types of patients seen and treated. The hospitals now have a new role, in which the custodial element has disappeared. Out-patient work and treatment in the community have greatly developed. The division of responsibility between the Hospital Services and the Local Authority Services has developed in a setting of confusion and duplication of effort. In no field is this more apparent than in the provisions made for children with mental or emotional disability.

INTRODUCTION

The purpose of this chapter is to give a general outline of the main psychiatric hospital services in England and Wales during the period since the NHS was created. I shall consider the broad outline of the provisions made for in-patients and out-patients, for adults and children, for the mentally ill and for the subnormal. The future historian of psychiatry will certainly see this period as one of rapid emancipation from the restricted and isolated practice of psychiatry in the old mental hospitals. To psychiatrists whose only experience of their subject was in such hospitals, the new world which was opened to them was unfamiliar; they were largely ignorant of it and they had not been trained to meet the demands it would make upon them. Nevertheless the story is one

of remarkable achievement. The main areas of psychiatric provision—for the mentally ill, the subnormal and the disturbed child, for which after 1948 the NHS assumed responsibility, and with which this chapter deals, were at first thought to be comprehensive. That this was not so, and that within any community there are other large groups of patients in distress, or who cause distress to others, was gradually appreciated. Consideration of the circulars sent to Regional Hospital Boards and to Boards of Governors over the last twenty years by the MOH, demonstrate the gradual awareness of these problems and the need to do something about them. During this period the Ministry offered advice on many particular matters; among them were the following.

1. Advice was offered in 1950, 1957, and 1965 on the problems of geriatric patients who are mentally infirm (RHB(50)26; HM(57)86; HM(65)77).

2. In 1950 also psychiatric aspects of offenders serving short-term sentences were recognized, and the responsibility towards such people of the Hospital Service was accepted (RHB(50)39).

3. In 1953 and 1956 the special psychological and psychiatric disabilities of epileptics were recognized and recommendations made for comprehensive assessment centres (HMC(53)12; HM(56)57).

4. Drug addiction was recognized as a national problem first in 1961 and advice offered again in 1967 and 1969. Similarly the great problem of alcoholism (350,000 chronic alcoholics who are mostly disabled) received Ministry attention first in 1962 and again in 1968 (HM(61)94; HM(67)16; HM(69)43; HM(62)43; HM(68)37).

5. The increasing problem of 'attempted suicide', or 'self-poisoning acts' first received attention in 1961 (HM(61)94), and was the subject of a special report in 1969 (*Hospital Treatment of Acute Poisoning*).

6. The need for in-patient accommodation for mentally ill and seriously maladjusted children and adolescents received attention in 1964 (HM(64)4). A recommendation was made for both short-term assessment units (twenty to twenty-five beds per million

population) and long-term treatment units on a scale of twenty-five beds per region for children. Similar provisions were recommended for disturbed adolescents who are an increasingly serious problem. At the time the Ministry Committee considered this matter, no reliable figures as to the actual need were available. The four to sixfold increase in the bed provision recommended was based on a rough assessment, known to be an underestimate.

7. Following a Joint Working Party with the Home Office (20), it was accepted that there should be joint appointments between the Prison Medical Service and psychiatrists in the NHS—the object being to improve the former Service and to bring psychiatric practice and treatment into the prisons. Here was yet another area in which the scarce psychiatric manpower was to be deployed.[1]

I shall consider later some of the consequences that recognition of these large groups of patients and the recommendations made to help them will have on psychiatry. Before 1950 none received official recognition, perhaps because they were not regarded as suffering from 'diseases'. Their numbers are now to be assessed in hundreds of thousands. Shortage of financial resources, shortage of psychiatrists, social workers, teachers, nurses and psychologists has meant that only token provision has so far been made for a number of these groups. The shortage of medical manpower has finally made it unlikely that where provision has not already been made, it will not be so perhaps for one or two decades.

PSYCHIATRIC HOSPITALS

Before 1948 when the NHS started, there was no public awareness of the extent of psychiatric morbidity in the population. Only gradually since then from data collected from many sources, has this awareness increased. It is one of the aims of this monograph to look at the extent of the problem as it has become apparent when viewed from different points of view. Many different health agencies and persons are involved and each sees the problem rather differently. Thus the nature of the problem seen through the eyes of the GP is very different from that seen by the large psychiatric

1. A summary of relevant Ministry circulars during the period 1950–67 is given in Appendix I.

hospital. The problems of the Medical Officer of Health are certainly different from that of the casualty department. While reliable statistics in any field are difficult to obtain and in some are non-existent, a cursory review of the activity of the psychiatric hospital services indicates that since 1949 there has been enormously increased therapeutic activity.

After the Mental Treatment Act of 1930, mental hospitals were free to admit voluntary patients and to set up out-patient clinics, many of which came to be in general hospitals. There can be no doubt that as a result many patients who would not formerly have been admitted to hospital were so. As a result a number of non-psychotic patients (those with acute neuroses, personality disorders and patients suffering emotional crises in their lives) came into the clinical experience of the psychiatrists working in the mental hospitals. The scope of psychiatric practice increased and the need for a more extended and deeper view of what psychiatry was about became evident. By 1948 the stage was set for a fundamental reappraisal of the role of the hospital in psychiatric treatment. Even before the discovery and introduction of the psychotropic drugs after 1954, there was already the belief that much of the invalidism of chronic mental illness, particularly schizophrenia, was the consequence of hospitalization and the institutional environment which over decades had been mainly of a custodial nature. Moreover many of the symptoms of chronic illness were by then considered the result of the social process in the hospital, not intrinsic to the illness itself. As a result of policies introduced which were consequent upon these ideas, the immediate and intensive use of drugs and ECT, the changed attitudes to the mentally ill, the open door policy in the mental hospitals was started, with the opening of ward doors which were previously locked, the removal of barrier walls around, the disappearance of padded rooms and a great reduction in the number of patients who were detained on compulsory orders.

Although the number of beds in psychiatric hospitals has declined by 20,000 in a ten-year period, and in their place psychiatric units have been set up in general hospitals (70 units in 1966 with between them 5,500 beds and a further 1,100 beds in teaching hospitals, May (21)), there is evidence of a greatly increased

TABLE 3.1. *In-patient services*

	Admissions			*Discharges*	*Total in hospital*	
	Thousands	% *formal*	% *re-admissions*	*Thousands*	*Thousands*	% *formal*
1949	54·9	39·0	32·0	53·1	146·1	83·3
1950	55·9	36·0	33·3	na	147·3	81·5
1955	78·6	22·9	na	116·0	151·7	73·5
1959	105·7	na	na	146·5	143·8	49·1
1961	125·6	20·2	na	156·9	135·9	9·3
1965	170·5	19·7	48·1	180·4	127·2	7·0
1967	181·1	17·8	47·6	188·5	121·9	6·8
1968	187·1	17·5	47·2	195·1	118·4	6·8

na—not available.

Data from the *Annual Reports of the Ministry of Health (England and Wales).*

activity in those that remain. Table 3.1 and figures 3.1, 3.2 and 3.3 set out the position between 1949 and 1967.

The number of admissions has more than trebled, as have the discharges, while the total number of occupied beds for mental illness in psychiatric hospitals in any year has progressively fallen from 146,000 in 1949 to 118,000 in 1968. These facts are explained in part by the increased readmission rate, which in 1949 was 32 per cent and in 1968 had risen to 47·2 per cent. Nearly half the admissions (187,000 in 1968) are now readmissions. A striking consequence of the new policy, which has certainly influenced the public and the patients' attitudes to hospitalization has been the steady reduction in the percentage of those retained in hospital on compulsory order—a fall from 83 per cent in 1949 to 6·8 per cent in 1968. Moreover the percentage of those admitted on order has been halved, from 39 per cent in 1949 to 17·5 per cent in 1968. The average length of stay in hospital has progressively declined and is now measured in weeks rather than in months.

The clear evidence is then of a greatly increased movement in and out of psychiatric hospitals, but in a smaller number of beds; admissions and discharges have increased by 300 per cent but the beds have been reduced by 17 per cent. The Ministry of Health, as have many leading psychiatrists, has explicitly stated the preference for several short admissions rather than continuous residence in hospital. In many instances it would seem that an

Psychiatric hospital services. England and Wales

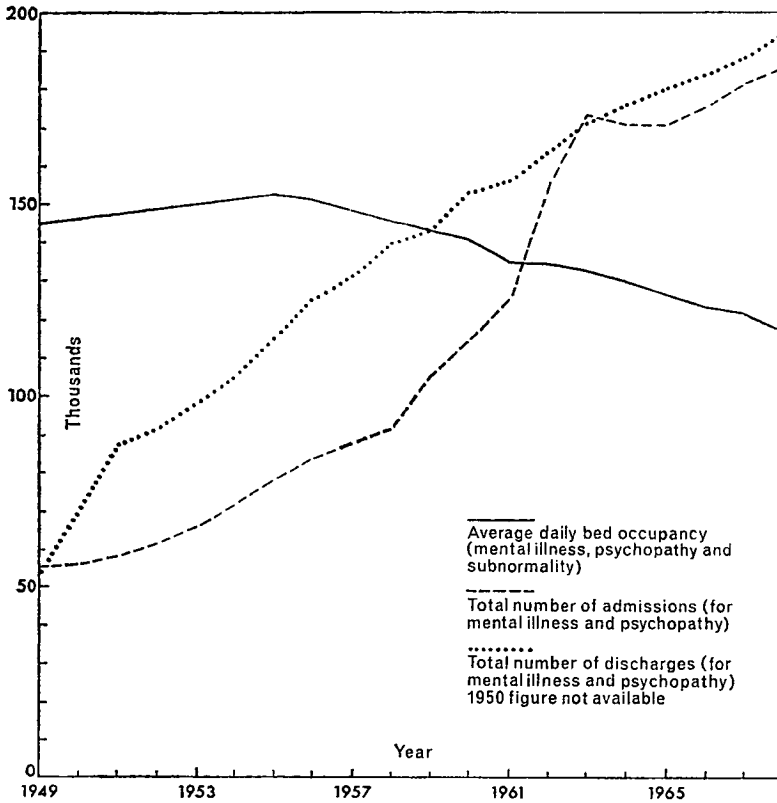

FIGURE 3.1. Psychiatric in-patients, 1949–68

illness which would have formerly lasted many months or years, is fragmented by repeated hospital admissions during which the symptoms remit, only to relapse again when the patient is discharged. The wisdom of this therapeutic policy has occasionally been questioned, but in addition to the ultimate effects on prognosis of such a policy—which is still unknown—there is the question of the effects upon the families of the patients concerned. It is not necessary to exaggerate the important implications of the present policy, or to emphasize the risk, as some have done, that by its enthusiastic implementation we are creating a potentially new class of destitute mentally sick, destitute not in the old pauper

Psychiatric hospital services. England and Wales

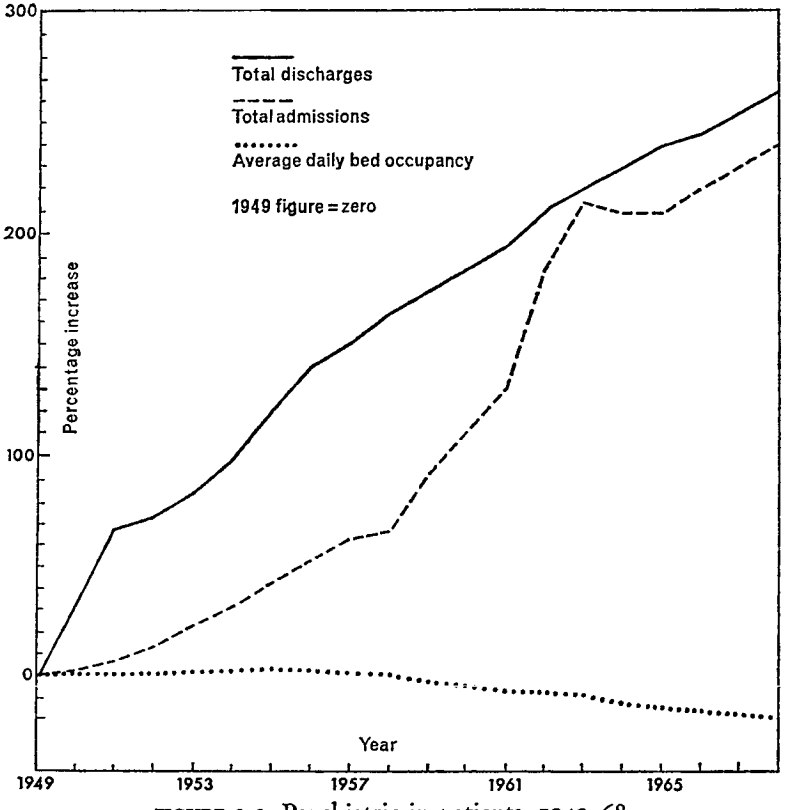

FIGURE 3.2. Psychiatric in-patients, 1949–68

sense, but destitute in that they may be incapable of earning a living—a financial, physical and emotional burden upon their families and relatives. The policy is based upon an optimistic view of its therapeutic consequences, and the belief which only two more decades of observation can prove justified, that the outlook for chronic schizophrenia in particular has been changed, that sufferers from this hitherto most intractable illness will not as in the past, ultimately require continuous hospital care.

OUT-PATIENT SERVICES (ADULTS)

A great increase in out-patient work in the period 1949–68 followed the development of out-patient clinics in general hospitals

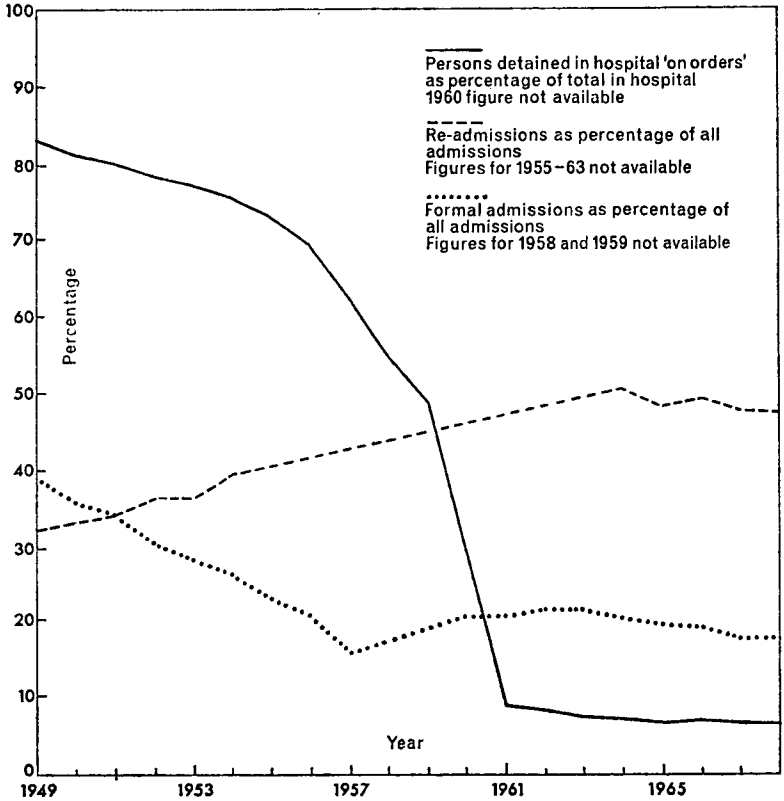

FIGURE 3.3. Admissions to psychiatric beds, 1949–68

staffed by psychiatrists from the local psychiatric hospitals, and later by the creation of in-patient and out-patient units in those general hospitals (figure 3.4). The teaching hospital departments played little part in coping with the load. The number of new out-patients is seen more than doubled, rising from 100,000 in 1949 to 200,000 in 1968. In part this has been made possible by the increase in consultant and senior registrar establishment (see chapter 9, p. 144), but there is a clear limit to the number of new patients attending for diagnostic interviews which a consultant can see. Psychiatric work compared with other fields is time-consuming—the average consultation time required being from

TABLE 3.2. *Out-patient services (adults)*

	New out-patients	*Total out-patient attendances*
	Thousands	
1949	93·8	436·2
1950	102·8	523·2
1955	127·1	714·0
1960	149·0	1,132·3
1965	177·0	1,254·0
1967	194·0	1,319·0
1968	196·0	1,336·0

Data from the *Annual Reports of the Ministry of Health (England and Wales)*.

45 to 60 minutes for each new patient. Since the Ministry, attempting to cope with the medical manpower shortage has now placed a ceiling on doctor establishment in the mental health services, it follows that the total number of new patients that the mental health services can cope with under existing arrangements has now nearly reached the limit, if it has not already done so. Although the total number of attendances for therapeutic help is less determined by the total consultant time available—junior psychiatric staff, psychiatric social workers and psychologists here making a contribution—these too have a clear but less easily determined limit. The shape of the curves in figures 3.1 and 3.4 suggest that in this respect too the mental health services are approaching saturation unless the therapeutic personnel available are to be increased. Between 1949 and 1968 the percentage increase in total out-patient attendances has trebled, the number of such attendances in 1968 being 1,336,000, of which 196,000 were first or diagnostic interviews. This indicates that many patients are subsequently seen on a number of occasions, and that a greater therapeutic effort is being made (table 3.2).

Since therapeutic practice varies so much thoughout the country, not only dependent upon the theoretical orientation of psychiatrists, but also upon the availability of personnel, e.g. psychotherapeutically trained workers, it is not possible to determine on a national basis the average type of clinic practice throughout the country. However, since it can be presumed with confidence that the incidence of functional psychotic illness—schizophrenia and manic depression—has remained for practical

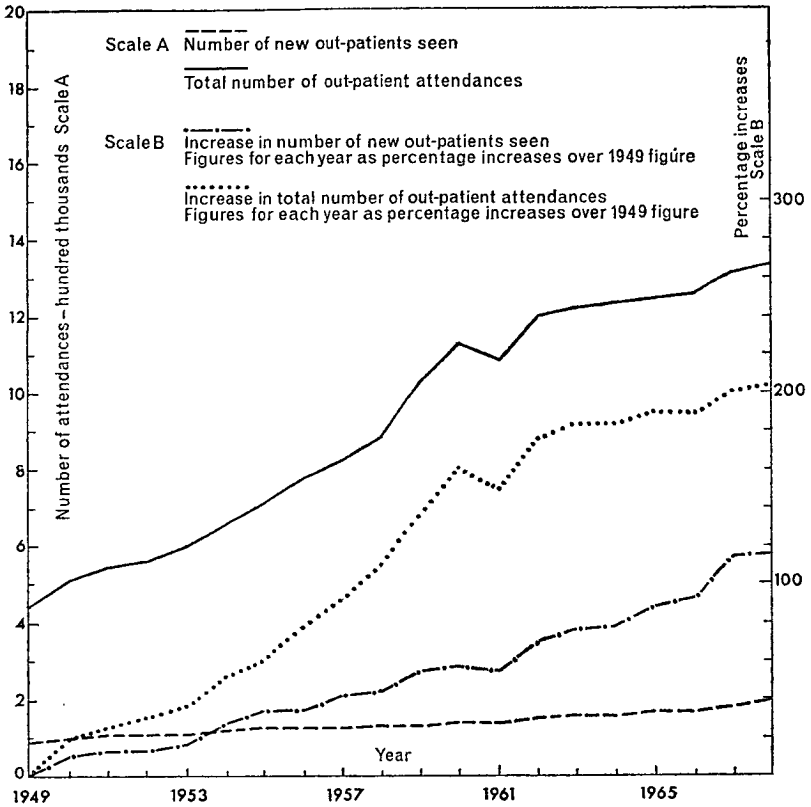

FIGURE 3.4. Adult psychiatric out-patients, 1949–68.

purposes constant, although many are now treated in the community, the enormous increase in out-patient attendances, both the new and further attendances, must mean that psychiatrists have increasingly been requested to advise upon the problems of many other types of patient and have responded positively to this request. There can be no doubt that many patients with neurotic disorders, and disorders of personality, those with alcoholic and drug dependence, those suffering from psychosomatic disorders and adolescent problems, who formerly had no help from the psychiatric services, are now receiving it.

CHILDREN WITH MENTAL OR EMOTIONAL DISABILITY

I do not propose to attempt to examine in detail either the provisions made for the numerous persons of subnormal intelligence or the demand which the public makes and is likely to make in the future for increased provision of such services, important though these are. At present these services are provided separately but in an uneasy partnership between the hospital and Local Authority Services. It has been suggested that the hospital services should provide for all those who require continuous nursing or medical care, while the Local Authority should provide for the rest, who constitute in aggregate the far larger proportion. The hospital provision for the subnormal since 1950 has increased by 5,000 beds and, as with the mentally ill, the number of patients admitted and discharged has very greatly increased—more than threefold. Great efforts are now being made towards the education and social rehabilitation of the higher grade subnormals, and with increasing success. The number of subnormal persons in Local Authority care has also risen significantly but the most striking increase is the far greater provision made for residential care (840 in 1949, 4,818 in 1967) (table 3.3).

The Local Authority Services have responded to the much greater financial assistance given to them over this period but are limited, as the Hospital Services are in every field, by the shortage not only of psychiatric manpower but also by the even greater shortage of special teachers, medical and psychiatric social workers and others required to develop the service. Abel-Smith (22) stated that 13 per cent of the NHS budget was spent on the mentally ill—about ½ per cent of the national income (but only four-fifths of that spent on the police force). At that time (1963) the bulk of public expenditure on the mentally ill went to the hospitals, but the provision by Local Health Authorities had risen from just over £1 million in 1949 to nearly £10 million.

The Seebohm Committee Report (1968) showed that in the previous year 382,300 children were in the care of the local authorities, in approved schools or on licence, in special schools or attending child guidance clinics (23). Despite this considerable aggregate, the unmet need was considered enormous. One in eleven

TABLE 3.3. *Mental subnormality*

	Hospitals		*Local authority*	
	Daily bed occupancy	*No. of discharges*	*Total in care*	*Number in residential care*
1949	na	na	70,362	840
1950	*	†	69,596	820
1955	52,923	4,685	79,281	1,056
1959	56,167	6,400	81,309	na
1961	56,930	9,842	na	na
1965	57,815	11,624	90,384	3,526
1967	58,183	12,239	97,476	4,818
1968	58,217	12,656	99,820	5,645

na—not available. * 1953 figure 51,256. † 1951 figure 3,672.

Data from the *Annual Reports of the Ministry of Health (England and Wales).*

of the child population were estimated in 1966 to suffer some form of mental handicap. The Seebohm Committee computed the number of children in special need of help at over a million, made up of 232,000 subnormal, 40,000 severely subnormal, and 789,000 children with psychiatric disorder. No doubt these estimates are only approximate (from Appendix Q, Seebohm Report), but 'what is clear however . . . the present services are falling far short of meeting the extent of the need. *At least*[1] one child in ten of the population will need special educational, psychiatric or social help before it reaches the age of 18, but at present *at most*[1] one child in twenty-two is receiving such help.'

Table 3.4 summarizes the steadily increasing provision made for the mentally ill and the subnormal by the Local Authority Services. A key figure in these services is the social worker. For years this country's health services have suffered from a shortage in this important professional group. The psychiatric hospital services have seen in recent years a steady loss of psychiatric social workers not only to the Child Guidance Services of the Education Departments, but also to the Local Authority Health Services. I will consider this matter later. From table 3.4, however, in 1968 it is evident that 1,872 Local Authority social workers were involved in care of over 194,000 patients. The ratio of social workers to the total case-load has always been and remains such that nothing more than nominal (one hopes not trivial) care can

1. Author's italics.

TABLE 3.4. *Local Authority services*

	Total in care		*Total in residential care*		*Social workers total*
	Mental illness	*Sub-normality**	*Mental illness*	*Sub-normality*	
1956	na	80,627	na	986	625
1962	51,032	83,984	968	1,435	1,247
1965	71,379	90,384	2,044	3,526	1,571
1967	87,279	97,476	2,846	4,818	1,794
1968	94,158	99,820	3,366	5,645	1,872

na—not available. * Includes severe subnormality.
Data from the *Annual Reports of the Ministry of Health (England and Wales).*

possibly have been given to the majority of persons supposedly in need.

THE CHILD GUIDANCE CLINIC

The development of psychiatric services for children had a complex origin, in that the Child Guidance Service developed within the Education Service, partly in the context of the School Medical Service. The object was to help 'children over difficulties which were preventing them from benefiting from education'. This, however, is only part of the picture. It ignores the undoubted fact that the psychiatrist is as an essential member of the team as the educational psychologist or the psychiatric social worker, and that a substantial proportion of Child Guidance Clinics (or Child Psychiatric Clinics) have been organized and established within the Hospital Service, and notably within teaching hospitals for many years. The clinical training of psychiatrists and social workers has in the main been carried out within these hospital departments, and much of the research in this field has been developed by them.

We owe to Frances Galton the idea that individual differences in ability and temperament could be subjected to scientific identification and measurement in children, no less than in adults. In 1893, on the initiative of Galton, the British Child Study Association was established. Later in 1905 Binet and Simon in France provided the first test of intellectual ability—the intelligence quotient. In 1913 the London County Council appointed the first psychologist—Sir Cyril Burt, in a Local Authority Service,

'to investigate cases of individual children who present problems of special difficulty and who might be referred for examination by teachers, school medical officers and care committee workers, magistrates or parents, and to carry out, or make recommendations for suitable treatment or training of such children'. As Child Guidance Clinics began to appear they were to do so in relation to the School Medical Service, although later these clinics came to be paid for by the Education Authorities. The educational psychologist has a major role to play in these clinics, since the main object is to ascertain children who are dull and need special education, to identify children who are unusually gifted and to provide remedial teaching and vocational guidance. From the start, therefore, the Local Authority Clinics had a largely educational function. They were not equipped to deal with maladjusted, emotionally disordered or mentally ill children. Although it was appreciated that psychiatrists would be needed, their role was thought to be a limited one—on a part-time basis. In many of these clinics the educational psychologist was forced to accept a quasi-medical function, and took it upon himself to refer to the child psychiatrist such cases as he thought fit.

With a background and training in education, the educational psychologist could hardly be regarded as an expert in clinical problems and able to diagnose minor from major emotional problems, physical from emotional problems and to take a clinical history from parents (24).

In 1932 the Birmingham Education Department opened the first Child Guidance Clinic in the country, staffed by a psychologist, a psychiatric social worker and the Medical Officer for Special Schools as its director. At first wholly supported by private funds, it was later taken over by the Department in 1935. By 1939 there were 17 clinics wholly maintained, 5 partly maintained by Local Education Authorities. In 1955 the Underwood Committee recommended a comprehensive child guidance service available for the area of every local Education Authority, involving the school psychological service, the school health service and the child guidance clinic—all working in close co-operation. They suggested that the Education Authority provided the clinic, employed the psychologist and the psychiatric social worker and

TABLE 3.5. *Child psychiatric services*

	New out-patients	*Total out-patient attendances*	*In-patient discharges*
1949	3,139	3,0099	0
1950	5,083	3,8946	15
1955	14,198	117,816	26
1960	18,300	133,100	61
1965	29,000	192,000	1,131
1967	32,000	202,000	1,362
1968	33,000	201,000	1,617

Data from the *Annual Reports of the Ministry of Health (England and Wales).*

that the Regional Board provided and paid for the psychiatrist. They foresaw a need by 1965 for great expansion—to 140 full-time psychiatrists, 280 educational psychologists and 420 psychiatric social workers, and at that time (1955) less than half these numbers were employed.

Figure 3.5 and table 3.5 show how the child psychiatric services have expanded since 1949. In 1968 the Seebohm Report stated that the 'situation is not much better now'. The waiting list times in 1964–5 for a selection of these local authority clinics ranged from two weeks to eighteen months, with an average of six months. 'There is a dire shortage of skilled staff in child guidance clinics.'

The recommendations of the Underwood Committee that child guidance clinics should, although 'joint', remain and become wholly the responsibility of the local authorities was bitterly opposed by nearly all medical bodies, including the RMPA, the BMA and the British Paediatric Association, on the grounds that medical issues could not be disentangled from psychological and psychiatric ones. These bodies suggested that clinics should be part of the hospital service. It was certainly true that if a mentally ill child required special investigation or in-patient treatment, the hospital service would have to provide it. The trouble was that very few in-patient units for mentally ill children existed in the country—only 18 units with 370 beds in aggregate in 1963 (8 per million of the population).

There can be no doubt that C. P. Blacker (25) was right when he emphasized that the psychiatric children's services could be

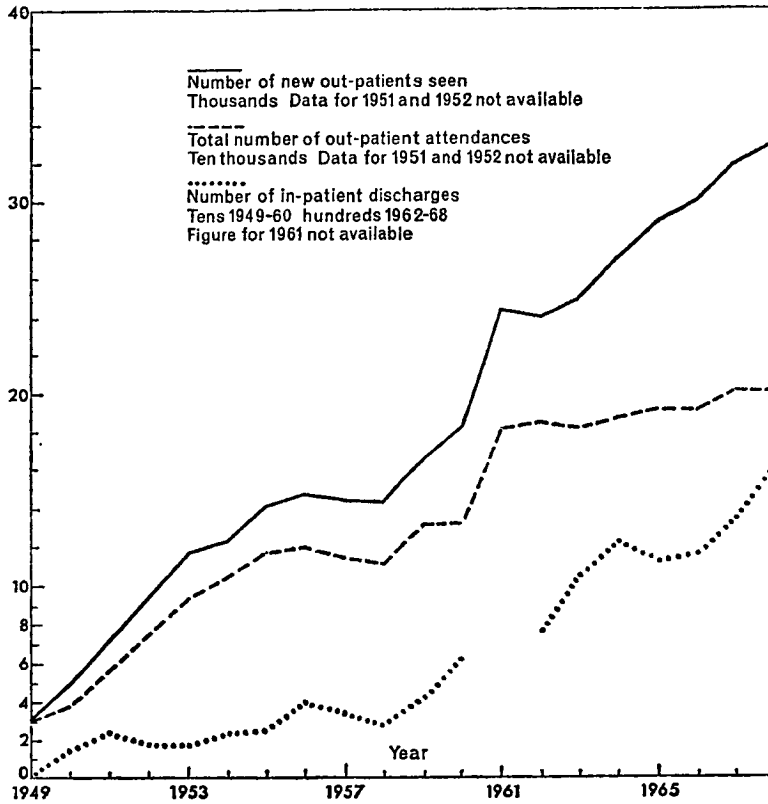

FIGURE 3.5. Child psychiatric services, 1949–68

divided into those clinics with a mainly educational function (local authorities) and those with a mainly clinical function (hospital services). Moreover the NHS Acts (1946) gave the hospital services the clear responsibility for providing care for children suffering from 'mental illness and maladjustment'. These terms in fact were taken to cover both emotional and behavioural disorders. J. G. Howells (24) who has developed the department of Family Psychiatry at the Ipswich and East Suffolk Hospital defines the area of clinical practice as follows:

Emotional disorder in children manifests itself in changes of mood such as apathy, anxiety, phobia, obsessions, lack of concentration,

sleep disturbances and tension, and also such psychosomatic signs as restlessness, anorexia, tics, speech anomalies, enuresis, encopresis and indeed signs of disfunction in any bodily system, and lastly of deviations of behaviour such as awkwardness, aggression, destructiveness, temper tantrums and many signs of delinquent anti-social attitudes. In addition a very small number, approximately 1 per cent of children accepted at such clinics, manifest signs of mental illness or psychosis.

The medical interest in the emotional problems of children came first from paediatricians and psycho-analysts. In 1918 Hector Cameron, the paediatrician at Guy's, published *The Nervous Child* which was to become a classic. He emphasized the close link between the emotional and the physical well-being of a child. In 1920 the Tavistock Clinic was opened through the efforts of Crichton Miller and a separate children's department was started in 1926. In this field great contributions have come from voluntary financing and from benevolent foundations. With help from the Commonwealth Fund of America the London Child Guidance Training Centre was opened as a clinic in Islington in 1927, and was the first in this country to carry out the training not only of psychiatrists, but also of psychiatric social workers and psychologists; William Moodie was the first director. The Maudsley Hospital, soon after it was opened in 1923, started a children's clinic, and was later in 1938 to open the first in-patient unit for mentally ill children. Since the war there has been great expansion in general and teaching hospitals. By 1961 there were 71 clinics in general hospitals, 17 in children's hospitals and 13 in psychiatric hospitals. Paediatricians have shown an increasing interest in the field and there can be no doubt that the future of child psychiatry, not only as a developing clinical subject, but also as a subject in which research is desperately needed, will depend upon these clinics in general hospitals, particularly teaching hospitals with links with their medical schools. Now nearly all these have departments or sub-departments of child psychiatry (child guidance) and the collaboration with paediatricians is becoming ever greater. The training posts for child psychiatrists are for practical purposes all in these clinics and the Department of Health has recently increased the provision for such posts.

Research has shown that it is not possible clearly to demarcate the emotional and behavioural problems of children from those consequent upon general defects of intelligence or specific defects, nor those arising from physical handicap from psychological handicap. Moreover biological handicaps have the greatest deleterious effects when the social and environmental experience of the child has been a bad one. There is therefore in my judgement a very strong case for the future development of this subject within the hospital service and in a medical setting where the range of clinical expertise necessary is available. Comprehensive assessment centres are required. The problems of providing help for the very numerous emotionally or psychologically disabled children is a far more complex and difficult one than can be coped with by a purely educational service concerned in the main with scholastic failure. It would not seem desirable, as the Seebohm Committee recommends, to transfer the Child Guidance Services to a comprehensive Social Service Department run by social workers, the psychiatrists being seconded from the NHS, the psychologists from the Education Departments, both on a sessional basis.

While the Seebohm Committee (22) assessed the number of mentally handicapped children in England and Wales as over a million (1 in 11 of the child population), it was evident that those with subnormality only formed a small proportion of the total (272,000 subnormals compared with 789,000 with psychiatric disorder). In 1966 it seemed that only one-fifth of this large population were receiving any sort of help. Nevertheless we are still ignorant about which children who are emotionally disturbed require the most urgent help. We do not know which types of disorder are temporary and remit spontaneously; which types are of malignant prognosis for future development, leading to later disability in adult life. This is a matter to which I will return in a later chapter.

4

The variety of psychiatric disorder

The extent of the total psychiatric morbidity in the population is unknown. Hospital statistics give only a partial picture. A substantial part of the GP's work is concerned with patients suffering from neurosis, personality disorder and psychosomatic illness. The evidence for this is examined. The difficult role of the GP is discussed and the limitations which he may impose upon his own responsibilities. GPs continue to provide management for the great majority of the 'visible' mentally sick, but it is a mistake to assume that the 'minor' disorders carry little social incapacity, or economic disability. Accident and emergency departments of general hospitals see another group of the mentally ill and those in emotional distress, whose problems may be unknown to GPs. Prominent among this group are those who attempt suicide.

A proportion of the population are unhappy all the time, and many are unhappy or emotionally disturbed some of the time. What is the relationship between unhappiness or emotional distress and the minor forms of psychiatric illness? There is little reliable evidence other than common clinical experience. Yet there have been many population surveys in different countries to try to get an idea of the size of the problem. Different groups of workers have used different techniques and the results have consequently varied and to an astonishing degree. Some surveys in the U.S. have suggested that more than half the population are in need of psychiatric help! When strict criteria to identify a 'psychiatric case' are used, the proportion falls greatly, but is still between 14 and 20 per cent. I shall discuss this important but difficult problem and the methods available to try to solve it in chapter 6. There is little evidence that the severity of unhappiness or distress of itself determines whether or not the sufferer presents himself to a doctor or medical agency, yet there was a commonly held view in the war that there was a limit to the stresses, particularly

their duration, which any soldier could tolerate. Every man seemed to have a breaking point, although, of course, not the same one.

The psychological and social stresses of civilian life are, however, of quite a different order and of a different kind than those experienced by combatants in war. Acute situational crises dependent upon bereavement, anger, jealousy or sudden disappointment are common enough, but there are also very many people who are subjected or subject themselves to years of frustration, resentment and emotional tension from adverse environmental circumstances or unsatisfactory marital or family relationships. Evidence from various sources suggests that the proportion of the population who suffer in this way is considerable and that many of them present to their doctors, or to other medical or social agencies, with neurotic symptoms, or deviant behaviour of one sort or another. They or their families, their employers, or the courts ask for help. What is the size of the problem? There have been no large-scale population studies in this country aimed specifically to answer either the question, what is the prevalence in the population of chronic emotional distress, or what is the prevalence of those (who may or may not consult their doctors) who suffer from minor psychiatric disorders such as neurosis.

The National Morbidity Survey set up by the Royal College of General Practitioners (26) gave the very high figure of 338·7 per thousand of the population at risk who consulted their doctors either for 'formal psychiatric illness' or for conditions listed as 'psychosomatic'. The latter is an unsatisfactory term either for diagnostic or survey purposes, for different doctors as well as psychiatrists have varying opinions about which disorders should be regarded as psychosomatic. This high prevalence rate of nearly 34 per cent of the population constituted in fact nearly half of all patients who consulted their doctors during the survey period. In a previous study (27) when the classical and limited view of psychiatric disorder was taken, the prevalence rate was found to be 5 per cent; when all patients showing any manifest psychological disturbance were included regardless of the diagnosis, the prevalence rate rose to 9 per cent; when in addition all patients for whose physical symptoms no organic cause could be discovered were included, the prevalence rate rose to 38 per cent. Finally

when those cases commonly regarded as psychosomatic, such as asthma and peptic ulcer, were added, the total prevalence rate rose to 52 per cent. This study of Professor Kessel's was carried out on one London general practice but it serves to show the difficulty of arriving at true prevalence rates, even among patients consulting their GPs for minor psychiatric disorders.

We have little information about the prevalence of such disorders in the population as a whole. Several reports have appeared from the U.S. (28, 29). These suggested that about 20 per cent of the general population suffered from serious psychiatric symptoms which were partially disabling, but that only about 20 per cent of the population surveyed were entirely free from symptoms of emotional disturbance. My colleague Professor Michael Shepherd (30), reviewing the American population survey work—several studies of which have been carried out since 1941—states that 'to the extent that these findings are reliable, the evidence points to the presence in all communities surveyed of a large sub-group of mentally sick or emotionally disturbed persons, amounting to between a tenth and a fifth of the total population'. How this group is composed, what demands these potential patients make upon the medical and caring professions, are matters to which I will now turn. It is not possible to obtain a comprehensive view (see chapter 6). The problem will be considered from the points of view of the GP and the accident and emergency department of the general hospital.

THE PROBLEM FOR THE GENERAL PRACTITIONER

The lack of professional satisfaction in the hospital service is the direct consequence of undermanning and inadequate facilities. These in turn are the result of shortage of money—a simple diagnosis, even if the remedy is more elusive. The problem for the general practitioner is more complex. It amounts to a deep-rooted uncertainty about his proper role in the medicine of the future. Must he become nothing more than a supplier of certificates and a posting station to the hospital? How much direct treatment ought he, or can he, provide for his patient? Can he reconcile the individualistic traditions of his calling with the collective needs of modern medicine? Underlying all the complaints of the GP there is this bewilderment as to what his job will amount to and whether it will prove satisfying (31).

The diagnosis of *The Times* leader writer may in 1967 have been the correct one, but it might be thought that the recommendation of the Royal Commission on Medical Education that all doctors, including GPs, should in future receive postgraduate vocational training appropriate to their work, will provide the necessary remedy. Certainly the study of psychiatry has been identified as a subject of the first rank, vital to the work of the GP —together with obstetrics and gynaecology, paediatrics and geriatrics—according to evidence submitted to the Royal Commission by the RCGP. The Royal College had for years pressed for organized professional training and had been supported in this by numerous bodies including the Working Party on Vocational Training in Medicine set up by the Nuffield Provincial Hospitals Trust (32). The failure of the National Training General Practitioner Scheme started in 1948 was no doubt due to the lack of an academic component in the scheme which was largely an apprenticeship and the competing financial advantage of early entry into independent practice. The crisis in manpower due to emigration from general practice may now have reached its zenith and the tide may have turned. The prospects for the future of this large section of the profession may seem brighter in many ways—not least by the gradual disappearance of the single-handed doctor—the increase of group practices and the creation in large numbers in the country of health centres, the attachment of Local Authority nursing and other personnel to such practices, the building of teamwork in which the individual doctor will have more time, much better facilities and support for what he needs to do. In the future the GP should also be provided with the academic professional training suitable for his vocation.

If it is granted that a substantial amount of the work of the GP is concerned with patients who are emotionally distressed—and I propose to consider the evidence in this country that this is so—there is one issue which cannot be disregarded and which is unique to psychiatric work and which distinguishes it from nearly all other branches of medicine. Put simply it is that many doctors, like others in the general public, feel an antipathy for psychiatric patients. There are those, perhaps 10 per cent of GPs, who have an active interest in the subject,

equip themselves by attendances at postgraduate courses, take special courses in psychotherapy such as those provided by the Tavistock Clinic, and arrange their practices so as to be able to give time to their emotionally disturbed patients. Dr Henry Walton (33) of Edinburgh has shown that the attitude to various types of emotionally disturbed patients by GPs varies from a total refusal to treat, through willingness to treat only in an emergency, to the positive attitude, a complete willingness to treat whenever possible. This study was carried out on doctors attending a postgraduate course in psychiatry and therefore concerned a group who had presumably already declared an interest in the subject. They constituted a group from among the 10 per cent referred to. They accepted with little reservation that they had a responsibility towards psychosomatic and psychoneurotic patients and would wish to treat them.

Rejection starts to be apparent in the case of patients who are un-cooperative, and of patients whom a doctor comes to dislike. Patients who become emotionally dependent on the doctor are seen by these practitioners as a clinical burden whom few will want to treat; alcoholics are a category who are not acceptable to half of these manifestly responsive doctors; suicidal patients understandably, these practitioners want to hand on to others for treatment. The type of patients least acceptable to them are psychotic patients. Only a tenth of the doctors will treat psychotics (33).

These different attitudes towards classes of patient which influence clinical practice so seriously, must be unique to psychiatry. They are inconceivable in any other branch of medicine. They are not explained by the agreed lack of psychiatric education or lack of factual knowledge. Indeed many are anxious to acquire more factual knowledge of psychiatry but its acquisition makes little difference. Nor should it be thought that these varying attitudes are peculiar to GPs or to any other specialist group. I have no doubt that similar variation in attitudes towards patients are experienced and indeed are often expressed by psychiatrists. In their case in one particular the attitudes described are usually reversed, in that many *only* wish to treat psychotic patients, have an antipathy for psychoneurotic patients, but share with GPs the

dislike for those whose dependency-needs are felt to make demands upon them. Many psychiatrists too, unless their training has specifically led them to understand and accept these aspects of themselves, have a natural tendency to reject the unco-operative and patients they dislike. Many psychiatrists whose training has been inadequate, share with others the intolerance which may amount to anxiety, if their emotions are painfully aroused by their patients. It requires long training and exposure to the hazards covered by suitable support, to overcome these natural tendencies. They are more difficult to overcome than the medical student's horror at first meeting the dissecting room, the autopsy, the surgical theatre or the accident department.

It is a requirement of the treatment of most psychiatric patients to provide on-going care over prolonged periods of time. Older doctors are less interested in doing this than younger ones. There is evidence that a reflective turn of mind and a tolerance of uncertainties are the qualities of personality that are required for this type of work (34). If it proves true that it is not only knowledge and training, but also differences in temperament, over which there is little control and which cannot be altered by training except to a limited extent, which determine the degree to which any doctor will involve himself in the care of psychiatric patients, there is no reason to doubt that similar issues affect the role-taking of other workers in the medical and psychiatric fields. This is a matter, given adequate verification and methods of measurement sufficiently sure to enable predictions to be made, which should be considered very seriously when personnel selection is introduced for work in medicine and in the para-medical professions, as no doubt it eventually will be.

What then are the attitudes of the 90 per cent of GPs who do not profess any special interest in psychiatry? Shepherd and his colleagues in their survey of *Psychiatric Illness in General Practice* (35), which included a sample of twenty-seven London practices, initially met with considerable difficulty in mounting the research and obtaining co-operation of the doctors. They state that the attitude of most towards psychiatry was one of tolerant indifference, not active aversion, but there were exceptions.

One was altogether averse to psychiatry, and blamed psychiatrists for encouraging neurotic patients to avoid their responsibilities; the second stated that the neurotic patients on his lists were so few and so easily identifiable as to render any systematic study unnecessary; the third commented simply that all neurotic patients were ungrateful and that there was nothing to be done for them.

Yet, given the state of medical education and the place of psychiatry in it and the lack of vocational training for general practice, there is nothing surprising in this. Indeed it is remarkable how much the average GP is able and willing to do for his neurotic patients.

There has been a general belief that at least 30 per cent of the GPs work is with mentally ill or emotionally disturbed patients. Indeed there have been a number of reports from individual GPs, particularly those with a strong psychodynamic interest, suggesting that from 35 to 70 per cent of all attenders at surgeries suffer from psychiatric disorder in some degree. The reason for doubting the reliability of these figures has already been given. The most comprehensive attempt to arrive at a true estimate of this particular aspect of the GPs work-load, paying detailed regard to the methodology of the work and the potential sources of error, is, I believe, the survey referred to (35), which was supported by a substantial grant in 1958 from the Nuffield Foundation. The results were published in a monograph, *Psychiatric Illness in General Practice,* in 1966. The pooled figures from 27 practices (80 doctors) gave a total prevalence rate of 140 per thousand persons at risk, and an inception rate of new cases (those who had not consulted for the condition within a year previously) of 52 per thousand at risk. These figures agree with those obtained in other surveys in the U.S. where similar diagnostic criteria had been used and place psychiatric disorder among the commoner causes of consultation in general practice. Women patients predominated in a ratio of 2 to 1, there being a high prevalence rate in middle-aged women, a finding consistent with other studies. In this survey children were excluded, the prevalence rate of 14 per cent of the practice populations consulting their doctors refers to all persons aged 15 and over. No significant association with social class was found, unlike the findings from psychiatric hospitals.

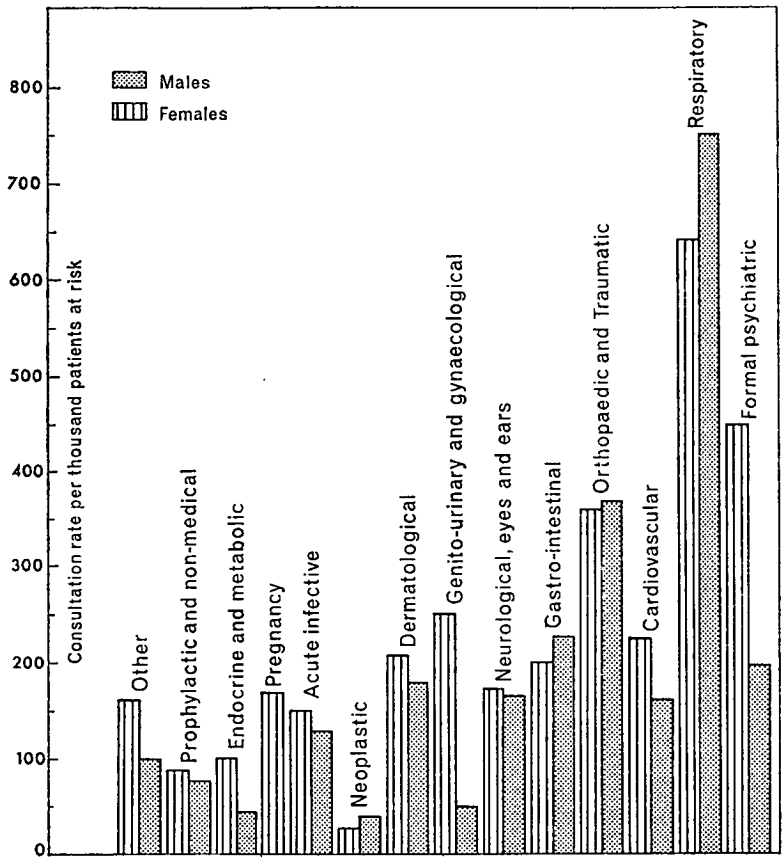

FIGURE 4.1. Consultation rates per thousand at risk for each category of morbidity
Data derived from Sheperd *et al* (34).

The RCGP found psychiatric disorders to be the fourth commonest cause of consultation after the common cold, 'rheumatic conditions', and bronchitis. The findings in this survey were not dissimilar and figure 4.1 shows the consultation rate per thousand of population at risk (14,697 persons) for each category of morbidity.

The consultation rates for psychiatric illness showed a steady rise from the 15–24 year age-group to a maximum in patients aged

45-64, thereafter to decline. At all ages the rates for women were nearly twice as great as for men. The diagnostic categories accepted for inclusion in the survey included under 'Formal Psychiatric Illness', the psychoses, subnormality, dementia, neurosis, personality disorders (as categorized in the *ICD* Section 5), and those patients with 'psychiatric-associated conditions', described as those physical illnesses or physical symptoms 'where psychological mechanisms have been important in the development of the condition, or which have been elaborated or prolonged for psychological reasons'. There was a further group of psychosocial problems. In aggregate this second group of psychiatric-associated conditions gave a consultation rate for both sexes of 48·6 per thousand, women again having a higher rate than men. This second group contributed about a third to the total psychiatric morbidity. It is seen that figure 4.1 does not include the 'psychiatric-associated' conditions and therefore gives an underestimate of the comparative morbidity of psychiatric disorder as a whole.

An important observation made in this survey was that the patients suffering from chronic psychiatric illness who were frequent attenders on their doctors were a highly vulnerable group from the point of view of loss of work and permanent incapacity. Moreover these patients also showed a higher rate of general morbidity and 'more categories of illness per head than the remainder of the patients consulting their doctors'. Chronic physical illness often appeared to be associated with psychiatric symptoms; further, there was a higher rate of illness among the husbands and children of female psychiatric patients than among a control group. The findings in this survey make it quite clear, and they are supported by other relevant studies in the U.S., that the pattern of psychiatric illness for which patients consult their GPs is quite different from the pattern of illness seen by the psychiatrists working in a psychiatric hospital. It probably more nearly resembles the pattern of illness experienced by the psychiatrist working in the out-patient clinic of a general hospital. Three-fifths of all patients diagnosed as having a psychiatric illness by their practitioners were considered neurotic; only 4 per cent were classified as psychotic. There seemed to be a 'spectrum of illness ranging from textbook cases of psychoneurosis

at one extreme to the emotional concomitants of chronic physical disease at the other'. Over half the total psychiatric case-load was 'chronic'—defined as having a duration of over one year, and in a further sub-study it was found that of these chronic cases a quarter had been ill for over ten years. Nevertheless there was a substantial recovery rate among new cases presented—over two-thirds of the patients who could be identified recovering within a year—irrespective, one can assume, of what treatment or help was given to them. Shepherd and his colleagues reach a conclusion which seems fully justified when they write that

> it is clear that psychiatric illness represents an important part of the burden of chronic ill-health in the community and that it is a serious cause of economic disability, quite apart from the cost it exacts in terms of suffering and the impoverishment of human relationships. This conclusion is underlined by the established association between psychiatric morbidity and other forms of chronic ill-health.

The average GP can expect to be consulted two or three times yearly for each patient on his list. Some he will not see at all in the year; a few once, others he will see many times. This means that a doctor with 2,500 patients on his list, might expect to provide at least 5,000 and possibly 7,500 consultations annually for adults alone. With a larger list the number would increase proportionately. The arithmetic is not difficult. It means that if the appointments were evenly distributed throughout the year (which they are not), and over every day of the week including weekends, the average GP would have to give at least twenty consultations daily. For some parts of the year the concentration of visits and consultations is greater than others. It is therefore not surprising that the average consultation time in general practice (as reported in the London survey) is not much over five minutes and very rarely over ten.

Considering all the pressures on GPs, it is surprising and indeed gratifying that the great majority consider that patients with emotional disorder fall within their clinical responsibility. Nevertheless as has been pointed out there is a tendency to reject patients who make undue demands, those who demonstrate excessive dependency, those whom they dislike, and in particular the psy-

chotic. Shortage of time, lack of a specific training in psychotherapeutic skills, and lack of interest and enthusiasm means that except for a minority of doctors who have a special psychiatric interest, the help given is often of a cursory kind. It is probable that most GPs have had a long acquaintance with their patients and their families, and have a unique knowledge of the social situations in which they are placed, are well aware of the psychological, personal and social stresses to which their emotionally ill patients have been subjected. There is not much evidence that the majority act on this knowledge or, for example, in appropriate cases, take advantage either of the Local Authority Health and Welfare Services or the help which may exist particularly in large urban communities of the various voluntary agencies which exist to help such patients. Various courses of action are, of course, open to the doctor.

He may reject the case as not a medical problem and to this difficult theoretical question I shall return in chapter 8. He may seize upon any physical symptom of which the patient complains (and the communication of neurotic patients to their doctors is often in terms of the somatic accompaniments of anxiety) and, despite his conviction that the condition is of emotional origin, refer the patient for investigation to a specialist clinic at the hospital. He may hope the patient will thus be reassured, or he may need assurance himself that there is no organic disease. Most often this is only delaying action, but in terms of his patient's interest it is a disadvantage, tending to promote chronicity and an increased preoccupation with bodily function. He may repeat this process each time the patient presents with another anxiety symptom, somatically experienced. On the other hand the GP may accept personal responsibility that his patient's condition is entirely psychogenic and treat it himself. Doctors with personalities of the paternalistic, extroverted, authoritarian type will usually offer direct advice and reassurance, and this may be associated with the prescription of a sedative, tranquillizing or other psychotropic drug. Doctors of a different cast of temperament (36) found them to be reflective, thinking introverts, tolerant of uncertainty, and with a psychodynamic orientation to human nature, may attempt psychotherapeutic intervention. For

this the doctor must set aside special time for his emotionally disturbed patients and he is likely to become known in his neighbourhood for his interest and sympathy for this class of patients who will surely accumulate on his practice list. This may have a considerable adverse effect upon the remainder of his practice. Lastly, of course, the GP may decide to refer his psychiatric patients to a consultant psychiatrist at a local clinic. It is remarkable that GPs in fact accept responsibility, one way or another, for about 95 per cent of their emotionally disturbed patients and do not refer them. If they did the mental health services of the country would be swamped. Yet psychiatrists who have studied at close quarters the types of patient normally treated by GPs and not referred, find the patterns of illness with which they deal are little different from the patterns presenting at out-patient psychiatric clinics.

THE ACCIDENT AND EMERGENCY DEPARTMENT

Another window through which we can get a partial view of the pattern of psychiatric morbidity in the population is provided by the work of accident and emergency departments of general hospitals. This subject is chosen because many psychiatric patients, not referred by their GPs, attend these departments. Unlike patients with physical injury or acute physical illness who are referred in the main by their GPs, psychiatric patients are 'self-referred' or brought by the police or by the ambulance service or by both together. It is a characteristic of such patients that they appear at the hospital late at night or in the early hours, and most frequently *alone*. The majority of these attendances are due to acute crises in the lives of the patients, many of whom have disorders of personality, and are an expression of the urgency of the plight in which the patient feels himself to be. Many such patients have no homes or fixed abode or may be living in common lodging houses; it is essentially an urban problem of the metropolis and the large cities. Unlike the experience of general practice and of out-patient psychiatric clinics, the majority of these 'casual' attenders are men of middle age. Nearly half the episodes for which these patients attend or are brought to hospital present as a problem of 'attempted suicide',

but many have collapsed in the street or in some public place with symptoms suggesting an acute physical or mental illness. About a tenth present as a problem of alcoholism and an almost equal number because of social or emotional stress, occasioned by a recent event in their lives (37). Many such patients attend casualty or emergency departments repeatedly, refusing help offered them by other health agencies. What is the size of this problem?

A number of reports of the work of teaching hospital casualty departments in London have appeared (37, 38, 39). There is substantial agreement between them. My colleague, Dr J. P. Watson, examined psychiatric problems during 1965 presenting in the accident and emergency department at King's College Hospital, which is the regional unit for a large part of south-east London, where in that year there were 37,000 new patient attendances. The other two references were concerned with the work at the Westminster Hospital and at Guy's Hospital. During 1965 the King's accident department dealt with 920 psychiatric 'episodes' which was 2·5 per cent of the total attendances. At the Westminster Hospital, Whiteley and Denison (38) found the percentage higher (6·6 per cent), 984 attendances, and this was double the number of new cases referred to the psychiatric out-patient clinic of that hospital. This, however, is only a reflection of the relative sizes of the two psychiatric out-patient clinics and of the population the hospitals serve. At King's 47 per cent of the attendances were in relation to a problem of suicide, 21 per cent to a 'collapse', 9 per cent to alcoholism, and 7 per cent to a situation of social or emotional stress. Two-thirds of these patients had arrived by ambulance or had been brought by the police. Referral by the GP is rare (at Westminster Hospital 2 per cent). This population of patients is different from that with which the GP deals, and different again from that presenting to the psychiatric out-patient clinic of the general hospital or to the psychiatric hospital itself. Although about 10 per cent of patients are brought to emergency departments because of a crisis in psychotic illnesses, very few are neurotic patients. The great majority are patients in emotional crises of one sort or another, who have made suicidal gestures or attempts, people who are socially adrift, alcoholics, and many with serious disorders of personality which have led to social isolation

and maladjustment. At King's more than 500 patients attended the accident department, mainly in the night after 'attempting suicide', but between 100 and 200 were not regarded as significantly ill physically as a result of their acts by the time they were seen.

In 1961 the MOH advised (HM(61)94) all hospitals that patients attending after attempted suicide should receive adequate psychiatric care and should be investigated by a psychiatrist before discharge. This has proved impossible to implement except in a few general hospitals with well-developed and well-staffed psychiatric departments. For many it would mean the employment of one full-time psychiatrist and a psychiatric social worker to deal with attempted suicide alone. At King's, however, in 1965 nearly 400 patients (43 per cent of those attending) were admitted to hospital. Their stay in hospital was usually very brief. At the time of attendance only 12 per cent of all patients in the series was seen by a psychiatrist usually because of the Casualty Officer's doubts about their fitness for discharge from the department. It is a striking fact that 88 per cent of the patients (not admitted) were treated by a Casualty Officer or a Duty House Physician alone, and a quarter of all self-poisoned cases were allowed to go home. Very few of those attending hospital in this manner, with the exception of a small proportion of those admitted after suicidal attempts and the psychotic, subsequently received any help or attention from either the mental health services, their GPs, or the welfare agencies.

It would be possible to select from among the varied groups of disturbed patients attending these departments, any one particular group for special consideration, e.g. the alcoholics, the vagrant and unemployable, the unstable drifter. In chapter 7 I will refer to some of these patients. The problem of attempted suicide, particularly presenting as 'self-poisoning acts', has now, however, reached epidemic proportions in this country, and I have chosen it for this reason and because of the real challenge which it presents. In what follows I have drawn particularly upon the work and opinions of Professors Erwin Stengel and Neil Kessel, the experience of the Edinburgh Poisoning Treatment Centre (Dr H. J. S. Matthew), and the recent report of the Joint Committee of the Standing Medical Advisory Committees of

the MOH and the Scottish Home and Health Department (40).

ATTEMPTED SUICIDE

Suicide occurs in all civilized communities, among all classes and at all ages. No section of society is exempt, and probably only a proportion of those who kill themselves are suffering from psychotic illnesses. Many depressed patients and some schizophrenics of course kill themselves, but 7 per cent of chronic alcoholics also do. It appears to be a particular hazard for the medical profession. Every month in Great Britain (41) on average one doctor kills himself. Six per cent of all doctors' deaths under the age of 65 are from suicide—about the same number as for lung cancer. The rate is about 2·5 per cent higher than for all males, and 1·5 per cent higher than for males in social class I. Psychiatrists would appear to be particularly at risk. Other countries have reported similarly. Among children and early adolescents suicide is rare but among older adolescents is not so uncommon.

The risk of suicide increases with advancing age, reaching a maximum in men at seventy. The pattern of successful suicide is quite different from that of attempted or non-fatal suicide. The latter is commoner in young women; the former in elderly men. Suicidal threats and even attempts are not rare below the age of fourteen and are particularly common in older teenagers. The ratio of non-fatal to fatal suicidal attempts is much higher in the young than in the elderly—perhaps 50:1, according to one estimate in the U.S. The lower income groups are over-represented among those who make non-fatal attempts, and the problem is essentially an urban one. Both suicide and attempted suicide are most frequently accomplished by drugs, mostly by those only available on medical prescription, of which until recent years the barbiturates have featured most prominently. The chief agents of fatal poisoning have in the past been carbon monoxide, barbiturates and salicylates, but now psychotropic and tranquillizing drugs are increasingly used.

Between 1957 and 1964 the hospital admissions for poisoning in England and Wales increased more than threefold, from 15,900 to 50,400. Undoubtedly with the exception of children under the

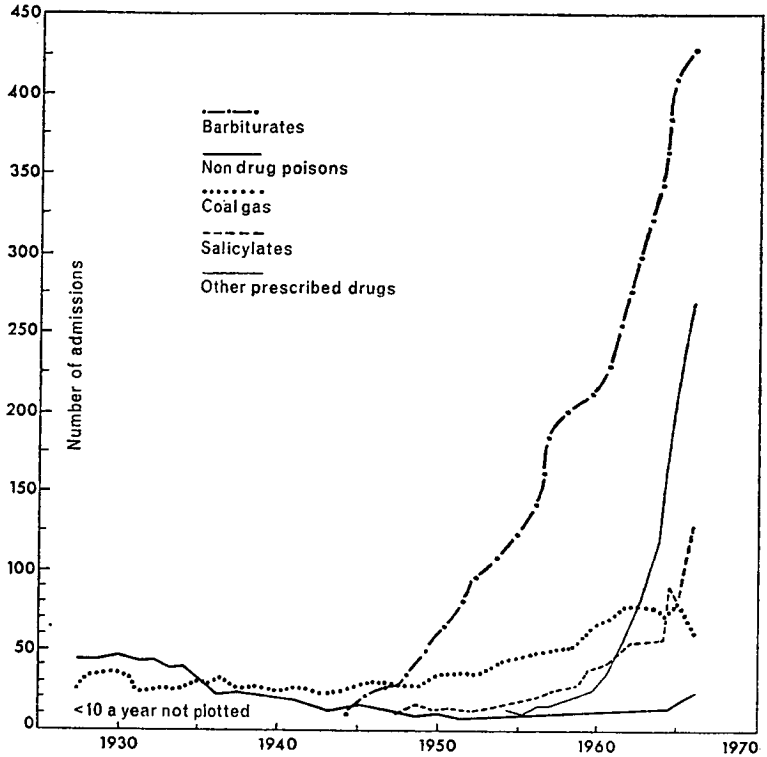

FIGURE 4.2. Yearly admissions of poisoned patients to the poisons treatment centre at the Royal Infirmary Edinburgh, 1928–66

This figure is reproduced from *Hospital Treatment of Acute Poisoning*. Report of the Joint Sub-committee of the Standing Medical Advisory Committees, Ministry of Health, and Scottish Home and Health Department. London, HMSO: 1968.

age of 5 years (accidental), the great majority were due to deliberate self-administration—'self-poisoning acts'. The majority of self-poisoning acts—about two-thirds, are carried out on an impulse, not long premeditated, and the patient is in a state of angry despair. Girls and young women are particularly involved. The figures from the Edinburgh Centre which provides a comprehensive admission service for all patients poisoned in the city, indicate that 'one out of 500 girls in Edinburgh between the ages of 15 and 19 poisoned herself in a single year'. For women under

the age of 20, the married are more likely to poison themselves than the single, and marital disharmony is the major precipitating factor. In Edinburgh 40 per cent of the men and 8 per cent of the women were alcoholics and many had been drinking before the self-poisoning act. About 20 per cent of patients repeat the act within one year, usually within two to three months, and the great majority are readmitted to hospital. In Edinburgh 1·6 per cent of patients who had been in the ward killed themselves within one year. The pattern of presentation to hospital of attempted suicides, is as one would expect very similar to that of general psychiatric patients presenting at emergency and accident departments. Their admission is mostly in the evening, during the night and at week-ends.

The average GP encounters few cases of serious self-poisoning for the majority are brought in as emergencies by the police or the ambulance service. Yet of those cases in which the GP is called to the patient's home and can arrive in time, he probably treats in the home and does not refer to hospital more patients than is realized. In the Sheffield region, Parkin and Stengel (42) found that one in five cases seen in the patients' own homes by their own doctors were treated without referral to the hospital. The figures of total hospital admissions therefore give only a partial view of the total incidence. The GP should, of course, be closely involved in the further care of patients after discharge from hospital, but in what proportion this occurs it is difficult to assess. He has usually, but by no means invariably, prescribed the drugs which the patient has taken. About a third of all these patients on physical recovery from poisoning are found to have been involved in an acute situational crisis in their lives, giving rise to severe emotional turmoil and distress. Very often their behaviour can be seen to have been clearly motivated to obtain help. Only a small proportion, less than 10 per cent, suffer from serious psychotic illnesses. The evidence from the few special Poisoning Treatment Centres which have already been established suggests that after physical recovery a quarter of these patients require further psychiatric in-patient treatment, over a third require out-patient treatment from a psychiatrist or social worker, and that a similar number require no further specialist treatment.

The percentage of admissions to hospitals in England and Wales of patients suffering from poisoning was in 1964 6·8 per cent of all general medical and paediatric admissions. The percentage had doubled in five years. No doubt the greatly increased admission of these patients is due to the fact that more patients less seriously ill are now admitted than formerly. The recommendations of the Joint Sub-Committee (40) are comprehensive and aimed at better hospital facilities for this group of patients and in particular for better after-care, which at present except in a few places is haphazard or non-existent. Their implementation, however—particularly the recommendation that there should be special Poisoning Treatment Centres, based on District General Hospitals throughout the country, sited where psychiatric units are established—may be very difficult in the present manpower shortage. This would involve the creation of an emergency service, medical, laboratory and psychiatric on a seven-day basis, night and day throughout the year in each of these hospitals to deal with this particular class of patient.

5

Patterns of psychiatric care

The psychiatric units in District General Hospitals, working closely with the Community Local Authority Services and with GPs, epitomize the movement to reintegrate psychiatry in medicine. Psychiatrists responsible for some units have suggested that the future in-patient accommodation required will be much below the prediction made for 1975 of 1·8 per thousand of the population. This leads to a consideration of the work which these units undertake. The work of three different units, with different types of organization, is reviewed and contrasted.

INTRODUCTION

The policy to run down as far as possible, and ultimately perhaps to eliminate the old mental hospital was based upon the prediction that far fewer beds would be required in the future for the hospital care of psychiatric patients. Tooth and Brooke (43) from their knowledge of the scene from the MOH, made the famous prediction that by 1971 the bed occupancy would be 1·8 per thousand of the population. In 1946 the figure had looked to a very competent observer to be more like 4 per thousand (25). This policy which became the official guide to action by the Ministry after 1961 was not, as some cynics have suggested, to save the tax-payer money, for it was known that the alternative would prove just as expensive, if not more so. It was based on the strongly held and justifiable beliefs that the large psychiatric hospital was a bad place to treat patients, that patients should be treated as near to their homes as possible, that treatment in the community rather than in hospital was preferable and that if hospitalization was required, in general it should be as brief as possible—for investigation and assessment, for treatment during acute and crisis periods of illness, and to relieve personal and family stress.

The development of in-patient and out-patient units in general hospitals has been discussed in chapter 1. These are now seen as an essential alternative to the large psychiatric hospital, but it has always been realized that if they are to succeed, they could not be miniature replicas of such hospitals—they would have to develop very close working relationships not only with the Local Authority mental health services of the region they served, but also with the geriatric services and the general hospitals in which they were placed. The prophesy was repeatedly made, particularly by observers from large psychiatric hospitals, that these new units would either soon become silted up with chronic patients, particularly elderly people and schizophrenics, and be unable to fulfil their functions, or be compelled if they were to achieve their comprehensive objective, to transfer their chronic sick to the large psychiatric hospitals which would become repositories for old people and 'dumping grounds' for all patients of poor prognosis and would acquire a new stigma.

The important question, now that in many areas of the country psychiatric services based on the district general hospitals have been in operation for some years, is whether in fact they are or can be made self-sufficient, and truly comprehensive so as to meet all the needs of the populations they serve, for in this event ultimately the large old psychiatric hospitals could be demolished. We are not, of course, within sight of this yet, but there are promising indications of progress. The number of psychiatric patients in hospital each year is certainly declining, but the decline is very uneven throughout the country—as low as 2·07 per thousand population in the Oxford region in 1964, but still 3·38 in Liverpool in that year (44). Reports from the Manchester Region, containing some striking claims that great reduction in beds can be made, will be considered later in the chapter. From workers in London several equally enthusiastic and optimistic reports have come, notably from Oldham (45) working in Southwark and Baker (46) working in Kensington. The experience of Southwark suggested a future need of 0·7 and that at Kensington 0·5 beds per thousand population. There are, of course, plenty who see these figures as grossly over-optimistic, who question the data upon which they are based and who do not accept these predictions. One major

fear has been that the policies implemented bring undue hardship and stress to the families of those treated. The most important criticism is that such predictions will only be realized by excluding from care an important proportion of patients who need it—in fact by ignoring them. Administrative success should not, moreover, be identified with therapeutic success. So far very few studies have been made of therapeutic efficacy.

Those who have described the organization of these new units emphasize that their success does not depend upon the existence of an adequate number of beds so much as upon the existence of a series of intra-mural facilities and extra-mural collaborative help, particularly with the regional geriatric services and with a well-developed Local Authority mental health service. In such units day care is as important and large a facility as in-patient care. An occupational centre and industrial workshop are important. The elderly mentally infirm should be treated in the geriatric department by geriatricians advised by the psychiatrists of the unit. At Burnley it is stated that the chronic sick do not accumulate as in-patients in the department because of an adequate number of geriatric beds, good relationships with geriatricians, and because the local social services are well-developed and fully supportive—'home helps, night sitters, wardens, meals on wheels and hostel accommodation' (47). Hostels for the elderly and the mentally ill who do not require hospital care are one of the greatest contributions the Local Authority can make in this field. Each of these units is developing its own distinctive policy of patient care, its own pattern of relationships with other services. The principle is generally accepted that continuity of care, through out-patient, in-patient, day hospital, and community, is a primary objective and that the exercise depends upon teamwork. All those in the unit, including psychiatrists, nurses, and occupational therapists working from the hospital should work *with* their colleagues in the community, the GPs, Medical Officer of Health, social workers, mental welfare officers, and disablement rehabilitation officers (46). Nurses are increasingly used in domiciliary follow-up and therapeutic supportive work not only in the hospital but also in the community. Of the St Mary Abbotts (Kensington) unit Dr Baker wrote in this connection:

At the ward conference which is attended by doctors, nurses, social workers and welfare officers from the Local Authority, a decision is reached on which of these has the most significant relationship with the patient, and who should therefore be responsible for long-term follow-up. Nurses are encouraged to take part in a domiciliary visiting service and supported in developing their own initiative on these visits.

In the context of the optimistic claims expressed by some psychiatrists working in these new units, it is necessary to examine what their therapeutic objectives are, and so far as it is possible to what extent they are able to realize them. To what types of patients and to what proportion of the mentally sick are they able to offer care? It seems likely that there will always be in every community a group of people with severe psychiatric handicaps who will require some form of permanent care (48). Such people have been identified in the past and are still being so within the framework of the psychiatric services I have considered. A further objective in this monograph is to draw attention not so much to the groups of patients who are identified and who are receiving help, but to examine the plight of those disabled or likely to be disabled who, whether identified officially or not, are not receiving help. A consideration of general practice has shown a major group, of which perhaps the great majority are neurotic patients. To what extent do the psychiatric units in general hospitals make provision for their treatment or offer help?

THREE PSYCHIATRIC SERVICES COMPARED

I will make some broad comparisons between three psychiatric departments, geographically widely separated, with different types of organization which reflect different ways of working, and to a certain extent different clinical and therapeutic objectives. There can be no doubt that the clinical practice in each of these three departments is distinctive in that each emphasizes and probably concentrates its efforts upon a different part of the spectrum of psychiatric illness. Each, of course, within the compass of its organization provides care to those patients presenting to it, which is comprehensive to the best of its ability. Consideration of the work of any one of these departments viewed alone, would

lead the observer to have a different and I would claim a partial view of the psychiatric needs of the population. Looked at together they raise more problems than they solve, but we should be aware of these problems. The three departments chosen are first, one based on a District General Hospital; second, one based on a Mental Health Centre; and third, one based on a London Teaching Hospital.

The District General Hospital department at Burnley was selected from among those in the Manchester Region because it has no formal connection with its neighbourhood large psychiatric hospital, claims to provide comprehensive care for a population of known size and is stated to be self-sufficient, i.e. it refers no patients to the psychiatric hospital. Moreover the results of its work have been publicized since 1961 and it was one of two hospitals in its region studied by the Department of Psychiatry of Manchester University and the Regional Board in a combined investigation of the efficacy of local psychiatric services (49).

The service based on a Mental Health Centre at Plymouth (the Nuffield Psychiatric Clinic) has been chosen as the second, not only because it opened in purpose-built accommodation also in 1962 and its work has been published since then, but also because it too has been the subject of special inquiry (50). A distinctive feature of this department is that while like Burnley it is sited in the grounds of the general hospital and provides comprehensive care for a known and defined population, its in-patient accommodation is entirely in the major psychiatric hospital, Moorhaven, thirteen miles away. Unlike the department at Burnley, therefore, the closest possible links are maintained with the psychiatric hospital which is an integral part of the service. The last major difference from the department at Burnley is that the Mental Health Centre is jointly organized and administered by the Regional Board and the Local Authority with joint usership. There is therefore maximal *integration* rather than *co-operation* between two authorities.

The Middlesex Hospital acquired a professorial unit of psychiatry in 1961, which was sited in the main teaching hospital, and as a result the psychiatric services in that teaching hospital were greatly increased. Moreover the work of this department is familiar to me and has been observed (51). Unlike the District

General Hospital and the Mental Health Centre this department had no responsibility at that time for any population; it also had no formal or informal connection with any large psychiatric hospital. By reason of its site in central London, and the character of its neighbourhood population, it had minimal contacts with the various Local Authority Mental Health Services of London; in these respects it differed fundamentally from the other two departments.

THE DISTRICT GENERAL HOSPITAL UNIT

The Manchester Regional Hospital Board decided soon after the war to create psychiatric units in the major general hospitals of its area, the policy being that they should each provide a comprehensive psychiatric service for a declared population. By 1962, 17 units had been developed with a total of 1,815 beds, which were 36 per cent of the short-stay psychiatric beds in the region. At this time the large mental hospitals had 9,931 beds, and had 64 per cent of the short-stay beds. Nevertheless in this year, the general hospital units received 57·4 per cent of the patients, and the psychiatric hospitals only 42·6 per cent. The out-patient work too had for practical purposes been entirely transferred to the general hospitals, which by 1962 were doing 92 per cent of the out-patient work. In aggregate 76 per cent of all new psychiatric patients in the Manchester Region were dealt with by the general hospital units.

The department at Burnley General Hospital, which for some years has been directed and developed by Dr E. T. Downham (47), serves a mixed urban and rural population of 171,000 people living in 100 square miles. In 1956 the psychiatric wards must have resembled in appearance and function the most undeveloped wards in the old mental hospitals for they were locked and badly decorated, treatment was custodial, seclusion was much used, there were many long-term patients on compulsory orders, and there was no out-patient department. With the appointment of psychiatric medical staff (one part-time consultant, one registrar, and an SHO), great changes were made and a modern department developed. The seclusion register was closed in 1957; no long-term compulsorily detained patients have been admitted since

1959; the wards are now unlocked and in 1960 an out-patient department and treatment centre were opened. At present this department has three consulting rooms, four treatment rooms and a large convertible general purpose room. In 1959 day-hospital care became available for eighteen senile patients, and the pressure on accommodation for this group of patients has also been reduced since then by both the development of adequate geriatric services and beds in the general hospital, and by the Local Authority provision of hostels for the elderly. The Local Authority Mental Health Services also increased their establishment of Mental Welfare Officers and satisfactory collaboration between the Unit and these Services has been promoted. There is a good deal of help from voluntary organizations.

Since 1950 the number of annual admissions has increased from 167 to 811 in 1966, the major part of the increase being for women. In ten years the attendances at out-patients has doubled, being over 6,000 in 1966, but the majority of these are not for new patients, the latter only increasing from 406 to 488. Dr Downham (47) states that 'treatment sessions for psychotherapy, abreactive and analytical procedures, supportive measures and physical treatments are used by all medical staff throughout the week'. The ratio of treatment to diagnostic sessions is about 10:1. The major emphasis of treatment and care in this department is evidently in the hospital itself, in its out-patient department, in its day-care provision and in its rehabilitation workshop. Most of its patients are brought to it (by MWOs) or referred by GPs or other doctors. While the contribution which the Local Authorities make to the psychiatric work of the department is evidently important, the emphasis is not on domiciliary visiting. Nevertheless a main objective is to treat patients as far as possible while they live at home, to prevent long periods of hospitalization, and to admit a patient repeatedly for short periods, if it is necessary. From published reports from this and other units in the Manchester and other regions, it is evident that a major preoccupation of these units is to demonstrate, as they claim to have done, that they provide comprehensive treatment and care for the populations they serve, and that as the years go by, fewer and fewer patients are referred to the large psychiatric hospitals. Burnley by 1965 had reduced

this number to one in a year! This it is appreciated has only become possible through the provision of really adequate geriatric services. If it is true that the wards of these departments are not becoming silted up with chronic patients, particularly schizophrenics and demented patients, then the objective of closing the major psychiatric hospitals may become realizable when the chronic patients, who form such a large proportion of their resident population finally die.

Yet there is one issue of even greater importance to the future of the psychiatric services of the country which is made prominent by the work of such units as that at Burnley. Dr Downham with an in-patient unit of 129 beds and an incredibly small staff,[1] claims to be able comfortably to provide a comprehensive psychiatric service for a population of over 170,000 and believes he could cope with a population of 200,000. This is a provision of 0·35 beds per thousand population—a figure far lower than the 1·8 predicted by Tooth and Brooke (43) for 1975. Dr Downham's view is supported in general terms by others working in similar departments in other areas of the country, but not by all. Figures such as these are, of course, most acceptable to those who have to make financial provision for future medical services in the country. Before accepting them, however, at their face value, it is necessary as far as we can, to ask in what context they have been provided, what is the nature of the psychiatric service which the District General Hospital offers, and what are the consequences for the patients?

Dr Hoenig and his colleagues at Manchester (49) carried out a four-year follow-up study of patients seen at Burnley and at another unit in the area, the object being to try to assess the burden on the community, particularly on the families in this type of service. They concluded that the total subjective and objective burden was 'considerable'—more than half the households had been affected. They found that 40 per cent of the families, although complaining of severe burden, had not received any help from social agencies. Since the patients with neurotic and personality disorders were so numerous and formed such a large proportion of all patients (about 45 per cent) an important observation was that the families of this group showed 'a very considerable amount

1. See Appendix II.

of objective burden'. This led to the conclusion that the term 'minor psychiatric illness' seemed hardly justifiable. Another survey with similar objectives comparing two types of psychiatric service in southern England (52) reached much the same conclusion. This work compared a service based on a psychiatric hospital with a community service associated with short-term admissions to its hospital. The family burden was particularly evident in the latter service and in respect of one group of patients in particular: 'these were the younger, mainly psychoneurotic patients'. The answer here seemed to be that the community service was not providing social support to the families.

The context in which psychiatric services have developed in the last fifteen years varied in different parts of the country. Every region has done the best it can, given its heritage of old hospitals remote from its main centres of population, the character of its communities, the availability of medical, nursing and other manpower, and its financial resources. Some regions are better endowed than others; some with apparently equal resources have developed differently. Superficial comparisons may not disclose deep differences of policy or of attitude, but they are a useful way of examining regional differences (40).

Tables 5.1 and 5.2 show some similarities but a far greater number of differences between the Oxford, South-western, and Manchester Regions. Manchester inherited a number of old hospitals with 2,000 beds or more; Oxford had none of this size. Oxford has converted its smaller hospitals to modern use; Manchester has built new units in general hospitals. Nearly a quarter of the wards in the psychiatric hospitals of Manchester had over 70 beds in them; in Oxford there were none. The number of resident patients per thousand population in the two regions were about the same, but in almost every other respect the two regions differed. The admission and discharge rate were higher in Oxford and the number of new patients attending out-patient clinics much greater. The amount of out-patient treatment compared with in-patient care which the average patient received in Oxford was far greater than in Manchester. Yet relatively more day-hospital care, industrial rehabilitation and domiciliary visiting was done in Manchester.

TABLE 5.1. *Psychiatric hospital services in three regions, 1964*

Index (*Ministry of Health 1968*)	*Regional data* (*Ministry of Health 1968*) *percentages* M	SW	O	*Regional rank order for index* M	SW	O
Service beds in hospitals with more than 2,000 beds	47·1	20·3	nil	11th	5th	1st equal
Service beds in hospitals with less than 100 beds	2·8	1·4	nil	2nd equal	5th equal	13th equal
Service beds in hospitals with 100–500 beds	12·6	4·3	4·7	3rd	9th	8th
Resident patients for 1,000 population	2·32	3·18	2·07	3rd	10th	1st
Resident patients in whole-time industrial work	9·9	12·7	5·9	8th	3rd	11th
Admission rate per 100,000 population‡	261·6	379·5	276·7	*	*	*
New outpatients per 100,000 population‡	206	368	296	11th	2nd	8th
Out-patient attendances per 1,000,000 population‡	1,507	2,193	2,124	12th	6th	7th
Out-patient attendances per 100 in-patient days†‡	1·8	1·9	2·8	9th equal	6th equal	3rd
Day-hospital attendances per 1,000 in-patient days‡	12·0	14·0	5·0	2nd	1st	9th equal

M=Manchester Region, SW=South-western Region, O=Oxford Region. The regional rank orders were derived by the author from data given by the Ministry of Health (1968) referring to 1964. The lowest rank was given, per index, to what the author considered the 'best' region, not to the region with the highest score. For example, Oxford has 0 per cent of beds in hospitals with more than 2,000 beds (ranked 1st equal), and 0 per cent of beds in hospitals with less than 100 beds (ranked 13th equal).

* The admission rates were not rank-ordered. The reason for this is discussed in the text.

† Ratio of out-patient attendances to 100 in-patient days.

‡ The Ministry data (43) for these indexes cover 12 regions, the four metropolitan regions being combined as one, so that the rank orders range from 1 to 12. The range is from 1 to 15 for the other indexes in this table, and for all those in table 5.2.

It is when we look at the staffing provision in the two regions (table 5.2) that the most striking differences appear. The provision of psychiatrists per thousand resident patients is nearly twice as great in the Oxford region, and that for nurses, trained or others, about 50 per cent more. Similarly there are more psychologists,

TABLE 5.2. *Psychiatric staffing in three regions, 1964*

Index (Ministry of Health 1968)	*Regional data (Ministry of Health 1968) percentages* M	SW	O	*Regional rank order for index* M	SW	O
Consultant psychiatrists per 1,000 resident patients	2·5	3·2	5·5	15th	11th equal	1st
Other psychiatrists per 1,000 resident patients	6·5	7·3	11·7	15th	13th	1st
Trained nurses per 1,000 resident patients	7·9	10·4	12·2	15th	7th	2nd
Other nurses per 1,000 resident patients	13·5	15·7	17·9	10th	5th equal	1st equal
Psychologists per 100 resident patients	0·14	0·07	0·21	3rd	9th equal	1st
Psychiatric Social Workers per 100 resident patients	0·14	0·36	0·18	12th	1st equal	11th
Therapists* per 100 resident patients	0·63	0·44	0·72	9th	13th	5th

* Occupational-, physio-, and speech-therapists.

The regional rank orders were calculated as in table 5.1.

M, SW and O refer to the Manchester, South-western, and Oxford regions.

psychiatric social workers and other therapists in Oxford. The writers of the Ministry Report are careful to emphasize that a high or low value for any one of the thirty-nine indexes of activity which they published for the regions, did not mean that a judgement was being made, either good or bad. I will not be so tactful as this. I assume that in general it is 'better' to have more rather than less doctors and nurses and other workers to man a psychiatric service; that it is better to do more rather than less work in outpatients; that unless one assumes gross difference of morbidity in different populations, it is better to identify and treat more rather than less new patients. Moreover it is 'better' to site psychiatric services in relation to small units rather than large ones. Tables 5.1 and 5.2 show that in almost every respect the figures for the Manchester Region put it towards the lower end of the league. They are 'worse off' in almost every respect, when compared with Oxford, which is at the top end of the league. Manchester is particularly

badly off for all types of staff, except psychologists, and naturally its psychiatric services treat either as in-patients or out-patients far fewer patients per unit of population than Oxford does. Yet in two respects Manchester comes off better. First it is high in the league for the number of small units of under 100 beds—its District General Hospital Departments of which it is proud; and secondly there has been compared with other regions a greater development of day-hospital care, industrial and occupational rehabilitation.

In my view the claims of the 'Lancastrian Movement' promulgated by a number of psychiatrists working in the Manchester District General Hospitals (47, 53, 54) that a 'comprehensive psychiatric service' can be operated from departments having far fewer beds than the national average must be seen in the context of the physical and human resources available to them. It may well be that in the future fewer beds will in fact be required than the prediction of Tooth and Brooke (43) suggested. There can be no doubt that the Manchester units show what can be done with the most limited resources. Most competent observers, however, believe that if this turns out to be so, it will only be because the psychiatric services operating in the community have been greatly extended and developed, and they will require a far greater provision of staff. The conclusion that these units are 'comprehensive' is difficult to sustain. Silverman (53), in particular, has denied that these departments are little more than modern versions of the old observation wards, or emergency units providing short-term treatment for the psychotic and the psycho-geriatric patient. On the other hand, published reports do not specify what is done for the neurotics, the adolescents, and the many patients with personality disorders, who in aggregate make up nearly half of the psychiatric sick.

THE MENTAL HEALTH CENTRE

The psychiatric services of Plymouth are for a population of about 320,000, mainly in the City of Plymouth (220,000) and the rural neighbourhood of west Devon. The services are based on an integrated system of the psychiatric hospital, Moorhaven, which is thirteen miles from the city, an out-patient department in the

Plymouth General Hospital and the Mental Health Centre (the Nuffield Psychiatric Clinic) which is in the grounds of that hospital. The finance for the building of the centre was provided by the Nuffield Provincial Hospitals Trust and it was opened in 1962, Dr K. M. Weeks being appointed Medical Director. The important decision to have a Joint Management Committee composed of hospital and Local Authority representatives was taken at the start, and the cost of running the Centre was shared. The Centre provides accommodation for social workers from the hospital and Local Authority, a day-hospital of 50–60 places for different categories of psychiatric patients, therapeutic social clubs, rooms for individual psychotherapy, and a conference room. In the same building the Child Guidance Clinic of the area is situated, and nearby in the grounds of the hospital, the Local Authorities have built School Health and Dental Clinics and a new Maternity and Child Welfare Clinic (55).

The objective has been achieved of bringing together those working in the mental health services under one roof. The senior psychiatric staff of Moorhaven do diagnostic work in the General Hospital Out-patient Department, but treatment work in the Mental Health Centre; the MWOs of the Local Authority, the Hospital Psychiatric Social Workers, the nursing staff of the day-hospital and of the children's department are all accommodated in the Centre and meet daily. Dr Weeks's account of the department (55) suggests that a blurring of the distinction between those who work *only* in the hospital or Centre and those who work *only* in the community was planned as far back as 1957 and is already well marked. An example of this is the nursing after-care service in which a number of staff nurses work part-time, visiting discharged patients in their homes; in 1964 there were 2,870 such visits paid by five nurses. In that year of all new patients 14 per cent had been seen first by psychiatrists in domiciliary consultation. Contacts between the Service and GPs are therefore well developed and nurtured; the great majority of patients are referred by their GPs, and the proportion of patients brought to the hospital for admission by MWOs, without prior assessment or psychological preparation for admission, is probably smaller than in most other places.

TABLE 5.3. *Three psychiatric services compared*

Service	*Population served*	*Number of beds*	*Number of day places*	*Data for 1966* *New out-patients seen*	*Total of attendances*	*Number of admissions*
District General Hospital (Burnley)*	171,000	129	20–30	488	6,381	811
Mental Health Centre (Plymouth)*†	305,000	761	60–70	754	5,493	1,057
Teaching Hospital‡	Not Applicable	85	17	1,489	16,352	731

* Data kindly provided by Dr. E. T. Downham (Burnley) and Dr. K. F. Weeks (Plymouth).

† Figures for the Plymouth Mental Health Service operating through the Nuffield Psychiatric Clinic, Moorhaven Hospital, and Plymouth General Hospital.

‡ The Middlesex Hospital, London. Personal data.

An obvious advantage, but one which is not openly declared, is that the Services of Plymouth enjoy the use of a psychiatric hospital which is not too large—761 beds—but which is nevertheless sufficient, and that the scheme for the development of these Services came in the first place from the senior staff of that hospital and were not imposed from outside. As a result there is no preoccupation with how many or how few *beds* are required to run the service—a preoccupation which in so many parts of the country has become an obsession. Rather the emphasis at Plymouth is on care in the community, continuity of such care being carried out by whosoever is best qualified to give it. The hospital in this context becomes a vital link in the chain of services provided, but it is not the only one, nor indeed the most important one. Table 5.3 gives some comparisons between the three departments under discussion.

The MRC Unit inquiry (50) showed that in 1961, 78 per cent of new patients to the Plymouth service were referred by GPs, 15 per cent from the general hospital doctors, and only 6 per cent *directly* from the Local Authority or other agencies. Forty per cent of new patients were psychotic; 50 per cent were neurotic. Of all new patients seen in the year, 43 per cent were admitted in that year. The provision made for the treatment of neurotic patients, even in 1961, was remarkable—psychotherapy of one type or another was given to 35 per cent of all new patients and social

work to 6 per cent. The facilities of the Nuffield Clinic, and the fact that the staffing between it and the psychiatric hospital was fully integrated and shared, made the therapeutic effort possible.

The South-western Region, in which the Plymouth service is situated, is in many respects more favourably placed than the Manchester Region, but is less so in most indexes than the Oxford Region (see tables 5.1 and 5.2). Nevertheless it comes at the top or very near the top in certain interesting ways. In the time spent in day-hospitals as opposed to that in the in-patient accommodation, it heads the list of all regions, and in the number of new patients seen per unit of population it is second. It has relatively more psychiatric social workers than all other regions and there are relatively more therapists (occupational and others) than all but one. Nevertheless it is badly off for psychiatric medical staff, consultants and others and not too well placed for nursing staff. It is not surprising, having regard to the geography of the region and the staffing in the departments that the admission rate, compared with other regions, is high. Despite all the difficulties it is evident that the psychiatric ethos of the South-western Region typified I think by the work of the Plymouth Mental Health Centre, is towards continuous care *in the community* and the integration *to this end* of hospital and Local Authority personnel.

THE TEACHING HOSPITAL DEPARTMENT

The Middlesex Hospital is situated in central London within a quarter of a mile of Oxford Circus. The surrounding population mostly commute to work from other areas of London; the residential element is small, heterogeneous, and mostly transitory. There are few families. The teaching hospital and its new medical school are in immediate proximity with one another; the latter admits 100 medical students a year. For teaching purposes there are close links with the Central Middlesex Hospital at Hounslow, but the Middlesex itself has not as yet accepted responsibility for any defined population in the area. Like most teaching hospitals, patients are referred to it from all areas of London, from the Home Counties and from further afield. It has a well-established preclinical school in which the biological and physical sciences are well represented but as yet there are no behavioural science

departments and no formal links with other university schools in which such departments exist.

In 1922 an approach had been made to the Board of Governors by St Luke's, the charitable foundation to which I have referred in chapter 1, suggesting an out-patient and in-patient clinic at the Middlesex for psychiatric cases, and for a time a few patients were admitted and treated under the care of a psychiatrist from St Luke's. At this time a new hospital at Muswell Hill was contemplated and was finally built in 1930. The association between the Middlesex and St Luke's continued and in 1935 the senior psychiatrist at St Luke's became the physician in psychological medicine at the Middlesex Hospital (the late Dr Noel Harris). At the Middlesex, however, his work was in the out-patient department only, where he taught students, and the hospital itself had no in-patient unit. With the start of the NHS, St Luke's joined the Middlesex, was designated a constituent member of the Teaching Hospital Group and the seventy beds at Muswell Hill became the in-patient unit for psychiatric cases of the Middlesex Hospital. It was situated at a distance of about four miles from it. In 1960 the University created a Chair of Psychiatry at the School, on the condition that fifteen psychiatric beds were opened on the Middlesex site. The academic unit was opened early in 1961. As a result the Middlesex at that time had the largest psychiatric department in terms of staff, beds and facilities in a London teaching hospital. It had eighty-five beds and was well endowed with consultant and academic staff, psychiatrically trained nursing staff, psychiatric social workers and occupational therapists.[1] The teaching load was, however, great since a three-month, full-time, clinical clerking attachment was instituted for all students, and behavioural science teaching was introduced into the pre-clinical curriculum (56). The academic unit had been created to stimulate teaching and research and this it endeavoured to do.

I have chosen the Middlssex department, not only because until 1966 I was associated with its work for a period of five years and therefore have first-hand knowledge of it, but also because there were opportunities which were unique at that time to explore the role of a psychiatric department in a teaching hospital, when that

1. See Appendix II.

department was adequately staffed with full-time psychiatrists and fully integrated with the other departments of the hospital itself—situated on the same site. It has been said that fashions in psychiatric referrals come and go, and that the enthusiasm of individuals, and the contemporary interests of consultants in different areas of medicine are important determinants of the extent to which they overlook, identify or exaggerate the psychological factors in their patients' illnesses. No doubt there is some truth in this, and that the extent to which the psychiatrist's help is seen to be needed is a function in part of such intangibles. The effects of placing a full-time psychiatric staff, both senior and junior, *within* a large teaching hospital, particularly when a number of the senior members' interests are oriented towards the problems of psychosomatic disorders, neurosis and personality disorder, discloses very soon a new area of psychiatric practice, which although previously known has in the past been largely neglected within the general hospital scene. An objective after 1961 at the Middlesex was to explore this area and to this end a liaison service was created with as many in-patient departments as possible. Despite a generous provision of psychiatric staff it was not possible to make this comprehensive, but particular effort was made towards general medical and medical specialty firms, and towards the professorial departments of medicine and surgery. All psychiatrists in the department, of rank above SHO, were given liaison appointments.

It is known that the prevalence of psychiatric illness among *out-patients* attending non-psychiatric clinics, particularly medical clinics is high. Davies (57) surveying reports from this and other countries, found a wide range of case-identification of which the mean was nearly 30 per cent of all patients attending such clinics. Of course the proportion is greater if the numerous patients with known organic disease and associated psychological disorder are added. Probably the proportion of patients attending with purely psychoneurotic illnesses uncomplicated by physical disease is much smaller and may approximate to the proportion of the GPs work with this type of illness. Indeed, as suggested in chapter 4, many such patients are referred to medical out-patient departments by their GPs for reassurance or to reassure the GP himself that no physical disease has been missed.

There is evidence, however, which indicates that a substantial number of psychiatric patients of all types pass the consultant's screening in out-patients and are admitted to the wards for further investigation. At Guy's Hospital 0·7 per cent of 50,000 admissions over a five-year period were referred for a psychiatric opinion. Most came from medical wards and there was a high incidence of depression and hysteria among them—about a third presenting with physical symptoms (58). At another London teaching hospital (King's), two-thirds of the new patients seen in the psychiatric department came from sources inside the hospital (584 patients in one year), but nearly half of these patients had been admitted for 'attempted suicide' (59). Neither of these general teaching hospitals in south London had a district responsibility, neither of them had full-time senior psychiatric staff, nor a psychiatric liaison service.

The experience of all those who have reported is that the pattern of illness seen in the general hospital shows a low incidence of psychosis, but a high incidence of depression, neurosis and personality disorder. The figures in table 5.3 refer to the work of the whole department at the Middlesex, which includes that of the Professorial Unit. It shows that compared with the District General Hospital *treble* the number of new patients was seen, the total attendances were also more than twice as great, but that the number of patients admitted to the department as in-patients was about the same. The number of beds were not dissimilar. In numerical terms the total work of the teaching hospital department more nearly approximated to that of the work of the department based on the Mental Health Centre at Plymouth. Yet at the Middlesex the patterns of illness of the patient clientele were entirely different from those in the other two departments.

Having no working relationships with Local Authority Services, and no responsibility towards a given population, no patients were admitted by MWOs, although patients could be, and were, compulsorily admitted to a sixteen-bed ward specially built at St Luke's for acutely suicidal and disturbed patients. The department's work was wholly derived from GP referrals, referrals from other hospitals and from internal sources in the Middlesex Hospital itself. Over a four-year period (51), for each year

more than half the new patients referred to the department came from within the Middlesex, either from out-patient clinics or from the wards. A third of the total new patients were referred by the general physicians. The latter saw between 4,000 and 5,000 new patients each year and referred over 4 per cent of them to the psychiatric department. As the academic unit in the department developed and became known a larger number of patients were referred to it by GPs and the total case-load increased—there were 731 new patients in 1966, of which 52 per cent came from within the Middlesex, 48 per cent from GPs and other hospitals.

The work of the liaison service has been described by Dr A. H. Crisp (51) (now Professor of Psychiatry at St George's Hospital Medical School) who helped to develop it and who took personally a very active part in it. He was attached over a four-year period to the wards of two general physicians with 18 beds in a male ward, and 20 beds in a female ward. These physicians were in the habit of coping with the help of MSWs with many of the psychological and social problems of their patients. In the four-year period these physicians formally referred to Dr Crisp 10 per cent of all their admissions (about 80 out of 800 admissions each year). A breakdown of the diagnostic categories in 307 patients referred is shown in table 5.4.

Nearly all these patients, except those with suicidal attempts, had been admitted to the hospital with physical complaints which raised in the physicians' minds the possibility of organic disease. Only a very few suffered from formal psychiatric illnesses of psychotic degree. About a third of all cases were seen only once or twice by the psychiatrist and given advice. Only 17 per cent were transferred subsequently to in-patient beds in the psychiatric department; 13 per cent were given psychiatric treatment while in the medical ward. About a fifth subsequently were treated as out-patients of the psychiatric department, and a few were taken on for formal psychotherapy. The large proportion of patients referred, nearly a third of all cases, with psychosomatic diagnoses (including rheumatoid arthritis, essential hypertension, ulcerative colitis, peptic ulcer, asthma and diabetes) deserves comment. It is evidence that in the minds of sophisticated physicians, no less than in that of the psychiatrist concerned, psychological and social

TABLE 5.4. *Psychiatric diagnoses in two medical wards*

Depression (excluding attempted suicide)	58
Attempted suicide	45
'Organic' mental state	18
Psychoneurosis	59
Schizophrenia	9
Subnormality	4
Addiction (including alcohol)	17
Psychogenic somatic complaints	19
Homosexual conflict	8
Personality disorder	8
Psychosomatic disorders (formal)	93
Others	10

Table 5.4 from A. H. Crisp (51) 348 diagnoses and partial diagnoses following psychiatric assessment in 307 patients referred from two general medical wards, one male, one female, October 1961—October 1966.

factors play an important part in the causation or perpetuation of these very common chronic physical illnesses and that investigation and possibly treatment by a psychiatrist is worthwhile.

The work of this teaching hospital department was very different from that of the District General Hospital described. It had different responsibilities, different objectives, and had an entirely different pattern of psychiatric illness with which to deal. It more nearly resembled the work of the Mental Health Centre at Plymouth, for that department acquired 15 per cent of its new patients from within the general hospital. But it is fundamentally different in that at the Middlesex nearly all the energies of the department were deployed within the hospital itself; at Plymouth these energies were deployed towards the sick population who were living in the community. Each in its own way throws partial light on the burden of total psychiatric morbidity in the population. The only possible common link between the work of these three different departments is the doctor of primary and continuing contact, the GP. He alone, it might be thought, should have the opportunity of seeing the whole range of illness in the community, and this may be true for patients whose problems fit most easily into a *medical,* as opposed to a *social* context. For the latter, more often than not, this depends upon whether other agencies inform him that a patient has made contact with the

psychiatric services organized by them. Examples of this group are the patients involved in public behavioural disturbance who are taken to casualty departments of hospitals by the police, and most important of all the children whose behaviour disturbance is identified at school and referred by the care committee to the local authority child guidance clinic. In the majority of such cases there is a family in which other members are psychologically disturbed.

6

Morbidity surveys

Screening methods for estimating the total psychiatric morbidity of a population are not available and the reasons for this are examined. Methods of identifying particular groups at risk, of which the reliability and validity are known, have however been developed in recent years. The example of the Isle of Wight survey in which all children in a particular age-group were screened by such a method, and then those identified as 'potential cases' examined individually is described. Cumulative psychiatric registers for defined populations are now being developed in Britain. These provide the means of studying chronic mental disorders in depth and of carrying out prospective studies. True prevalence rates for such serious disorders may also be obtained by this method, which is undoubtedly the best instrument so far developed by which to carry out research on the natural history of major psychiatric illnesses.

The number of patients resident in mental hospitals is no indication of the prevalence of psychiatric disorders; nor are the numbers attending out-patients, or their GPs. The 'invisible' and unidentified patients may in some communities be almost as numerous as the 'visible' and known. To obtain an idea of total psychiatric morbidity of a given community it is necessary to sample a defined population, and sampling procedures in psychiatry are themselves fraught with difficulty. Preferably the population studied should have known and stable demographic features, and have a low mobility so that the proportion of people entering and leaving it is small each year. Even if such a costly research exercise could be launched and the administrative difficulties overcome, there remains the fact that the objective-type instruments available for detecting mental disorder, although greatly developed in the last few years, are in general most useful for detecting particular groups of patients, and few are comprehensive which are not too unwieldy. Moreover the risk of refusal to

co-operate by a proportion of the sample, which inevitably occurs, is greatest in those most likely to be mentally ill. In all urban populations also there is a socially isolated, highly mobile group of individuals who may not be known to GPs or to the social agencies and are likely to escape detection. It is particularly among this sub-group, who may be numerically quite large although forming only a small percentage of the whole, that psychiatric morbidity is high (see chapter 8).

There are no physical or psychological tests which can be used either as a screen or to identify cases. For the former purpose it is possible to use questionnaires, of known reliability and validity, and for the latter, psychiatric interviews carried out by psychiatrists who can record their observations according to an objective and structured plan. Moreover, since the task is great, a number of psychiatrists will have to be used whose inter-rater reliability is known and of a high order. Whichever method is used—the questionnaire or the psychiatric interview—there will always remain the problem of deciding when a person is a 'case'. This difficulty is not, of course, one confined to psychiatric epidemiology, for it has been encountered in many areas of medical research in which chronic diseases have been the subject of population surveys. But it is greater in psychiatry for survey methods have been greatly embarrassed by the lack of hard diagnostic criteria, especially any based on physical or laboratory tests and by the varying opinions and different diagnostic and therapeutic practices among psychiatrists themselves.

I have suggested in chapter 4 that a large but unknown proportion of the population are at any one time suffering from unhappiness or social distress. Many are afflicted by minor complaints of a physical or psychological nature; some tolerate them most of the time and only regard themselves as in need of help occasionally; others constantly feel the need for help and seek it. Yet others while feeling the need for help, do not believe that they can be helped and therefore do not seek it. Population surveys carried out in the U.S. (see p. 57) indicate that if a liberal view of what constitutes morbidity is taken, and if the method of assessment is the psychiatric or personal interview, only about a fifth of the population can be regarded as psychologically healthy. This has

led to the frequently made claim that the known figures of morbidity derived from the hospital or GP referral rates are only the tip of an iceberg.

No attempt at a total population morbidity survey has been made in this country, and the cost and difficulties involved, the doubtful meaning of the results likely to be obtained, have hitherto made it unjustifiable to attempt one. Nevertheless diagnostic instruments of tested reliability and known validity are now being developed, which can be used as screening devices to detect not only the major, but also the minor disorders. Dr D. P. Goldberg (60) who has developed such an instrument for non-psychotic patients makes the point that it must be easy to administer, acceptable to respondents, fairly short and objective in the sense that it does not require the person administering it to make any subjective assessments about the respondent. Nevertheless such questionnaires can only be used as the first stage in psychiatric case identification if a population survey is undertaken. By their use 'potential cases' can be reliably identified, but these must be interviewed by a psychiatrist using a standardized interview of known reliability. The 'actual cases' are then selected by this second process, when a criterion for what constitutes a 'case' has been defined.

THE ISLE OF WIGHT SURVEY

If it is not yet possible or scientifically justifiable to attempt a population survey of total morbidity, the value of a survey to study the psychiatric disability in a 'captive' population of limited size, restricted mobility and restricted age range is undoubted. In no age-group is this more important than in children. The Isle of Wight survey was set up by Dr Michael Rutter and his colleagues (59) with the financial support of the Department of Education and Science and of the Association for the Aid of Crippled Children. The objective was to study the psychiatric, physical and educational handicaps among schoolchildren on the island. This large ambitious programme is not yet completed but some studies have been reported. The prevalence of psychiatric disorder in 10- and 11-year old children attending schools on the island, with the exception of those attending private schools,

was reported in 1966. The method of a two-stage approach was used, in which first all children of this age were studied by means of multiple screening procedures, and then those selected as potential cases were subjected to more intensive study. It was necessary to identify all children of this age who were under the care of any of the relevant services, and all who had come before the juvenile court, were attending a psychiatrist on a given date, or had been in care for six months or longer on that date. All children who were not attending school, all those known to be attending school on the mainland, those in hospital, and at training centres or special units had to be identified, as well as those attending maintained schools on the Isle of Wight.

The total population of children aged 10 and 11 years was 2,193, and of these 284 (13 per cent) were selected by the screening method for more intensive study. The screening method was to give to the teachers and to the parents separate behaviour questionnaires of which the reliability was known and of a high order for the same teacher or parent, and for different teachers. In the case of parents the correlation between the scores from fathers and mothers was less high but still significant. The value of these two screening procedures was known in that they had been shown from previous work to discriminate reliably between children who were under psychiatric care and those who were not. Moreover, previous work with these methods had shown that they could reliably discriminate between children with different types of psychiatric disorder—such as neurotic and anti-social disorders. Rutter and Graham (61) obtained excellent co-operation in this study and in one month in 1965 received behavioural questionnaires completed by teachers for 99·8 per cent of the children, and by parents for 88·5 per cent of the children.

Clinical experience of the psychiatric disorders of younger children has often suggested that in many cases behavioural disorder which is witnessed by the parents in the home may not be evident in the school and vice versa. Moreover previous pilot studies on samples of schoolchildren reported to the Underwood Committee (62) had supported this, the findings suggesting that schoolteachers may see anti-social behaviour which does not occur at home, while parents often observe neurotic behaviour which is

not evident at school. The Isle of Wight survey confirmed this in that while the parental and teacher scales selected about the same proportion of children (6 per cent and 7·1 per cent respectively), and subsequent clinical examination showed that both scales were equally effective in identifying children with psychiatric disorder, to a considerable extent they selected different abnormal children. There was little overlap. Yet the simple explanation which had previously been put forward that parents identify neurotic children and schoolteachers, anti-social dull children, whatever the screening device used, is not adequate and is not supported by this study. Other more intangible factors determine the differences, but it is clear that psychiatric disorder in children cannot be identified by a method of inquiry which is directed either to parents or to teachers alone. How a child behaves is greatly determined by the situation he is in, and this is also true of psychotic behaviour in adults.

The screening procedures identified 13 per cent of the population for further study. This for all 284 children involved an interview with the parents, a report from the teacher and a psychiatric examination of the child; in addition psychologists administered intelligence and reading tests. At every stage the reliability of information obtained was checked, by using standardized procedures, second interviews and assessments and examinations carried out by two psychiatrists independently, whose inter-rater correlations were examined and shown to be of a high order. Six months after the initial teacher screening, the new teachers of the selected children completed the same questionnaire on the children and were asked to provide free comments on their behaviour in school. An over-all assessment on each child was then made by two psychiatrists independently, with two main questions in mind. The first of these was the psychiatric state of the child; the second the need of the child for psychiatric help. The inter-rater reliability at this stage of the exercise was again high (0·88).

Of the total population of 2,193 children aged 10 and 11 years, 124 were finally selected as having some definite psychiatric disorder; 48 had severe disorders. This very careful study indicated that 6·3 per cent of the total population of children of this age could have benefited from attendance at a child psychiatric out-

patient clinic. About a third were thought to need 'diagnosis and advice only', a third 'possibly required treatment', and a third 'probably required treatment'. The prevalence of 6·3 per cent was certainly a minimal one, for children with educational disorders, those with mental subnormality and children with mono-symptomatic disorders such as enuresis were excluded. However, the rate of 2·2 per cent for the severe psychiatric disorders should be regarded as an important indication of the need for increased services for this group of children. At the time of the survey (1965) only 0·7 per cent of the children were actually receiving treatment.

The Isle of Wight study has provided important evidence that there are many children in need of psychiatric treatment of one sort or another, who are not receiving it. It is known that waiting lists for new patients, especially in London, are very long. Many months may elapse before a child referred to a child psychiatric service can be seen. As at present developed, the child psychiatric services could not possibly cope with the number of patients which the prevalence of serious disorder alone (2·2 per cent) demonstrates are most clearly in need of help. Yet it is likely if the child psychiatric services were greatly extended and such help became available, many parents of abnormal children would not use them. The situation here is analogous to that of many neurotic adults who do not seek medical or psychiatric treatment, even if gravely incapacitated or unable to work. In the case of children, however, neurotic attitudes, ignorance or lack of sophistication may prevent parents from seeking advice or help for their neurotic or anti-social child. They may also feel ashamed at having such a child, or feel guilty that they may be responsible for its problems.

It is one thing, of course, to demonstrate the prevalence of psychiatric disorder in children, quite another to make a case for the psychiatric services to be expanded to meet it, even though it may be generally agreed that the normal happy development of children to the maximum of their potentiality should have a high priority in the use of its resources by a modern democratic society. Rutter and Graham (61) make the point that while there is evidence that short-term psychotherapy, drug treatment and other methods can all be therapeutically effective in children, the case

for increased provision of services should not rest upon this alone —it should not depend upon the ability of psychiatrists to *cure* children of their disorders. Diagnosis, advice and counselling of parents and schools are also important functions of the service. Moreover, in the case of children who have long-standing severe disorders causing suffering for themselves and their families, even in the absence of effective treatment, the parents and the family require help and support throughout a very difficult time.

Unfortunately we are still largely ignorant of the natural history of any of the major psychiatric disorders of childhood. Little is known as to which symptoms or behavioural phenomena are transitory in nature and 'spontaneously' disappear, and which are the precursors of more serious disorder later in life, which tend to lead to chronicity. The study carried out by Shepherd *et al.* (30) of schoolchildren in Buckinghamshire which was supported by the Nuffield Provincial Hospitals Trust indicated that about two-thirds of children attending a child guidance clinic had improved after three years, about a quarter were unchanged and 13 per cent had deteriorated. This group of children was compared with a group of matched children with similar behaviour disorders who had not received psychiatric treatment, obtained from the school sample. The untreated group, *as a group*, resembled as far as the improvement or deterioration was concerned, the treated group, there being no significant differences between them at follow-up. These findings can be interpreted in several ways, but it would not be justifiable to conclude that child psychiatric services provided no useful function. It was suggested that whether or not a child was referred to a child guidance clinic depended on the 'tolerance' of the parents of disturbed behaviour. The mothers of the clinic children were found to be more anxious, depressed and more easily upset by stress, than the parents of the children not referred for help. This suggests that neurotic parents tend to seek help for their neurotic children, and non-neurotic parents do not. The concept of the sick family rather than the sick individual as the proper unit for investigation and therapeutic intervention is very relevant here. Rutter and Graham (61) found that children selected by the parental questionnaire rather than by the teachers' questionnaire, came from significantly smaller families. Interviews

with parents suggested that when there were several abnormal children in a large family, the parents often regarded as abnormal only the child thought to be *most* deviant.

Neither the total morbidity survey carried out on a delimited age-group, nor the sample survey in which fairly large numbers of individuals are identified according to certain criteria, treated as a group and followed up, can provide answers to the essential problems of emotional disorder in children or what treatment facilities should be made available. Prevalence studies have been, however, of great value in setting the frame of reference and of testing the instruments by which further studies can be launched. Children, of course, do not refer themselves for help; they reach the sources of potential help because they have upset or caused concern to others—their parents, their teachers or the courts. Children at different ages would appear to cause concern differently. Dr J. A. Baldwin (63) working in Aberdeen has shown that referral rates for boys are much higher than for girls, both in urban and rural areas of north-east Scotland. Similar results had been obtained in earlier studies. However after the age of fifteen, the referral rates for girls rose steeply and greatly exceeded those for boys up to the age of nineteen. Throughout the whole of childhood, conduct disorder as a reason for referral is much more common than neurosis, but the latter begins to increase at puberty, particularly among girls and by late adolescence the referral rates have reversed.

It has been known for a long time that detailed longitudinal studies of adequate numbers of children should be carried out. Baldwin points out that there is a case for viewing the whole period of human development from birth to maturity without regard to the administrative boundaries which at present exist, as far as services are concerned, between childhood and adolescence. Certainly puberty and early adolescence are critical periods for psychological and social development. Now that reliable screening instruments have been developed by which children at high risk can be identified, the task is not so great as it was when the Underwood Committee reported in 1955. Nevertheless extensive and detailed longitudinal studies would only be possible and valuable if all the information relevant to the children and their

families could be reliably obtained from all the health, welfare and social agencies potentially involved. This means that such studies would only be practicable in a population where a case register record-linkage system had been developed and was operating efficiently throughout the whole period of the study. The task would still be very formidable but it has now become possible.

PSYCHIATRIC CASE REGISTERS

Cumulative morbidity registers based on a record-linkage system have been set up in many parts of the world, either to study a particular disease or group of chronic diseases. Psychiatric registers were started in Aberdeen in 1962, and in Camberwell, London, in 1964. They are based on populations living in precisely defined geographical or administrative areas. The Aberdeen Register covers a mainly agricultural area of north-east Scotland with a population of 480,000, but including the university city of Aberdeen with 185,000 inhabitants. There is very little immigration. The Register is situated in the Department of Mental Health of the University (Dr J. A. Baldwin). The Camberwell Register covers a population of 175,000 living in the old Borough of Camberwell (now part of Southwark). The population has changed very little since 1951. Camberwell is part of the greater London conurbation, but there is less geographical mobility than average for London. The population have mainly upper working-class and lower middle-class occupations. The Register is located and administered in the MRC Social Psychiatry Unit (Dr John Wing) at the Institute of Psychiatry. In a recent study (64) certain aspects of the work of two British registers were compared with one another and with that of a similar register which had been set up in 1961 in the State of Maryland, U.S. (the Baltimore Register). The 'reported' prevalence of psychiatric disorder on one day—i.e. the number of patients in contact with a psychiatrist on that day—was examined in the three geographical areas which have different cultural and demographic features, and a further analysis was made of those patients who started an episode of contact during the year subsequent to the census day. The over-all rate was strikingly similar in Aberdeen city, Baltimore city and

Camberwell, being roughly 1 per cent of the populations over the age of 15 years in contact on the census day, with another 1 per cent making new contacts during the subsequent year. The argument which follows upon this is not that 2 per cent of each of the populations studied gives an indication of the 'true' prevalence of psychiatric disorder—it obviously does not—but that in each of the areas studied the proportion of the community resources devoted to psychiatry is much the same. In what follows I shall refer mainly to the Camberwell Register, and to the work of Dr John Wing, Dr Lorna Wing and their colleagues.

The Camberwell Register was set up for two main purposes. The first was to provide a sampling frame for the study of particular psychiatric illnesses of sufficient severity to result in contacts with hospital or community agencies. Being cumulative the Register would provide a complete picture over time of the particular illnesses to be studied within the known population. The Register covers all contacts with all the agencies and types of service in the area and is kept up-to-date in the sense that information is constantly being collected about patients making new contacts and those regularly in contact. Thus by its use prospective as well as retrospective studies can be carried out—the former an exercise which in the past has always been very difficult. The second main purpose of the Register was to provide statistical data about the patient population and the available facilities and changes in these, so that data could be used to plan and evaluate local psychiatric services. Such data would, of course, also be of value nationally as well as locally. Wing *et al,* (65) assert, that the cumulative psychiatric register is more suitable for both these purposes than the usual survey methods. For example, a population study cannot be used to study schizophrenia in depth, for it would be necessary to screen 100,000 people in order to find 15 new patients in a year, and then the acute phase of the illness would be likely to be missed. There are several important advantages to the Register provided it is truly comprehensive. Since practically all serious cases of mental illness are identified in the Register, not only at the point of first contact with the psychiatrist, but also at all subsequent contacts with hospital or other social agencies serving the population, and since the latter is defined and

known, there is no danger of duplication of cases and *for such serious illnesses true prevalence* can be arrived at. Moreover, since the Register is cumulative the 'path of the patient can be traced through contacts with many agencies, the pattern of first contacts can be compared with the pattern of re-contact, changes in pattern of contact over time can be observed and the effects of introducing new services in an area (for example day hospitals and community care) can be followed'. The problems arising from the policy of discharging patients at an early date from psychiatric hospitals, of treating as far as possible the mentally ill without admission to hospital have already been discussed (chapter 3). The cumulative psychiatric register should be able to illuminate these problems. It is still not known what proportion of the mentally ill who previously would have remained in hospital for long periods are now accumulating on the books of community agencies, or disappearing from the medical scene.

The Camberwell Register was set up to identify all adults and children making contact with the psychiatric and subnormality services. This naturally meant that it was mainly concerned with the severe psychiatric disorders and disabilities, and the large population of patients who consult their GPs and are not referred, are not included. The process of setting up a reporting system for this entirely urban population, situated in a large conurbation was a complex one. In or near Camberwell there are three undergraduate teaching hospitals, six other general hospitals, two mental hospitals and a postgraduate teaching psychiatric hospital, quite apart from services provided by the local health and education authorities, the Ministry of Labour, voluntary organizations and the courts. To quote:

> The starting date was 31 December, 1964. A census was completed for this day by the Register staff. They visited and searched the records firstly, of all in-patient hospitals which now or in the past accepted patients from Camberwell; secondly of all the hospitals with psychiatric out-patient clinics within the area, and those outside the area, at ever-increasing distance, until no more Camberwell patients were found; and thirdly, of the local health authority Mental Health Department. Altogether seventy agencies were visited, and thirty special and private units for adults and children in other parts of the

country were contacted by letter. Thirty-four agencies continue to supply information for the on-going Register (65).

All the basic information about the patient, changes in that information, diagnoses and follow-up data are recorded in coded form on magnetic tape to maintain confidentiality and to simplify computer storage and retrieval. Information from the chief agencies is collected weekly, others report monthly and from others there are quarterly or annual returns. It was found that there is a very rapid fall-off in numbers contacting psychiatric agencies with geographical distance from Camberwell. Patients who see psychiatrists privately are not included but there is evidence to suggest that the numbers are very small indeed.

During the first three and a half years of the Register's existence 3 per cent of the population of Camberwell made contact with the psychiatric services. On four census days in each year, the one day reported prevalence of *adults* in contact with the services remains fairly constant—between 632 and 673 per 100,000 of the population and the pattern of age and sex distribution also showed consistency from year to year. There was the familiar increase of prevalence with age for both sexes, women always exceeding men after the age of 25, and nearly double at ages over 65. These rates did not include patients with mental retardation or patients with no fixed address, who in Camberwell because of the large reception centre (see p. 115) in the area constitute a considerable number each year. The one-year reported prevalence rates—the one-day reported prevalence with the incidence rates for new episodes of contact during the subsequent year—showed that just under 2 per cent of the adult population were in contact with a psychiatrist in one year and that the rates were increasing slightly year by year.

The Register showed that the total number of psychiatric beds occupied varied from 294 to 329 per 100,000 population (compare chapter 5) with long-stay beds accounting for approximately three-quarters of them. There appeared to be a slow but steady decline in the number of the latter. Two-thirds of the patients admitted were discharged within two months, a further quarter within one year and 6 per cent remained longer, perhaps to join

the long-stay group of patients. The Register will make it possible to find out firstly, whether the number of long-stay beds required will ultimately be reduced, and secondly whether a new class of long-stay patient is accumulating. The amount of data which the Camberwell register, now smoothly working for more than three years, can provide is very considerable, and will be of the greatest value to those who have to provide the psychiatric services for the area. I wish to refer to a few selected topics which the third report (66) on the work of the Register has highlighted, and which are of relevance to matters which I have considered in other chapters.

Out-patient services

There were more adult Camberwell residents in a spell of out-patient contact on any census day than there were in hospital or attending a day-hospital. Only 25 per cent of those seen were admitted as in-patients. 'Out-patient contact' included all reported contacts with psychiatrists in out-patient or casualty departments, on domiciliary visits or by referral from a general hospital ward. The number of out-patient contacts during 1967 was 8,692 (4,958 per 100,000) *which is almost twice the national average.* The psychiatric services in this area of London which includes Camberwell are highly developed. They include the very large out-patient department and emergency 'walk-in' clinic of the Maudsley Hospital, and the out-patient facilities of King's College Hospital and St Giles Hospital. Wing and Wing (67) in their report on this aspect of the work calculate that if the out-patient services now available for the residents of Camberwell were to become the standard for the rest of the country well over 200 extra consultant psychiatrists would be needed in England and Wales.

There must be few other areas in the country where specialized forms of psychotherapy are so readily available as they are for Camberwell patients. During 1965, 41 Camberwell patients were receiving 'specialized psychotherapy', either group or individual psychotherapy. A few patients were seen several times weekly, but most once a week, for an hour at a time. About fifteen hours of psychiatrist's time per week were spent actually in treatment for this group of patients. In fact Camberwell patients are under-represented in the Psychotherapy Department at the Maudsley

Hospital, for while they form 20 per cent of all out-patients at the hospital, they are only 6 per cent of those receiving psychotherapy. It has been shown elsewhere that factors other than diagnosis determine whether or not a patient is recommended or accepted for this form of treatment. Such factors include social class, educational status, age and marital status. By an examination of the case records, derived from a computer print-out from the Register of all Camberwell patients attending the psychiatric services in 1967, Wing and Wing (67) made an assessment of how many Camberwell patients 'might have been referred for specialist psychotherapy' on the basis that their case-notes seemed in no way different from the notes of patients already attending the psychotherapy department. Instead of the 41 patients who were receiving treatment it was assessed that 202 might have been referred, and if this had happened the entire case-load of the Psychotherapy Department could have been taken up by Camberwell patients alone. This estimate was arrived at after rigorous exclusion of 'unsuitable' patients—and omitted all aged 45 or more. It was therefore a minimal estimate. Wing and Wing conclude that the figure of fifteen hours of psychiatrist time spent each week in the practice of psychotherapy for Camberwell patients 'could easily be multiplied by four or five'.

The figures for supportive psychotherapy, as opposed to group or individual psychotherapy were also examined. These showed that in 1965, 127 'supported' patients made 3,496 visits, each lasting approximately twenty minutes. 583 hours of psychiatrist time was involved, or 11 hours a week. Again despite the apparently good provision made for Camberwell patients, it was evident that many more patients would have received this form of supportive help had more facilities been available. Wing and Wing suggest that the number could have been four to five times greater.

These issues are inevitably bound up with the scarcity of manpower. The various forms of psychotherapy are highly complex and skilled procedures, to be undertaken by those who have had special training in them. The figures provided by the register for out-patient attendances by Camberwell patients and the numbers who are actually receiving specialized psychotherapy

and those who 'might receive it if the facilities were available' are derived from operational data. They do not, of course, imply that such treatment should be given, for the data itself cannot determine whether as the result of providing such facilities the morbidity in patients and their relatives is reduced. Other inquiries involving the evaluation of all types of out-patient treatment would have to be undertaken to establish whether or not this is so. Nevertheless if the data are taken at face value, and if the provisions for out-patient treatment actually made for Camberwell patients was increased to what might have been given for them—if this was used as a standard for the country—400 extra consultant psychiatrists would be required for England and Wales.

These are large issues. Wing and Wing (67) have suggested that the advocates of the psychotherapeutic approach in the treatment of mental illness must compete with many other protagonists, for the small allocation of resources. Supportive psychotherapy, for example, cannot be considered in isolation from rehabilitation, domiciliary supervision, sheltered work and living arrangements and social worker services, all of which are seriously lacking in most areas of the country. This is certainly true for the provisions which have to be made for the care of chronic psychotic patients, such as schizophrenics. Yet for patients suffering from neurotic disorders, disorders of personality and those with sexual difficulties, the forms of social care and help offered are either of little value or quite inapplicable. It must be remembered that such patients constitute the vast majority of the mentally disordered, and that psychotic patients are in the minority. To what extent will society in the future demand that help be offered to such patients?

The role of social workers

The Camberwell Register records the contacts made by all new patients seen by the local authority mental welfare officers (MWOs). In addition over a six-month period *all* contacts made by patients with MWOs were registered and collated with other data. In this period, 1,510 patients made contact with psychiatric and MWO services, or both. But in fact 7 per cent saw an MWO only, and 9 per cent saw both an MWO and a psychiatrist. The majority (78 per cent) of patients saw a psychiatrist only and had

no contact with the MWOs either during the six months or before the period of the study, i.e. these patients were unknown to the local authority services. Very few (9 per cent) of the in-patients discharged from hospital during the period saw an MWO within a month of discharge. The evidence, therefore, was that the psychiatric services for Camberwell at the time of this study (1966) was overwhelmingly 'medical and hospital based'. The patients seen by the MWOs tended to be those in need of long-term support, were heavy users of the medical services, and were more likely to be of low social class and be diagnosed as psychotic. However, an interesting observation was made. A small group of patients were seen many times, ten or more within the six months, by the MWOs and about half of these patients were suffering from neurotic depression. This suggests that the local authority social workers had developed a concern for this group of neurotic patients, and felt that they had the means of helping them by personal interviews, and that they were in fact carrying out the function of 'supportive psychotherapy' which is usually considered to be the psychiatrist's prerogative.

The psychiatric services in the Camberwell area of London have undergone changes and some development in the last three years. In 1968, two years after the study just referred to, a number of joint hospital–local authority appointments of psychiatric social workers, MWOs and other social workers had been made. A work analysis was undertaken of the various groups of social workers in the service. At this time there were 9 MWOs appointed by the local authority, 27 hospital-based social workers and 4 with joint appointments. 86 per cent of the interviews by the hospital-based social workers were carried out in their hospital offices, in a day centre or in a ward—and only 14 per cent in the patients' own homes. On the other hand, two-thirds of local authority social workers' interviews took place in the patients' homes, and only a third in their offices, in the day centre or a hospital ward. Social workers with joint appointments divided their work equally between hospital and home.

The well-known dichotomy between the work of hospital-based and local authority social workers is illustrated by these figures. Tradition and the historical development of hospital and

local authority services which have had different origins have led to this situation which is deplored by many. It has led to lack of communication between the two, much duplication of effort, and many consequences not in the interests of patients. Joint appointments for social workers is one answer to this problem, and is an attempt to link the work done for patients while in hospital with that which is necessary for them after they leave. It is a part-answer to the general problem of providing continuity of care which for the mentally ill is so important, and which to be effective involves the continuing contact by the patient with *one* 'clinician' whose responsibility is felt by him to be a matter of personal concern. I have used the word 'clinician' here advisably following Wing *et al.* (67), who in using the term include all those who provide clinical service—social workers, nurses, occupational therapists and doctors. A major question which will undoubtedly face a modern psychiatric service in the future will be that although teamwork in the care of the mentally ill is accepted by all, no one yet has decided who shall be responsible for providing the essential continuity of care, who shall be the 'personal clinician'. This is an issue which I believe is important for medicine. It is a matter of vital concern for GPs. I shall return to the question of their role and their relations with the mental health services in a later chapter.

7

The drop-outs, the drug addicts and the vagrants

This chapter draws attention to some of the people who suffer from psychiatric disorder but receive relatively little help from GPs, hospitals, or local authority services. Three groups are considered—university students, chronic alcoholics and vagrants. The health and social services are poorly equipped to help these patients. Some reasons for this are examined.

The discussion so far has been concerned with the 'visible' aspects of psychiatric morbidity in the population. From surveys carried out in selected populations, and from case registers we now have a far better idea of the total morbidity of the major psychotic conditions and to a lesser extent of the minor, but often equally incapacitating neurotic conditions. In general the former are dealt with by the hospital and community services, the latter by GPs. The long-term efficacy of what is being done remains unknown, although there is widespread optimism that the chronic disablement from say, schizophrenia, is being reduced. There is practically no evidence that the same can be said for the great numbers of chronic neurotic patients who do not contact the hospital services. GPs with inadequate time, and as the majority admit, inadequate training for their task, manage to contain and support vast numbers of the chronic neurotic sick. There remain for consideration the partially known and largely unidentified 'invisible' psychosocial sick, who increasingly are causing public concern through anti-social and deviant behaviour. While increasing numbers of such people are making contacts with the psychiatric services—or having such contacts thrust upon them, it is largely non-psychiatric agencies, both those set up by local authorities and those by voluntary organizations who accept as far as they can

the major responsibility. Nevertheless in the last ten years the Ministry of Health, as a result of recognition of special groups, has recommended that facilities should be created to help some of them. Among these are the mentally disturbed aged, the emotionally disturbed adolescent, the drug addict, the chronic alcoholic and the psychopathic offender, but there are many other individuals, who have become socially adrift in society, homeless and without family ties, without employment and either the capacity or the motivation for it, who increasingly are disturbing the public conscience and are a burden on our limited financial resources.

There is much confusion both in the minds of the public and in official circles of the meaning of the present wave of social unrest which is so evident in all countries, would seem to affect all social classes, but is largely confined to the adolescent and the young of all populations. There is difficulty in distinguishing between the consequences of social changes which may be transitory and ephemeral in a period of rapid social reorganization, and the consequences of bringing to the surface in all permissive societies the 'invisible' quantum of what amounts to illness, that is to say phenomena which should naturally fall to the responsibility of doctors and the 'caring professions', rather than the courts or the forces of law and order. The recent amalgamation of health services and those concerned with social security and welfare is an example of the acceptance by government that medical and social incapacity are in complex ways bound together. They cannot any longer be kept apart. The creation of one government department for health and social security does not of itself solve any problems, but it indicates the firmly held intention to try to do so. There is a great need for clinical and social research in many areas. How far should the perimeter of psychiatric and medical responsibility be extended to encompass the problems of individuals who present with social incapacity and disability and whose disorders can as yet only be understood as the consequence of social and economic factors? In this chapter three groups from among many of individuals in distress will be identified.

STUDENTS IN DISTRESS

The development of student health services in most universities has brought recognition of the fact that university students are at high risk for psychiatric illness and that the drop-out from studies, and often the failure to realize intellectual potentiality is due in major degree to psychological factors. The prevalence rate for 'mental sickness' in one university (68) was 9 per cent for men and 15 per cent for women. The psychotic rate was not much above expectation, but the great majority of identifiable disorders were neurotic in type and there were a significant number of disorders of personality. Yet there were about as many students who presented psychological symptoms or abnormal behaviour which could not be classified as formal psychiatric illnesses. A further number (10 per cent of men and 14 per cent of women) declared that they had been 'emotionally or nervously unwell' during the survey year, but had not sought help for their troubles. Figures such as these have been replicated by studies in other universities. It has proved very difficult to identify any common social factors which are significantly associated with morbidity in students. There is a declared need for psychotherapeutic help for a proportion of the university student population but who indeed is to provide it? The Royal College of Physicians of London commented:

> the need for psychotherapy is usually so great that there should also be non-medical as well as medical part-time psychotherapists available, preferably as part of the student health service team. The most serious personality disorders and the frank psychoses need the help of the local mental health services (69).

But the *British Medical Journal* (18 June 1966) in discussing this issue remarked: 'Students command no privilege to justify diversion of NHS resources to their special care.'

THE CHRONIC ALCOHOLIC

The chronic drunk has more often been seen as a figure of fun or a butt for contempt than as a medical case. But the steady drip-drip of statistical evidence from the Courts makes the truth inescapable. The largest proportion of men who appear in Court on charges of

drunkenness are advanced alcoholics for whom repeated prison sentences or fines do no good (*Guardian* leader, 28 August 1969).

Chronic alcoholism is now recognized internationally as a chronic 'disease', carrying very serious physical and psychological consequences. There are about 350,000 chronic alcoholics in England and Wales and many are jobless, homeless and 'down and out'. What happens to the patient is in part determined by social class—the middle-class patient tending to remain to a greater extent within the orbit of family protection and to gain access to medical and psychiatric help—the down and out lower-class individual to go to prison. Chronic alcoholics become progressively more isolated socially and many become vagrants. Great numbers appear repeatedly before the courts. Every year in England and Wales there are about 75,000 convictions for drunkenness. Gath *et al.* (70) examined 151 men charged with drunkenness immediately after an appearance before the magistrates in two metropolitan courts, one in an area frequented by vagrants, the other in a mixed middle-class and working-class area. About a third of the men had been arrested three or more times in the preceding twelve months, while only 19 per cent had received any psychiatric treatment for alcoholism. 'A mere 12 per cent had found their way into an alcoholism rehabilitation centre.' There was little difference in the severity of the alcoholism in the two courts which were chosen. Few of those charged were 'casual roisterers'—the great majority had a serious drinking problem, and half showed evidence of dependence on alcohol as determined by morning shakes, morning relief drinking, amnesias, inability to stop drinking and hallucinatory experiences. Chronic alcoholism is a disorder largely confined to the large towns and cities. It is predominantly, in so far as it becomes 'visible' to social and legal agencies, a disorder of the male. It is a very serious condition, carrying a poor prognosis (about 7 per cent kill themselves) and causes untold suffering to families, marital partners and children.

The most advanced cases, grossly socially isolated are to be found in certain deteriorated areas of the great cities—the so-called 'Skid Row' alcoholics. Dr Griffith Edwards and his colleagues working for some years with financial support from the Nuffield

Foundation (the Alcohol Impact Project) has provided evidence about this and other groups of alcoholic patients (71). 'Filthy and dishevelled, with faces often blackened by the smoke of the fires which are lit in derelict houses or on bombed sites, the Skid Row alcoholic is not difficult to recognize.' These men are predominantly of lower socio-economic status, about a third have been married but the marriages break irrevocably; few have ever acquired an occupational skill and very few indeed have ever held a steady job for five years or more. Once they leave their parental homes, their careers of drift begin. Many are arrested repeatedly for drunkenness; many have been in prison; few have come to the notice of the psychiatric services. They obtain their money for alcohol, usually crude spirit, in various ways—casual work, welfare sources, 'pooling with a gang', borrowing, begging, pilfering and charity. The origins of this disorder lie in their damaged personalities and can be traced back to childhood 'where the benefits of human contact were scant indeed'.

The Ministry of Health (HM(62)43) recommended the setting-up of alcoholism in-patient units in psychiatric hospitals and a number of such units have been in existence for some years. A few can claim gratifying therapeutic successes. Many alcoholics, however, deny their dependence and refuse admission to hospital. If greater numbers were prepared to accept help the present resources of the hospital system could not cope with the demand. Nevertheless there is a new belief that more could be done by community treatment if hostel accommodation was offered to sufferers from this condition. So far endeavours to help by community resources have been mainly started by voluntary agencies, and therapeutic functions can probably best be carried out by trained social workers rather than doctors. To what extent in the future will the local authority mental health services recognize these potential patients as being their responsibility to help, and if they did so, how much of the scarce resources of money and manpower could be directed their way?

THE VAGRANT IN THE RECEPTION CENTRE

The last remains of the old Poor Laws which set up workhouses and then casual wards for vagrants, are the reception centres of

which in 1965 there were nineteen in the United Kingdom (72). After 1948 the National Assistance Board had the responsibility for the welfare of 'persons without a settled way of living', and reception centres had the function of providing temporary shelter for them; now the Department of Health and Social Security is responsible.

The reception centre in Camberwell is one of the largest in the country and provides shelter each night for up to 1,000 men. About 10,000 pass through its doors every year. A number of studies have been made of different aspects of those who use it. A one-night census (70) showed a great heterogeneity within the total pattern which emerged.

> Under one roof are being performed the functions of an Old People's Home, lodging house for the itinerant labourer, alcoholism rehabilitation centre, mental aftercare hostel, half-way home for the discharged prisoner, and perhaps a dozen other functions besides.

About a quarter of the men seen were addicted to alcohol, and 45 per cent had been arrested for drunkenness. About a quarter had been in mental hospitals and 7 per cent within the previous six months—a reflection on the after-care arrangements made for these patients. Nearly 60 per cent had served prison sentences, mainly for trivial offences. Those who conducted the survey wrote:

> it is unlikely that for many of these men imprisonment any longer serves as a deterrent, and it is difficult to believe that prison is for them rehabilitative. . . . (The various prisons) have become just further points in ceaseless circulation, part of the way of life, part of the muddle, aids to the process of desocialisation.

The picture which emerges from this survey is that the majority of men demonstrated chronic psychosocial problems quite as disabling for them, just as great a burden on society and often more so, than many psychiatric populations which are known to the mental health services.

In this short chapter I have briefly identified three areas of psychiatric morbidity which until recent years were 'invisible'. In selecting university students, the alcoholics and the vagrants I have chosen, it may well be thought, a group from among the

most 'deserving' to a group among the least 'deserving'; first a group to whom the maximum available resources of society should surely be directed, to a group who should be placed lowest in order, when priorities have to be decided. Yet the practical problems which emerge are not so dissimilar. Those who recognize the great need to provide psychotherapeutic services for university students and those who see that if social care, hostel accommodation, sheltered work and supervision could be offered to the alcoholic, the vagrant and the recidivist, prognosis might be altered, are met with the same two answers. The first of these is that trained manpower, medical or social worker, psychiatrist or psychotherapist is not available; adequate training provision, careers and opportunities have not been made in the past for the medical and caring professions, and even if the size of the problem which has loomed on the horizon for many years had been recognized—the human and financial resources of our society, given the national priorities which have been determined were hopelessly inadequate to meet it.

The second answer is perhaps the more cogent one, but it is rarely heard, and those who give it are in the main most responsible for what they deplore. Reluctantly medicine itself, in the wake of psychiatry, has accepted the idea that it is its business to treat disorders of human behaviour, the pathological and the deviant. But how far should this go? Drug addiction, for example, is seen as both a sickness and a moral defect, a cause for medical treatment and for punishment. In the U.S. the punitive element remains side by side with the therapeutic objective. In Britain the punitive attitude has been scrupulously avoided; the medical responsibility fully accepted. The new provisions recently made within the NHS were the result of public clamour, and the decisions taken were the result of political necessity, not in the sure knowledge that any known treatment of proven efficacy for say, heroin addiction was known. This is the point at which the scientific argument emerges, and there is some justification for it. If society's scarce resources are to be deployed to a far greater degree than hitherto, a case must be established that effective treatment methods or at least methods to alleviate suffering for the individual or distress to society can be provided as a result.

Those who would make the case, would find it difficult if they expected the type of controlled studies which are now fashionable in medicine, to show that effective treatments exist for a wide range of disordered behaviours associated with personality defect. There have, of course, been modest advances, but as a general statement this remains true of drug addiction, alcoholism, juvenile delinquency, sexual deviation and many others. Yet those who claim that since so little is known about how to help, so little should be done to help, have to answer the accusation that during years when these problems were becoming 'visible' in our society, there has been an almost total neglect of what was most needed—clinical, social and psychological research. For this failure there have, of course, been many causes, but medicine itself cannot escape responsibility. These are issues which have been a recurrent theme in this monograph. There has been the great difficulty of escaping from the limited view of the doctor's responsibility being confined to the 'medical' or physical disease; the absence of training in medical schools in the sciences of behaviour, the study of the personality and the individual in his social and interpersonal context; the failure of medical education to provide future doctors with knowledge or any skills in these areas. Above all perhaps, has been the failure to make room for, to attract into the medical field and into the caring professions, social scientists whose knowledge and skills would be of such value to medicine. Lastly, if we can examine our own consciences clearly, we have to admit that all too often the concern of doctors and those who educate them has in the past been mainly with themselves and their own professional responsibility; they have done very little to support, made few attempts to understand, or to work with those many other professional persons in the caring professions, whose skills are different from theirs and of which until the present time so few have been seen to be complementary.

8

Some theoretical and practical problems

Psychiatry still suffers from medicine's heritage of ancient theory about the nature of disease. The physical and psychological approaches to mental disorders are still regarded by many as antithetical, and the limitations imposed by the view of mental disease as only 'physical' disease are still serious. The effect upon classification, therapeutic practice and the theory of psychiatry is examined. The differential influence of psycho-analysis and the theoretical system of Kraepelin upon American and British psychiatry is examined. Finally some evidence about the attitudes to these issues of students and their teachers is presented.

The debate on the law governing legal abortion reached a climax with the passing of the recent Act. The intensity of the feeling aroused in different sections of the medical profession and in different religious groups, did not abate with the passing of the Act; they still continue, and still influence the way in which the Act is being implemented. The crux of the issue was whether 'social' as well as 'medical' factors should be taken into account when decisions had to be taken as to whether a woman should be relieved of a pregnancy she feared or did not want. If we confine our attention to the attitudes of the profession itself, and ignore as best we can the influence of religious beliefs and prejudices, this debate made it clear that for a proportion of the profession, quite a large one, the word 'medical' had a different meaning than it did for others. For them the word 'medical' is very often identified with 'physical', or more precisely with physical disease. From such a standpoint many physicians, GPs, gynaecologists and psychiatrists take the view that it is the business of doctors to alleviate or to prevent the consequences of physical disease, and that social distress is not their business. Others give the word 'medical' a wider connotation, not restricted to the narrow conception of physical disease, and find difficulty in drawing hard

and fast lines between the physical and social consequences to health of adverse circumstances.

I have taken the example of the debate on abortion because of its contemporary interest, but there are many other issues which demonstrate the antithesis of viewpoint within the profession as to what is or should be a *medical* responsibility and what is not. The varying attitudes towards medical responsibility for distressed homosexuals, towards the behavioural consequences of alcoholism and drug addiction, towards adolescent emotional instability, delinquency or neurosis are other examples. In the case of termination of pregnancy the attitudes of psychiatrists before the passing of the Abortion Act were fairly sharply divided. There were many who were restricted in the advice they offered by their opinion as to whether or not the patient either had or was likely to have a 'mental disease'—*a psychosis*. Given this conception of disease only a very small proportion of pregnant women, referred by their GPs or others for psychiatric advice, were recommended for termination.

A major issue facing the profession, one which will have greater importance as the population increases in size and is better educated and more sophisticated, is the extent of our responsibility towards those in distress, who may or may not have physical disease as it is commonly understood. It is necessary to look at the widespread beliefs which underpin our conceptions of what 'disease' means, even our ideas about human nature. These matters have been felt to be of little importance in most areas of medicine throughout the recent period of technological advance, but even for medicine as a whole they are now becoming issues which cannot be neglected. For psychiatry they have always been of fundamental importance and have greatly influenced the practice of the subject.

From earliest recorded time there have been two views expressed about the nature of all disease, and mental disease in particular. These can be called the biological and psychological conceptions. There were those who believed in the primary biological or physical nature of man and of his diseases, and those who conceived man as a primarily psychological being, and although he operated through a physical structure, his behaviour

both normal and abnormal and hence his 'diseases' were also regarded as psychological in nature. The latter view of man was almost certainly the earliest, had its origins in primitive animism and later gave rise to psycho-physical dualism—a conception of man which is still very widely held both by the scientific and the lay public alike. In ancient times the two views were often accepted together. Plato believed that mental diseases could either arise from physical disease of the body (the biological approach) or be divinely given (the psychological approach). The Hippocratic writings for the first time gave a clinical and objective approach to the phenomena of disease, and were essentially biological. Thomas Aquinas, more than a millenium after Plato, still followed him in dividing mental disorders into those of 'natural' (i.e. physical or biological origin) and those of 'unnatural' origin, the latter by his time being due to demoniacal possession. As is well known, the psychological conception of mental illness, in its most bastard form of demoniacal possession, took hold of the human mind throughout many centuries, reaching its zenith in the late fifteenth century after the publication of the famous *Malleus* to which I referred in chapter 1. For centuries, as a consequence of the religious authorities' acceptance that mental illness was due to witchcraft, the subject was largely removed from medicine as a proper matter for observation, inquiry or therapeutic intervention. Indeed physicians who tried to help the mentally afflicted often did so at their peril.

The consequences for medicine and for the mentally ill in particular, to which these attitudes gave rise throughout the civilized world, have been and still are profound. On the one hand they resulted in a reluctance on the part of doctors to involve themselves in the problems of mental illness unless such illnesses could be shown to be, or believed to be a result of '*physical disease*'; and on the other they suggested to both doctors and the public that those who were mentally ill, but *not as a consequence of physical disease,* were somehow or other morally to blame, that such disorders were the result of vice or bad habits, with which no one would wish to concern themselves unless, of course, it were the priests. When recently as a result of a brilliant piece of medical detective work Macalpine and Hunter (73) showed that the

recurrent mental illness of George III was probably the result or porphyria, this was hailed not only by the authors, but also by many commentators as evidence which removed from the King and his descendants the stigma of mental disease!

An attitude of the scientific mind is the urge to classify. The classification of disease was until recent times one of the main preoccupations of the doctor with a scientific bent. The study of the history of classification both in medicine and psychiatry gives us a revealing picture of the contemporary thoughts and attitudes towards our subject at any period we care to choose. Karl Menninger (72) who has provided an excellent review of the history of psychiatric classifications since the time of the ancient Greeks, shows that once the witch theory was at long last dispelled, physicians began to coin other names for the varying pictures of queer behaviour, partly to master their own fear, but partly to serve as a kind of communication and classification device. After Sydenham (1624–89) the movement acquired a great impetus and thousands of new names were proposed for the various forms of madness. It was a movement which affected medicine as a whole, and reached a zenith in the syndrome period at the end of the last century. By the end of the eighteenth century when Pinel and the other humanitarians had done their work, the variety of mental 'diseases' had reached enormous proportions, literally hundreds of different conditions became recognized, each identified according to a single symptom or attribute—biological and psychological phenomena being inextricably mixed.

Pinel's classification, like that of others who instigated the reforms in the treatment of the mentally ill, was a very simple and pragmatic one. He abandoned the disease entity tradition of the movement which had been started by Sydenham, and recognized four major categories only—four fundamental clinical types—mania, melancholia, dementia and idiocy. It was a return to a simple Hippocratic classification based on clinical observation. Disorders were grouped by the major clinical features which distinguished them, and not according to any preconceived notions about the physical, biological or psychological causes which might be responsible. Nevertheless, as Menninger (74)

put it, 'the search for the specific causes of a plurality of diseases was on, and was to dominate psychiatry for another hundred years, culminating in a psychiatric nihilism from which we are only now emerging'. Psychiatry having at last been freed from a mythological psychology was now to be enchained in a mythological pathology.

THE INFLUENCE OF EMIL KRAEPELIN

Throughout the nineteenth century clinical syndromes were identified in all areas of medicine, and a new multiplicity of disease entities were recognized. In this, particularly from the work of European physicians, psychiatry obtained its full share. The development of laboratory techniques, particularly microscopy and later bacteriology and those related to morbid anatomy, began to provide evidence from autopsies of pathological processes in the brains of many patients dying of 'mental disease'. The recognition of GPI, first as a clinico-pathological entity—to which Haslam had made a contribution—and later as a disease associated with syphilis of the brain was a major triumph, and provided a model for the research which it was hoped would enable classification with an aetiological basis and specific causes to be founded. It was to culminate at the end of the century in the great unifying classification of Emil Kraepelin (1855–1926) in Germany, which to a major degree has influenced all the classifications at present extant in the world today.

Those who preceded Kraepelin, whose work he developed into a unified and logical system, had been mostly psychiatrists working in continental mental hospitals where, of course, only custodial treatment could be provided. Their experience, therefore, was confined largely to the chronic insane. In Germany the first university psychiatric clinics had appeared where the clinical experience was more varied, but by this time the general advance in the laboratory investigation of physical disease had begun and its influence upon the first scientifically minded psychiatrists was overwhelming. In the search for the specific causes of the clinical entities which had been described, the physical and biological approach to mental disorder became the major if not the only preoccupation. As a result, disorders which could not be identified

as 'disease entities' were largely ignored. In any case, patients who presented with them did not come the way of those who were making such massive strides in developing psychiatry as a scientific subject. Kraepelin assumed that ultimately discoveries in cerebral pathology would lead to understanding of all forms of mental disease—even the two major functional psychoses which he had identified and distinguished from the evidently organic diseases which morbid anatomy and histology had already described. He believed that such knowledge would in time give an understanding not only of the causes of such illnesses, but also explain the psychopathology—their symptoms, course and prognosis. Kraepelin's achievement, particularly the differentiation based on observation of dementia praecox (later to be called schizophrenia) from manic-depressive psychosis, was acclaimed internationally. The classification of mental disorder which he provided was firmly based on the anatomico-pathological concepts of disease which at that time existed throughout medicine.

There were, of course, embarrassing aspects for him in the system. As Stengel (75) has pointed out, although Kraepelin recognized the psychogenic origin of neurotic disorders, it did not apparently occur to him that disorders having a psychogenic aetiology would be disqualified as mental diseases. Nevertheless this alleged dichotomy between disorders of psychological origin (e.g. the neuroses) and disorders of physical origin, which became identified very quickly with the name *psychoses*, was followed and developed by those who succeeded him, and has had very serious consequences not only for the world's classificatory systems, but also more importantly for the thinking, training for, and practice of psychiatry and not only in the English-speaking world. Thus the ancient belief in the dual nature of mental illness has been continued.

There was a logical way out of the difficulty which could maintain the unitary nature of the Kraepelinian system, and this has been followed by many European and British psychiatrists till the present day. While on the one hand it is necessary to admit the psychological causation of the neuroses, and to exclude them and all psychogenic reactions from the classes of mental disease in the strictly defined sense, one could regard them as 'abnormal

varieties of sane mental life'—a form of psychopathic personality, which within the Kraepelin system was believed due to some inherent degeneration or defect within the nervous system. Thus in this way neurotic disorder, evidently 'caused' by psychological factors (the psychogenesis), occurred only because the individual was inherently vulnerable. As a result the neurotic disorders in many major textbooks of psychiatry are still classified under 'psychopathic personality', and although the meaning of the latter term continues to change each decade, the underlying idea behind it remains much the same. The early term 'constitutional psychopathic inferiority' gives the clearest notion of what is meant. It perpetuated the idea that at least one large group of the mentally sick were inferior individuals, constitutionally weak, the products of inferior protoplasm. But as far as the teaching and practice of psychiatry were concerned, in many parts of the world it resulted in therapeutic nihilism, particularly towards neurotic patients and those with personality disorders. For those who have followed psychiatric teaching derived from the Kraepelinian tradition, the problems of the neurotic and the individual with personality disorder have been thought to be beyond help, for what are they but the results of an ill-disposed fate? It was hoped for many years that psychiatric genetics would validate this opinion, but it has not done so. At the same time for those who needed it, there is a ready-made intellectual defence for psychiatrists who, faced with the everyday problems of neurosis and emotional distress, are aware of their own inability through aversion or lack of training, to do anything to help. In justifying their standpoint and their practice it was natural that each generation of teachers of psychiatry should pass on to their students their opinions and the intellectual arguments which favoured them.

The sharp division between psychosis on the one hand and neurosis and personality disorder on the other, had had strange consequences for the meanings which are attached to these words, particularly *psychosis*. Since mental disease was identified with brain disease, even though the evidence for the latter in many clinical entities remained mere supposition, mental disease became equated with psychosis, and this became a descriptive term to define the classes of all mental disorders. All those classes which

could not be included as mental disorders were *ipso facto* not psychotic. The word psychosis was also identified with the old words insanity, lunacy and madness, and provided the grounds in many places for compulsory detention of the patient.

The psychiatric section of the *International Classification of Diseases,* Section 5, has followed this distinction between psychosis and neurosis even in its last edition (76). Very few countries, apart from Britain, have officially pressed for its use, and the reasons for this reflect the on-going debate, still as lively as ever, about the nature of mental illness. It epitomizes in public form the ancient controversy about the relative importance of the biological and psychological elements in mental illness. In the U.S. and in Britain, two countries in which some unanimity of opinion and practice might have been expected, important and representative committees were set up to examine and interpret the *ICD* classification. In the U.S. the American Psychiatric Association Committee reported in 1968 (77) and provided a glossary of terms and in Britain the committee set up by the General Register Office also reported and provided a glossary the same year (78). There are profound differences between them, but it is only necessary here to consider the issues arising out of the use of the terms 'psychosis', 'neurosis', and 'personality disorder'.

The British committee took a diplomatic line over the question of a definition of psychosis and decided that no definition was required for the effective use of the classification and therefore gave none. They added, however, that

> to many psychiatrists the so-called psychoses have this in common, that they are largely due, or are supposed to be due, to an organic process. On the other hand, not all mental disorders ascribed to brain lesions are described as psychotic. There are for instance personality disorders due to brain lesions which do not fall into any of the so-called psychotic categories.

The American committee had the clear and forthright opinion that patients are to be described as psychotic when their mental functioning shows certain psychological characteristics which they then described. Whether these patients had suffered cerebral

disease or injury was another matter, but not relevant to whether the patient was psychotic or not. They reported that

> some *non-organic disorders,*[1] (and here they included schizophrenia, the affective disorders and the paranoid illnesses), in the well developed form in which they were first recognized, typically rendered patients psychotic. For *historical reasons*[1] these disorders are still classified as psychoses, even though it is now generally recognized that many patients for whom these diagnoses are clinically justified are not in fact psychotic.

The British committee did not give any definition of neurosis, and did not feel the necessity to justify not doing so. They amplified the *ICD* classification of such conditions by brief descriptive accounts of the clinical phenomena of each. The American committee made a psychological distinction between psychosis and neurosis. Having defined psychosis by the presence of certain psychological symptoms, they proceeded to treat neurosis similarly. The distinction between the two was, they stated, that while the psychotic patient experiences distortion of, or misinterprets external reality and shows personality disorganization, the neurotic does not exhibit any of these features (with the possible exception of hysteria). Here then the distinction between psychosis and neurosis is based on psychological differences and nothing else.

There is a further important difference of viewpoint which a comparison of the American and British reports reveals. The *ICD* (76) places the neuroses and personality disorders together, thus following Kraepelin's classification. In this the assumption is reasonable that both groups share some common characteristic such as organic vulnerability or predisposition which, as I pointed out the followers of Kraepelin readily accepted. In modern terms we might interpret this common feature by saying that both neurotic and personality disorders are dependent upon some developmental failure, without specifying its nature. Certainly the British committee accepted a common factor, but the American committee did not do so and in arranging the *ICD* for their own use, separated the neuroses from the personality disorders and gave each a category to themselves. In this they expressed their

1. My italics.

strongly held opinion that neuroses are illnesses, not developmental defects. To their minds the corollary, of course, is that neuroses can be treated.

American psychiatry has been far less influenced by the Kraepelinian system than British psychiatry. Psycho-analytic theory and practice and the psychological and sociological study of human behaviour became an integral part of American university teaching, long before the majority of university departments of psychiatry existed in this country. But for a number of years between the wars, when the influence of Freud and Kraepelin on psychiatry in Europe was at its height, the teaching of Adolf Meyer (1866–1950) at Johns Hopkins dominated American psychiatry for more than a generation. He provided an intellectual link between the psychology which was taking root in his country and the emergent psychology of Europe. By giving equal emphasis to the biological and psychological factors in mental illness, and creating a 'psychobiology', he at the same time introduced a humanistic and psychodynamic approach to the subject and, at least to the English-speaking world, a revolt against the mental disease concept. His influence upon the teaching of psychiatry at Edinburgh and London before 1939 was considerable. The major British textbook of those years (Henderson and Gillespie) was written from a Meyerian standpoint. By removing the focus of attention of the psychiatrist from the brain of his patient and transferring it to his personality and to the psychosocial environment to which that personality had to adapt, he provided new insights. To Meyer all mental disorder, whatever its causes or its character might be, whether psychotic or neurotic in form, whether physically or psychologically caused, were *reactions of a maladaptive kind* to stresses in the life situation of the patient. After Adolf Meyer the serious study of personality began. His influence upon psychiatric classification is still seen in the American insistence upon retaining certain categories, including psychotic categories, as 'reactive' disorders in the *ICD*—a meaningless exercise for those who ascribe to the view of mental disorder as being organically caused.

THE EXAMPLE OF DEPRESSIVE ILLNESS

In every context in which psychiatry is practised, whether it is in the GP's consulting room, the psychiatric department of the general hospital, its wards, or out-patient department, or the psychiatric hospitals themselves, depression is by far the commonest diagnosis made among those regarded as being mentally ill. Depression is one of the commonest of human ills but it has a variety of forms and many degrees of severity. There is no psychiatric disorder about which the debate has been warmer or more sustained, particularly in Britain where the nature of 'melancholia' has aroused particular interest and concern for centuries. In the *Anatomy of Melancholy* (1621) Robert Burton (79) suggested a dual classification in which one group were due to a fault in the brain or body, and the second had psychological causes such as a morbid preoccupation with love or scholarship or religion. This was not new for it typified the old Platonic opinion about 'natural' and 'unnatural' insanity but gave it a more modern guise. The two alleged types are now called 'endogenous' and the 'reactive' forms of the condition.

Following the general acceptance of the Kraepelin classification all forms of depression, with the exception of involutional melancholia, were believed to be aspects of the manic-depressive psychosis, a condition strongly held then, as now, to have an organic basis. The genetic factor in this disorder was clearly established some thirty years ago. The nature of the heredity remains obscure; it is clearly not understandable in simple Mendelian terms.

There was no place in the Kraepelin concept for psychogenesis. Yet from earliest time physicians had recognized that depression very frequently follows adversity and can indeed by a reaction to it. The example of bereavement is well known. Yet the disease-entity hypothesis about all depressive syndromes received wide acceptance, particularly among those who worked in university departments and in mental hospitals both in Europe and in Great Britain. In Britain and in the U.S. the influence of the psychoanalytic concept of depression gained ground after the First World War, particularly among those psychiatrists working in teaching hospitals, and in private practice. This gave to all depressive

illnesses a primary psychological causation, and a controversy was opened in 1926 when Edward Mapother (80) declared that he could find no clinical distinction between neurosis and psychosis, and that any attack of depression, whether apparently endogenous or reactive, was produced by the same pathological mechanism and 'whatever the origin and intensity . . . achieved a sort of autonomy'.

The controversy has continued and in recent years has stimulated much clinical research. Those who hold to the unitary view of depression, believe that the differences reflect degrees of severity and differences in the various psychological mechanisms involved in protecting the patient from unpleasant emotion and the stressful situation in which he is placed. Those who hold to the dichotomy between the two forms of depression, believe that there are two disorders, the one a disease-entity identified with 'psychosis', an unknown biochemical pathology, and a specific symptomatology; the other a psychological reaction to adversity, an 'abnormal variety of sane mental life', with again a specific symptomatology. It is alleged that the differentiation between the two can be made on the basis of symptoms. I have reviewed elsewhere the criticisms which can be levelled against the dichotomous hypothesis (81). The contrast of opinion is best exemplified by the way in which clinical data derived in the same way has been interpreted by Dr R. E. Kendell working at the Maudsley Hospital and by Professor Martin Roth and his colleagues working at Newcastle. The argument seems strongest that the varieties of depression can be placed upon a continuum with the severe psychotic form of the disorder at one end, the less severe neurotic form at the other, the majority of cases falling between the two extremes. There is important biological disorder in all forms of depression, and evidence for disturbed physiological functioning of the nervous system. Yet the psychological nature and meaning of depression cannot be restricted to its neurotic form. There is no essential genetic difference between them, but manic-depressive disorder, in which manic and depressive illnesses succeed one another sometimes with a degree of periodicity, and which is comparatively rare, may be genetically distinct and may therefore be shown to be dependent upon a distinctive and unique biochemical factor. The nearest analogue from general medicine is the distinction between the

common essential hypertension, and the malignant variety of the condition. Much confusion has resulted in the past from the failure to remove from the investigations the data derived from manic-depressive patients.

This controversy about the nature of one of the commonest psychiatric illnesses is no mere academic one. It has had serious consequences for the patients and the practice of the subject. An attempt has been made in the *ICD*, Section 5 (76) to provide categories to take into account the contrast in views about the nature of psychosis and neurosis, about the role of psychological stress, and particularly the American opinion which favours a psychological interpretation of the various phenomena of depression, and the European one which on the whole favours the disease-entity interpretation. Four diagnostic categories are provided—the depressive type of manic-depressive psychosis (296.2) which includes so-called endogenous depression; involutional melancholia, another psychosis (296); reactive depressive psychosis (298), and depressive neurosis (300.4). For the American committee this classification made some sort of sense, the distinctions, however, being based on severity, psychosis being recognized by psychological characteristics, and the words 'reactive' and 'neurotic' being used to imply the identifiable presence of psychological stress on the one hand and the presence of 'internal psychological conflict' on the other. These are all differences of degree rather than of kind. The British committee were not happy with this classification and in the glossary and instructions which the General Register Office issued, implicitly expressed their disbelief that a psychosis could be a consequence of psychological stress. They suggested that psychiatrists who do not recognize the category of 'reactive depressive psychosis' should use the category of 'manic-depressive psychosis, depressed type' (296.2).

Superficially these issues may seem largely academic. It is true that they will make for serious confusion when any attempt is made to compare the prevalence rates for depressive illnesses between different communities and different countries and also make the results of new therapeutic claims meaningless between different workers in different countries where the orientation to the issues of diagnosis differ. More important, however, in my

opinion, are the effects of the climate of opinion engendered among psychiatrists of perpetuation of the dichotomist's conception of depression, in which those patients classifiable under one category are *ipso facto* psychotic, and under another category *ipso facto* neurotic, irrespective of the severity of the depression, or of clear evidence of psychological stress or of emotional conflict. For once the word 'psychosis' or 'endogenous' has been applied to a patient's illness, that patient will more often than not automatically receive ECT or psychotropic drugs and cease to be the subject of psychological study, psychotherapeutic or social help. The converse may also apply, the patient believed to be suffering from the so-called 'reactive depression' or depressive neurosis may be denied the benefit of pharmacological or physical treatment. I will conclude the discussion of these issues with a quotation from Sir Aubrey Lewis (82) with which I completely agree.

> Many psychiatric conditions develop so gradually that there may be a lengthy initial phase in which the symptoms, although characteristic enough for diagnosis nevertheless are mild and unobtrusive, suggesting only a quirk of personality. Some patients, justifiably diagnosed at one stage as having some form of psychoneurosis gradually pass into a psychotic state. Such transitions testify to the vagueness of the distinction between psychosis and psychoneuroses, which rest on no secure foundation in pathology—neither somatic pathology nor psychopathology; it depends on the degree and proportion in which constitutional causes, psychological forces, attitudes, trends and responses to intervention can be discovered in them.
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> Psychoses can be seen as faulty efforts at self-protection and adaptation in the face of physical and psychological noxae. Among the latter are protracted frustration and conflict, with persistent anxiety, extreme reduction of sensory stimuli and exposure to steady hatred or isolation from compansonship.

THE INFLUENCE OF PSYCHO-ANALYSIS

I do not wish to attempt here any serious assessment of Freud's theories or to predict what will be the ultimate scientific status of his work. Thirty years after his death the influence of psychoanalysis upon contemporary thought in many fields, both in the arts and sciences, would seem to be as great as ever, and as far as

biological research into animal and human behaviour is concerned, much greater than it ever was. As a general theory of human nature, psycho-analysis takes its place alongside the great unifying conceptual systems of any age—one of the great 'explanatory hypotheses'. As such it cannot be proved or disproved. It had changed in Freud's own hands several times, and has continued to change in those of his successors so that now it is very difficult to say that there is a single orthodoxy. Nevertheless it continues to stimulate research in many fields despite the fact that the psycho-analytical method did not itself provide the essential instruments by which scientific research could be carried out. Freud had reached maturity and formulated the basis of his ideas before methods of measurement had been introduced into psychology or behavioural science. The complex model of mental function which he conceived was not devised so that its components could be objectively identified and measured by the methods of physical science. It was devised for the purpose of explanation, to provide understanding of the behaviour of individuals not for the purpose of making predictions. His clinical method, moreover, was designed to understand particular psychological events in individuals, and although he generalized from single cases, there was nothing in psycho-analytical theory or practice which could allow or disallow the discovery of general laws.

Like the physiologists of his era, Freud assumed that what was true of one individual would be true for all. We now know that in this at least he was partially wrong. Although Freud had been a distinguished neurologist and his conception of 'mental structure' is essentially a biological and unitary one, yet psycho-analysis rests firmly on psychic determinism. Many of his medical critics have not understood this and found their strongest ground for rejection of psycho-analysis in their belief that it perpetuates the psycho-physical dualism from which medicine and psychology have tried so hard to escape. This is particularly true of those critics whose theoretical orientation towards psychology and psychiatry is based essentially on the biological or 'medical' model. For this reason psycho-analysis has never had much influence on the continent of Europe. The intense hostility towards the subject which characterized the writings of psychiatrists and physicians during the first

three decades of this century was not so much because as is generally held, Freud had over-emphasized the sexual and unseemly side of human nature, as that psycho-analysis challenged the scientific status of a psychiatry based on the medical model of mental *disease*. Moreover, as time went on the unscientific status of such psycho-analytical concepts as 'psychic energy', and 'cathexis', in fact the whole energic or economic aspects of instinct theory became apparent and made it easy for critics in rejecting some to reject all. Similarly psycho-analysis as a method of treatment has been continuously under attack, mainly by academic psychologists rather than psychiatrists, on the grounds that there is little evidence that by its use the recovery rates from particular symptoms are any better than when physical or other psychological methods of treatment are used; and perhaps no better than the spontaneous remission rates. In this there has usually been a profound misunderstanding about the objectives of psycho-analysis as treatment, which go far beyond alleviation of symptoms. Symptoms in this context are regarded as incidental, unfortunate and often painful expressions of psychological defences against unacceptable impulses or effect, the true sources of conflict and mental illness. It is these in the psycho-analyst's view which the patient must be helped to cope with, accept and integrate in the personality; having done so the patient is free to pursue the goal of personal self-realization.

Leaving aside the controversial theoretical issues and the question of therapeutic efficacy of psycho-analysis itself, there can be no doubt that insofar as psychiatry has acquired any special skills which distinguish its practitioners from other doctors, these are psychotherapeutic in nature and are derived in a major degree from psycho-analysis. During the present century when the scientific study of mental illness by the methods of laboratory science, either biological or psychological, have developed so rapidly, there was grave danger that the human personality would be lost sight of. This has not happened. The personal psychological skills of the psychiatrist and those of the psychiatric social worker and of the psychiatric nurse are now realized as intrinsic to their occupations. Their degree of psychological perceptiveness, their skill in handling inter-personal relationships, their capacity to

tolerate the stresses involved in the business of helping patients—these personal skills which many have acquired, have been due at least in part to the contributions of psycho-analysis. Yet the subject in Britain has not played a significant part in medical or psychiatric education. A great challenge to psycho-analysis today is to develop a *psychotherapy* which those who are not psychoanalysts and have not acquired psycho-analytic training can use. A great challenge to psychiatric education and practice is to incorporate such knowledge and skills and to provide all those working in the mental health services with psychological understanding.

Psycho-analysis developed in the setting of private practice in Vienna with a small group of adherents and pupils around Freud. Freud himself never tried to influence psychiatric practice itself, although he endeavoured to get a hearing in his own university. His pupil C. G. Jung, who worked at the university clinic in Zurich, became interested in the psychology of patients with dementia praecox; there can be little doubt that through Jung's influence on E. Bleuler, he helped the latter to formulate the great psychological conception of schizophrenia in 1911. When the exodus of the small group of European psycho-analysts occurred with the advent of the Nazi regime, those who came to Britain continued in private practice as they did in the U.S. Psycho-analysis had by this time achieved a wide acceptance in America, so that their association with university departments of psychiatry was welcomed. It was in fact in America that psycho-analysis made its chief impact on psychiatry, and after the war influenced both undergraduate education and the training of psychiatrists to a great degree. The great majority of professors of psychiatry are psycho-analysts, but the role of a formal training in the subject, at one time almost mandatory in a few centres for the future psychiatrist, is now much less. I think it is true that psycho-analysis in the U.S. has not lost its acceptance as a general theory of human nature, but is becoming integrated more and more with both the biological and social sciences which study human behaviour.

The first psycho-analysts in Britain and notably the late Ernest Jones and Dr Edward Glover, undoubtedly influenced the thinking and practice of psychiatrists, neurologists and physicians work-

ing in the undergraduate teaching hospitals in London, although few of them had actually been analysed. The greatest impact was perhaps on child psychiatry as a professional discipline, and upon the emerging profession of psychiatric social work. Far greater, of course, was its influence upon the intellectual atmosphere in all fields of social science, literature and the arts. Private practice in London by psycho-analysts and those who, while not analysts themselves, had accepted its general theory and methods of treatment, flourished from the start. But there has been and still is little or no contact between them and psychiatrists working in the mental hospitals. The Institute of Psycho-Analysis was set up in 1923 for the training of psycho-analysts and a few privately organized clinics, notably the Tavistock Clinic (1920) developed in which psychotherapy was offered to patients on a fee-paying basis. The Tavistock Clinic was incorporated in 1948 into the NHS. Psycho-analytical societies were started before the war in many countries as well as training institutes. The subject soon acquired a vast literature and an international journal, but its clinical practice was mainly on a private basis and has remained so. Until quite recent years it is probably true that in this country and certainly in the U.S., the first preference of the professional, intellectual and educated well-to-do classes has been to turn in the first instance to the psycho-analyst if he is available for psychiatric help, rather than to the psychiatrist. Indeed in the U.S. the survey of Hollingshead and Redlich (83) at Yale showed that at that time social class was clearly related to where, by whom and for how long patients were treated. In London after 1948 a few psycho-analysts, apart from those at the Tavistock Clinic and at the Cassel Hospital, began to work in the NHS, particularly in child guidance clinics. Psycho-analysts were appointed as consultant psychotherapists at the Maudsley Hospital, their function being to teach psychotherapy and psychological understanding. This movement has grown and is now extending not only to university departments of psychiatry in the undergraduate schools of London, but also outside the metropolis notably in Scotland. It is therefore relevant that I should turn to such evidence as we have about the attitudes of teachers of psychiatry and their postgraduates towards the psychodynamic approach to psychiatry.

An investigation aimed to study the educational objectives among seventy-three teachers of psychiatry in the four Scottish university departments and one English department was reported by Dr Henry Walton in 1968. The responses to a large questionnaire were factor-analysed and the resulting components of each factor which emerged arranged in rank order. It is questionable whether similar results would have been obtained had his respondents been taken from five English departments. The first goal of these mainly Scottish teachers was to increase the student's awareness of psychological processes, not only making him more responsive to the patient's feelings and conflicts, but also increasing his understanding about his own emotional reactions. The second goal was to foster a scientific attitude to personality and human behaviour, giving the student a 'behavioural science orientation'. The third goal was to help students to learn how to relate to psychiatric patients in the clinical situation. The need was accepted for 'active contact with patients, in contrast to a passive spectator role during instruction'. After these first three goals came that of providing factual knowledge and lastly came the reaching of treatment techniques.

An interesting and unusual study of the psychiatric orientation and attitudes of medical staff, both senior and junior, at the Maudsley Hospital was reported by Dr Norman Kreitman (84) in 1962. This study tested the attitudes not only of the postgraduates attending the three-year course, but also some of their teachers, not all of whom were included. Questionnaires were constructed which were found to be reliable, and valid measures of the two main attitudes of particular importance. Two attitude scales were designed to measure an interest in and sympathy for the psychological and the organic approaches to psychiatric problems. The first of these was held to be derived largely from psycho-analysis, and 'expresses a greater interest in psychological factors, with emphasis on the need for "understanding" the patient and the exploration of unconscious factors, while relying heavily on interpersonal relations in therapy'. The second attitude scale tested the 'paramount interest in the organic aspects of mental illness, by avoiding all "subjective" or intuitive concepts, by deriving conceptual models closely allied to those of general medicine, and by

concentrating mainly on physical methods of treatment'. The postgraduate students who constituted the majority of the seventy-eight psychiatrists examined were undoubtedly the largest single group of postgraduates in the country at the time, and were further characterized by a high degree of intellectual sophistication and medical experience. The majority had acquired a higher medical qualification, either MRCP or MD, before entering psychiatry. Other personality tests were applied and in addition biographical data were obtained.

The results showed that the two attitudes were sufficiently distinct to be measured separately, but that they were not necessarily antithetical. An emphasis on psychological perceptiveness and on inter-personal relations did not necessarily mean an antipathy for the organic approach to psychiatry or for physical treatment. It was found as predicted that there was an association between the results of the attitude scores and certain temperamental characteristics of the psychiatrists, such as introversion (in Jung's sense) and neuroticism. An interest in the psychological, rather than the organic approach to psychiatry, was found to correlate 'with a self-assessment which includes many neurotic features'. But as Kreitman points out, this may mean either that a psychological or psychodynamic orientation is characteristic of the more neurotic doctor, or that such individuals have more insight into their own personalities. It was found that a long exposure to the practice of general medicine prior to entering psychiatry predisposed psychiatrists to resist the psychological orientation, but this could only be expected. Progressive psychiatric training was associated with a change towards a psychological orientation and a decreased sympathy with the organic approach. This was, however, not evident until the third year of training and continued thereafter. These findings support the contention of the Royal Commission on Medical Education that basic postgraduate training should last for three years.

There is, of course, a danger of being misunderstood when such matters are considered. No one can doubt that a blend of the organic and the psychological approaches to his subject is highly desirable in the psychiatrist. No one would wish to see psychiatry practised either by the 'physician manqué', or by the exclusive

psychopathologist. There is, of course, room for specialization in either field, but for the majority of general psychiatrists an optimal balance between the two orientations, a blending of both attitudes, is surely highly desirable in itself, as is the cultivation of the clinical skills which result from them.

9

Towards continuing care

The work of the various members of the mental health service team is examined and the recent expansion in these services recorded. There is considerable confusion about the roles of different professional groups, particularly since some work in hospitals and others in Local Authority services. It is evident that senior nurses and social workers now undertake supportive psychological treatment, and accept a degree of clinical responsibility formerly the prerogative of doctors. Roles are becoming blurred, but the essential requirement for the success of these developments—adequate training and supervision by teachers who have psychotherapeutic expertise—is lacking.

How can the psychiatric patient be provided with what he most needs, *continuing care*? The administration of psychiatric services has to be considered in formulating an answer to this question; many people have ascribed a variety of problems to the tripartite nature of the health services. The adverse consequences of the existing organization have affected not only the professional lives, opportunities, and status of all who work in these services, but also, and to the greatest extent, the patients whom the service exists to help. There is now a strong movement towards change, and evident intention by government towards devolution of responsibility from the centre and towards unification of the health services within local areas (the Government's Green Paper 1968 (85), the Seebohm Report 1968, the Royal Commission on Local Government 1969 (86)). There is some conflict between the various proposals which have been made, and the future pattern remains undecided. There are certainly differences between the concept of comprehensive area health boards in which the three branches of the health services would be unified, and the recommendations of the Seebohm Committee that there should be a comprehensive social service department in each area, adminis-

tratively distinct from the other services. Whatever plan is finally implemented, and whether or not experiment and 'piecemeal social engineering' will precede any general implementation, the success or failure of change is likely to be determined by other non-organizational factors. These are the professional status, opportunities, and role of the various workers in the different caring professions, the manpower problem, and the extent to which as a consequence of change those with different professional skills and responsibilities will be able to work together more effectively as a team for the patient's benefit. No new administrative structure can of itself resolve the important issue of who should be 'personal clinician' with continuing responsibility for the patient, or indeed, decide whether such a concept should be retained.

PROFESSIONAL STATUS

Status, as Lord Snow (87) has reminded the medical profession, is a very odd but important concept and a very subjective one. The status of any group or individual within a profession is related to prestige, and is a variable which can alter with time. Status is partly accorded by public opinion which affects groups and individuals within the profession differently. Further, the status of a particular group within a profession varies according to informed or academic opinion, and is related in part, but only in part, to the financial rewards which the individual can expect; it is also a function of the worthwhileness felt by its members, and is therefore bound up with self-evaluation as well as the valuation given it by its peers and the public. To this extent any professional group which feels inadequately trained for the role which it is called upon to undertake, or is not given the opportunities to do what it can do, and feels devalued by other professional groups with which it has to work, loses status in its own eyes and tends to become demoralized. Financial rewards of themselves do not compensate for self-devaluation.

It is said that the medical profession has in the last two decades lost status. The concept of an NHS in which for the future the patient could by right receive treatment, and did not have to purchase it or depend on charity, altered the relationship between those who practised medicine and those who administered it. The

latter progressively took control in areas which had previously been the doctor's prerogative. The relation between those who practised consultant medicine privately and in hospitals, and those in general practice altered. The former were no longer so dependent for their livelihood on the latter, and the happy relationships involving mutual respect and consideration which had been a characteristic of the profession for so long, suffered.

We must note with particular emphasis that the separation between specialized and general medical practice which grew up over the first half of this century, on a basis of differing clinical interests and education, has been reinforced by two further major differences: first, specialized medicine has been established firmly within the large hospital, while general practice has been left to the family doctor working in his local neighbourhood and sometimes in a small rural hospital; secondly, the fully trained and competent specialist normally hopes to attain the rank of Consultant—carrying responsibilities, status, and privileges which the general practitioner, however well qualified or experienced, cannot hope to achieve under the present system (11).

Academic medicine, thanks to great technological advances, made rapid progress and the gap in knowledge, skill and expertise between those who taught and practised in the hospitals and those who worked in the community progressively widened. The failure of medical education to provide future doctors with the knowledge and skills they would require for family medicine—in fact the indifference towards such matters shown by medical educators until the last decade—affected the relative status of the two groups not only in the eyes of the general public, but also in their own estimation. If the hospital doctor has now reached a new equilibrium, in which his understanding of his role is now established, this is not the case either for GPs or for the other professional groups working in the medical and social services. The dominance of the hospital in the status-hierarchy of the profession, now reinforced by the high status of scientific academic medicine with which it has associated itself, has helped to maintain the standards of British medicine. Its success, however, has been achieved at great cost to the larger sector of medicine which exists outside it. The unification of medical practice on an area

basis will not of itself cure these ills; the acceptance and definition of professional roles, backed by medical education adequate to sustain them, will do much more.

EXPANSION OF THE MENTAL HEALTH SERVICES

In previous chapters it has been shown that the proportion of psychiatric hospital beds in the old mental hospitals is declining, that there is a relatively larger number in general hospital units, and that psychiatric practice is tending to move away from the large mental hospitals. The number of patients admitted to hospital each year has steadily risen, the duration of stay in hospital has steadily declined, but the readmission rate has increased. There is a greater 'turnover' of patients. The pattern, however, in respect of all the measurable indexes of activity varies greatly throughout the country. An implicit belief in these developments is that patients should be treated as far as possible outside hospital, but that to provide the necessary care greatly increased provision will have to be made within the community. As a consequence of these policies there has been on the one hand a great increase in out-patients, day-hospital care, domiciliary visiting, and supervision in the patients' own homes by the psychiatric staff of the hospitals themselves; and on the other hand, considerable effort by the local authorities to increase the provisions for the care of the mentally ill and disabled for which they too have been given responsibility. The arrangements made between the two authorities concerned to share responsibility, to co-operate in the care of patients, have more often than not been haphazard and fraught with difficulty and conflict, although as was shown in chapter 5, this need not be so. Only occasionally, however, have efforts been made to involve the GP.

In table 9.1 figures are given for the increase in the staff of psychiatric hospitals between 1949 and 1967, and in figure 9.1 the rates of increase of such staff during the period are shown. The number of consultant psychiatrists has risen from 405 to 1,019. The number of psychiatric social workers in hospitals has shown a similar proportionate increase and at a similar rate. While the number of psychologists has remained very few, the rate of increase has been about the same. On the other hand the rate of

TABLE 9.1. *The staffing of psychiatric hospitals, 1949–67*

	Numbers of staff			
Year	*Consultant psychiatrists*	*Social workers*	*Psychiatric nurses*	*Psychologists*
1949	405	220	33,049	0
1950	454	271	33,315	0†
1955	568	331	35,259	114
1960	680	429	42,047	179
1965	914	507	48,931	228
1967	1,019	*	52,534	295
1968	1,040	*	52,562	340

* Statistics concerning social workers were presented differently from 1966 onwards. 'Trained social workers' numbered 220 in 1965 and 251 in 1968.

† There were 83 psychologists in 1951.

Data from the *Annual Reports of the Ministry of Health (England and Wales).*

increase of psychiatric nurses has been much slower and may now have levelled off.

The number of social workers employed by the local authority mental health services rose from 625 in 1956 to 1,872 in 1968 (table 3.4). They are very unevenly distributed throughout the country. Although psychiatric social workers, the most highly qualified group of all social workers in the mental health services, have hitherto worked mainly in the hospital service, there is now evidence of increased numbers in local authority employment, but they still constitute the minority. The majority of social workers in the local authority mental health services are mental welfare officers. The latter group emerged from a profession whose main work was concerned only with the statutory admission of patients to mental hospitals, and was therefore largely concerned with emergency situations. The reports of work from different areas, to some of which reference has already been made, indicate that different professional groups are providing much the same sort of care for a proportion of the patient population. There is confusion about the division of responsibility between different professional groups, the role which each member of the team should accept.

PSYCHIATRISTS

Most of the work of the consultant psychiatrist, working in a general hospital unit is now in the out-patient department and in

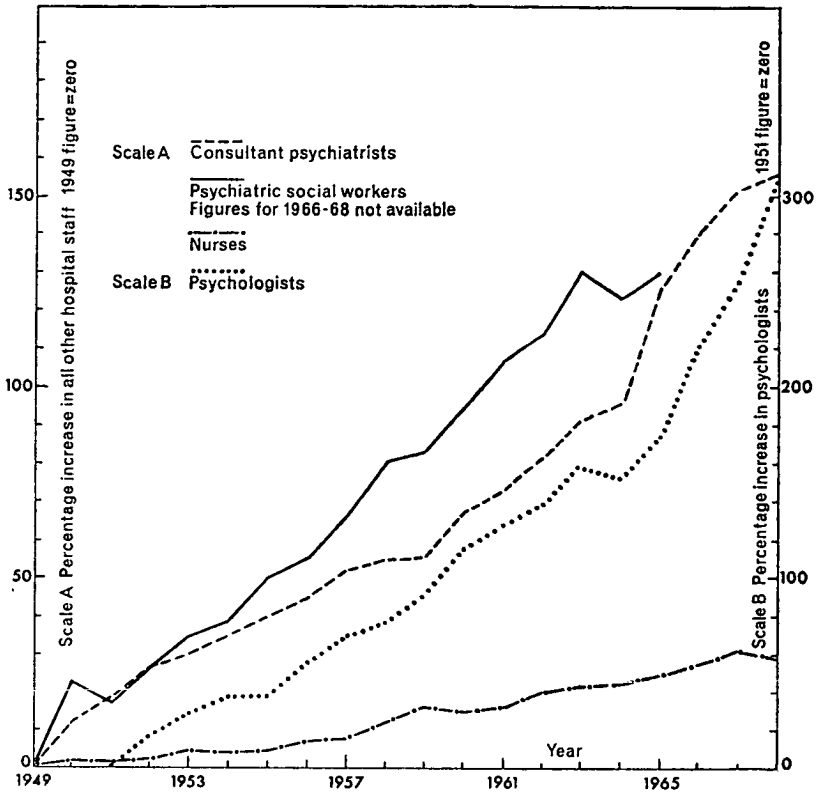

FIGURE 9.1. Psychiatric hospital staffing, 1949–68

the community, and to a lesser extent than formerly in the psychiatric wards where the routine work is carried out by his juniors whom he must supervise and teach. Where a community service has been developed, domiciliary visits, consultations with local authority social workers, supervision of day hospital patients and conferences with hospital and community workers in which the consultant is expected to 'lead' the team, occupy a further proportion of his time. If the psychiatric unit has become an integral part of the general hospital in which it is placed, rather than a 'foreign body' or a 'guest', the consultant will soon find himself called upon

to advise upon large numbers of patients in the general wards. Indeed as a description of three different units in general hospitals made in chapter 5 suggested, the consultant's whole time, depending upon his interests and skills, could well be directed to either of two occupations—as a hospital consultant, or as a community physician. Many psychiatrists are attempting to fill both roles.

Accepting all these responsibilities it seems unlikely that the consultant psychiatrist can do more for most of the patients he meets than provide diagnostic interviews and hold ward and outpatient conferences at which decisions are taken about further care and management which others will have to implement. Yet many consultants are well aware of the need for skilled psychotherapy for more than 30 per cent of patients who attend them. Many believe that drug treatment is not enough, and many patients present, as indeed they have done to the GPs who have referred them, with emotional distress dependent upon neurotic conflict which cannot be resolved by physical or social intervention alone. Although the consultant is backed up by a team of other non-medical professional people who are increasingly sophisticated in psychological understanding and personal skills—and many would be capable of providing formal psychotherapy given the training and supervision required—unfortunately psychiatric education has not provided many with formal skills in psychotherapy, and there are very few indeed capable of supervising others in training. This calls for advanced specialist experience and training, as I shall discuss later (chapter 10).

It is difficult to believe that the psychiatric hospital services, given the manpower provision as at present, can materially help the large proportion of the 'psychiatric sick' whose problems are dependent upon inter-personal neurotic conflict and personality disorder. They cannot do so any more than the GPs have been able to do so. This, of course, is not only due to lack of training in psychotherapeutic skills, but also, and perhaps to a greater extent, to the numerical problem these patients present and the time required to help them. As was suggested from the work of the Camberwell Register (chapter 6) which is concerned with one of the best staffed areas of the country, it would require 400 extra consultants to bring services in the country as a whole, including

the psychotherapeutic provision, up to the standard which some may think are required.

PSYCHOTHERAPISTS

There is no recognition within the NHS for the specialty of psychotherapy. There are no consultants in psychotherapy as, for example, there are in radiotherapy. Psychotherapy has not achieved the status of an applied science, but is a system of clinical skills used in the treatment of patients and rests upon a large body of theory derived in part from observations made on human behaviour. The validity of the theory and the reliability and meaning of the observations have been debated for the last fifty years. Nevertheless all the forms of psychotherapy which are used by psychiatrists, and others, as well as present understanding of interpersonal relationships were derived initially from psychoanalytical theory and the formal training in psychotherapy which is available in the NHS is in the main provided by psycho-analysts. It is therefore pertinent to the general argument that we need more psychotherapeutically trained personnel in the mental health services, to inquire what contribution psycho-analysts are making. Dr Irvine Kreeger has kindly made available to me the results of a survey he made on the membership of the British Psychoanalytical Society in 1967.

There are 235 qualified psycho-analysts in the United Kingdom, of whom 164 (70 per cent) are medically qualified. Of the total number, 77 per cent of the medical and 71 per cent of the non-medical analysts, hold appointments in which they carry out teaching, therapeutic or other work, apart from formal psychoanalysis. But the nature of the appointments held are very varied; 177 psycho-analysts holding in all 387 appointments. The great majority of these have a clinical function, but psycho-analysts are also employed, for example, in university departments of social science, in prisons and in student health services. Many are employed in the child psychiatry services, and there are about 80 consultant psychiatrists who are trained psycho-analysts. In the teaching hospital departments of psychiatry, undergraduate and postgraduate, 17 psycho-analysts hold appointments of which the majority are in London. The greatest concentrations of trained

psycho-analysts are found in the specialized out-patient psychotherapy clinics in London.

While it is evident that in the last decade more psycho-analysts have sought and been appointed to teaching posts in psychiatric hospitals, both in and outside London, the main influence on the teaching of psychotherapeutic skills has been the Tavistock Clinic, with its associated school of 'Family Psychiatry and Community Mental Health'. In 1968, 37 psycho-analysts took part in providing training courses for psychiatrists, GPs, non-medical child psychotherapists, clinical and educational psychologists, social workers, teachers and many other groups involved in community care. Another considerable group of 28 psycho-analysts are employed at the Hampstead Child-Psychotherapy Clinic (Miss Anna Freud). At this privately run clinic, supported in the main by American foundations, courses of training for non-medical child psychotherapists have been conducted for some years. The courses which last *four years* are open to university graduates with a degree in psychology or to others with appropriate diplomas in social science. Most of those graduating from these courses are subsequently employed in the child psychiatric services. It is a striking fact that the considerable educational effort and achievement which psycho-analysts have made through their organized institutions have not received any financial backing from Exchequer sources in this country, despite the fact that the mental health and educational services have obviously taken advantage of them.

THE PSYCHIATRIC NURSE

In the past the psychiatric nurse, like the doctor, had a mainly custodial and protective function—*on the ward*. Now most patients as they recover from the acute phase of illness spend little of their time on the ward and are engaged in activities outside it. Nurses remain hospital-centred and do most of their work in the hospital itself, but spend far less time in the wards. In 1968 the Ministry of Health published a report of the Joint Mental Health and Nursing Advisory Committees on *Psychiatric Nursing: To-day and Tomorrow* (88). In this an attempt was made to forecast the future role of the psychiatric nurse. It was evident that the skills of psychiatric nurses have increased and that their status has been

rising in recent years. This report went so far as to say that the nurse, 'who is often beside the patient all day, is the key therapeutic figure'. The increasing importance of the nurse's role, her position in the hospital as an individual with therapeutic responsibility, often of a complex and highly skilled kind, suggested that there was a need to offer more advanced psychiatric education which would prepare some nurses for an 'advanced clinical role'. There is a case for combining courses in advanced psychiatric nursing with those for a university degree in psychology and sociology.

The variety of units for treatment of special groups of patients—such as those for geriatric, alcoholic, drug-addicted, psychopathic, and adolescent patients and for autistic children—means that there is a very wide range of clinical experience open to the fully qualified psychiatric nurse. Nursing education and vocational training now aims to prepare the senior nurse for leadership in a therapeutic group atmosphere. For this nurses require the same knowledge, skill in interpersonal relationships and communication, and empathic understanding as the psychiatrist. The work at the Plymouth Nuffield Clinic (p. 84), as in a number of other mental health services, involves the psychiatric nursing staff of senior level in clinical responsibility for patients, not only in the day hospitals and out-patient departments, but also in the community. In some community mental health services, psychiatric hospitals and local authorities have arranged for psychiatric nurses on the staff of the hospital to visit former patients in their homes. These are patients 'suffering from a psychiatric illness who need during after-care a relationship such as that between nurse and patient, and the assurance that the supporting link with the hospital provides not only to them but to their families'. In this it is evident that the nurse is not only carrying out a supportive psychotherapeutic role in the broad sense, but is also performing some of the functions of the social worker. It seems likely that this practice will be developed even further, and that nurses may be asked to extend help to patients in the community who have not been in hospital. Both at Plymouth and at Kensington (Dr A. A. Baker), to which services I have previously referred, the principle has been accepted of giving the psychiatric nurse personal responsibility for patients in the community, and when it comes to a

decision in a clinical conference as to who in the psychiatric team is best equipped to meet the future needs of a particular patient, this responsibility may often fall upon the nurse. At Kensington the decision is based upon which member of the team 'has the most significant relationship with the patient'. But Dr Weeks (55) points out:

> Such a system depends upon a willingness to recognise statutory obligations, abilities in specific fields, and acceptance of the need to care for people outside the requirements of our own settings. . . .

It seems likely that selected senior nurses will in future undertake a variety of psychological treatments on patients, both individually and in groups, both those in hospital and those who attend from their own homes. If they do so it should greatly increase the status of the profession and attract into it many more men and women of high academic calibre. But an essential requirement for this development is lacking: suitable education and training geared to the requirements of the role and a sufficiency of trained teachers in psychotherapeutic skills.

SOCIAL WORKERS

The distinction between psychiatric social workers, who traditionally have been hospital-based and whose function was mainly case-work (see chapter 10) on in-patients and some after-care, and mental welfare officers employed by the local authorities whose work was traditionally legal and administrative, has gradually lessened. The former group has had high professional status, its members had acquired a university degree or diploma; the latter often had no special qualifications and no professional affiliation. Psychiatric Social Workers (PSWs) have joined local authority services, and Mental Welfare Officers (MWOs) in those services started to undertake this work, to take social histories, to involve themselves in the after-care of discharged hospital patients, and in certain areas to undertake within the hospitals themselves social work previously undertaken by PSWs. Nevertheless the statutory duties remain and still form a proportion of the work of MWOs. A most important development, of which an example was given

in the Camberwell service (chapter 6), has been the joint appointment of social workers between hospitals and local authorities.

In 1966 there were 991 trained psychiatric social workers in the country. About 90 students qualify each year. Most have acquired a degree in social studies or other relevant subjects or have taken a postgraduate certificate or diploma in social studies after another degree. Postgraduate courses leading to a diploma or certificate recognized for psychiatric social work, are provided by sixteen universities in Britain. In 1966 of 86 PSWs who qualified, 16 entered the hospital service, while 28 entered the local authority mental health services. While the majority of trained PSWs are still in the hospital service, mainly in child psychiatric clinics, 18 per cent are now working with the local authority services and the increase of the proportion in these services is progressive. National policy has determined this. The majority of students are seconded by their employing authority, and workers in the hospital services cannot be seconded for professional training. The local authorities are empowered to do so. Moreover the career prospects, and financial advantages for suitably qualified social workers in the local authority services are clearly better than those in the hospital services.

MENTAL WELFARE OFFICERS

Social workers have been employed in local authority mental health services in increasing numbers in the last five years. The Ministry of Health believed that five social workers per 100,000 population would be needed but recruitment has fallen far short of this target. In 1967 there were 1,794 in post, of whom 179 were qualified PSWs, 231 had the Certificate of Social Work and there were 1,384 without qualifications. The demand for *trained* social workers to meet the mental health needs in the community is very great. Rehin and Martin (89, 90), who have reviewed the work of social workers in the community and hospital services, and made an assessment of the likely situation in the future, predicted that administrators must face the 'very likely contingency of unfulfilled plans and insufficient resources, as they have been doing for several years now'. A comparison of the work of MWOs in different areas indicated that, almost certainly due to lack of

personnel, where the community services had 'matured', one in two out of all patients referred to the mental health services (including the hospital services) were in contact with an MWO; where the services were undeveloped as few as one in eleven were.

The functions of MWOs are no longer clearly defined. The proportion of their work which is concerned with statutory admissions on orders to hospital in situations of emergency has declined, due in part to the fact that only a small proportion of all patients admitted to hospital are now detained compulsorily. Much more of their time is spent in making assessments or investigations related to care or treatment, that is to say in 'case-work'. Even more is given to providing social support to patients, or their families, to follow-up of discharged patients and as is now becoming apparent, 'therapeutic discussions'. Thus it is becoming increasingly clear that social workers, whether trained or not, are reaching a different concept of their role. As in the case of nurses, this role involves continuing support for an increasing number of patients. For this they will require clinical supervision which at present is inadequate, and in their training the acquisition of just those same skills to which I have referred in the discussion on nurses. Again we have to ask the question who are to provide these essentials?

Uncertainty about their role, and resentment that doctors, either GPs or hospital doctors, do not appreciate their independent professional status, were no doubt among the factors which led the Seebohm Committee to recommend comprehensive social service departments in which all social workers would be employed. The local authority mental health services mount a twenty-four-hour emergency service and much of this type of work is done at night (91). Social workers no longer see their duty to obey the orders of doctors who demand that they should act under their statutory powers. Many emergencies arise as a result of a social crisis in a family. The family needs help as much as the individual patient.

The social worker by his very presence may relieve the crisis through the knowledge that the family problems will be taken up seriously and soon, and he may at this point of crisis be able to initiate a

relationship which will allow the complex of family dynamics to be investigated later (91).

The social worker now feels the right to exercise his own professional judgement on the nature of a crisis situation, the need or not for hospital admission, and the use of compulsory powers. Very few GPs work closely with mental health social workers; few understand the nature of the latter's work. When a social worker is called in an emergency by the GP, who expects him to remove a patient to hospital forthwith, it may often seem that the doctor has little understanding of his patient or the family, and little personal skill in handling psychosocial problems. But the situation need not be as bad as this, and there are, as has been shown in a previous chapter, many GPs highly skilled and sophisticated in these matters. Evans *et al.* (92) have described how a group practice in a new town can set up an organization to deal with the management of problem families in it. This group of GPs inaugurated weekly case conferences at which they met health visitors, social welfare and child care officers, welfare officers and psychiatric social workers. These conferences were a 'quick and easy way of exchanging important information, leading to rapid decisions'. These doctors appreciated the professionalism of the social workers with whom they had established liaison. The doctors doubted their own capacity or right to be the 'leaders' of the team. They considered the relationship between doctor and social worker should be one of 'co-equal partnership', and preferred 'secondment' of social workers from the local authority, rather than 'attachment' to them.

PSYCHOLOGISTS

Clinical psychologists in Britain, unlike their colleagues in the U.S., have not hitherto, with the exception of educational psychologists in the local authority children's services, regarded themselves as having a therapeutic function. In America psychologists work, equally with psychiatrists, in providing psychotherapeutic care of patients. My colleague Dr M. B. Shapiro, who is responsible for training courses leading to degrees in clinical psychology for many students each year, has suggested that those who work

in this field in Britain have three main functions. First the application of validated and standardized procedures of patient assessment; secondly the making available to other members of the clinical team the results of such assessments and giving opinions about them; and thirdly the carrying out of research aimed at improving and developing such methods. Clinical psychologists are therefore applied scientists, with knowledge and skills of their own which can be used in the diagnosis and assessment of change in patients. They must work very closely with clinicians, but psychiatry and psychology are separate disciplines. The recent development of psychological procedures (behaviour therapy) for the modification of particular symptoms, particularly among neurotic patients, has meant, however, that psychologists are now becoming involved in treatment. The future of their role in this is uncertain and must depend upon the successful development of this new field and its validation by research. However, as seems likely, behaviour therapy will find its place in psychiatric therapeutics, clinical psychologists may play a much larger role in the future, certainly as teachers of others, if not as therapists themselves.

10

Needs and prospects

A larger synopsis at the end of this chapter, summarizes the main themes of the monograph, identifies some needs and makes some proposals.

I have developed several themes in this monograph. First, the subject of psychiatry and the treatment of the mentally ill were seen as removed from medicine, and isolated from the main streams of scientific, educational and administrative advance, which began to change the profession even before the Second World War. The reintegration of psychiatry in medicine began after the Mental Treatment Act of 1930, and the process was accelerated and became a reality after the creation of the NHS in 1948. It received a further stimulus from the Mental Health Act of 1959 which legally and administratively removed the last distinctions between the facilities which the State made available for the care of the mentally sick and the physically sick. The importance of psychiatry in medical education was gradually accepted during these years of reintegration, and university departments of psychiatry were created in the majority of medical schools in Britain. Two further important events have recently occurred. The General Medical Council (93) in their recent recommendations have reinterpreted the aims and purposes of undergraduate medical education, which are no longer the production of the 'complete doctor' and 'safe general practitioner', but the provision of all doctors with a 'basic medical education'. To receive basic medical education means to move towards the possession of *'a comprehensive understanding of man in health and in sickness and an intimate acquaintance with his physical and social environment'.*

A corollary of this is that all doctors, whatever their subsequent careers may be, whether as hospital clinicians or laboratory workers, whether community physicians or GPs, will require vocational education and training suitable to their work. The

second important event has been that the Royal Commission on Medical Education (11) has accepted these principles and made recommendations aimed at implementing them.

The second theme which I have developed is that as soon as the process of integration of psychiatry in medicine began, it became evident that the facilities which previously had been provided were woefully inadequate. The facilities catered *only* for the needs of the psychotic and the subnormal, and such patients account for only a small proportion of the total morbidity in the population. New groups of sick and disabled people were recognized, and made claims upon resources which were already being used to the limit. This applied to available finance and medical manpower as well as to physical facilities. Piecemeal arrangements were recommended by the Ministry of Health as each new group became identified as a burden on the public conscience, but it has been difficult to implement them in a comprehensive way. The large number of patients with chronic neurotic disorders and disorders of personality have received no special consideration, and the degree to which they are an economic liability, and source of suffering within the community is still largely unknown. But it is evident that it is great and that GPs have continued, without adequate training, time or often inclination, to do their best for this section of the mentally sick. There is now a need to assess the nature and size of this problem, and evaluate the therapeutic procedures available to alleviate it. Only research can provide the answers.

A third theme relates to the great expansion of the mental health services, the increased provision of medical and non-medical personnel, and the increasing amount of work being done by social workers, particularly those in local authority departments. These developments have occurred rapidly, without adequate planning, and without any general understanding of the roles of all those concerned. It has too often seemed that the objective of providing continuing care for the patient has been lost sight of in the conflict of opinion about the roles and responsibilities of the several people involved—the GP, the hospital-based psychiatrist and the local authority social worker. In the development of mental health services, the needs of the patients have

sometimes been overshadowed by a preoccupation with how to make do with inadequate facilities and inadequate manpower. There has been an obsession with the question of how *few beds* are required, rather than with a continuing critical appraisal of what the actual needs of the patients are, and what is required to meet them. Administrative enthusiasm is in danger of supplanting good clinical judgement. In what follows I shall therefore turn my attention to two major questions. First, what are the needs of patients and their families? I will assume that the smallest unit to which medical and social care should be directed is the family. The second question is, what are the needs of those who have to provide that care? I will assume that it will be desirable to provide continuing care of the patient whenever it is required.

CONTINUING CARE

The concept of continuing care may have to be reinterpreted. Historically it referred to the role of the GP, the doctor of 'primary contact', the personal physician who, because of his special relationship with the patient and the family over many years is in the best position to advise and care for them. Only such a personal physician can have knowledge of the medical and social histories of the various members of the family group, their strengths and weaknesses, the stresses to which each has been exposed, the interpersonal conflicts which exist between them, and the total pattern of their lives—*over time*. This ideal of the GP is widely accepted both by doctors themselves and by the public. It will be a bad day for society and the profession if the concept of the personal physician who willingly accepts the lasting responsibility for his patients were to be abandoned. This responsibility and the nature of the personal relationship between GP and family, should make the contract between him and them an abiding one, and should have first priority. It should give to the family physician both first and last, and throughout the years that intervene, the first place in the social structure of the health services which have been created to help *his* patients.

Specialist organizations, both in the hospital and in the community, exist to help the family physician to provide what *he needs for his patients*. Within this concept of continuing care the

family physician must see these services and facilities as his 'servants', existing to be called upon whenever his patients need them. The specialist services are the 'servants' of the family physician, not his masters. They should not assume responsibility for patients which belongs to the GP alone. If this is to happen the GP's role must be defined and accepted by all those in the caring professions, and their *responsibility* not only to the patients they serve, but also to the GP, whose agent they become, must be understood. He on his part must comprehend the range of services available for his patients, and know how to use them to their best advantage, as well as expect that his responsibility as family physician to provide continuing care, will be accepted.

The family physician's role is a difficult one. If it is to be sustained and developed the GP must become the best educated—the most comprehensively educated—of all the doctors in the health service. Applying what was said recently by Professor Neil Kessel (94) about the role of a psychiatrist to that of the GP, we can say of him: that when he has completed his training he does not need to be (though he may sometimes pretend to be) a consultant physician or surgeon or paediatrician or psychiatrist; neither a lawyer or priest, or marriage guidance counsellor; not a social worker or police officer or school-teacher; not a nurse or health visitor or employment officer. Least of all, I think, should he aspire to be a psychotherapist, although he needs to share with all those in the caring professions a common psychological understanding. Yet if he is to be none of these he should know how all these people work and how they can help his patients. He may be asked to give advice to any of these professional people and he will often need advice from them. He ought to know when to refer a patient to any of them for their expertise but he should not aspire to that expertise himself. He needs to know what they do, but not how to do it himself.

ROLE-TAKING

The acceptance of a professional role is dependent upon its definition, the status that it is accorded by all those having related roles and by the general public, and the satisfaction which the role is felt to provide. As already suggested, success in a professional

role is related to prestige, self-esteem, and the value placed upon it by others. Role-taking cannot be imposed, but the opportunity to accept it can only be given by adequate education, vocational training, and relevant clinical experience. In the end it is acquired through personal encounter by identification with those who have already accepted it. Role-taking is only accepted when it proves enduringly satisfying and this depends upon the existence of harmonious relationships between the various professional persons who share a common endeavour. C. D. Leake (95) has proposed a general law:

> The probability of the survival of a relationship between individuals, or between groups of individuals, increases with the extent to which that relationship is mutually satisfying.

A corollary of this is that if either party to a relationship wishes the relationship to continue, it is necessary to do whatever is possible to make the relationship satisfying to the other party. In the field of mental health, no less than in the whole field of medical and social care, the failure to define, to understand and to accept the respective roles of those who work in hospitals, in general practice and in the community, has resulted in a lack of the personal psychological qualities without which a comprehensive system of medical care cannot be developed. We must escape from the contemporary ethos of medicine that the hospital consultant is a first-class citizen, the GP a second-class citizen, and those who work in the hospital laboratories and in the community services a very poor third in the social hierarchy.

RESPONSIBILITY

The role which I have suggested as the only appropriate one for the GP—that of family physician with the ultimate responsibility for continuing care of all his patients—would, if generally accepted require a reorientation of the attitudes of other professional groups towards him. The changes in the working arrangements of GPs, the progressive development of group practices, evidence for which is given in table 10.1, the building of health centres to work in, will offer a real opportunity for the family doctor to

TABLE 10.1. *General practitioner services, 1952–67*

Year	*Number of general practitioners*			
	Single-handed	*In partnerships of 2 or 3*	*In partnerships of 4 or more*	*Total*
1952	7,459	8,309	1,436	17,204
1955	6,715	9,874	2,194	18,783
1959	6,119	10,761	2,774	19,654
1961	5,598	11,171	3,238	20,007
1965	4,838	11,135	3,003	18,976
1967	4,646	10,623	4,540	19,809
1968	4,512	10,515	4,907	19,934

Data from the *Annual Reports of the Ministry of Health (England and Wales).*

accept the new role. But whether he will do so will depend not only upon attitude changes on the part of others working in the health services, but also on the development of new attitudes on his part towards them. Of course, these cannot be imposed, they can only be acquired by learning, and by the processes of communication and personal interaction. The new concept of basic medical education will, if acted upon, place the patient's physical, psychological and social needs in the forefront of all doctors' awareness, and will enlarge the scope of medical responsibility which all doctors will have beyond the narrow confine of 'disease' as physical disease in some bodily organ or system. But at least two decades will have passed before the effects of such changes in medical education can affect the organization of medicine.

Meanwhile GPs debate how the organization of group practice should be planned. There is on the one hand the opinion that group practice should be organized on the basis that all doctors in it should be 'generalists', that is to say, all should be GPs pursuing the same objective (that of family physician), having the same responsibilities. The alternative opinion is that a group practice should be composed of doctors with different areas of interest and skill, each becoming within his competence a minor specialist in some particular field such as paediatrics, obstetrics, geriatrics or general medicine. Under these conditions, patients on the practice list might go to different doctors at different times, depending upon the nature of the problem—and to successive doctors as new disorders developed. In this scheme family care ceases to be any one doctor's responsibility; at any

time the child in the family may be in the care of the 'paediatrician', while the mother attends the obstetrician, father the general physician, and granny the geriatrician (96, 97). If the organization of group practice in health centres followed the second pattern and became the general objective—that of a group of doctors each with his special interest and skill and each with his limited responsibility—the concept of the personal physician, responsible for the family unit, the doctor providing continuing care, would finally be lost and this role would disappear from British medicine.

The work of those in the psychiatric hospital services and those in the community services—who have difficulties of their own because of the imprecise definitions of their respective roles—presents a problem in relation to that of the family physician. Quite often the latter, having identified the psychiatric patient in need of specialist investigation, advice or care, is not sorry to hand over further responsibility. He may resent, but accept as inevitable, the fact that frequently he hears little more about his patient who may be taken off his hands for a long time—perhaps for years. He may learn, however, that this patient has left hospital, or ceased to attend for out-patient treatment, or that a local authority social worker is involved in his patient's further care. It has always been part of the ethos of medicine that the consultant or specialist is educated to a professional life in which he can provide at the highest possible level of skill, a particular service but a limited one for patients whose disorders fall within his specialty. The role of the personal physician is not part of this. When the consultant's work is done, he should by tradition send his patient back to whoever has this responsibility.

Psychiatrists, however, are frequently in a dilemma. It is of the nature of the relationship between patient and therapist (psychiatrist, social worker or other) which develops when the patient enters treatment that it is essentially personal, and binds the patient to a therapist on whom he becomes in varying ways dependent. It is part of the skill of the therapist to enable the patient ultimately to become independent of the relationship, but the process may take many months or even years. During this period the individual who accepts the role of therapist, whether he likes it or

not, becomes the 'personal clinician' in the eyes of the patient. In the past when the work of the psychiatrist was almost entirely confined to the hospital care of psychotic patients, the risk that he would take over from the GP the role of personal clinician after the patient left hospital was negligible. The psychiatrist rarely saw the patient before admission, and might not see him again after discharge from hospital. But this concept of psychiatric practice is now outdated. Continuing care within the community mental health service, which involves the patient in contact with several professional persons in succession and over long periods of time, means that the service as an institution, the hospital as a place, or the individual as a therapist, are felt by the patient to have assumed complete responsibility for him and his family. Yet the responsibility is still in fact limited, and does not include the duties of the personal physician whose responsibility is wider than that provided by the mental health services themselves.

It would therefore be desirable to reassess and if possible to define the roles and responsibility of workers in the psychiatric services and to do so in relation to those of the GP. Not only psychiatrists but also social workers accept in a therapeutic relationship very many patients whose problems they believe they can alleviate by psychological understanding, specific psychotherapy, or social care. The roles of social workers and nurses are as I have indicated changing. Social case-work, which has always been regarded as the particular function and skill of the social worker is acquiring new meaning. It no longer only involves the collection of social data and knowledge of community resources which the psychiatrist can use.

Case-work has been defined as

> An art in which knowledge of the science of human relations and skill in relationships are used to mobilise capacities in the individual and resources in the community appropriate for better adjustment between the client and all or any part of his total environment (98).

The Younghusband Report (99) emphasized that case-work is a personal service to the patient 'who requires skilled assistance in resolving some material, emotional or character problem'. The social worker seeks to do this 'on the basis of mutual trust'. The

social worker's services cover 'many kinds of human need, ranging from relatively simple problems of material assistance to complex personal situations involving serious emotional disturbance or character defect, which may require prolonged assistance . . .'

There can be little doubt that social workers, both in the hospital and local authority services are accepting roles involving psychotherapeutic responsibility, for which only a few, perhaps a very few, have received any training and for which they receive little or no supervision. All psychiatrists have to provide some form of psychotherapy for a proportion of their patients, but it is no secret that few of them have received any formal training in psychotherapeutic skills—and are in no position, as social workers well know, to train or supervise others.

The place of specific psychotherapeutic procedures (e.g. systematic interpretative psychotherapies) in the health services, the therapeutic efficacy of any one of the great variety of procedures available, and the training of those who should practise them are all matters of debate. The fact remains that the majority of psychiatrists, excepting those who cling tenaciously to the 'medical model' of mental disorder as 'mental disease' (chapter 8), believe that some kind of psychodynamic approach is an essential requirement and, with or without vocational training, practise it. The need for intensive research to evaluate psychotherapeutic procedures, both those of a specific and those of a general kind (supportive psychotherapy), is very great. No less important are the questions, in view of the limited resources of skilled personnel, of who should provide the training in these methods, who should be trained to do what, and how they should be trained.

I will now express some personal opinions about these difficult questions. I do not believe that there will ever be a place for formal psycho-analysis as a therapeutic service within the NHS, but there will be a great need for psychiatrists and also non-medical professional persons who are trained psycho-analysts within the services and within university departments, not to provide a service but to teach others to do so more effectively. There are several levels of knowledge and skill required. There is first of all, the need for *psychological understanding,* which should be acquired by all

workers in the mental health field—doctors, social workers, nurses and occupational-therapists and others. GPs need this as much as any other group. Psychological understanding can be acquired only in part from theoretical instruction, more importantly by personal involvement in patient-care under supervision by those who have acquired such understanding. It therefore can be taught to and learned by those whose motivations are towards it, and whose personalities do not inhibit them. The acquisition of psychological understanding should not be left to the period of postgraduate training of psychiatrists, or to the period of in-service training of social workers, for it is a process which takes time, which matures. It cannot be acquired in six months.

Psychological understanding enables the individual to comprehend more deeply and more usefully the emotional problems of patients, and by giving him some awareness of his own motivations and attitudes, provides him with a greater sense of professionalism and emotional security for his own work. As a consequence he is more likely to help than harm his patients, and he is more easily aware of the limitations which his own work imposes upon him, and to accept them. He will not attempt to enter into a therapeutic exercise which from his understanding, he has learned will not help his patient and only bring frustration and a sense of impotence upon himself. If specific psychotherapeutic skills are to be learned, specific training will be required.

I do not believe that the majority of psychiatrists, given a period of three years' basic vocational training for their specialty can acquire much more than *psychological understanding* and the skills needed to practice certain forms of psychotherapy—supportive psychotherapy and the psychotherapy of groups for example. To provide this training specialist teachers are required. I believe there will be an important place for consultant psychotherapists within the health services, both hospital and local authority. No doubt many such teachers will have had training in psychoanalysis. Their role should be to provide training for *psychological understanding* and the range of psychotherapeutic skills which depend upon it, to the many both medical and non-medical people who require them. Specialist psychotherapists should certainly have a background training in psychiatry, and entry to

their specialty vocational training must therefore begin after the basic three-year training period. If this was accepted, psychotherapy, like child psychiatry, subnormality and forensic psychiatry will become a specialty within the subject, and will require official recognition and the provision of career prospects.

EDUCATION

The future pattern of education, both undergraduate and postgraduate, for both doctors and for those postgraduates in social science who lead professional lives in the health services, will profoundly affect most of the issues which have been discussed in this chapter. But change seems promised, and as far as the education of doctors is concerned I have no doubt that the introduction of behavioural science into the pre-clinical and early part of the curriculum is a most significant development. Basic medical education is concerned to 'give the student knowledge of the sciences upon which medicine depends and an understanding of the scientific method'. But it is also directed to 'comprehensive understanding of man in health and in sickness and an intimate acquaintance with his physical and social environment' (100). To illustrate these principles the Report recommended that the student should

> learn about the organization of medicine, the scope of its various specialties, the role of the general practitioner, and the role of the public health services in the promotion of health. He has to learn the ethos of medicine, the responsibility of which the doctor has to his patients, and to the community.

Many of the objectives of basic medical education are surely the same for doctors and for social graduates who will later work in medicine. Although they come from different backgrounds—each having a deeper and wider range of knowledge in their own subjects, they will ultimately have to work together, understand and respect each other's roles and expertise and to a considerable extent share a common area of knowledge and skill. Many have recommended that at the most formative period of undergraduate education, medical and social science students should be provided with common courses, but lack of physical provision for teaching may impede such a development, even if the principle is considered

desirable. Decisions still have to be taken about the content of behavioural science courses for medical students and what the educational objective should be. The GMC (100) defined the objective as they saw it:

> The study of human structure and function should be combined with the study of human behaviour. . . . Instruction should be given in those aspects of the behavioural sciences which are relevant to the study of man as an organism adapting to his social and psychological, no less than to his physical environment. Instruction in the biological and sociological bases of human behaviour, normal, emotional and intellectual growth, and the principles of learning theory should be included.

The Todd Commission (11) generally approved these principles and spelt them out in great detail. However, there is a significant addition (paragraph 254).

> All students should be taught to recognize the effect of their own behaviour upon other people and should be given some understanding of social skills, some help in developing them and some practice in their application; all this will be directly useful in the clinical part of their course as well as in later life.

There are two contrasting and almost unrelated objectives promulgated by those who argue for a greater share in the medical curriculum for the behavioural sciences, and the same kind of distinctions apply to many who, outside medicine, organize the applied courses for graduates in social science. One objective is to make the student a more socialized and human individual, with greater understanding of his patients as persons, a greater capacity for relating to them in clinical situations, a greater understanding of their social and personal needs and the extent to which social and environmental factors are relevant to their condition. The other objective is to familiarize the student with the general theory, the field of knowledge, the methods of investigation, and the techniques of measurement of the sociologist and the psychologist, and as a result to produce a graduate whose main ability will be to detect the socio-medical needs of a population or of an individual, but not necessarily any capacity to personally intervene once those needs have been identified.

It is necessary to achieve both objectives. The first is essential

for all, doctors and non-medical workers alike, who will have the personal care of patients; to achieve the second will be to provide members of all the helping professions with basic knowledge about human behaviour and its variability and how deviant behaviour is related to illness and social pathology.

There is a danger that the opportunity which will also present at the later stage of vocational training, to bring the medical and non-medical professions on to a common ground, may be missed. Those who are being stimulated to launch nationwide vocational training for psychiatrists, must surely not ignore the role which other professional groups are now playing in the subject. If they do so the gap in understanding between the medical and non-medical professions will only widen. Outside the special knowledge and skills which psychiatrists require as part of their medical function, there is a large area of common ground concerning what they do and what they need to know which they share with the non-medical professions. The future of postgraduate training for psychiatrists will depend upon regional arrangements developed and shared between the NHS, the Royal Colleges, and the university departments. The educational component will no doubt be largely provided by university departments, and the vocational supervision of clinical training by the Royal Colleges. Much of the financial provision will have to come from NHS sources. Vocational training is progressive and carried out under in-service conditions and this applies to both medical and the non-medical professions alike. They have to work together, understand each other's roles and they come to share a common knowledge and a common understanding. It would therefore seem sensible that at least part, and perhaps a large part, of the vocational training offered should be shared and be provided by the same teachers. As far as university departments are concerned, this objective will not be realized until social scientists have a significant place and role in their establishments.

ON THE ORGANIZATION FOR CARE

It is uncertain what administrative shape the proposed area health boards will have, and how successful the subsequent changes will be in integrating into a single functional and administrative

organization the three hitherto separate parts of the health service. Divisions of role and of responsibility, particularly for individuals, will inevitably and properly remain and will have to be defined. There will be a need to establish these for GPs, hospital doctors and social workers. I hope that the responsibility of the GP as 'personal physician', the one doctor with a responsibility for continuing care will gain the day, and that the consequences of this which I discussed earlier will follow.

Implementation of the Seebohm Committee's recommendation to set up social service departments administratively distinct will produce great changes in the psychiatric services. Many psychiatric social workers may well leave the psychiatric hospitals and units, which will, with the rest of medicine, become entirely dependent for social work upon the social service departments. Such departments would be greatly strengthened by the addition to them of the most highly qualified social workers in the mental health field. This would raise the status, improve the professional identity and personal independence of social workers, and make them less dependent upon doctors, who many of them claim do not understand their work. However, unless the education and vocational training of those in the mental health field was greatly strengthened and shared in the relevant areas with that of psychiatrists, the new arrangements would have adverse effects upon the mental health services, and indirectly upon medicine itself. The effects upon the child psychiatric services will be particularly adverse and there is a strong case, as I have suggested in chapter 3, to retain these within the hospital organization and not to transfer them to local authority responsibility.

If it is decided that there are good reasons for implementing the Seebohm general recommendation it will, I suspect, be because of the failure to co-ordinate non-psychiatric areas of medical practice where hospital, GP and local authority co-operation is required; the community mental health services are already co-ordinated with success in many areas. Medicine's responsibility for this decision will have been very great. It will inevitably have been a product of the exclusive 'medical model' conception of human disease which has been so widely and naïvely accepted by doctors and by those who educate them.

Those who will work in these new departments will still have responsibility for the same patients as they have now, patients who at different times and in different ways are also the responsibility of doctors. The ideological separation of mental health social workers from psychiatrists, or from GPs, cannot be in the interests of the patients. These social workers will still be faced with the problem of communication with doctors and the necessity of working with them. Progressive and enlightened education for both doctors and social workers could have anticipated and indeed prevented the necessity for the Seebohm Committee's recommendations.

Those who decided that independent social service departments were required, and envisaged control of such departments by persons highly qualified in social work and administration, rather than in medicine, well understood that expert medical advice in many fields would be required, not least in that of mental health. The secondment of a consultant psychiatrist 'part-time', to the department was recommended for each local authority. Such appointments have already been made in different areas, the secondment being, of course, at present to the Medical Officer of Health. The object of these appointments hitherto has been to assist in the planning of services and co-ordination with those provided by the hospitals. Whether social service departments are created or not, recent experience of attempts to co-ordinate the work of hospitals and local authorities suggest that *joint appointments* to both and *at all professional levels* promises the best solution to many problems. But the enormously important question of education and vocational training of the various groups involved remains unsolved and will be even more relevant if the Seebohm recommendation is implemented. Two-way joint appointments should surely not only be made for advisory and planning functions but also for educational and training functions. Here again I must point to the need for a sophisticated level of *psychological understanding* for all those working in these services, to be shared by psychiatrists, nurses and social workers alike. If consultant psychotherapists are finally seen to be needed in the psychiatric services, as I have suggested, perhaps half their time should be spent in an educational and supervisory capacity with

social workers in local authority departments, the other half with psychiatrists in training.

The evidence in earlier chapters which I have presented showing the greatly increased 'turnover' of patients in the hospital system, and the larger number of out-patient attendances, both for new and old patients, raises the possibility that we no longer know what is the work of the consultant psychiatrist, whether what he does is what he thinks he should do, and whether what he does is what he considers he has been trained to do. To what extent are his therapeutic enthusiasms and skills denied their expression by his need to be an administrator? It has to be shown that he has not become, as some cynics have suggested, the 'doorman' directing the flow of human traffic at the 'revolving door' of the hospital.

It is clear to us that it is now time for an overall assessment of psychiatric services and the resources they should have, into their function in society, the contribution that they should make both within and outside the National Health Service, how much of their skill and time should be devoted to training other workers in the helping professions and to 'counselling', and how much to direct diagnosis and treatment of the very large numbers in the population with serious—not to mention minor—mental disorders. We recommend that this assessment should be undertaken urgently (Para. 703, Seebohm Report 1968).

I am content to end this book with this quotation and hope that it will be noticed by those who could take the necessary action. If another interdepartmental committee is set up to make this assessment and to advise, and no doubt it will take two or three years to do its work, I can only hope that it will be provided with the necessary relevant data. This is not at present available and it is perhaps time now to start the extensive research which will be needed.

SYNOPSIS AND SUMMARY

1. *Psychiatry, separated from medicine for centuries, is now an essential part of it. Ignorance of what psychiatry was about, failure to realize the enormous burden in the community of the 'minor' forms of psychiatric illness and disability have meant that the services are inadequate,*

despite the great expansion of physical facilities, and of both medical and non-medical personnel since 1948. The lack of facilities is particularly evident for children with mental and emotional disability, and for all patients with neurotic illness and personality disorder.

2. *For historical and political reasons there has been a preoccupation with defining the needs of psychiatric services in terms of the number of beds required. This has neglected the essential problem which is to identify and make provision for the clinical and therapeutic needs of the psychiatric sick in the community who may or may not require hospital admission.*

3. *The psychiatrist is now one of a team of professional workers who themselves provide therapeutic support to large numbers of patients, both in the hospital and the local authority services. Social workers and nurses are prominent in this group. Therapeutic skills are not the prerogative of doctors alone, and personal responsibility for patients is being increasingly shared.*

4. *Education for all doctors, including that for psychiatrists, has lagged behind the development of services provided in the NHS. Ideological barriers can be identified which have affected the whole of medicine, the important question of the doctor's role, the theory of psychiatry and the relationships between those working in hospitals, general practice and the local authority services.*

5. *GPs care for a large proportion of the psychiatric sick and disabled, but have received no education or vocational training for the work, are uneasy in it and uncertain of their role. There is a need to redefine this role and its relationship to that of others working in the mental health services. The role of the 'personal physician' with continuing responsibility for patients is here paramount.*

6. *There is a need to provide all—GPs, psychiatrists, social workers and nurses—with basic psychological understanding and personal skills in human relationships. Educational and vocational training in this area are woefully inadequate. Changes in basic medical education can be expected to improve the situation for doctors, but similar consideration should be given to social science students who will later have careers in the health and welfare services. Since doctors and social workers will*

have to work together and share common knowledge and skills, provision for joint postgraduate vocational training and education should be made during the in-service period.

7. *To promote psychological understanding specialist teachers will be required. There is a need for career posts for trained psychotherapists both in the university departments of psychiatry and in the mental health services.*

8. *Research is required to further our knowledge of the extent of psychiatric morbidity in the population, its character and severity, and the needs of patients; it is also urgently required to evaluate therapeutic procedures of all kinds, but particularly those based on the use of psychological understanding, as well as those in which specific psychotherapeutic procedures are used.*

APPENDIX I

Selected Ministry of Health circulars to Regional Hospital Boards and Boards of Governors, 1950–67

Year	*Reference*	*Title*
1950*a*	RHB(50)26 HMC(50)25 BG(50)22	*Care of the aged suffering from mental infirmity*
1950*b*	RHB(50)39 HMC(50)38 BG(50)34	*Treatment of the elderly chronic sick*
1950*c*	RHB(50)61 HMC(50)60 BG(50)55	*Psychiatric treatment of offenders serving short term sentences*
1953	RHB(53)118 HMC(53)112 BG(53)114	*Epileptics and spastics* (Enclosed Circular 26/53, 'Welfare of handicapped persons. The special welfare needs of epileptics and of spastics' (Nat. Asst. Act 1948))
1954	HM(54)72	*Refresher courses for qualified mental nurses*
1956	HM(56)57	*The medical care of epileptics* (Enclosed the report of the Standing Medical Advisory Committee of the medical care of epileptics)
1957	HM(57)86	*Geriatric services and the care of the chronic sick* (a commentary on the Guillebaud report, *A survey of services available to the chronic sick and elderly in 1954–55*, in the series on Public Health and Medical Subjects (no. 98), HMSO) (Enclosed Circular 14/57, 'Local authority schemes for the chronic sick and infirm')

MOH circulars to regional hospital boards

Year	*Reference*	*Title*
1959*a*	HM(59)23	*Child guidance* (Enclosed Circular 3/59, 'Child guidance', which introduced the accompanying Ministry of Education Circular 347, 'Child guidance')
1959*b*	HM(59)46	*Mental health services*
1959*c*	HM(59)96	*Registration of mentally disordered patients as disabled persons for employment purposes*
1960*a*	HM(60)57	*Mental health services* (Enclosed Circular 14/60, 'Mental health services')
1960*b*	HM(60)66	*Administration of psychiatric hospitals*
1960*c*	HM(60)69	*Mental Health Act 1959* (Enclosed Statutory Instrument 1960, no. 1241, 'The mental health (hospital and guardianship) regulations 1960')
1961*a*	HM(61)25	*Planning of the hospital services for the mentally ill*
1961*b*	HM(61)42	*Treatment of drug addiction* (Cmnds. Report of the Interdepartmental Committee on Drug Addiction (The Brain Report))
1961*c*	HM(61)94	*Attempted suicide*
1962*a*	HM(62)6	*A hospital plan for England and Wales* (Encloses Cmnd. 1604, 'A hospital plan for England and Wales'; and Circular 2/62, 'Development of local authority health and welfare services')
1962*b*	HM(62)43	*Hospital treatment of alcoholism*
1964*a*	HM(64)4	*Inpatient accommodation for mentally ill and seriously maladjusted children and adolescents*
1964*b*	HM(64)45	*Improving the effectiveness of hospitals for the mentally ill*
1964*c*	HM(64)93	*Enrolled nurses (amendment) rules* 1964
1965*a*	HM(65)60	*Review of the hospital plan. Development of local authority health and welfare services* (Encloses Circular 14/65, 'Development of the local authority health and welfare services')

MOH circulars to regional hospital boards

Year	*Reference*	*Title*
1965*b*	HM(65)77	*Care of the elderly in hospitals and residential homes*
1966*a*	HM(66)17	*Clinical psychologists*
1966*b*	HM(66)38	*Training of registered mental nurses*
1967*a*	HM(67)16	*The treatment and supervision of heroin addiction* (Encloses Second Report of the Interdepartmental Committee on Drug Addiction)
1967*b*	HM(67)70	*Pocket money for patients in psychiatric hospitals*
1967*c*	HM(67)94	*Social workers*

APPENDIX II

The staffing of three psychiatric services

This appendix shows, in tabular form, the 1966 staffing of the three psychiatric services compared in chapter 5. Figures are given for doctors, psychologists, and psychiatric social workers, but comparable data for nurses were not available. The figures exclude staff who worked in the psychiatric services but were employed by non-medical authorities (e.g. educational psychologists, mental welfare officers), and all staff working in child psychiatry.

	The Burnley General Hospital Psychiatric Unit	*Plymouth Mental Health Service (including the Nuffield Clinic)*	*The Middlesex Hospital Department of Psychiatry (including the professorial unit)*
Medical staff			
Consultants	1	4	5·5
Psychiatrists in training (senior registrars, registrars, and senior house officers)	2	6	10
Assistant psychiatrists (medical assistants, GPs)	3	1·5	1
Psychologists	0	0	2·5
Psychiatric social workers	1	4	4

The figures refer to staffing in whole-time equivalents.

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