MEDICAL PRACTICE

Today's Treatment

Psychological Medicine

Psychiatry in Britain: An Introduction

A. K. ZEALLEY

British Medical Journal, 1975, 1, 497-499

In recent years psychiatrists have strayed, or been lured, into fields as various as the quelling of student protests and prison riots, acting as long-stop in theological colleges, and advising on the design of houses and the prevention of shoplifting—the list is long. At the same time consumer dissatisfaction with psychiatry has grown, and many charitable or voluntary societies have been formed. Some have aims which include making good the gaps in statutory provisions for the mentally ill, improving the circumstances in which psychiatric patients are treated, and reforming the Mental Health Act (1959; 1960 in Scotland), while others take the form of “anti-psychiatry” lobbies. The latter unite in believing that much serious illness, such as schizophrenia, is created by people who designate it as such—namely, parents, doctors, and other professional people. Such movements certainly cause feelings of guilt among the relatives of seriously ill patients and often turn a blind eye to the handicap implicit in serious mental disorder.

Happiness as a Right

The extent of human misery at any given time seems to be in proportion to the facilities available for its alleviation. Certainly the increase in recent years in the numbers of psychiatrists, skilled social workers, and voluntary organizations offering counselling and help has not been attended by any

evident decrease in the apparent national level of unhappiness. Indeed a causal relationship has been postulated.

Since the implementation of the Mental Health Act there has been a steady change in the expectations of the man in the street. Increasingly, happiness is expected as of right. If he is unhappy, he assumes something is wrong with his chemistry, or with the world, or both. And the solution is all too often sought in a prescription from the doctor—a pill for every ill. Clearly it is much simpler to ask one's doctor or specialist to change one's internal arrangements than to adjust those external circumstances that have brought about the distress. The man who is psychologically distressed will, if he seeks psychiatric help, be required to offer more active co-operation than he would in almost any other branch of medicine. And it follows that if he disagrees with his treatment he is often unlikely to be helped by it.

Less Compulsion

During the seventeen years from 1954 to 1971 there was a drop of 29% in occupied beds in mental hospitals. This decrease was largely due to the rarity of schizophrenics becoming long-stay patients. Many of the patients who once occupied these beds went into lodging houses, reception centres, prison, or lived rough. In the whole of the United Kingdom the official figure for hostel places was only 2000 in 1972, and this despite an increase of about 30% in places in hostels and local authority homes since 1970.

Nowadays a patient coming into psychiatric hospital is unlikely to be one of the few who do so compulsorily. The fact that the proportion of compulsory admissions to psychiatric hospital varies in different parts of the country suggests that the provisions of the Mental Health Act are not always used impartially. The aim of the Act was to foster the care of the

Andrew Duncan Clinic, Morningside Terrace, Edinburgh, EH10 5HF
A. K. ZEALLEY, M.B., F.R.C.P.ED., Consultant Psychiatrist

mentally ill in the community, and this goal is still very much sought after today. Certainly the Act intended that no patient would unnecessarily be deprived of his ordinary civil rights. But criticisms can be made of the Act. Though it was never intended as such, it is sometimes wrongly invoked as an administrative convenience. People who seek formal review of its provisions feel that medical practitioners should be accountable to an independent body to whom they would have to explain their actions if called upon to do so. They also suggest that a patient who is compulsorily detained against his will should be able to have his case heard; he could be represented if necessary, with the right for his counsel to question the authorized medical and other officials who took the steps leading to compulsory detention.

Association with other Specialties

Over recent years there has been an increasing realization that psychiatry should align itself with the major medical specialties. One development has been the establishment of psychiatric units in district general hospitals. There is general agreement that such units should be the rule in these hospitals, not least because patients will often prefer them to mental hospital. These units do pose certain problems—for example, their proximity to the sundry adjoining departments in the district general hospital. It seems unlikely that they will be able to provide suitable care for longer-stay patients, and to this extent they cannot be comprehensive in their psychiatric function. Their best use will almost certainly prove to be for short-stay illness of acute episodic nature and for assessment. Certain specialized techniques may also be best applied in such a setting.

Forecasts that the older mental hospitals would all close down in the foreseeable future seem unlikely to be correct. Temporary and sometimes permanent asylum must still be provided when necessary. The relationship of mental hospitals to the total psychiatric service in Scotland is different from elsewhere in Britain and a greater proportion of the mental hospitals here are likely to be maintained.

Central Problems

What then are the central problems confronting psychiatry today? With little doubt, schizophrenia, mental handicap, and the psychiatry of old age. They are among topics to be discussed in greater detail in later articles in this series. Moreover, up to half of a general practitioners' consultations are psychologically determined.

Dr. J. G. R. Howie (Aberdeen) will write of the psychotropic drugs most often used in general practice and will draw attention to common hazards that lie in store when polypharmacy is practised. Despite the history of thalidomide it nevertheless seems probable that the family doctor has at his disposal some much safer tranquillizers and hypnotics than in the past. The case for prescribing phenobarbitone (except as specific treatment for epilepsy) must surely have disappeared. Yet it is a constituent of a large number of "cocktail preparations" used for treating illnesses as various as asthma and peptic ulcer.

General practitioners will rightly want to pass over to the psychiatric hospital the care of the acutely schizophrenic patient. As Dr. Peter Kennedy (Edinburgh) will be mentioning, the management of such cases leaves little time for philosophical speculation on the nature of mental illness. The risks with schizophrenia are great, and include suicide and injury to others. Only occasionally is compulsory treatment necessary, but, if it is, there is a clear responsibility to invoke it lest worse happen.

For patients with this disorder who are looked after out of hospital the burden can be heavy. The patient may quite commonly talk of suicide with his relatives, and his liability to social withdrawal and embarrassing behaviour, coupled with lack of conversation and night restlessness, underactivity or overactivity, conspire to disturb his family and friends. At

present the community care services are grossly inadequate. The families of these patients are often faulted by social workers who judge them to be reacting abnormally—overanxious, over-protective, or rejecting. There is a grave lack of hostels, which therefore tend to provide only an extended break for the parents or for the hospital.

Besides medicine, often by depot injection, one of the cardinal needs of the schizophrenic patient is occupation. Day centres, which may or may not be combined with hostels or sheltered workshops, may be invaluable to get the patient and his relatives out of one another's sight for some hours every day. For many of these patients small hostels would be the ideal, providing a permanent home, allowing close ties with nearby relatives when possible. Such hostels would facilitate independence, so that patients could go out to work or attend day centres. To provide these facilities a vast injection of funds into local authority social services is necessary, and it is grievously overdue.

Depression

In depressive illness the prognosis can usually be hopeful. There are still psychiatrists who remain sceptical about the efficacy of tricyclic antidepressants, though most find them of value. For the more severely depressed, especially when suicide is talked of, recourse may appropriately be had to electric convulsion therapy (E.C.T.). No one who has practised psychiatry for more than the briefest period can fail to be impressed by its effectiveness.

Whether lithium will prove to be as valuable in the prophylaxis of recurrent affective disorders as E.C.T. has been in the treatment of depression remains to be seen. In some patients its efficacy is quite striking, and the inconvenience of regular blood tests to check on serum levels of the drug are a small price to pay for the benefit that results.

Increasingly data on individual responses to the tricyclic antidepressant drugs show that the same oral dose will produce greatly different blood levels in different people. Some patients never have more than a very low blood level of the drug, and this may be associated with failure of response. It is still not yet clear whether increasing the dose in these patients to secure a blood concentration in the (wide) normal therapeutic range will do other than increase the severity or number of toxic effects, rather than causing a satisfactory therapeutic response.

Sleep difficulties—one of the most important symptoms of depression—will be discussed in a more general way by Dr. Ian Oswald (Edinburgh). He refers to the individual variation in the number of hours sleep that are needed. A complaint of insomnia is often a flag of convenience implying some inapparent source of preoccupation or tension. The number of people in western cultures who cannot think of going to bed without their hypnotic is quite alarming. The medical profession is often responsible for establishing them in their hypnotic habit. This start was often made unnecessarily, perhaps during some brief period in hospital. Fortunately the hypnotics now available appear to be less hazardous than the barbiturates. At least in overdose, the diazepam is most unlikely to do much damage.

Alcoholism

Problem drinking, as Dr. E. B. Ritson (Edinburgh) will be reporting, often goes undetected, but some studies have shown that as many as 1½% of some family doctors' patients aged 15 to 64 were either dependent on, or had problems arising from, alcohol. Treatment of delirium tremens can usually be accomplished satisfactorily in hospital and requires urgent medical attention. Hospital can also provide a useful "drying out" function, and this will be desirable in a patient known to suffer severe withdrawal symptoms when alcohol is stopped, or where his home does not lend itself to the drying out process.

Until recently it has been traditional to make total abstinence the inevitable and only goal of the alcoholic. Psychiatrists tend

to select for treatment patients with neurotic or personality problems, on the basis that treatment of these difficulties may help the patient attain an understanding of his repeated recourse to alcoholic anaesthesia. Patients who do best at the hands of psychiatrists are said to be those who still have a job, a spouse, and other social supports. With these assets they may have done well anyway.

Aversion therapy is little used today, but behaviour therapists are now interested in helping patients return to controlled, social drinking. Data from Australia and the U.S.A. suggest that this alternative to total abstinence is indeed possible for certain alcoholics, though it is not clear why it is not attainable by others. Otherwise, "no drink hereafter" continues to be asked of people who may have less than an average amount of determination.

For many of these people the abstinent life is an alien and lonely one. Should they make any departure from the straight and narrow way they know or believe they will be regarded as a "failure." Once they feel this, they are likely to throw the whole attempt overboard.

Psychopaths

The relationship between psychiatry and patients with so-called personality disorders is an unusual one. Those persons who persistently behave in ways that are outside society's norms of reasonable conduct, particularly if liable to aggressive or petty criminal behaviour, are usually designated sociopathic or psychopathic. Some evidence suggests that these people may ultimately be found to have some central nervous system dysfunction to account for their life style. Certainly they form an appreciable proportion of those people who come before the courts and occupy prisons.

Patients whose behaviour is less conspicuous than this but who make a complaint of their dealings with life fall into either the neurotic categories or one of the numerous and—as yet—crudely defined personality disorders. They tend to be treated only in those psychiatric environments where the doctor-patient ratio is especially favourable. The extent to which psychiatry succeeds in helping them feel differently is not very convincing.

Old Age

Not all depression is reactive to adverse life circumstances, and, as Dr. H. M. Hodkinson (Middlesex) will be reporting in his paper, depressive illness is often missed in the elderly. This is unfortunate because it is usually treatable. Physical illness is one of the commonest causes of mental disorder in old age, and there is a clear place here for "psychogeriatric assessment centers" in close relationship with geriatric units at district general hospitals.

Patients at high risk of psychiatric illness are the elderly who live alone or who have been recently bereaved or discharged from hospital. The risk is especially great if the patient is housebound, physically handicapped, or has a past psychiatric history. The entire field of psychogeriatrics is one that clamours for more attention from those willing to make a substantial commitment to it.

Physical Illness

The psychological aspects of physical illness can be important determinants of recovery and convalescence. There can scarcely be any clinical disorder which does not have implications for

some aspect of the patient's life, and these will be variably distressing.

I consider the term "psychosomatic illness" to be dangerously suggestive of an aetiological statement. No modern, well-conducted research has shown that psychological factors were any more the *cause* of such illnesses as asthma, peptic ulcer, and so forth than they were the *consequences*. Common illnesses are common, and all degrees of neurotic dysfunctioning are found in the community. It is thus inevitable that there will be patients in whom both physical illness and a tendency to worry will coincide. Psychosomatic medicine is surely what all medicine should be—a recognition that as much consideration be given to how the patient *feels* about his disability as is given to the somatic aspects of the illness.

When expanding on this theme Dr. R. Wood (Perth) will refer to the frequency of depression after many common illnesses, and will also discuss the psychoses that may be precipitated by a variety of drugs. Closer collaboration is urged between physician and psychiatrist.

Mentally Handicapped

One problem that continues to be a matter for debate is who best should look after the mentally handicapped? Clearly some are so severely handicapped that long-term hospital care is necessary. However, for the vast majority the service which the handicapped person needs is primarily social and educational, not medical. This emphasis has been successful in Scandinavia, admittedly with the expenditure of vastly more money than has been made available for handicapped people in Britain. And why segregate the education of the mentally handicapped from that of non-handicapped children? There are surely advantages for a handicapped child (and his normal contemporary) to be taught in an integrated school, where special classes exist for the type of teaching arrangements best suited to his handicap. Ontario in Canada has apparently shown the way here, and their experience deserves study.

In the early 1960s the "Wessex experiment" pioneered by Dr. Albert Kushlik worked on a pattern of locally based living units round Southampton. They coped with all degrees of mental handicap in children, and, almost certainly because the units were small, staffing problems did not arise. It was considered that the chief gain was the involvement that developed with the local community. It was much easier for parents to keep in contact, though it had to be admitted that, when the children became older and had to go and live in the older subnormality hospital some miles away, contact with the parents was less keenly maintained. Dr. A. D. Forrest (Edinburgh) will be writing on the characteristics of "subcultural handicap" and on other practical issues facing the parents of handicapped children.

From the patient's angle, the current climate of economic recession poses a real threat to industrial rehabilitation and community care programmes. Rehabilitation programmes may cost nearly twice as much as standard hospital care, and if regional unemployment rates are much over 2% the placement of such a patient becomes increasingly difficult. It is almost impossible if the level gets much over 5%.

Nevertheless, I think one can be hopeful. Whatever else, attention is now being paid to problems that matter by people using treatments that are increasingly carefully evaluated. While the psychotherapies have a useful role in contemporary psychiatry, the day of the psychoanalytic gold rush has gone. Every dogma must have its day, and the gold was alchemist's anyway. If the psychiatrist sticks to his last, he will receive the welcome he deserves—both from his patients and from his medical colleagues.