considerations might be seen as having clinical relevance in, say, marital conflict, one of the great mythological themes. Similarly, the clinical interview has a visual meaning only subliminally expressed in the English word 'interview'. It is the experience of the self as another which underpins empathy in mythological terms. In these ways, far from shunning the relationship of psychiatry to myths, psychiatrists should welcome the study of myths as useful to deeper understanding of their clinical work.

It is the genuinely held belief of many psychiatrists that psychiatry is in a rudimentary stage of development, comparable to many medical disciplines at the beginning of the nineteenth century. Such views imply the growth of a large, new specialty fuelled by the proper application of rigorous scientific procedures. What kind of research would be involved? At the present time, most prestigious psychiatrists favour research in neurochemistry, neuropharmacology and social medicine or epidemiology.

There is, however, a contrasting viewpoint. Psychiatry is the systematic application of the doctor's psyche to his patient's distress—the original meaning of the term. Psychiatry is viewed as an ancient discipline, resting largely on psychological understanding and previously manifest in varying forms in many religions and philosophical systems. More accurately, it was previously manifest in many educational methods which discussed religions and philosophical matters. Such a view draws heavily on cultural history, the study of words and the systematic study of lived experience—phenomenology. This view regards much contemporary research conducted by psychiatrists as inadequately psychiatric, having lost sight of the psyche. Clearly, the implications of this view for psychiatric research and education would be considerable.

Of course, both of these views of psychiatry may be mistaken; or some combination or development of the two may prevail. It may not be necessary to adopt an 'eclectic' approach after all. Which view prevails may, in the end, depend on factors quite other than those here mentioned, such as the views of powerful and important teachers of psychiatry—whoever they may be.

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Talking to the Police

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The police are now the only laymen in Britain who can pass judgement on a person's mental state and compulsorily admit them to places of safety.[1] Various papers have looked at how the police use this power, and one paper in particular[2] has shown that police are as efficient at recognizing persons in need of psychiatric care among those called to their attention as are medical practitioners who are not approved psychiatrists.

Police admissions on the whole are infrequent—probably around 0.5 per cent.[2] Sims and Symonds,[3] however, showed in their Birmingham study that police referrals were forming an increasing proportion of new referrals to the Mental Health Department. The number doubled in the years 1962–67. They felt that this was in part due to a greater willingness of the police to be involved in mental illness and to view some disturbances in the city as arising from mental illness. The distribution of these referrals was found to be markedly higher in the inner city and city centre zones (i.e. areas of multiple social disadvantage) and among people living on their own. The number of those of no fixed abode was also high. The commonest diagnosis was schizophrenia. Police referrals deal with the most difficult and disturbed psychiatric population,[2] i.e. those who have done physical violence to others and to property. Sims and Symonds[3] showed that 48 per cent of police referrals were 'markedly disturbed'. It is suggested[2] that it is the qualities of personality rather than their mental illness category which prevent these patients from entering psychiatric care through conventional routes, and that community services are at present failing to detect these cases or to maintain contact with them. These people are thus allowed to deteriorate until they become a nuisance to society. The increasing number of police referrals in inner cities may be seen as a symptom of urban disorganization.

While studies indicate the police are efficient at recognizing mental illness, researchers[4] in the USA have shown that an increase in psychiatric training for police results in an increased interest and sympathy for psychiatric problems and a minimization of bias against psychiatric patients. In a good community psychiatric service, good relations and communications between psychiatrists and the police are essential.

Liaison in the Fareham and Gosport Service

In October 1982 I was approached by the Inspector of the local police college with a request for a regular psychiatric contribution to their training course for police probationers. These probationers are trainee policemen who have already

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been 'on the beat' for about 15 months. (Interestingly, the request for psychiatric teaching came not from an objective appraisal of the course, but from a policeman's personal experience of mental illness.)

The psychiatrist's contribution was limited to one hour per course of probationers. The only other psychiatric instruction was a preceding hour with a police sergeant who outlined the law relating to mental illness and how to enforce it. It was possible to encroach slightly on this first hour, working with the sergeant to give clinical examples of patients detained in the various ways he was describing.

It seemed to me that the second hour would be most usefully spent, not in looking at diagnostic signs and symptoms, but rather in talking about what psychiatrists do and how they try to do it. A general outline of my aims was: (a) to attempt to correct any bias against the mentally ill; (b) to look at ways of talking and listening to psychiatric patients; and (c) to look at the areas of conflict which arise between the police and the psychiatric services. The hour took the form of a seminar and many points relative to these 'aims' were covered by spontaneous questions from the probationers. A handout of basic signs and symptoms of psychiatric illness was given for later, independent reading.

(a) Attempting to correct bias against the mentally ill

It is fair to say that a small proportion of each class coped with their feelings about mental illness by being derogatory. 'Loonies' and 'psychos' were terms often used in questioning towards the beginning of each session. Some illusions had to be dispelled. Most were astonished to learn how many of the general population need psychiatric help at some time in their life. Many believed that most of the people they transported to a psychiatric hospital stayed there for life or for many years. Some found it hard to believe that people with psychiatric illness might be indistinguishable from themselves after treatment or that most patients were not as disturbed as those with whom they had come into contact. Education about incidence, prognosis, outcome and the fact that most of our patients were voluntary was shown to be a necessary part of the task.

A description of the moves of psychiatry into the community seemed a useful way of illustrating our attempts to destigmatize psychiatric illness. We discussed the use of day hospitals and community services as more acceptable or appropriate means of treatment for the patient. The resultant emphasis on contact with relatives and other 'helping' agencies was also discussed and the burden we put on the community questioned.

The probationers expressed particular interest in knowing the ways in which the public has access to a psychiatrist. Police standing orders, at least in this area, state that for the purpose of Section 136, a 'place of safety' must be the local police station and not a psychiatric hospital. At almost every session the probationers expressed anger and frustration that the police were not permitted to ask directly for a psychiatric opinion but first had to have their request 'vetted' by a social worker—someone whom they felt had as little or even less psychiatric knowledge as themselves. They welcomed the relevant changes in the Mental Health Act regarding social work training in psychiatry, but still felt direct access to a psychiatrist would be more useful and time-saving.

The probationers were well aware of the stigma of our 'asylum on the hill'. Many had never seen the inside of a psychiatric ward, despite delivering patients to the door, and some admitted to frightening fantasies of what the ward held, and were often relieved to be able to hand the patient over to the nurses at the door. A description of the kind of people in an admission ward, what they do, how they go on leave and how they are initially settled into the ward seemed useful. At this stage, encouragement to ask to look around when next delivering a patient was warmly received.

(b) Speaking to patients

The concept of sympathy was a familiar one, that of empathy a new one. The idea of mentally stepping into the shoes of disturbed people, trying to imagine how they feel and then letting them know you are trying to appreciate these feelings was for some a difficult, even threatening idea. The importance of listening to the content of the person's talk before dismissing it as 'mad rubbish' was worth pointing out. Some found it difficult to grasp how far they should go in sharing the patient's experience—should they too duck the imaginary bullets on the way to the police car? Many thought that disturbed people would not remember the events leading up to their admission to hospital. It seemed important to emphasize that the police may be the patient's first contact with the helping services and the way this is handled may well influence the patient's readiness to seek help the next time. Empathy, quiet control and honesty may in themselves diffuse a difficult situation and win a person's trust and co-operation. Having said this, it was necessary to acknowledge and allow that psychiatric patients can be frightening and there is sometimes no alternative to immediate physical restraint.

The idea of sharing with colleagues the feelings of stress and fright which some of these encounters may engender, was, again, to some a novel idea. Recent papers, such as that of Cooper *et al*,[5] point out the high level of stress and even suicide in the police force. Advice on stress relieving techniques would seem to be another way in which police-psychiatrist liaison could be useful.

(c) Areas of conflict

This topic usually identifies problems probationers have found on the beat. Areas of frustration are basically those where the police feel psychiatrists are shirking responsibility or even are unable to see that someone is ill. Examples given include the cases of wandering, demented old ladies who refuse to give up their homes but who have crises where the police are called; the disturbed patient they have delivered to

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hospital whom they find in the street in a similar state weeks, or even days, later; those who have been released from Special Hospitals and who re-offend—this last they find a particularly sore point. Examples such as these usually lead to lively discussion about the interpretation of the Mental Health Act and human rights. How we decide someone is well is a frequent question. It seems important to say that we too suffer frustration when we can see the way someone's life could be less distressing and yet are unable to do anything about it unless they either agree or fulfil the criteria the law demands. It seems our inability to act in these cases is often seen as stubbornness and awkwardness until this is explained. Other areas covered include dealing with personality disorder, drug addiction, alcoholism and situational crisis. Our move into the community has meant a decrease in in-patient beds and, therefore, stricter criteria for admission. Case illustrations of patients who have been more usefully helped by avoiding admission are discussed.

Recently this educative process has become a two-way venture. The local psychiatrists have had a useful seminar from the police sergeant in whose 'patch' our hospital lies. We learnt of the difficulties in policing such an area, the restrictions on manpower and the difficulties the police have in encouraging people to seek medical help—bound as they are both by our confidentiality and theirs. That the police themselves have strict rules about confidentiality is frequently overlooked.

It does seem that such interchanges are already showing signs of strengthening co-operation and understanding between ourselves and the local police and would seem to illustrate, in small part, what community psychiatry is about.

Summary

The importance of these seminars seems to be in establishing communications, in correcting wrong impressions, in giving some practical guidelines in dealing with patients and in explaining how we are attempting to make psychiatry more acceptable. In the course of doing this, the sharing of anxieties and frustrations involved in dealing with the mentally disturbed person in the community does seem to correct misconceptions on both sides.

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Community Care: The Sham Behind the Slogan

NATIONAL SCHIZOPHRENIA FELLOWSHIP

The following letter and statement were published on 28 February 1984 and were widely circulated to influential bodies.

DEAR COLLEAGUES

Hospital closures and community care

I enclose a statement drawn up by the National Schizophrenia Fellowship in consultation with the Richmond Fellowship. It also has the support of the Psychiatric Rehabilitation Association, the St Mungo Community Trust, and the Salvation Army. Our aim is to bring to the notice of those with public responsibility and of the Press the deep concern felt by a number of national voluntary organizations involved with mental illness.

None of us want patients to be in psychiatric hospitals on a long-term basis if this is not necessary. We would wholeheartedly endorse the Government policy of closing old, run-down mental institutions if a range of appropriate and adequate services is made available to mental patients elsewhere before they shut down. We are against any policy which accentuates the social isolation and stigma experienced by those who suffer from mental illness.

But the drive, at all costs, to move mental patients out of hospital and into the community is at present leading to disastrous human and social problems. All our first-hand experience shows that there is widespread failure to provide adequate aftercare or to grant-aid those for whom this care is available. We are also convinced that the number of those suffering from severe mental illness who are very seriously disabled has been under-estimated. The needs of those requiring ongoing support of various kinds, including suitable support for the families, must be far more accurately assessed if adequate provision is to be made for them. Some may need lifelong care of a kind which *at present* only the psychiatric hospital provides.

Current plans will close large mental hospitals before

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