Contemporary community psychiatry*

Where *is* the therapy?

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When invited to give the Maxwell Jones lecture as part of the Fiftieth Anniversary Celebrations of the Henderson Hospital I was pleased and honoured, as well as somewhat surprised. I welcomed the opportunity to pay tribute to an outstanding social psychiatrist and to reflect on a decade of turbulent change within mental health services.

I congratulate the Henderson on its Fiftieth Birthday and thank Kingsley Norton and Stuart Whiteley for this opportunity to recall a distinguished pioneering, flamboyant and influential social psychiatrist. The Henderson and other like-minded institutions (notably the Cassel) kept alive the flame and idealism which energised the therapeutic community movement after the Second World War (see Dolan, 1996).

Dr Maxwell Jones

I was attracted into psychiatry by the idealism and communalism of the therapeutic community principle exemplified by Maxwell Jones at the Henderson and by Dennis Martin (1962) at Claybury Hospital. I identified at that time with the sense of community obligation which characterised much social, medical and moral thought (Lambourne, 1963) as well as the recognition that large and small groups were powerful treatment modalities.

When we returned from Uganda in 1974, Dingleton Hospital in the Scottish Borders still retained respect for its charismatic, puckish and 'pushy' Medical Director, Maxwell Jones, who had applied therapeutic community principles in the community – in people's own homes.

I am particularly indebted to D. W. Millard (1996) for a biographical chapter 'Maxwell Jones and the Therapeutic Community' which describes lucidly the early life of this influential man; 'Max' would have approved of having the 'last word' in the final chapter of this book.

Dr Jones was born in South Africa in 1907 and when aged five travelled to Edinburgh with his mother after his father's death. There he studied medicine in order to train as a psychiatrist under the influence of D. K. Henderson. Later he was awarded by Edinburgh University the Gold Medal for a doctoral thesis "Psychological Aspects of the Effort Syndrome in Forces Personnel". Subsequently, when faced with large numbers of returned prisoners of war in London, Jones was among the first to realise that their therapy would be facilitated by holding large meetings where personal worries were shared, and by encouraging a more informal non-hierarchical attitude of medical and nursing staff. This work as Medical Director of the Industrial Rehabilitation Unit at Belmont Hospital and then at the Henderson Hospital, his jostling with authorities and rescue by mentors (including Aubrey Lewis and Morris Carstairs) are described by Millard (1996), and by Maxwell Jones himself in an interview with Brian Barraclough (1984).

Fiftieth celebrations

There is always a tinge of reflection and even regret about a fiftieth celebration. It may be assumed that the best is in the past and that the future will be characterised by shrinking horizons or even despondency. Such an attitude, however, was far removed from that of Dr Jones (1988) who when aged 80 published a splendid book *Growing Old: The Ultimate Freedom* in

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which he looked back not with anger but with pride and made more explicit his spiritual and moral values, which may have been close to those which motivated his earlier innovations. He remained an excellent communicator.

It is not meaningless coincidence that there are two other fiftieth celebrations this year: the founding of the National Health Service and the first meeting in Bossey of Tournier's 'Medicine of the Person' Group. Those who had survived the War had a motivation to get things done – which got things done.

A recent report from Sarajevo (Carballo *et al*, 1996) showed how such therapeutic community principles might be particularly relevant because of the breakdown of communities, the effects of famine and hunger, damp and lack of shelter for women and children born with physical and learning disability.

Core therapeutic community concepts

I would like to discuss the possible relevance of these core therapeutic community values for generic community psychiatry services. Rex Haigh (1996) in a paper read to the Windsor Conference stated that the four 'articles of faith', (communalism, permissiveness, democratisation and reality confrontation) identified by Rapoport (1960) did not always describe what happens in many therapeutic communities and preferred to describe such work as a journey through developmental phases of attachment, containment, communication, adolescent struggle of involvement and the empowered adult position of agency – the finding of the self as the seat of action. Hinshelwood (1996) also described links between therapeutic community practice and individual therapy which included the 'Culture of Enquiry into Ritualised Practice', respect for the reality of self and others, a supportive and non-judgemental study of relationships (the community) and making links with others throughout the work of the day.

The 'Culture of Enquiry' was also an important theme in Stuart Whiteley's background (1980) and Norton's (1992) papers to describe the *reflection* on 'Living and Learning' and the thinking of the work group which characterised residents and staff when together for prolonged periods of time.

I believe that these facets of therapeutic community work are relevant not just to milieu therapy (sociotherapy) but also to generic community mental health services at the present time.

These facets may include:

(a) respect for persons.
(b) recognition that staff and users have in common their ability to be therapeutic.
(c) realisation that a 'containing' environment is essential and that leadership tasks, whether multiple or single, are evident and acknowledged. Some community services are indeed like sieves with no containment and no clear leadership.
(d) understanding the sociology of large and small groups and the "culture of enquiry" transmitted and maintained by core staff.
(e) values, not just mission "statements", incorporated in teams and shared by others outside the team.
(f) awareness of a potential for 'splitting' which must be recognised and then overcome (Hinshelwood, 1996).

At the present time psychiatrists responsible for adults 'of working age', are rather demoralised by the lack of resources and by increasing paper work. Such difficulties are closely linked to the reaction of Government to the public's realisation that mental illness not only exists but can be dangerous – and that mental hospitals are closing and not likely to be reopened. The Ten Point plan for improved Community Psychiatric Services did not appear to have had the same quality of preliminary thought or consultation as the Ten Commandments.

The Community Care Strategy has however encouraged inter-agency collaboration, yet there remains a persistent lack of clarity about care management, case management, minimal Care Programme Approach and the supervision register, and even uncertainty about the definition of severe mental illness (Burns, 1997). The Henderson has several privileges in this regard which include not having residents detained under the Mental Health Act, nor having a Care Programme Approach 'Newsletter' to read! *The* containment of *their* residents is within and by the community and it would be interesting to speculate what Maxwell Jones would have said about a 'top down' (yet appearing to be bottom-up) approach to multi-agency work within the community, and about the nature of anxiety caused by a top heavy management structure.

Where *is* the therapy in community psychiatry?

"Are therapeutic communities swimming against the tide" asked Paul Schimmel (1996) – or, I might ask, *is* the tide turning?

It could be argued for example that certain therapeutic community principles are to be found within present day mental health services. Recent papers in the *Irish Journal of Psychological Medicine* (Kapur *et al*, 1997); *Journal of Mental Health* (Smith *et al*, 1996) and *Psychiatric Bulletin* (Clunie, 1997) by general psychiatrists would support this opinion and suggest that

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interest in a sociotherapeutic approach on an admission ward is not altogether extinct. Thus *users* now make a more formalised contribution to care plans, and are educators of psychiatrists. There is greater awareness *of* the needs of carers and renewed appreciation of the need for leadership of a multi-disciplinary team, and for leadership training. In addition there is a demand for training in psychotherapy by all mental health professionals; dynamic and cognitive psychotherapy is now a mandatory training requirement for psychiatrists.

However, there is also a crisis in community care; the Royal College of Psychiatrists recently gave overwhelming support for a resolution critical of the Government's implementation of community care policy, and in particular the lack of appropriate residential accommodation. The College warned about dangers of an under-resourced policy which resulted in high levels of bed occupancy, long-term mentally ill discharged to hostels staffed by untrained volunteers, and the demoralisation of psychiatrists. The Government was urged to stop further closure of admission beds, to develop 24-hour nursed care hostels as well as havens and psychiatric rehabilitation units.

Although day hospitals have been shown to be more effective and cost-effective than in-patient care for selected patients with mental disorders, these studies generally give scant attention to styles of clinical management or to the specific ingredients of a successful multi-professional team. In a recent paper 'An ABC of Mental Health' (White *et al*, 1997) it was for example correctly stated that a multi-disciplinary team may include "psychiatrists, nurses, occupational therapists, psychologists, social workers and counsellors, supported by an administrative team" and that the psychiatrist is a "bridge' between in-patient and community teams, but the need to grasp the theory and practice of such team work, to understand the sociology of large groups and to be explicit about values is not described, even in outline. Yet these factors, though so rarely articulated, are important ingredients of a successful day hospital or community mental health resource centre.

In-patient units

Clinical experience had suggested certain benefits of applying therapeutic community principles to an acute admission ward. I first anticipated this possibility after working at the Royal Edinburgh Hospital on a ward treating neurotic patients with milieu therapy principles, but without pressure on beds and only an occasional patient detained under the Mental Health Act. Many such patients had a borderline personality or an eating disorder. We were certainly aware that this approach was advantageous for the training of psychiatrists and provided the background against which other therapies, including medication, could be considered. I nevertheless also wished to determine the extent to which this approach was therapeutic within a busy admission ward.

Between 1987 and 1992, and after a move to Keele, I found that holding community meetings, small groups, regular staff meetings and establishing a culture of openness and some flattening of the hierarchy was valuable within the context of an acute psychiatry service (Cox, 1991). The theory of this approach was based on 'good practice' of multi-model general psychiatry which required a psychiatrist to be familiar with both large and small group therapy, and also with diagnostic assessment skills.

The purpose of the community meetings included monitoring progress of patients, asking for opinion about improvement of other residents and discussing ward events (e.g. admissions and discharges, violent incidents or suicidal threats). The community meeting also provided a forum where the feelings of patients and staff about these events was expressed and understood. The psychiatrists, often stereotyped as prescribing only medication, had an opportunity to demonstrate a more 'holistic' management and to identify psychosocial stressors originating from earlier family relationships. The 'before and after' meetings between staff were fundamentally important for peer review for recording the group to report back to the ward team, and for support.

The theoretical model which underpinned this approach was the biopsychosocial model (Engel, 1980) which used systems theory to bring together dynamic, social and biomedical constructs. Each construct in this model was self-contained yet interacted with the others. *In-patient Group Psychotherapy* (Yalom, 1983) was also a useful reference book, although the chapters on active group therapy overlapped with much present day occupational therapy. The group interaction chronogram (Cox, M., 1978), as well as the other visual display systems, was particularly useful.

Such an approach to a ward milieu encouraged altruism as patients learned to support each other and so to gain in self-confidence. 'Acting out' was less frequent when large groups were held regularly; patients who required 'close observation' could be observed in a group and relieved the nurse temporarily from the demanding one-to-one observation. The community meetings therefore gave an opportunity for patients to talk about their feelings of despondency or aggression, rather than act on them. The large meetings were most economical of medical time, relevant information was rapidly

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gained about an individual's progress and the ward atmosphere, and such meetings enabled relevant psychodynamic hypotheses to be developed. There were however disadvantages of these meetings which included restricted time for individual interviews, problems of confidentiality, and the stress for staff exposed to critical and uncensored comments from patients. There was also the possibility that a ward group could be counter-therapeutic; in this situation the group conductor had to be familiar not only with group dynamics but also with relevant biological and psychosocial individual treatments.

Community mental health teams

Assertions about the relevance of such therapeutic community principles to a non-hospital psychiatric service have also been made by others, including Jones (1974) in a paper entitled 'Psychiatry, systems, theory, education and change'. He realised that exposure to the wider community outside a hospital through home visits would extend the "systems approach to an awareness of differing cultures whether racial or socio-economic", and he recognised a continuum whereby formal psychiatric training was widened from exposure to a small simplified system in a hospital to the "enormously more complex system in outside society".

Hinshelwood's (1996) answer to his own question "Can our knowledge, learned within institutions, be transferred outside to care in the wider community?" is particularly pertinent. His answer was within the notion of "containing" and of "reflective space".

Problems of inter-group dynamics within a dispersed community service pulling apart at the seams were, he said, problems which the therapeutic community movement understood. Holmes (1990) has also wrestled with similar problems and asked "What can psychotherapy contribute to community psychiatry and vice versa?" Community psychiatry had moved from utopia to ideology; in a post-institution era fragmentation, interprofessional rivalries are concealed under normalisation. Holmes stated his own belief that psychotherapy with a developmental perspective may help to resolve tensions in a community psychiatric team. It is indeed possible, however, that his shining knight in armour (psychotherapy) is more acceptable to community psychiatrists if coming with a large group perspective and socio-therapeutic skills, as well as with individual psychotherapeutic expertise. A *community* psychiatrist is more likely to recognise a kindred spirit in a *community* therapist.

In an introductory psychotherapy text Brown & Pedder (1979) also gave prominence not only to group therapy but to social therapy, and they observed that the principles of therapeutic communities had to be adapted to "hospital psychiatric wards". The staff needed to be free to make authoritative decisions, to cope with emergencies and to maintain a safe structure. Awareness of the principles of social therapy will help staff to remain flexible in their roles, and to share responsibility *as patients become ready to assume it.*

Indeed herein lies the skill of a general community psychiatrist who is familiar with the non-institutional 'community', and aware of the potential for therapy of the 'community' itself.

Conclusion

It is appropriate to conclude by quoting Maxwell Jones himself, who completed an interview with Barraclough (1984) by expressing his own aspirations and idealism, and the themes which may have been close to the source of his optimism and hope.

> "In the therapeutic community movement we have come to have a deep distrust of reductivism in the form of scientific research unless it is linked with a humanistic orientation and subject to constant discussion and recycling with a view to achieving consensus with all the participants.
>
> We are not afraid of social values which highlight morality and need to keep a constant check on the abuse of power. We evolved a democratic system which inevitably clashed with the more authoritarian and technocratic systems in other psychiatric facilities and in our surrounding environment dominated by professional tradition, rationalism and secularism.
>
> At the same time we became conscious of the effects resulting from our change from an individualistic society to one with a group identity. We began to experience new strength and a feeling of security which was badly needed to combat the constant attempts to liquidate us which came from our profession . . . We even dared to recognise a growing spirituality which helped us to explore new dimensions of consciousness, such as intuition and the motivating driving force . . . It has taken me forty years to arrive at this point as one individual with, I hope, many peers who epitomise this spirit of change which seems to grow daily everywhere. Can the gradual metamorphosis to holism be speeded up in time to prevent an atomic holocaust or famine on a world scale?"

General psychiatrists are indebted to the therapeutic community movement pioneered by social psychiatrists, and to the therapeutic community concepts which may become yet more influential over the next decade. This is more likely to occur if the boundaries which divide those specialising in therapeutic communities proper from the therapists in the community become more transparent. If this can happen then innovation and containment,

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the therapy of the large and the small groups and the therapy of the community could contribute to improved morale for all mental health professionals – and for psychiatrists in particular. Some of the therapy within an optimal community psychiatry service is, I believe, to be found within the core values of the therapeutic community.

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