Perspective

An occasional series in which contributors reflect on their careers and interests in psychiatry

Clinical Administration

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In times of pessimism when psychiatry is described as in decline, subject to public scepticism with the psychiatrist's role threatened by social workers, psychologists and community nurses, one's immediate reaction is to adopt a historical perspective. The advances achieved during the last 50 years which I recall are so impressive that it seems reasonable to see current legal and bureaucratic problems as resembling a ditch rather than a precipice! These advances have occurred in spite of adverse administrative situations. It is important to remember that in spite of its merits the National Health Service was not conceived with Mental Health Services in mind—nor were Social Work Services.

In the 1930s psychiatry as a professional discipline, with College appraisal of clinical standards and teaching facilities, did not exist. Indeed there were very few centres with organised teaching for post-graduates or specifically psychiatric research units. This does not imply that good work and leadership was entirely lacking but it had to be sought out in an atmosphere which lacked confidence and knowledge and where safety and legal responsibilities demanded paternalism and rigid institutional regimes. Psychoanalytic and Meyerian theories offered overall approaches to understanding but little of practical application in wards in which the smell of paralydehyde was ubiquitous and ampoules of morphine and hyoscine were readily available of necessity, whether to cover lack of skill or lack of staff.

Joining the ranks of the psychiatrists in these days was like leaving the orthodox church—it may be so yet but at least the nonconformists are much more numerous and better organised. My own conversion came in 1936, no doubt assisted by a family background of alternative medicine. During the spring vacation I joined a party of students to Berlin and London organised by the Glasgow University Medico-Chirurgical Society. We were hospitably entertained by medical students in Berlin though sometimes hi-jacked by the Ministry of Propaganda. A dinner was interrupted so that we could join our hosts in the crowd watching Adolf Hitler driving down the Unter den Linden; we spent an evening at a rally with a speech by Hermann Goering and we attended a lecture in which racial-genetic policies were rationalised. However, our sceptism was maintained and expressed in parody verses of our student songs which we assumed that our hosts would not be able to translate. The medical educational benefits were derived from lectures and demonstrations in hospitals where senior physicians and surgeons gave their time and displayed impressive German technology especially in radiology and by their skill in post-traumatic surgery and its rehabilitation. A series of visits to London teaching hospitals followed in which we met various teachers—Sir Thomas Lewis, Kinnear Wilson, Sir Frederick Price and others who were known to us as textbook authors of the time. At Guy's we had a demonstration of childhood and adolescence psychiatry by R. D. Gillespie, co-author of the Henderson & Gillespie *Textbook of Psychiatry*, accompanied by a psychologist and social worker. The 'holistic' approach was new to me and made such an impression that I acquired Henry Yellowees book on *Psychological Medicine* in H. K. Lewis's and after reading it on the train going back to Glasgow I was ready for more.

Pre-war psychiatry

Psychiatry teaching in these days was usually limited to some case demonstrations with little academic background but Angus MacNiven with Ferguson Rodger to help him made a real effort to upgrade the image at Gartnavel. I was encouraged to attend the Western Infirmary Out-Patient Clinic where my education might have been further enhanced if I had been able to follow Dr MacNiven's conversations with some of his patients in the Gaelic tongue. Contemplation of a psychiatric career meant a choice between training in psycho-therapy in London followed by an option of child psychiatry or a series of mental hospital posts. Scotland was fortunate in having the eight prestigious independent Royal Hospitals among its 24 asylums. The Edinburgh-Glasgow senior staff relationships fostered training plans and some enterprising juniors found ways and means of following the trail established by D. K. Henderson of a period as resident with Adolf Meyer in Baltimore or in other teaching centres in the United States.

Overall, however, mental hospital work in the UK was largely confined to in-patients as there was no ready mechanism for out-patient service connections between the administration of the mental hospitals which were only emerging from poor law status and the private practice orientated infirmaries for medical and surgical cases. An orthodox approach was therefore to acquire some experience of medicine and general practice then to join the promotion ladder in the best hospital with a job available. For me the possibility of such a programme had to be deferred when at the end of my final exam a haemoptysis led to hospitalisation for tuberculosis treatment, a period of unemployment then engagements as a ship's surgeon. When I was able to take up medical, surgical and psychiatry posts at Glasgow Southern General Hospital, the war was about to begin.

Wartime psychiatry

War-time experience brought new dimensions of practice to British psychiatrists. The experience of a wide range of syndromes occurring in Armed Forces and civilian casualties was available to those who were recruited from the mental hospitals and became the basic knowledge of the new generation of recruits to psychiatry. The treatment of the so-called 'traumatic neuroses' which revealed the effect of fear and conflict of loyalties brought so many demonstrations of the practical applications of psychodynamics that the traditional Freudian interpretations lost their dominance. Reports on vocational rehabilitation methods, the possibility of interpreting behaviour in group settings and of group therapy for both army and civilian patients brought in a new range of concepts. The consideration of fitness for service brought in new types of assessment. People with such a wealth of experience, though acquired at great price in human suffering, could never be re-compressed into pre-war patterns.

When I worked in the mental observation wards in Glasgow in 1939–40 the unusual system of informal admission for patients whose 'need for compulsory detention was unconfirmed' was in operation. Patients were so admitted for six weeks observation but could remain longer if they wished. This unique arrangement which dated back to 1887 was not the product of legal enactment but an arrangement with the Scottish Board of Control. It was inaugurated by Dr John Carswell who from his writings in the *Journal of Mental Science* must have been the first 'Community Psychiatrist'. Supervision of these wards was by Dr Alexander Dick, Superintendent of the nearby Hawkhead (now Leverndale) Mental Hospital who visited thrice weekly and met out-patients. This service which offered continuity of care must have been much more unique than I realised at the time. It had to be dismantled to fit in with the National Health Service local administration. Frequent clinical patterns which are now rarely met were florid delirium tremens, GPI (for which we received malarial blood from Horton Hospital) and catatonic posturing, stupor and excitement. My first duty was to learn from Rankine Good, whom I was succeeding, the technique of administering and managing intravenous Cardiazol convulsion therapy. He showed me his ECG research on the cardiac effects of the drug which produced most of the abnormalities of rhythm.

As my medical record was unacceptable to HM Forces my subsequent experience was in the Emergency Medical Service. At Gartloch I worked in the Specialist Psychiatry Unit to which psychiatric casualties from Dunkirk and elsewhere were admitted. The majority were returned to civilian life after initial treatment by sedation and often intravenous barbituate abreaction. The latter treatment was frequently of great value but it had to be accompanied by an active and supportive psychotherapeutic relationship. I transferred to the Bellsdyke Base Hospital at Larbert to be Deputy to the Medical Superintendent. The mental hospital had been largely evacuated and a hutted annexe added to provide a large general hospital for medicine, surgery and orthopaedics. One large building housed an Army psychiatric unit. The mental hospital's 'working patients' remained and it was said that as they shared the 'rations' from the kitchen with the general hospital and Army patients they had never before fed so well. Their contribution in the laundry and sewing room, kitchens and stores, farm and gardens and as cleaners was recognised in this time of manpower shortage. Most were socially withdrawn and hospital-dependent people who were reasonably effective in their work with a little encouragement and a leisurely pace. They had intermittent symptoms for which sedatives were prescribed but generally their daily routine was maintained. They received no money for their work but their parole was fairly free. Were they effectively slaves? The suggestions of discharge could be a threat to the patient and to his family as there was no Welfare State and every medical attention and pill had to be paid for. The fear of poverty was not much less than that of mental illness. 'Asylum' is the word to cover the situation. Maintenance at the person's best level was probably attained though it was not called 'rehabilitation'. The Beveridge Report outlining the possible lines of development of health and welfare services was a great stimulus in 1942. It offered hope of better times to come. For better or for worse the Welfare State ended the public incentive to provide the option of the asylum.

Waiting for the NHS

The thinking in advance on possible patterns for the NHS did not automatically include psychiatric services. In fact, considerable effort was required to avoid a separate Mental Health Service. A persuasive and optimistic memorandum from the RMPA put great emphasis on the value of new services for neuroses, child psychiatry and for the mentally handicapped. By 1946 it was obvious that the extent and organisation of the new regime depended on negotiations on finance, chiefly in regard to consultants' conditions of service. It seems likely that the psychiatrists would have settled with less debate to achieve the promised integrated administration. They looked forward to the demise of the Mental Hospital Boards which in areas such as

London, Yorkshire and Lancashire controlled and isolated thousands of beds.

I spent three years working in the Local Authority Services in Leeds, first in the Municipal General Hospitals then as Assistant MOH for Mental Health Services. Serving the committees of aldermen and councillors provided a different picture of 'getting things done' and I was very impressed by the ways in which changes could be made if a good case was presented. At first I had responsibility for several 'chronic sick' hospitals. I surveyed the long-stay patients there and found that some 37% had a secondary if not a primary psychiatric diagnosis and I confirmed that by good ward classification and management by objectives one could improve patient care and staff morale. Similarly, in the St James's mental observation wards a conglomeration of ages, diagnoses and objectives of hospital residence had to be sorted out. Henry Dicks, during his tenure of the professorship, asked me to prepare the unit for teaching purposes. The 1890 Lunacy Act allowed three days initial detention with an extension of only (and strictly) 14 days before transfer to mental hospital. There were a number of poor-law detainees who had to be transferred or discharged before we could take voluntary patients. Failing to obtain one of the rare psychiatric social workers, an experienced nurse took the label of social worker and acted as a prototype community nurse. The City fathers provided a villa for an ex-patient day centre and evening club. Unfortunately my successor did not have a hospital appointment and the service linkage disintegrated.

The impressive Mental Deficiency Service run by Leeds City Council, which included Meanwood Park Colony (Hospital), had junior and senior Occupation Centres, an Industrial Centre with two commercial travellers to dispose of its products, a laundry serving the municipal services and a variety of patients under guardianship. This was similarly disintegrated with the NHS, separated out the hospital for the benefit of the wider geographical population of the under-supplied West Riding and impaired the continuity of care which had hitherto been provided.

The early NHS

The NHS broke the mould of the traditional British psychiatric services by allowing integration with the general hospitals and by creating conditions of service applicable to all medical services. I spent seven years as part-time Regional Psychiatrist while continuing clinical work and teaching at St James's with Douglas MacCalman and Ronald Hargreaves, stimulated intermittently to review my philosophic assumptions by Harry Guntrip. This administrative post was important as the Regional Boards were dominated by the physicians and surgeons and the local political representatives on them were only exceptionally sympathetic to psychiatric needs. Lack of staff and overcrowding in the mental hospitals were the outstanding problems. The overcrowding was caused by absence of effective therapies, out-dated laws which discouraged discharges, increasing geriatric admissions following removal of the poor-law stigma, poor staffing levels and failure to return hospital facilities which had been taken over for medical and surgical purposes during the war. Planning involved the rationalising of services with populations and with other hospital facilities and making them as comprehensive as possible over the whole field of psychiatry. I had the advantage of attending the Regional Psychiatrists' meetings at the Ministry of Health where the problems and solutions of other Regions were exposed with Walter Maclay and Isobel Wilson, and I had the chance of visiting outstanding facilities. Some relief occurred when the tuberculosis sanatoria became redundant and when the Government gave a special £1 million spread throughout the whole of England and Wales for small mental health building improvements. The real possibility of change did not occur until the pharmacological revolution in 1953 and the legal changes of 1959.

Edinburgh

I was glad to come to the Royal Edinburgh Hospital in 1957 and to experience an orthodox job at last! The Medical Staff Advisory Committee had its first meeting on the day of my arrival. It consisted of the five consultants—Tam Munro (Physician Superintendent), Elizabeth Robertson and myself as hospital staff and Alexander Kennedy and Frank Fish, the University Honoraries. The same week I began to attend the Committee which was planning the new buildings—the Andrew Duncan Clinic and the Clinical Professional Unit. There was no doubt about Alexander Kennedy's charisma. He was dominant and determined but he could also be kind. He was a TV personality on 'The Brains Trust' and a radio script-writer and playwright in his spare time. He had plans for the hospital, the region, the local authority, the mental handicap services, for neuropsychiatry and for children's services—as well as for teaching and research. Alistair Forrest and Ian Oswald were his first recruits. The Teaching and Research Building, which should be called the Kennedy Tower, was in planning at the hospital entrance. His vision was of a coordinated service organisation with a built-in teaching and research component. These concepts were developed in a coordinating committee representing all concerned which produced a report incorporating his idea of a mental health centre based on extensive community services to demonstrate the needs and co-operation involved. Following his untimely death, Morris Carstairs brought the MRC Unit for Epidemiological Studies in Psychiatry to the Tower. He also brought John Smythies for pharmacological studies and with Henry Walton emphasised the psychosocial profile in Edinburgh teaching. At the same time Elizabeth Robertson negotiated the establishment of a Clinical Section for the MRC Unit for the Study of Brain Metabolism.

Pursuing the theme of management by objectives, I saw my role as a clinical administrator or co-ordinator who persuaded people in all the layers of the NHS organisation and beyond it along the lines of the subspecialisations required to provide ideal services for our patients and for the experience of our post-graduate students. This involved

the re-organisation of buildings and staff to suit the interests of alcoholism, problems of adolescence, psychotherapy, forensic psychiatry, psychiatry of old-age and rehabilitation as well as space for clinical psychology, social work and occupational therapy. Alistair Forrest led the move whereby some of the general psychiatrists accepted responsibilities in the mental handicap services. My own special interest was rehabilitation and long-term care. I attended the local IRU (Employment Rehabilitation Centre) weekly for 10 years and established the habit of having our doubtful patients accepted on a trial basis. I was lucky to be able to arrange the conversion of former nursing homes into rehabilitation hostels to maintain continuity of support during crucial periods of change. I always regarded the staff dining-room and coffee rooms as a parliament or market place for ideas and our Medical Advisory Committee including representatives of other disciplines, as the senate. I felt that I could be most effective as its Secretary for most of my 23 years when it was convenient to explain why, over the years, services had developed in particular ways and to propagate any new ideas. Of course we were blessed with having a 'psychiatry only' Board of Management which was not too subservient to the Region and the advice and encouragement of our group Secretary Drummond Hunter whose concept of 'power with—not power over' is an enlightening guideline for health service executives.

There is no doubt that the period 1960–1974 was one of advancement in psychiatry unlikely to be matched for some time. The outstanding advances in medications had been achieved. It followed the 1959/60 Mental Health Acts and we had some share in the expansion of resources. The efflux of patients from hospitals was within reasonable bounds and a specialised psychiatric social work service was in operation. Employment could be found. The slippage into more rigid bureaucracy had yet to come and the civil liberations were only on the horizon.

Community psychiatry

First we had catchment areas, then subspecialisation, then districts and now sectors. It is of historical interest that a community psychiatrist was appointed to the Burgh of Leith in 1913—a post which unfortunately had to be abandoned after the 1914 war commenced. From 1970 under Jock Sutherland's guidance a senior registrarship (now a consultant post) was established. The role envisaged was akin to liaison psychiatry in general hospital work with emphasis on conciliation and coordination of the work of all those who have responsibilities towards psychiatric sufferers in the community—advice to GPs, interpretation (if accepted) to social workers, encouragement to voluntary groups and day services and feedback to staff who were largely hospital bound. Community service personnel were known personally to the same extent as hospital colleagues. No holder of the post felt that there was too little work or that it was not appreciated. But a community base for the whole sector team seems essential. With Tom Walmsley I felt that I understood the situation better after an experiment which involved a base at an out-patient department on the other side of the town from our beds. There we met social workers and general practitioners from the more deprived areas of our sector and had alternate meetings in the offices of two social work teams. The hospital staff involved were medical staff, social workers on hospital attachment, a community psychiatric nurse and a ward nurse. In consequence there appeared to be a demand for joint psychiatric-social work team group work and patients/clients were invited to attend various groups with widely differing degrees of success. These covered some areas of special concern to social workers e.g. loss (reactive depression), mothers in distress (in which a health visitor was involved), alcohol problems and parasuicide aftercare. From this perspective the hospital was an obviously specialised service and we came to appreciate how remote it was from the daily life of the community and how 'foreign' were our more seriously ill patients to the generic social workers. The experiment was not passed on to our successors as our community social worker colleagues left to advance their careers and were not replaced by like-minded enthusiasts.

The new generation of general practitioners, many of whom have had pychiatric experience in their training, can guide psychiatrists, clinical psychologists and community psychiatric nurses to the appropriate patients. As we know, there is a wide range of psychiatric problems beyond the traditional out-patient attender but which we have not seriously explored. The epidemiologists are currently struggling to define this group by 'what is a case' studies. Such individuals may be brought to the psychiatrist's attention when he attends the Health Centre or Social Work offices. When he has little to offer the book is closed. Experiment and experience could increase our usefulness. The existence of this work should come into the reckoning of estimates of staff needed as general psychiatry moves into the community.

Rehabilitation

Patients in restorative programmes have specialist services which could be extended if there was more money for staff. There is more controversy regarding the patients who function at a noticeably impaired level and are recognised as within the orthodox area of specialists' concern (whether currently in-patients or not) but for whom the specialist has to admit that his contribution is restricted to maintenance of the patient at his/her best possible level. So who has the main responsibility to help—health services or social work?—and responsibility for what? Professional opinion is vague and politicians and administrators have been allowed to seek the cheapest option. Both health boards and local authorities see 'hotel costs' as their most unwanted burden and will adopt almost any scheme which avoids them. The scene is currently set for pragmatic local solutions which are liable to prove unstable over time. At a meeting with an itinerant Cabinet Minister I learned that in Whitehall it was regarded as essential that local politicians should have their interest maintained by involvement in personal services in addition to roads, sewers, etc.—what chance therefore for a clinically engendered solution!

The 19th century mental hospitals present the wrong image to patients, relatives and staff. Location and design may make them unacceptable as 'homes' and size brings the likelihood of institutionalism by management of people en masse and failure to attract enough staff to maintain rehabilitation practices. Scotland is relatively fortunate in having a wider range of accommodation styles some inherited from the days when the Royal Asylums offered patients 'circumstances to which they were accustomed'. The Scottish Home and Health Department have a Planning Note for a building for patients requiring the rehabilitation approach prepared with the help of College representatives with a special interest in rehabilitation.

In the community the current confusion regarding responsibility for services gives in some places duplication and elsewhere absence of hostel and day-care facilities. This stems from the planning concepts of medicine and surgery of the 1940s. The pattern assumed was hospital in-patient then continued out-patient treatment to be followed by 'after-care'. After-care meant industrial rehabilitation via the Disablement Resettlement Officer Service and the use of any statutory or voluntary services which may be or should be available. The psychiatric services have tried to fit into this pattern which is suitable only for the small group of recovering patients who are helped by half-way house accommodation required only for a limited period. People whose life-style is dominated by symptoms need continuing treatment—not 'after-care'.

As the price of our inclusion in the National Health Service and our equally valued partnership with social workers is, unfortunately, a clinical-administrative mismatch, we can only try to ensure that the management boundaries are defined as appropriately as possible. A psychiatric consultant requires on behalf of his patients to have facilities suitable for all levels of dysfunction. (Consultants rarely accept posts without at least the promise of proper facilities). When the patients' condition demands residential change there must be a minimum of administrative protocol. Thus, whereas the social worker is an important contributor to the rehabilitation team-work, social work administration in this area is an intrusion which can only split 'continuity of care'—which has a different meaning for administrators and clinicians. Unfortunately the geographical divide used to describe hospital and community services has been emphasised by high-level non-psychiatric administrators who see the community as local authority and voluntary agency territory and therefore at best only grudgingly allow money to be spent on any residential services outside the hospital grounds. The current Joint Planning and Support Financing scheme continues this pattern. It abrogates overall responsibility for the long-term patient. It demands financial rather than clinical decision-making and incorporates a concept of premature 'normalisation'.

I see the National Health Service responsibilities as supplying residential facilities appropriate to the needs of rehabilitation and long-term patients. This obviously requires hospital-staffed hostels—mostly extramural with the objective of providing treatment and training and supporting patients across the bridge to community life without traumatic changes in staff-patient relations and innumerable 'drop-out' episodes. Time-limits cannot be enforced and return to the starting tape must be allowed. The facilities should be available to all who have any chance of success and this can often be found out only by a trial. Such arrangements are not new but have been brushed aside by corporate rationalisers under financial pressure. I would accept the provision of transitional hostels by social work departments and special purpose hostels by voluntary agencies provided that at night they employ only hotel portering staff for safety arrangements—'monitoring staff' would indicate 'patient' status. There is plenty of scope in support and prevention services for local authorities and voluntary agencies to supply time-structuring and socialising activities for those who have already obtained community tenure and are functioning at a moderate to good level. These should include week-end and evening clubs and facilities to encourage previous absconders who wish to 'drop-in'.

Where is general psychiatry?

The College published its multi-professional Working Party Report in 1980 outlining the basic needs in rehabilitation services for a District. This was at the request of the DHSS. It ended by emphasising the special responsibilities of the Health Service and the need for more input by it. This includes the assessment of alternative approaches and the research effort which that implies—my post-retiral academic exercise on the measurement of rehabilitation outcome has made me much more aware of this. The Report was followed by a detailed *Handbook of Psychiatric Rehabilitation Practice* edited by John Wing and Brenda Morris which might be considered as the modern equivalent of the handbooks published for the RMPA when 'mental nursing' covered the field. The next important step will occur when the College re-defines the content of general psychiatry. Presumably this will cover both hospital and community practice. The general psychiatrist is already peripatetic but numbers will have to increase when patients have to be met at less convenient distances than in wards off the long corridor. Long-term case work has never been the popular end of the cure-care spectrum but responsibility for hostel patients classified according to level of functioning and association with the work of community psychiatric nurses and a wide range of others, introduces the more interesting dimensions recognised by those with a special interest in rehabilitation. Street contact and the media will bring to the average citizen the realisation of patient neglect but it will be some years before appropriate funds are provided to deal with it. This time should be used in getting a College-led agreement between professional organisations on patient/client needs. These should be considered in terms of functioning levels and the boundaries of clinical responsibilities, rather than territorially, in our so far ill-defined community psychiatric services. Blurring of roles which is acceptable at team level leads only to confusion in administrative and financial circles.