WANTED: A JOB DEFINITION

Anthony Clare

It is arguable whether now is the best time to pose certain questions about the status and prestige of psychiatry in Britain. On the one hand, the Department of Health and Social Security’s policy of moving the centre of psychiatric treatment away from the large mental hospitals and into smaller units attached to district general hospitals, the recent formation of the Royal College of Psychiatrists and an increasingly lively public interest in the plight of the mentally ill, all point to a vitality and vigour in contemporary psychiatry which bodes well for its future. On the other hand, there are the depressingly familiar accounts of low standards of patient care within the service, scandals on a Whittingham scale and a tendency to portray psychiatrists as insensitive, authoritarian, Establishment figures who have little time nor inclination to listen to their patients and have a predilection for treating them with drugs and ECT.

Yet, even in the face of such contrasts, the demand for psychiatric treatment appears insatiable. Of every 60,000 people living in this country, some 9,000 or 15% will this year seek the help of their general practitioner for problems that are in the main psychiatric. It is fortunate for the psychiatric services that only about 450 of these are referred onwards to a psychiatrist – fortunate in that if this referral figure was even slightly increased the services might well come to a standstill.

As it is, people attending as psychiatric outpatients for the first time have been steadily increasing – from 172,000 in 1961 to 227,000 in 1970 – and total out-patient attendances have also increased during the same period from 1,272,000 to 1,588,000. Day hospital attendances have shown the most dramatic increase of all with 1,062,556 patients in 1970 compared with 370,675 in 1964. It is also worth noting that the steady decline in the number of psychiatric patients in long-stay mental hospitals over the past decade has shown some signs of levelling off recently.

Number in need

These figures only refer to people already receiving assessment or treatment but it is known from recent studies that the actual number in need of some form of psychiatric assistance is very much larger. Psychiatrists working in general hospitals – and in future it appears likely that most psychiatrists working within the National Health Service will be doing so – are finding that their colleagues in surgery, medicine, obstetrics, etc., are referring more and more patients to them for help; these are patients who first come to the attention of the health services because of physical complaints but, in fact, are later judged to be suffering from psychiatric illnesses. In much the same way it can be anticipated that referrals for psychiatric assessment from social workers will increase as the local authority social services departments expand and develop their joint case conferences.

The prison population includes large numbers of people believed to be suffering from mental ill-health. West’s study of habitual offenders showed that nearly one-third were suffering from severe psychiatric disorders while over 80% had severely deviant personalities. Studies of people sent to prison for the first time have revealed equally high figures for psychiatric illnesses, personality disorder, alcoholism and drug dependence.

When one adds the number of alcoholics estimated to be living in Britain (somewhere between 300,000 and 500,000), the mentally ill among the growing number of destitute vagrants wandering the towns and cities and the people who consult their general
practitioners with psychiatric symptoms but for whom the correct diagnosis is missed, one can see that the needs and the expectations of the community for the provision of an adequate psychiatric service are nowhere near being met.

It must be said at once that there has been a steady increase in the number of psychiatrists and social workers employed in the NHS over the past two decades. Yet the service only keeps going because of an increasing reliance on doctors trained overseas plugging the gaps, staffing the less desirable posts and carrying the major burden of working in the large, out-of-the-way mental hospitals. Over 60% of the junior psychiatric staff in this country are from abroad and the past five years have seen a catastrophic decline in the numbers of home-trained medical graduates coming into psychiatry. The country remains desperately short of child psychiatrists, of psychiatrists specialising in mental handicap, of forensic psychiatrists, psychotherapists and specialists in adolescent psychiatry.

Harsh realities

These are the realities which shape the daily experiences of those who work within, and receive treatment from, the psychiatric services. The intellectually fashionable discussions about the existence or otherwise of mental illness pales into insignificance in the face of such harsh realities. The criticism that British psychiatry is excessively organic in its orientation and relies too much on treatments such as electro-shock therapy is placed in its context when one realises that, for example, a region such as Manchester, with almost 9 million people living within its own and neighbouring areas, does not have a single full-time psychotherapist employed within its regional psychiatric service.

It is often said that when a patient does eventually get to see a psychiatrist there is rarely time for more than a cursory discussion of his problem followed by the mandatory prescription for pills; this state of affairs can be better understood (though not accepted) when it is realised that a tripartite committee composed of representatives from the British Medical Association, the College of Psychiatrists and the Society of Medical Officers of Health, declared in the summer of last year that for minimum standards of psychiatric care and treatment to be achieved it would be necessary to double the number of psychiatrists working in the NHS and double them now. There is not the slightest chance of such a target being reached. At a recent conference organised by the

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Association of Psychiatrists in Training, Sir George Godber, the Chief Medical Officer at the DHSS, announced that the number of psychiatric consultants would be increased by 50% but he gave no time limit, and most informed observers thought that such an increase would only take place over a decade at the earliest.

Layman’s expectations

So who is going to cope with this veritable tide of human distress? And what are the skills and abilities particular to a psychiatrist? Laing’s view of a psychiatrist as ‘a specialist ... in events in inner space and time, in experiences called thoughts, images, reveries, memories, dreams, visions, hallucinations’ probably reflects the contemporary layman’s view of a psychiatrist as that specialist, in an age of specialisation, who comes closest to understanding madness, to making sense of insanity and reason of irrationality. It is the vision of a psychiatrist as a skilled expert whose knowledge and experience (including a knowledge and experience of himself) enable him, in the course of a therapeutic relationship between himself and his patient, to bring about a mutual understanding of the patient’s disturbance and its relief. Many psychiatrists would significantly qualify such a view and would lay emphasis on the importance of a psychiatrist having an expert knowledge of the biological and physical processes which both aggravate and alleviate mental disturbance. But I believe that the majority would overtly or implicitly agree with the layman’s expectations about the importance of some form of therapeutic relationship involving psychiatrist and patient.

It is the psychiatrist whom patients and relatives struggle so hard to see. Yet despite (or even as a result of) the current revolution in contemporary psychiatry, they will struggle even harder in the future. For the psychiatrist envisaged by the DHSS is less a therapist than a supervisor, less an interpreter than an administrator. His role will be as a leader of a small army of psychologists, social workers, occupational therapists, nurses, general practitioners – a therapeutic team which will be responsible collectively for the care and treatment of patients. For the planners believe and many community psychiatrists would agree that, to quote the words of the present Dean at the Institute of Psychiatry, ‘direct care by a doctor is unnecessary as well as impossible’.

It is judged to be impossible because of the demand for and the shortage of psychiatrists; unnecessary because some psychiatrists argue that much of what a psychiatrist does can be done just as well by other staff under psychiatric supervision. I believe this to be the real revolution taking place within psychiatry at the present time – a revolution not so much affecting where the patient is to be treated (though this is the aspect that has received most of the attention to date) but by whom he is to be treated.

The significance of this revolution is scarcely noted, let alone understood, by the layman or indeed by many professionals working in the field of mental health. Social workers labouring within the new Seeböhler creations, probation officers struggling with steadily expanding responsibilities, hostel workers grappling with problems for which they have received little preparation and less actual training, still look with anticipation and hope (except for those who have become thoroughly disillusioned) to psychiatrists not merely for assistance in the management of some of their clients but often for a therapist-client relationship which they believe some clients still require and which they also believe can often be best given by a specialist whom they have always regarded as specially trained to do just that. Yet the average psychiatrist, who was too busy in the old system with the burdens of his large number of mental hospital in-patients, is going to be too busy in the new system with the burdens of team administration and supervision.

Open to dispute

It would seem indisputable that, at the present time, a therapeutic relationship between a psychiatrist and a patient is only possible for a minority of patients suffering from psychiatric disorders. But the claim that such a relationship is unnecessary anyway is certainly open to dispute. It is not surprising that many psychiatrists, particularly those who are psychotherapeutically inclined and who regard the doctor-patient relationship as the corner-stone of psychiatric treatment, look at current plans with some suspicion and scepticism.

How attractive such a view of psychiatric practice (as is afforded by the community psychiatrists) will prove to medical graduates is difficult to assess. Their reluctance to enter psychiatry has already been noted and whether the shift in the psychiatrist’s role from therapist to supervisor will prove more attractive is difficult to say. Psychiatrists are still being trained as if they will function in a one-to-one relationship with their patients, patients still expect to be so treated and other professionals in the field still seek it and, in my experience, bemoan the difficulty in obtaining it –
yet such a style of treatment is now deemed not merely impossible but also unnecessary!

It seems to me that certain current dissatisfactions will persist. I do not mean either the ideological arguments of Szasz about the allegedly mythical quality of mental illness or the assertions of Laing and Cooper that schizophrenia is normal response to an abnormal society (though these are bound to be with us for many a day yet to thrill and stimulate innumerable television audiences throughout the land) but the somewhat more mundane, if equally relevant, dissatisfactions with the service itself.

Time and opportunity

At the present time, the main difficulty is finding a psychiatrist who does not come from overseas or, if he does, is not actually interested in psychiatry and is not marking time waiting for a medical post, doing his medical membership or learning English; a psychiatrist who can be seen regularly and who is not replaced every second visit by a colleague who readily admits to knowing next to nothing about the patient; a psychiatrist who has the time and the opportunity to actually employ his knowledge and skill – that has taken nearly fifteen years of training to acquire – in the service of his patient.

Few contest that patients are better treated in their homes or in small units attached to district general hospitals rather than miles from anywhere in large, overcrowded, poorly-staffed mental hospitals. Few argue against increasing the availability and the participation of other professional personnel – social workers, occupational therapists, psychiatric nurses, general practitioners – in the treatment of the vast majority of psychiatric patients. But there does appear to be a pressing and persistent demand for psychiatrists who do have time, who do take personal responsibility for their patients and who do possess special as well as general skills of understanding, care and management.

I do not believe that the public, the consumer, has accepted that the doctor-patient relationship in psychiatry is unnecessary. Many a professional within the psychiatric service also remains to be convinced. Perhaps now the discussion may centre not so much on how many psychiatrists are needed and where but on what it is that a psychiatrist should actually be doing, what special expertise he actually possesses and how he sees his job. The signs are – thankfully – that such a discussion is beginning at last.

SCAN

by Dymphna

A personal view of the social work scene

By the time these words appear in print, I understand that we shall have taken one more step, whatever that is, towards joining the European Community – whatever that is. (We have trouble enough defining what we mean by a community even within Britain; I can’t imagine it’s going to be any easier, in European terms, even to perceive the community, let alone define it.)

Anyway, before very long, people are going to start drifting about Western Europe in the quest of their own particular rainbows; and some of them are going to take their social problems with them. I don’t think social workers have begun to consider the situation yet. One of the problems that will immediately arise is that of transmitting, across national boundaries, the basic facts of casework material. I can’t see, for example, how a social worker in, say, Slough is going to make a meaningful referral to her opposite number in Minervino Murge whither one of her problem families has fled to escape the bailiffs.

And, of course, with the current shortage of secure accommodation for difficult adolescent girls, a social worker in Charleston-cum-Hardy may have to go as far as Bad Mergentheim to obtain a placement.

So it seems to me clear that a new International Casework Language will have to be developed pretty quickly. Fortunately the basic materials are already to hand.

The first thing we shall have to establish is the sex of the client: after all, the Walloons and the Lombards are going to have trouble enough with our Evelyn’s and Jocelyn’s and Obomole’s, and we shall have Clair’s and Henne’s coming the other way. So male and female symbols have to be developed, like this:–

Male –

Female –