THE CARE AND TREATMENT OF THE PSYCHIATRIC PATIENT IN THE HOME*

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With the implementation of the somewhat euphemistically entitled Mental Health Act, and its implications for more intensive community care of the mentally sick, it is opportune that meetings should be held at this time between those working in the specialist psychiatric field and general practitioners. One can go further than to remark that the latter are destined to play an increasing part in handling psychologically disturbed persons, for it is realistic to state that the fresh approach to these problems which has been evolving over the last decade, and of which the Act is merely one aspect, will surely fail without the active concern and intelligent co-operation of the family practitioner.

The subject matter of this paper, though new, is not original. In it an attempt is made to crystallize the major themes in contemporary psychiatric thought on the future development of the psychiatric services of this country, with particular reference to care outside hospital. No review of this subject can do other than make early reference to the experiments in community care of the mentally sick carried out in recent years at Worthing (Carse 1958). In a nutshell, it was there demonstrated that by providing adequate alternative care through intensive home visiting, outpatient services and day-hospital facilities it was possible to reduce the annual admissions to mental hospital from a large geographical area to 40 per cent of what it was previously, and further, that this approach was preferred by patients and relatives alike. It is important to stress that it is not enough simply to reduce admissions; this can only be beneficial if adequate alternatives are provided. From the

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Worthing area the previous admission level was high by national standards, but in many areas of the country a large pool of sick persons get neither the inpatient care which the Graylingwell Hospital at Worthing previously provided, nor the extra-mural community care they now receive. Variations on this important experiment have been successfully operated in other centres, notably Nottingham, Oldham, York, and Portsmouth. All these experiments have depended fundamentally on the closest possible co-operation between the hospital, local authority, and general practitioner, thus being the first true working examples of that much-desired but rarely achieved co-ordination of the three branches of the National Health Service.

In order to play his vital part in this service, the general practitioner must co-ordinate his work in this sphere with psychiatrists, psychiatric social workers, mental health workers, health visitors and voluntary agencies. The health visitor, having to some extent mastered her task of advising on physical problems, and with ready access to young mothers, children and the aged, is increasingly turning her professional curiosity towards this new field. In various centres she is already receiving training in psychiatric matters (Affleck 1960).

Limiting Factors in General Practice

For a variety of reasons the general practitioner, working in the National Health Service today, is not in a position to do all one might hope in this field. Firstly there is the question of time, and having said that one is immediately ensnared in the rigid network of contemporary national medical politics. On the Appointed Day, 12 years ago, the Government was committed to providing a comprehensive medical service for the entire community and had to spread out the general practitioner facilities to meet these commitments. In spite of subsequent adjustments the practitioner still has strong financial incentives for taking on a large list of patients; this has not made for a universally high standard of practice, though many patients have benefited who previously received little or no medical care. Under such circumstances it is hardly possible for the harassed practitioner to do more than provide basic physical medicine, and until this situation is rectified one feels that, in industrial areas if no other, hard facts of this nature will smother any attempts to interest practitioners in the psychological aspects of their work. The Willink Committee (1957) decided to reduce the intake of students to medical schools. The over-riding pressure behind this decision was probably purely financial—it was not that the country did not need more doctors, but that it could not then afford them. As the country progresses towards increasing affluence

and the prospect of a Health Service that is truly comprehensive becomes an economic possibility, this decision of the Willink Committee will increasingly call for revision. In short, a wealthier society must put more in the kitty for medical remuneration. When that is done, and allowing for the time lag for undergraduate training, then the financially optimum size of practices might drop to a level where the time-consuming techniques of psychological treatment will become a practical approach for the general practitioner. That authoritative opinion is now disturbed by the 1957 policy is evidenced by a recent adversely critical analysis by Lafitte and Squire (1960). It is of interest that the report not only recommended a ten per cent reduction in student intake but also suggested paradoxically that the maximum list should be reduced without undue delay to 2,500 in non-rural areas and to 2,000 in rural areas; in fact there has since been an increase in the average number of patients on general practitioners' lists.

The second limiting factor is the attitude of the doctor towards the mentally sick. The doctor has been subject to the same mental mechanisms as the population as a whole, when brought into contact with a fear-provoking situation which he does not understand; there are two classic ways of avoiding this stress—either by ridicule and contempt or by ignoring the problem and pretending it does not exist. For the doctor the pressures have been greater than average, for he has always had the feeling that as a doctor he should be doing something about it. Inadequately trained, lacking in time and feeling that the therapeutic problem is hopeless, he has turned his back so often on what constitutes one-third of his work, and because of the one-sided influence of his medical training has come to believe that what cannot be perceived by the crude senses does not exist. Was there ever a more illogical remark than " I have examined you and there is nothing the matter "?

This leads to consideration of the third limiting factor: undergraduate training. For most of the doctors now in practice the time spent in training in psychiatry has been ludicrously inadequate; he has often spent as little as two per cent of his undergraduate time in learning how to manage these important disorders which clamour for so much of his time as a qualified doctor. Many feel that psychiatry as a subject in its own right, as a body of knowledge, is an unreal abstraction. There is a widespread feeling that experience, a kind heart and a home-spun philosophy are adequate substitutes. Certainly they are very necessary ingredients in any doctor's psychological armamentarium, but if a doctor is not to be as bewildered as his patient he must have a firm appreciation of the kind of disorder with which he is dealing, and of what he is doing. Otherwise, if he is a self-critical person he will lose his nerve and

transmit his anxiety and uncertainty to the patient, or if he is less reflective he may press on in the darkness of his ignorance doing a great deal of harm with the very best of intentions.

Happily medical schools are becoming aware of their responsibilities and many centres are increasing their psychiatric tuition to undergraduates. Not only is it necessary to increase the student's technical knowledge and instil attitudes of objective curiosity, but it is also essential to sharpen a potential dimension of perception hitherto neglected in medical training. This is the factor of emotional perceptivity on which the trained psychiatrist relies so heavily in making a diagnosis. If doctors and specialists generally were better able to assess the emotional states of their patients much expensive investigation would be saved before referral to a psychiatrist reveals quickly the *belle indifférence* of the hysteric, the emtional incongruity of the schizophrenic, the sustained mood disorder of the depressive or the fatuity of the early dement.

Even if all students now commence a training in psychological medicine equal to their training in medicine, surgery and midwifery, it will be 25 years before even half the doctors in practice are adequately equipped.

Diagnosis

The practical approach to the psychiatric patient is essentially the same as the approach to any other sick person. As has been hammered home to students in other medical specialities for a hundred years, the first essential is to make a diagnosis. What broad group of disorders are we dealing with? As we become more skilful we may move on to consider the particular sub-group of the major category. The diagnostic formulation is not just an intellectual exercise: it gives the key to aetiological factors, the likely course without treatment, and the likely treatment responses. About all these factors there is a growing body of knowledge. It is perhaps through training courses organized in co-operation with the College of General Practitioners that this knowledge can best be disseminated. The principles are the same as in any other medical discipline, only in this case the symptoms and signs are in the spheres of perception, thinking, emotion, and behaviour. It must also be appreciated that in psychiatric disorders and many complex medical disorders such as arterial disease, peptic ulcer, and bronchitis which are now the subject of much investigation there is probably no one causal agent, but a number, which together insidiously or suddenly overwhelm the constitutional adaptive mechanisms.

Neurosis

The handling of the less complicated neurotic disturbances is

perhaps the greatest single challenge. The practitioner must try to appreciate that these are merely further naturally caused disturbances of the adjustment of the organism to the environment. These states are important, distressing, and worthy of any medical person's serious objective study. It is only in this way that their causes will be determined and that progress will be made towards their alleviation. Were the specialist psychiatric services increased tenfold they could not cope with this problem of neurosis, so high is the incidence. Of necessity it rests with the individual family doctor as to whether neurotically sick patients who come to him for help are treated or rejected.

Several practitioners have published figures of the estimated incidence of these disorders. There is fairly general agreement that psychological illnesses, including psycho-somatic disorders, psychopathy, sub-normality and also including primary physical illnesses with an important psychological component constitute about 30 per cent of all patients seen by the family doctor. Ryle (1960) found in his practice that anxiety states (under which heading he includes anxiety states proper, reactive depression and the controversial category of " anxiety hysteria ") are prevalent in 24 men and 70 women per 1,000 persons on his list per annum. New cases amount to 3 men and 10 women per 1,000 at risk; thus in a practice of 3,000 persons one could expect one such new case every 9 days, a figure which almost exactly accords with the Watts' previous estimation (Watts 1952). The initial interview with the patient is of supreme importance. It greatly helps the patient's morale if he can be given time to unburden all his major anxieties at one sitting and to feel that the doctor is in possession of all the relevant facts. It is at this interview that the doctor sifts all these facts and makes his diagnostic formulation and it is probably more often that shortage of information rather than lack of skill leads to serious errors. It has been claimed (Watts 1952) that to set aside an hour for such patients yields superior therapeutic results and saves time in the long run, for such an interview builds confidence to a point where the repeated, fruitless, mutually frustrating, importunate demands for help are diminished. In this context one must be careful to distinguish the chronic constitutional neurotics with gross personality defect whose distress no one can relieve for long and who create such a strain on their medical advisers and others. In most instances the " neurotic " is a person who, though vulnerable, normally adjusts and copes reasonably well until some personal stress (either obvious or so idiosyncratic that it can only be understood against the personal life experience of the patient) or some physical illness temporarily disturbs his unstable adjustment. In such persons the prognosis is

usually good, and if the practitioner feels that there is little scientific evidence that his endeavours materially affect the outcome, there are few who would dispute the comforting effects of his sympathetic attentions. In the pre-antibiotic days, doctors did not fail to attend febrile patients. The old adage is as true as ever, that our professional duty is to cure sometimes, relieve often, and comfort always.

The term " neurotic " thus not only covers chronic and acute neurosis but is a blanket term including such diverse disorders as the anxiety states, reactive depression, hysteria, obsessional states, hypochondriasis, neurasthenia, and depersonalization. These are discreet conditions occurring in different types of personality under different and often quite specific circumstances and each having different clinical features, prognosis, and treatment indications. Wallace and Whyte (1959) demonstrated in a three to seven year follow up of neurotic patients who had not received specialist treatment that 65 per cent were free or virtually free of symptoms by the third year, after which the prospect of spontaneous recovery became more remote. These figures accord closely with others reported from a wide variety of sources. The approach required of the family doctor is a judicious balance of talking out, explanation, reassurance, use of appropriate drugs, treatment of any provocative physical disorder, and manipulation of the environment to avoid temporary or permanent malign elements and potentiate benign ones. With this there must be a realistic appraisal of limitations set by genetic influences, constitution, and the immutable elements in the environment.

Marital and sexual problems are particularly time consuming and in the former, however one starts out, one must almost of necessity involve both partners in the treatment situation if any progress is to be achieved. A similar approach is necessary in dealing with psychological problems in children—the mother at least must almost invariably be involved in the treatment situation.

Depression

Depression is the second most common psychological disorder which the practitioner will encounter. On the basis of the Watts' (1952) figures the expected incidence in a general practice with 3,000 persons at risk would be one new case every three weeks approximately. Care is required here over definition. One school of psychiatric thought groups all depressions together with anxiety states. If this view is taken depression is the most common disorder. In my view, though there are many difficult border-line cases, there is a real distinction to be made between the ineptly named endogenous depression (psychotic depression, affective psychosis) and other depressions such as reactive depression and depression associated

with other primary psychiatric syndromes such as anxiety states, obsessional states, depersonalization, neurasthenia, schizophrenia, organic states, and epilepsy. The term " endogenous depression " is misleading for although this condition can arise " out of the blue " for no obvious reason, Garmany (1958) has shown that this only occurs in some 20 per cent of cases. In the remaining 80 per cent there has been a precipitating event. I maintain, however, that the condition has certain distinguishing characteristics of which a sustained mood disorder unreactive to environmental influences is the most important. Many present with physical symptoms and are investigated and treated unsuccessfully in this light.

From 1935 on the specific treatment was electroconvulsive therapy but in the last few years various anti-depressive drugs have proved effective in a proportion of cases. Where the depression is not severe there is a good case for trying these drugs first. Imipramine (tofranil) has been shown (Ball and Kiloh, 1959) to effect a favourable outcome in 74 per cent of such cases as against an 89 per cent favourable response to E.C.T. Twenty-two per cent responded to a placebo. The question as to whether imipramine is associated with a lower relapse rate is still to be answered, for unfortunately E.C.T. is followed by a relapse in approximately 1 in 3 cases (White 1959).* A controlled comparison of imipramine, phenelzine (nardil) and E.C.T. is shortly to be carried out on a very large scale by the Medical Research Council. A point which bears stressing because of its great practical importance when giving imipramine is to explain and reassure the patient about the side effects during the latency period while awaiting the desired anti-depressive effect which may take up to three or four weeks to develop. Since the introduction into general practice of imipramine and other drugs of the mono amine oxidase series: iproniazid (marsilid), phenelzine (nardil) nialamid (niamid) and cavodil, the number of depressives being referred to St James's Hospital Psychiatric Unit has fallen remarkably, and whereas E.C.T. was applied 2,650 times in 1958 this figure fell to 1,100 in 1959. In spite of this success, however, caution is necessary. If the drugs fail or the patient is severely distressed, skilled psychiatric help should be sought for there is always a continuing and very real suicidal risk. I hope that the medical ethic will alter whereby a doctor may feel perturbed after missing a diagnosis of cerebral tumour, mostly hopeless when

*Since this lecture was delivered further findings have been published (Kiloh L. G., and Ball J. R. B. 1961. *Brit. med. J.* **1.** 168). In endozenons depression the relapse rate among cases showing a good response to E.C.T. is so high that after six months the effects of E.C.T. and of imipramine (tofranil) are of a similar order.

diagnosed, yet will receive with equanimity the news that one of his patients has hanged himself in the kitchen.

Schizophrenia

Statistics from the London area (Norris, 1959) suggest that this condition will affect one in every 50 persons growing up through late adolescence and early adult life. Hollingshead and Redlich (1958) in the U.S.A. and our own Registrar General's statistics show that the brunt of this incidence falls in the lower social groups, being commonest in social group 5 (unskilled workers). It is the most devastating of all the forms of mental illness and Norris concludes that the prognosis is still gloomy, about one-third of patients admitted being unlikely to recover sufficiently ever to leave hospital, and of those who do leave one-third are in hospital again at least once in the next four years; this in spite of the intensive use of phsyical treatment over the last 25 years.

Patients are now being referred at a very early stage to our psychiatric unit in the general hospital, and with the newer drugs and good follow-up and after-care services, there is an impression, or maybe it is a hope, that this drastic figure may be improved upon. This impression is one which will require intensive and careful investigation. There are indications, however, that with the possible exception of manic-depressive depression which frequently fails to respond in the early stages, many conditions with intensive therapy can be halted in their tracks and turned back if the treatment starts early enough before the unhealthy mental patterns have become habitual.

Russell Barton (1959) has described the potentiating effects of the old time mental hospital routine on these and other grave disorders. Great efforts are now being made to bolster the precarious adjustment of schizophrenics in the community, for it is believed that this lessens the prospect of deterioration. Happily, however, where prolonged hospitalization is needed the therapeutic atmosphere in many mental hospitals has changed greatly for the better. Much effort is being made to discharge home or to hostels more chronic schizophrenics. This approach sets a challenge to the toleration of the general public and the family doctor. The latter should be able to share his burden with the hospital psychiatrist and the local authority psychiatric personnel. It is not only more humane to try and establish such people in homes or lodgings or hostels and encourage employment, but the stimulus of this more normal way of life does seem to improve the patient's mental state. The doctor who is supervising these patients at home, should realize that the tranquillizing and other drugs advised may be vital to success and should keep a specially watchful eye lest the supply of tablets

runs out, for such patients then may well fail to approach their doctor for more. Under these circumstances there is an increased danger of relapse.

It has been clearly demonstrated that social isolation is associated with schizophrenia (Faris and Dunham, 1939; Hare, 1956). Though there may well be an element of self selection in this there seems to be enough evidence for efforts to be made to prevent known schizophrenics in the community from withdrawing from human contacts and living entirely alone. The highest incidence can be expected in persons of low socio-economic status living alone and often in the poorer parts of city centres.

Caution must be exercised in assessing the degree of disturbed behaviour which the public will tolerate; a hostile patient may well generate such counter-hostility towards himself that it would be kinder for all concerned to arrange hospital admission. A number of ugly incidents could well bring the community approach into disrepute.

Paranoid psychoses

These often respond very well to the newer drugs if treatment is started really early. Paradoxically, these patients, though quite deluded, often co-operate well with the doctor in spite of apparent lack of insight. A little deception may be required as to the reason for prescribing the tablets and once these preparations are started they may have to be taken continually over a very long period, any relapse leading to deterioration. The best that can be expected with the newer drugs is that the delusions, though remaining, lose a great deal of their importance for the patient who is thus enabled to mobilize more positive personality assets to enable him to lead a relatively normal life.

Mental illness in old age

This previously rather obscure field has been much clarified in recent years by the work of Roth and his associates (Roth and Morrissey, 1952; Roth, 1955). Mental illness becomes increasingly prevalent with increasing age. Many are assumed to be dementing, but over 50 per cent of mental hospital admission in the over 60 age group are suffering from depression, and most of these can be successfully treated. Particularly in men having their first attack of depression in old age, there is an associated physical disorder which should also be treated where possible. The risk of suicide is very great in this group of elderly depressives and most should be referred for skilled psychiatric care and physical investigation, the practitioner's role here being largely diagnostic.

Of those who are dementing most are suffering from senile or

arteriosclerotic dementia and from these must carefully be distinguished those with delirium with its hallucinations, terror, and disorientation, for this syndrome nearly always indicates a physical illness which requires investigation and treatment, for the condition is fatal in half the cases and resolves in the other half. Prophylactically, social isolation should be avoided in the elderly and physical illness diagnosed and treated promptly, for loneliness, illness, and poverty are the major stresses of old age today. Special attention to the point of intrusion should be paid to the old person living alone.

General Considerations

Within the last decade psychiatrists have radically altered their ideas about the optimum handling of psychiatric patients. Early referral, the newer treatments, "open door policy" in hospitals, close links with general hospitals, and now the new Mental Health Act have all helped to create a new atmosphere. Patients and relatives are more ready to accept psychiatric treatment and the days are gone when it was felt expedient to hold on until the patient was so disturbed that admission frequently involved a panic induced roughhouse with the duly authorised officer. Only a very small handful of this minority group of compulsory admissions now offer physical resistance. At the St James's Psychiatric Unit last year, with 1,100 unselected admissions, damage amounted to two broken windows and one broken door (less than that caused by gales). There were only two " escapes " although, or because, all the doors are open.

With an average stay of 6 to 8 weeks, 90 per cent of patients returned home. This is only made possible through careful hospital follow-up treatment and improving standards of after care by general practitioners and local authority mental health staff. As yet preventive measures in psychiatry in the wider sense are few, as our views on aetiology are sketchy and controversial. It is for this reason that the use of the term Mental Health Act is at present premature. We are operating a mental treatment service that can best act prophylactically through the care expended on those who have already recovered or been relieved of a mental illness. The practitioner must feel he can turn to the hospital and local authority service when he needs further advice and help. As yet the numbers of trained personnel in local authority mental health services is small, but this is likely to improve as the benefits of this new approach become more widely apparent.

There is now widespread professional acceptance of the theme that much wider home care and treatment is practical and desirable. It demands tolerant concern from all parties—relatives, friends, employers, and professional people. Treatment in the home in

the light of the newer treatments and attitudes to mental sickness is a stimulating medical and social challenge in which the family doctor must play a key role. In doing so he may find increasing satisfaction in a sizeable section of his life's work which has previously in varying degrees been a source of irritation, frustration, and embarrassment.

This brief review of the field makes no attempt to be comprehensive, very little having been said for example about disorders of childhood, delinquency, psychopathy, or sub-normality, but if the practitioner can orientate himself emotionally and handle with objective concern these three numerically most important groups—neurotic and depressive illnesses and the mental disorders of old age—he will have taken a great step forward.

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A Preliminary Clinical Trial of " Broxil " in General Practice. B. Y. MARSHALL, M.B., B.CH., B.A.O., *The Practitioner* (May 1960). 184, 629.

Dr Marshall has used " broxil " in a series of 52 patients whose ages ranged from 11 to 60 years. He found that sensitive organisms quickly cleared, and good results were also obtained in patients from whom staphylococci " insensitive to penicillin " had been isolated. Five days' treatment is recommended to safeguard against relapse.