Community Care and the Difficult and Offender Patient

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Concern has been growing about a cyclical pattern or ‘periodicity’ in mental health care over the past 300 years, in which large-scale policy decisions have been made, and then reversed, paying little attention to the particular needs of differing patient groups. Turner (1985) drew attention to the reckless course followed by psychiatry, and how the ‘discipline that has lost its way’ (Lancet, 1985) may have done so owing to a poor grasp of its past history. In the movement towards community care, ‘difficult’ or the so-called ‘unrewarding’ (to use Scott’s (1970) term) patients are a particularly vulnerable group (Aviram & Segal, 1973; Bachrach, 1980). Increasingly, community services are compelled to cater for less disturbed patients through being selective about whom they will accept. To a degree, forensic services on both sides of the Atlantic have partially filled the gap so created in service provision. For this and other reasons, it is difficult to make a general statement about the effectiveness of deinstitutionalisation and community care. To be more specific, there are basic conceptual difficulties in defining continuity of care and identifying subgroups for which it has different implications (Bachrach, 1981), and there are major methodological difficulties impeding an analysis of such a diffuse and fragmented provision. Scull’s (1984) description of the overnight abolition of state facilities for juvenile offenders in Massachusetts in the US between 1969 and 1973 points to the impossibility of making a comparison ‘before and after’, when so much dissolution and decentralisation of services has occurred (see also Jones, 1982). A few model alternatives were described soon after the closures, and Bachrach (1980) has written about the dangers of generalising from model programmes, highlighting the differences between demonstration efforts and reality. It is proposed here that the difficult and offender population might act as a ‘litmus paper’ for the efficiency, or otherwise, of community care in general.

Over ten years ago in the UK, attention was drawn to the problems posed to hospitals and prisons by the difficult and chronic behaviourally disturbed patients, previously absorbed by the older asylums (Bowden, 1977; Bluglass, 1978; Orr, 1978). Difficulties within the originating family often leads to an early rejection from their family home (Grad & Sainsbury, 1968; Brown et al, 1972; Miles, 1981). These problem patients wander the streets, and if their behaviour becomes criminalised they may enter the prison system. Bachrach (1980), Caton (1981) and Lamb (1982) describe a rising tide of chronic behaviourally disturbed individuals who are young, single, occasionally schizophrenic, and often personality disordered. It could be argued that the closure of mental hospitals and the restricted admission to the smaller psychiatric units has led, inter alia, to the substitution of inner-city decay for back-ward neglect (Aviram & Segal, 1973; Sands, 1984). The open-door policy developed partly as a consequence of the ‘pharmacotherapy era’ and enlightened voluntary admission practices, but the situation is more complex than this. By examining the process in greater detail, the influence of, for instance, the neuroleptics can be put into proper perspective – the ‘revolutionary treatment methods’ can be demythologised, revealing the reality of community care (Dunham, 1965; Scull, 1984). The advantages of the neuroleptics, advanced by the policy makers as allowing deinstitutionalisation, might be seen as a rationalisation for the uncomfortable fact that social policy is strongly influenced by fiscal reality (Scull, 1984; Turner, 1985; Friedman, 1985). Scull (1984) has written provocatively on this matter, and draws our attention particularly to policy decisions behind what he calls ‘decarceration’. He points out that the political right found it expedient to close psychiatric hospitals for financial reasons, and the political left encouraged it for ‘libertarian reasons’. The 19th century saw the building of institutions and the subsequent neglect of the inmates, and the 20th century saw the dismantling of the institutions and the subsequent neglect of the released patients. Psychiatry, it appears, has not ‘taken its own history’.

Historical context

In the 18th century the mentally disordered were a ‘submerged problem’ (Jones, 1972). They constituted no specific group, and if they offended they were judged by the penal law: if they were poor and dependent they were dealt with by the poor law, and if they wandered outside their ‘catchment area’ they were dealt with by the vagrancy laws. This blurring of boundaries between the indigent, the criminal, and
the mentally ill, commented upon initially by Penrose (1939), and more recently by Steadman (1985), may still be with us.

At the turn of the 19th century, industrialisation and the emergence of a capitalist society effectively destroyed the socio-cultural homeostasis of a more rural community, increasing the proportion of the socially vulnerable. The population of London doubled between 1750 and 1770, and the precipitate drop in the mean age of the populace led to the labour market being flooded with the young, and with unemployment came an explosion in crime. Hughes (1987) provides an exhaustive account of how England temporarily solved the problem by colonising Australia and establishing penal settlements. It is possible that the psychologically vulnerable (the 'Johnny Raws') made up a sizeable population of these unhappy convicts. Foucault (1961) and Scull (1979) ascribed the building of asylums to a growing need for the social control of the psychologically vulnerable (the 'Johnny Raws') made up a sizeable population of these unhappy convicts. Bentham's (1843) Panopticon provided one model for the re-creation of institutionalisation, and led to several other inquiries from which allegations were proved and prosecutions followed (Martin, 1984). The conditions of the mentally handicapped in-patient population had arguably catalysed deinstitutionalisation, and the research of Tizard & Grad (1961) and Kushlick (1965) provided some hope for a movement towards care in the community.

In fact, an 'elective', community-based approach had been developing for some time, with attempts being made particularly to distinguish between custodial institutions and acute treatment facilities. In the US, Dr Adolph Meyer suggested that psychiatry should look at the person in his environment and not at the disease. For the first time in 1905, social workers helped families rehabilitate ill relatives (Rosen, 1968). Aviram & Segal (1973) described how the community clinics derived their impetus from movements in child welfare and child guidance, and the growth of public awareness about mental health problems, as well as the influence of the mental hygiene movement. There was also official recognition of the large number of psychiatric patients from World War I for whom the organism's efforts to diagnose and treat proved woefully inept (Showalter, 1987).

In the US, farm colonies were set up to relieve hospital overcrowding and during the depression of the 1930s, state hospitals initiated family care programmes, placing mentally ill patients in foster care (Segal & Aviram, 1978). In the UK, the 'therapeutic community' developed in military hospitals during World War II, as in the Northfield experiment (Bion, 1961). Psychoanalysis was a tool with an increasingly recognised potential (Jones, 1952), and other innovative psychological treatment methods were developed. The discovery of psychoactive drugs in France in the early 1950s further facilitated the movement away from the merely custodial function of psychiatry. However, although the community had been recognised for its own therapeutic potential, too often in practice discharge into the community meant a transfer from the frying pan into the fire (Jones, 1985; Sarteschi et al, 1985). In the UK, the community rehabilitation of Graham Young from Broadmoor ended tragically (the uproar this caused in the House of Commons led, inter alia, to the Aarvold (Home Office & Department of Health and Social Security, 1973) and Butler (Department of Health and Social Security & Home Office, 1975) reports, drawing public attention to the particular rehabilitation difficulties facing forensic psychiatrists.

Current issues

A core group exists amongst the mentally handicapped, the severely behaviourally disturbed, and the elderly, for whom community management
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remains particularly difficult; indeed, they act as a pawl against the ratchet movement of deinstitutionalisation. Yet at times, the ‘forensic’ ranks are swollen by patients perhaps not justifying segregation (Orr, 1978; Scannell, 1986). For example, difficult patients are often thrown upon community resources ‘early’, and it is easy to be prejudiced against them if facilities are already stretched. The small psychiatric units are reluctant to treat them, particularly if they have ‘collected’ a criminal charge, and it takes experience and forbearance to overcome this group’s rejecting attitudes, when high professional achievement militates against a sympathetic approach (Bachrach, 1980; Martin, 1984).

Similarly, nursing these generally ‘chronic’ patients is as distressing and ‘depleting’ as nursing acutely ill (and dying) patients (Menzies, 1960). All this can lead to staff burn out. Thus these difficult and offender patients are often excluded from the mainstream of psychiatry. Torrey & Wolfe (1986) described the community mental health centres in the US as creaming off the ‘worried well’. Probation services and social services do exemplary work, but they have become overburdened. The streets are filling not only with ex-psychiatric patients (US General Accounting Office, 1977), but also with untreated ‘psychiatric patients’ (Brickner et al., 1986). They are only the tip of the iceberg, and David (1988) hopes that the UK might avoid ‘America’s national tragedy’, where homelessness is a way of life for many mentally disabled. Additionally, Scull (1984) has written of a ‘New Custodialism’, of patients overmedicated and institutionalised in their own homes, and Schmidt et al. (1977) describe the morbidity simply being decanted from hospitals into nursing homes. The problem has become again a submerged one.

An additional factor from the American experience is the uneasy fit between legal restraints and psychiatric practice, and Stone (1985) asserts that the greatest iatrogenic problem of the mental health system today is the failure of continuity of care – ‘legal reform has allowed us to rationalise our failures’. The requirement of unequivocal dangerousness with a recent act makes civil detention very difficult. Ill persons deteriorate and may eventually strike out or offend, and it is then that mental health laws can become operational, not before. Such legal restrictions and inadequacies in psychiatric care both contribute to the ‘criminalisation’ of the mentally ill. Teplin (1983) has reviewed the various ways a person’s behaviour may be deemed disordered (justifying psychiatric intervention) or disorderly (warranting arrest).

The situation in the UK

The Glancy report (Department of Health and Social Security, 1974) examined the facilities for difficult patients in National Health Service hospitals, and identified a need for 1000 secure beds nationwide. The Butler report (Department of Health and Social Security & Home Office, 1975) identified the open-door policy as a major contributor to the inappropriate placement of offender patients in special hospitals and prisons. Two thousand beds on a national basis were recommended to be provided within so-called regional secure units (RSUs). The community care recommendations of the Butler report were, however, relatively unemphasised, compounding the stagnation of clinical care seen in special hospitals, as communities continued to be reluctant to rehabilitate these patients (Lancet, 1986); a similar fate threatens the population in the RSUs. Over ten years ago, Bowden (1977) expressed concern that the RSU development would ignore the needs of the large population of the remanded chronically disturbed recidivists. It was proposed (Lancet, 1986) that RSUs and special hospitals should be dismantled, and that this patient group should be managed within a flexible district-based service. This author recognises the importance of this thinking, but would not make so bold a proposal (Scannell, 1986). The liaison role familiar to forensic psychiatrists is akin to the community mental handicap teams utilising general as opposed to specialist health facilities (Bicknell, 1985), but there are self-evident problems, such as the RSUs silting up (Lancet, 1986) if the general psychiatric provision continues to suffer cutbacks. Butler’s concept of an RSU as being only part of a comprehensive service for this client group has not been realised.

Discussion

A healthy controversy continues about the fate of the RSUs in the UK, and while Snowden (1987) wonders whether we should return to Scott’s (1970) recommendation for treatment facilities within the prison service, others consider that district health authorities should take over the management of patients currently in special hospitals and RSUs (Lancet, 1986). There is at present a variety of regional forensic services, and clearly these different services should be properly evaluated before major policy changes are proposed.

An understanding of the vicissitudes of mental health resources is highly relevant for those planning the treatment of difficult and offender patients, as
the size of this population may increase as the general psychiatric provision decreases. A continued emphasis on special-interest jobs may enable an a priori integration by further enhancing the liaison role. Bluglass's (1978) admonition that 'planning should concentrate on developing services . . . and move away from a pre-occupation with bricks and mortar' had, sadly, been poorly heard. Innovative treatment approaches and sophisticated community programmes enabled the initial movement away from institutions and, in their absence, the RSU development may initiate a period of reinstitutionalisation.

The Department of Health and Social Security hitherto has concentrated on funding the RSUs, leaving the development of supporting community services subject to the usual fiscal restraints (Hansard, 1984). However, the South West Thames Region, because it is building a much smaller unit, has recently obtained permission to allocate central RSU monies throughout the region at a district level, so minimising the gap between the unit and the district-based services.

Alternative housing and hostel provisions are crucial additional community resources (David, 1988). By not seeing the social needs early enough, we might well be seeing a reinstitutionalisation of the difficult and unrewarding patients, especially in the particularly deprived sectors of the community—the early signs of which are already showing, with an identified preponderance of West Indian patients in secure units and hospitals (Littlewood & Lipsedge, 1988; McGovern & Cope, 1987). Of equal concern, young black people are proportionally more likely to receive Section 53(2) sentences than other forms of (often more lenient) youth custody or detention centre disposals (NACRO, 1988). This litmus reading can be ignored only at great cost to both patients and policy makers.

References


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