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Some Mental Health Premises

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IT WAS IN THE CITY OF YORK that the Reverend Sidney Smith (1771–1845), that eighteenth-century wit and cleric, made a punning observation that will help us in our current debate concerning mental health services.

He was, at the time, walking down that famous York street called The Shambles, a typical medieval narrow street lined with half-timbered houses whose upper stories lean so close together that their occupants might almost shake hands. In fact, two occupants whom he encountered were not so much shaking hands as shouting at each other across the street in a furious argument from the top windows of their respective houses. He stopped and pointed out to them that their trouble sprang from the fact that they were "arguing from different premises." He subsequently described this as the worst pun in the English language. We in our debate concerning mental health services are perhaps doing exactly the same, and we may well be in a worse position even than those eighteenth-century ladies because we are arguing not only *from* different premises, be they logical or architectural, but in fact arguing *about* different premises, mostly those regarded as alternatives to that central and major premise—the psychiatric hospital.

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The Major and Mistaken Premise

It is, as Dr. Rose has pointed out, the state psychiatric hospital that has become the major target for public mental health reform, and this is as true in the United Kingdom as in the United States. Indeed, any review of progress in the mental health field invariably seizes upon the reduction in the mental hospital population as an index of success. Thus in England it is claimed that in the last twenty years the average length of stay of patients in mental hospitals has fallen dramatically, although the number of people admitted to mental illness hospitals and units has increased. In 1966, the number of people in hospital at any one time was 120,000. The number had fallen to 83,000 by 1976, and it is estimated that it is falling by some 3 percent a year. In 1966, ninety-one hospitals had over 1,000 beds, but by 1976 only forty-one had so large a number.

Local and district psychiatric services have been replacing in a very irregular pattern many services provided by the mental illness hospitals, and in the United Kingdom there are about forty general-hospital acute psychiatric units already in being, with a considerable increase expected over the next decade. In the United States, whereas in 1967 there were some 256 community mental health centers (CMHCs) funded in the previous two years under the federal grants program, there are currently some 675 such CMHCs covering almost half the country. Therefore, in both countries, alternatives to the large mental hospital have been the major goal. In the States in the early 1960s, deinstitutionalization became a political goal in the Kennedy administration. It was in the early 1960s that I, like others, enjoyed the hospitality of the Milbank Memorial Fund, who were concerned in the cross-fertilization of American and British ideas concerning both the reform of psychiatric hospitals and the community care of the psychiatrically ill. To travel round the States in those days was to know something of the reforming zeal of the mental health movement at that time.

In this country, the Hospital Plan of 1962 forecast the closure within ten years of a number of psychiatric hospitals. (As medical superintendent of one of these, I well remember holding discussions with staff as a morale-boosting exercise designed to allay anxieties caused by the threat of redundancy and closure. The decade came and went, and the credibility gap of forecasters widened.)

The introduction of general-hospital psychiatric units led to the assumption that such units could themselves replace the mental illness hospitals. In the years that followed, many staff in mental illness hospitals became disillusioned because the promised new developments did not materialize on the scale expected, and when in fact the hospitals did not close. We have, therefore, been arguing about different premises, whether they be state hospitals and the community mental health centers in the States or the National Health Service psychiatric hospitals and acute psychiatric units in general hospitals in the United Kingdom.

There has been a considerable reduction in the inpatient population of large mental hospitals in both countries, but it may have been that this in itself was a self-fulfilling prophecy and that it was based not so much on the extrapolation of cohort studies as on a definite administrative plan. One can fill or empty psychiatric hospitals as an act of deliberate policy; I might remark that when I first took up my present post, in 1952, it was regarded as estimable to increase the number of beds in local psychiatric hospitals as much as possible—but a few years later the fashion (and I shall be returning to this subject of the cycle of fashion) was to empty beds.

Some Origins of the Premises

It should not be forgotten that psychiatric hospitals came into being as part of a community venture and to make good the obvious deficiencies that previously existed in the care of the mentally ill. In illustration of this, I might usefully quote from the first advertisement for the creation of the York Lunatic Asylum (now Bootham Park, from which hospital I am writing this paper), which appeared on 25 August 1772 in the *York Courant:* "Sensible of the deplorable situation of many poor lunatics in this extensive county who have no other support but what a needy parent can bestow or a thrifty parish officer provide, we do recommend to the public in general a subscription towards erecting a public edifice for the reception of such unhappy people."

Therefore the very reason for the foundation of at least these particular mental health premises (in both senses of that word) was to make good the failure of the family and of the local authority; today, it might be thought that the originators of the scheme would

have done better to be more concerned with underpinning the emotional needs of the patients' families and the financial needs of the parishes.

Dr. Rose reviews the history of the last fifteen years, but I would suggest that the development of what are called mental health services (though I think they ought to be called mental illness services) goes back much further than that. One might quote the words of Adolf Meyer, who in 1909 said (Lief, 1948) that "one of the most important lessons of modern psychiatry is the absolute necessity of going beyond the asylum walls and of working where things have their beginnings; experience shows that then only organized cooperation will achieve success."

If one were to review the history of those comprehensive mental health services that existed in Great Britain and to some extent influenced the development of the American mental health services, one would find that they were not so much concerned with the closure of the local psychiatric hospital as with its incorporation in the local mental health service. The premise that the closure of the local psychiatric hospital is a major target is, I think, utterly mistaken and has led to a great deal of confusion both in the States and here in Great Britain. It is odd how often conferences have been called to consider other alternatives to the mental hospital, always with the concentration on the destruction of the local psychiatric building.

The emphasis has been too much on structure and too little on function, but if I may quote from the memorandum that in 1953 became the first attempt to crystallize the idea of a mental health service here in York, the underlying philosophy was as follows:

> The problems of mental health are closely concerned with the conditions under which the patient lives. The mental and nervous illnesses may be in large measure a reaction to the circumstances of life, and consequently the diagnosis, treatment and rehabilitation on recovery of the patient demands a first hand knowledge of his domestic and social setting as well as clinical skill. (Bowen and Crane, 1957: 4)

It was argued, in forming the local mental health service, that no radical increase in personnel was either necessary or sensible, as there were already a vast number of people engaged in social work of one kind or another in this country. Attention was drawn to this fact

by Professor Wilson (1952), who was then professor of education at Bristol University. He pointed out that

> there are in this country 10,000 or so officers of the National Assistance Board, 4,000 health visitors, the staffs of the Local Authorities Welfare Committees, the school welfare officers, the almoners, the probation officers, the psychiatric social workers, the industrial personnel officers, the youth leaders and the staffs of Children's Departments. There are the voluntary organisations, including in the mental health field, the National Association for Mental Health and the Mental After-Care Association. The list can be multiplied ad infinitum.

We locally thought and said, "There is a danger, as well as a needless expense in adding to the numbers of social workers and organizations. What is needed, and especially in the field of mental health, is integration, not more addition."

It is curious how in the York Mental Health Service and in many other mental health services, which at that time were fashionable in this country, the principles were those of continuous and flexible service, a point that the late Walter Maclay emphasized in the Adolf Meyer Lecture in 1963, wherein he said, writing about mental health services, "My main text is a plea for continuity of care and for flexible service" (Maclay, 1963: 209).

Such services did not see deinstitutionalization as the major policy, but rather saw the hospital as an integrated part of the service and not a place set apart structurally, functionally, and culturally from the ordinary world. The York service (which was created because of the clinical needs of psychiatrically ill patients) was a mental illness and not a mental health service, and its continuous and flexible arrangements ranged all the way through from family doctors, to domiciliary visits by consultants, to outpatient treatment including the day hospital, to inpatient services including rehabilitation units, to hostels and the general aftercare agencies readily and immediately available.

Yolles, writing in October 1967 in a supplement to the *American Journal of Psychiatry,* noted that the diversity of local needs had resulted in the diversity of flexibility in meeting those needs, and he went on, "If there is one word to describe the process of organizing community mental health centers, that word is flexibility; in patterns of financing, in the grouping of service components, in community participation" (Yolles, 1967: 2).

For at least the past fifteen or twenty years the emphasis has been on the creation of mental health services, and the singling out of the elimination of psychiatric hospitals is in many ways a distorting premise.

The Cycle of Fashion

It would, I think, be a mistake for us to concentrate our present debate purely on deinstitutionalization. To look at the mental hospital alone is not only too narrow but also too short a view; too narrow because, as has been argued above, the mental health service can function only because of a wide range of facilities of which the mental hospital is but one; and too short because the fifteen years that Dr. Rose mentions is but a small part of a length of time during which fashions and philosophies concerning the treatment of the mentally ill have been changing. Indeed, to concentrate on deinstitutionalization and only that is to set up that notion of paradigm that Dr. Rose refers to in the latter part of his paper.

One of the distressing things about the history of the last couple of centuries or so has been the way in which fashions have waxed and waned. It is a curious thing that, despite the considerable advances that have been made, there does not seem to be any enduring or well-proven body of knowledge from which each generation makes fresh advances. Take, for example, the question of open doors in psychiatric hospitals. It was in the early part of the 1950s and slightly later that open doors were heralded as a revolutionary change in the therapeutic community; but in 1881 Dr. Tuke in this country noted that the doors of Fyfe and Kinross had been open for ten years, and he remarked that "liberty of action is no more controlled than in the wards of a general hospital" (Bowen, 1960: 45). Dr. Cameron of the Midlothian Asylum, in the same year, said, "It is now possible to traverse the entire building without requiring to use a key" (Bowen, 1960: 45). Dr. Saxty Good at Littlemore Hospital in 1922 noted (Bowen, 1960) that security was best achieved not by locking doors but by patient-staff relationships. Yet now over recent years, in this country at least, one sees a return to the locked-door system; various reasons are put forward, such as that it confers greater security upon the patient, or else that it is necessary for the safety of the large numbers of elderly people who now inhabit our hospitals.

A survey of changing fashions even in the last quarter of a century would include the fashions for the day hospital, for group therapy, for crisis intervention centers, for walk-in clinics, and for a whole host of apparently new methods of treatment, all of which have been acclaimed as bringing about remarkable recoveries and modifications of behavior, and equally all of which disappear into limbo as their protagonists lose interest.

Even the concept of the "therapeutic community" itself, once so fashionable, has not enjoyed universal support, and a critical survey of this was published by Zeitlyn (1967). As he pointed out, a source of confusion, as he put it, has to do with the use of words less to convey meaning than as clichés and catch phrases; certainly this has been a characteristic of many of the "recent advances" that have appeared in psychiatry as part of the mental health scene during recent years. Current American trends in the development both of specialized mental health language and in the forecasting of future fashion appeared in a recent issue of the *American Journal of Psychiatry,* in an interesting collection of topical papers (1978) on future systems of delivering mental health care. In many ways these articles support Dr. Rose's pessimism, and particularly an article by Dr. Sharfstein (1978), entitled "Will Community Mental Health Survive in the 1980's?" vis-a-vis the 675 community mental health centers in the States, querying whether these as a national program are headed for extinction or whether they will enjoy a new vitality in the next decade.

There has been, talking of clichés, a curious fashion of talking about such meaningless things as "maximizing the therapeutic potential" or "utilizing mental health resources." I mention these matters only because I think they conceal the fact that it has always been extremely difficult to define what we are talking about, and in particular to define the goals of our mental illness services. One of the hardest things in the world is getting mental health professionals to say what they are actually doing.

Certainly Dr. Rose is right in thinking that the reduction in number of long-term patients was embodied as a national policy by the federal program in the United States and equally in this country. It might be worth mentioning, in passing, that there is a difference between the States and the United Kingdom, perhaps partly because of America's acceptance of psychodynamic thinking with its emphasis on personality growth and change. It has been argued that

any American community mental health program should be planned to develop with this end in view. In other words, with the goal of mental health rather than the relief of mental illness. It would seem, and this is another aspect of the evaluation and deciphering of the complexities of policy and program analysis, that a continuing evaluation of the philosophy, as well as the operating effectiveness, of the new community health programs must be a vital part of the national goal, as Jeanne Brand pointed out at the Airlie House Conference in 1966 (Williams and Jossey, 1968).

And yet there has been no lack of evaluation studies; certainly one of the major contributions of the Milbank Memorial Fund over the years has been precisely in this direction. One thing, however, that is worrying is that Milbank Memorial Fund publications gather dust on shelves, as do so many other equally worthwhile studies of the effectiveness of mental health programs in general and psychiatric hospitals in particular, and what is learned in one decade is not necessarily used by the psychiatrists of the subsequent one.

Premises and Promises

One of the difficulties in looking at the development of mental health services has been the fact that those who brought about changes were often inspired more by humanitarian and, as it were, philosophical concepts than they were concerned with the demonstration of the efficacy of new systems of treatment. Indeed, if one goes back to the days of Philippe Pinel, one finds that it was a dramatic demonstration, such as striking the chains from the lunatics, rather than any controlled trial that brought about the impetus for reform.

Propaganda and publicity have gone hand in hand, and the introduction of the so-called moral treatment of insanity at The Retreat here in York was greatly helped when the Reverend Sidney Smith, mentioned in the opening paragraph of this paper, publicized it in an article in the *Edinburgh Review* in 1815, called "Mad Quakers," which praised them for their concept that kindliness to patients was a method of treatment.

Throughout the history of mental health reforms one comes up against the fact that individual and often charismatic figures were concerned to advance a particular system or treatment under a variety of banners. Perhaps banners and slogans have to be essen-

tially simple if they are to command any large following, and the idea of emptying the large psychiatric hospitals has certainly been one such slogan. Kessel (1966), writing in a Milbank publication, drew a useful distinction between innovators and evaluators, the innovators being enthusiastic reformers, and the evaluators being more concerned with trying to discover what the innovators thought they were doing and trying to find out if they were in fact doing it.

As Professor Paul Sivadon said at a conference on community mental health programs some years ago (and he quoted, I think, the words of a former teacher of his), "In order to run a service you have to love it; in order to research it you have to hate it" (Williams and Jossey, 1968). Certain services have had well-defined objectives; for example, the Dutchess County Service in the Hudson River State Hospital was concerned with reducing the incidence of the social breakdown syndrome, and was set up under the auspices of the Milbank Memorial Fund by Gruenberg and others. Other programs have had less well-defined objectives.

In the 1950s and thereabouts, there came into being in this country a variety of mental health services. MacMillan at Nottingham, Pool at Oldham, Carse at Graylingwell, as well as the York Mental Health Service, brought into being mental health services that were in part designed to prevent people entering psychiatric hospitals, or to speed up their departure therefrom, but generally lacked evaluative statistics. In fact, it was difficult sometimes to define what the objectives of these services were; all of these services were preceded by Thomas Beaton's work at Portsmouth, United Kingdom, in 1926.

In the States there was the San Mateo service in California, and there was the Clarinda experiment, to take two examples almost at random. Fort Logan in Denver, Colorado, was also a new development, and its success or otherwise should be read in conjunction with the function of the Colorado State Hospital at Pueblo.

If deinstitutionalization was the banner of mental health reform both in the States and in this country, it was too simple a slogan, too mistaken a premise, and, as Dr. Rose has suggested, it is extremely doubtful whether deinstitutionalization has taken place. Indeed, it would seem that both in the States and in this country the effect of the attempt to empty psychiatric hospitals has been merely to distribute the patients amongst other different forms of institutions—but still institutions—some of which have not been as

satisfactory as the psychiatric hospital. Other patients, of course, have found themselves on the streets—going from back wards to back alleys is a fair description.

The other point that Dr. Rose mentions, in relation to the promises made for deinstitutionalization, was the saving in money. Here again it is very doubtful whether in Great Britain, any more than in the States, any financial saving has been brought about by deinstitutionalization services. In this context it would be well worth remembering Querido's Amsterdam mental health services. It will be remembered that he was appointed as a direct result of the financial difficulties of the economic crisis of the 1930s, his instructions being to reduce the number of patients in mental hospitals. Querido later thought that the history of public health showed that if new ways are to be opened up, some serious stress situation, whether this be economic, social, or biological, must be present. He provided a first-hand service on the spot, seeing the patient in his or her own surroundings at the time of crisis. Querido had worked under Cannon at Harvard and used the principle of homeostasis, that is to say, the re-establishing of equilibrium in the disturbed patient rather than the concept of cure.

Apropos of the cycle of fashion, it is interesting to note that the financial argument was advanced as long ago as 1838 by Sir William Ellis, then resident physician at Hanwell Asylum, who in a plea for half-way houses or hostels remarked in that year, about patients discharged from hospital, "A home until they can procure employment would be an invaluable blessing to them; if such an institution was established, even at the cost of the parishes, it would in the end prove a saving" (Bowen, 1960: 44). It is doubtful, in the light of later financial analysis, that this is so.

There are some differences between the States and Great Britain over this matter of financial savings, because of the National Health Service in this country, but what is clear is that times of financial crisis bear harder upon the psychiatric hospitals, which do not command so strong a political voice as other parts of the medical spectrum. If, therefore, we are to understand the extraordinary complexities of policy and program analysis both in the States and in this country, we really have to redefine our aims with much greater clarity, and we have also to be much more concerned with function than with structure, with the basic logical premises than with merely architectural ones. One might echo Kraft's comment from Fort

Logan, that it is not enough for a few mental hospital administrators to have new ideas; unless they can find staff to develop these ideas, the innovations in mental health can turn out to be nothing but new buildings housing traditional programs. He went on to say that we may find we have participated only in an architectural revolution. Dr. Rose's paper makes depressing reading to anyone who has been concerned with the introduction of mental health services, and his point is well taken concerning the fact that the shift from custodial care to community-based care is more a substantial relocation of treatment practices than a redefinition of the nature of the problems to be addressed.

So are his comments on the dominance of the psychiatric view, but I would not think that any psychiatric dominance as such has, as he suggested, pre-empted any reform or thought about the problems of the mentally disabled. A feature of many mental health services has been their emphasis on the contribution to be made, not only by the therapeutic community in the hospital and in the psychiatric facilities, but also by a much larger therapeutic community, that is to say, their neighborhood and country. Nevertheless, the function of a psychiatrist is to practice psychiatry. In other words, one would make a plea for a much sharper definition of that phrase often used in a pejorative sense, "the medical model." The cobbler should stick to his last.

When the York Lunatic Asylum opened its doors, the first patient being admitted on 1 November 1777, my medical predecessors of two hundred years ago had no difficulty in defining what they were doing. They had three diagnoses: flighty; flighty and wild; and melancholia. Simple unadorned diagnoses, free from observer error and carrying no connotation of any social breakdown. In the last two hundred years things have changed. Personality disorders, the elderly, and social problems of all sorts, some defying a strict medical "diagnosis," are now accommodated in the psychiatric hospital; and more than 50 percent enter for social reasons.

If difficulties of evaluation arise in relation to mental health or social services, they arise also in the question of the introduction of some of the newer (comparatively newer) methods of medication. Specifically, in this context the matter of the drug treatment of mental illness can usefully be considered. Dr. Rose calls into question the role of modern neuroleptics in the effective treatment of mental illness.

The classical paper on this is "Drugs and 'Moral Treatment,' " by Anthony Hordern and Max Hamilton (1963). They noted that the advent of the phenothiazines as a treatment for chronic schizophrenics had been enthusiastically hailed as a great advance. They commented that the history of medicine teaches that the enthusiasm with which a new treatment is greeted is not necessarily a measure of its efficacy, and they thought that perhaps the phenothiazines had not bettered the results of those who introduced "moral treatment" over a century ago. However, what also emerged from that paper was the two main patterns of response observed and reported with neuroleptics since 1954. 1) In Britain generally, and in the small highly staffed psychotherapeutically oriented psychiatric hospitals of the United States, neuroleptics did not appear to have shown any striking advantage over established methods of treatment; whereas 2) in the large state hospitals of North America and in mental hospitals in other countries, particularly those with meager programs of treatment, the efficacy of neuroleptics had been reported as little short of miraculous. It would seem, therefore, that both in specific medical treatment and in the nonspecific factors involved in the therapeutic community, it is as much the effect on the staff as on the patients that yields favorable results.

However, one would think that neuroleptics now had an established place in the treatment of major psychotic illness, and from a purely clinical standpoint there can be little doubt that outpatient administration, particularly of long-acting phenothiazines, has permitted people to live outside hospital who in former days would have been incarcerated there for the greater part of their lives. The effectiveness of modern psychotropic drugs came home to me a month or so back when I found by accident, in a cupboard at one of the local psychiatric hospitals, a former register of mechanical restraint and seclusion, which at one time had to be made out for every patient secluded (restraint was never employed) and had to be countersigned by myself as medical superintendent. I had completely forgotten how disturbed was the behavior of so many patients, those years ago, who had from time to time to be secluded from their fellow patients because of their aggressive conduct. The picture now has completely changed, a change due largely to the phenothiazines. It is true that more is initially claimed for new methods of treatment than the subsequent results confirm, and it has long been observed that new methods of treatment throughout the last fifty years and longer came

in with a 90 percent recovery rate on first introduction, but eventually showed no more than the usual 30 percent remission.

As long ago as 1882 Hack Tuke, descendant of that Tuke who founded The Retreat here in York, compared the results of the treatment that had been brought into being since the year 1841 (in which year Thurnham's *Statistics of The Retreat* was published) and noted the puzzling failure, as he put it, of patients to respond to new methods and new drugs on the market, and in memorable words said, "Each remedy, while failing to fulfill all the hopes raised on its first introduction, leaves behind, let us hope, a certain residuum of usefulness" (Tuke, 1882). Words that we could echo today.

The effect of neuroleptics in large psychiatric hospitals was to bring about not only, one would think, a marked change in previously untreated patients, but also a marked change in the attitudes of the staff. Equally Smith, Bower, and Wignall (1965), reporting from the Colorado State Hospital and commenting on the effect of the introduction of psychotropic drugs, thought that they had not in fact brought about any marked change, and went on to say that after certain administrative alterations in the hospital there was in fact a considerable change, and they thought that the degree of therapeutic advance brought about by psychotropic drugs in mental hospitals was determined by the policy of the hospital and its administrators. The administration policy, they suggested, was more significant in determining the population of the state hospitals than is generally recognized.

Future Premises

If, as I hope I have shown, deinstitutionalization by itself was a mistaken aim and premise in the mental health reform of the past twenty-five years, the present time is an appropriate one to look, as Dr. Rose has done, at what has or has not been achieved; and perhaps also to consider the present state of play.

Undoubtedly, mental health services as such are a thing of the past in the United Kingdom, and their passing has been mourned by at least those who worked in the successful ones, who have found much to criticize in, for example, the generic development of social work and the absence of sophisticated and skilled case workers in the mental health field. What has happened is a more general spread of

services for the mentally ill throughout the country as a whole, and the government has addressed itself to the development over the next twenty-five years of these particular services, as witness the Command White Paper, *Better Services for the Mentally Ill* (Department of Health and Social Security, 1975). It is interesting that, in the foreword, the then secretary of state referred to deinstitutionalization, saying that "without increased community resources, the numbers in mental hospitals cannot be expected to fall at the rate they might otherwise have done." She went on to say that the delay in building up local services meant that it was unlikely that we should be able to see in every part of the country the kind of service we would ideally like within even the twenty-five-year planned horizon. As was said, the White Paper was not a specific program but simply a statement of objectives; very little material progress in the shape of any physical development was expected in the next few years and even that would depend on the general economic situation.

At times such as this there is a danger that we are going to return to one of those downward swings in the cycle of fashion, which has in the past led to therapeutic nihilism and to a regression of worthwhile changes in the lot of the mentally ill. The realization of a twenty-five-year planning cycle is inclined to perpetuate that disillusionment noted after the Hospital Plan of 1962 came and went, because promised new developments did not materialize.

The White Paper took account of certain factors stressed by Dr. Rose, that is to say, the need for support services well beyond the narrow confines of the psychiatric or medical model—for example, housing. It was recognized that in many instances people recovering from mental illness required ordinary housing rather than any specialized residential accommodation, and that local housing authorities had an important contribution to make; and—again in the wider field—that the wide range of employment and training services provided by the Department of Employment and the Manpower Services Commission could help the resettlement of mentally ill people.

The same problem of a broader-based community mental health service is raised by Dr. Sharfstein (1978). He notes that there is evidence that community mental health centers are mutating from a clinical medical program toward a social program, and that the numbers of psychiatrists and nurses in CMHCs relative to other staff are decreasing. He raises the question of a companion social in-

surance program to fill in the gaps in the national health insurance. (It may be relevant to note that just as there is a Department of Health, Education, and Welfare in the States, so Health in this country is linked with Social Security.)

The core of the White Paper was the development of district services, so that it should still be possible for the same enthusiasm that motivated and innovated mental health services in the past to be put into the district framework. Indeed, it might well be argued that the concept of the psychiatric team has been a major advance. In most psychiatric hospitals now this team comprises all disciplines concerned with individual patients. From time to time, different members of the team would take on the major responsibility; for example, a doctor being concerned with diagnosis and appropriate medical treatment, a nurse perhaps more with the day-to-day organization of the patients' lives, and a social worker covering a wide range of activities, particularly in relation to resettlement. Indeed, at the time of writing this particular paragraph I had just returned from such a meeting in one of the hospitals at which were present (apart from the psychiatrists) the nurses, the physiotherapists, the social workers, the psychiatric community nurses, and the occupational therapists, all of whom had a contribution to make in the discussion of particular problems.

While the organization of such a team in a multidisciplinary or multiprofessional fashion might seem to be a recent development, it was as long ago as 1965 that a paper on the psychiatric team by Bowen, Marler, and Androes (1965) laid down certain principles. Chief amongst these were that whereas a group of experts, none of whom listens to the others, did not comprise a team, the three necessary features to form a team were 1) the ability to contribute knowledge not available to other members of the team, 2) the readiness to receive contributions of others, and 3) the capacity to carry out decisions. In other words, responsibility, authority, and competence are essential parts of the multidisciplinary team; and the concept of the "key worker," whether this be a nurse on the ward, a psychiatrist at the outpatient clinic or in the ward, a social worker, or a clinical psychologist, reflects the changing roles of the members of the team. But there is another team that, at least in Great Britain, is of very considerable importance: the primary care team. This phrase refers in particular to the involvement of the general practitioner.

Perhaps we should be talking more about a general practice than a general premise in looking at the future of the psychiatrically ill in the United Kingdom. The general practitioner is, as Michael Shepherd has pointed out, the chief purveyor of psychiatric treatment in this country. He refers only one in twenty of his patients to the psychiatrist. Maybe the organization of general practice in the United Kingdom represents a marked difference from similar services in some parts of the United States, but there is no doubt that, as far as the future is concerned, it is the general practitioner who is going to be the key figure in the treatment of psychiatric illness, the more so because there are now effective agencies for controlling both the major psychoses in the community and the treatment of, for example, depressive illnesses.

Another important development referred to in the Command White Paper was that of research. The review of research priorities carried out by the Department of Health and Social Security, with the assistance of their chief scientific organization, might make good the deficiencies apparent in the previous individual mental health services. Whereas some of these may well have been founded by individual enthusiasm, they often lacked any objective evaluation of the aims of the particular service, and often still more the evaluation of such services by nonparticipating observers. These deficiencies will be made good. One can look, for example, at a recent study to examine the feasibility of a national survey of patients discharged from mental illness hospitals, carried out on behalf of the Department of Health and Social Security by the Social Survey Division of the Office of Population Censuses and Surveys.

So far from losing impetus, the national services for mental illness in the United Kingdom are constantly being up-dated and are transmitted to the various regions in the country so that the official guidelines issued form the basis for a comprehensive service. In this concept, all the inpatient, outpatient, day patient, general practitioner, and local authority services jointly offer a district service to be used as flexibly as possible, in which the emphasis is on rehabilitation and the preservation of continuity of patients' personal relationships and contacts with the local community. Examples of guidelines are included in *Hospital Services for the Mentally Ill* (Department of Health and Social Security, 1971), and *Priorities for Health and Personal Social Services* (Department of Health and Social Security, 1976).

And Now What Is The Answer?

Dr. Rose, in his summary and conclusion, refers to the reigning paradigm in the mental health field. I guess that one of the handicaps of being a clinician is that one is more influenced by hypothesis than by paradigm.

Moreover, and again perhaps because of an individual clinical orientation, one is inclined to argue from the particular to the general and, as far as the economic considerations of the state are concerned, to which Dr. Rose refers, I would not have thought that these were tied up with therapeutic innovations. For example, the first memorandum of the York Mental Health Service (Bowen and Crane, 1957) contained the following paragraph:

> Prevention of mental illness and psychiatric social disorder is part of the functions of the Local Authority. While this would be one of the functions of a mental health service, prevention may in part lie within the non-medical welfare arena, and Professor Wilson of Bristol recounts a case which is repeated here because it bears upon this question. He details the affairs of a family, the parents of which married in 1928. By 1941 there had been nine pregnancies, with seven living children. The family was hit by a whole series of misfortunes, beginning with prolonged unemployment in the 1930's and culminating with being bombed out and then unsatisfactorily re-housed during the War. In spite of all this, family ties were never broken and personal loyalty was always robust. Nevertheless by 1950 the family was in a worse plight than ever, three girls had drifted into promiscuity and three other children had been removed from the home. Over the twenty years some thirty-seven different branches of the public services and voluntary social organisations had been concerned with the family's affairs, and direct expenditure from public and voluntary funds was of the order of £8,000.

It was suggested that help provided for mothers at the right time might be a lot more useful—and a lot cheaper—than skilled social work or psychiatric help applied too late. (Incidentally, the £8,000 translated into present-day terms must be at least ten times that figure.)

It might also be worth stressing that cost-benefit analysis of psychiatric illness has yet properly to be undertaken, although Conley, Conwell, and Arrill (1967) attempted so to do.

It is appropriate that the Milbank Memorial Fund should once again be concerned with a debate concerning mental health programs, and certainly one would agree with Dr. Rose's statement that a multidisciplinary, multifield investigation is called for. Indeed, the overriding impression that one gets from any survey of the development of mental health services, either in the States or in Great Britain over the last twenty-five years, is of the extraordinary complexities and the very large number of variables that have to be taken into account. The difficulty has been, and indeed still is, that simplistic solutions are put forward to claim that this premise or that premise or these premises or those premises are "the answer."

Our ancestors here in York two hundred years ago were more sure than we are today that they had the answers, or an answer, to the treatment of mental illness. We are not so sure.

It is said that when the American poet, author, and seeker after truth, Miss Gertrude Stein, lay on her deathbed, one of those around the bedside, seeing that the end was near, leant forward and, hoping for enlightenment, asked "And now, what is the answer?" Miss Stein—ever a lady of unusual perception—rallied her failing powers and replied, "What is the question?"

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