

The evolution of psychiatric care – a spiral model

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The present trend towards community care with the continuing closure of the old Victorian institutions has given rise to much argument for and against community care. Incidents of violence by mentally ill patients against members of the public have resulted in some backlash against community care. There are fears of a return to the days of the institution. It is proposed that these changes can be predicted from a model that we have called the 'spiral model'. An understanding of this model might help to prevent history from repeating itself.

Psychiatric care has been undergoing rapid change over the past few years. In Britain this has occurred in conjunction with changes in the structure of the National Health Service (NHS). The most significant has been the movement away from institutional care to care in the community.

The government reinforced the move towards community care by introducing the NHS and Community Care Act of 1990. The community care section of the act was the culmination of a series of steps over the previous five years (Thornicroft, 1994). This has been accompanied by further closure of the old Victorian asylums leading to a decrease in the number of psychiatric beds. There is concern that care in the community is a political device to reduce costs rather than to provide better care to patients.

The Short report (House of Commons Select Report, 1985) has warned that community care should not be done on the cheap. The public has also been aroused by homicide incidents such as those leading to the Clunis and Buchanan enquiries which have led the call to restrict freedom in the community and to introduce legislation for stricter supervision. It has been suspected that measures such as supervision registers proposed under the pretext of community care are in fact a mistaken policy that "yet again proposes a bureaucratic solution to what is essentially a problem of inadequate resources" (Holloway, 1994). The proposal for a community supervision order was drawn up by the Royal College of Psychiatrists but rejected by a Parliamentary Select Committee. Nevertheless, the government has introduced extended leave and after-care under supervision.

It appears that care in the community is again being reshaped to restrict the freedom of the

mentally ill in the community. The more optimistic view of community care is that this "fragile infant could be assisted by the profession and reared into something that is really helpful to patients, mental health key workers and planners" (Tyrer & Kennedy, 1995). Even the profession is divided on these issues. In an attempt to predict what course care in the community will take, we reviewed the course and development of psychiatric care over the last two centuries in search of a pattern.

The spiral model

One constant feature of psychiatric services is that the quality of care at each stage of evolution is better than the corresponding previous stage of care, whether it is in the community or in the institution. To analyse the evidence in the progress and evolution of psychiatric care we propose the spiral model of evolution of psychiatric care (Fig. 1). In this model we postulate that psychiatric care has taken a spiral course of evolution, vacillating between institutional care and deinstitutionalisation (the horizontal axis), while advances of the quality of care have continued to be made (vertical axis). This model accommodates the fact that, throughout history, change in the locus of care (community or institution) has been met with resistance, followed by a rebound shift towards the previous locus of care. But the process has never been a complete reversal; the return to the previous locus is always on a higher level. We suggest that the shift towards either locus inevitably raises the original locus of care to a superior level. This spiral course is not always obvious but does represent continuous advance.

We would like to substantiate the proposed model by mentioning briefly the history and the progress of psychiatric care.

History of the evolution of psychiatric care

Before the eighteenth century in Europe there were no special provisions for the care of the

mentally ill. The only hospital in England for the mentally ill was the Bethlem Hospital founded in 1247. The mentally ill lived in the community but without any care (Fig. 1; level 1, locus A). The Vagrancy Act of 1774 made the first distinction between lunatics and paupers. Private 'madhouses' were developed for the mentally ill who could afford to pay and for some paupers who were supported by their parishes. Around this time, a few hospitals were established, for example the lunatic ward at Guy's in 1728 and St Luke's Hospital in 1751. 'No care in the community' had shifted to custodial care within an institution, (Fig. 1; level 1, locus B), at least for a limited number of patients.

At the end of the eighteenth century there was increased public concern regarding the welfare of the mentally ill, with Pinel in Paris leading the way by releasing patients who had been restrained in chains. In Britain, William Tuke founded the York Retreat, with pleasant surroundings, providing patients with recreation and occupation rather than restraint. This marked the beginning of care without restraint for the mentally ill and community care (Fig. 1; level 2, locus A).

In spite of these efforts, in the early nineteenth century many mentally ill people lived as vagrants in workhouses or in prison (Jones, 1972). There was increasing public concern about the conditions in some madhouses. The County Asylum Act of 1808 provided for the building of mental hospitals in every English county, however, progress was slow. In 1845, the Lunatics Act

was implemented and required each county to build an asylum. This marked the shift towards institutionalisation for 'better care' (Fig. 1; level 2, locus B). Initially, the asylums provided good care to their patients, encouraged by the pioneering work of Gardiner Hill at the Lincoln Asylum and John Connolly at the Middlesex County Asylum (Gelder *et al*, 1989).

This was not to last. Under increasing pressures of overcrowding and staff shortages the pendulum swung back again, moral care giving way to a custodial approach. The Lunacy Act of 1890 imposed restrictions on the discharge of patients from hospital. These restrictions continued into the twentieth century.

In England, after the First World War there was a return to liberal policies which marked the beginnings of modern community care. The Maudsley Hospital was opened in 1923 and provided for out-patient treatment and voluntary in-patient treatment. The Mental Health Act of 1930 did away with many of the restrictions of the Lunacy Act of 1890, allowing asylums to accept voluntary patients (a shift towards locus A at level 3, Fig. 1). These changes continued after the Second World War. The discovery of chlorpromazine in 1952 made it easier to control disturbed behaviour and discharge patients into the community. At the same time there was a large reduction in the number of beds in mental hospitals. It soon became apparent that resources outside the hospitals were inadequate to deal with the patients being discharged and a proportion became vagrants or prison inmates. From figures published it is clear that the rate of hospital rundown has far outstripped the development of successor services (Audit Commission, 1986). The dangers of deinstitutionalisation imperfectly implemented are clear. Those discharged face the prospect of impoverished, segregated, isolated and under-stimulated lives (Thornicroft, 1989). "Did we dream as we marched out of the asylums, that we would have lost so much - budgets, expertise, facilities, and morale - in the name of community psychiatry? But it is our patients who will be the real losers if they are either neglected in the pseudo community or re-institutionalised as result of public backlash" (Robertson, 1994). Some still warn that "It may yet decay into the disillusionment of reinstitutionalisation" (Elpers, 1987). In fact Watson (1994) argues for "a range of wards in the community, which could recreate the best of old asylums".

The history of the developmental stages fits the model clearly and the net result has been improvement in the quality of psychiatric care. It also shows how care has vacillated between institutions and community, and how each locus inevitably generated grounds to shift the original locus of care.

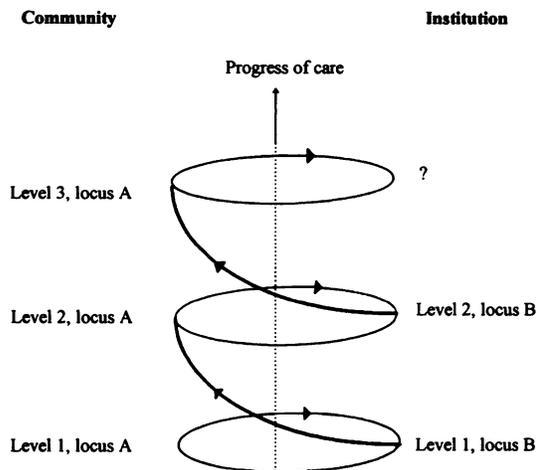


Fig. 1. Evolution of psychiatric care - A spiral model

What is the future?

Can we predict where it will go from here? Urgent action should be taken to bridge the gaps in the provision of comprehensive care for mentally ill, for otherwise people might interpret the gaps as indicating failure of the philosophy of community care. Unless remedial actions are taken the spiral model will lead to a change towards reinstitutionalisation, although at a higher level.

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