

nurse has serious doubts about whether a new facility will function properly it won't. Exit interviews with staff leaving for other posts would reassure if they have blossomed in developing the new service and want to spread the word, and will warn if they are leaving frustrated with a sense of failure.

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Community Mental Health Centres: Policy and Practice

By Nigel Goldie, David Pilgrim and Anne Rogers. *Good Practices in Mental Health*, 380–384 Harrow Road, London W9 2HU. Pp 28. £4.00.

Community Mental Health Centres (CMHCs) have popped up on the mental health map with outstanding rapidity, with more than 120 in operation or in a planning stage since the first ones surfaced in the late 1970s. A passing fad, you may wonder? Or an indication of the substantial changes that have taken place in community mental health that have accompanied the move to close large institutions? This short review asks many relevant questions about CMHCs, and it will not surprise you to hear that it provides few answers.

Based mainly on evaluations that the authors carried out on two existing CMHCs, they quickly establish their own position by stating that they are “committed to the transformation of current services” and “... welcome the development of CMHCs ... as providers of (services) with better access, less stigma and psychological and social models of assistance to users”.

In attempting to deal with a number of rather complex issues, this report only provides stark headlines which could be productively used by any community mental health team working or planning to work in CMHCs. Doctors: should they be leaders? Do CMHCs recruit generic mental health workers or professionals with specific skills? Staff selection: does the team have any say? Full time or sessional contracts? All hot chestnuts that need peeling and tasting.

Some more time is spent, quite rightly in my view, on management issues. The particularly thorny problem of management of a multidisciplinary group of staff, which can undercut traditional professional line management, is discussed in some detail, as well as the philosophical necessity of involving consumers

of the service in a centre that aims to offer relevant sensitive psychiatric care. No help here on how you go about finding “community representatives” that don't have too many axes to grind. Or maybe they should?

Problems of equality of access to CMHCs have been highlighted by a number of authors in this country, and more appropriately, in the USA, where the CMHC movement started in 1963. A great deal of attention, misguided in my opinion, has been focused on the notion that CMHCs only deal with the “worried well”, a term which I personally despise. In the first place, because it supports the idea that any professional can determine levels of personal suffering, and judge that individuals with chronic psychotic conditions deserve more attention than those with equally handicapping neurotic symptoms. Secondly, because in my own experience, sector responsibilities in the NHS make it less likely that any particular client group will be ignored, especially if a final common pathway of care can be identified to all referrers. What must be addressed, however, is the impact on resources that these new developments will engender. There is no doubt that easier access to services increases the number of people that use them, not necessarily by reducing the number of chronic psychotic conditions, but by increasing substantially the number of often serious family and relationship difficulties (including incest and sexual abuse) and intractable neurotic symptoms, such as phobias, obsessional disorders and chronic anxiety states.

There is naivety running through this report which I found irritating at times. Clearly this must come from evaluators who have had little “on hand” experience, but a lot of ideological assumptions to colour their views. The suggestions that Social Services will make referrals to CMHCs because they are likely to be “ideologically compatible”, or that CMHCs should accept people under section 136 (have they not heard of place of safety?), or that self referrals, by defining the nature of their problems, will clash with the judgements made by staff, thus “... (reducing) the autonomy and control exercised by the consumer ...” seem to me to be quite daft.

The authors set a challenge to professionals working in CMHCs to change old psychiatric ‘habits’. They would like to see more consumer choice, an emphasis on non-biological interventions and priorities given to social resources over therapies of all types. Nothing wrong with all of this, you might say, but does a CMHC then also become a hybrid Citizen's Advice Bureau, non-specific Counselling Centre and Social Services Department all rolled into one? It was precisely because of this lack of definition, and grandiose all-encompassing goals, that some American CMHCs fell into disrepute, and the scenes of never ending local political disputes.

It is a shame that the report has failed to pinpoint a dangerous split which I see developing between hospital and extramural mental health facilities. I have purposefully avoided using the term 'community' because it is my belief that all these services are placed in the context of a community, however ill-defined this may be, and that it serves no purpose to introduce false wedges between two aspects of what should be a comprehensive and integrated service. The sooner we stop maligning all hospital or institutional practices, and idealising all extramural ones, the earlier we shall benefit from the fertile mix of creative ideas arising out of both settings – especially if staff have dual responsibilities, both in and out of hospitals. After all, users have the same experience!

I was pleased to notice attention being given to the layout of buildings used for CMHCs. Some may say that this is only a trivial matter, but having worked in unsuitable settings, shouting to get myself heard over the roar of juggernauts, or fighting with colleagues to find a desk where I can write up my notes, I can only concur with the authors' view that issues of design, architecture, accessibility, soundproofing, and I may add, privacy and safety for patients and staff, should be given high priority before people commit themselves to carrying out work there.

The verdict? Good as a debating tool. Poor in scope and depth. A very necessary area for evaluation and research, but perhaps it is too early to write the definitive treatise on policy and practice.

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Caring for Huntington's Chorea patients

Dr Peacock and Professor Harris (1989) recently reported on their study of the cost and location of care for persons suffering from Huntington's disease. The authors are a senior clinical medical officer and a medical geneticist respectively. The patients were ascertained through the North Western Regional Genetic Register based at Manchester.

Their chief findings were:

- (a) One quarter of cases were in residential care. Of these, about 70% were in hospital. Of the latter 39 patients, 24 were in some type of psychiatric ward.
- (b) Naturally, patients who were in hospital were older and more chronic than those at home
- (c) Neurologists handed over long-term care to psychiatrists.
- (d) About half presented with psychiatric symptoms (17% dementia; 35.5% "behaviour" problems).
- (e) Care at home (£114 p.w.) was cheaper than residential care (£175 p.w.).

- (f) Most of those cases in residential care were bereft of adequate care outside (single, divorced, excessive burden, etc.).

The authors called for planned, phased care through day centres to residential care, and they noted the distress caused to relatives and the increase in behavioural problems in patients associated with transfer to psychiatric facilities.

There is the usual introduction about the promises for "prevention and cure" from recent work in recombinant DNA technology. Apart from the huge ethical and social difficulties surrounding such research, it is important to note that Huntington couples still opt for having babies, a very human characteristic, not a few do not understand the advice given by geneticists, and, despite some early hopeful American reports of doubtful methodology, reactions to positive predictive testing can be severe (including suicide) (O'Shea, 1984; O'Shea & Falvey, 1988). It is also important to note that there is a small false-positive and false-negative reporting rate with these tests, and a sufficient number of willing close relatives from at least two generations are needed to do the test. Foetal testing is positive but its implications are not universally acceptable, although there are trends towards greater acceptance of termination. Genetic engineering, while exciting to the pure scientist and ethicist, is in its infancy. My own imagination extends to defining the gene and its mRNA exactly, and then its protein product(s). The latter may then be modified by chronic drug-taking or its influence reduced by a diet, much in the same way as with PKU.

Although the various national Huntington societies have the support of very dedicated founders, few countries have been able to get more than one or two specialised residencies for their afflicted relatives (O'Shea, 1989). Support groups in general receive scant support from professionals (O'Shea, 1989), and politicians have rarely become interested except for the usual reasons. Huntington's disease exists amid a myriad of other debilitating disorders, some of which are far commoner. The flood of Alzheimer cases in our wards has been met by a totally inadequate political response, and, interestingly, some of us have been blocked from discharging these patients into nursing homes because, we are informed, it is cheaper to maintain them in chronic wards.

No matter what our sums say about cheapness, figures never tell us about the cost to relatives of looking after the severely disabled. Apart from the socio-behavioural manifestations of Huntington's disease, which are often profound (O'Shea & Falvey, 1988), there is a significant psychopathology associated with just being in a Huntington family (O'Shea, 1984; O'Shea & Falvey, 1988).