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Comprehensive Psychiatric Community Services for the Severely Disabled

SIR: I was interested in Wing & Furlong's plans for a "haven community" to serve the future needs of West Haringey's chronically mentally ill (*Journal*, October 1986, **149**, 449–457), as their proposals have much in common with the developments which have taken place within Oxford's Department of Rehabilitation and Community Care. They rightly stress that disability in one aspect of life does not necessarily imply an equal disability in all areas; any one patient should be able to obtain a unique combination of residential, occupational, and recreational services (Gan & Pullen, 1984).

In 1980 a service was started at Littlemore Hospital to meet the needs of Oxfordshire's 'new long-stay', although patients are accepted on the basis of clinical criteria rather than length of previous admission. This has evolved into the Young Adult Unit, based on a 24-bedded ward, The Eric Burden Community (EBC), on the edge of the Littlemore site (Pullen, 1986). The same building also houses the Unit's out-patient department and is the administrative centre of a developing network of hostels and group homes specifically for the young adult chronically mentally ill. Day care for this group includes a centre, based in an Oxford church, run by the Oxford branch of MIND (Hope & Pullen, 1985).

Our experiences confirm the necessity of providing continuity of care for the severely 'socially disabled' by a single team. A sense of 'haven' can also be created by the knowledge that wherever one happens to be living at the time one still 'belongs' (once accepted, patients remain on the case register of the department indefinitely).

One anxiety I have after reading about the Friern plans concerns the capacity of the proposed 12-bedded mother house to re-admit patients during their inevitable relapses. We have retained the EBC as a hospital ward (albeit one run as a therapeutic community in which, for example, the residents are responsible for the provision of most meals) because we feel that it is at times of crisis that long-term patients most need the care of those who know them well. The psychiatric hospital bed is an essential component of community care.

The Friern Haven appears to be an exciting and imaginative response to the present needs of some of the hospital's existing long-stay patients and to the future needs of Haringey. Elsewhere, other patterns of service will be more appropriate, but in every case there will need to be an integrated network of varied services. I join Wing & Furlong, however, in arguing "that responsibility for the most severely disabled and disturbed group... should be given high priority rather than left as a residual group to be provided for only when all other services are in place".

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Delineating Social Phobia

SIR: Solyom *et al* (*Journal*, October 1986, **149**, 464–470) state that "the problem of overlap may also arise because both agoraphobia and social phobia may be based on fear of having a panic attack, i.e. both may suffer from panic disorder."

DSM–III and DSM–III–R (8/1/86 draft) attempt to distinguish social phobia from panic disorder and agoraphobia. Social phobics in DSM–III and DSM–III–R are defined by the occurrence of intense anxiety specifically in response to feeling scrutinised or evaluated by other people (or in anticipation of this). This differs from the panic attack associated with Panic Disorder or Agoraphobia. To meet the DSM–III–R definition of Panic Disorder, an individual has to experience intense anxiety episodes occurring at times when the patient is not the focus of others' attention.

Soylom *et al* appear to be questioning this diagnostic convention. The reasonable question to ask is: does the convention make sense? Specifically, is there a meaningful basis to distinguish between the anxiety experience of Social Phobia and the panic attacks associated with Panic Disorder or Agoraphobia with Panic Attacks?

Several lines of evidence suggest qualitative differences between the anxiety experience of social phobic and panic disorder or agoraphobic patients. Aimes *et al* (1983) noted differences in the symptom pattern.