Module:
Mental Health in the Community

Week 1
A history of 'madness': Deinstitutionalisation to community care

Topic in Action 1.3
Community psychiatry

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Lecture transcript

Slide 3

Let's say something about community psychiatry. So I'm going to give a very brief introduction. I will talk about the rise of community care, which as I said earlier, has been a UK policy since 1930. I'll say a little bit about the US 'Community Mental Health Centre' movement, the 1959 Mental Health Act from England and Wales, say something about community psychiatry and community mental health, and then explore community mental health services. Taking a lot of this from an important textbook by Graham Thornicroft and colleagues-- the Oxford Textbook of Community Mental Health, which was published in 2011.

Slide 4

So an early book by Szmukler and Thornicroft provided the definition for community psychiatry. They said 'community psychiatry comprises the principles and practices needed to provide mental health services for a local population by establishing population-based needs for treatment care, providing a service system linking a wide range of resources of adequate capacity operating in accessible locations,' and finally, 'delivering evidence-based treatments to people with mental disorders'. In parentheses, it's important to emphasise that services aren't in themselves treatments, or they don't necessarily themselves provide care. They're a platform for the offering of treatment and care.

Slide 5

Now, on to community mental health and the community mental health movements. This involves the idea of services improving local community mental health. In the US, the Community Mental Health Centers Act of 1963 supported a network of community mental health centres, which in practice focused on providing holistic psychodynamic therapy for people with relatively minor psychiatric disorders and the CHMCs that links with the state mental hospital system. In retrospect, the CMHC movement is seen as an abject failure both in its own terms and in providing for the wave of newly deinstitutionalized patients. In its own terms, it was described as 'trying to drink the ocean'.

Slide 6

In wealthy countries, community care is based on the infrastructure of a welfare state. That is to

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say, state benefits that support the live-in care of people outside hospitals. Of course, low-income countries where there is no such safety net, community care is dependent on families, the efforts of NGOs, and quite minimal outpatient services to supplement a very stretched hospital-based system.

Slide 7

Now I'm going to say a little bit about my own adventures in community psychiatry. I started off actually working in a day hospital, and day hospitals I think its fair to say are probably now a bit of a thing of the past, certainly in England. I've worked in primary care liaison, which has rather largely transformed itself into something called IAPT, which we'll talk about later. I've worked in community mental health teams, in assertive outreach, set up assertive intervention psychosis services, and crisis intervention stroke home treatment teams. I've also had a lot to do working with new long stay individuals, that's to say people accumulating in hospital in the era of deinstitutionalisation, and in rehabilitation psychiatry, and involved in working with and setting up NGO or third-sector organisations.

Slide 8

Primary care liaison is important. In the UK, most treatment for mental disorders is in primary care, which is universal and filters traditionary access to secondary care, and there are various models for working with primary care. The first is shifted outpatients. That's to say, holding in clinics not in a hospital or an traditional outpatient clinic, but within a GP practice. The second is going to the practices to provide education or consultation, and then there are more or less elaborate systems of shared care where there's good communication of the care of particular individuals between primary and secondary care. And finally, a system where there's relatively easy access to specialist care and rapid referral back from specialist care. More recently, we've had IAPT-- that's to say Increasing Access to Psychological Therapies-- which offers the option of direct access by the GP to more or less low-level psychological therapies. The current reality of specialist mental health services is an enormous drive to return people as soon as possible from secondary care to primary care, even if that does in fact turn out to be a false economy.

Slide 9

So a little diversion onto IAPT-- as I said, Increasing Access to Psychological Therapy-- it's an ambitious programme that provides access to psychological treatments, which may or may not work. We're still waiting for definitive data on evaluation, but its enthusiasts are very enthusiastic.

Slide 10

The next thing is the community mental health team, and these are multidisciplinary teams, which are based in a locally accessible team base. They have a catchment area-- a defined catchment area-- either geographically or in relation to a set of GP practices, and have a clear relationship to an inpatient service. The teams offer continuity of care under the Care Programme Approach, which is a peculiarly British phenomenon and will link closely to local GPs. There's quite good evidence of really good outcomes from a generic community mental health team, particularly in the PRiSM study by Graham Thornicroft and colleagues, published in 1998 (I've got a bit of a declaration of interest there because I was one of the participants).

Slide 11

The generic CMHT actually works extremely well; but it has at times been supplemented by more specialist teams. The first of these was the Assertive Outreach team. Assertive outreach has an enormous international literature with, for example, Cochrane Collaboration Reviews. It was for a period government policy in England to develop assertive outreach services under the Policy Implementation guide. It's much liked by patients and staff and has very excellent principles. Unfortunately, the data from Europe and certainly from England is that it's not been shown to being

superior to a generic community mental health team, even though it's actually more resource intensive. So we have seen in recent years an increasing pressure on mental health service budgets and a closure of assertive outreach teams in some places. It's a very clinically nice model and like I said, patients like it.

Slide 12

Early intervention in psychosis services were also mandated in the Policy Implementation guide and again, are clinically very attractive, intuitively a very sensible idea, and very, very fashionable. The idea is that for people, particularly young people, who are early in their psychiatric career in developing psychotic illnesses, a specialist team works with them intensively to diminish the effect of the psychosis on their developmental trajectory, and therefore in principle improving their subsequent illness and life career. The evidence base in fact suggests that any early gains are lost once the patient reverts to treatment as usual. So although it's very fashionable, it's not without, I have to say, significant criticism, but further research has been actively done in this.

Slide 15

Another team is the crisis resolution home treatment team; again, mandatory in England, and in fact, they are still very much part of the landscape. They provide ga'tekeeping' for admission, support to people as an alternative to admission, and in particular, support to facilitate early discharge. There's some evidence for a significant reduction in admissions when you put a CRT in place, although when it's instituted, there's much less reduction in overall 'bed days' then you might hope for.

Slide 16

Now, one might ask, and the early proponents of community care hoped, that with the elaboration of good quality community services, including services for high support care, the need for admission would be diminished and the need for long stay care would be abolished. This has not proved to be the case. So, admission rates are, broadly speaking, pretty similar, and new long stay individuals have continued to accumulate in acute mental health services, therefore psychiatric rehabilitation services and their sister services within forensic services-- that's to say for all offender patients-- very much remain a part of the landscape.

Slide 17

Now we've currently moved to a situation in England of functionalised mental health services. This is a crude term for a compelling idea. And the idea is that, just as in all other branches of medicine, you develop specialisms, so that there is first a split between community services and inpatient services. So in the original CMHT, I was a consultant working within a CMHT, but also looking after the CMHT catchment area patients in the acute wards which is an extremely cost-effective and effective model. But then inpatient split now is in place, so community services are run by one group of staff, inpatient services are run by another. And that's got a complex, and as yet, not really written in history. We also get multiple specialists, teams, and services. So in addition to the generic community mental health team and assertive outreach team, perhaps, early onset team, we get eating disorder teams, adult ADHD teams, community learning disability teams, community forensic teams, community assessment treatment teams, and recovery long-term teams-- a plethora of specialist teams covering a much broader catchment area.

Slide 18

And to remind you about the 'third sector' area, which is very much involved in social inclusion and peer-led services. So that for example, Rethink Mental Illness has been instrumental in developing carer support projects and there's a lot of work now in improving the social inclusion of people with mental disorders.

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Slide 19

The role of 'third sector' is entirely specific to any particular health and social care system, and currently the policy in England supports the use of personalised budgets, which in theory allow people to purchase the care they need from wherever they want it. And where this isn't in place, a lot of care is by social-care providers working to local contracts.

Slide 20

One aspect that's quite neglected is the importance of creative, social, and leisure activities. We know creativity is important in the narratives of people who have gone on recovery journeys; seen, for example, in Davidson and Strauss's seminal paper, 'Sense of self in recovery from psychosis,' published in 1992. And we must be aware that there are barriers for individuals of stigma and social exclusion. These services trying to address those barriers are under-resourced and are also diminishing, and they're not really particularly valued by health or social care funders in times of shortage of funds.

Slide 21

Now, all the implications for the story of community psychiatry that I've been describing. Firstly, there's good evidence that services developed during the deinstitutionalisation era worked quite well. The functional split in contemporary services have some strengths, but also weaknesses, and we lack the data to be confident about what should work and for whom in the very new landscapes of health and social care that are emerging. Not everything works well everywhere, but there are some general principles. I'll end by saying that yet again, services themselves aren't treatments. The available technologies do not obviously support a return to the community mental health movement of 50 years ago. I'm very pleased to have participated in community psychiatry over the past decades. I have to say, it most certainly can be fun.

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