Module:
Mental health in the community

Week 4
Psychosocial approaches to care in the community

Topic 3
Community care in practice – Part 1 of 2

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Lecture transcript

Slide 3
In this talk, I'm going to discuss social approaches, what we might say is community care in practice. I'm going to start with a declaration of interest, talk about mental health care moving beyond just medication and psychological treatment, discuss what we mean by 'community care,' introduce the concept of need in community psychiatry, go back to talking about quality of life and its domains, say a little bit about recovery and rehabilitation, and provide a vision for a competent service system.

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So a declaration of interest-- I was appointed in 1987 as a consultant commuity psychiatrist, and that role was as medical lead of the Camberwell sector closure programme at Cane Hill Hospital and also a lead for the local psychiatric day hospital. I was co-lead for a research study looking at the outcomes of Cane Hill closure and developed with colleagues reprovision, residential care, day care, and employment services, most of which was in the third sector, non-government organisations. I've acted as a board member for third sector organisations.

I've undertaken research into inpatient bed requirements and the needs of long-staying patients in the post-asylum era and developed and worked in the local community mental health teams. I've participated in trials of assertive outreach and early intervention in psychosis services versus standard mental health team care, and researched and published in the areas of needs, quality of life, rehabilitation, and recovery. I've had a long-term involvement in the field of rehabilitation psychiatry as a practitioner, author, and member of the rehabilitation and social psychiatry faculty at the Royal College of Psychiatrists. Finally, I've been a medical manager of local adult mental health services for almost 20 years, up to 2010.

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So in terms of experience, what have I learned? I've learned that mental disorders are complex, multifaceted, and often chronic or recurrent. I've learned that mental disorders cause people and those around them a lot of suffering and impairment in functioning. I've learned that society doesn't much like the fact that many people live with mental disorder. I've learned that good quality treatment helps and that people can live well, despite continuing mental disorder, because of - or even despite - the involvement of mental health services. Finally, I've had to conclude reluctantly that there's no 'magic bullet' against the impact of mental disorder.

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Much of this course is devoted to describing the psychological and biological basis for mental illness, mental disorder, mental health - whatever construct you want to use - and treatments based on psychological and biomedical theory. However, we've already seen there are important

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social factors determining the occurrence and presentation of mental illness, mental disorder, mental health and vital social and organisation aspects to alleviating mental ill health and promoting mental health.

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If you look at the literature, Medline tells us there's a lot of literature, for example, devoted to community mental health, 44,000 papers; slightly more papers devoted to the topic of community psychiatry as the key word, nearly 46,000; rather less on community mental health services, some 23,000; and no less than 165,000 papers in Medline on community care. Now, most of this is irrelevant to this talk, and it's important to be clear: this number of citations is dwarfed by the citations on particular disorders, such as schizophrenia, which run into the millions.

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I've accumulated over the years quite a few books on community mental health care, and indeed I've got quite old, early books on the topic. These include books on common mental disorders by Huxley & Goldberg, books on community psychiatry, books on community mental health teams and specialist assertive outreach teams, and large scale textbooks on community care and community mental health, of which the most recent is The Oxford Textbook of Community Mental Health, edited by Graham Thornicroft and his colleagues.

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Interested in community psychiatry, so what is it? Peter Tyrer tells us community psychiatry is 'a portmanteau couplet that can mean many different things. To some it merely seems to imply "extramural psychiatry"... to others, it represents a specific form of care that involves particular skills and procedures... to others still, it appears to be a form of policy to close outdated hospitals.

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Community care has never been without its critics. In 1984, the National Schizophrenia Fellowship published an open letter in the Bulletin of Royal College of Psychiatrists, that winning title, 'Community care: The sham behind the slogan.' To quote from it, they say, 'But the drive at all costs to move mental patients out of hospital and into the community is, at present, leading to disastrous human and social problems. All our first-hand experience shows that there is widespread failure to provide adequate aftercare or to grant aid those for whom this care is available. We are also convinced that the number of those suffering from severe mental illness who are very seriously disabled has been underestimated. The needs of those requiring ongoing support of various kinds, including suitable support for the families, must be far more accurately assessed if adequate provision is to be made for them. Some may need lifelong care of a kind which at present only the psychiatric hospital provides.'

So here, the National Schizophrenia Fellowship, which is now Rethink, were articulating serious concerns about the community care policy. 1984 is significant because it was at the time that, finally, plans were being made actually to close the large mental hospitals which had previously been just getting smaller over time. There's also a famed criticism of community care, that it is riddled with a sort of political correctness that is nonsensical and doesn't really have much basis in the actual gritty, messy realities of the experiences that people and their carers are going through; and that's true for all community care groups.

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In 1984, there was concern that the closures of mental hospitals, when it finally happened, would result in significant harms for patients. That closure process was quite carefully studied in England, in particular by Julian Leff and colleagues in the team for the assessment of psychiatric services, or TAPS. Leff published and edited the book Care in the community: illusion or reality in 1997.

So that book-- its contents are of quite considerable interest to the historian of community care. So it begins with a chapter on the evolution of policy and shows a really quite tortuous and ideological route that policy went through. We also get lessons from the American experience

in the failure of the community mental health movement in America. We get good evidence that residential care for people with mental illness who move out of mental hospitals works well. We also find that community care proved to be no cheaper than care in the mental hospital.

An important finding, which is often overlooked, is that as the large mental hospitals closed in the early 1990s, there was a very significant breakdown of the acute hospital service because of the importance of the residual long stay provision that was in existence in the mental hospital for an efficient and effective acute mental health service. There was a useful chapter on the training needs of staff, which remains a constant issue in reprovision services, and an interesting chapter on the attitudes of the media and public to the closure programme showing that integration, with effort, could work. There's an important series of chapters on the pitfalls of closure-- so the downside of reprovision on the pitfalls of closure.

So a chapter on the downside of reprovision and, in particular, the need to 'future-proof' services. The issue of patients who are too difficult to manage in the community who, as I showed some time previously, do mostly improve over time. But people with severe disabilities have not gone away because the mental hospitals closed. There's a chapter on how to provide a comprehensive community psychiatric service, which became a reality in England for a while in the late 2000s. Then, a concluding chapter on the future of community care, which points out that there has always been a false antithesis between hospital and community. Hospital is part of the community. Hospital serves the community.

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Thornicroft and colleagues have described community mental health care as comprising 'the principles and practices needed to promote mental health for a local population,' and that composes of four elements. Firstly, addressing population-based needs in ways that are accessible and acceptable; secondly-- this is more an attitude of mind, I think, than a service-- building on the goals and strengths of the people who are experiencing mental illnesses; next, promoting a wide network of support, services, and resources, adequate capacity; and finally, emphasising services that are both evidence-based and recovery-oriented.

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One of the things that I've always been interested in is the concept of need. In 1994, which is a long time ago, I identified two contrasting approaches towards understanding need, and I think these remain broadly applicable, although some of the language has changed. When I was writing in 1994, which was at the time of the peak of the hospital closure movement, a fashionable movement called 'normalisation', which underpinned the 1980s and 90s provision programme, was flourishing. That's now been largely replaced by the rhetoric of 'recovery'.

So there is a positive, user-focused, strength-based, recovery-oriented approach which emphasises empowerment and engagement, though perhaps it's a bit short on detailed content as to what helps other than psychological treatment for problems of living. But there's also always been a rather less fashionable approach to need that focuses on the problems and difficulties of people with mental illness who experience them and a pragmatic and multifaceted response to these problems, which includes an eclectic range of treatments, as well as care and support and understanding.

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So the 1994 paper identified two contrasting models of mental disorder and community care. One, an implicit model based on the concept of ordinary human needs; at that time based on normalisation theory (but now on recovery principles); focusing on strengths; largely provided by non-professional staff; with an aim to provide an 'ordinary life' within a pseudo-family and now floating support and support workers. This is contrasted with the psychiatric model-- again, not a very fashionable term-- which focuses on needs for specific treatment and care by a psychosocial model of mental illness; a focus on problems and weaknesses; a reliance on professional interventions, of course with involvement from non-professional carers; which aims to minimise

symptoms and maximise social functioning.

The implicit model focuses on the individual user. The psychiatric model takes an epidemiological perspective. The implicit model shows a commitment to user involvement, empowerment. The psychiatric model attempts to gain adherence of the patient to treatment. In the implicit model, the problems are located largely within society. In the psychiatric model, the problems are located largely within the individual.

As we've seen, that dichotomy, society versus the individual, is a false antithesis. In the implicit model, the approach is holistic, attractive, fashionable - I think basically optimistic - whilst the psychiatric model, the emphasis is perhaps on biological treatments. It's perhaps seen as unattractive and unfashionable and has been characterised as basically pessimistic.

The implicit model may lead to staff burnout. The psychiatric model may result in staff cynicism. The implicit model is at risk of people 'rotting with their rights on'. The psychiatric model, however, in contrast, may be coercive and confining. Perhaps there's a middle way.

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I want to say a little bit about need and, in particular, a measure of need called the Camberwell Assessment of Need, which is in a number of forms. But the most popular one is the CANSAS, the Camberwell Assessment of Need Short Appraisal Scale. It looks at 22 domains of need and provides ratings of whether there is no problem in that domain, there is a met need, and an unmet need, and finally whether one simply doesn't know about the existence of need in that particular domain.

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So what are those domains? In terms of adult mental health, they are basic, practical things like: accommodation, food, ability to look after the home, self-care, issues such as daytime activities and physical health, symptoms, like psychotic symptoms, psychological distress, issues such as safety to self and safety to others, the provision of information on the condition and its treatment, further sets of problems with, for example, drugs and alcohol, issues related to social life, company, intimate relationships, sexual expression, whether the person requires help with childcare, whether there are educational needs, whether there's access to telephone and mobile phone, whether the person needs help in terms of transport, and finally, matters related to money and benefits. So those areas are all areas that are potentially impacted upon by mental disorder and all potential areas for intervention by services.

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Another way of looking at need comes from the underlying philosophy behind a very influential service model called assertive community treatment. In the paper describing a controlled trial of assertive community treatment, Stein and Test described key requirements for community tenure of people at risk of hospital admission, and these were material resources-- for example, food, shelter, clothing, and medical care. This is an American study, so from a US perspective, medical care is not necessarily universally accessible.

But also, people need coping skills, practical things like budgeting, cooking, using public transport. People need motivation-- so systems to help people cope with the stresses they're experiencing. They need support and education of the people around them, the community members, to help the community members interact appropriately with the patient. Particularly important for Stein and Test for vulnerable individuals was an assertive support system that would preclude the tendency of people to drop out of care.

Finally, and this is a particular construct of interest to the authors, they were keen to stress that people, to survive in the community, needed freedom from dependent relationships and break a so-called cycle of dependency. I'm not sure that that would be seen as being particularly relevant nowadays. Implicit, of course-- in order to live out of hospital a good life, if you've got a severe

mental illness, you do need effective treatment of symptoms and distress.

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Yet another approach which provides an agenda for action for services is in a quality of life assessment scale, called a Manchester Short Assessment of Quality of Life (MANSA). This scale asks people how satisfied they are both with life as a whole and then in particular domains. So how satisfied are they with their job or training, opportunities for sheltered employment? How satisfied are they with their financial situation, with their friendships, leisure activities, accommodation? How satisfied are they with their personal safety? Remember, victimisation and vulnerability are common factors for people living with severe mental illness. How satisfied are they with their relationships, both the people with whom they live or living alone, with their sexual relationships, with their family relationships? And finally, how satisfied are they with both their physical and mental health? So again, a set of dimensions which form an agenda for action for services, which goes beyond CBT for psychosis, for example, or a typical antipsychotic for persecutory delusions.

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So the Camberwell Assessment of Need, the MANSA, and the ACT model all point to things that services need to be doing or facilitating if people are to achieve good outcomes. So these go beyond alleviating symptoms and include provision of functional skills, somewhere to live, an appropriate set of relationships, activity and occupation, and perhaps also meaning.

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