
Michael Coffey
Public Health And Policy Studies, College of Human and Health Sciences, Swansea University, Wales, SA2 8PP

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Community Mental Health in the UK: Restructuring for the 21st Century

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Michael Coffey
Lecturer in Community Mental Health Nursing
Centre for Mental Health Studies
School of Health Science
Swansea University

Ben Hannigan
Senior Lecturer in Mental Health Nursing
School of Nursing and Midwifery Studies
Cardiff University
Abstract

Mental health service delivery in the UK has been subject to renewed policy scrutiny over the past decade. Mirroring moves in other countries, the focus of care has shifted from large institutions to community based services. There have been many benefits and some problems with this shift, not least in regard to public perceptions of the dangerousness of individuals with mental health problems. Concerns about discrimination and the social exclusion of the mentally ill are receiving attention by both central government and the devolved assemblies. The rise of the service user advocacy movement is evidenced by the increasing attention given to service user views in policy, research, education, service development and evaluation. Despite the clear rhetoric of involvement these changes have occurred in the face of calls and subsequent government moves to increase levels of compulsion and treatment of the mentally ill who are deemed dangerous. Mental health service development in the UK is aiming to restructure and ‘modernise’ for the 21st Century, and proclaims itself to be doing so with recourse to the development of evidence-based interventions. However we also acknowledge a 19th Century zeal with which larger and larger forensic units are being built in what might be regarded as the effective re-institutionalisation of the mentally ill.
Introduction

The changes currently taking place in community mental health care in the UK are as significant as any which have taken place since the beginnings of community care in the immediate post-world war 2 years. Since 1997 UK community mental health care has been subjected to a ‘modernising’ agenda which is challenging professional and organisational roles and responsibilities, is introducing new occupational groups into the workforce, is bringing forward controversial new legal frameworks, and is much more tightly prescribing the work undertaken by mental health professionals. In order to better understand these processes, we aim in this paper to:

- review the origins and development of community mental health care in the UK;
- analyse the benefits and problems of community care;
- and discuss the contemporary ‘modernisation’ of services.

In the UK community mental health care, as elsewhere in the industrialised world, emerged in the years following the end of the second world war. Goodwin summarises the variety of factors driving forward community care: the synthesis of new medications; the emergence of more enlightened professional attitudes; the need to reduce the cost of expensive hospital services; increased lobbying from organised groups of service users (for example, the UK’s largest and most influential mental health campaigning group, MIND, was founded in
the influence of anti-institutional critiques, from commentators such as Erving Goffman; and the influence of anti-psychiatric ideas, which raised questions about biomedically-dominated, hospital-centred services (Goodwin, 1997).

Community mental health care developed in a very piecemeal way in the UK. For example, a handful of hospitals pioneered what became known as an ‘open door’ policy in the early 1950s. Nowadays, community mental health nurses are the largest professional group charged with the specific task of providing specialist services to people with mental health problems living in their own homes. The UK’s first community mental health nurses appeared at two ‘open door’ hospitals in the middle of the 1950s: Warlingham Park Hospital in Surrey and Moorhaven Hospital in Devon ((Nolan, 2003). In terms of policy landmarks, *Better services for the mentally ill* in 1975 was the first UK document to explicitly look towards the creation of the multidisciplinary, sectorised, community mental health team (CMHT) as the best means of delivering comprehensive services to localities (Department of Health and Social Security, 1975). CMHTs, staffed by a variety of occupational groups employed by both health and social care agencies, subsequently became central to the provision of care throughout the 1980s and 1990s.

Publicly funded primary health care, provided by general medical practitioners, nurses and others, is at the centre of the UK’s National Health Service (NHS).
Community mental health services are jointly provided by the NHS and by local councils. Different professionals, with different educational backgrounds, cultures and ‘languages’, are required to collaborate together. In order that care and treatment be ‘seamless’, or ‘joined up’, it is critical that the family-oriented system of primary care effectively integrates with secondary, specialist, mental health services. Potentially, there are significant ‘gaps’ for people with mental health problems to fall through: gaps between primary care and secondary mental health care, gaps between hospital and community mental health services and gaps between different professional groups.

**Benefits and Problems**

Community mental health care has increasingly come under the spotlight in recent years. Many service users and professionals have made the point that community care is significantly preferable to institutional care, and has helped deliver an improved quality of life for users. Community care has also increased the availability of mental health services to the general population, and is, arguably, less bio-medically dominated than hospital care. The system of UK community mental health care has, however, been criticised for its lack of professional and organisational role clarity. Policy frameworks, too, have sometimes been inconsistent and contradictory. For example, guidance on the coordination of health care and social care was contradictory throughout the 1990s (Hannigan, 1999). Professionals and service users have repeatedly claimed that community care in the UK has been under-resourced, a finding
borne out by the Audit Commission, which in 1994 found that two-thirds of all resources for mental health care were tied up in hospital services (Audit Commission, 1994). Most damningly, the current New Labour government has controversially declared that community care ‘has failed’ (Department of Health, 1998).

Public Perceptions

It has been suggested that the cost of community care in the UK has been profound public indifference to the plight of the mentally ill (Morrall 1999). Large scale surveys in the UK reveal that the general public are embarrassed by the mentally ill, are frightened of the mentally ill because they feel they are unpredictable and prone to violence and equate mental illness with other stigmatised identities such as paedophilia (Huxley 1993, Read and Baker 1996, Repper et al, 1997). Such attitudes appear to be entrenched and resistant to change. This level of fear and ignorance leads to discrimination and social exclusion.

One response to this has been the argument in the UK that we should move our discussion of stigma toward a discussion of discrimination as stigma locates the problem with the person with the condition whilst discrimination shifts the focus onto those who perpetuate the discrimination (Sayce, 1998). Studies in the UK indicate the social networks of the mentally ill typically amount to just 7 people and this will for the most part consist of professionals and other service users
Only a minority of people with serious mental illness in the UK actually achieve full time paid employment and the consequence of this is further social and economic exclusion, limiting opportunities for developing and sustaining relationships and developing and maintaining social skills.

**Service User Movement**

The service user movement can be seen as a direct response to professional dominance in post-modern society where professional power is weakening and assertive self-advocacy prevails. The mental health professions have to a limited extent recognised the potential value of service user views in determining treatment effectiveness and in highlighting what works and why and also why some treatments and service provision fail (Simpson and House, 2002). The UK service user movement however has also become more adept at political lobbying and direct action. We see in Britain for instance a greater willingness to engage in peaceful demonstration, to respond to negative stereotypes in the media, to reward positive reporting about mental health issues in the form of annual awards for the media and to provide evidence in the form of research and expert opinion to parliamentary committees.

Many service user organisations now exist and see the value in forming alliances to enable them to have a greater voice in mental health policy and legislation. One consequence of this move is that service users now expect to be consulted in any new service development and this is often explicitly indicated in central
mental health policy initiatives. Another consequence is that service users are now initiating, conducting and disseminating their own research which addresses their own research agendas.

**The Modernisation Agenda**

‘Modernisation’ is a term which is being increasingly, and rather loosely, applied to changes being driven by UK government across all of the public services, including in the spheres of health, social care and education. In the mental health context, ‘evidence’ to underpin effective interventions is being seen as increasingly important. Evidence is, for example, often incorporated into policy guidance such as England’s *National Service Framework for Mental Health* (Department of Health, 1999). This document is driving forward all mental health services in England, and has standards for the development of services in a number of areas: mental health promotion, discrimination and social exclusion; primary care and access to services; services for people with severe mental illness; services for carers; and the reduction of suicide.

‘Modernisation’ has also brought forward new mechanisms for the scrutiny of health care provision. For example, an independent body, now called the Healthcare Commission, has the specific responsibility to scrutinise health care provision, and to report on standards of care and the degree to which policy guidelines and best practice are being followed. ‘Modernisation’ is also directed towards changes in the composition of the UK’s mental health workforce, and to
the boundaries between occupational groups. Recent policy tends to see the divisions between occupational groups and organisations as being a hindrance to effective care. For example, *A health service of all the talents* (Department of Health, 2000) criticised the rigid regulatory and professional frameworks which prevented mental health nurses and mental health social workers from working effectively together.

The modernising agenda is now beginning to change role and responsibilities. For example, mental health nurses are beginning to take on more of a direct role in the prescription of medication, a role previously fulfilled by medical practitioners only. The Draft Mental Health Bill, a highly controversial piece of proposed legislation for England and Wales which plans, amongst other things, the introduction of compulsory treatment in the community, also promises new roles for nurses and others in making applications for the use of compulsory powers (Department of Health, 2004). In addition, modernisation is seeing the appearance of new occupational groups in the mental health workplace. One example is the emergence of graduate primary care mental health workers; there are planned to be some 1000 of these in England, working with primary care staff in the delivery of evidence-based interventions to people experiencing commoner mental health problems such as depression and anxiety.

We perceive, here, an interesting contrast between centrally produced policy aimed at improving and developing service provision and proposed mental health
legislation. Policy does not have the same level of power as legislation. Policy suggests improvements which can be enforced only by recourse to scrutiny and clinical audit to ensure that the service delivery is moving in the desired direction (for example in offering psychological interventions that are known to help in conditions such as schizophrenia). Legislation on the other hand has the full power of the law behind it. It can be enforced with greater authority. The advantage for the consumer, however, is that it can be successfully challenged through the judicial process although this requires much time and expense. It is interesting however to note that policy in the UK is suggesting greater emphasis on evidence based practice and participation and involvement in services while legislation – for example, as proposed in September 2004’s Draft Mental Health Bill – is attempting to create new groups of patients (for instance people with severe and dangerous personality disorder) for which there is currently a lack of an evidence base for treatment, and moving toward more compulsion and coercion (Manning 2002). These moves appear to us to be contradictory and are likely to lead to tensions in the delivery of community mental health care in the UK.

The Return of the Asylum?

In tandem with the much vaunted move towards community care and treatment of serious mental illness there has been a large scale hospital closing programme in the UK which has seen almost all old style psychiatric hospitals closed and often sold for building development. It has been argued however that
a quieter, more stealthy re-institutionalisation is progressing across many European countries and the UK is experiencing a similar move (Priebe and Turner 2003). In recent years the numbers of forensic medium and low secure beds has been increasing steadily – in some areas the numbers of such beds have increased by as much as 100% or more. The impact of these increased forensic services is not to be underestimated. For example, forensic services create a significant demand on health resources and require to be staffed by professionally qualified nurses, doctors, psychologists etc. To achieve this forensic services in the UK have traditionally offered improved salaries. The impact on surrounding services can be such that they struggle to attract and retain qualified staff. This has the effect of essentially jeopardising other community care developments. Perhaps it may even prevent the type of developments that are likely to reduce the need for secure service care. The number of compulsory admissions to hospital has similarly increased.

It appears also that psychiatry is increasing its reach to claim professional authority over ever more marginal groups of people who previously were outside the remit of professional services. This reach is further accentuated by the presence of assertive outreach teams. Additionally there is an increasing number of people supervised in supported housing – this may also be regarded as a form of extended re-institutionalisation.

Transcarceration is a concept which highlights how the mentally ill can be locked into a perpetual cycle of movement between mental institutions and prison and in
some cases community supervision and welfare control. Arigo (2001) refers to people in such situations as “prisoners of confinement”. Rather than the utopian ideal of collaborative and independent community living that community mental health care might aspire to the reality is that many people with mental illness have swapped one type of institution – the mental hospital – for another – the prison. It is estimated that between 70 and 90% of men in prisons in the UK have mental disorder (Office of National Statistics, 1998) and with the standard of care there unable to reach comparable terms with the health service many will suffer increased distress while in prison only to be released with insufficient follow-up, increasing their chances of re-arrest or re-hospitalisation. A further consequence is they are likely to be subject to formal community supervision once they are successful in getting a service

**Conclusion**

Community mental health care in the UK we would argue is marked by significant contradictions. These contradictions contribute to a tension between genuine professional altruism on the one hand and a steadily creeping form of social control of the mentally ill reminiscent of a bygone age. We recognise that mental health professionals have for a long time managed to practise in the community with an awareness of the need to find a balance between these co-existing pressures (Coffey and Jenkins 2002). We question however whether such a balance can now be struck given the shifts in power between professions and service users and whether it is now time for mental health services to resist
moves towards more coercive mental health services and move from the rhetoric of involvement and partnership to a more tangible practice of collaboration.

References


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