King's Fund College

Psychiatric Services in Transition
Paper No.1

DEVELOPING PSYCHIATRIC SERVICES IN THE WELFARE STATE

David Towell and Susan Kingsley

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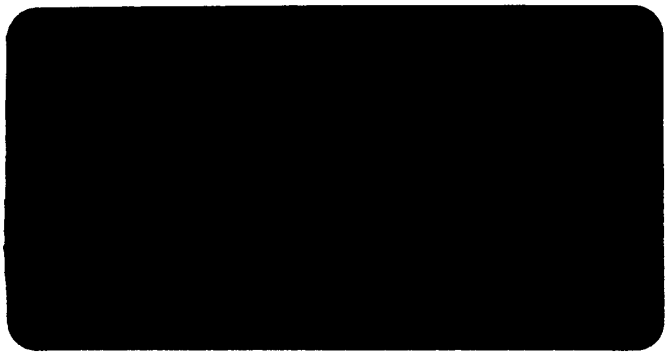

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INTRODUCTION

In Britain as in many other countries, the period since the Second World War has seen significant changes in psychiatric practice, the general trend of which has been the shift away from the Victorian inheritance of institutional provision towards a more community-based pattern of services (1). National policies promoting these changes have not, however, evolved in a single, coherent way. Nor have they been implemented uniformly. Reform in psychiatric services necessarily emerges from the complex interplay of bureaucratic, professional and community pressures, within the wider economic, social and political context (2). In devising strategies appropriate to developing psychiatric services in the next decade, it is important that lessons are learnt from earlier experience.

Two examples will suffice to introduce the major themes of this paper. The immediate post-war years saw Britain with a government committed to major social reconstruction. Its large majority reflected a popular mandate for radical change, including introduction of the Welfare State and with it, creation of the National Health Service. The mental hospitals were incorporated into the NHS and though most were slow to benefit, there was a scatter of institutions, typically with young doctors back from military service in leadership positions, where an early start was made on a programme of liberalisation. Wards were unlocked, custodial attitudes challenged, meaningful work provided for patients, links established with the developing community health services and rehabilitation actively pursued. These changes were carried further in some places through the development of the therapeutic community philosophy with its stress on democratisation and open communication. The doctors became administrative therapists and Britain led the European movement towards social psychiatry (3).

These innovations took time to generalise and twenty years on were still being introduced in some places. By the mid-60s however the movement for reform had changed in significant ways. The 1959 Mental Health Act gave legal expression to some liberalisation in the status of mental patients but the psychotic drugs were commonly given much of the credit for previous achievements. In the National Health Service there was expensive investment in District General Hospitals and psychiatric units were gradually incorporated into these centres of high technology medicine. Further

reform in psychiatry was seen as achievable through the integration of acute provision for mental and physical illness and it was hoped that such integration would also bring new public attitudes to psychiatric disabilities. The administrative therapists again became proper doctors and the therapeutic community approach declined in influence (4).

Now, another twenty years on, the situation of British psychiatry reflects this history. The emphasis on rehabilitation and the shift of acute services have led to a large reduction in the occupancy of mental hospitals - a reduction which would have been much more dramatic but for the inappropriate admission of confused elderly people turning many institutions into huge old people's homes. After a century or more of use, the physical condition of the original asylums is declining and they are increasingly costly to maintain. There are again significant pressures for change, focusing on closure of the institutions and the use of their resources to develop local alternatives.

Past failure to integrate different aspects of reform and to sustain the momentum for change means that in 1986 the implementation of good community-based mental health services still constitutes a major challenge. Moreover progress must be sought under conditions which are quite different from those of earlier reforms. The Thatcher government is committed to cutting public expenditure and its social policies offer limited support for liberal attitudes or concern with the disadvantaged. Much of the current impetus for change derives from the National Health Service bureaucracy and its preoccupation with more efficient use of resources tied-up in the mental hospitals. The vision of alternative provision is poorly defined however and there is considerable danger that rather than developing new services, the relocation of resources will merely reproduce old services in new places.

In our view the scale of this challenge has been underestimated. Real change in psychiatric provision will only be attained where it is possible to achieve new status for people with psychiatric disability, new roles for staff and new public attitudes all within a single movement for reform.

We cannot be sanguine about the prospects for success in the next few years. From what is already happening, often on a small scale, in different parts

of Britain (5), we are convinced however that even within the existing climate and framework for public services, there are significant opportunities to make progress. Focusing particularly on the pattern of mental health services required to support people with severe psychiatric disabilities, the remainder of this paper examines the practical strategies required to make good use of these opportunities.

ELEMENTS IN STRATEGIES FOR PURPOSEFUL CHANGE

Our analysis suggests that successful strategies for developing community-based psychiatric services have two fundamental requirements: change should be principled and change should be systemic.

Defining service principles

In arguing for principled change, our concern is to overcome the weaknesses in provision which can be expected if the combination of ill-defined national policies, professional conservatism and traditional pragmatism allows present assumptions to colonise the future. Instead it is vitally important that change should be guided by explicit principles which make clear how new services will enhance the life experiences of people with particular psychiatric disabilities. This is especially the case in considering the futures available to people requiring help on a long-term basis, who may be most at risk of being devalued and have certainly suffered from inadequate services in the past.

As the MIND manifesto Common Concern (6) argues more fully, explicit service principles provide the foundation both for service design and subsequent quality assurance. The definition of these principles needs to address two sets of questions: the first concerned with effectiveness and acceptability of services to individual users; the second concerned with accessibility of services and their relevance to needs of the local population. In the former category, we believe these principles should stress the importance of guaranteeing the rights, maintaining the dignity and avoiding stigmatisation of people with severe psychiatric disabilities. They should also underline the objective of providing services which support people in living their lives as far as possible in ordinary neighbourhoods and minimising their handicaps. In the latter category, important aims should include providing services which are comprehensive - through offering a range of support to everyone in the local population with severe

disabilities, and appropriate - through recognising variations in need among different users (7).

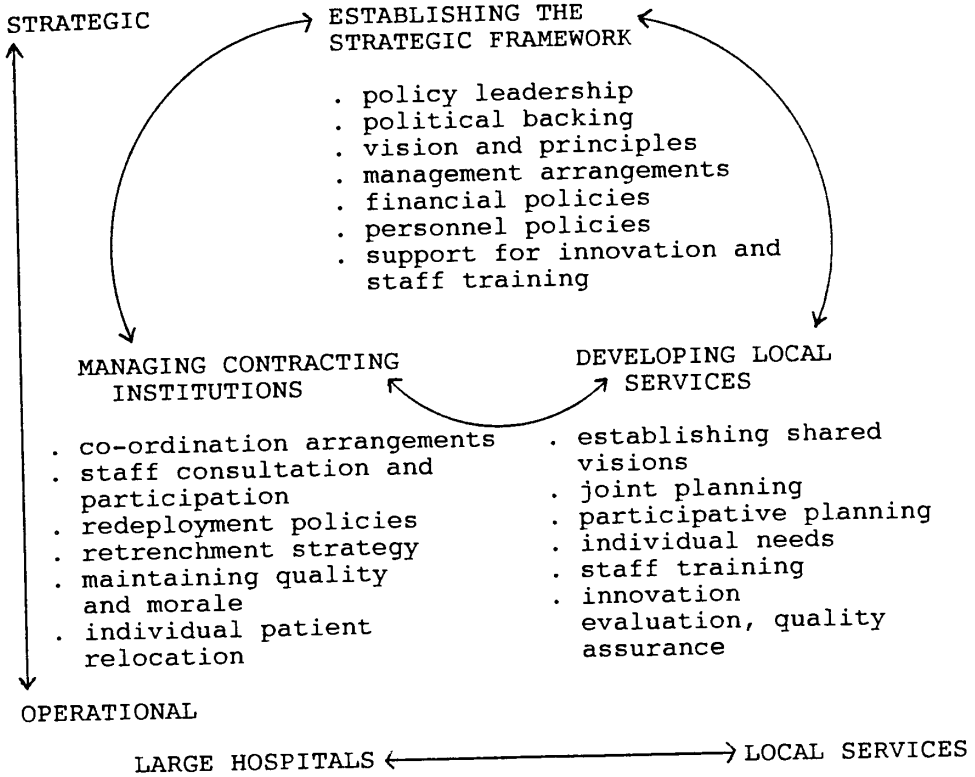
Addressing the total system of psychiatric provision

In arguing for systemic change, we aim to draw attention, first to the complex organisation of major public agencies and their interactions with the people and communities they serve; and second, to the variety of interest groups necessarily affected by the transition to new patterns of provision. The questions for reformers are: - How can a coalition in support of principled change be assembled? - What activities will be required to secure implementation of local services based on these principles? In examining the current organisation of relevant services in Britain, we have found it useful to distinguish three main components of systemic change:

* establishing the strategic framework;
* managing existing services, particularly the contracting mental hospitals;
* developing community-based services.

The diagram (opposite) illustrates the inter-dependence of these three components and lists key issues which need to be addressed in planning action. Our discussion of these issues seeks to identify lessons from British experience about how best to achieve purposeful change.

Key issues in a concerted strategy for change



Establishing the strategic framework

As we noted earlier, in contrast with other periods of reform, the main thrust behind current plans to relocate resources from the institutions stems from government and regional authorities and their quest for efficiency (8). As with other bureaucratic reforms, it is all too easy in this situation for mental hospital staff and patients to see themselves as victims of change rather than active participants in creating community-based psychiatric provision. While impetus from government and regions may be important in sustaining the momentum for change, new patterns of services cannot be achieved solely by `top down' planning and mechanistic control. Our own work with authorities in different parts of the country has shown that real change in services at the point where people with psychiatric disabilities and front-line staff meet requires strong local leadership and mobilisation of widespread participation in an organic process of development (9).

In the past psychiatric services and their users have not been given consistent priority in the contest with more `popular' causes and acute medical specialities. Given the magnitude and duration of the transition towards local services, progress is only likely to be maintained where efforts are made to build explicit political support for reform - represented, for example, in the interest and commitment of local and health authority members. As experience in the South East Thames region has demonstrated (10), this political support is particularly important in ensuring that the necessary resources are made available both to fund local services and meet the extra costs involved in transition.

There is no doubt that the substantial assets of money and skill tied up in the old institutions can be used more effectively in providing community-based alternatives. Given the poor quality of past provision however, experience, for example, in Exeter, Riverside and the North East Thames region, is suggesting that the total public sector cost of acceptable new services is likely to be greater than current expenditure - although drawn from a wider range of sources, including significant increases from the Social Security budget. During the transition period there is also a need for `bridging' finance to create the infrastructure for new services and meet the increasingly expensive unit costs of the contracting institutions before their total replacement (11).

Bringing these points together, it follows that the task of government and regional agencies is to establish a broad strategic framework designed to encourage local leadership and provide incentives for decentralised service development. Among the issues this framework will need to address are the rate of change towards community-based service, the financial policies required to offer incentives for local innovation while protecting standards in the contracting institutions, and the personnel and training policies necessary to foster staff commitment to change and ensure that appropriately skilled people are available to provide new services.

It is also important that this strategic framework is based on recognition that support to people with psychiatric disabilities should in future draw upon the contribution of several different public agencies, including the National Health Service, Local Authority Social Services, Housing, Education and Leisure Provision, Employment Services, and Social Security Offices, as well as from the voluntary sector. In the past these services have often been fragmented and there is no doubt that coordinating development across the multiplicity of agencies in each large hospital catchment area is a complex organisational challenge. Nevertheless significant change is unlikely to be successful unless the main agencies work together in planning and implementation. Our own research has shown that the creation of joint forums and wider networks which address the total system of psychiatric service provision are essential mechanisms for coping with this complexity (12).

Managing existing services

A central component of the current service system is of course the mental hospitals whose position and contribution require careful attention during the period of transition. There are two possible risks here. One is that existing institutional concerns will dominate local planning and seriously handicap the fresh thinking required to create community-based alternatives. The other is that the mental hospitals will be excluded from planning for the future and their staff left to struggle with the consequences of development elsewhere. Both these risks can be avoided however if relevant parts of the mental hospitals are represented in the local planning and coordination arrangements established to ensure the successful relocation and rehabilitation of present in-patients.

At the same time it is vital to recognise that management of the institutions during a lengthy period of contraction is itself a major task. The mental hospitals continue to need high quality management committed to involving staff in maintaining and where possible improving standards while relocation is proceeding.

A significant weakness in many British initiatives for change however has been the belated attention given to securing the support of existing staff, the majority of whom still work in the mental hospitals. It is to be expected that staff interests may mobilise to protect the status quo, particularly at a time of mass unemployment, unless from the outset personnel and training policies are negotiated which seek to maximise continuity of employment. Neither the maintenance of standards in the contracting hospitals nor appropriate preparation for patients moving to local services is likely unless efforts have been made to gain the support of existing staff for change (13). How this can be done is again well illustrated by experience in Exeter and Riverside (14).

Developing community-based services

New patterns of local services can only be created where traditional bureaucratic approaches to planning and implementation are replaced by an organic process of service development which promotes widespread participation in achieving change on the basis of explicit values and principles. We have already argued the importance of a principled approach to change. As people in North Lincolnshire have demonstrated (15), it is at local level that all the legitimate interests (people with psychiatric disabilities, the public, professional groups and representatives of the service - providing agencies) can be engaged in the debate necessary both to shape and gain commitment to a new vision of future provision. An essential task of local leadership is to ensure this debate starts from the experiences of people with psychiatric disabilities. On this basis, the new Social Psychiatry will be just as concerned with promoting their status and participation in the wider community through attention to income, homes and jobs as with specific interventions to reduce handicaps and encourage personal development.

In the past, particularly where planning has addressed the requirements of large populations, client needs have been aggregated into ill-defined categories which fail to reflect individual diversity. There has also

been a tendency to concentrate on people's disabilities rather than their abilities and to define needs in terms of the way services are currently provided rather than functionally, by the assistance actually required. The resulting services have often been agency rather than client-centred. The new approach to planning begins instead from a careful assessment of individual strengths, needs and wishes and seeks to deliver services which meet changing individual requirements (16).

It follows of course that local planning must involve people with psychiatric disabilities themselves, where necessary establishing independent sources of advice and representation to strengthen the consumers' voice in service development. For example, staff from Friern Hospital and Camden Social Services have shown that for patients currently living in the mental hospitals this may involve local project teams in intensive `getting to know you' exercises which make the person's own experiences central to identifying his or her future requirements (17). The development of outreach services from generic citizens advice bureaux and more specific one-to-one advocacy schemes are two possible ways of offering patients independent support, as well as assisting their access to services like Social Security (18). This concern to plan on the basis of client needs and wishes must also include people with psychiatric disabilities already living in the community, whether or not they are regular users of existing specialist services.

The development of genuinely community-based services cannot of course be achieved solely by welfare agencies and their professional employees: rather, the participative approach to planning must seek to foster partnership between community services and the community itself, both to gain public support for new patterns of local services and in the longer term to promote fuller integration of people with psychiatric disabilities in community life. Appreciating individual client needs, developing services which are responsive to local differences, for example in demography and ethnicity, and building this partnership are all more likely where planning for the populations of large administrative areas (health districts, boroughs, etc) starts by addressing the requirements of small localities, as the wider experiments in decentralising public services are demonstrating (19).

In the context of these several aspects of innovative planning, new patterns of services can be designed.

Essentially service design involves assessing how well alternative models of provision meet individual needs and are consistent with agreed principles. Typically a range of alternatives should be considered, drawn from promising experience elsewhere (20) and from local invention.

Again as the Exeter experience suggests, this creative process of local service development must go beyond planning to ensure that good intentions are realised in practice and high quality services are maintained and improved in the light of experience. First, this involves ensuring that planning and implementation are closely linked: staff who are to lead service delivery should be involved in planning these services; service design should be expressed in detailed operational policies and management arrangements; and all staff should be trained in the procedures required to put these policies into practice. Second, this requires that local services should build in explicit arrangements for quality assurance, again starting from the principles upon which services have been based. Finally, running through these local development processes and growing from the shared experience of new forms of service provision, there will need to be a major effort to clarify the values, concepts and personal skills required to underpin the practice of community-based psychiatry.

ENERGISING REFORM

To return to our starting point however, these prescriptions for incremental reform must be related to the wider context. Britain's continuing economic difficulties and the influential ideologies which devalue public services and seek to stretch further the informal caring contribution of families are a major handicap to the modest aspirations we have described. There are real dangers for vulnerable people that change in this climate will at best result in `transinstitutionalization' and at worst add to their poverty and neglect (21).

While recognising these dangers, our position is that people with severe psychiatric disabilities cannot wait for more desirable economic and political conditions. More positively, our analysis of the best of what is already being achieved in different parts of the country suggests that real opportunities are available even in current circumstances to make progress in enhancing the status and support for people with psychiatric disabilities in their own

communities.

We appreciate the scale of the challenge. The British Welfare State is the largest and most complex bureaucratic organisation in Europe. To use its strength as a vehicle for addressing individual need in a community context will require inspiration, commitment and ingenuity. We have summarised what we believe should be elements in the movement for reform. Most important among these is the need for local people to reclaim the leadership for change - mobilising active coalitions of relevant interests (including consumers, community representatives, progressive staff, managers and policy-makers) around a vision of future services which is rooted in the experience of people with psychiatric disabilities and reflects their entitlement to something better.

We believe such leadership can link further reform of psychiatric provision to the wider values already visible in early post-war achievements and still reflected in popular support for the Welfare State. In particular, the concepts of citizenship and community, suitably updated to reflect the social conditions now prevailing, have continuing appeal. For people with psychiatric disabilities, citizenship implies the right to participate in economic, social and cultural life and to receive the support necessary to make this possible - decent housing, income, work opportunities and professional help when required. The idea of community suggests that these rights can only be realised through a partnership between public services and ordinary people. The fuller participation of people with disabilities would constitute a community achievement: reflecting the community's commitment to accepting all its members and developing all its human resources.

In conclusion we should emphasise again that our expectations for the benefits of psychiatric reform are modest. While community mental health should benefit from collective action designed to secure wider social change, we remain doubtful about the converse proposition: that society itself can be changed through initiatives addressed primarily to people already suffering major disadvantage (22). In making some gains for and with this vulnerable group of people however, what we learn may well have rather wider relevance. We may see more clearly what would be involved in achieving citizenship and community for us all.

Notes and Further Reading

1. The Government White Paper Better Services for the Mentally Ill (London: HMSO, Cmnd. 6233, 1975) still provides the fullest official expression of this trend, although current national policies have been recently restated (DHSS 'Mental Illness: Policies For Prevention, Treatment, Rehabilitation and Care' in Government Response to the Social Services Committee, 1984-5 Session Cmnd. 9674, London, HMSO, 1985) and given added impetus through the financial mechanisms of the Care in the Community initiative (DHSS Health Service Development: Care in the Community and Joint Finance HC(83)6 LAC(83)5) and legislative changes which define the rights of individuals requiring treatment (See Gostin, L. A Practical Guide to Mental Health Law London: MIND, 1983)

2. For further historical analysis, see for example, Ramon, S. Psychiatry in Britain London: Croom Helm, 1985

3. Discussed further in Clark, D. H. Social Therapy in Psychiatry London: Churchill Livingstone, 1981

4. Comtemporary studies include: Hoenig, J. and Hamilton, M. W. The De-Segregation of the Mentally Ill London: Routledge and Kegan Paul, 1969; Baruch G. and Treacher A. Psychiatry Observed London: Routledge and Kegan Paul, 1978 and Towell, D. Understanding Psychiatric Nursing London: Royal College of Nursing, 1975

5. For a detailed review, see Towell D. and McAusland T. (eds.) 'Managing Psychiatric Services in Transition' Health and Social Service Journal 18 October 1984 Centre 8

6. Common Concern: MIND's Manifesto for a New Mental Health Service London: MIND, 1983

7. Good examples of well-designed local services based on explicit principles, in this case relating to ordinary housing for people with major long-term disabilities, can be found in the GPMH Housing Information Pack London: GPMH, 1985

8. An analysis of Regional Health Authority strategies is presented in Common Concern op. cit

9. See for further discussion Towell D. and Harries C. J. (eds.) Innovation in Patient Care London: Croom Helm, 1979

10. See Korman, N. and Glennerster, H. Closing a Hosital London: Bedford Square Press, 1985

11. These financial issues are discussed further in Towell, D. and McAusland, T. op cit. Detailed cost projections have been prepared by a number of health authorities, notably Riverside DHA

12. See, for example, Towell, D. `Developing Better Services for the Mentally Ill' in Barrett, S. and Fudge, C. (eds.) Policy and Action London: Methuen, 1981

13. Issues elaborated in Towell, D. and Davis, A. `Moving out from the Large Hospitals: Involving the people (staff and patients) concerned' in Care in the Community - Keeping It Local London: MIND, 1984

14. See the contributions by King, D. Colclough, P., Dexter, M. and Foley, B. in Towell, D. and McAusland, T. op cit

15. See for details, Collin, A. J. `Transistion in Mental Illness Services - Creativity in Planning' Hospital and Health Services Review September 1985, pp 235-237

16. A model for implementing this approach in relation to existing hospital in-patients has been developed in our work with Claybury Hospital. See McAusland, T., Towell, D. and Kingsley, S. Assessment, Resettlement and Rehabilitation: Designing the arrangements for moving people from psychiatric hospitals into local services Psychiatric Services in Transition Paper No. 2 London: King's Fund college, January 1986

17. Described by Braisby, D. `On the road to self-reliance' Social Work Today 6 August 1984 pp 16-17

18. See for example, Davis, A. and Hayton, C. Who Benefits? Birmingham University Department of Social Administration, 1984 and Inside Advice London: Tooting Bec Hospital Citizens Advice Bureau, 1985

19. One approach is described by King, D. and Court, M. 'A sense of scale: the shift to locality planning' Health and Social Service Journal 21 June 1984 p 734

20. One useful European compilation is Alternatives to Mental Hospitals London: MIND/IHF, 1980. An information service on innovative local projects is provided by Good Practices in Mental Health (380 Harrow Road, London W9 2HU).

21. See, for example, House of Commmons Second Report from the Social Services Committee, Session 1984-5: Community Care with Special Reference to Adult Mentally Ill and Mentally Handicapped People London: HMSO, 1985

22. For discussion of a more radical position, see Banton, R. et al The Politics of Mental Health London: MacMillan, 1985

NOTE This paper is the draft of a chapter to appear in Ramon, S. and Gianichedda, M. (eds) Psychiatry in Transition (1987, forthcoming)

Psychiatric Services in Transition

This paper is one of a series of publications which report the experience and conclusions of the King's Fund 'Psychiatric Services in Transition' workshops and associated field development activities. These have been designed to address the varied needs of health service and local authority personnel charged with designing and implementing the development of community-based psychiatric services. The programme has covered creating new services where none existed before; relocating resources from institutional services; and the policy framework required to support change. Further details are available from the King's Fund College.

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