Planning and Monitoring Community Mental Health Centres

Collected Papers Edited by Tom McAusland,
Long Term and Community Care Team

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Preface

This collection of papers was produced following the King's Fund conference Planning and Monitoring Community Mental Health Centres held in May 1984. It includes plenary papers from the morning of the conference together with a number of reports from the afternoon workshops. To these have been added contributions from staff and planners in other Community Mental Health Centre projects and a summary paper and booklist drawn up as a result of a series of meetings at the Centre over 1983 and 1984. The May conference dealt with management and information gathering and it is these themes rather than professional or clinical skills that are covered in the papers. Our aim has been to bring together, in condensed form, some of the ideas and experiences arising out of C.M.H.C. developments in Britain up to mid 1984. It is a field that is growing and changing almost daily. Many of the projects described here have already moved on to a new phase, and other initiatives which have sprung up in different parts of the country now contribute to the overall picture.

Even among the relatively small number of 'pioneers' represented here, no single view of Community Mental Health Centres emerges. All of them share a positive commitment to moving the 'centre of gravity' of psychiatric services to a more accessible local environment, but the scope and pace of the transformation is a matter for debate. Reading the papers collected here does highlight important differences in opinion about how to help people who suffer from mental illness and about how to bring about change in psychiatric services. In the wider world Community Mental Health Centres have already experienced powerful 'backlash' and for different reasons. There are fears that the lessons of the international CMHC experience will not be heeded and that Britain may be reinventing the wheel (and in many cases the flat type). There are doubts about whether the CMHC is a robust enough vehicle (bandwaggon) to undertake the hazardous journey from the back ward to the high street in the face of some strong professional opposition to the desegregation of psychiatry.

The CMHC pioneers have ambitious goals, but this is balanced by a concern for monitoring and a search for evidence of effectiveness that is far from common in mental health services. CMHCs are plagued by uncertainties about their place within psychiatry as a whole, worried about the gap between their stated objectives and the day to day realities of their work, puzzled by the complexities of inter-professional coordination - and rightly so. Occasionally, it might be useful to ask how far these problems are really unique to CMHCs. If we look with the same attention at the average Day Hospital or Admission Ward might we find similar ambiguities and difficulties? One thing that is particularly encouraging in the papers collected here is the willingness of CMHC innovators to acknowledge problems and to adapt, experiment and improve. Perhaps in the long term one of the most important roles CMHCs can play is as a test bed for psychiatry as a whole where conflicts and confusions that are universal can be honestly and openly confronted.

I would like to thank all of those who contributed to the production of this publication which I hope will be the first of many such stocktaking exercises.

Tom McAusland
Project Officer (Mental Health)

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COMMUNITY MENTAL HEALTH CENTRES -- TWO MODELS

Dr. Donald Dick
West Dorset Health Authority

We have come late in Britain to CMHCs. Let us hope that we can develop from the experience of others and build upon what we already have in this country's psychiatric services.

The attempts to produce local centres for specialist psychiatric services are the result of many years unfulfilled policy dating back to the 60s, indeed to the 50s; many years of frustration in which I suspect that almost everyone at any time over the past decade or two could have invented a better system than we have in order to do our ordinary work. But it is quite clear that good ideas generated by pioneers take time to roll within the NHS. It was clearly the 1960s that saw the blossoming of projects like the earliest experiments in CPNs, the spread of day hospitals, industrial therapy, sheltered lodgings and the schemes for managing people other than in hospital. Whereas those were pioneering ideas 20 years ago, they are now standard practice. There are other schemes which have fallen by the way because they were not practical or because people could not in fact effect them. The mental health centre is another rolling concept that will develop in the beginning through pioneers and then later become a standard way of delivering services.

However, we need good working models. We might all have in our minds the intention to shift the focus of care out of large institutions, out of isolated hospitals, but have not been able to discover the models to replace them. It is one of the great problems of the transition from large mental hospitals into alternative community-based services that even if the money was there we do not know what we want to do instead of working mainly in hospital. One model to add to the range of alternatives to the institutional care of the mentally ill is something called a CMHC. It is not only buildings; it is not only the groups of staff that are involved, it is the combination of both. It is a particular style of managing the psychiatric morbidity of a community which assumes that the principal site of care is in the living room and not in the mental hospital. The importance of this commitment can be seen in the steady move out into the community over many years. Services invent different varieties of day hospital, different schemes for sheltered living, sheltered work and sheltered social activities eventually leading to greater independence. So may I present two possible views of what a CMHC might be?

The first model is the headquarters of the specialist mental health services for a community, which only passes on the work which can not be done locally to a central site. In other words it is the base for a comprehensive community service for specialist mental health services. Specialist mental health services only claim some 10% of the work of helping and treating the mentally ill in a community. The rest belongs to other agencies: primary health care and social work teams, voluntary organisations, but mainly to the relatives and friends and carers of those that manage mentally ill relatives or friends. This type of CMHC is the headquarters for all the comprehensive services for the acutely mentally ill, the chronically mentally ill, the elderly mentally ill, people with drinking problems, young people with problems, people who abuse drugs and other substances. The size of community served by a CMHC is a matter for speculation but in Europe and probably in the United States as well, a figure of between 40 and 60 thousand of the population seems to be a comfortable figure for good organisation.

The other model is a specialist service for selected people whose needs can be met by a particular style of treatment. What is offered excludes certain categories of people who require care elsewhere in the community. It excludes people whose needs are not met by what is available. That might be a more honest approach to the development of a local Centre in that it is not offering more than it can achieve. However, there is a risk of writing exclusion clauses which make sure that the only people who are treated in a CMHC are those who happen to fit a particular set of skills of the available staff. Exclusion clauses are the bane of comprehensive services:

"what don't you treat in this Centre?"

"Well, we don't like alcoholics, people who wet themselves, people who are too old, too nasty or too aggressive",

and therefore exclude a very large number of the people who require care.

I give you two models. One, the headquarters set up quite deliberately as a focus for organisation, and another where the Centre is a place of excellence using skills which are available. Of course there is room for both in the current phase of development and indeed room for varieties of both. It is a phase of development which is likely to last some years before a list of what constitutes a comprehensive service for the mentally ill in a health district makes a CMHC obligatory. There is room for both. My own preference is for the model of CMHC as the principal site of all community services but the development of specialist services must also be encouraged until they grow together to be the component parts of a comprehensive whole service.

LESSONS FROM ITALY, THE USA, AND YORK

Professor Kathleen Jones
University of York

My first-hand knowledge of the United States is now over four years old, so I can only talk about the best of what I saw. My knowledge of Italy is much more recent, as I made a two-week visit there in April 1984 with an Italian-speaking interpreter. I propose to discuss the Italian reform movement, to add some comments on the best of the United States practice, and then to indicate the outlines of our tentative plans at York.

To start with Italy. There has been a good deal of recent publicity for Psichiatria Democratica, the radical reform movement. Meetings were organised in several centres in England in the Spring of 1984, there have been articles in the Nursing Times and the Guardian, and Community Care ran a special issue on March 1st 1984. The Community Care issue included pictures from Trieste, where the movement started, showed patients in hospital before the reforms, patients sitting in deck chairs in the sunshine, patients building a symbolic Trojan horse, patients breaking down the steel gates of the hospital - stirring stuff. The caption to this particular set of pictures says "steel gates at the hospital were taken down, inmates symbolised their move out by making sculptures of the Trojan horse, festivals demonstrated to the outside world what was happening, patients set up their own homes, holidayed at the seaside, found new loves". What we need to know now is how widespread this kind of movement is, and whether the services provided as alternatives to hospitalisation are adequate to the needs.

Trieste is not Italy, and for much of its history has not even been Italian. In order to find out how far the Trieste experiments had influenced the rest of Italy, my interpreter and I cut a section through the country from north to south, from Como on the Swiss border to Reggio di Calabria in the extreme south. In most respects, the industrial north of Italy is well in advance of the backward and rural south, and it was important to discover how generalisable the reports of reform are to the country as a whole.

It can only be said that the reality was very different from the publicity. The Psycho-Social Centres, which are claimed to be the equivalent of CMHCs, were organised on several different patterns. There were a few rather like the ones described by Dr. Shulamit Ramon in Social Work Today and Granville Daniels in the Nursing Mirror which were comfortable friendly units, drop-in centres providing crafts and other activities, together with an out-patient service. These were pleasant places, made more so by the Italian habit of serving wine with meals (something which all the English commentators seem to find attractive). But two qualifications are necessary. Centres of this kind do not provide a psychodynamic environment. The whole ethos of Psichiatria Democratica is against analytic processes of any kind, because neo-marixism and neo-Freudiansism do not mix; and such experiments are based on de-skilling, not on multi-disciplinary work as we understand it

The accounts of Italian centres in the British press, if you read them carefully, stress the fact that the doctor did the washing up, or scrubbed the floor. Professional status (and therefore professional skill) is discouraged - perhaps because in Italy professional skill is very limited and training opportunities are few. There has been no psychiatric training for nurses in Italy since 1975, so the only nurses who have a training are now ten years out of date. The majority of nurses in the community centres are untrained, though they may have mental hospital experience. Social workers in Italy are also often of rather limited professional standing. At present, the best of the Psycho-Social Centres have no dynamic professional input. They run at the level of conventional wisdom and common sense, and have no more to offer than good local authority day centre care in Britain; but comparatively few Psycho-Social Centres seem to be organised on this model. A much more common pattern, we found, was one in which the centre was a doctor's office with community nurses in attendance. The doctors wore white coats and sat behind their desks. The untrained nurses ran a community nursing service, and patients came in to see the doctor by appointment.

The third pattern we encountered was a strictly medical out-patient clinic held in the general hospital or in the mental hospital, with patients sitting in rows waiting for treatment. That is the preferred model of the medical opponents of Psichiatria Democratica, who are suspicious of community services.

However, in some areas, there were no alternative services at all. In the south of Italy we found no Psycho-Social Centres, no community nurses, no out-patient clinics. In Salerno, a town of more than 250,000 inhabitants, the choice was a stark one: in-patient treatment or nothing.

On the hospital wards, throughout Italy, many of the patients were on locked wards, and some of the patients were under restraint. Many were in strait-jackets and we saw one strapped to his bed. Officially, such people are not patients but "guests", since the mental hospitals have been "closed", but their condition is far worse than anything one could encounter in a British mental hospital, and there are at least 55,000 of them. It is necessary to make this clear in order to counteract the myths about the Italian mental health services. There are some good ideas, and some good practices but most of Italy is a century behind Britain; mental health, like most other areas of Italian life, is highly politicised. Any social development tends to be encouraged by the Communist Party and opposed by most of the medical profession, which relies heavily on psychopharmacology. Medical politics and professional politics are interrelated.

America offers a very different kind of experience. On the last occasion when I visited the United States, in 1980, there were some 800 community Mental Health Centers operating under the Community Mental Health Center Act of 1983. About two or three hundred of these are considered first rate by the American Medical Association. The best are in the North-East, and that is where most British visitors go. The big ones, particularly in New York and Washington, are superb. They are more like small hotels or university colleges than hospitals, with small rooms for seminars, coffee bars, nice carpets and good lighting. Some of them now employ interior designers - they go in for palms and potted plants. One attached to the City Hospital in New York had stained glass windows. I asked if this did not put off some of the clients from the back streets but was told "No, Americans expect the best". The big centres are very well organised, with a full-time director and Section Chiefs. At Washington Heights in Black Harlem, I attended a meeting of Section Chiefs, and made the obvious comment - "If you have so many chiefs, how many Indians are there?" There were over 200 staff in all. The chiefs were in charge of sections such as Drug Addiction, Detoxification, Adolescents, Children, Old People, and other specialist services. There was a Housing Chief whose job was not only to find homes for individual people but also to find premises for groups associated with the Centre. This is what the Americans call 'outreach' - the linking of a variety of community groups with the CMHC.

The range of services in these big centres was very good indeed. They provided counselling, group therapy, support groups for relatives, psychodrama, a Crisis Service, a drop-in clinic, educational films and many other specialist services. However, not all CMHCs are of this comprehensive kind. The smaller centres in the southern states, such as Florida and Georgia, tend to be not much more than out-patient clinics with a social worker in attendance.

A paper from the Tontine Road Centre in North Derbyshire makes the point that a CMHC is dynamic, growing and changing as needs change. In a sense it cannot be defined. We start from a base and weave different kinds of services into it. Its operation depends on who the personnel are, and what the needs are, and the dynamic relationship between needs and service. The American CMHCs were good at providing lateral support. If a patient came to a drop-in Centre in a distressed state and the professionals were busy, someone would say, "Well you come over here and talk to Hank and Chuck" and Hank and Chuck would be two other patients. They would sit down and have a coke or a coffee or some curious stuff they drink called Mountain Dew, and Hank and Chuck would cope until a nurse or a social worker was free. Perhaps in England we do not think enough about lateral support - the kind of support that patients and relatives can give one another.

'Outreach' was exciting: 'store front' psychiatry which involved taking over a shop, perhaps only for a short time and using it as a base to raise local consciousness; and 'street psychiatry', run by some remarkable young psychiatrists with enormous idealism. These are the inheritors of the civil rights tradition of the Kennedy era, going round the streets without the structuring of a surgery, a receptionist or a white coat, trying to make live relationships with damaged people. 'Outreach' programmes were used to mobilise local community leaders - rabbis, priests, black power groups, and trying to make them part of the mental health movement, treating them as co-therapists. There was a tremendous amount of excitement, enthusiasm, energy - what the Americans call zip - and this was so different from our very phlegmatic British services. Perhaps it is because we are so phlegmatic that we automatically warm to American zip or indeed to Italian grand opera.

800 centres spread across the vast areas of the United States is very limited provision. Some states have only one, and the need for development is acute; but in the last four years, the Reagan government has severely chopped the mental health programme both for the National Institute of Mental Health and for the CMHCs. CMHCs were founded on federal funds which made them attractive to the individual states; but the federal grant was only a pump-priming grant, usually for eight years, and the result is that when the federal government ceases to pick up the tab and the states have to foot the bill, they become notably less enthusiastic. Some CMHCs may be running down hill for that reason. Another problem, as in Italy, has been growing medical opposition. A few of the younger doctors were extremely keen and idealistic, but many psychiatrists were not attracted to a multi-professional approach. Some complained that they wre being turned into prescribing machines. In several CMHCs, the Director was a psychologist or a social worker. The doctor would come in and sit down and patients would be brought forward and a nurse or a social worker would say "Why don't you double his Modecate?" or whatever the local name of the drug was. The doctor would write out the prescription, but had no real contact with the patient. One can understand that this is not very satisfying for the medical profession. There has been a considerable backlash in the States against CMHCs - back to medical formulations of mental illness, and to medical control.

What lessons can we draw for England from the Italian and American experiences? The first is that we must work with the medical profession. The American CMHC movement became anti-medical, and they are paying the price now. I worked in Florida State University at Tallahassee for three months teaching mental health, and saw the doctors literally run the CMHC out of town. Doctors in private practice resented losing patients to the CMHC because this affected their fees. Mysteriously the lease was foreclosed on the existing premises, other sites were not available, sweet little old ladies were found to come to meetings and protest - "We don't want all those crazy people around here". The CMHC is now well out of town, on the Circular Road. That was a long and interesting saga. It is very important that the mental health professions other than medicine do not get into a position where the medical profession unites in opposition to them. Clearly we need both a medical and a social approach, because working together across professional boundaries is vital; but in both Italy and the United States conflict with doctors is hampering development.

The second lesson is that a CMHC must have clear and limited aims. The American CMHC movement over-reached itself, taking on all the problems of the local community. The enthusiasts might have learned lessons from the War on Poverty and from our Community Development Projects: it is not possible to solve all the problems of an area with micro-methods - some of them are macro-problems and need macro-solutions. Perennial problems such as bad housing, unemployment and racial inequality simply cannot be solved from a small local base, particularly such a slender base as a mental health service. It is important to decide just what a CMHC can do, and do sensibly. Some of the American CMHCs became far too diffuse.

The third lesson is to resist de-skilling. In Italy, this results from a lack of training opportunities. In the United States, pressure has come from the "indigenous para-professionals". This rather heavy term means that in black Harlem a CMHC has some black staff who know the local culture and the local networks. They are paid as staff, irrespective of whether they have qualifications or not. In Spanish Harlem (where to my surprise everyone spoke Spanish and nobody spoke English) it is necessary to have staff of Spanish origin, who will translate for other workers or work in Spanish. Some of the indigenous para-professionals in the States have demanded power - claiming that they are the people who know the area and the population, they do not need the white folk, or their professional skills. They have produced their own version of de-skilling, and I doubt whether it is any more useful than the Italian version.

A fourth lesson is to take measures against 'staff burnout', as the Americans call it. A group of young idealists set us a new CMHC. They pour all their energies into it, and at the end of five years, they have nothing left to give. The same could happen to the much more limited work of Psichiatria Democratica in Italy. In England, we need to realise that staff in this new and exposed position are going to need support, and that one of the major tasks of the psychiatrist should be to back up the other staff. Training groups, staff support groups, multi-disciplinary case discussions are not optional extras, they are basic to staff survival.

We are now trying to plan a CMHC in York, and this is an exciting prospect, if the Health District and Social Services can agree to promote it. There is a possible territorial base - premises which are almost ideal, consisting of a row of houses of good quality and pleasant type backing on to a mental hospital, approachable from a side road. There is a large car park at the end of the road. The houses are in a long row, so that it would be possible to put the De-Tox at one end and the child psychiatry unit at the other. If it is necessary to keep different groups apart, it is possible to do so. A group of enthusiasts has been over these houses, mentally knocking down staircases and pushing down walls. It is essential that the service should be comprehensive from the outset. A scheme which starts off with an out-patient clinic and a couple of social workers may never get any further. This scheme is fairly ambitious in that it involves a whole row of houses, perhaps a total of about 50 rooms. It would include existing services such as community nurses, social work for the mentally ill, a new alcohol unit, a drug unit, out-patient clinics, day hospital work, day centres. We hope that there will be workshops - Industrial Therapy and Occupational Therapy. There is room for patients' clubs and a staff common room. Opportunities could be built in for educational work with general practitioners, who will be very important to the whole service, and with social workers and other groups. It could be the power house of the mental health services of the City of York, with a population of 105,000. The first stage is to move the existing services into a common territorial base. The great advantages of a common territorial base are that it is identifiable to clients, there are economies of scale, and new facilities can be grafted on. Community mental health work needs a strong organisational base. If it is scattered and fragmented, the hospital is the only real organisation in the field and there is still a powerful undertow to hospital values, hospital styles of management, hospital ways of thinking. A community base can develop its own values, styles and patterns of thought.

In York, premises are available, and Health and Social Services have begun discussions. The run-down of the mental hospitals in the area, of course, provides the spur. A general problem is that in this transitional phase, the need is for two services - a mental hospital service running down, and a community service building up. The total cost is more than it would be for either on its own. The unit cost rises as the mental hospital is run down, because the same facilities have to be provided for smaller numbers of patients. This is the time when extra money is needed for mental health services to make the transition effective; but if the DHSS is sympathetic, the Treasury turns a deaf ear.

A major problem at York has been that of who would be eligible to use the service, and how they would contact it. The psychiatrists have been concerned to preserve referral through general practioners, while social workers were equally insistent on open access and a drop-in clinic. That problem has now been solved with goodwill on both sides. The psychiatrists would take their referrals from general practioners, the social workers would have open access and be able to rely on psychiatric back up. If the social workers wanted to transfer a case and if the psychiatrists wanted to take it on, the general practioner would be informed as a matter of courtesy. Of course, if the centre organises groups for general practitioners, and the general practicioners get to know the social workers, that will make the situation easier. Another major problem at York has been that of who should run the centre - and this could have been a source of inter-professional rivalry. It may be important to find the right person rather than the right profession - not a director or administrator at the top of a professional pyramid, but a sort of hotel manager-cum-community worker, a facilitator who could work with professionals without directing them.

The ideal is a centre which is not like a hospital or an out-patient clinic, but much more like a university college or a good small hotel; where professional people can meet without the barriers that distance creates, where patients can come freely, where the workers can share information and ideas and support one another, where there are common catering and secretarial services, and some research and evaluation. The centre should grow and change, adapting as the mental health needs of the area change. Franco Basaglia, the founder of Psichiatria Democratica, said that the solutions of one country are not necessarily applicable to another; and it may be that quite small areas will develop on their own individual lines. The solutions of Haringey or Kensington may not work in York, and vice versa.

THE BLACKDOWN CENTRE - DORSET

Penny Gray
Blackdown Hospital,
West Dorset

Blackdown has evolved as a centre over the past 30 years and it is only in the past 2 years that people have been taking a closer look at Blackdown and realising that it now has many of the resources required to form a CMHC.

Blackdown serves Weymouth and Portland which has a population of 57,000 but with a considerable summer holiday increase. The Centre is situated between the 2 towns in a residential area and there is easy access to all local facilities. 30 years ago Blackdown was a large residential house in its own grounds. It was bought by the Health Authority to be used by 12 patients from Herrison Hospital (a large psychiatric hospital which serves most of Dorset) for convalescent purposes before return to the community. The time and the situation altered. Blackdown took 20 day patients along with 12 residents, many of whom actually worked in Weymouth and it was necessary to employ an Occupational Therapist. The number of day patients continued to increase as more ex-hospital patients were found sheltered accommodation through the rehabilitation team; and it was decided to hold an outpatients clinic to help care for the increase in numbers in the community. Over the next few years there was a general increase in day patients and outpatient clinics but the actual number of residents seemed to drop to around 6. It was also decided to open a clinic for Depot injections. Eventually the buildings were enlarged and by 1977 the new Occupational Therapy unit was opened with facilities for 25 day patients. There was also a new outpatients department which included reception areas, clinic rooms and interview rooms and offices. The general policy for Blackdown was reviewed and so that patients admitted to the night hospital, which the residential part is called, would in fact be day patients who relapsed, patients whose medication needed monitoring or "stepping stone" patients returning to the community from Herrison. The day patients were usually patients who had received rehabilitation or the elderly mentally ill needing support and observation, but occasionally there were a few patients who were referred to as 'acutely mentally ill'. Because of the variety of illnesses people had to attend on set days according to their needs. With the new buildings new members of the team joined Blackdown. Officers were used on a part-time basis by CPNs, Psychiatric Social Workers and 2 Consultants had out-patient clinics along with the increase in number of Depot clinics. By 1980 phase 1 of the unit for elderly severely mentally infirm was completed. This was a day centre that also offers support for relatives, advice and guidance, CPN and social work support. Blackdown was now beginning to provide a full complement of service in the local community and at the same time beginning to focus on prevention. At present plans for phase 2 of the ESMI unit - a 10-bedded unit providing holiday relief, weekend admission, crisis admission and assessment fo the ESMI patient - is under review.

At the present time Blackdown has 11 beds, used as overnight 'sanctuary' beds, or to review medication and a 'prevention' service for those patients on the verge of breaking down. The only patients we are now unable to take are those with extreme behaviour problems. These people go to Herrison but are transferred back to Blackdown when well enough. We find we cannot cope with such patients because historically night nursing staff levels have always been very low. Blackdown also offers partial hospitalisation; (day care support) that helps prevent admission. There is a planned programme of care usually agreed by the team and implemented by the relevant members - these are usually the OT, Nursing and Community Nurses. This operates at present only from Mondays to Fridays. It does seem that Blackdown shuts down over the weekend, except for the residential night hospital, but we are trying to introduce weekend day care for selected patients. Emergency care on a 24 hour basis is beginning to develop. Any member of the team can request admission to the night hospital for overnight care for a client - that is the crisis bed - and we also occasionally take admissions from GPs if the patient is actually known to a member of the team. After one night's stay we have to carry out a complete admission by a member of the medical team. We also offer drop-in facilities. This is at present used by ex-patients, and is not a well known facility.

Other agencies - health visitors, district nurses, social workers, home helps - are now beginning to ask for advice, and we liaise with them for follow-up support in the community. At the present time contact with other agencies is very small and I think the responsibility lies with us to educate them. We plan to hold working lunches inviting other groups so that we can discuss what we have to offer them and they to us. I think we could also liaise with the general hospital when it comes to, for example, management of overdose patients - that is something we have got to look at.

On the basis of our experience we would offer a few practical hints.

- firstly, as a place develops, as Blackdown did, it is important to make sure staffing level keeps pace. We have a very poor nursing staff level and medical cover is not available on a 24-hour basis

- secondly, we found that employing recently qualified staff was successful. They found it easy to adapt to the flexibility of the service. They brought in new ideas and helped to change attitudes.

- thirdly, encouraging all members of the team to maintain flexibility and relate well to each other is important 'though it is not always easy to achieve;

- fourthly, it is a great help if at least one member of the team knows the local area very well. In our case there is a domestic who can tell us who does cheap bed and breakfast and what times the shops close;

- fifthly, for management and administration of our service, we have not found it helpful to operate as part of the large hospital. Although contact between the two is usually good there can be problems like the availability of notes and ordering drugs. Any major decision on spending, for example, is made by Herrison, not always key people on our site who are aware of the needs. This problem also occurs in discussing future policy. We now hold an all-day meeting notifying all interested parties 3 months in advance with request reminders. For the meeting we chose most of the departments and included everyone from the gardener to the head of the school of nursing at Herrison, so that everybody is aware of what the future holds for them.

THE BRECKNOCK PROJECT

Tessa Jowell
Assistant Director, MIND

The origins of the Brecknock Community Mental Health Project go back to October 1979 when with £12,000 in grants from the King's Fund and the Drapers' Foundation, MIND in collaboration with the Tavistock Institute opened a drop-in community mental health project in Brecknock Road in North London. For the first four months the project was run entirely by local professional volunteers, and once the funding position became more secure a full-time organiser was appointed.

The aim of the project was to create a pioneering initiative which would attempt to confront some of the problems of people who were disabled by the effects of isolation and loneliness and who may or may not have had personal experience of mental illness. It was intended that the project would provide a place where people could come together and begin to develop constructive solutions to their personal and social problems.

To begin with it was local and essentially innovative and therefore in the business of operating on a fairly high risk basis. The means adopted to achieve these aims were first of all that activities would develop and be organised on a self-help basis and that the project would operate an open door. It was devoutly hoped at the beginning that it would not ever become necessary to exclude anybody, and that the activity generated within the project would be created on the basis of the evident need as represented by people who used the project. The project has now been running for 5 years and has been characterised by a flow of peaks and troughs in its activity. It has developed to a point that bears not very much relation to the project as it started.

Two important statements about the experience of project users have applied throughout the majority of the project's life. First, that the sort of activities which the project ran, particularly in its early days - drop-in advice and information, a daily lunch provided at very low cost, discussion groups, opportunities for counselling, personal problem solving - to an outside observer might look not substantially different from the sort of activities provided at a more progressive local authority day centre or by other voluntarily developed projects. But our conclusion was, from the evaluation carried out in the early days, that it was the experience of people using the project that was different. Measured against their experiences of other drop-in centres or day centres provided by the health or local authority - people who use the project identified the difference as their sense of belonging and the sense of community. This perhaps is explained by the analysis we did of the family characteristics of users. Many were only children, or were people who had experienced isolation, periods of their childhood in care and had lacked the experience of a satisfying close network, either family or other network, during their early to mid lives - into their 20s.

Stages that the project went through:

First of all there was the very early development before a full-time organiser was appointed in late 1979, which was also a time of great financial uncertainty. The project opened in a short-life house in an extremely poor state of repair and much of the energy in the early days was devoted to simple maintenance of the fabric of the house.

The second stage, which accounted for the first full year of the project's operation, was concerned with determination of the project's personality, the establishment of activities, the emerging rules of operation of the project.

The third stage was the move by project users to take much more substantial control of the management and daily running of the project. The developing debate about control - financial control, control over the behaviour of users and the preoccupation with criteria for selection of users, relationship with statutory and other voluntary agencies - became a major preoccupation a year or 18 months into the project's life.

Then a definitive event occurred when the project was burnt out of its house. I think that, in retrospect, this clearly characterized the burnout stage that the project had also then reached, two years after the project was first started. The project was then homeless and was given space in a room provided by local social services area office. The strength of the sense of community and devotion of project users to its facilities was highlighted by the fact that this homelessness period spanned a winter, and on days when there was no accommodation for project users they would congregate outside the local launderette and then find somewhere where 6 to 10 of them could gather and spend the day together. During this time we were negotiating with the statutory agencies about new premises and not surprisingly Islington housing department, who had given us the first house, were not that keen to offer us another tenancy. Eventually we were provided with what we realised at the outset to be unsatisfactory accommodation, out of the area and on the edge of a large and extremely run-down housing estate at King's Cross, but the project users wanted to go there because they felt that by that stage it was better than nothing.

This move proved to be disastrous for the project - it was very difficult for people to get to, relationships with the local community were extremely poor and crystalized around one or two incidents. By that stage the project was largely providing for a hard core of extremely deprived, extremely disturbing people who had been through, and been rejected by, the other services. In a sense the quality of our relations with the local community were summarised by a petition which was circulated by the local Tenants' Association and said, "Would you like the Hall (which the project had been provided with) to be used by your Tenants Association or would you like it to be used by a group of psychopathic rapists?". That really marked the end of the possibility of our operating in that area. The project then fragmented, there were a number of other activities already beginning to generate, self-help groups were being created for people who were coming off tranquillizers, and a group of project users for a short time developed their own separate break-away group, running essentially a lunch club in premises provided by the local authority.

The mistakes we made taught us as much about innovation as the many undoubted successes of the project. The key lessons that I think the 5 years of the project's operation have taught us are.

Firstly, it is extremely important, if you go for public funding, to be quite clear of the responsibilities expected of you as an innovative project by those public agencies.

Secondly, we believed at the beginning that it was possible to provide an open door community mental health approach which would actually combine strategies of primary, secondary and tertiary prevention. But we now feel that you can not get in at the primary preventive end and combine that with effective work with people who have been through the psychiatric mill and whose problems are of such an order that they are incompatible running side by side with mothers' and toddlers' groups and the more low-level self-help support group.

Thirdly, we were never sufficiently clear about the relationship between an internal self-help organisation and the imperative to manage from the outside. That was a dilemma that, in retrospect, we should have been much clearer about right at the outset.

"608" - THE COMMUNITY MENTAL HEALTH CENTRE IN LEYTONSTONE

Deirdre Fitzgerald, Sharon Woolf, Judith Buck
Community Mental Health Centre, Waltham Forest

We are three members of a team working at '608' Leytonstone High Road, a Community Mental Health Centre in East London.

What is '608'?

'608' is a relatively new project which has been in operation for about 8 months. '608' consists of the upper two floors of a terraced house in Leytonstone High Road - a busy road and a shopping area well served by public transport. The basement is the local Community Health Council offices.

There are two small interview rooms, a Conference/Group room and two offices plus one toilet and a small waiting area. The building and everyday running costs are provided by the NHS. All except two of the staff who work at '608' were already working in Mental Health within the catchment area. The two especially employed full-time for '608' are:

our Co-ordinator - a Social Worker funded by the Local Authority
and
our Centre Administrator - funded by the NHS.

The rest of us work on a rota basis and also carry case loads which do not solely consist of '608' referrals - so we contribute to '608' on a part-time basis. Thus the team comprisses: Co-ordinator, Centre Administrator, Community Nurse, Consultant Psychiatrist, Senior Registrar, Psychologist, 5 hospital-based Social Workers (i.e. the social work team including Senior Social Worker based at Claybury for this catchment area) and, Community Occupational Therapist - thus the professional input is in fact divided evenly between Social Services and the NHS plus Centre Co-ordinator. This has not, so far, caused problems relating to accountability. We also have an Advisory Group made up of heads of the various departments, Centre Co-ordinator, Consultant, Centre Administrator, G.P. and a representative from the Community Health Council.

'608' opened in February 1983 after three years of planning, putting forward proposals and seeking funding from both the NHS and Waltham Forest Social Services Departments.

'608 acts as a base for co-ordination of referrals in the 16 - 65 age range from a specific catchment area of 160,000 population in the Southern part of the Borough of Waltham Forest. There are no beds or day places at the Centre. The work carried out from the Centre is initial assessment, and ongoing treatment which may be on an individual, marital, family or group work basis. Sessions may take place within people's homes, at '608', or using rooms in local buildings such as Adult Education, Health Centre, etc. We prefer to carry out initial assessments in the client's home with as many members of the household present as possible, although ongoing sessions may not take place in the home.

The catchment area already had a number of Mental Health professionals working within its Community who were based at Claybury Hospital, some 5 miles outside the area concerned. Psychologists had close links with some GP practices as did the Community Psychiatric Nurses and the Community (Mental Health) Occupational Therapist. A Psychiatric out-patient clinic was held weekly at each of the two main Social Services Area Team offices in the catchment area. Domiciliary visits by psychiatrists were available when required. Thus there had been community input available from various professionals for some time but there was little liaison and co-ordination of these services which sometimes allowed considerable overlap and a degree of confusion over the treatment being offered to an individual. There were obvious disadvantages in being based in a large psychiatric institution away from the catchment area when trying to focus input on helping clients/patients in their own homes and locality.

The aims in setting up '608' were as follows:

1. Co-ordination of existing community professional work and of various aspects of community psychiatric care.

2. A venue for brief and quick assessment of psychiatric problems by a multi-disciplinary team in a non-hospital setting located within the community. A base for domiciliary assessments.

3. To facilitate an increased awareness of Mental Health problems by a multi-disciplinary team in a non-hospital setting located within the community.

4. Focal point for voluntary and other agencies whose activities have relevance to Mental Health and who may wish to use the Centre's facilities.

5. Research aimed at surveying local Mental Health needs - (areas, vulnerable groups, housing, employment, etc.), provision of services, evaluating patterns of care and developing new ones.

Referrals

Referrals may be made by professionals telephoning the Centre to provide basic information and outlining their reason for referral. We do not normally accept self-referrals although if somebody presents themselves at the Centre, they will, if possible, be seen by the Co-ordinator who will advise that they visit their GP and request referral to the Centre. If such a situation occurs and the client is very distressed, it may be that we would contact the GP to explain the situation and to seek the GP's agreement to our assessing the client's needs. When the referrer is not the patient's GP, the GP is contacted to inform him/her of the referral and to request that the GP maintains medical responsibility for the client - this is also necessary when the GP is the referrer.

Process

When a referral has been made, checks are made with the Social Services Area Offices, psychiatric out-patient clinics and Medical Records at Claybury - plus any other agency known to have been or to currently be involved with the client in order to obtain any further information that may assist in the assessment.

An assessment appointment will then be made to take place within the next few days. We prefer to carry this out in the client's home and with any other members of the family/household present, where possible. We also prefer to carry out joint assessments which have the benefit of more than one professional perception of the situation. This also enables the workers to have some support from each other. There are times when the client expresses a wish not to be seen at home or where this is not possible, in which case they are seen at '608'.

At present there is one worker 'on duty' each day from 1.00 - 4.30 p.m. for initial assessments. Where a joint visit is desirable, this duty worker will visit with either the Co-ordinator, another worker whose time has been requested especially or with a Psychiatrist if this has been requested by the referrer or seems likely to be particularly relevant/helpful.

The purpose of the assessment is to gain as full a picture as possible of how the client sees his/her difficulties at present, what the precipitating event may be, personal/family/social/medical/psychiatric history and whether or not the client seems likely to accept any help that may be offered.

We have a Team meeting for 2 hours each week during which all newly assessed cases are presented, discussed and decisions reached re: allocation to a Centre worker, referral elsewhere or perhaps referral back to the referrer with some suggestions about future management, occasionally the assessment session has resulted in a client feeling that he/she has achieved what they needed and does not require further input.

Ongoing work and cases for closure are also discussed when a worker wishes to bring them to the meeting.

1.	Total number of referrals	156
	Male	54
	Female	102

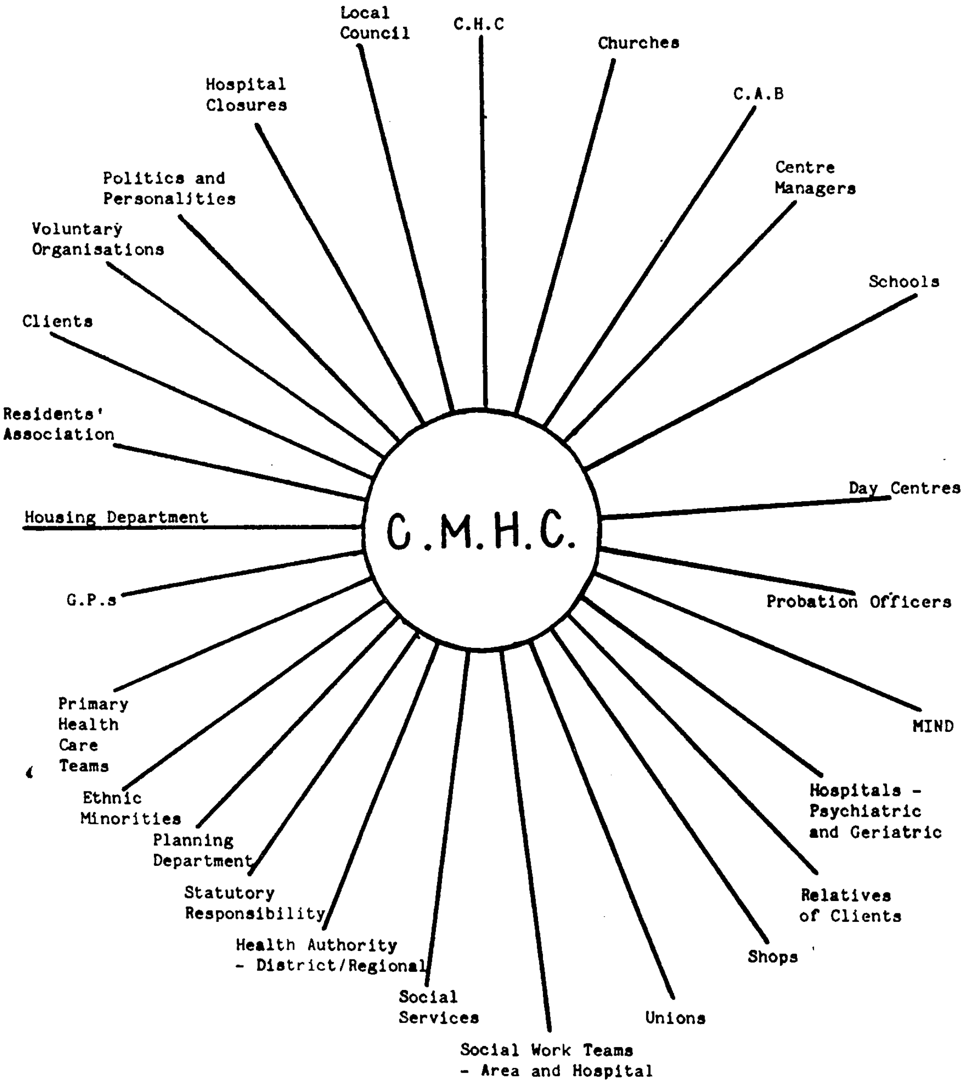
2. We have received twice the number of referrals for clients living in the more immediate locality than in the other parts of our catchment area.

3. There are 48 GP practices of whom 34 have made referrals to '608'. Altogether, clients of 37 practices have been referred.

The numbers seen up to October 1st 1983 are too small to be able to draw conclusions and many cases have not yet been closed. However, it appears that where the help offered has been taken up initially, the client is 3 - 4 more times likely to continue to attend than to drop out of treatment.

Until now, our main focus has been on multi-professional initial assessment and offering ongoing treatment to clients referred by other professionals and on the co-ordination of our work - i.e. the first two of our five original aims. The third, closer liaison, consultation and joint-work with other agencies is something that we hope to improve. We do not want to be seen as a very separate, specialised agency that takes on all mental health work but more to support others, to learn more about local needs and to continue to work with clients developing our approach through experience, discussion, feedback etc.

EXERCISE TO SET LOCAL C.M.H.C.s INTO THEIR CONTEXT



It was recognised at the outset that research/evaluation was necessary. We have, through the generous contribution of our local MIND group, been able to install a computer at the Centre which will greatly facilitate this process.

We are going to deal with some general issues surrounding community mental health centres and some more specific aspects of planning and monitoring derived from our experience at '608'.

One of the initial problems in planning a community mental health centre is trying to define which community one is going to serve. In an attempt to clarify this octopus-like issue we felt it may be useful to think about three communities one might aim to serve.

The first is the professional community which can be divided into two groups. Firstly, those professionals who already have direct access to existing psychiatric services i.e. GPs, general hospitals, Social services, police etc. and the second group are those who have more limited access i.e. Probation Officers, Housing Dept., DHSS, Citizen Advice Bureaux, Welfare Rights Organisations etc.

The second group one inevitably needs to consider is the client community. Again this can be divided into the existing client group already defined (by professionals) as mentally ill, or having mental health problems but who are not receiving psychiatric professional help. The second group of potential clients may well be receiving considerable support at present from primary health care workers, but this may be as much through lack of alternatives as through choice. From our own experience, this might include, for example, people referred by GPs for help in 'coming off' minor tranquilisers.

The third community one can consider is harder to define as it is broadly speaking the general public in a local area e.g. schools, employers, voluntary groups, local council, relatives, friends and neighbours.

Whilst one might wish ideally to be able to provide a service to all three groups, in practice this would be difficult to achieve in one community mental health centre not only because of external constraints i.e. resources available but also because the different groups requiring different styles of service provison.

For example, in providing a service to professionals one aim might be to make the process of referrals easier for GPs. This could be done by setting up an attachment scheme with GPs or health clinics or by providing a point of referral which gives access to a variety of skills i.e. a multi-disciplinary team in one place.

Focussing on the client group one aim might be to provide easy access for potential clients which might involve manning a telephone line 24 hours a day. taking on self-referrals and providing a drop-in facility.

For the general public one aim might be to take on an educational political role which might involve having staff trained in community work who would work with schools and liaise and pressure the local council in acting as a pressure group.

There are of course masses of different options but the point we are trying to make is the need to be clear about the practical implications of choosing to serve the needs of any particular group or combination of groups.

"WHO, WHAT, HOW"

Professional Community	Client Community	General Community
Those who already have access to psychiatric services, e.g. GPs general hospitals, Social Services	Those already in contact with the psychiatric services	Friends of clients Relatives of clients Schools Employers Local organisations
Those who have indirect access to psychiatric services e.g. Health visitors, Probation, Education Welfare Officers, Housing Dept.	Potentially new clientele	
Possible aim	Possible aim	Possible aim
Point of easy referrals	Easy access	Educate Politicise Consciousness-raising
Method	Method	Method
(a) Multi-professional team in one location	(a) 24 hour telephone line	Community work Liaison with local Council
(b) Provide attachment service	(b) Self-referral	
	(c) Drop-in facilities	

How these choices were made in planning '608'

A few comments about the background to the planning of '608' and some of the constraints placed on the planners. It was decided to aim the service of 'existing' professionals - those already working in the field of mental health care - and 'existing' client groups.

The objectives of the Centre as summarised in the planning documents, were as follows:

(1) Co-ordination of existing professional input and various aspects of community psychiatric care.

(2) Provision of a venue for brief and quick assessment of psychiatric problems by a multi-disciplinary team, in a non-hospital setting located within the community.

(3) To facilitate an increased awareness of mental health problems, by providing a venue for seminars, and supervision/consultation for GPs, social workers, health visitors, district nurses etc.

(4) Provision of a focal point for voluntary and other agencies whose activities have relevance to mental health problems, and who may wish to use the Centre's facilities during the evenings or at weekends.

The stated objectives and plans for the Centre were bound by three main constraints:

(1) The attitude of the local psychiatric hospital - and fears that the Centre would denude or detract from existing services.

(2) Staff time: no new professional staff could be employed. The Centre would be staffed by those already involved in community mental health provision, who would be 'redeployed' to the Centre on a sessional basis (only the co-ordinator's post would be 'redeployed' full-time).

(3) No purpose-build accommodation would be available.

These constraints - especially that of staff time - can make one question whether a Community Mental Health Centre should have gone ahead.

There were other important background issues that had a bearing on the service that was being developed.

(1) The Local Authority was not willing or able to provide a 24-hour crisis service.

(2) Initially mainly psychiatric social work and medical management were involved in planning the Centre. Neither of these groups had a well-established community base, unlike the other professional groups (psychologists, community psychiatric nurses) who later became involved in the planning.

The psychologists and community psychiatric nurses were already working GP-attachment schemes - and wanted to retain this base.

(3) The over-65 age group were not involved - because of the completely different organisation of the psychogeriatric service which involved different staff.

(4) At the planning stage there was a full-time planning advisor from the Local Authority who was very involved. She was responsible for research and evaluation. She left the Department - and the post (and her Assistant's post) has been lost.

Two further important points set the Centre in context:

(1) '608' was intended at first to be a 2-year project - with all the research implications this holds. It is now, however, regarded as an 'open-ended project'.

(2) Finally - when '608' was planned there were no plans to alter the local psychiatric hospital services. Now '608' needs to be seen in the context of plans to close the local psychiatric hospital.

At present we are able to offer:

(1) A quick response to professional referrals

(2) A range of multi-professional skills

(3) On-going individual, marital and family work

(4) Consultation and support to existing and 'new' professionals

(5) Initiating research and monitoring.

Multi-Disciplinary Team

It was decided at the planning stage that the Centre should be staffed by a multi-disciplinary team. In retrospect, we feel there were some issues that should have been given more consideration then.

Firstly The team consists of staff redeployed from a hospital base only able to offer sessional time to the Centre. This has obvious limitations and creates confusion, i.e., the first issue is that the management structure of '608' is unclear as we as individual team members are accountable to our own separate departmental management. A possible solution might have been to have gained at the planning stage a firm commitment from all departmental heads to developing a new management structure for '608'. As yet we have no direct management at '608'.

Secondly Little thought was given to the practicalities of creating a multi-disciplinary team. Initially we were expected to work as individuals offering sessional time but this in itself did not exploit the advantages of having a multi-professional team in one place and our only forum for pooling our expertise was in presenting assessments to the whole team at a weekly meeting. At this stage we were a team only in name - we have developed into a team by a gradual process.

We have now developed the following practices:

(1) Going out to do assessments in pairs and joint working.

(2) Creating space for review days which have looked at issues such as hierarchy etc., different styles of working, to foster team cohesion.

(3) Also having fortnightly business meetings to discuss policy issues and future developments as well as looking at current practice.

These have all involved negotiating for more staff time and bring us back to the issues of management which we are now actively involved in looking at. Of course there are many other practices that we could have adopted, e.g. staff support group, and I am sure other community mental health centres have different ways of encouraging skills sharing without devaluing individual professional's expertise.

Research

We will deal only superficially with the research project at '608' and will just raise a few points:

(1) Initially one of the aims of the research was a political one as the Centre only had funding guaranteed for two years and we needed to be able to show how the existence of '608' had improved the service. In order to do this it was felt we needed to find a control group to be able to give any picture of the impact it was having in our area. This was attempted by trying to monitor the existing service before '608' opened. This research was unsatisfactory as the data collected from the psychiatric hospital was rather crude, centring on admission rates and also because it was difficult to co- ordinate the gathering of data from different professional groups already working in the field. Another option open was to compare the northern part of the Borough (without a community mental health centre) with our part once '608' was operating. However, due to differences in the population and resources of the two parts of the Borough this would have been very unsatisfactory.

(2) Since the Centre has been open we have lost a full-time planning adviser who was funded by the Local Authority and this has slowed down the development of research.

(3) At present we are, however, in the process of organising a case register that will provide us with a broad data base to use in future research projects. In setting up the case register there has been much discussion around the implicit assumptions and hypotheses expressed in the questions that were asked and those that were not.

(4) One thing that was picked up was that we were still asking questions that individualised mental health problems and located them in one identified patient and that we were not giving due weight to the perceptions of the problems of other family members. As much of our work is done with couples and families, this was a bias we have attempted to correct.

(5) Another function of the case register was to use it as a means of achieving a total picture of the service being provided to our area, this has involved getting the case register adopted by all other mental health workers in this part of the Borough. We will then bein a position to try to increase co-ordination of mental health services and also to plan more coherently for future development.

(6) One research project that in retrospect we felt would have been valuable to have undertaken at the planning stage was research into the expectations and recommendations of the professionals for the service they would have liked set up. As this was not done at the planning stage we are now over a year on formulating a questionnaire which will enable us to get some response from professionals, such as GPs, about the service we provide and developments they would like to see.

(7) We also have not been able to begin to embark on consumer research, although we feel this is an important task and it would give us valuable feedback.

One general point is that we have found it difficult to give time to developing research as it has to compete with our commitment to '608' clients, professionals and other places of work and would recommend any other Centre to try and get a research worker who is there solely to do this vital work.

MULTIPROFESSIONAL MENTAL HEALTH ADVICE CENTRE, LEWISHAM

Martin Collison
Senior Social Worker

The Centre serves a catchment area of 80,000 in Lewisham, South London. The service now comprises three teams:

A Multiprofessional Team composed of psychiatric nurses, social workers, rehabilitation therapists, psychologist and psychiatrists. These are all people who give a part of their time to working with the Centre's clients. This client group comprises people who walk into the Centre, either referred by their family doctors or other agencies, or who refer themselves for help. They are seen initially for assessment by a duty professional and subsequently a programme of help is worked out at a multi-disciplinary meeting where a Keyworker is allocated. Most of the clients are in an acute state of emotional distress when seen and receive a period of short-term counselling/psychotherapy.

See - "Mental Health Advice Centre - Three years of Experience".
Research - N. Bouras, M.D., Ph.D.

A Crisis Intervention Team also operates from the Centre in order to see Clients referred by other professionals, e.g. GPs, health visitors, social workers. These clients are usually people who are unwilling or unable to attend the Centre or are in need of very urgent or intensive help. The team's intention is to offer an effective alternative to inpatient assessment and treatment. The Crisis team comprises: Two psychiatric nurses, Consultant Psychiatrist (Team Leader), psychiatric registrar, social worker, secretary.

See - "Mental Health Advice Centre - The Crisis Intervention Team".
Research Report No. 2.
Bouras, Tufnell, Brough and Watson.

The most recent addition to the service is the Rehabilitation Team which is currently engaged in assessing clients living in the community who have a diagnosis of schizophrenia with a view to offering an integrated programme of rehabilitation. The Rehabilitation Team comprises: two Rehabilitation Therapists, Community Psychiatric Nurse, Art Therapist and Social Worker. All posts with the exception of the social worker (½ time) are full-time.

Some general issues on developing CMHCs from the experience in Lewisham:

1. Carefully define specialist task, e.g. assessment or day care.
2. Gear resources accordingly, e.g. right personnel available, suitable premises.
3. Work within capacity.
4. Start working rather than planning.
5. Keep good records of work done - research if possible.
6. Be conscious of need of adequate support systems for staff.

NOTES

1. Many Centres are unclear at the outset whether, for example, to provide a 'drop-in' day centre type service. Handen Road MHAC functions to provide assessment and follow-up for people. Continuity visits to the Centre for support (unless for attendance at a specific group) are discouraged. It must also be decided whether the service is going to be in addition to existing facilities or replace or develop another service.

2. Resources necessary will depend on the above. Suitable premises are necessary if people are going to be seen for treatment and occupation in the Centre if people are encouraged to 'drop-in' someone must be available with time to see them.

3. Limits should be set on the volume of work which is undertaken. There are many pressures to take people from outside catchment areas. At Handen Road 'walk-in' Centre, referrals are accepted from 9 am - 1 pm which has a number of advantages over a 9am - 5 pm service. We have not had evidence that this is too limited and feel it makes better use of available staff time.

4. An important lesson we learned is to start a service functioning rather than spend extended periods in discussions of finer points which are often not clarified until operational conditions are experienced.

5. Good records of work done are essential and measures to safeguard confidentiality are important, number of clients using the Centre, help offered and referring agents need to be identified, for reference in planning.

6. The operation of such a facility places staff in a very exposed position. Sympathetic support and supervision must be readily available to all staff.

Other important points relating to our own experience suggest that the setting up of a "League of Friends" has given a focus for voluntary effort and provides invaluable financial and practical assistance.

It was also felt very strongly by Dr. Brough, the Director of the Centre, that in setting up a service initially it would have been better to start with the Crisis Team which of course would have a direct influence on the most acute situations. A walk-in service, on the other hand, tends to encounter many unmet needs in the community and therefore generates new work for the psychiatric services. It is therefore important that resources exist to deal adequately with priorities that are chosen.

Another important step was the setting up of groups of GPs, led by Dr. Brough, in order to inform them of the scope of the Centre. Attendance was good, the family doctors using the sessions to raise many problems they experienced in the practices with mental health matters and individual patients. The existence of these groups provided a sound basis for later co-operation.

Lastly, it is worth mentioning that we organised a meeting with representatives of the local residents and were able to reassure them about the Centre's use and were also able to air some of their concerns in mind when organising the service.

The main thrust of questioning from outsiders seems to focus on the problems we encountered in multiprofessional working and issues concerning responsibility and accountability. I have noticed that these issues have dominated discussions on these topics for years and without resolving them in a theoretical sense to the satisfaction of everyone concerned. This, I am sure, has led to the inhibition of many projects. It is important that realistic boundaries of accountability are agreed at an early stage - an example being my own job description which includes provision for accountability to be shared between my employer - the Director of Social Services and the Director of this Centre - Dr. D. I. Brough. Our own experience suggests that a properly structured service with adequate provision for discussion of work being done, in which people from different professional backgrounds clearly share objectives, can overcome the likely problems arising.

On the question of the likely effects of financial constraints, we would draw attention to the research aspect of our work which supports us in arguments for resources. This is a strategy others should follow.

THE ROLE OF CRISIS WORK IN INITIATING COMMUNITY MENTAL HEALTH SERVICES COMBINING OUT-REACH WITH A 24 HOUR 7 DAY RESIDENTIAL CRISIS CENTRE

Steven Newton
Coventry Crisis Intervention Project

Introduction

This paper will outline some of the events which influenced the establishment of Coventry Crisis Intervention Team. These events had a significant bearing on why it was established and the direction it took as an action research project.

I will then give a brief over view of the objective of the project, the team, organisation and research components. Finally, the future direction of the crisis team will be outlined as the research element has now ended and the establishment of the team as part of the community mental health service in Coventry is just beginning.

History of Crisis Intervention in Coventry

1. April 1977

Rolf Olsen approached Coventry Social Services Department and local Psychiatrists in an attempt to undertake "AN EVALUATION OF SOCIAL WORK THEORY AND PRACTICE IN MENTAL HEALTH EMERGENCIES". Professor Olsen wanted to replicate an American study carried out in the late 1960s by Donald Langsley in Denver.

This study had shown that by utilising community based family crisis intervention techniques with a multi-disciplinary team, patients in acute mental health crises could be kep out of hospital and provided with as good, if not better, 'treatment' if indicators like return to work rates and further breakdowns were looked at. After much discussion this proposal was not accepted by the ethical committee.

2. Late 1980 early 1981

The concept of Crisis Intervention was raised at an Area Health Authority meeting. This stimulated some debate at a Joint Consultative Authority Committee and a small working party looked at the need for a crisis intervention service in Coventry.

Two of the local consultant psychiatrists analysed retrospectively 100 admissions over a two month period. They found that up to 50% of these admissions were not admitted purely on grounds of mental state alone. They also postulated that a significant proportion could have been kept out of hospital if the following resources were available:

An Emergency Mental Health Hostel
Intensive Social Work Help
Intensive Community Psychiatric Nursing support

3. August 1981

Professor Olsen again approached Coventry Social Services Department with a further research proposal to look at the effectiveness of crisis intervention on psychiatric admissions. Again this was a controlled study having an experimental and a control group.

However, as the Social Services Department were going to provide the resources in terms of social work staff, it was thought that an action research project would provide more valid and useful data as to what was needed in terms of service provision.

A further factor as to why we ended up with the Action Research Project was perhaps the passage of the Mental Health Bill through Parliament. There had been much discussion about treatment in the most appropriate place and there was some thinking within the Social Services Department and among the
Psychiatrists that we needed to test out the reality of alternatives in the community.

4. Autumn of 1981 - through 1982

Discussions continued within the Social Services Department and with the local Consultant Psychiatrists on the appropriateness of an action research model. The consultants had, in principle, agreed to this idea on the 16.4.82 and finally in September the Social Services Committee approved the necessary funding for a sixmonth project, with the Psychiatrists giving final approval in October 1982. Professor Olsen did not feel able to become involved in this project. However, a multi-disciplinary steering group was set up, which was to have oversight of the project and included:-

A Consultant Psychiatrist to represent the Division of Psychiatry

A Senior Registrar undertaking the medical liaison and some research

A Senior Nursing Officer

Deputy Director of Social Services acting as Chairman

Principal Officer of Social Services

The Project Leader for the Crisis Team

Statistician and Computer expert from Social Services Forward Planning

Composition of the Team

Initially the Team was set up with 6 Level III social workers, one to act as the Project Leader, 2 experienced Community Service Volunteers and a full time Clerk. It was staffed on the basis of a 6 month project with an agreement with all staff that no holiday would be taken during this period. Initially discussions had taken place been Health and Social Services to have more of a multi-disciplinary in-put in terms of Community Psychiatric Nurses but funding was not able to provide for these.

Team Organisation

All the social workers worked as field, residential and research workers. The team operated on a 7 day week, 24 hour service and it was necessary for them to work very closely as a team.

A Team Meeting, on a weekly basis, became a key junction point where information regarding clients referred to our Team was shared, direction and planning on cases was worked out and key-workers appointed.

Referrals

As we were trying to test out the hypothesis that there were people getting into the Psychiatric service who could be diverted into community alternatives, all our referrals were taken from people who had already been assessed by some member of the psychiatric service. Clients came to us following domiciliary visits, sometimes on a joint basis with a member of our Team; from out-patient clinics; following overdoses and assessment for compulsory admission; as well as people who just walked into the Psychiatric Unit with no prior appointment.

Operational Policy

Once referred, clients were seen within 24 hours and hopefully within an hour or two of referral. They were assessed by a crisis worker, sometimes in pairs, and if possible with the referring doctor. If there was an agreement between social worker, referring doctor and the client and a contract was drawn up, the client became a research project case.

Our base at St. Paul's Road had 4 crisis beds available, but only a percentage of clients referred to us spent any time as residents at St. Paul's Road. As the project has progressed more and more people are being kept in their own homes and supported intensively there. Initially the operational policy indicated that clients would be worked with on a contract basis for up to 6-8 weeks. No re-referrals were taken so that research follow-up would not be confused.

Research

1. To study the influence of C.I.T. in Coventry on Psychiatric admission during the six month project.
2. To compare the admission rate of individuals who receive the services of the project for the year before and after intervention.
3. To study the cost effectiveness of C.I.T.
4. To identify the nature and patterns of crisis.
5. To provide data to establish whether or not there is a need for a permanent service.
6. To study and correlate C.I.T. process variables with outcome.

Dr. Chand the Medical Researcher and myself designed a data referral form (Form 1) and an initial enquiry and statistical data form (Form 2). Form 2 was filled out on all research cases within the first few days of acceptance by the project team and the majority of data on form 2 is computerised to form part of the data base of clients seen by the crisis team.

Other research tools that are being used are:-

1. General Health Questionnaire
2. Social Assessment scale

   Both of these have been designed by the General Practice Research Unit of the Institute of Psychiatry

3. Follow Up Consumer Survey — 1 month after the closure of our research cases.

The research component of the Project will continue for at least another year at a reduced level. The Medical Researcher will be following up old clients and will be administering the General Health Questionnaire and Social Assessment Scale as well as trying to assess their general level of functioning since their period of intervention with the Crisis Team.

Outline of the future of the Crisis Intervention Team

Initially the research project was set up for a six month period to run from March 1983 to August 1983 and as it had been so successful in the initial six months that further money was found by Coventry Social Services to continue the project for another six months. During this time negotiations took place between Coventry Area Health Authority and Social Services Department to try and identify continued funding so that the crisis team could be established as an on-going part of the Community Mental Health Service.

It has now been agreed that the Team will continue and be slightly expanded. Staffing from April 1st will include Project Leader, six Level III Social Workers, two Sister/Charge Nurses Community Psychiatric Nurses, two Community Service Volunteers and a Clerk.

Discussions are still taking place between practitioners in the Health and Social Services to work out how to integrate the Crisis Team into the Mental Health Service, in particular how to open the referral base to other agencies other than people who have already got into the psychiatric services. It is anticipated that we would experiment with taking referrals from general practitioners and other social workers in Coventry.

After feedback from the Consumer Research and discussions with the crisis team it has been decided to increase the length of time the clients can be worked with from 6-8 weeks to 10-12 weeks. The Crisis Team is also looking at how it can develop other preventitive strategies including group work and identifying gaps within community provision for people experiencing mental health problems.

As we are only just moving from quite a tightly controlled action research project into a service, the Crisis Team is clearly in the process of evolution and change, although the basic concepts of our work and our model of intervention will continue.

Coventry Crisis Team is clearly not a Mental Health Centre but is certainly developing elements of Community Mental Health work. In these notes we will describe the way in which we established ourselves and how, by setting up as a Crisis Service, you can move your boundaries into broader areas of Mental Health work in the community. I think our main point is that our experience indicates that a neat, tidy, well argued and agreed service plan does not necessarily have to be drawn up. The route we took was perhaps more ad hoc, setting up a six month action research project as a way of demonstrating need for a Crisis Service.

a) This was acceptable to our medical colleagues as it was research orientated.

b) There was no detailed budget, therefore Finance Department and Personnel Departments could accept it as a temporary project.

c) It meant, once we had established and proved ourselves, there was more support to finance a permanent service.

If we had tried to rally support with Psychiatrists, Administrators and Social Services for a new service at a time of significant financial restraint, with a budget of £130,000, then I am sure it would never have got moving. I think Leeds Social Services are experiencing these problems with a well worked out and rational plan for an on-going service provision of 2 Crisis Hostels.

Key points in setting up our Project

1) My experience of planning on both Social Services and Health is that rational argument is not necessarily the most effective means of achieving a successful outcome.

2) One has to look at the local situation, the politics of both Health and Social Services Department and attempt to get support for a scheme/ project. A research project is a good start which fits local needs and gets broad based support. It is important to make sure the right approach is made to different people in the Health and Social Services which necessitates very skilled and detailed knowledge of significant people in the two Authorities.

3) You do need significant people in Social Services and the Health Department who are on your side. One of the advantages of our research project was that the Deputy Director and one of the Principal Officers formed two out of three of the Planning Group within Social Services. Myself being the third. This cut through a great deal of red tape.

4) If there is any existing local research which can be of benefit, it is important to pick this up. Our case in Coventry was helped by two of the Consultants, who did some retrospective analysis of 100 admissions. This seemed to indicate that there were people being admitted to the Psychiatric Unit who the Consultants themselves felt could have been cared for in the community if there had been adequate available support systems, such as Crisis Hostel, intensive social work support, community psychiatric nurses etc.

5) We found it was useful to liaise with and obtain backing from knownsupporters, especially in the Psychiatric Group.

6) It helps to plug-in to national and current concepts in mental health - we were lucky with Crisis Intervention in that it was in vogue with the new Mental Health Act and was subsequently mentioned in the Memorandum to the '83 Act, and even though our service has not diverted vast numbers of people from compulsory admission it is there as an option.

Who should be involved in planning?

1. Health and Social Service professionals

2. If there is a good relationship between the Director of Social Services and the local Health Authority Administrator, this is an important relationship to utilise. Joint financing is often decided by these two Officers before Joint Consultative Committee meetings.

3. The Division of Psychiatry is an important group to discuss plans with and to gain support from. In our case it lead to the setting up of a Multi- disciplinary Steering Group with representation from theConsultants and Senior Nursing Staff.

4. Members of the City Council/District Health Authority were also involved at an informal level at quite an early stage so that there was support for the proposal when it went to committee.

Public Relations/Management

1) Our centre is managed by a Team Leader, who is answerable both to Senior Social Service Managers and the Multi-disciplinary Steering Group.

2) It has been important to keep Social Service Committee wellinformed on a formal level.

3) It has been important at an informal level, to work on significant Councillors and to arrange sub-committee visits to the Unit for discussions with Committee Members.

4) It has been important to also gain recognition from outside bodies who visited Coventry to look at mental health resources viz:

    1) The Royal College Training visit

    2) Mental Health Act Commission

    3) Health Advisory Service

5) As part of the philosophy of C.I.T. clients are treated very much as people in a collaborative relationship. This has lead to significant positive feedback from clients of our services, especially in comparison with what they have received from the psychiatric services in the past. It is important that some of this feedback was actually directed towards the Director of Social Services, especially when funding has been rather tenuous.

Development into wider Community Mental Health Service

Experience has shown us that many of the clients referred to the Crisis Team required more than the short term contracted type of intervention. One of the problems with many of the clients has been to try and integrate them into normal social activities, at a time when their mental health is fragile and perhaps their past level of social skills was not high.

As an experiment a Social Committee has been developed in partnership with current and ex clients of the service, giving significant responsibility to the clients in the running of this committee.

Hopefully this will act as a bridge to enable clients to move on into more normal social activities when their confidence has improved. It also enables some clients to have some informal contact with our Centre and at times some informal counselling, although we try to keep people's problems separate from the rest of the Social Committee.

SOME REFLECTIONS ON THE EXPERIENCE OF THE NORTH DERBYSHIRE MENTAL HEALTH SERVICES PROJECT - TONTINE ROAD CENTRE, CHESTERFIELD

Andrew Milroy,
Project Co-ordinator,
Derbyshire County Council Social Services Department

Description of the Service

The Project is

The Mental Health Services Project is a resource team, working to develop an infrastructure of services for the effective care in the community, of people living in North Derbyshire who experience mental health problems.

Who Staffs the Project?

The team is one Senior Social Worker, designated Project Co-ordinator/Centre Manager, three Social Workers, two part-time Clerical Staff, cleaning and caretaking staff to support the operation of the community mental health centre. Also working with the team are various staff on temporary short term contracts and various volunteer workers.

The Project Works With....

The Project is a part of the Residential and Adult Day Care Division of the Social Services Department. The Project aims to work closely with the Area Social work offices covering the population served by the Chesterfield Hospital Psychiatric Services; the Community Mental Health Teams being set up in the four areas making up North Derbyshire; the Probation Service: Youth and Community Workers and, of course, most importantly, leaders and active members of the different local communities. Services developed through the Project are accessible, directly, to all workers who are involved with people experiencing mental health problems.

Who is the Project for?

The Project has been established to develop services for people who experience mental health problems, people who develop a lasting disability arising from these experiences and those people who may be at risk of experiencing psychological disturbance. Therefore, the Project is concerned with those people who may have a history of "psychiatric" disturbance (with or without a clear psychiatric diagnosis) and those people for whom there is concern about their "mental state" related to their social functioning. Services developed through the Project are directly accessible to anyone wishing to make use of the, without a referral from a professional worker. However, no "casework" service is offered through the Project and individuals who may need intensive individual help are referred to a relevant agency.

How are Services Developed

Services developed through the Project are geared to be responsive to the changing and infinitely variable needs of individuals and groups. Services are not prescriptive but responsive and the assessment of needs, preceeding the development of an aspect of the service, is a mutual process shared by everyone interested, most importantly the people who will use the service, whether they are individuals or groups.

We believe this to be an important principle since the people we aim to help are not a homogeneious group but a collection of diverse individuals connected by common themes of isolation, exclusion from ordinary social processes, collapse of personal confidence, powerlessness and helplessness. Thus the activities of the Project will reflect the wide range of needs of individuals.

Where are the Services Based?

The Project has the use of the Tontine Road Centre, in the middle of Chesterfield. This is a multi-purpose community welfare centre and the home for a wide range of groups and services. Project staff are responsible for the management of the building.

Many of the groups and activities of the Project are based at the Centre. However, the central policy of the Project, reflecting the "ordinary life strategy" adopted by the County Council, is that services should be developed which enhance people's ability to participate in ordinary community process and that where special help is needed it should be provided in the communities with which people identify, in a way which conveys a respect for the dignity and importance of each person. Therefore, increasingly, the efforts of the Project are directed to develop services outside the Centre as a part of a network of support, using the buildings and community organisations, in the local communities of North Derbyshire.

What Services?

The Centre is used by the Project as a base for a therapeutic community for about 35 people; a social support club for 90 people, organised by a supported self-help group and a range of mental health groups; local branch of the N.S.F., Alcoholics Anonymous, amongst others. The Centre also provides space for groups run by other workers, e.g. the group for people who experience Agoraphobia is run every Thursday by one of the community psychiatric nurses. The Centre is also a base for a day care service for older people run by a semi-independent voluntary organisation. A further 20 voluntary organisations use the Centre for a wide range of purposes and we estimate that as many as 1,050 people can use the Centre in one week.

The programme of outreach work includes: establishing local community day care organisations, providing an intermediary day care service for older mentally impaired and depressed people; local social support groups for people who by reason of their degree of disability arising from mental health problems, are unable to enter or sustain themselves in more ordinary social groups; employment schemes; sheltered housing; community and professional education programmes.

Historical Background to the Project

The Building

The Tontine Road Centre, previously used as a day care centre for physically handicapped people, became available for a different purpose in 1980, when the day care service moved to new buildings. Traditionally organised day care provision for people experiencing mental health problems in North Derbyshire, had only been available from the day hospital service, which was grossly over stretched and often inappropriately organised to meet the needs of the people using it. There was also no formal day care provision for older people except the day hospital and a complete absence of a range of services. There was and still is no hostel accommodation in North Derbyshire.

Planning for the re-use of the Centre took place within the Development Section of the Social Services Department, involving discussions with various organisations, including the Health Authority. It would be true to say that the plans which emerged reflected an opportunity for development in an area with a complete absence of services and the sudden availability of a building to use. The philosophy of the approach contained positive elements but showed a pragmatic response to service development with an existing organisational strucutre.

The plans were taken to the Joint Care Planning Committee, at the beginning of 1981, proposing a "Joint Funded/Joint Staffed Community Mental Health Resource Centre". The then Derbyshire Area Health Authority declined to support the plan, so the Social Services Department proceeded with what amounted to 50% of the staffing. Funding for the capital and revenue costs for the building and the social work, clerical and ancillary staff had already been allocated by the Social Services Department.

Evolution of the Service

Planning Implementation

Within days of the Project formally commencing a detailed re-think of the original model commenced. With the help of the Principal Development Officer Mental Illness Services, we drew up a statement of aims and objectives, outlining proposed fuction of the service in broad terms. its philosophy and proposed structures for co-ordinating implementation with existing services. The paper served as a focus for a process of consultation with a wide range of groups, agencies and individuals, which was to last in its initial phase, for over six months. After this time, we felt it politic and important in order to establish and maintain credibility, to begin to develop services based on the conclusions reached. These conclusions were not detailed but indicated that the philosophy was appropriate and that we should proceed to respond to the needs of individuals and groups as they were presented to us.

This strategy reflected our concern that the existence of a building, very limited manpower and very traditional expectations amongst professional mental health workers, as to the nature of the service which was to be provided, would lead to a "dumping" of people needing support with a consequent elimination of the capacity of the team to develop resources. Practical concerns dictated the direction of planning and may have helped to offer new and more imaginative solutions.

The absence of staff time for solely direct work with individuals ensured the involvement of other professional staff and prevented the isolation of the service. Where groups have developed, especially within the functioning of the Centre, these have reflected strong expectation that people are able to share responsibility for each other and can help one another to develop appropriate solutions to "life problems". We have found it possible to help people focus on their ability rather than their disability, by ensuring that the services offer a multiplicity of real roles and opportunities for people, to develop their sense of power and control over themselves and re-build their confidence in themselves as people. Those who need intensive support or who find it difficult to join groups, where there already exist strong individuals, are offered appropriate support.

Monitoring our Development

Our development is an evolution which requires continual appraisal and critical evaluation. This requires us to develop structures to ensure that we are able to question ourselves and be questioned by others. For us the most important features must be:

(a) Time to evaluate our progress set against clear statements of our aims and objectives.

(b) Systems which ensure a continual process of negotiation and re-negotiation between ourselves and those who use our services.

We have been able to obtain some independent help with first the determination of the shape of the service and, secondly, some specific evaluation. This came in the form of an independent research programme. During our first year, Clive Newton who had worked on the Sheffield University Study into Social Work Services for Mentally Ill People and Their Families was contracted to undertake a modest research study aimed to offer a voice to the views of potential consumers of our services. This move was rooted in our firm belief that professional assessment of need usually involves a process done by professionals to people and often reflects the structural interest of the professionals rather than the needs of consumers. Despite our conscious attempt to be critical of ourselves, we doubted our ability to remove ourselves completely from the organisational and structural forces within which we work.

The second element of Clive Newton's work has been to critically evaluate our model of a therapeutic community structure. His work led us to adapt our approach in the light of our failure to achieve some of the objectives we had set ourselves. We hope to continue the element of external evaluation.

The people who use our services are encouraged to take up responsibilities to criticise the service and to change it. Within the Centre the Community Meeting or "Users Group" is seen as the supreme decision making body, with Staff and the Users Co-ordinating Committee, working together as a form of Executive Group. Self help groups are organised with formal constitutions usually designating a Project staff member as a non-voting advisor, but with some constitutional power to ensure no one person or small group of people can use the power of the group against the majority.

People using more structured programmes within the services of the Project are helped to develop their own plan for the use of the service which might involve the adaptation of existing features or organisation of entirely new elements. The formation of an occupational workshop, Tontine Users Repair Collective, as an independent sheltered co-operative, reflected the needs of four individuals and came from their demands.

In our experience, monitoring must be a dynamic process involving all those contributing or using the service. In a system which must be geared around the needs of individuals, we need to recognise that the system will never achieve any permanence but will continuously alter its shape and form, as the needs of the individuals alter either over time for each person or as new people enter the system. Further, a service seeking to utilise ordinary community processes and structures must recognise that no one model for the delivery of service will be appropriate for all circumstances. In the area we cover, we recognise that what may be seen as useful and acceptable for an area like Chesterfield, a conurbation with 96,000 people, may be irrelevant for West Derbyshire a huge rural area of approximately 450 square miles with 67,000 people. In West Derbyshire the local vicar may be seen by people as more useful and relevant to them than a psychiatrist, social worker or community nurse. Our professional response should be subservient to these local needs. We should work to strengthen, educate and assist existing local structures, not brush them aside because of our own difficulty in coping with our so called professional identity. This usually makes it difficlt for us to accept that some forms of help may not fit our model and yet are invaluable.

Integrating our Work with other Agencies

Planning Teams

The need for a comprehensive network of mental health services is such that careful attention will need to be paid to planning new services, co-ordinating existing ones and developing an effective strategy for community development. Within the four districts that make up North Derbyshire it is hoped that local planning groups will be formed, bringing together staff from health, social services, other agencies and most importantly representatives from relevant voluntary organisations and community leaders. The experience of Psychiatrica Democratica in Italy suggests that a genuine community mental health strategy cannot be effective if it involves the imposition of professional policy and ideology on local communities, with an absence of a genuine political debate. We cannot plan for people; we must plan with them.

The rapid expansion of services in North Derbyshire; this Project, the development of a new strategy for psychiatric services with the formation of community mental health teams, the experimentation with various models of community nursing services for elderly mentally impaired people; has seriously overloaded existing planning and co-ordinating structures, both within the Social Services Department and District Health Authority. At times, joint planning can seem a travesty of the concept, with either side simply using the forum to inform the other agency about matters already decided. There now a need to develop new methods to co-ordinate and monitor established policy. It is possible that a district co-ordinating

group could be developed, commencing within Social Services, which would ultimately bring together everyone with a first line managerial responsibility for any element of the service. This would ensure a more responsive method by which the operation of the service could be evaluated and recommendations for policy adjustments made.

The needs of people who experience mental health problems are considerably varied and involve diverse demands. From the old and young, from people with acute yet temporary problems through to people whose disability arising out of mental health problems is such that they may remain dependent upon social and health services for long periods. Flexibility and accessibility are critical components of any comprehensive service. To achieve this a variety of workers and agencies must work closely together. Close reciprocal working arrangements must be established through trust and mutual respect for respective skills, and acknowledgement that everyone is committed to improving the range and quality of mental health services. This respect and trust for our professional colleagues must feature in our attitude to the communites in which we must work and the people who will use our services. Modesty in our approach can help to enhance the extensive skills and potential within everyone we meet. To achieve this, every agency must abandon organisational arrangements geared to centralise and control activity, which only tends to stifle effective spontaneous working relationships between staff and agencies. This should not imply a rejection of the importance of planning, co-ordination or proper accountability. Rather, it is to assert that planning must not be allowed to become the goal itself and, consequently, obstruct effective development by providing a vehicle for individuals or agencies to act out an irrelevant power struggle. We must recognise that at times the need to respond to spontaneous opportunities thrown up by local communities or to meet individual needs, may conflict with the demands of a sometimes unavoidably slow management and planning mechanisms. Although at times the process may become uncomfortable for all of us, as we hear rumours of what people have done or said, it can be sustained by open positive communication and a trust in the cause to which we are all committed.

During the past two years the Project has been able to substantially increase the range and quality of mental health services. This has been achieved with the support of a range of agencies and workers with whom we have worked closely. Our experience shows us what can be done even within an ad hoc and confused planning process and provides important indicators as to the way forward, in what must be seen as a prolonged task.

PLANNING FOR INDIVIDUALS

Dr Judith Gray
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When I started in North Manchester a couple of years ago I was asked to evaluate the possibility of setting up a Day Centre in the south east corner of the district. At the time there were already written plans for the centre and there was a spare building which was available. The approach that I wanted to avoid was the common health service planning process of starting with a building and creating the service to fit with that. I wanted to challenge the assumptions that the building is an essential and that 'a service' almost equals 'a building and its contents'.

The group planning process that we took part in included many people - people we felt were essential and without whom change would be impossible. We brought together 2 psychiatrists, a psychologist, a nurse, an OT and others to take part in the planning of a day facility for mental health in this part of the district. Within the planning group there was a core group - myself, a research assistant who was working voluntarily, a psychologist together with an outside facilitator. This core group met regularly between planning sessions so that we could make sure that what went on had some structure to it, that the practical details of booking rooms, organising paper and pens were done and that we had a clear idea of what we were trying to achieve by the end of the day - an important point we identified early on. The planning group met regularly and we made sure that everyone gave a high commitment to each meeting, putting aside sections of time from a day to half a day for the meeting. In this and subsequent planning processes we have been involved in with staff such as nurses from the wards, it has been very important to negotiate with the 'top of the hierarchy' to agree in advance that time off from normal duties and appropriate cover would be organised.

In this particular exercise I was lucky enough to have someone prepared to work on a full time voluntary basis who was able to do a lot of the necessary background work. Planning does not just happen, it is something you have to work very hard at.

We set some important ground rules from the beginning - for example, no "jargon" would be used in the planning group meetings. We set out deliberately to forget old assumptions based on professional labels and tried to avoid the feeling that the people/patients we were planning for were very different to us. We also had to ditch some of our own most favoured cherished ideas. At the beginning I thought we would plan a community consciousness raising whole food co-operative/family therapy/bicycle co-operative all rolled into one.

We thought we would like to plan directly from the needs of the people who would use the service and we tried to explore alternative ways of finding out what these needs might be. In doing this we were conscious that the methods of working on the task would actually change our views and attitudes as planners and that is something we considered valuable. In the end we found the most helpful way from a document called "Getting to Know You".

There are some important assumptions behind this process - that all people have very similar needs and that many of these needs are completely neglected in our service planning - the need for autonomy, individuality, protection of rights, personal continuity, participation and status in the community.

In planning from the needs of the people who would use the service we started with a set of questions

- who are these people?
- how can we get to know them to be clear about what their needs are?
- how can we create good ways to meet their needs?

Our first step was to identify some named people this service was intended for. Having identified them, individual members of the planning group spent a period of time with one of these people - eating the same meals, listening, observing, asking the person about their interests, their past, their life now, going with them to therapy sessions, being as bored as they were. meeting friends if there were any, asking staff about how they saw the person, asking about the past, views about her needs as seen by staff - lastly looking at any records.

It is important to give you an idea of what we found when we looked at individuals' needs and particularly when we considered their lives in terms of their presence, participation and status in the community. In our group meetings a number of common themes emerged:

- there was very little opportunity for them to work and play among different types of people
- there was little opportunity for them to make relationships or to meet people who were not either mentally ill or staff of mental illness services.
- they had few possessions
- there was no sense of autonomy or individuality
- they had little continuity in terms of either the staff looking after them or the places they were in.

The other half of getting away from traditional perspectives in our planning was getting to know the community. In parallel with building up our understanding of the people and their needs we looked at the resources, skills and opportunities in the community. This included physical resources, community groups, professionals and paid helpers. We found that our community was certainly not a cure-all. It could be hostile, unhelpful, dangerous, and lacking in resources and knowledge. Nonetheless it was important to have information, to build participation and to find ways to empower the community rather then to manipulate and exploit.

We tried to see our task as service developers as integration - co-ordinating and linking as far as possible the needs and the strengths of the individuals with what was already (and potentially) there in the community.

We looked at the skills and resources already in the community and at the needs apparent in the lives of the people and tried to estimate what additional inputs would be required from our service. I will not describe here the detail of what we are planning but some of the features of it include

- appointment of a 'community co-ordinator' to maintain the process of the original planning exercise
- a commitment to work as much as possible outside the four walls of the centre
- active monitoring of the project in terms of successful integration and use of ordinary facilities and community resources
- a future programme of similar planning activity for other aspects of the services so that this scheme does not remain in isolation within the overall psychiatric service.

Ref Brost. M et al. 'Getting to Know You'. Wisconsin Council of Development Disabilities (1982).

Note

Since this paper was written the service - Powell Street Project has opened in North Manchester District.

EAST SUSSEX: EXPERIMENTS AND EVALUATION

Linda Bailey
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In May, 1979 I was recruited to the Centre for Medical Research at Sussex University. One of my tasks was to 'evaluate the development of experimental community mental health centres in East Sussex'. The work was funded by The Area Health Authority for two years, but, in fact lasted until the demise of the Area Health Authority in March, 1982.

At the time of my appointment there were no centres in operation. Two were at the planning stage: one in Lewes and one in Hastings. Others were under discussion. Both the centres being planned were experiencing delays and uncertainties about funding, staffing, and premises. Inevitably this was affecting the groups' willingness and ability to look much beyond the already stated aims and objectives and get down to the hard work of how they were going to turn these into practice. Not surprisingly the planning groups, who were, in any event, only engaged in planning the centre on a part-time basis, were reluctant to give much time to what began to 'feel' for them like increasingly academic discussions about the planning and implementation of the projects. They were instead anxious to just ensure that the Centres opened. This them left me fairly free to focus on the literature on evaluation and on the development of such centres in other countries, most notably the United States. The literature was most revealing but one particular quotation from Zubin writing in 1978 about the Functions of a Community Mental Health Centre both highlights and encapsulates the fundamental dilemma and central theme of this paper:

"I have been unable to find any consensus on the need, and even less on the goals and purposes of Community Mental Health Centres except in general non-specific terms. Until these are spelled out no evaluation is possible".

This extract drawn as I said from the American experience hardly provides an encouraging start to our discussions about the evaluation of Community Mental Health Centres. Yet it does serve to underline a fundamental dilemma, that is that evaluation, however defined, is not possible without clear statements about what a centre is, what it intends to do, who it intends to serve, how it proposes to achieve its aims and objectives, resource requirements, timetable etc. In other words, evaluation is dependent upon sound planning.

How then would we define the term evaluation? This question is best answered by the master himself: Suchman who states evaluation is "a method for determining the degree to which a planned programme achieves the desired objectives". Evaluation research asks questions about:

- the kinds of changes desired
- the means by which change is to be brought about
- the signs according to which such change can be recognised - in other words how can we recognise and measure the success or failure of the enterprise - its outcome.

(You might like to note that this is the first specific reference to this all important point - OUTCOME). But this for me reveals another and as yet untouched on dilemma. Evaluation is concerned with assessing the value or worth of a particular activity or programme. Now if this judgement is accepted it follows that there is no objectivity in evaluation. 'Value' and 'worth' are essentially subjective judgements which will vary from individual to individual and from group to group according to the roles, functions and points of views of the interested parties - a point well demonstrated for me, for after all who was to be the client of my efforts: the group planning the centre, centre staff, District Health Authorities, Social Services, who owned one of the centres being planned, or the Area Health Authority? All of these groups had different interests, different information requirements and different expectations of the evaluative process. But there is another interested and often neglected party: the client. Timms and Mayer in their study "The Client Speaks" highlighted the very different perspectives of the professional and the client. In one example, there were the social workers who aimed at 'insight' as a positive outcome of their psycho-dynamic casework, and the clients who were disatisfied because they did not get the material and practical help and advice that they had expected.

So where are we? What we have established is that the first point that needs to be considered in any evaluative process is what aims are being pursued, and whose they are. What are the needs or problems that the programme has been designed to meet. What are the means that have been chosen to tackle specified needs or problems in order to achieve desired objectives, and finally how can we recognise success or failure - by what criteria can we measure this. All of this implies the need to have a point of comparison, and this, as Professor Wing has pointed out, is itself fraught with problems! No doubt you are now screaming "why bother?". Why should we want to embark on the difficult process of evaluation strewn with a variety of apparent minefields. The answer is linked with issues about accountability, arguments about the deployment of scarce resources, the most effective delivery of care, cost effectiveness and safeguards against the indiscriminant adoption of the new and trendy without due regard to the efficacy and appropriateness of the care being delivered.

Certainly these are all important issues, for me there is an even more important reason. Evaluation gets discussion going. It makes people confront the hard and crunchy issues about the needs of localities, the present services being provided, the relationships and links between services, the shortcomings in provision, how these might be overcome, the resources needed, and questions about how might we assess, albeit initially in crude terms, the success or failure of particular initiatives. It provides a marvellous opportunity to involve a wider community in discussions about needs, the organization and delivery of care, and outcomes.

Our focus is not then on what Scrivens calls 'summative evaluation' where summary statements are made about the success or failure of an enterprise, but on formative evaluation where the aim is to help centre planners and staff clarify aims and objectives and feed back information on progress towards the implementation and impact of programme objectives. These points are best made by demonstration.

Aims and Objectives:

- To provide a therapeutic or rehabilitative experience for those who are mentally ill, and for those people who although not formally mentally ill are experiencing some emotional or personal crisis in their lives.
- To receive referrals from any source, professional or lay, including self referrals to the Centre.
- To prevent crises resulting in breakdowns or hospital admissions by providing help at an early stage.
- To provide a service which will be geared to their needs ...... and for a hopeful rehabilitation away from the need for service.
- To make available a much wider range of services than simply offering occupational activities.
- To provide a professional worker at the Centre, Monday to Friday, 9 am to 5 pm, to respond to and co-ordinate any crises that are referred.
- That a crisis service will be developed for evenings as well as daytime hours once the centre becomes established.
- To provide a forum for all professionals by whatever training ...... and to work together and to plan the work of the Centre.
- To develop courses and seminars for those related disciplines interested in developing counselling and helping skills.
- To provide a base for voluntary organisations working in similar areas to that of the Centre.
- To recruit and train volunteers to take on individual work with particular attenders and also make a general contribution to the value of the Centre.
- As the Centre develops to compile a register of volunteers who will be available to provide assistance to individuals in crisis, both at the Centre and out of it.

These are some statements drawn from an operational policy document which was prepared by one of the Centres that I was dealing with. You can see that there are a large number of aims and objectives fairly broadly expressed.

In the first one you have a mixture - statements about therapeutic or rehabilitative experiences for those who are mentally ill and information about who the Centre is going to serve. If I were talking to the Centre staff about their aims and objectives I would immediately be trying to ask them some questions - "You are talking about a particular population you are going to serve. It appears that you are going to serve everyone by what you were saying. If that is literally the case, are there priority groups, are there groups that are going to be excluded from this particular activity? What do you actually mean when you are talking about therapeutic or rehabilitative experiences? Are you talking about setting up particular individual activities? Group activities?"

So you would be fleshing out the details of what it is that they are trying to do.

To provide a therapeutic or rehabilitative experience - I would see the priority here as being clear about how that objective would be translated into practice and some consideration of outcome either for particular groups of clients or for the broad program. It would be useful to know more about what would be seen as acceptable outcomes for this activity. It would also be helpful to explore early on whether there are any specific worries about this; whether for example there are any specific groups of clients who are at particular risk of being missed, or not being referred.

In relation to "receiving referrals from any source, professional, lay including self referrals to the Centre" - I would be thinking that the Centre should pick up information about just that - where are the referrals coming from? That will be very important to monitor.

What are we talking about in relation to crises? What do we mean by the term? When are we saying that we are going to help prevent admissions to hospitals? Is it something that is immediately going to happen once the Centre is open or are we talking about something that is more long term? Is this in six months, a year, two years?

It is very, very important to make sure that the aims and objectives are clear, to identify any undetermined assumptions that there might be relating to these and to identify conflicts in some of the objectives which you have - they are always there.

One of the things that it is useful to do in evaluation work is to look at what people say they are going to. It has been my experience that people planning and running a service find it easier to set out the detail of how they are going to do something than to set out the underlying aims and objectives. In practice though there are often important gaps between the activities which were envisaged and real life. In one Centre I worked with I documented the planned and real progress of referrals.

In planning, the process was seen as follows:

1) a referral from any source would go to the duty worker or coordinator

2) there would be an allocation meeting to discuss the individual

3) there would be an initial assessment period

4) a key worker would be allocated

5) there would be a planned programme of work

6) there would be regular reviews and hopefully the client would be discharged

7) there would only be relatively short contact with the Centre.

A key part of the purpose of the Centre was seen as edging into a planned programme of work with individuals. Yet when we examined the one hundred and sixty four people referred during a nine month period only one case had actually been reviewed and in only five cases had review dates been set. There were a very large number of cases still open and very few cases were closed.

The Centre had not been able to put into practice, even at this early stage (or perhaps because it was at this early stage) what it had set out to do.

When we picked this up and tried to understand why, there were a number of reasons - staff were not clear about different groups that were available, they were uncertain about the individual skills of other professional workers and, perhaps above all, the staffing structure of the Centre made it difficult to oversee individual programmes in the face of other competing activities - duty work, running group work and individual sessions, attending meetings and so on. Now of course it may be that at that point in time the Centre's sense of priorities was right and that it was not so important to concentrate on individual programme planning. It is important that everyone recognises that this is the case and that a gap does exist between the written aims and the day to day allocation of staff time and resources. That might be a key element in evaluation.

What then am I advocating? I'm arguing that the first step in the evaluation process are good descriptive studies of Centre clients, the help or services they receive and how these are organised. Such studies can provide valuable information on who is attending: their personal situation: age, sex, living circumstances etc. Who referred them, why they are there: the nature of their problem, whether they have had previous contact with health or social services, what they obtain in the way of services or help, whether they disappeared after that first referral never to be seen again, whether they were then referred elsewhere etc. If an ongoing descriptive system can be developed which enables those providing the service to monitor such activities then we can move closer to an evaluative exercise. If we can build into this process a system which embodies objectives and action plans relating to the individual clients such as that envisaged, for example, in planned programmes of work, this will enable us to go beyond simply monitoring who was there and who gets what and enable practitioners and administrators to compare problems, plans, and actual achievement on an individual, or an aggregated basis by client groups, sources of referral, geographic locations, reasons for closure and so on.

It will be very clear that such a monitoring system requires the active collaboration of Centre staff. The system will be dependent on them completing the data collection instruments (forms) and any additional documentation required. To do this routinely they need to be convinced that the information that is being collected is useful and relevant. There has to be something in it for them. They have to see the usefulness of the data, which should be used to stimulate discussion about achievements and working practices, or mismatches between aims and centre performance. But let's not forget the client in all of this. They too can be involved in the process or review and assessment particularly if working practices seek to involve the client.

The basic information requirements of program evaluation:

- catchment area characteristics
- centre goals and objectives
- client information
- information on the use of services

- information on staff activities
- links with community
- financial information

To sum up then, a routine monitoring system is capable of identifying trends in client characteristics, problems presented, help requested, service responses, resource requirements, and the achievement of objectives. This information can provide base lines for further operational research and outcome studies. It can highlight areas where further more detailed study is required if new schemes and policies are to be soundly based. This path is not without its own problems: who is to do the work, who's to pay for the work to be done, whoever it is done by. But it's important work, and provides a vital source of information for the delivery and development of services: including the assessment of outcome. I wish you luck with your voyage of discovery.

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COMMUNITY MENTAL HEALTH CENTRES - WHERE NEXT?

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There are three established Community Mental Health Centres operated by Eastbourne Health Authority - Avenida House, Burnt Mill and Eastgate House; (the last is run jointly with East Sussex Social Services Department). Despite their relatively recent origins or perhaps because of them, there seems to be a great deal of uncertainty about these centres proper use, their role in the overall delivery of mental health care and their future. This short paper is designed to promote discussion about their role and to review their use and functions.

Co-ordination of Services - A fundamental objective of all the Community Mental Health Centres is to co-ordinate the various mental health services offered to the communities that fall within their areas. One part of this co-ordination is the bringing together of the psychiatric team in revised form outside of the hospital. Instead of professional groups and individual workers going their own way in the delivery of community services, the Community Mental Health Centre offers an opportunity for team work and a unified approach. In practice, independent referral routes have been retained by all the various professional groups involved but a new referral route has been added in the shape of referral to the Centre. It is not necessary to have a Community Mental Health Centre to have a community mental health team, but team work is much harder to achieve without a Centre to work from.

A second and perhaps even more important part of the co-ordinative work of a Community Mental Health Centre is the pulling together of mental health workers from different agencies.

Social Service participation is of particular importance and is likely to be of even more importance in the future, given the Government's plans for the funding of care. The new Mental Health Act also underlines the important role Social Services play in Mental Health Care. The recently developed patch-work approach philosophically marries well with Community Mental Health Centre objectives. How Community Mental Health Centres relate to patches and approved Social Workers depends on the perceived value of such links from both sides of the fence. With the exception of Eastgate House, the existing Centres are in danger of being seen, or of seeing themselves, as Health Service resources which perhaps only require hospital social work input.

Voluntary Sector participation is of equal importance. Voluntary Sector workers both paid and unpaid often serve the most disadvantaged clients and those whom statutory workers have either failed to help or have given up hope with or have never seen. Many voluntary groups by their nature tend to function in isolation and have to work hard to keep "body and soul" together, not least because of their precarious funding. Despite their base in the community, they often have little opportunity to influence the overall pattern of care provided. They often have a limited awareness of statutory services and vice versa. The mixing of statutory and voluntary is a very skillful and demanding process but if it is not achieved the community part of Community Mental Health Centres is rendered meaningless.

Co-ordination is a desirable objective but in practice no service wishes to be co-ordinated by another service and professional and agency rivalries and prejudices ("agency chauvinism") all too often work in favour of fragmentation rather than co-ordination and co-operation. At the lowest level Community Mental Health Centres work to inform and update workers and users of resources and services but at best enable effective joint working between the Health, Social Service and Voluntary sectors. With the possible exception of Eastgate House we currently seem a long way from the second option.

Philosophy of Care - Much of the care currently offered by the Centres takes the form of individual and group work similar to what one might expect to find in outpatient settings or progressive Day Hospitals. The operational policy statements of the Centres that have them (one Centre is still working on a policy), and the early planning documents such as that drawn up by the Clinical Policies Group at Hellingly Hospital, lead one to expect a patern of care which emphasises:- self-help; early intervention; a higher priority for consultative as opposed to direct patient care; family work; community development work such as support networks for "high risk" individuals; an emphasis on normal- ization; and preventative work and mental health education. Why have the Centres by and large not developed along these lines?

The planning process of the Centres failed to bring into the open the numerous conflicts of professional and service interest. The Centres were opened with only a small increase in staff establishment and as a consequence any siezeable expansion in the direction of new treatment activities would necessitate a reduction in existing treatment facilities - a process which would require very strong political support for the Centres' stated priorities. The original objectives may have seemed laudable to all concerned, although this seems unlikely, but the actual priorities for practice have proved to be much more conservative.

The planning process also failed to take adequate account of the skills required by the Centres' staff: for example the recruitment of workers with skills in health education, consultation and community development. It is perhaps not surprising that staff arriving at Community Mental Health Centres have found it easiest to put into practice their skills derived from other psychiatric settings. Innovative practices such as those listed below require skills as well as commitment:-

preventative work with at risk groups;

sensible and effective programmes of mental health education directed at particular target populations;

the establishment of appropriate consultative machinery for referral agents and others working closely with the mentally disturbed;

the ability to tap and generate supportive social networks for particular individuals and groups.

The slow start of the Centres may also be a product of the lack of clear leadership within the Centres. The American Community Mental Health Centre Programme opted for "Centre Directors" who could be senior members of any mental health profession. In Eastbourne we have opted for Co-ordinators at Burnt Mill and Eastgate House and neither a Co-ordinator nor a Director at Avenida House; these arrangements seem to beg the question who leads and with what authority? The Co-ordinator posts which have been created are not highly graded. (At Eastgate House there have been 3 Co-ordinators in 4 years). The core staffing of the Centres needs to be reviewed and clear structures for decision making have yet to be generated.

The management of the Centres varies considerably but in general it has been difficult to achieve a management structure for the Centres which adequately reflects the groups with a legitimate interest in their running. If a coherent management structure involving Health, Social Services and the voluntary sector is missing there can be little hope of joint working on the ground.

Evaluation - The Centres were originally seen by the Area Health Authority as experimental in nature and some money was made available for them to be evaluated. Sadly with the demise of the Area Health Authority the Regional Health Authority has continued to view the Centres as experimental, but evaluation has effectively ceased. In the absence of any evaluation it is not possible to make any authoritiative statement as to the Centres' worth, success or failure. This seems particularly serious in that the Centres are likely, unless then can prove their worth, to end up as specialist treatment resources and adjuncts to hospital units, or some may even be closed before they have got started.

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If you, your group, or organisation have any comments you wish to make in response to this paper, please send them to Richard Pemberton at the Victoria Hospital, Nevill Road, Lewes.

EVALUATION OF THE WESTMINSTER ASSOCIATION FOR MENTAL HEALTH RESOURCE CENTRE

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The role of the evaluator:

When I was asked by the W.A.M.H. to help them evaluate the service they were planning to develop, we agreed upon a role for me, which I would describe as co-ordinator or consultant: I am only part-time involved, and I see myself as an adviser to the staff - or what you might call a 'critical friend'. The assumption is that the staff themselves are interested in looking critically at what they do through some ongoing monitoring of their activities and their effectiveness. My role as an outsider (based at the King's Fund College) with some previous experience in evaluation work is to make sure that critical questions are being asked; to assist in answering them by helping to collect relevant information; to see that the information is being analysed; and to write a final report. In other words, the model of evaluation adopted in this case is not one in which evaluation is a research activity which is separate from the activities related to the service delivery. Yet is is not entirely one of self-evaluation. Rather it is between the two extremes, and the advantage, I think, of this model is that it provides some elements of impartiality without being too costly. (See more about my role in the final section on report writing).

The aims of the evaluation:

The evaluation exercise has two braod aims: first to describe and analyse the operation of the service as it develops over the first two-three year period; the extent to which it meets the needs it aims to meet; and the ways it compares with and links in with other existing services. The main findings will be published in a report, which hopefully would be available to any interested practitioners or researchers in the field. In other words, this aim has to do with 'telling the story' about what happened in the project and the lessons to be learnt from it. (in evaluation language, referred to as 'summative evaluation'). 'Formative evaluation', on the other hand, which could be said to describe our second broad aim, has to do with some ongoing monitoring of the service. The purpose of this activity is to keep ourselves informed constantly about how we are doing - to ensure so to speak that we are going in the direction we intended to go, or that any change of direction is a conscious change. Evaluation in this case is simply a kind of management tool, which ought to help us make better decisions regarding the use of resources and delivery of services.

What is a 'successful' project?

One of the questions most frequently asked of an 'evaluator' is 'was the project successful?' or 'how do you measure success?' Often the expectation is that achievement can be measured in terms of effect or outcome. In this model, the service/programme being evaluated is seen as a system processing an input - clients - resulting in an output which is different from the input; the clients or their circumstances would be expected to have changed as a result of going through the system. Moreover, it is expected in this model that such change(s) can be observed and measured, and that ideally one would compare the effect on the clients going through the system with a group of people who did not have any contact with the system: a control group.

There are a number of reasons, however, why the success of a programme like the W.A.M.H. resource centre cannot easily be measured primarily in terms of outcome. First, it shares with all other programmes of social intervention the problem that is is methodologically difficult to isolate the effects of the programme from the effects of the social world in general with which the clients would inevitably be in contact. Also, there are practical and ethical problems in making comparisons with a control group of clients who would have to be excluded from the programme in question. Even if those problems could be overcome, however, it is doubtful whether in the case of the W.A.M.H. resource centre success would be seen as having much to do with effect or outcome. What distinguishes this centre from more conventional forms of treatment is that it aims to be a facility to be used by a wide variety of people in the local community - not just those who have a history of mental illness. It aims among other things to prevent breakdown by supporting those at risk and to prevent recurrence of mental illness. It aims to do so in a way which minimises the difference between 'helpers' and 'helped'. In fact, 'users' is the preferred term for those coming to the centre rather than 'clients' or 'patients'. In other words, people are not seen as objects undergoing treatment, but as active participants in a system of mutual help and support. In the light of this, therefore, it is not surprising that the staff/management prefer to express 'success' by referring to what will actually happen at the centre, i.e. questions like 'will it be able to function at all?' 'Who will use it?' 'What will the users themsleves think of it? In short, the emphasis would be on processes rather than effects. Having said this, however, in view of the growing pressures on all health and social services to be 'efficient', and the prominence given to the development of performance indicators, it would be foolish not at least to attempt to identify any benefits the users might gain from the centre beyond those of the immediate use of the centre.

What information do we want?

Having stressed above the importance of mapping out the processes of what actually happens at the centre as well as the need to look out for outcome measures, I would suggest that ideally we would like to collect the following information.

1. Who are the users? (e.g. demographic characteristics; social circumstances; past contacts with services/hospitals)

2. Circumstances of initial contact with the centre.
   (e.g. who refers them? reason for making contact).

3. The nature of their contact with the centre
   (e.g. how do they use/relate to the staff and each other? length and frequency of contact; users' views of the centre).

4. 'Outcome' of contact.
   (e.g. any changes in their circumstances, quality of life? to what extent can the centre meet their needs?).

5. What is the impact of the centre on other services?
(e.g. is it a resource to other services? Does it contribute to more appropriate use and higher take-up of other services?)

6. How does the centre work from the point of view of the staff?
(e.g. are their skills and abilities used in the best way? are they satisfied?).

7. Policy and management issues.
(e.g. problems in launching the project; role of funders; role of steering committee)

8. Comparison with other services
(e.g. pros and cons of voluntary vs statutory provision).

This list refers to the types of areas which one would ideally like to know something about, but which of these areas are selected and how much information can be gathered within each area depends of course on the time and resources available. In the case of W.A.M.H. centre the actual gathering of information, in particular the recording of routine information will depend entirely upon the staff. I would hope that two types of routine information systems would become part of the day-to-day work of the centre: a record system on the users, and a daybook in which the staff would record events, experiences, problems, views - all of which would contribute to painting a picture of the centre.

In addition to this routine information gathering some one-off studies of specific issues would be conducted by contracting in some outside help on a temporary basis. Some (modest) funds are available for this, but in addition to this it would perhaps be possible to recruit students to do some research as part of their training. The purpose of these one-off studies would be partly to get some more in-depth, qualitative information, for example some case studies of a sample of users would throw light on some more dynamic aspects of their problems and their use of the centre - developments and changes over time, which routine statistics could not describe in the same way, another project would be to interview a sample of users about their views of the centre and their views of their needs in general. Also, the environment in which the centre is operating could be looked at more closely, for example by focusing on all the other services in the nearby community which could be said to be dealing with similar clients. A questionnaire survey asking their views about the needs of their clients and the extent to which they feel able to meet them, would be extremely useful in relation to the whole issue of care in the community as an alternative to institutional care. Another useful avenue is to compare the operation of the centre with a similar service in the statutory sector. In our case we have already identified and established links with such a service, so a comparative analysis should be a relatively easy task. However, nothing detailed has been decided as regards these one-off studies at this stage. The choices will have to be made, not only on the basis of knowledge about funds available, but in the light of the operation of the centre itself.

Analysis and report writing

It is not much use recording and collecting a lot of information unless there is time to analyse it. It needs to be made clear from the start who is responsible for extracting information from the records and for analysing the daybook, and how often it should be done. The question of how often would depend very much on how often it is decided to review the operation of the service. It may be useful to distinguish between major reviews undertaken once a year, for which as muich information as possible would be desirable, and regular monthly reviews using impressionistic and very basic evidence. Decisions about how much should be analysed and who should do it must be made jointly between the evaluator and the staff. As the evaluation coordinator, I see myself as responsible for making sure that relevant information is being produced, and I would undertake to do some of the analysis myself, but I would also depend on the staff to do a great deal of this work.

At the end of the three year evaluation period, there will be a report, 'telling the story' of the centre, the lessons learnt etc. The writing of this is one of my main responsibilities, although of course this does not preclude the possibility of the staff themselves producing something in writing. What it does mean though is that as well as having an obligation to produce a report, I also have the right to do so in the following sense: I have full access to records and other information collected during the period in question, and I undertake to treat this as confidential. The release of the report for wider circulation and/or publication would happen only after negotiation with the staff and management that it is fair, relevant and accurate. Release of the report can only be delayed or restricted if it can be shown that this would unfairly disadvantage a user or a staff member. In other words, although hopefully both the staff and the evaluator would be as committed to the service itself, as well as to telling the whole truth about it, it is in the interest of both to spell out from the very beginning their mutual rights and obligations.

COMMUNITY MENTAL HEALTH CENTRES - A VIEW OF THE LANDSCAPE

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The establishment of Community Mental Health Centres is a key feature in many districts' plans to redevelop psychiatric provision outside of large institutions. Faced with writing an operational policy, we have been considering some of the issues and trying to gauge from unpublished papers what the current 'state of the art' is around the country.

To those with experience of Health Service planning and politics it will probably come as no surprise to learn that once you proceed beyond the umbrella title, Community Mental Health Centres display a remarkable lack of homogeneity. This can be revealed by a short consideration of each of the three components of the title.

'Community', at the very least, envisages a development away from the major site of current psychiatric services. Such a bald transfer of accommodation from one site to another is hardly sufficient to warrant the community label. Most Districts seem aware of this and are trying, with varying degrees of both commitment and success, to stimulate local interest in the project. A key factor in making progress in this field would seem to be an initial planning model based on communities that local people recognise as being communities rather than abstract catchment populations. Such locality planning, as it has been named, aims to place the new service for a specific area in a location which the residents view as a focal point, e.g., close to shops, schools etc. Having identified the particular population, approaches should be made to groups and individuals in the locale with the aim of receiving suggestions about the proposed service as well as informing them of its impending arrival. Some districts tie in this process with an elaborate needs analysis, of which more later. Most policies see a role for volunteers within the building, but without such a locality basis and a pro-active planning and public relations exercise, such a vision may remain just that.

Positive action also needs to be taken if the use of 'mental health' is to be more than symbolic. Most operational policies mention preventative work, but with no clear outline of how it is to be undertaken, and it is an objective that appears to be neglected in practice. Some districts, however, would not necessarily lament this omission, viewing their Mental Health Centres as a secondary rather than a primary resource. This is particularly true where large institutions are in the slow process of closing. Thus the emphasis in these districts is on the acute psychiatric patient referred on from a G.P. or discharged from hospital and under the clinical care of the psychiatrist. Centre staff would also have a maintenance role with those chronic patients leaving the hospital for alternative forms of residential provision. In districts without such a background the emphasis in Community Mental Health Centres has a more primary emphasis with less medical input, G.P. referral to a variety of centre staff and self-referral, drop-in facilities.

'Centre' also contains a variety of connotations. Some districts are planning large new buildings which will become the centre of gravity for the Psychiatric Service and involve a day hospital and refuge beds as well as office accommodation. Others, if considering providing all three components of the service in the community, are placing them in different locations, with the office accommodation taking the Community Mental Health Centre name. The degree of usage by, and thus planning for, local groups also varies, with some restricting access to health orientated groups with direct health concerns, whilst others view the facility as more of an open social centre.

Some Common Features

The service objectives will normally make reference to accessibility, with the premises being in a shopping or residential area served by regular local transport. Many of the Community Mental Health Centres that involve merely an office base have occured in converted residential housing, with the larger ones inheriting NHS or Local Authority buildings. New builds are uncommon, largely because of expense, timescales and the absence of available building land in central locations. Mention is often made of the Community Mental Health Centre being part of a comprehensive service, although the emphasis, consciously or not, tends to be on acute situationly disturbed adult clients. Community Mental Health Centres rarely have patients.

Stress is laid on the Multi-disciplinary Team. The concept is of equality between professionals with everyone involved deploying their professional and personal skills as thought fit by the Team. Some policies go so far as to talk of Mental Health Professionals, on the grounds that overlapping of available skills and therapies make thinking in terms of defined professional groups obsolete. We have yet to hear of a district recruiting on this basis or seriously addressing the difficulties relating to line management arrangements which could arise. Most centres are based around Social Workers and Community Psychiatric Nurses. In addition, many employ Psychologists, Occupational Therapists and have varying degrees of Consultant and Junior Medical input. The more established centres are starting to develop beyond these rather traditional groups and, in response to their perception, or actual expression, of local needs are employing Home Maintenance Therapists, Art Therapists, Nursery Nurses and Transactional Analysts etc. Initial planning on the basic teams seem to have involved a fair degree of ad hocery and cutting of cloth to fit revenue available. Despite the discussion of team work and equality, the difficulties endemic to pay differentials, traditional status and clinical responsibility are usually passed over.

Most centres propose an on-duty professional, usually from 9.00 a.m. to 1.00 p.m., although this could extend to 5.00 p.m. if staffing levels are sufficient to allow it. Each of the Care Professions, with the exception of Doctors and Occupational Therapists, undertakes this commitment on a rota basis. The function of this worker is to be present in the Centre for the allotted period to see non- appointment self-referrals and arrange assessments for those clients who appear via more usual channels. This assessment is normally undertaken by two of the Centre workers, often in the clients home. Urgent referrals are dealt with in under 24 hours, or referred onto the Crisis Intervention Team, if available. Such teams routinely consist of a Senior Registrar, Nurse and Social Worker and are usually organised on a district basis.

Referrals are taken from GPs and Voluntary Organisations, with the on-duty professional presenting the details of the referral and subsequent assessment to a weekly allocation meeting. A key worker is chosen on the basis of which of those present seems to have the most appropriate skills and caseload space. Some policies mention an element of patient choice, although no details of how this is to be exercised are included. Even in centres without regular medical input, a consultant is usually in attendance at these allocation meetings.

It is difficult to ascertain from policies how much the potential problems inherent in such a method of working have been anticipated or have arisen What happens to referrals which arrive specifying attention from a particular centre worker, particularly a consultant? Do all new referrals to consultants need to pass through the allocation meeting, and if not how can the range of therapy options be ensured for the patient? What steps can be taken to prevent the drift towards the YAWVIS (Young Attractive White Verbal Intelligent Sophisticated) client consequent upon a community based worker interested in dynamic therapies taking referrals from GPs? What is the power relationship between theoretical equals in an allocation meeting when a dispute occurs about a course of therapy which is under discussion?

The model of organisational relationships may talk of managerial team leaders, but it is not made explicit that any authority in one field will carry over into problems relating to clinical team issues. No doubt there is a formal role for the line managers in all but one of the professions involved, but it is rarely clarified.

The method of selection of the team leader varies. Some have her elected for a limited period, others appointed as the foundation of the development. Some teams have dispensed with the leadership concept entirely. Those that have not often give the leader a budget responsibility, managerial oversight of clerical and domestic staff and a representative role on the Centre Management Committee. Those centres that employ a co-ordinator usually devolve the first two of these three duties to this administrator.

Most policies envisage a policy/planning/management committee which will largely comprise of people not working within the Team, eg UMT members, a GP, Local Authority representatives and some specific places for the Community Health Council and Voluntary Organisations. These committees decide policy for the centre and have an oversight of staff recruitment, budgets etc.

There are several points to be made about such a formal, and in many ways traditionally hierarchical structure. If CMHC teams are genuinely to develop as a focus of mental illness services for a specific catchment population/community then they must surely be granted more autonomy than outlined above. These teams should appreciate best the needs of their area, and have the delegated responsibility to plan accordingly. Such delegation must involve a budgetary independence, for instance sums for staff recruitment and staff development. Professional accountability will remain to line management heads but team accountability should be to the UMT, to whence statements of need for capital developments etc. should be channelled. It is to be hoped that CMHC teams will involve community and client representatives in their planning process. Whether such innovations in management style, which could be as radical as the change in service provision, will come about is difficult to predict.

It is worth remarking that the early, and thus now established, CMHCs tend not to detail any formal management arrangements in their policies. This is perhaps because such teams were self-selecting and therefore committed to the concept of community team work. However, such teams have suffered problems from a lack of expression of organisational assumptions when they have undergone staff turnover or prolonged sickness. Particular difficulties arise when the absent individual was the originator and/or lynchpin of the development and the authority behind the team facade. Any districts which are tempted to let management issues resolve themselves as new teams evolve should not be misled by the apparent success of these innovators. Their self-selectivity cannot be repeated and their later difficulties are instructive. Furthermore, the sort of management delegation of responsibility outlined above presupposes clear accountability. Nonetheless, as part of the local planning process, teams should be encouraged to review management arrangements and activities regularly. There is no reason why teams should not develop management teams to suit their particular personal and professional mix in the same way as they will their clinical operational methods. The only imperatives here are that agreement will be needed by the body to whom they account and that all systems are well documented.

Nearly all operational policies make reference to evaluation. Largely this is perceived as a compilation of activity analyses, with attendant data on diagnoses, D.N.As etc., although there is little doubt that many teams would like to go further. Most are constrained by the esoteric nature of more detailed research, and the additional revenue necessary to fund it. That centre which has made most progress here has had considerable charitable support. Furthermore, once the material is collated and published it needs to be comprehensible to those planning services and thus presented so that it has a positive impact on service provision. To accomplish these two tasks it is vital that professionals point researchers in the direction of questions that are capable of widespread comprehension and relevant to definite service issues. The former might be less of a necessity if detailed planning was delegated to teams as suggested above. Either way, good research is based on clear objectives, much as the centres are themselves.

Most policies make reference to education and changing public attitudes. These are often vague and sanctimonious, giving the impression that C.M.H.Cs will emit enlightenment like a lighthouse in the darkness. Experience tends to show that unless specific programmes are put together then this aspect of the centres work is pushed to the bottom of the pile.

These, then, are the elements of the average policy. Certain clear lessons come through both from the experience of and the documents relating to current centres. These can be quickly summarised.

Clarity of objectives is crucial. These should be agreed by the team and limited to a realistic number with a clear programme for their implementation. Pious statements of liberal sentiments may boost the writers' egos but will do little more. Regular review of the objectives, as well as methods of achieving them, should be written into the organisational arrangements and backed by relevant research.

Mechanisms, both professional and social, need to be developed to allow contact and trust to evolve between centre staff and those still operating in the more traditional environments. This will help overcome feelings that ward-based staff have in some sense been left behind; they are as an important a part of a comprehensive service as the centre team. Staff rotation should be encouraged where possible.

Sophisticated needs analysis prior to deciding the nature of service and facilities would be ideal, but it is more likely that this will develop as the centre team grows to understand the local environment. Formal techniques, such as a local resources survey, 'day in life' analysis, 'getting to know you' approaches and consultation with local groups could all help in this process. Client and population impact on service provision is vital if MHCs are to warrant the community complement.

As mentioned earlier, the innovatory centres were probably staffed by teams that were self-selecting. The rapid increase in centres planned makes such initial unity of purpose in team staff difficult to create. Districts could explore team building methods used by organisations such as theatrical companies. This may well generate an ability to discuss professional and personal misgiving which could otherwise impede team function. Furthermore, team selection for additional/replacement workers would help produce individuals with skills and attitudes liable to complement that team.

A proactive Public Relations exercise to announce the arrival of the centre seems essential; this involves liaison with local GPs, production and distribution of leaflets, open public meetings to which Headmasters, Youth Leaders, Councillors, Voluntary and Ethnic Minority organisations are invited. Such an exercise should have a commitment to encouraging those contacted to say what they want from their Mental Health Services, not merely be an account of what they are to receive. The establishment of a local link group could be explored as a new style approach to involvement and fund-raising.

This Public Relations initiative and other contacts will probably generate volunteers. The operational policy must specify a clear role for these people and contain thoughts on screening procedures, induction, training etc.

One or two districts are moving into areas which will undoubtedly be problematic, but possibly rewarding. Client access to files is being proposed. New workers, such as Transactional Analysists and Paraprofessionals, may arouse professional sensitivities. Staff support groups are being suggested to help avoid 'burn-out' and relieve intra-team tensions.

There is little doubt that developments in CMHCs will be as diverse in form as are other NHS facilities around the 192 districts. If these diversities stem from a careful assessment of varying needs in different populations, that can but be a good thing.

COMMUNITY MENTAL HEALTH CENTRES

FURTHER READING

Note

Tom McAusland maintains a file of operational policies and unpublished papers from British C.M.H.C. Available for inspection at the Centre on request.

BABIGIAN, H. M. The impact of community mental health centers on the utilization of services. Archives of General Psychiatry. Vol 34 no.4. 1977. pp.385-94.

BASHEERUDDIN, M. Attitudes of mental health center staff: changes over a five-year period. Hospital and Community Psychiatry. Vol.29 no.4. April 1978. pp.240-242.

BEIGEL, A and others. Towards increased psychiatric presence in community mental health centres. Hospital and Community Psychiatry. Vol 30 no.11. November 1979. pp.763-767.

An analysis of the decline of involvement by psychiatrists in CMHCs and a series of suggestions by which the problem might be tackled.

BOURAS, N. and BROUGH, D. I. The development of the mental health advice centre in Lewisham Health District. Health Trends. Vol.14 no.3. August 1982. pp.65-69.

Describes the work of Handen Road centre which aims to give a service integrating primary health care with mental health professionals and with easy access for patients to psychiatric and psychological help.

CALDERON, Guillermo. Mexico's San Rafael community mental health centre: six years of progress. Bulletin of the Pan American Health Organization, Vol.16 no 1. 1982. pp.17-27.

CHU, F. D. and TROTTER, S. The madness establishment. New York, Crossman, 1974.

Though now 10 years old, this powerful attack on the failures of the American community mental health centre programme is all too relevant to much of the recent service planning in Britain. It has useful warnings to offer on the confusion of objectives, the professional drift away from chronic patients, failure to co-ordinate community and hospital provision, accountability and participation.

CRINE, A. Ring and walk in. Community Care, 9 September, 1982. pp.14-16.

A brief description of the work of the Andover Crisis and Support Centre.

FELDMAN, S. Community mental health centres - a decade later. International Journal of Mental Health. Vol 3 no.2. 1974. pp.19-34.

A positive commentary on the impact of CMHC: and their importance as the basis of major changes in psychiatric service provision for the future.

FELDMAN, S. Ideas and issues in community mental health. Hospital and Community Psychiatry. Vol 22 no.11. November 1971. pp.17-21.

A positive rather general review of the achievements of the community mental health model.

FELDMAN, S. Promises, promises or Community Mental Health Services and Training: ships that pass in the night. Community Mental Health Journal. Vol. 14 no.2. Summer 1978.

Discusses disillusionment with community mental health centres due to 'inflated expectations' and poor staff training.

FIESTEN, A. R. and FORT, D. J. A method of evaluating the impact of services at a comprehensive community mental health centre. American Journal of Community Psychology. Vol 6 no.3. 1978. pp.291-302.

A presentation of the procedure used by one CMHC to evaluate the impact of its services on residents of its catchment area.

GIBBON, M. Psychiatry for the asking. World Medicine. Vol 15 no.10. 1980. pp.66-67.

Reports on a centre in Sussex designed to make psychiatric help available more easily and informally than hospital services. Based on US model of psychiatric advice clinics.

HARGREAVES, R. Brindle House: an alternative structure for the mental health service. Social Work Today. Vol 9 no.43. 1978. pp.21-22.

Describes a community mental health centre which integrates the skills of various professions.

KNIGHT, L. and SPILLMAN, E. The open door in Handen Road. Mind Out. June 1981, p. 20-21.

Brief description of the Lewisham service.

LEVINE, M. The history and politics of community mental health (USA). Oxford University Press, 1981.

A well ordered review of the American experience.

MOLLICA, R. F. Community mental health centres: an American response to Kathleen Jones. Journal of the Royal Society of Medicine. Vol 73. December 1980. pp. 863-870.

A thoughtful warning to British service providers on the pitfalls encountered by the CMHCs in the USA; particularly the drift away from 'chronic patients'.

PARDES, H. and STOCKDILL, J. W. Survival strategies for community mental health services in the 1980s. Hospital and Community Psychiatry. Vol 35 no.2. February 1984. pp. 127-132.

Some practical strategies for CMHCs facing financial cuts including service priorities, integration with primary care, lobbying. Much of it is specific to the USA, but the general advice is relevant to planning in a tight economic climate.

POSTLEWATE, J. Informality helps the disturbed mind. Pulse, Vol 39 no.21. 1979. p.18. The walk-in service at Lewisham's mental health centre.

RACUSIN, Robert and KRELL, Helen. Quality assurance in community mental health centres. Administration in Mental Health. Vol 7. no.4. Summer 1980. pp.292-303.

RUMER, Richard. Community mental health centers: politics and therapy Journal of Health Politics, Policy and Law. Vol 2. no.4. Winter 1978. pp.531-559.

SEGALLER, Stephen. Brindle House clients prove a novel approach can work. General Practitioner. 26 March 1982. p.20.

SIMPSON S. WILSON L.B., HENRY S.S. Creating comprehensive gero-psychiatric care in the community. Social Work in Health Care, vol 7(4), Summer 1982. A strategy for making sure the elderly people have access to the CMHC programme.

TESSLER, R. and GOLDMAN, H. The chronically mentally ill: assessing community support programs. Cambridge, Massachusetts, Ballinger Publishing 1982. Excellent material on the failures of the American CMHC movement and practical strategies for evaluation.

TORBAY HEALTH AUTHORITY and DEVON SOCIAL SERVICES. The way forward. Torbay Health Authority. 1983. Copies available from P. Colclough, Unit Administrator, Exminster Hospital, Exeter EX6 8AD.

An extensive background paper on Community Mental Health Centres with proposals for the Torbay service.

WERTHEIMER, Alison. Lambeth's Cowley House. Community Care. no.465. 16 June 1983. pp.20-22.

WHITE, Stephen. The community mental health center as a matrix organization. Administration in Mental Health. Vol 6. no.2. Winter 1978. pp. 99-106.

APPENDIX I

THE RANGE OF PROPOSED AIMS AND ACTIVITIES IN COMMUNITY MENTAL HEALTH CENTRES

The lists below are extracted from operational policy documents in a number of centres; broken down into three groupings.

a) Direct services to people with emotional/psychiatric problems

b) Indirect support services to mental health professionals and managers

c) Services to the general public, professionals and managers outside the mental health field.

I have included them as a possible tool for decision making by planning groups:

- how many/which of these objectives are you going to tackle?
- how do you propose to allocate your time/resources/energy across your selected objectives? (e.g. 40% intake, 10% crisis? etc)

a) Direct services (Secondary and Tertiary Prevention)

These cover a variety of distinct objectives.

1) intake, screening and referral to appropriate services	'a net to catch as many people as possible'. 'to reach those who currently do not use mental health services or make contact too late'. 'a drop in referral service'. 'a source of expertise and information in local services and facilities'.
2) multi-disciplinary assessment, and individual case management through a 'key worker'.	'a venue for brief and rapid assessment of psychiatric problems'. 'assessment of daily living skills'; 'to ensure continuity and coordination of care for the individual through the allocation of a key worker'; 'investigation of organic states'. 'the provision of multi-disciplinary team assessment'.
3) crisis intervention and residential crisis support.	'prompt an appropriate help so that acute crises and emotional problems do not degenerate into chronic illness'. 'a crisis service...for evenings as well as daytime hours'. 'the primary emphasis is to provide crisis intervention and support to patients who would otherwise have to be admitted to in patient facilities'. 'a base for the crisis intervention service'. 'a refuge for persons under stress'. 'supervised hostel accommodation for limited periods'. 'a hot line for informal carers'.

4) treatment, therapy and education by CMHC staff to bring about change in the individual client.	'Individual counselling'. 'individual and group psychotherapy, ongoing individual marital and family therapy'. 'alternative therapy'; 'psychiatric and clinical psychology outpatients clinics'; 'experiential psychotherapy including gestalt, psychodrama and remedial drama'. 'behavioural therapies'; 'social skills training'; 'home economics, relaxation, yoga, literacy, pharmacotherapy'.
5) ongoing social support and maintenance	'a social as well as therapeutic centre'; 'contact for isolated people'; 'preparation and participation in communal meals'; 'craft and activity groups'; 'overview and continuation of drug programmes'; 'relative support groups'; 'evening social club and coffee bar'.

b) Indirect activities

1) administration and office accommodation.	'Headquarters of the specialist mental health services'; 'administrative base for CPNs'; 'an office for the DRO'; 'a branch office for the probation service'.
2) integration and coordination of mental health agencies.	'coordination of existing community professional work and of various aspects of community psychiatric care'; 'maximising contact and joint work between different agencies'; 'the development of a coordinated system of care to replace the traditionally fragmented services...' 'coordinating and improving psychiatric services in the area'; 'a focal point of a community based mental health service'.
3) research and information gathering.	'research aimed at local mental health needs'; 'identifying the changing needs of patients in the catchment area'; 'maintenance of a local mental health register'.
4) supporting volunteers and voluntary groups.	'the selection and deployment of voluntary resources'; 'to recruit and train volunteers'; 'a focal point for voluntary agencies'.
5) training and support for professional groups	'a venue for seminars and meeting place for community based professionals'; 'to increase awareness of mental health problems through supervision and consultation for GPs, social workers, health visitors'.

6) an agent of change in the management of psychiatric services.	'a power house of mental health services'; 'the thin end of the wedge in the move to the community'; 'the centre will be associated with a shift in emphasis from a hospital based service in moving the centre of gravity of the mental health service into the community'; 'the promotion of innovative techniques'; 'to pilot methods of interdisciplinary management'.

c) **Activities aimed at the wider lay and professional community**
(Primary Prevention)

1) an agent of change in society at large.	'reducing the stigma of mental illness'; 'identifying the most fruitful areas of preventive intervention, supplying specialist expertise to assist in the planning of preventive meassures'; 'to enable the public to play an important part in the process of mental health provision'; 'mental health education in schools and the wider community'.

T McAusland

APPENDIX 2

The following questions were suggested by staff of the Brindle House C.M.H.C. as a useful basis for exchange of information between different projects.

If you would like to pass on information about your local work, please send a copy of the questions with any other information you think would be particularly interesting to:

Tom McAusland, King's Fund Centre, 126 Albert Street, London, NW1 and/or
Brindle House CMHC, 34 Church Street, Hyde, Cheshire, SK14 1JJ.

Your Name/Designation:

Name and address of Project:

1. Are you fully operational? YES/NO
2. If not, are you in part?
3. If not, when do you expect to be?
4. What is your annual budget?
5. How are you funded?

	Capital	Revenue:
Social Services		
Health		
Voluntary		
Other		

6. Who is in your team? List posts with number of sessions/work devoted to the project against each member.
7. What times are you open?
8. Are your premises your own? YES/NO
9. If yes, what other organisations/groups use them?

10. To what extent do you aim to provide all the mental health resources for your community?

11. Do you have a catchment area?

12. Which groups are excluded?

(1)	(2)	(3)
children	drug abusers	behaviour management
acute	alcoholics	sexual deviants
elderly	chronic	criminally insane.

13. To what extent have you changed from your original aims?

14. Do you have a director?

    a) medical
    b) social services
    c) other

15. What kind of a management body do you have?

16. Do you have particular target groups of clients?

17. Who holds accountability for clients in your team?

18. Do you do any initial assessment? If yes, which members of the team are responsible for that?

19. Do you have open case files?

20. List sources of referral (with rough percentages)

    e.g. G.P.
    Self
    Social Services.

21. What number of clients do you see in a year?

22. What major mental health services operate in your area.

23. To what extent do you collaborate with these?

24. To what extent is there overlap?

25. What are the three things you would most like to improve in your project?