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Community Mental Health Nursing in Wales: An overview of policy, practice, education and research.

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Community Mental Health in de U.K., Restructuring for the 21st Century

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

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intros as to who we are (mention book!)

- changes currently taking place in community mh care in the UK are as significant as any which have taken place since the beginnings of community care in the immediate post-ww2 years.

- Since 1997 UK cmh care has been subjected to a 'modernising' agenda which is challenging professional and organisational roles and responsibilities,

- is introducing new occupational groups into the workforce,

- is bringing forward controversial new legal frameworks, and

- is much more tightly prescribing the work undertaken by mental health professionals.

In order to better understand these processes, we:

- slide 2, objectives

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

In this session we will:

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

UK community mental health care

- Emerged in the 1950s
- Piecemeal, localised developments
- Community mental health nurses first appeared in Surrey and Devon
- Complex interprofessional and interagency environment
- Community mental health teams from the 1970s onwards

•Post war development of community mh care, as elsewhere in the industrialised world.

•Driven by variety of factors: new medications, enlightened professional and public attitudes, economics, service user lobbying, anti-institutional critiques, anti-psychiatry, etc

•Very piecemeal in the UK. Eg, 'open door' policy in the early 1950s

•First CMHNs at Warlingham Park Hospital in Surrey: extended psychiatric jurisdiction into the community, supervised by a consultant psychiatrist

•Then developments at Moorhaven Hospital in Devon. More family oriented, nurses encouraged to develop a more therapeutic role. Supervised by social workers

•Always a complex environment: contributions made by different professional groups and different agencies/organisations.

•*Better services for the mentally ill* in 1975: first document to look towards the creation of the multidisciplinary, sectorised, CMHT

The system of UK community mental health care

- Here's how it is now…
- Lots of local variations on this theme
- Critical for 'joined up' services that family-oriented system of primary care interface effectively with secondary, specialist, mh services
- Potentially lots of 'gaps' for people to fall through

Benefits and problems

Benefits

- Preferable to institutional care
- Improved quality of life for service users
- Greater availability of mental health services to general population
- Less bio-medically dominated than hospital care

Problems

- Lack of professional role clarity
- Lack of organisational clarity
- Contradictory policy frameworks
- Under-resourced
- Community care ‘has failed’

•Community care has come under the spotlight in recent years…

•New policy and legal initiatives taken

•Questions asked about the success, or otherwise, of community care

•Some of he perceived benefits and problems are given here

Public Perceptions

- Stigma
- Discrimination
- Fear
- Ignorance
- Social exclusion

It has been suggested that the cost of community care in the UK has been profound public indifference to the plight of the mentally ill.

Large scale surveys in the UK reveal that the general public are

embarrassed by the mentally ill,

are frightened of the mentally ill because they feel they are unpredictable and prone to violence and

equate mental illness with other stigmatised identities such as paedophilia. Such attitudes appear to be entrenched and resistant to change.

This level of fear and ignorance leads to discrimination and social exclusion

Indeed it has been argued in the UK that we should move our discussion of stigma toward a discussion of discrimination as stigma locates the problem with the person with the condition whilst discrimination shifts the focus onto those who perpetuate the discrimination

Studies in the UK indicate the social networks of the mentally ill typically amount to just 7 people and this will for the most part consist of professionals and other service users. Only a minority of people with serious mental illness in the UK actually achieve full time paid employment and the consequence of this is further social and economic exclusion, limiting opportunities for developing and sustaining relationships and developing and maintaining social skills.

Service User Movement

- Response to professional dominance
- Beneficial in determining treatment efficacy
- Political action
- Role in service development
- Role in researching services

Service user movement can be seen as direct response to professional dominance in post-modern society where professional power is weakening and assertive self-advocacy prevails

The professions it has to be said, have to a limited extent recognised the potential value of service user views in determining treatment effectiveness and in highlighting what works and why and also why some treatments and service provision fail.

The service user movement however has also become more adept at political lobbying and direct action. We see in Britain for instance a greater willingness to engage in peaceful demonstration, to respond to negative stereotypes in the media, to reward positive reporting about mental health issues in the form of annual awards for the media and to provide evidence in the form of research and expert opinion to parliamentary committees. Many service user organisations now exist and see the value in forming alliances to enable them to have a greater voice in mental health policy and legislation.

One consequence of this move is that service users now expect to be consulted in any new service development and this is often explicitly indicated in central mental health policy initiatives.

Another consequence is that service users are now initiating, conducting and disseminating their own research which addresses their own research agenda.

The Modernisation Agenda [1]

- Greater emphasis on evidence based practice…
- …driven by national standards and guidelines…
- …and closely scrutinised by new bodies such as the Healthcare Commission

•Evidence – important!

•NSFs, NICE guidelines etc

•Often use 'hierarchy of evidence' approach

•Scrutiny – a new thing for the NHS. CHI: first work undertaken was review of services for older people with mh problems in England's Lake District

The Modernisation Agenda [2]

- Redefining professional and organisational roles and responsibilities
- Contradictory policy initiatives: tackling social exclusion, involving service users and increasing participation…
- …*but* also increasing coercion

Modernisation is also directed towards changes in the composition of the workforce, and to boundaries between occupational groups. Policy generally sees divisions between occupational groups and organisations as being a hindrance to effective care.

For example, now mh nurses are beginning to take on more of a direct role in the prescription of medication. The Draft MH Bill proposes new roles for nurses and others in making applications for the use of compulsory powers. New occupational groups are appearing in the workplace: Graduate Primary Care MH Workers; etc.

We perceive an interesting contrast between centrally produced policy aimed at improving and developing service provision and proposed mental health legislation.

Policy does not have the same level of power as legislation. Policy suggests improvements and it can be enforced but only by recourse to standard measures and clinical audit to ensure that the service delivery is moving in the desired direction for example in offering psychological interventions that are known to help in conditions such as schizophrenia.

Legislation on the other hand has the full power of the law behind it. It can be enforced with greater authority. The advantage for the consumer however is that it can be successfully challenged through the judicial process although this requires much time and expense.

It is interesting however to note that policy in the UK is suggesting greater emphasis on evidence based practice and participation and involvement in services while legislation is attempting to create new groups of patients for instance in the form of Severe and dangerous personality disorder for which there is currently a lack of an evidence base, and moving toward more compulsion and coercion. These moves appear to us to be contradictory and likely to lead to tensions in the delivery of community mental health care in the UK

The Return of the Asylum?

- Re-institutionalisation
  - Increasing number of beds in forensic services
  - Increasing scope of psychiatry
  - Increasing use of compulsion
  - Increasing range of supported housing
- Trans-carceration
  - Criminal justice system increasingly the location for the management of the mentally ill
  - Perpetual movement between agencies

In tandem with the much vaunted move towards community care and treatment of serious mental illness there has been a large scale hospital closing programme in the UK which has seen almost all old style psychiatric hospitals closed and often sold for building development.

It has been argued however that a quieter more stealthy re-institutionalisation is progressing across many European countries and the UK is experiencing a similar move. In recent years the numbers of forensic medium and low secure beds has been increasing steadily – in some areas the numbers of such beds have increased by as much as 100% or more. The impact of these increased forensic services is not to be underestimated. They create a significant demand on health resources and require to be staffed by professionally qualified nurses, doctors, psychologists etc. To achieve this forensic services in the UK have traditionally offered improved salaries. The impact on surrounding services can be such that they struggle to attract and retain qualified staff. This has the effect of essentially jeopardising other developments.

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

Transcarceration is a concept which highlights how the mentally can be locked into a perpetual cycle of movement between mental institutions and prison and in some case community supervision and welfare control– Arigo's "prisoners of confinement"

Conclusion

- **Contradictions**
- **Professional altruism versus social control**
- **Finding a balance**
- **Moving from rhetoric into practice**

Conclusion

Community mental health care in the UK we would argue is marked by significant contradictions

These contradictions contribute to a tension between genuine professional altruism on the one hand and a steadily creeping form of social control of the mentally ill reminiscent of a bygone age.

We recognise that mental health professionals have for a long time managed to practice in the community with an awareness of the need to find a balance between these co-existing pressures.

We question however whether such a balance can now be struck given the shifts in power between professions and service users and whether it is now time for mental health service development to drop the rhetoric and start practising what it preaches.