Chapter

23

Changing Services I: Clinical Psychiatric Perspectives on Community and Primary Care Psychiatry and Mental Health Services

Trevor Turner

The transition from asylum life to the everyday world is a stage of peculiar difficulty with the recovered patient. The home and family life to which he returns may be unsuitable or unsympathetic; employment may be hard to obtain, and friends may be unable or unwilling to help.

Royal Commission of 1924–6[1]

Introduction

The social and organisational development of community psychiatry in the UK has been covered in other chapters in this book (see also Chapters 10, 30 and 31). The best overall description of the meaning of 'community psychiatry', however, was provided by Douglas Bennett and Hugh Freeman in their magisterial 1991 textbook in which they outlined its principles, its origins and its progress.[2] Key features of the latter were, of course, the 1959 Mental Health Act; the process of 'normalisation' in the asylums; the discovery of chlorpromazine and other effective psychotropic medications; and the social underpinnings of whatever was meant by the term 'community'. The rising critique from the anti-psychiatry movement, and the notion that psychiatric illnesses were understandable reactions to social stress (rather than formal illnesses that could be medicalised), became a dominant theme (see also Chapter 20). Yet different localities proceeded at a different pace in terms of developing actual community care resources, there being no formalised process. Stumbling out of the fog of change came the Community Mental Health Teams (CMHTs) and, more specifically, in 1991, the Care Programme Approach (CPA),[3] developed by the government's managerialist Department of Health. Likewise, evaluating the effectiveness of community care teams has been extremely difficult and often very localised. Numerous thoughtful papers on the process of community care have been published (e.g. 'Deinstitutionalisation: From hospital closure to service development' by Graham Thornicroft and Paul Bebbington)[4] and there have been endless policy papers published (e.g. *Better Services for the Mentally Ill* in 1975)[5] as well as the *National Service Framework for Adult Mental Health* (NSF) in 1999,[6] these rarely involving or consulting frontline practitioners (see also Chapter 12).

As a result, the term 'community care' has come to be mocked in, for example, TV comedies and public attitudes and has been associated with public homelessness (see Chapter

https://doi.org/10.1017/9781911623793.025 Published online by Cambridge University Press

26) and inquiries into homicides (see Chapters 27, 28 and 29) as well as being considered as indicating the neglect of psychiatric services. In a 2001 paper, Julian Leff asked, 'Why is care in the community perceived as a failure?'[7] Having developed the model TAPS project for the closing down of Friern Barnet Hospital in North London,[8] he admitted that 'a comprehensive community psychiatric service, catering to all the needs of the catchment area population, exists nowhere in the British Isles and will never be achieved'. He noted at the time that few people were aware that 'of the 130 psychiatric hospitals functioning in England and Wales in 1975, only 14 remain open, with fewer than 200 patients in each'.

From the point of view of a practising consultant psychiatrist working in the system, this chapter will therefore be an impressionistic understanding of how community care has developed and not developed and the extent to which it can be seen as a success or failure. The former is reflected in patients' greater personal freedoms in choosing their daily lifestyles and the latter in the doubling of the prison population over the last forty years as well as the concomitant institution of numerous medium-secure forensic health units. This process has been labelled 'reinstitutionalisation'.[9] There has also been a rise in the use of the Mental Health Act and the pernicious development of 'risk assessment' as the driving factor in working with patients (see Chapter 27). This is despite the fact that there is no evidence that risk assessment protocols show any effectiveness in terms of predicting who will or will not go on to become a 'mentally disordered offender' (see also Chapter 29). One could even consider that the primary role of the asylums, to deal with the neglect and corruption of the private madhouses, has now been reversed, in that private provision for the seriously mentally ill has become dominant.

Moving into the Community

There is no clear definition of 'community psychiatry' apart from the belief that it is not hospital-based. The original term for it was 'extramural', and the initial programme involved the gradual sizing down of the asylums (often many thousand strong) into smaller units with the development of general hospital psychiatric units. Thus, in 1974, if you developed a serious mental illness in Hackney in East London you were put in an ambulance and taken to one of the larger Surrey hospitals/'bins' outside to the southwest of the capital or possibly to Friern Barnet in North London. By 1975, the link between Hackney and the large asylums had been broken, with the setting up of specific, local psychiatric wards in Hackney Hospital. This hospital was an old workhouse infirmary and looked as grim as anything could, but it was local.

A feature of this development was also the need to establish clear catchment area limitations for any psychiatric hospital unit, a local responsibility arrangement harking back to the old parish responsibilities of the nineteenth century. This was because the theorisation of community psychiatry seems to have forgotten that a key feature of psychiatric treatment, particularly in the inner city, was the use of the Mental Health Act for patients lacking insight into their condition and their needs – the application of the Act requiring the engagement of local social services. Thus, variably unwilling asylum physicians had to move into general hospitals (often to the dismay of fellow consultants) and try to look after CMHTs, which in themselves were undefined and variably developed. The practicalities of doing this were never carefully outlined and, although the asylum bed numbers declined gradually, the detention rates soared and the shortage of psychiatric beds (illustrated by often being 120 per cent occupied!) became a dominant concern, particularly from the 1980s onwards.

https://doi.org/10.1017/9781911623793.025 Published online by Cambridge University Press

In Manchester, for example, in the late 1990s, it was reported that there were more than twenty patients detained under the Mental Health Act but awaiting admission.[10] NHS resources often could not fund proper bed availability, this depending on the extent to which psychiatric professionals (especially consultants) were able to bully managers into making appropriate provision; and although CMHTs were primarily focused on looking after those with psychotic conditions ('the new long-stay'), there grew a rising demand for the treatment of common mental health problems, which some dismissed as the concerns of 'the worried well'. These patients were asking for help with depression and anxiety in the context of heavily advertised new antidepressant medications such as Prozac and the better recognition of the meaning of depression.

In essence, therefore, the process to deinstitutionalise and move towards community care was stumbled upon by accident, rather like the British Empire. A number of charismatic psychiatrists had led the way, for example Maxwell Jones at Belmont (his book *Social Psychiatry* was published in 1952; see also Chapter 20).[11] Yet the practical problems of setting up a CMHT depended substantially on the goodwill between NHS and local social services. Trying to get community psychiatric nurses (CPNs), consultant psychiatrists, psychologists, occupational therapists, social workers, senior and junior, and the 'lowly' support workers to live and work together required immense time and effort and there were often fractures in the teams, who differed in terms of background culture, training and pay grades. Latterly, the primacy of primary care in terms of funding local resources has generated a particular demand from GPs to have CPNs and psychologists working for their primary care resource, thus further depriving specialist mental health services of staff who might otherwise have been available.

Another key feature of community care has been the regularity of shocking newspaper exposés – for example, the 1980s articles by Marjorie Wallace in *The Times* and the relentless publication of homicide inquiries (e.g. the report on Christopher Clunis produced by Ritchie in 1987).[12] In this regard, whenever a lurid headline or TV news report announced yet another murder by a psychotic patient in the community, every thinking psychiatrist's first reaction was to find out where the event had taken place (hoping it wasn't in their catchment area). Fear of being called to appear before an Untoward Incident Inquiry, therefore, became part and parcel of being a consultant psychiatrist, certainly in the inner city, and the ultimate insult was when the process of inquiries was in itself privatised.

Homicide Inquiries

Homicide inquiries became the hallmark of psychiatric care in the 1980s and 1990s, gradually fading out only as pressure on the newspapers not to publish them too often started to work. This was achieved in terms of anti-stigma campaigns. The most offensive of these inquiries was the Luke Warm Luke case,[13] running to some £75,000 in costs (thanks to the chair, Baroness Scotland) and several volumes of standardised prose, largely rewriting the CPA and adding nothing new to our understanding of the management of serious mental illness. The incident was due to the girlfriend of a psychotic patient refusing CMHT advice that she not visit him at home and her ending up murdered by the patient. As noted, however, the most influential report was the inquiry into the care of Christopher Clunis,[14] which outlined all the problems of providing care in the community in a fractured framework of varying local mental health provision (see also Chapters 28 and 30).

Christopher Clunis was first detained in hospital in Jamaica (see Tables 23.1 and 23.2) and diagnosed with paranoid schizophrenia. Subsequently, however, he was detained in a number of different hospitals, mainly in London, with diagnoses changing constantly. Like many

https://doi.org/10.1017/9781911623793.025 Published online by Cambridge University Press

Table 23.1 The Clunis inquiry: diagnoses, 1986–92

1986	paranoid schizophrenia
29.6.87	schizophrenia with negative symptoms
2.7.87	schizophrenia or drug-induced psychosis
24.7.87	depression
1.1.88	drug-induced psychosis, or manipulation for a bed
29.3.88	psychotic or schizoaffective illness
3.5.88	schizophrenia, drug-induced psychosis or organic illness
7.6.89	paranoid schizophrenia
23.7.91	schizophrenia
5.5.92	paranoid psychosis
14.8.92	paranoid schizophrenia
26.8.92	(diabetes)
10.9.92	normal mental state, abnormal personality

Table 23.2 The Clunis inquiry: lengths of stays, 1986–92

1986	Bellevue Hospital, Jamaica	Not known
1987	Chase Farm Hospital	25 days, 4 days
1988	Chase Farm Hospital	3 days, 4 days
	King's College Hospital	7 days
	Dulwich North Hospital	9 days
	Brixton prison	21 days
	Dulwich North Hospital	169 days
1989	St Charles Hospital	110 days
1991	St Thomas's Hospital	21 days
1992	Belmarsh Prison	24 days
	Kneesworth House Hospital	80 days
	Guy's hospital	34 days

difficult patients, he ended up with being 'diagnosed' as having a 'personality disorder'. Records showed his constantly assaultive behaviours were noted but tended to improve with appropriate medication. Like many insightless patients with paranoid schizophrenia, however, he would not continue medication on discharge from hospital, and one night in North Finsbury station (in North London) he stabbed Jonathan Zito in the eye, killing him. This assault very much reflected Clunis's own psychotic experience of feeling that people were somehow interfering with him by looking at him, and he had assaulted a number of other people in the eyes beforehand.

https://doi.org/10.1017/9781911623793.025 Published online by Cambridge University Press

The Clunis case can be seen as a template for the problems in community care. None of the members of the teams standing in the rain outside his front door trying to assess him in North London on more than one occasion had ever seen him before, thus he was able to walk out of the house without being recognised. The disjunctions of care between South and North London were noted, as was the tendency of mental health staff to downplay assaultive behaviours and their significance. The subsequent criticisms directed at the team ultimately landed with assessing him were unfair (they had minimal information and none of them had ever assessed him before), but the outline of the problems of community care was well adjudged. An important corollary was the development of a voluntary organisation called the Zito Trust (led by Jayne Zito, wife of the murdered man) which developed a full review of homicide inquiries, some 120 reports having been published by 2002, summarising and outlining them to a helpful degree.[15] Like many other such voluntary organisations, for example Marjorie Wallace's development of SANE, the general view of the concerned public was that asylums should not have been closed so quickly and that there should be more hospital beds. As noted, bed shortages have been, perversely, the dominant theme in the community care debate.

The impact of homicide inquiries on the morale of CMHTs was substantial. Staff felt stigmatised by their work and reports regularly considered failures in communication and the inappropriate use of CPA documentation as problematic. The use of complex forms to be filled in at every assessment became a negative, however, with some CPA documents taking up nine to ten pages and requiring regular reiteration when each clinical review was carried out. This was despite there being no evidence at all that filling in such a form correctly predicted the outcome for individual patients. Homicide inquiries were infused with the problems of hindsight and the counterfactual thinking generated thereby.

Along with the development of CPA and risk assessment, there was an attempt by the government in 1999 (Patients in the Community Act)[16] to introduce supervision registers. These required doctors to fill in a form to determine the risk of every patient in their care, a bit like filling in the 'proscription' levels as noted in ancient Rome or being asked to identify potential Jews in your locality in Germany in the 1930s. Such central government impositions on practice were driven by a managerialism that has become intrinsic to NHS organisations, with little input from frontline clinicians, whether nurses, doctors, psychologists or social workers. The notion of community care as 'outdoor relief' or the transferring of care away to untrained staff on part-time contracts became increasingly part of our understanding of 'care in the community', CMHTs generally having to work out their own ways of managing patients. Heroically, supervision registers were mainly ignored.

Later Developments

In 1999, the Blair Labour government introduced the National Service Framework (NSF),[17] this demanding that Trusts set up specific teams for the assessment of crisis intervention (for acute and severe mental health problems), early intervention (for patients with first-episode psychosis) and assertive outreach (for those patients whose mental ill health was thought to cause serious concern but who were not engaging with mental health services follow-up). From the organisational point of view, the need to develop a series of teams that could be specific and could not be diluted by other NHS

https://doi.org/10.1017/9781911623793.025 Published online by Cambridge University Press

demands (as many mental health initiatives have been) enabled the NSF and funding for it to be forced through the NHS system (see also Chapters 10 and 11). This was a clever piece of government initiative but it imposed significant limitations in terms of how mental health teams operated. In particular, the dividing up of the CMHTs into these sub-teams generated arguments as to who looked after whom and created unrealistic expectations in those given, for example, early intervention services. After being moved on from their early intervention service (with its high inputs and regular support), they were in fact referred on to the badly resourced CMHTs.

While the government's introduction of these specialist teams was welcomed in terms of funding and resources, the role of the standard CMHT remained deracinated and uncertain. Furthermore, the crisis intervention teams took on the burden not only of seeing people in crisis (however defined) but also of being the 'gatekeepers' to admission to hospital. This led to arguments with consultant psychiatrists, who had known patients for many years, who were advised they had to resort to a nurse and social worker (relatively untrained compared to them) in a crisis care team to allow admission. The earlier difficulties of putting together multidisciplinary CMHTs were recreated and psychiatrists were deskilled, as their clinical activities became limited to certain interventions such as crisis management or early intervention. The ability to look after a patient right across their lifestyle and their lifetime, whether as an inpatient or outpatient, reviewed in the community, became limited. This fragmentation of services went against the standard findings of all homicide inquiry reports, namely that there should be connected services right across the spectrum.

Debates about the value of specialist teams went on in community care forums, with considerable division as to whether they were effective or not. A number of psychiatrists enjoyed the limitations of, for example, just doing assertive outreach, despite losing their skills in terms of managing patients with depression, anxiety and other non-schizophrenic disorders. Many assertive outreach teams became essentially rehabilitation teams, and a number have been gradually phased out in this context.

Overall, therefore, while the NSF engendered increased funding for psychiatry, the break-up of CMHTs generated limitations in the kind of work that could be provided. For example, new trainees found themselves either just in a crisis team or in an assertive outreach team or in an early intervention team and not seeing the overall picture in terms of management of patients with a range of conditions, in the community and in hospital wards. Thus, they missed out on being part of what has been called the 'general psychiatry' attitude. This imposition of excessive specialisation has been amplified by the hiving off of forensic psychiatric care into locked units (indoor psychiatry) and the push for many practitioners now to just conduct 'primary care psychiatry'.

Primary Care Psychiatry

Regarding primary care psychiatry, this again has developed in a patchwork way, depending on the willingness of GPs to have psychiatrists in their surgeries. As a keen young psychiatrist in the 1980s, my offer to see patients at GP surgeries was met with varying degrees of perplexity and receptivity. A number of thoughtful practices were very welcoming but other smaller practices found it difficult to accept having another doctor sitting in their offices (and often there was no room to do so). While GPs have been known

https://doi.org/10.1017/9781911623793.025 Published online by Cambridge University Press

to be at the front line of psychiatric services for many years,[18] their main engagement has been with patients with non-psychotic conditions and meeting the requirements of advice as to therapy as well as the best antidepressants and anxiolytics to prescribe. There could also have been a fruitful exchange of information between GPs and psychiatrists, in terms of the complex social and physical conditions that patients present with and the appropriate use of medications or other treatments. However, it is not untypical to review a patient's GP notes (a rich source of information) and find that they have been prescribed three or four different antidepressant selective serotonin reuptake inhibitors (SSRIs) over the years, with limited benefit and with no review of the patient's compliance or underlying mental state. Many patients asked about old prescriptions will often say they did not take the pills for very long, if at all.

Fortunately, the improvements generated by the IAPT (Improving Access to Psychological Therapies) programme have helped very much with the provision of cognitive behavioural therapy (CBT) for common mental conditions (see also Chapters 10 and 33). Resources, however, have varied from area to area. This has been one of the genuine positives of community care. The fact that many GPs, having undergone a psychiatric attachment in their rotation, are now trained in identifying and managing mental health problems has also enhanced the ability to develop appropriate psychiatric services in conjunction with GPs. This is in contrast with the failure of the Royal College of Physicians and the Royal College of Surgeons to embrace psychiatric education as any part of their training programmes.

Conclusion

The development of community care in the UK has been haphazard, deriving from theory rather than practical consideration. The human resource problems of putting together CMHTs in different areas have been little understood by central government, and the development of such teams has largely been based on the goodwill of local professionals to ensure communication and provide office space and support. The regular negative views of community psychiatry in the public perception have further limited the development of services. The impositions of paperwork and additional documentation based on risk management have led to many CMHT members spending half their day at their desks doing paperwork. This over-engagement in paperwork is well known throughout the NHS, and one only has to review a typical patient's GP notes to realise that most of what is written there is reduplicated and not clinically necessary. For example, blood test findings are mentioned under various different categories. The notion that 'every form filled out means a kindness foregone' can be seen as a key difficulty of community-based care.

As ever, psychiatry has been substantially undermined by the persistence of stigma (see also Chapter 27) and the intrusions of a powerful, socially generated belief that mental distress can be distinguished from mental illness. The battle to get mental illness back on the agenda has been prolonged, but a number of Trusts continue to downplay the need for a formal diagnosis and it is now possible to have an assessment for your mental health needs carried out by an individual who has no training as a psychiatrist but who may well be called a 'high intensity practitioner'. While the diminution of the consultant psychiatrist's role from their predominance in the old asylums has its benefits, in terms of introducing other expertise into the management of those with mental health problems,

https://doi.org/10.1017/9781911623793.025 Published online by Cambridge University Press

the need for expertise in psychiatric diagnosis, the management of psychopharmacology and leadership of a team with many diverse backgrounds is central to what a psychiatrist has to do whether in hospital or in the community care sphere.

The rise of risk management has been a dreadful negative, in terms of looking at the role of a consultant psychiatrist and in terms of the importance of carrying out an appropriate mental state assessment and diagnostic review. The prevalence of criminalised drug usage (e.g. cannabis and cocaine in particular) has further complicated matters. Given the vulnerability of mentally ill patients using drugs to improve their mood or lower their anxiety, this drugs 'prohibition' policy has major negative effects in terms of criminalising the mentally ill (see also Chapters 28 and 29). The extension of low-secure and medium-secure mental health units (often privatised) reflects the reinstitutionalisation of mental health care generated by a risk avoidance strategy and a more punitive attitude towards those with mental illness. The extraordinary rise in the number of prisoners in the UK (as noted in the Introduction to this chapter) is a key reflection of Penfold's theory that there is an inverse relationship between prison and asylum care.[19] Visiting HMP Pentonville in the late 1990s, I was advised by one of the senior prison officers that 'this is the largest medium secure unit in the country'. This imprisonment of the mentally ill is against the background that the number of homicides committed by mentally disordered offenders has not increased since the 1950s,[20] by contrast to the numbers of homicides committed by 'normal' citizens, which has increased markedly.

Key Summary Points

- The process of de-asylumisation into a community care–based mental health system has been a messy business, a social crusade rather than a clinically thought-out process.
- Concomitants like modern psychopharmacology and the effects of the Royal College of Psychiatrists' anti-stigma campaigns have helped but care has varied substantially in quality across the country.
- Community care has relied on the qualities of individual psychiatrists and CMHT members, as well as local GP and/or social services support, and generally has not been helped by the numerous government White Papers.
- The reversion to medium-secure mental health units and reinstitutionalisation has been a core feature, publicly unrecognised.
- Mental health services have coped to varying degrees despite their core asylum resource being stolen from them, and the key need now is for the elimination of the primacy of risk assessment and the maintenance of the generality of general adult psychiatry.

Notes

1. The Royal Commission of 1924–1926 (the Macmillan Commission) quoted in K. Jones, *Asylums and After: A Revised History of the Mental Health Services from the Early 18th Century to the 1990s*. London: Athlone Press, 1993, p. 133.
2. D. H. Bennett and H. L. Freeman, eds, *Community Psychiatry: The Principles*. London: Churchill Livingstone, 1991.
3. Department of Health Circular, HC(90)23/LASSL(90)11, London, 1990.

https://doi.org/10.1017/9781911623793.025 Published online by Cambridge University Press

4. G. Thornicroft and P. Bebbington, Deinstitutionalisation: From hospital closure to service development. *British Journal of Psychiatry* (1989) 155: 739–53.

5. Department of Health and Social Security (DHSS), *Better Services for the Mentally Ill*, Cmnd 6233. London: HMSO 1975.

6. Department of Health, *National Service Framework, Mental Health*, London: HMSO 1999.

7. J. Leff, Why is care in the community perceived as a failure? *British Journal of Psychiatry* (2001) 179: 381–3.

8. Team for the Assessment of Psychiatric Services (TAPS), *Preliminary Report on Baseline Data from Friern and Claybury Hospitals*. North East Thames Regional Health Authority, 1988.

9. S. Priebe, A. Badesconyi, A. Fioritti et al., Reinstitutionalisation in mental health care: Comparison of data on service provision from six European countries. *British Medical Journal* (2005) 330: 123–6.

10. Personal communication.

11. M. Jones, *Social Psychiatry: A Study of Therapeutic Communities*. London: Tavistock Publications, 1952.

12. M. Wallace, A caring community? The plight of Britain's mentally ill. *Sunday Times Magazine*, 3 May 1986: 25–38; J. Ritchie, D. Dick and R. Lingham, *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*. London: HMSO 1994.

13. P. J. Scotland, H. Kelly and M. Devaux, *The Report of the Luke Warm Luke Mental Health Inquiry*. Lambeth, Southwark and Lewisham Health Authority, 1998.

14. Ritchie, Dick and Lingham, *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*.

15. D. Sheppard, *Learning the Lessons: Mental Health Inquiry Reports Published in England and Wales between 1969 and 1996 and Their Recommendations for Improving Practice*. ZitoTrust: 1996.

16. Mental Health (Patients in the Community) Act 1995.

17. Department of Health, *National Service Framework, Mental Health*.

18. M. Shepherd and D. L. Davies, *Studies in Psychiatry*. London: Oxford University Press, 1968.

19. L. S. Penrose, Mental disorder and crime: Outline of a comparative study of European statistics. *British Journal of Medical Psychology* (1939) 18: 1–15.

20. P. Taylor and J. Gunn, Homicide by people with mental illness: Myth and reality. *British Journal of Psychiatry* (1999) 174: 9–14.

https://doi.org/10.1017/9781911623793.025 Published online by Cambridge University Press