

COMMUNITY CARE FOR THE LONG TERM
MENTALLY ILL:

An Evaluation of the Community Mental Health Team Approach

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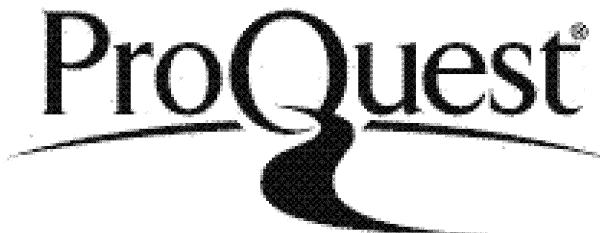
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ABSTRACT

The thesis addressed two research questions: 1) Why has community care of long term mentally ill people been so difficult to implement? and 2) Do Community Mental Health Teams (CMHTs) provide an intellectually viable and practically sustainable model of service provision? These questions were approached by an analysis of the wider literature and a multi-method case study evaluation of an innovative CMHT in one inner city area of London from 1979-1992. The thesis concentrated on interchanges between theory, policy and local practice.

It was found that community care of the long term mentally ill was difficult to implement during the 1980s because adoption of new approaches depended on their delayed acceptance by the psychiatric profession and even then, the required social and environmental approaches to care were only partially adopted. Policy became dominated by professional and managerial influences and clients continued to have a low political profile. Administrative inadequacies were severe and deep rooted and there were unreconcilable differences between Health and Social Services. The collectivist ethos of CMHTs was undermined.

The CMHT approach can provide a practically sustainable approach to service provision when certain conditions are met. The CMHT service must: be comprehensive, or supported by a full range of complementary services in the local community; receive genuine political commitment to the long term mentally ill client group and an on-going level of adequate funding; be introduced with a clear acknowledgement of where lead responsibilities rest; and harness the enthusiasm of professionals and catalytic individuals. The CMHT approach is a system of care and in so far as a new care model emerged during the 1980s, it was the Care Programme Approach. Yet the CMHT approach provided a vital source of experimental energy during the 1980s and now needs to be formally recognised by central government as a valuable vehicle for change.

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INTRODUCTION

This thesis is about community care services for people with severe and long standing mental health problems (termed the "Long Term Mentally Ill"). The issue has been forced onto the political agenda in recent years by the gradual closure of the larger state institutions, major concerns about the numbers of homeless people with severe mental health problems and the growth in this population's representation in the prisons and probationary services. Incidents such as the mauling of Ben Silcock in the lions' den at London Zoo in early 1993, have added to the concerns. The most recent response from the Secretary of State for Health has been to announce a contentious new ten-point plan for developing "successful and safe" community care, including new legislation to provide for supervised discharge of psychiatric patients (DH Circular H93/908). However, it is judged by some authorities that the case for new legal powers is not proven and that the new plan gives undue emphasis to health care needs as distinct from social care, overlooks key issues of administrative and managerial lead and ignores resource issues (eg White 1993). In short, community care for the mentally ill is the subject of on-going controversy. Yet, why has community care in mental health taken so long to develop? Why has it been so unpopular and received the most explicit political criticism and where does the future of community care policy for the mentally ill lie, particularly for those with the most severe psychiatric and concurrent social problems?

It is an interesting paradox that Community Care was first used in a policy context and as a stated goal of government with reference to the mentally ill. Yet, in practical terms it has progressed more slowly for this client group than for any other. People with learning difficulties, offenders and the elderly have also been affected by the policy shift away from providing care within large institutions towards care in the community. What has been meant by community care in these areas has been fairly well defined, and service providers and policy makers have generally had a much clearer idea of their

goals than their equivalents in mental health service provision. Clear alternative models for service delivery have been developed, one example being the ENCOR Model in mental handicap (Campaign for Mentally Handicapped People 1978). Even in acute mental health, accepted models of care have emerged, concentrated in general practitioner primary care services, out-patient departments and psychiatric units in general hospitals, but in relation to people with long term mental health problems, clear, accepted models of service provision have been lacking.

This thesis aims broadly to consider community care provision for the long term mentally ill in the UK during the 1980s and early 1990s. It is hypothesised that community care for the long term mentally ill was slow to develop because there was not a widely accepted model for service provision and because ideological and financial pressures have been immense. In so far as there has been a model, it is the Community Mental Health Team (CMHT) approach, widely used in the US and Italy. In the UK, however, utilisation of this model has been contentious and generally regarded as problematic. A substantial literature has appeared assessing the CMHT approach, but it is all closely aligned to professional practice issues and centred around ideas imported from other countries (Bachrach 1988b). The theoretical work has tended to be more general with little policy reference. In addition, most policy prescription has not been closely related to policy practice in the UK at the local level. This thesis therefore aims to concentrate on interchanges between theory, policy and local practice in one local experiment with the CMHT Approach, that began in the early 1980s and continued through to the time of writing and beyond.

The two central research aims of the thesis are to evaluate why community care of the long term mentally ill has been so difficult to implement effectively and to question whether CMHTs provide an intellectually viable and practically sustainable model of service provision to overcome past problems with the policy and particular problems of providing

a community service to the long term mentally ill. Hence, the thesis is essentially an evaluation of change, innovation and implementation in the provision of community care services to this client group at the local level. The methodology chosen firstly combines inputs to the debate from the wide variety of complementary literatures that exist and secondly, tests this against a case study example of what has happened in practice at the local level. The field work upon which the thesis is based, concerns one particular variant of the CMHT model, pioneered in Battersea, South London, that initially provided a specialist service to a group of long term mentally ill people and then went on to prioritise work with the long term mentally ill within a sectorised catchment area model.

The thesis aims to be of interest to both practitioners and policy-makers as well as other researchers. In particular, it is intended to be useful and comprehensible to potential end-users in the field and to focus on the issues and problems that arise in practice on a day to day basis. In the past, it has been a common observation that there are obstacles to communication between research and practice. The subject material of research is often not relevant to the issues which are current for practitioners. Hulbert (1992) suggested researchers need to spend more time in practice agencies and gear their research to crucial issues that arise. He claimed that action research has an important place in observing practice as it happens and in defining factors which really help or hinder policy. Such an approach is adopted in this thesis.

Completing this study has been part of a personal journey. During my college and undergraduate days I began to develop a growing interest in what the so called "helping professions" were doing for their clients. I took part in voluntary work in a variety of areas including work with young offenders, the homeless, people with learning difficulties and the mentally ill. For two years I ran a "Contact" agency within Leicester University placing student volunteers in a broad range of community projects in both the statutory and voluntary

sectors. Between 1988 and 1990, I worked for psychology departments in the National Health Service, firstly in a child and family psychiatric unit, then at a specialist unit for people with head-injuries and neuropsychological problems. Throughout this time, I was questioning the value of therapeutic work that seemed to make little attempt to address social inequalities and asking myself whether I could contribute effectively to working within a large bureaucratic organisation, or whether I would be more usefully employed elsewhere. I was particularly concerned about the potential for innovative work and became fascinated by how change comes about in service provision.

I began the work for this thesis while working as an independent researcher for a CMHT in Battersea, the team upon which the case study material in this thesis is based. It was at this time that I became particularly interested in work with people with chronic and disabling mental health problems. The questions I was asking myself fell more naturally into the realm of social policy than that of psychology and this thesis is the product of my last four years of inquiry. This research was therefore undertaken at a time when I decided I needed to gain a deeper understanding of the issues involved and the practical possibilities of how to start to address some of the entrenched problems of service provision to a historically marginalised client group.

Thesis Structure

The research design of the thesis is presented in chapter one. It details the central research questions and the different discourses that will be used as tools for evaluation. A multi-method approach is used drawing on both practical and theoretical contributions to the study of community care for the long term mentally ill from a variety of perspectives. The thesis is structured in three parts.

PART 1

Part 1 defines the thesis subject area and explores the range of background literature and academic theory relating to

community care of the long term mentally ill. Service problems begin with confusion over who the long term mentally ill group are, how they can be defined and who the community is who should be caring for them. What services are needed and who should most appropriately provide for them? What have services achieved in recent years? Chapter two outlines the "professional and practice" literature in this area and aims to establish an understanding firstly of how community care of the long term mentally ill has apparently been neglected and proved so unsuccessful and secondly what the CMHT approach is said to offer as a solution to the problems of service provision. Chapter three then presents theoretical literature analysing community care more generally from a "structural/philosophical" perspective. It explores how different theoretical approaches have been used to explain the slow development of the policy in the past. Chapter four then aims to explore the additional contribution that can be gained by considering literature related to innovation and implementation in public policy.

PART 2

The theoretical literature presented in Part 1 is then used to help understand the experience of one case study CMHT. Part two of the thesis presents the findings of the thesis field work. Chapters five to twelve concentrate on one policy innovation, the Doddington Edward Wilson Community Mental Health Team (DEW). This team was set up as a new development using an innovative approach for working with clients with long term mental health problems in an inner city area of London.

The case study utilises two different kinds of process material taken from practice. The first takes an "administrative anthropological" view of the service (Glennerster et al 1983) and studies the process of introducing a CMHT in one area of London, focusing on documentary and interview material. The objective is to illustrate what the authorities actually did to plan services and how community services developed over a thirteen year

period. This historical data is presented chronologically in chapters five to ten with accompanying analytical discussions of each period of development and the themes that were perceived by interviewees to have been most important.

The second approach draws on an empirical evaluative study of the DEW service in which the author took part. This empirical data is presented in chapters eleven and twelve. Chapter eleven considers the specialist model of working with the long term mentally ill that the case study CMHT developed and the manner in which this could be distinguished from services that already existed in the area. Chapter twelve evaluates whether the case study CMHT subsequently succeeded in prioritising work with long term mentally ill clients when they changed focus to become a catchment area team.

PART 3

Chapters thirteen and fourteen aim to synthesise material from theory and practice presented in parts one and two. Chapter thirteen reconsiders the "structural/philosophical literature" presented in Part 1 to evaluate how far it helps us to understand the structural and philosophical problems experienced in the formation and implementation of policy at the local level. Chapter fourteen reconsiders the contribution of the "professional practice and public policy literature" by synthesising the main findings from each of the case study chapters presented in Part 2. Conclusions about issues that are crucial for the future development of CMHT services for the long term mentally ill will be formulated and the relevance of the research findings for current developments in community care policy for the long term mentally ill will be explored.

During the writing of this thesis, dramatic changes were occurring in the UK on a national basis regarding community care policy, triggered by new central government directives. The field research covered the period 1979 to 1992, with the main body of empirical data collected between 1990 and 1992. The research was initially planned before the passage of the

NHS and Community Care Act 1990 which followed Griffiths (1988) *Community Care: Agenda for Action*. At the time of writing, implementation of the Act became a major focus for all those involved in the provision of health and social care for the long term mentally ill and other client groups.

No research takes place in a vacuum, particularly when it concerns the combination of so unpredictable a subject as mental health and the shifting implementation of community care reforms. It is important, therefore, to locate this thesis within the context of the overwhelming uncertainty that beset mental health service providers in the UK during the 1980s and to accept that it only begins to touch on community care developments that subsequently gained momentum in the early 1990s. The implementation of these community care reforms has since become, in the words of Bebbington (1993) "something of a research industry", and the Personal Social Services Research Unit at the University of Kent, amongst other such units, is currently undertaking research to monitor the progress of the changes. I am presently employed by the PSSRU doing further research with the AIDS/HIV client group concerning community care and care management systems, again with a particular interest in innovative care systems.

The implementation of a CMHT model in Battersea during the 1980s in some ways anticipated changes which are now taking place more widely, involving statutory and voluntary agencies. Readers will therefore find lessons for the present and future in this evaluative account of the pioneering venture of a group of staff in one health authority. The case study illustrates the initial process of attempting to modernise community care for the long term mentally ill in the UK that underlies the current community care reforms. Given the intractability of the problems of the long term mentally ill, the aim of this thesis is to locate problems where solutions might be tried and to highlight the unresolved issues relating to the care of the long term mentally ill in the community that emerged during the 1980s and early 1990s, focusing on CMHTs.

Over the past decade, the dominant trends in community mental health care have not involved any dramatic improvements in medical technology, but instead have consisted of changes in outlook and approach. The two central questions of this thesis are concerned with the problematic nature and products of these changes:

- 1. Why has community care of the "long term mentally ill" been so difficult to implement in Britain?**
- 2. Does the Community Mental Health Team (CMHT) Approach provide a viable model of service provision for "long term mentally ill" clients?**

The methodology chosen to tackle these questions is based on the notion that there is a need to bring together a range of material that relates specific instances and issues found in practice to wider and more general theories (Hill et al. 1979; Ham 1985). A multi-method approach is therefore used in this thesis, embracing complementary ways of approaching the central research questions. The aim is to evaluate or "judge the worth of" the CMHT model by considering interchanges between theory, policy and what can be learned from practice. Hunter (1980) suggested that the relevance of research of this nature is in demonstrating the need for a different, albeit less neat and tidy approach to policy formation and implementation.

Box 1: Methodological Approaches Used in the Thesis

PART 1: THEORY- COMPLEMENTARY LITERATURES

- 1) Professional and Practice Community Care Literature
- 2) Philosophical and Structural Approaches to Community Care
- 3) Public Policy Literature on Policy Innovation and Implementation

PART 2: PRACTICE- THE CASE STUDY

- 1) Administrative Anthropology:
Interviews, Observation and Documentation of the History of a Specific Pioneering CMHT
- 2) Process Evaluation:
An Empirical Assessment of Service Style and Working Patterns in the Case Study CMHT

PART 3: SYNTHESIS

Analytical Synthesis of Complementary Discourses

PART 1: THEORY- COMPLEMENTARY LITERATURES

Three kinds of literature exist that help to explain why community care for the long term mentally ill has been slow to be fully developed. There are a growing number of mental health service evaluation studies published in the psychiatric and social professional journals and a body of professional literature surrounds these. There is also a substantial set of more general structural and philosophical literature on community care using models drawn from sociological, philosophical and political theory, as well as some approaches based in economics. In addition, there has been the contribution of social policy in studying innovation and implementation of public policy.

1) Professional & Practice Community Care Literature

In this thesis, "professional and practice" literature refers to the vast volume of writing that has appeared in recent years clarifying professional practice issues relating to community care and describing the implementation of the CMHT model. Much of this literature first appeared in professional journals, research reports and conference papers. In chapter two, a review of this "professional and practice" literature will be used to introduce the thesis topic and to give an account of recent developments in community care for the long term mentally ill client group from a professional viewpoint, with particular emphasis on the progress of the CMHT approach.

Chapter two initially discusses definitions of the "long term mentally ill" client group on whom we wish to concentrate in this thesis and shifting definitions of "community care" itself. It then aims to determine what community care for the long term mentally ill meant in practice during the thesis study period. A backlash that developed against community care policy during the 1980s, mainly from within the psychiatric profession, will be briefly described. An account of what is meant by the term "Community Mental Health Team" is then given with a brief description of developments in CMHT services in the 1980s. Specific associated ideologies and goals of the CMHT approach concerning "case management" and "The Care Programme Approach" will be introduced.

2) Philosophical and Structural Approaches to Community Care

On a more general level, basic structural and philosophical explanations have been put forward to account for the origins of community care policy and the subsequent difficulties in policy implementation. It is this literature that will be discussed in chapter three. A comprehensive history of mental health policy is not presented as this has been widely documented elsewhere (eg. Busfield 1986; Jones 1988; Martin 1984). Rather it is the intention to present explanations of the policy's problematic nature. As Easton (1965a) points out, policies are dynamic in nature and change over time. It is

therefore important to be aware of the shifting definitions of issues and evolving interpretations of policy. Existing explanatory models will be reviewed and while the distinctions between them are not always clear cut, in this thesis they will be grouped under the following six headings:

- a) Traditional/Pluralist Interpretations
- b) Sociological/Anthropological Interpretations
- c) Marxist Interpretations
- d) Economic Interpretations
- e) Elitist Interpretations
- f) Feminist Interpretations

3) Public Policy Literature on Policy Innovation and Implementation

Chapter four gives an overview of selected themes from a third strand of literature that has developed, which ascribes the problems of community care not to the origins of the policy itself or to the structural factors alone, but to difficulties faced in service innovation and policy implementation. There is a need for the inclusion of such an analysis as existing accounts of the closure of large institutions have had a structuralist bias, with more emphasis upon the impact of regional and national policy and on the machinery of collaboration than on internal politics or the effects of local power relationships (Korman & Glennerster 1990). Very little is presently known about inter-service relationships and dynamics at work both at the level of inter-professional working and inter-agency working (Smith 1976). As a corrective to this tendency to ignore internal dynamics, chapter four aims to give an overview of work on innovation and implementation in public policy. The overview of this literature deals with the following topics:

- a. The Perception of the Problem
- b. The Origins of Change
- c. Central or Local Policy Determination
- d. Decision-Making
- e. Joint Planning
- f. Conflicts and Constraints in Implementing Change

The Aim of Part One

The professional and practice literature informs us of the specific difficulties that have arisen in providing community services to the long term mentally ill and the progress that has been made in tackling these through the use of the CMHT model. From structural and philosophical explanations we can gain some general ideas about why community care policy for the mentally ill has been so fraught with difficulty. However, little attention is devoted to the long term mentally ill in this set of literature. The literature on innovation and implementation in public policy further informs us about why there may be institutional reasons for the very slow implementation of community care policy. It is suggested in this thesis that a true explanation about why community care policy for the long term mentally ill has been problematic lies in an interaction between these three perspectives. The aim in Part One is therefore to present an overview of each of these largely disparate sets of theoretical literature which will then be used as a basis to evaluate a specific local case study of a CMHT in Part Two.

PART 2: PRACTICE- THE CASE STUDY

Part Two utilises a localist bottom-up approach, rather than the top-down approach which underpins virtually all national policy statements regarding the care of the mentally ill. Throughout the thesis study period no coherent model for community mental health development was being proposed by central government and so it would have been a mistake to view policy as coming in at the top, being successively refined and translated into operating instructions as it moves down the hierarchy to operatives at the bottom. The approach taken is hence akin to that of Barrett & Fudge (1981), who state that the relationship between policy and action cannot be regarded as a simple transmission process. Rather, it must be viewed as a "complex assembly job", involving the fitting together of different interests and priorities. The policy-action relationship is not seen as a linear step-by-step progression by which policy is translated into anticipated consequences, but is better described as interactive and recursive. Policy

is not regarded as a constant - it is seen as being mediated by actors¹ who may have been operating with different "assumptive worlds" (Young 1977) from those formulating the policy. Policy in this sense, inevitably undergoes interpretation, modification and in some cases subversion.

The case-study approach has been recognised by several theorists to be of value in the study of social policies. For example, Williams stated:

"The most useful studies have been factually dense with lots of information about what people actually did in trying to make a programmatic decision operational. Case-studies have been critical." (Williams, 1980, p21)

Donnison et al (1975) argued that case study accounts of administrative processes often make them appear deceptively simple and continuous, but it is important to bear in mind that the material upon which they are based is complex and diverse. The decision process in which one has an interest,

"...more typically consists of one item at the end of a crowded committee agenda, a telephone call made the following month, a paragraph in a memo prepared over the weekend dealing mainly with other matters, then a hurried departmental meeting followed by a chance conversation between two people on their way to lunch. Such are the scattered incidents, if the researcher is fortunate enough to be able to trace them, which should be threaded together to produce what participants may later regard as an unrecognisably coherent story". (Donnison et al, 1975, p46)

In order to evaluate the entire development of the thesis case study team, a research period was chosen that spanned from 1979 to 1992 and two main methodological approaches were used.

1) Administrative Anthropology: Interviews, Observation and Documentation of the History of a Specific Pioneering CMHT Development

Chapters five to ten of the thesis use an approach that has been described as "administrative anthropology" (Glennerster et al 1983) or an "academic field-trip into the administrative jungle". The objective was to gather material to illustrate how various interested parties and individuals (termed actors) in the case study area interpreted, perceived and responded to policies and how they enabled or disabled the accomplishment

of these policies. Emphasis was placed on understanding the unique characteristics of the interior of the case study organisation, its codification system, its elites, its decision-making processes, its culture, its self image and its history.

The administrative anthropology material aims to move from a description of how the case study service came to be, through an exploration of how it evolved. Discussions relating the case study evidence to the theoretical literature presented in Part one will be included in the second part of each chapter. Chapter five details psychiatric provision in Battersea prior to the birth of the CMHT in 1979 and chapter six discusses the innovation in CMHT service provision that occurred in 1983. The next three chapters then concentrate on themes that were defined as important by the actors interviewed. Chapter seven describes the process of "building the team". Chapter eight details the development of the CMHT operational policy and describes the way that the service style developed. Chapter nine considers barriers to CMHT implementation that were subsequently faced and chapter ten concludes the story by considering the battle for the future model of care that took place after 1988. The study period under discussion ends in 1992. Three different methods were employed to gather the research material:

a) FORMAL SEMI-STRUCTURED INTERVIEWS

An aural history was obtained from twenty three formal semi-structured interviews conducted with the main actors who were most closely concerned with the design and implementation of team policies. The definition of "main actors" is inherently judgemental but the task was approached by following a "log-rolling" trail. Staff members of the CMHT were interviewed first and each was asked to suggest other actors who had been involved in the CMHT development. A second round of interviews were then carried out with actors from this list of suggested contacts. These included mental health unit management representatives, the heads of professional departments in the hospital, local GPs, social services staff and other staff

members who had worked closely with the team or who were known to have strong views on the team's development. A full list of the actors who were interviewed is presented in Appendix 2.

It was the intention to avoid reading subjective ideas into the respondent's views or partially reporting the interviews. To minimise the possibility, the resultant documents were given to the interviewees for comments, with an invitation to talk further or elaborate in writing. Using "Respondent Validation", in this way it was hoped that the report provided a documented and agreed basis for analysis.

b) INFORMAL INTERVIEWS AND OBSERVATIONS

The author spent a protracted period working within the case study organisation between 1990 and 1992, with offices both at the CMHT base itself and in the psychology department at the local psychiatric hospital. Informal interviews and informal observations of policy in progress were carried out during this time in the hospital and the community. It also gave the author an opportunity to become familiar with the local services, local geographical area, issues that arose in day to day working and to get to know some of the CMHT clients².

Weekly CMHT team meetings in the community were attended by the author for one year, as well as seminars, training days and conferences held within the local psychiatric hospital (Springfield) and the adjacent St Georges' General Hospital. A "typical working day" was spent with each staff member of the CMHT and a community psychiatric nurse from the neighbouring catchment area, accompanying each in their daily routine of home visits to clients and appointments with other professionals from both the statutory and voluntary sectors with whom they were carrying out joint work or liaison regarding specific clients.

Visits to local community and hospital resources were undertaken and further informal interviews were carried out with actors encountered on these visits, including some representatives from voluntary organisations. It included, for

example, the hospital industrial therapy unit and occupational therapy department, the Cottage Day Hospital, Hazlewell Day Centre and local voluntary organisations such as the Doddington Family Centre and Battersea Counselling Service.

To obtain the views of service users and their carers, several of the "Community Support Groups" listed in chapter seven of this thesis were visited and the author accepted the opportunity to take part in some group sessions. These included attendance at the "Garfield Support Group" held in a local community centre, "Yorkshop" (a sheltered work group again held in a community centre on one of the Battersea housing estates), the "Sports Group" held in the local leisure centre and the "Relatives Support Group" held in the local church. Material was also drawn from a survey of user's satisfaction with the CMHT, conducted in 1989 (Macdonald et al 1990).

c) DOCUMENTATION

Historical documentation was addressed and analysed, including minutes of key-meetings and policy and strategic documents. Material was gathered to illustrate what the authorities in the case study area actually did to plan community mental health services for the long term mentally ill and how these services developed over the period from 1979 to 1992. Documents and correspondence were obtained directly from the "main actors" mentioned above and from local libraries and archives. The documents referred to in each chapter will be referenced and noted at the end of the relevant chapter throughout Part Two of the thesis and all the documents consulted will be listed in chronological order in Appendix 1.

2) Process Evaluation: An Empirical Assessment of Service Style and Working Patterns in the Case Study CMHT

Between January 1990 and April 1992, the author was commissioned as an independent researcher to conduct an empirical evaluation study of the case study team and their priority clients. The work was supervised by Professor Glennerster, Dr McLean and Ms Leibowitz. The ensuing results

have been published as a separate report (Rickard et al 1992) and part of this will be referred to in chapters eleven and twelve of this thesis. Data collection batteries used are included as Appendix 4.

The importance of acknowledging the dimension of process in the design and conduct of evaluative research has been emphasised strongly by other researchers (eg Hammersley & Atkinson 1983). The empirical component of this thesis aimed to concentrate on process factors in the case study organisation, rather than outcomes. Chapters eleven and twelve hence aim to explore empirically some aspects of the two variants of the CMHT model that were developed during the study period in the case study area. The first is the specialist service for long term mentally ill clients and the second is the later model that was adopted based on comprehensive catchment area responsibilities, giving priority to work with the long term mentally ill.

1) COMMUNITY CARE FOR THE LONG TERM MENTALLY ILL IN THE SPECIALIST CMHT MODEL: WAS IT ANY DIFFERENT TO SERVICES THAT EXISTED PREVIOUSLY?

The first study compared retrospectively the treatment carried out by the Doddington Edward Wilson (DEW) Community Mental Health Team, when they were operating as a specialist team for long term mentally ill clients, with the traditional treatment as carried out by the hospital-based Community Psychiatric Nursing Service (CPN). It was a retrospective case-note study of two cohorts of long term mentally ill clients, one cohort from each service. Essentially, two accepted research methodologies were combined:

- a) performance measurement of the two teams on some of the goals and principles stated in the CMHT operational policy (termed "goal-directed evaluation" in the literature).
- b) "network analysis" which documents the client contacts with agencies in a service system. Inferences are drawn from the total number of contacts and different patterns of agency contact regarding improved social functioning

and alleviation of social problems.

The sample comprised 100 subjects in total, 50 from each service, matched for age, sex, diagnosis and ethnic origin and the aim was to establish whether there were any differences between the cohorts on selected variables of length and type of service contact; community group and day centre attendance records; liaison attempted/achieved with community agencies; reasons for discharge; frequency and length of admissions; and type of counselling undertaken.

2) PRIORITISING THE LONG TERM MENTALLY ILL IN A CATCHMENT AREA CMHT MODEL: WAS IT FEASIBLE?

The second study focused on an evaluation of the DEW Team when they changed focus to become a "comprehensive" catchment area team no longer specialising only in work with the long term mentally ill group, but still aiming to prioritise work with this group. The study looked at the distinction that the team developed between long term mentally ill and "acute" clients to discover whether the team's policy of prioritising the long term mentally ill group was observable in practice and to see if there were any differences in the kind of service offered to the two groups.

A major consideration in designing this second study was to develop a simple methodology that avoided making extra demands on staff and which could be used by other CMHTs with little access to research staff. Maximum use was therefore made of data routinely collected by the team. The study adopted three main approaches:

- a) a retrospective computer study of long term mentally ill and acute client categorisation over time;
- b) a prospective study of the time spent discussing clients from each group at the weekly multi-disciplinary team meetings;
- c) a crude study of staff-client contacts with long term mentally ill and acute clients on the "current" case-load.

The Aim of Part Two

It is proposed in this thesis that studies of what actually happens at the local level are needed to gain a more detailed understanding of the development of community care provision for the long term mentally ill, as it is necessary to do more than offer a general explanation of why problems may exist. Since there have been a wide variety of responses to the community care problem in the U.K., it would not be possible in one thesis to conduct such a study on a national scale. Therefore, the aim in Part Two of this thesis is to present a detailed case study of one particular innovative CMHT set up to work with the long term mentally ill in an inner city area of London. This constitutes but one of many such case studies that need to be completed to ascertain whether the theories presented in Part One are plausible in the local context and hence to learn from the experience that local innovations in community mental health care can provide.

PART 3: SYNTHESIS

The final two chapters of this thesis consider the possibility of a synthesis of this diverse material and attempt to answer the research questions set out at the beginning of the thesis on the basis of case study evidence. Chapter thirteen considers research question one in the light of the structural and philosophical literature reviewed in Part One. The question was "Why has community care of the long term mentally ill been so difficult to implement in Britain?" Conclusions are drawn detailing the kinds of structural and philosophical problems that were experienced in providing care to the long term mentally ill in the case study CMHT.

The first part of chapter fourteen considers research question two in the light of the "professional and practice" and "public policy" literature that was also presented in Part One. This second question was "Does the Community Mental Health Team Approach provide a viable model of service provision for long term mentally ill clients?" Conclusions are drawn from summaries of the discussions presented in each of the case study chapters. At the end of chapter fourteen, the

relevance of such findings in the rapidly changing community care policy context at the time of writing is detailed.

Background Details about the Case Study Area and Research Period Chosen

As described above, the thesis is based on a case study of an innovative CMHT in one inner city area of London. The Doddington Edward Wilson Mental Health Team (DEW) was established in Battersea over a three and a half year period from 1982 to 1986, the period between which proposals were made and the team came into being. It was in 1979 that discussions first began which led to the creation of the team. Hence, the period studied in this thesis takes us through the whole development from 1979 to 1992. The team went on to develop further after this period, but the author was no longer directly involved with the service and so 1992 was taken as the cut off date for this research. However, it is important to bear in mind Donnison's words that,

"A case study is not a self-contained, static or completed edifice, but part of a more general and continually evolving collective response to the changing needs of society". (Donnison et al, 1975, p44)

The Battersea catchment area is in an inner city community whose Jarman indices for the majority of the electoral wards lie within the 5% most under privileged in the U.K.. It is an area of particularly high morbidity and before the DEW Team was set up, the psychiatric hospital in the area was seen not to be meeting the needs of the local population of long term mentally ill clients. The DEW Team was therefore established to do outreach work from a converted pram shed on one of the local council estates. Initially it was supernumerary to the hospital service and operated as a specialist service to long term mentally ill clients. The DEW Team as originally constituted, changed focus in October 1988 to become a catchment area team: a comprehensive CMHT for North East Battersea.

The particular features that promoted the choice of this case-study team were twofold. Firstly, the timing of the team's

development was important. The team was initiated in the early 1980s. It was one of the first mental health services in the U.K. to set up using a CMHT model, specialising in work with the long term mentally ill. The CMHT model had previously been utilised mainly in the US and Italy. Therefore, this study provided an opportunity to comment on the importation and modification of a model mental health programme into the U.K. and the process of its initiation and development. Organisations such as "Good Practices in Mental Health", the "Kings Fund", "Research and Development in Psychiatry" and the "Personal Social Services Research Unit" have been monitoring many such CMHT developments in the U.K. and this thesis is seen as complementary to their work.

Secondly, the team operated from its beginning with a strong commitment to self evaluation. Therefore, it was possible to chronicle events from its earliest days and this provided an ideal opportunity to reflect and learn from the team's experiences. Developments in British community care policy for the mentally ill in the past decade have increasingly moved towards emphasis on "priority working", "case management" and "care planning" and many new services based on these principles are being quickly and fairly widely established, in accordance with new government legislation. The pace of change is alarming, leaving little opportunity for reflection and assimilation of learning experiences. The case-study CMHT had already established a form of care planning for the priority long term mentally ill group six years before the introduction of recent government initiatives making case management and care planning a statutory requirement. Hence, it provided an ideal chance to assess the policy implementation process where a system had been devised and modified and was being used in the day to day management of the long term mentally ill.

A Note on Thesis Methodology

As a part of discussing the research design of this thesis, it was thought necessary to elaborate on the context in which the fieldwork research took place, to detail the limits of the research questions posed and the research design chosen, with

particular emphasis on what it was not possible to do, and to qualify the way in which the results are instructive. This thesis aims to be sceptical in the best possible sense.

Working with theory and evidence it is important to remain very clear about the scope of the findings and the conditions under which they appear to hold true. Top-down methods of assessment of mental health services utilise relatively "hard" data that is easy to collect routinely, but has only a statistical relationship to individual need. The bottom-up approach used here is personal and can be more closely directed towards an understanding of the complexity of individual cases and the true nature of the decision making process. It was recognised at the outset that data gathered was "soft", complex, full of value judgements and difficult to generalise from. It is therefore hoped that this thesis research will provide an opportunity to complement other studies through its deeper appreciation of the internal context and policy process during the last decade. It is hoped that even this limited effort can dissolve many of the crude stereotypes and sweeping generalisations that so often bedevil discussion of community mental health services.

Naturalistic designs, such as the multi-method approach used, while lacking conventional scientific credibility do not have to lack rigour. Concerns about the "complexity" of technical problems in evaluating care, while they are undoubtedly very real and continually highlighted throughout this thesis, can detract from the endeavour to gather knowledge about CMHTs and community care for the long term mentally ill from every available source. It will be emphasised throughout the thesis that when service aims are translated into objective operational terms, such as increasing the number of clients in contact with local community agencies, the intentions are clear enough, but it cannot be assumed that fulfilling these targets will ipso facto reduce social disablement or improve quality of life. Some evidence to that effect has to be forthcoming. It was not possible to extend the thesis to include this evaluation task.

There are some very obvious drawbacks in the methodological approaches used in the fieldwork research. Firstly, the time-scale of the empirical evaluation was far from ideal. Shepherd (1991) drew attention to the problem of the time-scales commonly feasible in an empirical evaluative study, which are of the order of six months to two years, and the acknowledged very slow progress of clients where changes become apparent only over intervals of three to four years. For funding reasons the empirical work included in this thesis was limited to a two year period. It is, therefore, unable to contribute to a discussion of change in clients' overall well-being and quality of life over time. In the first empirical study, only a very limited control measure was available in the local area, in comparing the DEW service to the CPN service. The second study was subject to a high degree of methodological experimentation. Also, in common with many new CMHT services that have been set up in recent years, the case study CMHT had to engage in a "hard sell" of the kind of service that it offered. Reporting biases resulting from such a "DEW centred" evaluation can only be registered and efforts made to reduce their influence.

In Brief

Part 1 firstly highlights specific problems and issues in community care service provision to the long term mentally ill client group and describes the emergence of the CMHT model, by considering the "professional and practice" literature. On a macro level, it then considers the more general theoretical contributions of various social science theories and literature on innovation and implementation in public policy. A major proposition of this thesis is that to make the theory more useful, elements of each theoretical approach need to be extracted and tested against what is happening in practice. In Part 2, a case study of a CMHT in one area of London will be used to look at process factors in policy development at the local level. Material will be drawn from a detailed historical account of events and empirical studies of the policy process. Part 3 constitutes an evaluative synthesis of material from all the discourses considered in the thesis.

1. The term "actors" is used to refer to various interested parties and individuals involved in the policy process.
2. There is some debate in the literature about the most preferable term to be used. The terms "patient", "service user", "mentally disabled person" and "client" have been variously used, none of which are considered by the author to be ideal. However, for the sake of consistency with the terms used at the case study CMHT, the term "client" will be used throughout this thesis, except where referring to hospital inpatients.

**PART 1: COMPLEMENTARY LITERATURES ON
COMMUNITY CARE**

In Part 1 of this thesis, material drawn from the three theoretical literatures outlined in the research design will be presented in the form of three distinct chapters. These embrace three different types of literature: professional and practice literature (chapter two); philosophical and structural interpretations of community care policy and its origins (chapter three); and more general work on innovation and implementation in public policy (chapter four).

The intention is to explore the main tenets of each set of theories and to establish what each can contribute to an understanding of community care development for the long term mentally ill. This material will then be used to evaluate a local case study of a Community Mental Health Team throughout Part 2 of the thesis and to focus the discussion in attempting to answer the research questions in Part 3.

CHAPTER 2:

Community Care of the Long Term Mentally Ill: Professional and Practice Literature

During the 1980s and early 1990s, there has been a growing emphasis in the professional and practice literature on the psychosocial aspects of psychiatric morbidity, accompanied by a move towards viewing mental health service provision as being more closely connected to the social world in which it is practised. This signifies a shift away from the concentration on medical advancements that had been the primary focus of the professional and practice literature in previous decades. Chapter two aims to review this literature in order to give an account of the content and range of the on-going professional debate about community care policy in the 1980s and early 1990s, specifically focusing on the long term mentally ill.

Definitions of the key terms used in the thesis will initially be briefly discussed, moving on to a clarification of the main issues that have driven professional assessment of community care as a policy. Within this discussion, it is the intention to map out what community mental health care for the long term mentally ill meant in practise during the 1980s, describing the ways in which it was suggested to have extended beyond the traditional patterns of institutional care. The emergence, ideological foundation and practical application of the CMHT model will be described, together with a brief discussion of the concepts of case management and care planning which have been closely associated with CMHT development.

The Definition of the Long Term Mentally Ill

There are an estimated forty million people worldwide who are severely disabled by mental health problems (World Health Organisation 1973, 1987: Cohen 1988). To give an idea of the magnitude of the problem in the U.K., Goldberg & Huxley (1980) showed that 250 out of each 1,000 members of the population in Britain will each year experience symptoms which may be regarded as psychiatric or psychological in nature. Of these,

just less than two percent seek the help of a psychiatrist, the majority being helped by family and friends, their family doctor or other primary carers. This gives some indication of the proportion of the U.K. population who seek help with mental health problems from the health and Social Services. Of these, fewer still suffer severely disabling mental health problems over long periods of time. It is this relatively small group of the most disabled clients (referred to as the "long term mentally ill") who have presented the greatest challenge to those who devise and implement community care policy and on whom we wish to concentrate in this thesis .

The long term mentally ill have been variously described as "real lunatics", "chronic mental patients", "people with enduring mental health problems" and the "severely mentally disabled"¹. In the last decade it has become common practice to distinguish them from those who experience more short term "acute" episodes of mental disturbance. In general terms, the former suffer from severe illnesses such as organic mental disorders, schizophrenia and bipolar affective disorders, while the latter comprise depressive illnesses and anxiety-related disorders that are much more likely to resolve spontaneously with time. Lavender & Holloway (1988) suggested that the issue of definition of the long term mentally ill is essentially concerned with the nature of the individual's primary difficulty. This usually involves an inner experience of a particularly disturbing nature that people are likely to have to live with for long periods during their life time. The primary difficulty can include any of the following:

1. a strong feeling that people with whom you come into contact are against you and are plotting, sometimes with elaborate means, to attack or keep you under surveillance.
2. a distressing experience, such as hearing arguing voices or seeing images that no-one else can see or hear.
3. a strong belief in or idea about events in your life that others neither believe nor understand.
4. a feeling of great despair out of which it seems impossible to break.
5. a feeling of the greatest optimism and belief in yourself that seems to others completely unjustified by your circumstances and that seems to be often followed by deep despair.

6. a feeling of severe isolation from other human beings where any contact becomes a painful experience to be avoided.

People with these disturbing experiences also have other and often related problems which interfere with their ability to lead "normal" lives in the community. Wing & Morris (1982) called these "social disablements". They may include an inability to hold down a job, difficulty in maintaining stable relationships or lack of basic skills necessary for everyday living. The treatments that people receive for their mental health problems often lead to additional difficulties, such as the side effects of medication and/or the effects of spending years segregated from other members of the community in a psychiatric hospital. The social implications of all these difficulties are profound. In particular, a link has been noted between homelessness and long term mental illness. For example, Tantam (1991) found that between 25% and 35% of the homeless have a psychiatric history or display psychiatric symptoms at interview. He suggested that psychiatric clients constitute the lowest rank in the pecking order of street life. Van de Wijngaart (1990) showed that they were easy victims, easy to rob, easy to deceive, turn away and ignore.

The experience of long term mental illness is that of a disturbance of the emotions that affects both thinking and action. In the medical tradition such disturbances are defined as symptoms and diagnostic labels are attributed to certain patterns of these symptoms. For example, hearing voices arguing when there is no tangible source, is often diagnosed as schizophrenia. The International Classification of Mental Disorders (ICD-9)(9th edition-WHO 1978), published and updated by the World Health Organisation, is the official classification in the U.K. and is a categorical system of diagnosis. It defines mental illnesses as involving disorders of thought, memory, mood, perception or cognitive ability, developing in individuals whose psychological function was previously normal. It also divides illnesses into psychoses and neuroses. Psychoses are said to entail symptoms outside normal experience, such as delusions and hallucinations. They

tend to be severe illnesses in which the client loses insight and confuses subjective experience with reality. Neuroses are more common, in which the symptoms are understandable as an exaggeration of the normal response to stress. Conditions not classified as mental illness but involving abnormalities of development or behaviour are also included. These include personality disorders, alcohol and drug abuse, sexual disorders and eating disorders.

The Diagnostic and Statistical Manual (DSM III) (third edition- APA 1980) is the official classificatory system of the American Psychiatric Association and is a multi-axial system with five axes. It is of interest because workers in the U.S. have taken the lead in formulating operational definitions of mental disorders and the system is increasingly used in the U.K. in addition to ICD-9. It is less fragmented than ICD-9 and offers rigid, clearly stated diagnostic criteria in contrast to the more flexible diagnostic guidelines of ICD-9, although the two systems correspond and with new revisions they are converging quite quickly (Goldberg & Huxley 1992).

However, definitions of the long term mentally ill tend to straddle several categories of these classification systems and the issue is complicated by the multiple diagnoses given to many in the population who cannot be placed neatly into any one diagnostic category. Therefore, other indicators have been used to distinguish the long term mentally ill from those with acute disorders. In the U.K., the long term mentally ill have often been defined by psychotic diagnosis (eg Borland et al 1989) or numerous lengthy or compulsory hospital admissions (eg Shepherd 1984; Franklin & Solovitz 1987) and some studies have taken as their criteria the presence of "a perceived risk of re-hospitalisation" (eg Bond et al 1988). Differences in definition have meant that it has been difficult to compare epidemiological data across the country and even within small geographical areas, let alone internationally.

With the move to community care, three groups of long term

mentally ill clients have become evident, further complicating the issue of definition. First, there is the group of "old long stay patients" who have chronic problems and have lived in institutions for a major part of their lives. They have particular problems of independence in carrying out daily living tasks such as cooking, washing, finding accommodation and sustaining themselves generally with few social contacts. Ford et al (1987) found in their survey that 30% of this group were aged over 75 years and that they tended to be frail and socially isolated, with 74% seldom leaving hospital.

"New long stay patients" have been identified as a second group, those who despite the development of community based services and newer treatments are unable to sustain life in the community and hence live in hospital. Conceptually, this group constitutes those who began their "psychiatric careers" in a post-institutional climate and Mann & Kree (1976) identified that 52% of this group are female, the most common diagnosis is schizophrenia and despite their relative youth they have long psychiatric histories.

Third, there are the "new chronic patients", people with long term mental health problems who have not had the experience of being incarcerated in a mental hospital for years on end, but who nevertheless suffer enduring mental health problems with associated social disablement and make frequent use of a variety of services on a prolonged and repeated basis. Kastrup (1988) conducted a national study of young adult psychiatric patients and their need for hospitalisation and found that typical "new chronics" were young males, with psychosis or personality disorder, perhaps misusing drugs or alcohol. The U.K. study by Lieberman et al (1988) supports these findings.

The acute population, on the other hand, have not prompted such attention to definition, and are generally regarded as those who have had neither experience of hospital nor a psychotic diagnosis. It is accepted that they require services mainly revolving around counselling and psychotherapy, and a higher proportion of young adults, women and the middle

classes are represented in the acute population (Goldberg & Huxley 1980).

There are presently many theories about the origins of long term mental health problems involving genetic, chemical, psychological and social explanations (for a consideration of the debates and current evidence see Kerr & McClelland 1991: Goldberg & Huxley 1992). None is definitive and simple answers cannot be given, but whatever the view of causation and diagnostic practices, it is clear that most people with long term mental health problems require help over long periods and pose the greatest challenge to those who develop community care policy and deliver community services. It is discomfort and dysfunction that bring these people to seek help from services, not the pathology which may underlie them and it has therefore started to be recognised that while practitioners require bio-medical knowledge, this must also be informed by the social sciences.

The Definition of Community Care

The term "Community Care" first appeared officially in the 1930 Annual Report of the Board of Control (Jones 1988). It was used to refer to a policy then being advocated to provide for the mentally handicapped to live outside hospital wherever possible. However, Community Care for the mentally ill, as an explicitly recognisable policy with that name, dates from the Report of the 1954-7 Royal Commission on the Law relating to Mental Illness and Mental Deficiency (the Percy Report). From the early 1960s, plans were put forward to reduce the total number of psychiatric beds and even to phase out mental hospitals altogether and these plans became policy when they were announced in Enoch Powell's "water tower" speech at the 1961 Annual MIND Conference. Valuable accounts of the way that the term community care has since diversified in its use and application are given in Busfield (1986), Goodwin (1990) and Tomlinson (1991), to name but a few, but the intention here is just to give a brief definition of what was meant by the term in the 1980s and to describe why the policy was considered problematic for mental health services on a general level. A

discussion of structural and philosophical interpretations of community care policy as it developed will be the subject of chapter three.

During the 1970s it became clear that the shift to the provision of public community care services was problematic and the policy had met with little success. By the 1980s it was recognised that alternative community services for the mentally ill had still only been provided in a piecemeal fashion (House of Commons Social Services Committee 1985). For example, between 1979 and 1988, residential facilities in the community increased from only 5,607 beds to 9,745, with most of this growth (some 2,500 places) being in the private sector (Goodwin 1990). There had been ideological and financial retrenchment on the original intentions stated in the Percy Report and by the mid-1980s, new definitions of what community care meant continued to appear. In 1985 the Department of Health and Social Security (as it then was) stated its definition of community care as follows:

"Community Care is a matter of marshalling resources, sharing responsibilities and combining skills to achieve good quality modern services to meet the actual needs of real people in ways these people find acceptable and in places which encourage rather than prevent normal living." (Department of Health and Social Security, 1985a, para 3 p1)

Underlying this definition was the basic assumption that most people who required long term care should and could be looked after in the community. The ideal was a system of care where people continued to reside and to receive treatment in the local community and if hospital admission was necessary, this was as brief as possible to preserve community ties and reduce dependency. It was being advocated that discharge should then be followed by careful maintenance of aftercare² with continuing liaison between staff working in the hospital and in the community.

At the same time, new emphasis was attached to care within and by the family (eg Royal Commission 1979) and in a range of service agencies including the voluntary and private sector

(eg Griffiths 1988). Also, policies were aimed at meeting individual needs with tailored services rather than at mass provision for the whole spectrum of needs (eg House of Commons Social Services Committee 1985; Department of Health 1989a). A low profile political campaign promoting self reliance, privatisation and the drive for efficiency also began to manifest themselves in community care policy formulations.

By the mid-1980s, it became clear that institutional closure was succeeding very slowly but new community provision remained sparse, being subject to ad hoc planning and poor monitoring in many cases (Hunter & Wistow 1987). In 1986, the Audit Commission report Making a Reality of Community Care highlighted the fact that community care implementation had been slowest with the mentally ill client group and reduction in hospital provision had outstripped the development of new community services. Gross geographical variations in services had arisen, with complex organisational arrangements and perverse funding policies, particularly at the point of service delivery. Failure to address the training needs of staff in new community services was also an issue.

The associated closure of the institutions (with attendant statistics about patient numbers and bed usage) was the subject of numerous reports, articles and planning briefs. It was noted with irony that it took forty years before any major hospital was actually closed (Korman & Glennerster 1985). Institutions were shrinking in size, with admission policies being tightened up and some services were being devolved from the main hospital site, but the number that had actually closed was small. By 1988, firm closure programmes had been devised for only 43 out of 178 hospital units for mentally ill clients in England surveyed by the National Schizophrenia Fellowship (National Schizophrenia Fellowship 1988).

Powick Hospital in Worcestershire, Banstead and Exminster Hospitals were all closed during the 1980s under the scrutiny of commentators. None of the three schemes appeared to have resulted in the worsening of service to the mentally ill, but

the dramatic improvements which the revolutionary nature of the move would suggest were not in evidence (Tomlinson 1991). However, the extent to which hospital closure has driven community care developments cannot be overstated, fuelling it both in terms of reprovision for needs and financially. At the outset of the hospital closure programme and community care policy implementation, there was a strong belief that it would offer a cheaper form of care to that provided in the institutions (see chapter three). The reshaping of the mental hospitals undoubtedly did release a lot of money, on which the first call ought logically to have been funding community care programmes for the mentally ill, but in 1991 it was estimated that over half of the 1.5 billion pounds spent on hospital and community services supported just 40,000 patients remaining in the large hospitals. Less than half supported the many hundreds of thousands of clients in the community, many of whom were at least as disabled by their illness as those in hospital (HRH Prince of Wales speech 1991). Although there was some expansion in private and voluntary sector care, there exists little information on exactly how many long term mentally ill clients had found their way into such accommodation nor what the standards of care were like.

Recent government legislation, following from the Griffiths Report (Griffiths 1988) introduced into the National Health Service (NHS) the financial and managerial efficiency of the business world. The subsequent period of rapid organisational change has been one of severe financial constraint on the NHS and other public services. Throughout the period that this thesis was being written, dramatic changes were occurring in government directives and legislation regarding community care policy in the 1990s (eg Department of Health 1990). The relevance of the current inquiry to the policy context that has subsequently developed will be explored in the final chapter of this thesis, but for now it is the intention to concentrate on the patterns of service provision that resulted from the policies of the last decade and their problematic nature.

What Community Care for the Long Term Mentally Ill Meant in Practice

In the early 1980s, it was recognised in the U.S. that the most highly qualified psychiatrists, social workers and psychologists all tended to concentrate their treatment on people who were less ill and more likely to recover (Bachrach 1982). In hospitals the long term mentally ill always tended to be left to the care of nurses whether qualified or not. Traditionally health professionals had been looking for ways to cure people and when cure itself was not a likely result as major advances in medical technology were not forthcoming, the investment in care for the long term mentally ill was often left to the least qualified staff members. Mollica (1987) described this problem as "upside down psychiatry" and emphasised that it was ironic that the more problems a homeless mentally ill woman had, the less she would probably be served by psychiatry. Similar tendencies were observed in institutional and community provision in the U.K. in the 1980s, where services drifted towards concentrating mainly on "acute" cases or those with less severe problems (Sayce 1987: Melzer et al 1991).

Concern was expressed about high morbidity in the community. In addition to their failure to adequately and coherently meet the needs of the long term mentally ill, specialist psychiatric services were only dealing with a small "pool" of morbidity that existed (Broszkowski & Baker 1974) and significant numbers of long term mentally ill clients had repeated admissions to hospital. The term "revolving door" patients was coined to describe clients who displayed this cyclical pattern of hospital admissions (Hoult 1986). With poorly coordinated inadequate community services, the long term mentally ill continued to be a major strain on the reduced hospital services (Kanter 1989). Allen et al (1992) followed up 120 people discharged after short admissions in London and found that one year later there was evidence of inappropriate use of services, those with the greatest needs were not the most frequent service users and there were generally low levels of service receipt.

Outside the institutions the long term mentally ill became highly vulnerable since for employment, housing, social security, social work and even medicine, these people seldom received any priority. Additional problems associated with the less than warm welcome that the long term mentally ill received from their new neighbours in moving into ordinary houses on ordinary streets also had to be faced. While it was recognised in the U.K. that community mental health care extended far beyond the boundaries of traditional institutional provision, this recognition was not reflected in the actual services that were provided. Institutions had been open all year round, all day and all night long. In the 1980s, community services were still rarely available at half an hour's notice or through the twenty four hours. Nor were they available for more than once a day, or over a continuous period for months or years on end. Bachrach (1984) highlighted that hospitals had functions that needed to be replaced by community services: accommodation, comprehensive medical care and monitoring, respite for families, social network and advocacy, and above all, safety and security. Kastrup (1988) concluded that asylums would always be needed for the long term mentally ill in terms of their function rather than the place. This supported similar studies in the U.K. (eg Mann & Cree 1976: Lieberman et al 1988).

Service delivery problems in cities were particularly extensive and severe. The impermanence and anonymity that are part of urban living almost certainly exacerbated many difficulties experienced by the long term mentally ill. For example, because such people were often forced to wander from one area to another in the city due to their housing and social problems, they were often hard to find and so case-finding efforts were needed to counteract the invisibility of many people who were most in need of help. These individuals would often not come to services, so the services had to find them and go to them. Even where people engaged with services initially, drop-out³ rates ranged from 20 to 50% (Baekland & Lundwall 1975; Gournay & Brooking 1993). There was also a danger of over-generalising urban problems to the country as

a whole and in Britain, London's mental health services did not all compare favourably with other larger cities. Community care services had developed in a patchy and unsystematic fashion across the country (Hunter & Wistow 1987, 1988).

Traditional aftercare provision for long term mentally ill clients leaving hospital existed in the Community Psychiatric Nursing (CPN) service established at many hospitals in the U.K.. However, as the number and variety of community based services expanded in the early 1980s, it was questioned whether CPN provision was broad enough to cater for the needs of the long term mentally ill. Woof, Goldberg & Fryer (1988) conducted a study in Salford monitoring the work undertaken with individual clients by CPNs and Mental Health Social Workers (MHSWs) and found their work to be significantly different. They found that the CPN service focused mainly on psychiatric symptoms, treatment arrangements and medications. They concluded that care of the long term mentally ill living outside the mental hospital required more long term co-ordinated multi-disciplinary input and attention to social care and the needs of relatives.

Other studies showed that clients and relatives expressed disappointment when they perceived that an emphasis on administration of injections displaced "conversation" with the CPN (Hunter 1978). In addition the location and type of CPN service delivery was found to have an influence on client care. Sladden (1979) found that clinic contact times were one seventh the length of community visit times and concluded that the range of information which nurses could derive solely from contacts at the clinic was very restricted. In the 1980s, the CPN service remained, in many areas, the only form of community aftercare for long term mentally ill clients, except where alternative innovative approaches were tried, many of which used the Community Mental Health Team model.

Community Mental Health Teams

Community Mental Health Teams and Centres (CMHT/Cs) were the most visible manifestation of attempts to provide alternative

innovative mental health care within the community in the 1980s (Sayce 1987). They first appeared in Britain in the 1970s, established under the NHS, Social Services or under joint management. According to surveys conducted in the U.K. by "Research & Development in Psychiatry (RDP)", there were probably 160 CMHCs nationally by 1990 (RDP 1990), although definitions varied considerably. In May 1984, the Kings Fund hosted a day conference on the topic and many models of service delivery ranging from mental health resource and advice centres to, in some cases, progressive day hospitals, were presented under this umbrella term. Several authors have since attempted to define the terminology and it has been noted that policy documents and stated service aims suggest a number of typical values and practices (McAusland 1985; Sayce 1989; Huxley et al 1992). The keynotes are listed below with some examples of how they have been translated into practice in the U.K.:

1 LOCAL CARE

The centre or team-base was located in an acceptable and easily reached site. Decor, furnishings and overall image were supposed to be admissible to all sections of the community from tramp to stock-broker. The catchment population was given information about what services were available and where they could be obtained. A walk-in service was often provided in a residential or shopping area such as the "608" Centre in Leytonstone, London (Goldie & Waite 1989).

2 ACCESSIBLE SERVICE

Referrals were accepted from a wide variety of sources, particularly clients themselves and local GPs. Speeding up the process of obtaining help was also considered crucial. A randomised control study in Lewisham showed that people allocated to the CMHC achieved a faster route to treatment than those allocated to a traditional outpatients' department (Boardman et al 1987). Provision of a response to crisis through a crisis prevention service was often provided, such as that of the Lewisham Centre who saw people within 24 hours or faster in an emergency. This contrasted with a route through multiple "filters", such as GP to psychiatrist to psychologist, underpinned by a wait of four to six weeks for an appointment which was normal in traditional hospital aftercare services.

3 NON-STIGMATISING CENTRES AND STAFF

Attempts to counteract stigma, often involved use of an ordinary house, where staff did not wear uniforms and working methods addressed the social and personal, in addition to the medical aspects of mental health. Some

teams made specific attempts to change attitudes, not through argument and indoctrination, but through familiarity and mutual tasks. A few centres additionally tried to attract under-represented groups, such as black and ethnic minorities or women with young children. Hence, for instance the creche at Gable House in South London (Pilgrim & Rogers 1987).

4 FOCUSED, COORDINATED SERVICE

Providing a focus for an area's mental health service and encouraging co-ordination between the Health Authority, Social Services and other relevant local agencies was given emphasis. For instance, the Hove Centre in Sussex collaborated with local branches of the National Schizophrenia Fellowship and The Association of Carers, and many centres and teams had regular liaison meetings with GPs and local voluntary organisations. Also, with a multi-disciplinary team made up of Health and Social Services personnel, there was apparent potential in overcoming fragmentation between sectors. An independent evaluation of Gable House in London concluded that multi-disciplinary working was excellent (Pilgrim & Rogers 1987). The aim of co-ordination met with certain successes. Some centres were notable for the extremely broad range of agencies with which they were in active contact, going well beyond the mental health sector (Clifford & Craig 1988).

5 EMPOWERMENT

Empowerment of service users (sometimes with the corollary that this required a lessening of the power of professionals) was also emphasised, though active client run programmes were rare in Britain. Empowerment was usually limited to advocacy on the part of clients and some involvement of clients in the running of day care centres, resource units and service user groups such as Nottingham's linked patients' councils and team based service user groups.

The CMHT model originated in the United States. Following the 1963 Community Mental Health Centres Act introduced by President Kennedy, CMHCs proliferated and in an era of high civil rights activity, they aimed to provide a free, local, accessible mental health service for all. However, certain ideological and practical tensions characterised their development, reflecting social, economic, professional and organisational forces often working at cross purposes (Levine 1981). The radical potential of many centres was declared unrealised (Okin 1984; Good 1987) and in the 1980s they were accused of a "loss of perspective" on the grounds that they had avoided the task of providing the therapeutic services

necessary to maintain the long term mentally ill in the community (Mollica 1983; Hollingsworth 1990; Bush et al 1990).

In Britain, such service failure was also readily apparent. Research & Development in Psychiatry (RDP) found that of 67 CMHC/Ts sampled, 90% defined their target clientele in very broad terms like "all mental health need", but their stated aims did not suggest a focus on the long term mentally ill (RDP 1990). "Long-term treatment /support" was cited by only 18%. Patmore & Weaver (1991) studied six comprehensive CMHTs, who had been given start-up funding by the Department of Health in 1986 and found that usually "long-term" clients were heavily outnumbered on the team case-loads by clients who had neither experience of hospital nor a psychiatric diagnosis. Typically they comprised around two-thirds of a CMHT caseload and in consequence most teams lacked space to serve more than a quota of their catchment area's known sufferers from long-term disorders. There were only one or two exceptions to this pattern. Yet all these teams had been set up with a specific brief to prioritise work with "long-term" clients. In short, the one model to promise care for the long term mentally ill in this country appeared to be failing to deliver.

In the U.K., CMHTs grew in numbers during the 1980s and they also began to attempt wider, more ambitious roles, being increasingly pushed into adopting "comprehensive" roles in catchment area provision (Patmore & Weaver 1991). Yet lack of knowledge about models of practice was problematic and policies tended to be vaguely framed with reference to trends in community development advocated by key government publications (eg Department of Health and Social Security 1985) and philosophical ideas, notably as expressed in normalisation theory⁴ (Wolfensberger 1970, 1984) and in influential documents such as MIND's Common Concern (MIND 1983).

The effectiveness of the CMHT approach has been evaluated in its various forms in the United States, with a particularly

voluminous literature emerging about "Community Support Systems"¹⁵ (for reviews see Bachrach 1982,1987; Anthony & Blanch 1989; Hollingsworth 1990) and in Italy under the "Psichiatra Democratica" reforms (eg for review, see Crepet 1990). Evidence is equivocal. The most coherent and widely researched form is that provided by an "Assertive Community Treatment Team" (Olfson 1990). However, evaluations have tended to concentrate on such teams' effectiveness in decreasing hospital utilisation as compared with control conditions (Stein & Test 1980; Hoult et al 1984,1986: Fenton et al 1982) though it is unclear whether this form of care is more effective in reducing symptoms and improving community functioning in the long-term (Olfson 1990) and whether in practice it constitutes a coherent alternative service model that fulfils its aims. The experimental services described in these studies showed marginal but not startling advantages (Rushton 1990) and British replications of these studies have shown similarly undramatic results (eg Dean & Gadd 1990).

In general, progress towards monitoring the effectiveness of CMHTs for the long term mentally ill in the U.K. was somewhat slower than in the U.S. and Italy (Sayce 1987). Exceptions included an outcome study undertaken at the Hove CMHC in Sussex, which found significant improvement in terms of General Health Questionnaire scores and clinical ratings in relation to the treatment programme (see Peck & Joyce 1985); a study of the Daily Living Programme in London comparing community and hospital based treatment, which found community treatment reduced hospital use by 80%, more input was needed for psychotic than neurotic illnesses and cost was 25% lower overall in the community but 10% higher for schizophrenics (Muijen et al 1992); and qualitative work that has tended to indicate success at meeting certain objectives but failure with others (eg Goldie et al 1989 found successes in geographical access but limitations in catering for the long term mentally ill in two London CMHCs). Outcome studies conducted so far suggest that knowledge of the effectiveness of social care is the major missing link, plus knowledge of predicted costs and benefits for different types of long term

mentally ill client.

During the writing of this thesis, further case-studies of locally based innovations in community mental health provision started to appear in the U.K.. Powell & Lovelock (1992) carried out a study of the development of the Cosham mental health service in Portsmouth and concluded that it had substantially exemplified the diversity, informality, outreach and critical feedback required of new models of service provision. King (1991) carried out a case-study of the move away from hospital services in Exeter towards new community initiatives. He suggested that "community solutions are better value for money (and) people prefer them", but cited little actual evidence in support of this notion aside from a few anecdotes. Clearly, further research is required.

Essentially, CMHT/Cs that were developed in the U.K. during the 1980s were plagued by fears that the lessons of the international CMHT/C experience had not been heeded and that Britain may have been "reinventing the wheel" (and in many cases the square type). There were doubts about whether the CMHT was a robust enough vehicle for change and CMHTs were uncertain 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 and puzzled by the complexities of inter-professional coordination. It is useful to ask how far these problems were really unique to CMHTs, as similar ambiguities could be found by directing the same attention at the average day hospital or admission ward. However, the willingness of CMHT innovators during the 1980s to acknowledge problems and to adapt, experiment and improve has meant that, to some extent, they have provided a test bed for community psychiatry as a whole, where conflicts and confusions that are universal have been confronted.

Case Management

The term "Case-management" appeared in the health and welfare literature from the mid-1970s onwards and is, at its most basic, a strategy for distributing and coordinating services

on behalf of clients (Modcrin et al 1985). A very brief description of the term is included here as many of the claims that have been made for case management closely parallel those of CMHTs. The aims of a case management system have been defined as the enhancement of the continuity of care and its accessibility, accountability and efficiency (Intagliata 1982). The basic functions that a case management system should carry out in order to achieve these aims were generally agreed to be: careful assessment of need; comprehensive care-planning; coordination of services utilising a "mixed economy of care"; and provision of follow-up arrangements, with regular reviews of outcomes (Clifford & Craig 1988; Renshaw 1988; Department of Health 1989a). In Britain, useful reviews of case management became available towards the end of the 1980s (Renshaw 1988; Kanter 1989; Thornicroft 1991).

In practice, case management amounted to the allocation of an individual client to one member of staff who planned and monitored the care to be received from a variety of sources, and made new plans jointly with the client, carers and health or social service staff. However, different kinds of system existed that varied on a spectrum from being individually or team oriented, embracing direct care or brokerage, involving interventions of different intensities, with different degrees of budgetary control, having health or Social Services as the lead agency, varying in status and specialisation of the case manager, having different staff-patient ratios and varying in terms of the degree of patient participation, the point of contact, the level of intervention and the target population (Thornicroft 1991).

Holloway (1991) extracted from the literature a number of characteristics shared by effective services for the mentally ill which undertook case management functions.

- 1) A clearly defined client group and a defined range of options for staff to draw on when developing packages of care related to individual need (Olfson 1990).
- 2) Teamwork (Watts & Bennett 1983; Wooff et al 1988) which in itself provided continuity of care, improved workload management and ensured the establishment of common priorities (Overtveit 1986). There was evidence that when

community-based staff work in isolation from multi-professional teams, standards of care were poor and case-loads, excessive (Woof et al 1988).

- 3) Effective working between case managers and colleagues in other services. The relationship with the hospital services was noted to be particularly important (Stein & Test 1980; Kanter 1989).
- 4) Realistic case-loads of case managers. Case loads ranging from 4 to 50 clients were reported for case management systems (Intagliata 1982; Kanter 1989; Patmore & Weaver 1991).
- 5) The recognition of monitoring and management problems and attention paid to professional and personal support given to staff (Intagliata 1982).

The concept of case management was recently enshrined in British Government policy for community care (Department of Health 1989a: Department of Health 1990) and the major responsibility for its implementation was given to Local Authorities.

The Care Programme Approach

The NHS and Community Care Act 1990 also legislated for other major changes in the way in which health and social care were delivered, involving different approaches to resourcing and operational practice. In April 1991, it became a requirement of all mental health services that long term and more disabled clients (the long term mentally ill) had an "Individual Care Plan" agreed and regularly reviewed by the multi-disciplinary team. This requirement was stated in the Joint Health/Social Services Circular HC(90)23/LASSL(90)11 and was referred to as the "Care Programme Approach". The circular placed different obligations on Health and Local Authorities. Health Authorities were required to implement the Care Programme Approach, but Local Authorities were simply asked to collaborate. The 1990 guidance from the Department of Health specified that Health Authorities could determine the exact form that the Care Programme Approach should take locally, but must include four particular elements:

1. Arrangements for assessing the health care needs of patients who could potentially be treated in the community, and for regularly reviewing their needs.

2. Arrangements agreed with Social Services Departments for assessing and reviewing what social care would give maximum benefit from treatment in the community.
3. Effective systems for ensuring agreed services are provided to those who can be treated in the community.
4. Patients themselves and their informal carers must have the chance to take part in discussions about proposed care plans.

There was a potentially fraught relationship between the Care Programme Approach and case management. Two main differences could be identified as distinguishing the two approaches. First, the Care Programme Approach adopted a "key worker" model with emphasis put on the relationship between client and key worker and the recognition of this role by other workers. However, unlike the "case manager" the key worker never held a budget and remained responsible for delivering a clinical service as psychologist, community nurse and so forth. This made the Care Programme Approach a narrower and less ambitious model than case management. Second, whereas the Care Programme Approach was health-led (implemented by Health Authorities), case management was social care-led (implemented by Social Services and Local Authority services).

For many mental health teams in the U.K., embracing such models was a considerable departure from the ways in which teams had traditionally operated and it was not surprising that the Care Programme Approach developed fitfully. Hogman & Westall (1992) concluded that the policy had done little more than provide "window dressing" without substance. A monitoring report from the Social Services Inspectorate in early 1993 found that only 49% of authorities had a system in place and of these, 20 said it had been implemented for all mentally ill patients known to the psychiatric service, 18 to in-patients only, and 11 cited a range of selected groups, such as new patients, those considered to be particularly at risk and long stay patients about to be discharged from hospital. Therefore, there is currently a need for an extension of both knowledge and expertise and one aim of this thesis is to establish how much can be learned from developments that occurred during the

1980s.

The Backlash Against Community Care Policy for the Mentally Ill

The overview of the professional and practice literature presented so far neglects to convey the extent to which community care policy for the mentally ill in the 1980s remained a highly emotive issue from a professional viewpoint. Some psychiatrists used evidence of the problematic nature of community care provision to argue for a return to old policies and to old hospitals. A backlash developed against the policy that extended to the medical profession as a whole. Both the British Medical Association and the Royal College of Psychiatrists called for the rundown of psychiatric hospitals to be stopped. In an article published in the British Medical Journal in March 1985, the following statement was made:

"The BMJ gets little satisfaction from saying that 'We told you so' - but we have argued consistently and repeatedly since 1966 that community care had to be shown to be more than a politicians catch-phrase. So too has the British Medical Association. In 1973, we warned that it was difficult to believe that an existence of aimless destitution is preferable to the organised and structured life in a well run mental hospital." (BMJ, 1985, p290)

Psychiatrists protests were supported by clinical analyses (eg Weiner et al 1987) and many articles appeared in academic journals and books debating the issue (eg see Hoult 1986 and Turner 1986). Thornicroft (1990) conducted a survey of members of the Royal College of Psychiatry looking at the effect of widespread decentralisation on quality and organisation of mental health services. 20% of respondents thought services had deteriorated and preferred hospital-centred models of care, yet Thornicroft noted a general lack of interest in evaluation of new community services.

More controversially, the hospital closure debate was picked up by the national media. The National Schizophrenia Fellowship (NSF) supported the psychiatrists position and this led to a bitter public row with fellow lobbyist MIND. The media largely supported the protests against community care

(Cohen 1988) and some new pressure groups were formed calling for the slowing down of hospital closures, such as "Concern" spearheaded by Dr Weller of Friern Hospital (Weller 1989). Although much of the content of Weller's proposals were valid in themselves, the theories of causation cited were questionable and showed a singular denial of any new community facilities that had emerged, such as those based on the CMHT model.

Hence, community care received a mixed reaction in the professional and practice literature of the 1980's that extended to the national media and one aim in Part Two will be to see how far local community mental health development was affected by this apparent backlash. The outright hostility to community care displayed by some psychiatrists in the 1980s became more muted in the early 1990s and translated into the more pragmatic concern of organisational functioning. One especially thorny issue arose concerning the location of power and responsibility in multi-professional teams based on a consensus model of organisation (Caldicott 1993; Tyrer 1993). Such issues of power within the psychiatric profession will be further explored in chapter three.

In Brief

During the 1980s, changes in paradigms for mental health care delivery were accelerating in the U.K., culminating in major shifts in government legislation and directives in the early 1990s. Throughout this period, the CMHT movement embraced one of the only discreetly identifiable attempts to offer an ideologically distinct alternative to the institutional system. However, even within the CMHT model, community care of the long term mentally ill population continued to be the most problematic. This chapter has presented an account of community service developments from the perspective of the "professional and practice" literature. Much of this literature, while it includes conflict and debate, occurs within a shared framework of beliefs that do not question the basic parameters. In the following chapter, it is the aim to broaden this outlook by considering the structural and

philosophical theories that underlie community care developments.

1. There is controversy over the use of all these terms, since they ignore the variation that exists within the client group and may unwittingly be stigmatising and self fulfilling. The term "Long Term Mentally Ill" is used throughout this thesis, since this was the term that was in common usage in the case study team evaluated in Part Two of the thesis.

2. The term "aftercare" is used to describe a class of services designed to ease the transition of institutionalised clients to community based service sites.

3. The term "drop-out" was used here to refer to clients not accepting services which they were considered to need. It included clients actively refusing services as well as those passively failing to attend services for assessment or some kind of planned intervention. It also took into account clients of community outreach services who refused contact with staff.

4. The principle of "Normalisation" is to enable the "deviant person to function in ways considered to be within the acceptable norms of his society" (Wolfensberger 1970). The development of CMHT services for the mentally ill in the U.K. has been influenced by ideas rooted in normalisation theory, which originated in the learning difficulties field. However, there has been no equivalent explicit drive for change based on this theory within the mental health field and the principle itself has been viewed with some scepticism (eg see Perkins 1992).

5. The National Institute of Mental Health defined a Community Support System as "a network of caring and responsible people committed to assisting a vulnerable population to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community" (NIMH 1977).

CHAPTER 3:

Interpreting the Community Care Story: Philosophical and Structural Interpretations

There is a whole spectrum of interpretations that have been put forward to account for the origin of community care policy and its purported subsequent difficulties. These interpretations are based on alternative philosophical and structural positions. As such, they direct attention to issues which may not be the stuff of headlines in the way that hospital closures and distressing media stories of the plight of ex-psychiatric hospital patients are, but which nevertheless underlie attempts to provide solutions to the problems of community care. In this chapter an attempt will be made to try to disentangle such positions and present a framework of distinct approaches, based in different schools of thought. Establishing such a framework of interpretations is not an original approach. Allsop (1984), Busfield (1986), Glennerster et al (1982), Goodwin (1990), Ham (1985) and Harrison et al (1990) all structured their research around the distinctive insights afforded by such theories. The framework presented in this chapter is different to those used by the authors listed above, but draws on their frameworks as sources. Although there is some overlap between different theoretical models, six different approaches can be discerned.

- 1) Traditional/Pluralist Interpretations
- 2) Sociological/Anthropological Interpretations
- 3) Marxist Interpretations
- 4) Economic Interpretations
- 5) Elitist Interpretations
- 6) Feminist Interpretations

The accounts of each set of interpretations presented are necessarily brief, as detailed discussions exist elsewhere. The broad intention here is to discern the variety of different theoretical positions and provide some examples of the concepts that have been developed. The framework will be used in Part Two to try and connect macro theory to the

specific policy issue of community care for the long term mentally ill.

1) Traditional/Pluralist Interpretations

Much of the traditional social policy literature on community care uses a familiar pluralistic perspective that views the move away from institutional provision and towards community care policy in a positive light. Central to this interpretation are three main elements. The first is the "Medical model"¹ of care. In basic terms, this is an ideology that rests on the notion that mental illness is akin to physical illness and treatment of mental illness is hence located within the remit of the medical profession. The medical task is seen as curative and it is claimed that over the last fifty years or so, medical practitioners have been increasingly successful in treating mental illness, aided by advancements in medical knowledge and technology and growing confidence and specialisation within the medical profession. A contributory factor to account for the move to community care policy is located in this notion that medical knowledge and treatment of mental illness has improved to the point where care outside institutions is both possible and preferable.

The second element is that modern society has become increasingly humane. The development of community care out of the institutional system is seen as part of a general moral advancement, an evolutionary step in the natural progression towards a more civilised world. Third, the traditional position rests on the notion of a plurality of interests embracing a range of opinion from politicians and professionals through to service recipients and their carers. Each interest group is seen as having exerted different pressures determined by their main areas of concern and each is thought to have had a balancing effect on the next. The combination of these competing demands is considered to have determined the subsequent development of community care policy. Interests that previously had made no contribution to the policy process such as those of clients, carers and

pressure groups were enabled, it is claimed, to join the debate by organising themselves more effectively. Community care is therefore thought to be an improvement on previous institutional policy as all interests have contributed to produce the most satisfactory system possible.

The most authoritative proponent of this account has been Kathleen Jones (1972, 1983, 1988), who drew her evidence from an historical analysis of mental health policy. For example, she stated that the 1959 Mental Health Act was the first major advancement in care of the mentally ill. It embodied enabling powers to do away with the stigmatising of mental illness and abandoned the old restrictive legislation while improving the powers of Local Authorities to provide for patients in the community. The Act itself specified little, but in doing so, allowed enlightened thinking to develop. Suddenly there was room for evangelical and radical new methods to be put into practice, made possible by technological advancements.

"Probably the most important single factor was the development of the psychotropic drugs, which made possible the control of mood swings and hence suppression of symptoms..... It also made possible a massive reduction in mental hospital beds by enabling many patients to be treated by their GP or in out-patient clinics and others to stay for much shorter periods" (Jones, 1983, p226).

Such a position has been supported by other theorists such as Martin (1984). Evidence is seen in the fact that the introduction of the drugs coincided with a fall in the in-patient population, after more than a century of steady increase in the numbers held in mental hospitals.

In relation to the second element of moral improvement, Jones provided examples from the succession of scandals in mental health service provision that occurred in the 1960s, when large scale public enquiries into poor institutional management took place. Horrifying stories of neglect, squalor and ill-treatment at Ely, Farleigh, Whittingham, Napsbury, St Augustine's, Normansfield and Rampton, were seen to have created the public concern and media attention that resulted in improved standards. Jones proposed that community care

partly arose from the realisation that a further improvement in the quality of care would result from the closing of institutions and their replacement by new services in the community.

Jones also took up the theme of pluralism as central to the development of community care. Throughout her historical analysis, she demonstrated how different interest groups have bargained with each other to establish and refine policy. For example, she emphasised that by 1968, both political parties favoured a decrease in mental hospital populations and saw an increasing responsibility for social services (see Seebohm Report 1968). However, by the time of the reorganisation of the Health Authorities in 1974, it became obvious that Health and Social Services had different responsibilities, patterns of organisation and styles of management (Thomas & Stoten 1974). There were some advantages to this, but it ultimately resulted in a lack of coordination between organisations and effectively delayed the full adoption of community care as a policy.

A further element of this theory is that service users and their carers have contributed to the pluralistic process. The belief is that community care enabled service users and their carers to become empowered and through the influence of pressure groups they had some impact in articulating and politicising their position. While it is recognised that such development has been slow, it is considered to have been happening gradually. The work of groups such as MIND and the National Schizophrenia Fellowship (NSF) is seen to have spurred the nation's conscience, spreading knowledge about the common nature of mental illness and mobilising politicians as spokespersons. Evidence for this position is drawn from developments that occurred in the U.K. in the 1950s and 1960s. The slow pace at which community care policy has been implemented is also seen as being due to the fact that this educational process is itself inherently slow. Yet, the interpretation is that knowledge is gradually spreading and the goals of community care will eventually be achieved.

Pluralists do not deny that development of community care has been problematic. They attribute this to remediable and short term funding and administrative failures in providing the structures necessary to implement the policy, giving the psychiatric profession insufficient freedom to follow what it considered to be scientifically necessary or desirable. Problems with the allocation of financial resources are also blamed, for which a lack of specific grants for non-medical services are considered to provide a typical example. The slow pace of re-education of professionals, politicians and the public that was being promoted by user-groups was seen as an additional problem and a lack of progress in the relevant areas of scientific knowledge, together with scepticism based on a lack of evidence of the success of community alternatives are also recognised to have contributed.

Some evidence quoted in support of the traditional interpretation can be questioned due to its optimistic view of what science can offer. For example, regarding the supposedly causal link between the development of drugs and the fall in hospital admissions, when one looks more closely at what happened, it becomes obvious that psychotropic drugs were not the miracle-workers they had been perceived to be by many. It has been noted that

"In certain progressive hospitals in Britain, active attention to rehabilitation and resettlement ... had led to a swift and drastic reduction in the number of in-patients ... considerably in advance of the phenothiazine drugs" (Sedgwick, 1982, p198).

Such time discrepancies are even greater in other European countries (see Goodwin 1990).

As an interpretation, the traditional/pluralist account can also be criticised for failing to explain why and how some interest groups became more powerful than others in affecting policy. In response to this criticism a "neo-pluralist" critique has emerged. Unlike the classic pluralists, neo-pluralists do not see the powers of interest groups as being balanced and equal but rather lop-sided. Big business corporations and the state are seen as the major forces to

reckon with (Lindblom 1977; Dunleavy & O'Leary 1987). While it is still seen that there are a range of issues where democratic processes can predominate and where new groups and interests may enter the arena and command some influence, neo-pluralists concentrate their main attentions on the predominance of more closed, oligopolistic policy making. The concept is put forward of policy "networks" inhabited by government departments, professional bodies and large corporations where private bargaining and compromise occurs (Rhodes 1988; Wright 1988). Health policy examples include government reluctance to publicise scientific evidence of the health effects of certain foodstuffs, partly because of the pressure from agribusiness and voluntary agreements drawn up with drug and tobacco companies (Harrison et al 1990).

However, there are other problems with the pluralist theory. The extremely slow pace of community care development undermined the pluralist position, since pluralists assumed that political pressure existed to force change, yet implementation of community care did not occur for over forty years. Governments repeatedly failed to respond. For all these years, demands made for better services yielded little result. The divergence between the rhetoric and reality of the policy, where governments consistently failed to match policy statements with sufficient funding, suggests that rather than increasing the social rights of the mentally ill, they were in actuality ignored. Even the neo-pluralist account is limited to the foreground of political action. The focus is on manoeuvre, tactics and how this has affected the outcomes, but little is said about the deep structures such as demographic change, the ideological climate or the background pattern of ownership and control. Decision making processes therefore appear more indeterminate, unpredictable and open-ended than the actual history of outcomes indicates.

With regard to the input of user-involvement in the pluralistic process, evidence suggests that it is only the more vocal who have had any impact (Lee & Mills 1982). Pressure groups have supported the use of advocates to enable

clients to have their say, but frequently they still argue the case only for the most articulate people. The long term mentally ill seldom have a voice. This suggests another flaw in the traditional pluralist argument. The mentally ill themselves are not a homogenous group. People have differing degrees of disability that demand a response on many different levels. In addition, the pressure group voice itself is divided between people who have different definitions of the problem and propose different solutions. This is amply demonstrated by the rivalry between MIND and the NSF over ideological and policy issues. So the potential pressure from the already weak voice of the long term mentally ill group is divided.

User pressure groups are not the only group to experience deep divisions of interest. For example, professionals in the mental health field are also divided. The Health and Social Services have not agreed on solutions to the problems of community care, and there have been particular difficulties reconciling the views of social workers and psychiatrists (Ramon 1988). The evidence for the pluralistic process is therefore fraught with generalisations about homogenous groups working together.

Most of the pluralist literature is at the level of national politics and does not consider local examples. The intention in Part two will therefore be to see how applicable the theory is at the case study level. Despite all the evidence negating its general utility as a policy interpretation, the traditional pluralist position remains probably that most widely held.

"There is a sense in which, because of the multi-causal, indeterminate character of the theory, pluralist accounts can degenerate into blow by blow story-telling from which it is very hard to extract any larger patterns of constraining and enabling forces" (Harrison et al, 1990, p17)

2) Sociological/Anthropological Interpretations

In contrast there have been many "micro" studies concerned with the anthropology of institutions for the mentally ill. The introduction of a sociological dimension to the debate became particularly well documented in the 1960s when it was seen to result in a movement often referred to as "Anti-Psychiatry". Within this movement there was considerable theoretical and political diversity, but broad themes can be extracted concerned mainly with the problem of definitions of mental illness. Anthropologists objected to the cultural relativity of such definitions, while sociologists pointed to a lack of consensus about them and the difficulties of distinguishing mental health from social conformity and nonconformity. Together they criticised psychiatry for viewing mental illness as a form of socially unacceptable, rule-breaking behaviour and for retaining a medical focus on organic processes in the conceptualisation and treatment of mental illness (thereby making a moral judgement under the guise of a scientific one), while failing to recognise this. Psychiatry was considered as an institution of "social control"².

One application of this set of interpretations can be found in the work of Goffman, who wrote Asylums in 1961. He concentrated on studying mental hospital inmates, and analysed the way that they were controlled and manipulated in the interests of the maintenance of staff power. He believed mental illness was seen as a form of deviance from "normal" human behaviour, but rather than disrupting societal stability, as commonly believed, it maintained it. The implication of this model for the history of mental illness policy was that institutions were not curing the deviant, but perpetuating the deviancy by reinforcing a sense of alienation from the rest of the community. This was embraced in his concept of "Total Institutions", defined as:

"...a place of residence and work where large numbers of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life." (Goffman, 1961, p11)

Goffman went on to describe institutional patient-hood as a "downward career" with the person assigned to the patient role being forced into "Secondary Adjustment" and "Personal Extinction". So Goffman was concerned with the negative effects of the institutional environment on patients and suggested that institutions were forms of social control perpetuated by the state to enable easy maintenance of social order. Such practices, he claimed, were designed to strip away elements that previously constituted the patient's social identity and replace them with institutional ones. Evidence for his theory was based on data drawn mainly from his work in a Washington hospital in 1955, much of which was highly selective and concentrated exclusively on the failures of the system.

The sociological studies of the 1960s and 70s were by no means confined to the study of mental illness. For example, Terence and Pauline Morris used a similarly sociological approach attacking institutions, the focus of their study being a London prison (Morris & Morris 1963). The Morrises postulated that although responses were not homogenous, prisoners were manipulated into conformity through a process of "prisonisation" (the taking on in greater or lesser degree of the folkways, mores, customs and general culture of the penitentiary) caused not by the tyranny of official control but its pettiness and triviality. Furthering these ideas, Pauline Morris went on to publish "Put Away", a study that aimed to examine the range and quality of mental handicap homes (Morris 1969). General conclusions were that physical living conditions were appalling, being deficient in both space and comfort. The dominance of the medical model in institutional practice was noted, inspiring uniform methods of treatment that encouraged a child-like dependency in patients.

At the same time, labelling theorists such as Scheff (1966) expanded upon the social control theme in attempting to formulate a theory to integrate individual and social systems of behaviour. He attempted to show the relevance to studies of mental disorder of findings from research in diverse areas of

social science such as race-relations. His conceptual tools included the idea of "Residual Rule-breaking" that referred to social norms for which society had no social label. The idea was that mental illness was a social role and that people labelled as such were rewarded for that role and punished when they attempted to return to a normal role. Hence, psychiatry, rather than helping to cure sickness, became its creator. By the early 1970s the "anti-institutional" movement was losing momentum and the work of Kittrie (1971) helped revive the old debates through his lawyer's perspective on the power of therapists to mould and change human behaviour in mental hospitals.

In sum, the sociological/anthropological interpretations suggested that the increasing recognition of the anti-therapeutic nature of institutional care, highlighted by a diverse range of studies, led to general support for policies of shifting care away from the mental hospitals towards the community. This enhanced a reconceptualisation of therapeutic activity away from the positive value given to the social order of the institution towards treatment that focused on the individual and included psychological and social approaches to care. The sociological/anthropological interpretations have hence been important in questioning the philosophical and political basis of care and did have an impact in forcing changes in the institutional environment. In suggesting the perpetuation of the sick role for purposes of social control, they also had some impact in making people question how far clients needs were manipulated to fit in with treatments available.

Yet, like the traditional interpretations, they did not account for why community care for the long term mentally ill, in particular, took so long to develop or why the introduction of community care policy for the mentally ill was so problematic. A further problem is that they might establish a good case against institutions, but not for any particular alternative solution. Also, it would be a mistake to identify the negative effects of institutions exclusively with large

hospitals and the professionals who staff them as similar problems can also occur in small units not staffed by psychiatric professionals (King et al 1971: Allen et al 1989). Sociological/anthropological interpretations are negative and sceptical accounts, from which it can only be concluded that the language used to conceive of mental illness, the way it is dealt with and the question of who is given responsibility for it, is essentially a political matter.

Also, concepts of social control need to be more precise. For example, some authors have hypothesised that in the same way that the groups who had an interest in sustaining institutions and did little to help the mentally ill, retain those interests in controlling community care policy (eg Holland 1988). Alternatively, others have suggested that in modern social networks individual idiosyncrasies in behaviour or beliefs are easily respected and the general reluctance not to get too much involved or invade the other's privacy leads to isolation of the patient to be and an exacerbation of bizarre, dangerous, suicidal or psychotic behaviour. In this latter sense, it has been suggested that social control is not so much corrective as evasive in nature resulting in withdrawal (eg Goffman 1971).

Fears have been expressed that care in the community has turned out to be a total institution turned inside out. For example, Schnabel stated:

"Now it is not the institution itself, but the bureaucratic system that tries to tend to the needs of each individual patient by way of differentiation of functions, specialisation in treatment and categorisation into groups" (Schnabel, 1992, p60).

Schnabel envisaged city councils setting up institutions to comply with the community's demand for the control of troublesome people, proposing that the long term mentally ill are seen to be putting others at risk and are at risk themselves from the intolerant behaviour of normal people. It is necessary to look to case study evidence to consider such ideas.

3) Marxist Interpretations

Another set of interpretations embrace those based in Marxist theory. Like the sociological schools of thought, theorists who set their ideas in a Marxist context concentrated on the idea of power and social control. However, this control was seen as an integral part of a class based capitalist society. The capitalist class was seen to have shaped and moulded the development of medical practice, with medical practitioners acting as agents of social control. Hence, power was conceptualised as essentially economic, concentrated in the hands of those who owned the means of production and who formed the ruling class. It is difficult to classify theorists into this school of thought, because many have a broadly Marxist basis to their ideologies. This section will start by considering the work of the French philosopher, Michel Foucault, since his work straddles the sociological interpretation described above and a more Marxist conception of events, although it really exists in a category of its own.

Madness and Civilisation (1975) was the British translation of Foucault's Histoire de la Folie (1961) and represented a structuralist interpretation of historical events concerning the treatment of the mentally-ill. His main concern was to analyse the inter-related structures of ideas about mental illness, rather than to explain them in causal terms, and he set his work within a broad range of ideas about the historical period. He looked back to a time before the Middle Ages when he postulated that there was a split in the Western world between "Reason" and "Unreason". Foucault claimed that until 1800, insanity was considered part of everyday life. It was at this time that the mentally ill began to be perceived as a threat and asylums were built for the first time, erecting a wall between the insane and the rest of humanity. He called this "The Great Confinement" and claimed that this was replaced in the nineteenth century by the "even more sinister regime of 'moral treatment'". Evidence for his interpretation was made up of arguments based on supposed historical events, with reference to artistic and cultural records, but he was criticised for the dubious factual content

of these. The significance of his work was more in raising disturbing questions about the symbolism attached to mental illness, which changed radically over time and in introducing ideas about the interests that medicine served as the major locus of power over the mentally ill. His work was hence important in challenging conventional assumptions.

Navarro (1976, 1978) was the most prominent Marxist to comment on the power of the medical profession to support and sustain capitalist society as agents of the ruling class. He distinguished a hierarchical class structure within the health services, and found that the "corporate class" was disproportionately represented amongst the controllers of resources. He drew attention to the role and position of a range of health service workers, considering the social backgrounds of those who made up the medical hierarchy and concluded that the health care system was controlled by the ruling classes and the health care structure provided a way to contain the stresses of the existing capitalist order. In addition, he argued that the health care system dealt with sickness arising from the misery and alienation of the capitalist society itself. He claimed that medicine acted as an ideological and practical panacea, transforming structural exploitation into individual sickness.

Such orthodox Marxism often took a very mechanistic view of the relationship between the state and society. For "neo-Marxists", the picture was both more complex and more plastic (Harrison et al 1990). The class structure itself was conceived in more fractured and variegated terms and the state was seen as a battleground over which various class interests struggled (Poulantzas 1978). The state was ultimately viewed as the captive of capitalism. For example, if the state wished to increase welfare spending on community care it had to increase taxes, which impacted on the business community who lost confidence, failed to invest and thereby provoked economic crisis. The likely electoral consequences obliged the government to scale down spending on community care. "Neo-Marxists" therefore, still saw the capitalist class as

exercising strong constraints on the state's ability to expand public expenditure, but they began to make important distinctions between different categories of such expenditure (strongly criticised by some theorists- see Dunleavy & O'Leary 1987). Interests were said to be divided, for example, between industrial and finance capital, or between local and international capital. The state was seen as a force in its own right, but it was thought that it could only manoeuvre within certain limits or its economic underpinning would collapse.

Recent attempts to assimilate a Marxist ideology into a practicable theory of mental illness have tended to co-opt psychoanalytic models. For example, Banton et al (1985) presented a psychoanalytical account of individual development understood within a general Marxist perspective. Undertaken at a self-critical level, the authors placed a heavy emphasis on a dynamic concept of the unconscious and proposed that the class-based power structures that existed at the institutional level also existed at the inter- and intra- personal level. Their main conceptual tool was the idea of "essentialism", which is the concept that every individual born inherits a set of attributes that are pre-existent and constructed outside society. The authors proposed that this idea was deeply embedded in the medical power structure and in the organisation and practice of mental health services.

The specifically Marxist content of this theory was that the motivation for perpetuating the essentialist position was rooted in class control. The authors proposed that community care would not be a success until non-essentialist ideas were taken on board and since personal and political change were intertwined, a distinctly political approach was required at all levels. Traditional Marxist theorists would argue that therapy is wrong because it ameliorates pain rather than allowing it to fester and eventually break out in revolution. The authors' belief in an idea of the split in the unconscious, meant that they did see a role for therapy, in healing this split, but therapy itself was seen in the context

of class struggle and they proposed that it should be performed in a way that challenges social structures.

Evidence for this interpretation was taken from an in-depth analysis of the authors' own therapy sessions. The example was cited of a depressed women who was given tranquilisers to alleviate anxiety generated by the burden of caring for her husband and children. This was seen as an adherence to the essentialism of the medical model. A more successful therapy would have been to give the woman emotional support and encouragement to perceive her difficulties as a product of the appalling social provision of child-care in this society and the isolation of young mothers, thereby actively seeking to change the foundations on which society was based. On this account, the move towards community care in the U.K. only represented a change in the nature of control of the state over the individual. Responsibility for care was transferred from the state to the family or to smaller institutions, without a change in the fundamental concept of mental illness itself. A community version of essentialism was therefore created, which was inherently unsuccessful. The authors proposed radical therapy as an effective and implicitly political alternative. They stated:

"There is no world outside politics – neither the macro world of public life or the micro world of the caring caress". (Banton et al, 1985, p175)

Like the sociologists, the problems concerned with community care were attributed by those with a Marxist slant to a fundamental misconception about the ideological framework of mental illness itself. But it was more than this, because the problems of community care could not be seen in isolation from the macrocosm of the political world. As a solution, Marxists prescribed a radical increase in political participation in relation to community care. The "new left" lost some of the traditional Marxist scepticism concerning elections and representative democratic institutions and demanded the introduction of direct democracy particularly in the workplace and local community (Held 1987). They proposed that highly paid medical expertise should be made accountable to the public. Such major change was said to require a period of

class struggle during which sustained and organised pressure would be brought to bear on the existing power structure. Crisis and conflict rather than planning and debate were seen as the true authors of transformation (Harrison, et al 1990).

As with the other interpretations discussed, Marxist and neo-Marxist concerns have also been peculiarly macro in their focus. They were built very much on a theoretical understanding with little application to local examples, except where attempts were made to incorporate psychoanalytic models. Overall, Marxist interpretations are possibly the broadest, most ambitious and most complex set of interpretations to be considered in this chapter, claiming to show how whole societies grow and change. While this is understandable when concentrating on dominant ideologies on an economy wide level, their practical value is limited and the area of local medical politics has been largely neglected. To apply the Marxist notions of the importance of class divisions, on control over the means of economic production, and on the subtle role of ideologies in shaping issues and agendas, is a difficult task. From the Marxist stance, empiricism is seen as a naivety and most Marxist writers continue to concentrate on macro-theoretical predictions about the conduct of the capitalist state and the behaviour of governments. As Harrison et al pointed out,

"Detailed empirical testing is rare, and it is therefore hard to judge how consistent Marxism is below the macro level of analysis." (Harrison et al, 1990, p30)

It will be the intention in Part 2 to see how far interpretations based in a Marxist ideology can inform local CMHT policy development. Extending the set of Marxist interpretations discussed so far, three further traditions can be distinguished that have adopted a Marxist emphasis and have had a particular impact on thinking about community care. Within the thesis framework, these have been treated as separate sets of interpretations that will now be presented in turn.

4) Economic Interpretations

First, a distinct school of thought has developed around the idea that the history of institutions and the origin and problematic nature of community care can be explained solely in terms of economics and finance. One major proponent of this approach was Andrew Scull (1977, 1979, 1984). Scull considered the economic and political roots of the movement towards deinstitutionalisation that took place in the U.S. and U.K. in the post war period. He introduced the word "Decarceration" to refer to the move to empty institutions and explained the policy shift towards community care in terms of the economics of capitalism.

Scull claimed that institutions were built in the 1850s because at that time increased professionalism and scientific advance enabled the objectification of social control and administrative techniques were developed that could cope with the demands of large residential units. Of greatest importance however, was that at that time substantial financial resources were available and due to the rising wage-earning economy, it was an economic necessity to separate those suitable for work from those unsuitable for work. An added incentive was in decreasing the pressure on the Poor Houses. However, the introduction of the Welfare State in 1948 meant that segregative modes of social control became too costly and institutions became difficult to justify financially. A massive expansion in the role of the state in other sectors decisively transformed the social context and community care was implemented as a policy of "phase out before we go bankrupt". Scull's argument was that the development of welfare systems made "decarceration" feasible and the relative cheapness of this policy compared to institutional care made it, for the state at least, a desirable policy.

Scull suggested that the subsequent problems with community care occurred when it became obvious that the hoped for relief to the state fiscal system did not happen. Community care proved to be as expensive as, if not more expensive than, the old institutions. As a result, patients were rehoused in poor

areas, which lead to their growing "ghettoisation" as they were effectively dumped in the community. Scull's interpretation suggested that the fiscal crisis was therefore solved, but it meant a sad, hopeless situation for the mentally ill, brought about by their dependence on economic trade in Britain. Scull's account of the move to community care was therefore negative. He saw it as a move from segregation in the asylum to misery and neglect in the community.

Scull drew evidence for his theory from a historical analysis of mental health policy in relation to economics. For example, he pointed out that the official peak of the residential population in British mental hospitals of 148,000 occurred in 1954. By then many hospitals had inherited the "Victorian barracks" of the nineteenth century which were in a state of decay. It would have taken "thousands of millions over many years" to restore them, involving a massive capital investment plan and so began a race to discharge patients. There was inevitably a subsequent decrease in the number of residents.

Methodologically this interpretation was avowedly Marxist and emphasis was put on the single determining factor of the requirements for continuing capital accumulation. As with many Marxist based accounts, Scull's interpretation displayed a tendency towards fundamentalism and he inspired a deluge of criticisms based on this inadequacy (eg see Lee & Raban 1988). His argument was reductionist, explaining almost everything in terms of the "needs" of capital accumulation, but the manner in which he assumed that the needs of capital would necessarily prevail in state policy formation, has been accused of losing any sense of dialectical method that most Marxist writers employ (eg see Coates 1984).

Commenting on Scull's thesis, Goodwin stated:

"He tends to ride roughshod over much of the data, imposing a theoretical structure without sufficient regard to the complexity of the processes involved." (Goodwin, 1990, p21)

For example, a key proposition for Scull is that community

care was adopted as policy since it was cheaper than institutional care. Concern with the cost of mental health services provision has played a major part in influencing the development of services but this does not imply a functional necessity. If it were so, it would be impossible to explain why the cost of mental health service provision in England continued to rise during the post-war period (see Goodwin 1990 for figures). Also there is a timing problem in Scull's analysis. He argued that the principle spur to decarceration was the fiscal crisis yet the mental health population peaked in 1954 and then began to decline, many years prior to any "fiscal crisis" (Sedgwick 1982a). Scull's interpretation has also been criticised for failing to account for the development of some community services outside the mental hospital, and the skewed pattern of these developments. As described in chapter two, it is not the case that all mental health services have been run down under the guise of community care, rather that aggregate expenditure on mental health services has increased, being channelled mainly into services for those with "acute" needs and neglecting services for the long term mentally ill.

Scull has, therefore, been criticised for being deterministic and too simplistic in stating that the fiscal relationship is so automatic and inevitable, but he has undoubtedly raised an important consideration for any understanding of community care. His contribution is important in showing the need to locate analysis within prevailing socio-economic conditions and the need to challenge the state's presentation of social policy as simply a process of reform intended for the common good. Overall, this interpretation suggests that proper long term care of the mentally ill in the community will never happen because it is expensive. However, allied to this point, one would expect that no money would be spent to try and improve community services. It is at the local level that such propositions need to be tested.

5) Elitist Interpretations

An alternative contention is that community care policy has been dominated by the entrenched power of the medical profession who have successfully resisted its full implementation through an elitist position and influence over government thinking. Since community care implies a broadening of participation in decision making, psychiatrists are said to have resisted the ideology and implementation of the policy in order to retain their elitist power. The problematic nature of community care is hence ultimately attributed to the continued elitist domination of mental illness policy by the psychiatric profession.

A major theorist in this area has been Ramon (1988). Her method was to undertake a detailed analysis of the professional and political debates over the last forty years, since community care policies first appeared. One theme of the theory that she developed concerned the development of a backlash against community care policy that she suggested had thwarted its implementation. Ramon proposed that major developments took place in the field of psychiatry in the 1950s, when after the introduction of the NHS the role of psychiatry expanded and became increasingly "psychologised and professionalised". Right up until the 1970s, the majority of psychiatrists desired to be recognised as clinicians within the mainstream of medicine and saw the promised transfer of their centre of work from isolated mental hospitals to new units in the community, situated alongside their medical and surgical colleagues, as tangible evidence of such recognition. Public demand for treatment nearer their homes, predicted decline in bed usage and progressively developing patterns of multiple, short-term admissions all contributed to the positive response given to community care plans at this time (Clare 1980).

However, Ramon contended that even in the 1970s, within psychiatry little was being done to actually promote the change. Community care involved threatening positions of power of a number of "sacred cows" and the necessity for new

relations between professionals, non-professional providers of care, service users and their carers was being resisted. Ramon suggested that the British psychiatric establishment gradually instilled a resilience to change into government thinking and their influence on politician's perception of the community care issue lead to conservatism and paternalism in policy making³. It was further suggested by Holland (1988), that the development of CMHTs during the 1980s was

"the stepping stone on to which psychiatry has made its territorial move out of the hospital and into the community." (Holland, 1988, p127)

Holland argued that by accepting CMHTs, psychiatrists adapted some of the language of social, causal methods of mental illness, but failed to acknowledge the issues. This implies that CMHTs have to some extent broken the deadlock of resistance to community care from psychiatrists, but only because the CMHT model could be moulded to accommodate the elitist practices of the psychiatric profession.

That some elitism exists in mental health service provision seems an almost trivial hypothesis, but the notion that every sphere is elite dominated appears to be too crude. A criticism of Ramon's analysis is that she has not paid enough attention to distinctions between different levels of analysis. The psychiatric profession, may be an elite, but it is also internally divided. The government, the BMA and the RCP may strike deals at the national level, but this may contrast starkly with the views and actions of the rank and file who implement policy at the field level. Also, service change depends on change in all the professions, not just psychiatry (Brown 1985) and it is not only the psychiatric establishment that have been responsible for the problematic implementation of community care policy. There have also been considerable shortfalls in the planning process at all levels and no other profession has really tried to assert an alternative position.

Furthermore, over the past decade, the power of psychiatry does seem to have been diminishing in some respects, particularly with the introduction of general management into

the NHS in the mid 1980s. Several practitioners have called attention to the fact that the psychiatric profession of the 1980s and early 1990s has, to some extent, had to struggle for its survival (eg Clare 1982). The Conservative Government in power since 1979 has exerted pressure for change in medicine generally. Perhaps the most recent example is the recommendations of the Tomlinson report (1992) upon which action awaits. In the mean time, health authorities in London have been amalgamated into larger Area Health Authorities and one of the main purposes of this exercise was to reduce the control and influence of the teaching hospitals over health provision. Such activity suggests that while Ramon's contention that the elitist domination of medical professionals has prevented community care service development in the past may be partially true, this is now being challenged to some extent. It is to case study evidence that we need to look to consider whether this challenge extends to policy for the long term mentally ill client group.

6) Feminist Interpretations

The interpretations considered so far have payed little attention to issues of gender in considering the development of community care. From the beginning of the 1970s, a considerable feminist literature has emerged that is presenting a challenge that none of the major schools of thought has been able to meet adequately. Work dealing specifically with gender issues and the mentally ill has concentrated on five particular broad topics.

First, it has begun to consider gender differences in patterns of health and sickness and in the use of mental health services. Women have higher levels of admission to psychiatric beds, form a higher proportion of residents, make more use of out-patient clinics and have more contact with GPs regarding mental health issues (Busfield 1983). Research has shown that one in eight women will be treated for a mental condition at some time in their lives compared with one in twelve men (eg see Goldberg & Huxley 1980). Two explanations have been forwarded to explain this situation. On the one hand, the

label of mental illness has been seen as a means of oppressing women who deviate from their traditional role. The idea is that women who have not defined themselves in terms of men and serviced men in the manner expected, have been defined as mentally ill. Some of what has been called "hysteria" and "personality disorder" and most "sexual dysfunction" might be seen in these terms (Chesler 1973: Perkins 1992). Drawing on the models developed by the sociological theorists, mental illness was seen as a label incorrectly applied to women as a means of social control. Psychiatric services have been criticised by feminists for attempting to sustain women in male-defined roles. On the other hand, mental illness has also been viewed as a product of oppression (Chesler 1973: Bachrach 1988c). It was seen as a product of women's disadvantageous social situation and a measure of it. Both these ideas have led feminist theorists to reject the "medicalisation" of mental illness and to see the psychiatric enterprise as a means of patriarchal control (eg Chesler 1973, 1989: Penfold & Walker 1984).

Second, some work has concentrated on women as professionals and workers within the health and social services and the questioning of equal opportunities between the sexes. Research has suggested that women have been over-represented in the health service labour force as nurses, domestics and technicians, but poorly represented as doctors and consultants at the top of the hierarchy (Stacey 1981; Oakley 1983). It has been suggested that this unequal situation has arisen due to patriarchy within the medical profession and, utilising a broadly Marxist framework, feminist writers have suggested that it is tied to the overall sexual division of labour within society.

Third, the role of women as unpaid, informal carers in the implementation of community care policy has been questioned from a feminist perspective (eg Finch & Groves 1983). Community care was seen to have been flawed because of the failure to consider these variables and the thrust of Finch and Groves argument was that the burden of such neglect

primarily affected women. Community care was seen to have legitimised minimal state activity in the private sphere of the home and family and to have disguised the minimal activity of men. It was postulated that historically, the underlying aim of community care developed to become the exploitation of the free labour of women and to disguise the sexual division of labour disadvantageous to women, both as unpaid carers and as professionals. For instance, both Ungerson (1985) and Dalley (1988) made statements in support of the community care idea that was being put forward in the 1950s and 1960s -that of reduction of the size of institutions and a move to smaller residential units in built-up areas, but saw a failing of community care policy, when the emphasis shifted by the late 1960s and 1970s, to the idea of community involvement that unfairly exploited the work of women as unpaid carers.

Fourth, feminist writers have analysed the Welfare State in relation to the family. For example, Dalley (1988) suggested that "informal networks" were seen as "low-cost solutions" in the 1976 DHSS document (para 1.20), but in fact their implied existence grossly failed to calculate the personal, financial and social costs which fell on individuals rather than institutions. By way of explanation, Dalley argued that the principles on which thinking was based were the principles of "familism" and "possessive individualism". She described "familism" as the link between individuals' circumstances of caring and society's organisation of welfare. The idea was that the family ideal was seen as the standard against which community care developed and all non-family forms were seen as deviant or subversive. The argument was that because of the hegemonic nature of familism, individuals subscribed to or internalised values of that ideology even though its dominance ran counter-productive to their interests. Men were seen as the possessive individuals and the concept was perceived to represent the source of women's subordination. It was suggested that these principles should and could be replaced by the principles of collectivism, abandoning notions of the nuclear family and changing the way that society thinks, and that community care cannot work until the old ideological

foundations are challenged.

Fifth, the ideology behind community care service provision has been further questioned from a feminist perspective. Brown & Smith (1989) drew a series of parallels between experiences of people with learning difficulties and people who used mental health services, with women in our society. They developed a feminist critique of the normalisation ideology that was seen to underpin community care, and discussed the mechanisms whereby people with learning difficulties, mental health problems and women generally were accorded second class status and hence experienced similar oppression. Brown & Smith suggested that the good intentions contained within the normalisation principle, themselves constituted an oppressive facade which encouraged people to:

"deny their own suffering and to normalise their situation, thus maintaining the existing structures of social organisation and of work." (Brown & Smith, 1989, p111)

The authors went on to challenge the "fashionable" liberal reaction to deny all differences that exist between people, whether in regard to mental illness or sex. They and other authors (eg Kitzinger & Perkins 1993) believed that the experience of the feminist movement has shown that it is unhelpful to camouflage stress or underplay the reliance of the mentally ill on other people, by merely pretending that they are like every one else. They believed that community care has been problematic because it has attempted to hide and muffle the differences that exist between those classed as mentally ill and the rest of the population, providing an excuse to cut services and leave the burden of care to women, who after all are perceived as "natural" carers. Community care was seen to have inspired a situation where people with disabilities received services from people who themselves were exploited and discriminated against. Clients and their carers have hence become "ghettoised together". Brown and Smith (1989) proposed that community care policies cannot be successful until the tension between power over people for whom one cares and powerlessness to meet one's own needs are

dealt with.

Feminist writers have been criticised for the accuracy of the historical detail that they provide, and for re-creating women as a stereotype that transcends the real nature of human complexity and variety. Sedgwick (1982) suggested that feminist critiques have deflected attention away from campaigning for better facilities for the mentally ill, especially for the long term mentally ill. In general, it is true that most of the feminist literature on mental illness has tended to concentrate on those with acute disorders (eg Chesler 1973, 1989: Penfold & Walker 1984), though more recently some attention has been given to women with long term mental illness (eg Perkins 1992: Bachrach 1988). The historical shift in services (that was described in chapter two), from long term mental illness towards catering for those with acute disorders has largely been reflected in the feminist literature until recently.

However, in general many feminist writers have tended to deny the existence of long term mental illness and assumed that all problems are essentially remediable with the correct therapeutic approach, the elimination of patriarchal oppression, or both. This assumption that all difficulties are an invention or product of oppression seems dangerous, as it is difficult to conceive of the processes by which all long term mental illness will be eradicated along with patriarchy. Yet, gender must be brought into any analysis of community care and case study evidence must be considered to see how far the feminist arguments can be supported and what relevance they have for the future of community mental health services.

In Brief

The aim in this chapter has been to establish and present a framework of different interpretations of the origins and purported failings of community care policy for the mentally ill client group. They are each essentially competing accounts, although no one perspective can really be isolated from the next. Both the traditional/pluralist and

sociological/anthropological interpretations implicitly suggest that community care has been a move forward in policy and provide a positive account of the changes. Then there are the more sceptical interpretations, the most extreme view being the Marxist interpretation, with a slightly weaker exposition in the related economic, elitist and feminist interpretations. Some commentators such as Foucault, cannot obviously be defined as contributing to any one set of interpretations.

Hence, no one interpretation provides a sufficiently coherent and comprehensive explanation of events on its own. However, they provide insight into the nature of the problems, the history and the development of services for the mentally ill. Taken in combination, it is contended that they have value in providing the basis for a much more critical analysis of the issues, which can be used to assess local case study evidence. However, a discrete set of literature has also arisen around implementation problems which contrasts with the structural explanations discussed in this chapter. It is the aim in the next chapter to review this other kind of literature to give a further handle for analysis of local community care policies for the long term mentally ill.

1. Several authors oppose the use of the term "medical model" since it has become vague and imprecise. For example, Busfield (1986) prefers the term "liberal-scientific" approach and Ramon (1988) uses the "clinical-somatic" perspective. The term is used here to refer to the broad ideology upon which both the tasks and methods of the practise of psychiatry are based and their perception of the nature of mental illness, recognising that this changes over time.
2. Social control means control by others in their own or society's interest.
3. This draws on the notion that politicians look to the psychiatric profession as "experts" for overall directives about community care, with dialogue being maintained through various professional bodies such as the British Medical Association (BMA) and the Royal College of Psychiatrists (RCP) (eg see Castle 1980; Crossman 1977) and at the same time see themselves as the ultimate decision-makers.

CHAPTER 4:

Innovation and Implementation in Community Care: Public Policy Literature

Problems encountered with making community care policy a reality, not only reflect structural considerations discussed in the previous chapter, but are also related to the politics and constraints of the policy process itself. In the U.K., they are intimately bound up with the way that the National Health Service (NHS) and Personal Social Services (PSS) are organised and operated through the Department of Health and Social Security (DHSS) or more recently the Department of Health (DH) and Department of Social Security (DSS). It was in the mid-1970s that a distinct set of literature began to emerge around these issues in British health care, that had both an explicit policy focus and an analytical intent. The texts differed in their focus, ranging from concentration on political dynamics to analysis of detailed institutional arrangements. For our purposes, this literature will be termed the "public policy" literature.

The aim in this chapter is not to present a thorough overview of all the "public policy" literature, but to extract themes which will inform our particular interest in innovation and implementation in community care. Much of the literature concentrates on party politics and the role of central government in policy determination and implementation. This level of analysis has generally been well-documented (see Hill 1980; Ham 1986; Webb & Wistow 1987). Since local level analysis constitutes the broad basis of this thesis, readers are referred to these other sources for consideration of the macro political perspective. Also, the policy process is not only a matter of central government responding to political demands. Local institutional realities impose limits on the extent to which central government can carry through innovative change, and most central government health and social care initiatives derive from local experiment (Davies 1993).

Few locally based studies of community services concentrating on service provision for the long term mentally ill client group had been completed when this thesis research began. Most of the existing work centred on the elderly (eg Hunter et al 1988; Challis & Davies 1986) and to a lesser extent, people with learning difficulties (eg Booth et al 1990; Glennerster et al 1983). A broad aim of this chapter is hence to provide an overview of the literature to be considered in extending analytical debate to the long term mentally ill.

The Perception of The Problem

There has been some debate in the public policy literature about the means by which situations come to be defined as social problems. Becker (1967) noted that social problems have two components: a set of objective conditions and the definition of these conditions as problematic. However, these conditions are not sufficient in themselves alone, as they will receive no consideration unless an individual or group draws attention to them. Solesbury (1976) argued that issues must pass three tests if they are to survive. They have to command attention, claim legitimacy and invoke action. He points out that:

"public resources for dealing with issues are relatively scarce in many terms - money and manpower obviously since public finance and public servants are finite quantities, but scarce also in terms of legislative time, media coverage, political will, public concern... Political systems can only cope with a limited number of issues at once and these are always subject to displacement by new emerging issues of greater appeal and force." (Solesbury, 1976, p397)

Ham (1982) illustrated this point by reference to the relative neglect of hospital services for the mentally ill, mentally handicapped and elderly in the 1950s. Paradoxically, it was only in the late 1960s, when overcrowding and staffing conditions had improved a little, that the issue was placed on the political agenda. This occurred as a result of a number of hospital enquiries, extensive media coverage, pressure group activity and ministerial concern. Scandals created around conditions in particular institutions in the 1960s, reported by authors such as Robb (1967), came to symbolise the problem

areas of the NHS and were generalised into a wider concern with social justice and humanitarian values, thereby drawing the interest of established political groupings. Yet the problems had existed a decade earlier in a worse form and had not prompted concern at that time. Ham (1982) hence went on to suggest that issues also require "particularity" and "generalisability" to command attention. The extent to which these notions are helpful in relation to community care of the long term mentally ill at the local level will be considered in part two of this thesis.

Manning (1985) argued that a social problem is what the powerful define it to be. It can therefore be summarised that since the long term mentally ill are not a powerful group, the definition of their problems and scrutiny of the effectiveness of local policy for them has not yet occurred. Davies (1993b) supported this idea in relation to community care in general and contended that:

"Arguably, community care suffers from the weakness that its beneficiaries are marginalised and dispossessed. Policy areas whose benefits are for the more powerful and articulate will create effectively democratically accountable systems for ensuring the effectiveness of local policy systems." (Davies, 1993b, p27)

Ham (1982) also suggested that issues must invoke action and "avoid suppression, transformation into other issues and token or partial responses". This concerns the more subtle business of preventing some issues from reaching the agenda in the first place (Bachrach & Baratz 1970; Lukes 1977). Edelman (1971) developed the notion of "symbolic policy-making" to describe action intended to demonstrate that something is being done about a problem, rather than action that is a real attempt to tackle the problem. Again, Ham (1982) illustrated this by showing that despite successive attempts to give greater priority to groups such as the mentally ill, the allocation of additional resources and budgetary shift towards services for this group have not accompanied their raised profile. Also, the sought after shift of resources from general and acute hospital services to the long term care of the mentally ill in the community has not occurred. A strategy

of policy maintenance rather than policy change has been observed to have been pursued, and it has been suggested that much of the activity of the DH and lower levels in the NHS is not in fact concerned with policy making or implementation (Webb & Wistow 1987; Ham 1982). It is the intention to see whether such insights are reflected in the thesis case study.

The Origins of Change

There is a huge literature on the origins of social policy change (eg Hall et al 1975). Some writers have concentrated on party politics and ideology (eg Beer 1969), others on external pressure groups (eg Downs 1967) and some on administrators. Increasing interest has however focused on the origin of policy within professional groups. Donnison et al (1965, 1975) were the first to clearly contend that the origin of health and social service policy was primarily located in the professional group. This work was based on case-studies of social services carried out in the 1950s and 1960s. Innovations were found to be most likely to happen amongst professionals who were trained and skilled and given considerable discretion in the practice of their own work and when the services they provided depended largely on their own direct contacts with those served, rather than on costly capital investment and provision of cash payments. The main local implication of this, is that it suggests formally approved changes in policy announced by the governing body often simply recognise and codify a process worked out over several years by people at humbler levels of the providing group.

Similar observations have been noted in other areas of public policy. For example, Heclo (1974) in studying the history of social insurance programmes in both Britain and Sweden, proposed that policy-making was a form of collective puzzlement on society's behalf. Heclo, however, contended that the central actors in this process were not professionals, but "policy middlemen", intellectuals, policy experts and civil-servants. Banting (1979), in his work exploring poverty and politics, suggested that policy making was essentially

confined to a small number of innovative thinkers.

Only one similar study of the process of innovation in mental health services had been carried out at the time of writing. Towell (1981) undertook a three year study of Westville psychiatric hospital, exploring the complex agency networks involved in developing better services for the mentally ill based in the community. Like Banting, he proposed that while innovative activity was initiated by the professional group, it primarily involved only a small number of individuals operating at the periphery of the organisation. Amongst the main body of professionals, he found examples of different professionals dealing with common problems in isolation or passing issues up the organisation, rather than confronting them on the spot. He encountered a pessimistic climate within the institution in which the staff were more aware of the constraints against establishing community based services, rather than the possibilities and opportunities. Innovative activity was confined to a small number of forward-thinking individuals operating outside the main stream activity of the professional organisation.

Dunleavy (1981) extended Donnison's work in his study of policies of mass housing. He concluded that professionals act as ideas brokers, who monopolise knowledge and subsequently become important power brokers in the determination of policy. Such an assertion has been observed to be equally applicable to the development of mental health policy. For example, Ramon (1986) described the creation of the diagnostic category of the psychopath. She observed that while both the government and the psychiatric profession recognise the incongruity of the concept of the psychopath, neither are averse to the continued existence of the category or to the incorporation of those diagnosed under it within the umbrella of mental disorder. She proposed that the function of the term is to enable psychiatry to maintain its mandate over those whose conduct is socially undesirable but who do not fall within the criminal justice system. Hence, this constitutes an example of how professionals create and sustain policy via their claims

of elitist knowledge.

Several authors suggest that locating the source of innovation in the professional group, confines policy control to an elite amongst service providers. Wilding (1982) saw this as being highly problematic in three respects. Services may only be introduced where they serve professional interests rather than public interests, services are organised around professional skills instead of client needs and biases develop in policy implementation because dominant groups in particular professions are able to control policy. Wildavsky's work on "change-agents" (1972) also contributed to these ideas. He recognised that the maintenance of higher rates of change depend critically on the ability of those who produce it to make others pay the associated costs. The needs of the members displace the goals of the organisation. The public processes that the organisation was supposed to serve give way to its private acts and its own hidden agendas start to dominate. Lipsky (1980) argued that the decisions of "street level bureaucrats", the routines they establish, the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out. He claimed that their policy-making roles are built on two inter-related facets of their positions: relatively high degrees of discretion and relative autonomy from organisational authority.

A brief look at the professional psychiatric journals and reports considered in chapter two, provides a good indication that it is within the professions themselves that emerging trends in expert opinion relating to services for the long term mentally ill are located. Such expert opinion goes far beyond the reaches of traditional medical expertise, commenting extensively on policy planning and objectives (Crossman 1977). The policy debates and criticisms that are heard in Parliament and the press regularly originate here.

The Donnison notion of professionals taking the lead in innovation fits in well with the suggestion that it is often

one individual who adopts and champions a particular innovation in service provision. Williams (1980) stated that the best "game plans" for innovation only take one so far. The need is for a guide (or fixer) who can keep the group headed the right way by figuring out where to go and how to proceed. Other authors have suggested that it is inevitable that an individual service entrepreneur will start to identify themselves with a policy initiative at the local level.

Levin (1976) studied the urban planning process in relation to new towns and town development schemes and subsequently developed a concept of "commitment in planning". This is the idea that during the evolution of a plan, people who take decisions become attached to them and defensive of them. To have a previous decision reversed is to lose, or to perceive you will lose, self-esteem, sovereignty of your discretionary area of control and perhaps credibility in the organisation. Also, as plans become more specific and detailed, so the commitment grows. The drive to see through alternative solutions increases proportional to the frustration. Levin suggested that it is not merely individuals who become committed to past plans or ways of proceeding, but whole departments. Often a "departmental view" will emerge which once hammered out and enshrined in an official document survives changes in personnel. Past plans and current practice cast a long forward shadow, not least because they are usually capital plans which have engaged people's time and energy for a long period of time. They are highly specific and very costly to reverse in pure financial terms in relation to past design costs, penalty clauses in contractor's or professional's contracts and having an empty site.

As can be seen this later literature, that began to appear in the 1970s, was more sceptical, also seeing professionals as the source of innovation, but implying that this related to their own self-interest rather than a response to observed needs. The economic arguments of the "public choice" schools also began to become more influential at this time (see Dunleavy 1991)¹. From this perspective, innovation is seen

essentially as professional aggrandisement and innovations in service provision are hence expensive devices that imply budget expansion. In this view, the welfare state has become an unsustainable burden on the economy as a whole and in addition, its organisation and processes (particularly concerning professionals) have become a threat to the liberty and freedom of individuals (Harrison et al 1990).

Public Choice theory is usually associated with the values of the new right (Dunleavy & O'Leary 1987). A strand of this theory asserts a fundamental hostility to the welfare state. For example, Niskanen (1971) suggested that public sector bureaucracies had an almost universal tendency to over supply their services because senior officials attempted to maximise their own utility in the form of maximising the size of their departmental budgets. With the world economic crisis of the mid-1970s, in Britain and the U.S. attacks on the parasitic, costly, self-interested bureaucracies of health care and personal social services became rife (Pollitt 1990).

The public choice remedies for the problems of community care include weakening the monopoly power of professionals by changing their terms and conditions of employment and by subjecting them to the quasi-market disciplines of performance indicators and other types' of managerial monitoring and control. Yet, with reference to professionals, the public choice theorists have little to say about such concepts as altruism, professional ethics or public service. They argue that the sphere of planning must be diminished and that of the market mechanism increased, encouraging private health care and giving individuals the right to exit the welfare system and choose to go elsewhere (Hirschman 1970). In addition, it is suggested that public services should be required to charge for the benefits they offer to deter "free riders". Such policy proposals were the applied tactics of both the Reagan and Thatcher governments during the 1980s and constituted the foundations of the 1989 White Paper (DH 1989b).

The literature discussed at the beginning of this section

suggested that innovation rooted in the professional sphere was a good thing, but the public choice schools of thought suggest that this is not necessarily the case. They see innovation, not as good or bad, but as a systematic bias in public service organisation towards professional interests rather than the interests of individuals in the wider society. Case study evidence presented in part two will be used to comment on the validity of these alternative contentions.

Central or Local Policy Determination?

Central departments see policy implementation as a process in which local agents adapt central guidance using local knowledge (eg DHSS 1976a). However, the theme of many local studies is that what happens at or near the point of delivery is as important, if not more important, than what is dictated by central government. There has been an appreciation that local health and social service administrations do not simply act as transmitters of national legislation and guidance (Barrett & Fudge 1981; Ham 1981) and central government possesses little direct operational control over the implementation of most national policies (Haywood & Alaszewski 1980). Evidence on the nature of the implementation process across a range of varying policy contexts has lead to an acceptance of the "bottom-up" approach to policy, rather than the "top-down" approach (Ham & Hill 1984).

Central government has more potential power in a service that it funds directly, like the NHS, than in a service that is funded indirectly. Ham (1985) and Pollitt (1984b) emphasised that central government has exercised considerable influence through its control over the global sum of resources going into the NHS, the allocation of this total between health authorities, specific approval of large capital schemes and the increasing practice of "earmarking" revenue funds for particular purposes. Several authors suggest that there are "strategic highs" or key policies that central government is always willing to enforce strongly (eg Palmer 1985). Examples given of such action include the recent experience of ancillary services within the NHS where the government

required services to be put up for tender. Ministers effectively determined the course of implementation rather than local administrators (Ham 1986). Evaluation of the extent to which such influence has affected innovation in community mental health service provision at the local level will be one theme of the case study presented in part two of this thesis.

Decision-Making

In the 1960s and 1970s it was widely suggested that health care politics was "incrementalist". The notion originated from the work of Lindblom (1959), who criticised "comprehensive rationality" (see below) as a method of decision making and put forward the notion of muddling through, both as a better description of actual organisational life and as a preferable alternative, especially in a tight budget climate, such as that which existed in the health and social services in the 1950s. "Incremental budgeting" was the norm. This meant that changes in emphasis from, for example, acute hospital medicine to community based care, tended to be slow and of narrow scope, rather than systematic or radical (Brown 1979; Lee & Mills 1982).

The incremental method of decision making is characterised by what Lindblom (1965) termed "partisan mutual adjustment", where no one actor or institution can impose change though several may be able to veto it (Ham 1985; Klein 1983). Webb & Wistow (1986) referred to this notion in contending that health policy

"is best understood as contingent and residual: it is not....a coherent and efficient application of resources in pursuit of agreed outcomes; it is more usually the end product.... of conflicts and ad hoc bargains." (Webb & Wistow, 1986, p158)

Within this process, several authors have noted that bargaining often results in small changes in the status quo, and this tends to be to the advantage of established interests (eg Brown 1975). The medical profession, for example, wields influence by frustrating those who wish to alter its conditions of service, training and patterns of practice (Allsop 1984; Haywood & Hunter 1982; Klein 1983). Clinicians

and senior managers hence hold positions of power over lay health authority members (Allsop 1984; Ham 1985; Hunter 1980) and even more so over users and user organisations (Lee & Mills 1982). The role of health authority managers in these conditions has been reactive. The emphasis has been on avoiding conflicts, being diplomatic and seeking consensus (Ham 1985; Hunter 1980). Klein (1983) suggested that the policy inertia resulting from this process has been further exacerbated by the extreme occupational complexity of the health service as a whole and underpinned by an extremely durable political consensus reflected in the high and continuing public popularity of the NHS.

The "Rational Comprehensive" model of decision making is the opposing paradigm to these incrementalist ideas (eg Patten & Pollitt 1980). On this view decision making is planned and systematic. Tensions and clashes of interest are perceived as irrational and are defined as technical problems such as failure of communication, poor information and cognitive failure (Ham & Hunter 1988). Several authors have suggested that while the incrementalist model does seem to apply to the policy process conducted by health authorities (Harrison 1988a), this is not so true of central government intentions and is becoming less and less so (Harrison et al 1990). For example, the initiatives and changes relating to community care that originated in the 1983 Griffiths Report and the 1989 White Paper (DH 1989b) frequently emphasised the need to state clear objectives, cost alternative means and monitor performance. These elements of reform appear to reflect a rational framework. Hence, the accuracy or usefulness of the notion of incremental politics has been difficult to assess as it appears to fit some levels and issues better than others. One aim in part two of this thesis will be to see how well it accounts for decision making in community mental health in the case study area during the thesis research period.

Joint Planning

In the 1970s, governments in the U.K. put increasing emphasis on planning as a main instrument of policy making and

implementation. In the health and local authority services this involved a particular stress on the importance of joint planning and collaboration (DHSS 1973). The idea was that if there was a determination for different organisational authorities to work together, many of the problems of community care could be solved. A variety of organisational arrangements and inducements were, therefore, established to achieve this purpose, but the general experience of these efforts was widely judged as disappointing (Glennerster et al 1983).

Joint planning in the health and personal social services encountered severe handicaps. In part this can be understood as reflecting inadequacies in conceptions of planning which were adopted. Booth (1979) found that there was a tendency to regard planning as being associated with the availability of extra resources. However, he contended that this was inappropriate in a period of severe financial constraint. This weakness was magnified where attention focused too narrowly on creating new facilities rather than developing services. In fact, planning was a means by which central government sought to contain and direct local agencies within the limits of its public expenditure controls. It was never a good vehicle for joint working because different central departments each ran their own separate planning systems (Glennerster et al 1982).

Further problems with joint planning in mental health arose from important organisational differences between Health and Local Authorities. Many authors suggest that the government too readily assumed that shared goals and priorities could be arrived at locally (eg Towell 1981; Hunter & Wistow 1988). Webb & Wistow (1986) pointed out that the complex organisational structures and lack of coterminosity caused considerable difficulties for many local planners. Problems were often exacerbated by the latent tensions in the network of relationships between agencies and tiers involved in the total mental health services. Mutual scape-goating and defensive rigidity were observed, where having someone to blame when things went wrong became more important than trying

to get something right. Both Ramon (1988) and Glennerster et al (1983) contended that in the case of community care, the DHSS was not able to articulate community care policy sufficiently clearly to lead innovation. Professional organisational politics meant that innovations during the 1980s were usually health and medical service driven.

Conflicts and Constraints

Implementation of community care policy has already been noted in chapter two to have been significantly problematic. Hence, concern with the ineffectiveness of the policy, requires the asking of questions not only about the source and character of the policy and the way that policy innovations were introduced but also about what is wrong with the implementation process itself and the receiving environment. The public policy literature identifies a wide range of general constraints on the implementation of policy.

In practice any new policy will be adopted in a context in which there are already many other policies (Hill 1980). Additionally, innovations seldom have a clear start and finish and it is rare that there is only one innovative activity going on at any one time (Donnison et al 1965). Local social policy innovations develop in an environment where competition is endemic and service providers always have rivals competing for resources. Downs (1967) called these competitors "Allocational rivals" (those who compete within a service) and "Functional rivals" (those who can win customers away from the service). Such rivalry inevitably leads to constraints and mistrust in implementation.

Implementation problems also arise from policies that express their goals in general or unclear terms. Donnison et al (1965) found that the aims of the social services and the agencies responsible for them were ill-defined and noted that there was no dominant, comprehensive social ideology on which all the actors involved agreed. Barrett & Fudge (1981) suggest that usually innovators do have an ideology of some sort, but this is seldom explicit at the outset and does not evolve

simultaneously and uniformly. The implementation literature suggests that however strong the thrust behind a new policy, if there is a weak link in any part of the implementation process this can be seriously detrimental to the new policy. Donnison et al (1975) gave the example of lack of administrative support for new services blocking their successful implementation. Sometimes the political ambivalence about a policy is reflected not so much in the policy itself as in the constraints that are set upon the implementation process. The simplest form of constraint is the failure to provide the means, in money, staff and organisational space, to enable the policy to be implemented properly (Hill 1980). Bardach (1977) developed an extensive analysis of the various implementation games that may be played by those who wish policies to be delayed, altered or deflected.

Before an innovation begins, providers of a service tend to be fully employed in coping with their existing responsibilities (Donnison et al 1965). Their work has expanded or compressed to fit the time and other resources available to them. Often they have difficulties in redeploying existing resources without upsetting someone. Innovation in service provision is hence necessarily disruptive. It requires changes in the way people work and think, and subjects cherished ideas to re-examination. Literature suggests that attitudes to significant social change are characterised by ambivalence, even when supported, and displaced policies retain a residual potential strength (Billis 1984). New ideas lead to anxieties about the disruption of familiar patterns and relationships. Innovating groups can easily become isolated from their colleagues and their innovations put at risk, unless it is possible to sustain a dialogue in the implementation phase between "progressives" and "traditionalists" within the wider management structure which supports and contains open debates. Several authors have pointed out that a great awareness is needed of the sometimes unrecognised aspects of tensions and relationships between individuals and groups (eg Barrett & Fudge 1981). As mentioned above, new policies are implemented under the close scrutiny of a broad spectrum of local actors.

Consequently, advantages must be made plain to those who receive, deliver and pay for them.

An inevitability of the involvement of multiple actors is that conflicts develop in the implementation phase. Pressman & Wildavsky (1973) drew attention to the way in which the mere quantities of agreements necessary may, even when all parties are committed to a policy, undermine or delay effective action. Donnison et al (1965) noted that when an innovation was activated, caseloads or overtime increased, rumours circulated, personal relationships deteriorated and other signs of stress appeared. Different interpretations of the situation arose and divergent views, when unreconciled, created conflict. Where conflict arose, contending groups then sought the support of those responsible for taking decisions. He observed that this was often the first that senior staff had heard of the conflict. It has been suggested that some conflicts can be settled by negotiation from which all parties can derive satisfactory outcomes and these are termed "Positive Sum Games". Alternative scenarios are "Negative Sum Games" where the gains of the winners are only achieved through a cost to the losers. Inaction results as this is deemed to be preferable to wrong action.

Hardy (1985) observed that conflict over the ownership of the original policy and the leadership of it challenges the legitimacy and authority of different actors. There is often conflict over who are the "change-leaders". For example, McKee (1988) found disagreements between managers and consultant psychiatrists over the source from which projects arising from community care policy were perceived to spring. She also found that this collision in perspectives was significant in revealing differences in the time-frames of the two groups. Consultant psychiatrists were concerned with long term change, but managers were often only in post for one or two years and were only concerned about short term solutions. The case study presented in part two will find some of these constraints operating more strongly than others.

In Brief

In this chapter, particular themes were extracted from the public policy literature which can be used to analyse innovative activity in community mental health service provision for the long term mentally ill. The literature suggests that community care policy is difficult to implement. As a policy area, it suffers because its beneficiaries are weak, the conceptualisation of the policy is ill-formed and much of the power to innovate lies at the local level in the hands of professionals. Major changes in local power and resource distributions have been contemplated which are difficult to achieve, even in a favourable climate. However, public policy literature that discusses mental health policy is sparse, especially in relation to the long term mentally ill client group and so the intention in this thesis is to contribute to it.

Using the analytical concepts and ideas generated in these last three chapters, the aim is now to evaluate a specific pioneering development in mental health policy at the local level. Rather than systematically deducing a set of hypotheses from a well articulated body of theory and then seeking to test them by attempting to disprove them, the complementary literatures presented in part one of this thesis will be used to engage in a process of generating discussion from observed phenomena in the case study location.

1. "Public choice" theory straddles the disciplines of economics and political science and focuses on public or collective choices as opposed to the private choices of individuals analysed by conventional micro-economics.

PART 2: THE CASE STUDY

Part two embraces the case study fieldwork on which this thesis is based. The aim is to test the consistency of the theory presented in Part one with evidence taken from day to day practice. Since the case study evidence is itself conditioned by underlying theory, does it "fit"? Given the current rapidly changing context of community care, do events that occurred in the policy environment in the last decade provide any fundamental clues as to the future of community mental health service provision for the long term mentally ill?

The history of the case study CMHT will be presented chronologically from 1979 to 1992 in chapters five to ten, with analytical discussions at the end of each chapter. Chapters eleven and twelve will present empirical evaluation data collected over a two year period between 1990 and 1992. This data concentrates on process factors in the implementation of a CMHT approach for the long term mentally ill. The aim is to consider in detail the process of introducing an innovative idea regarding service provision for the long term mentally ill and sustaining this throughout the implementation phase.

CHAPTER 5:

Mental Health Service Provision in Battersea Prior to the Birth of A Community Mental Health Team

This chapter introduces the case study area. It aims to examine the basis from which the issue of community mental health services arose in Battersea and to assess local policy progress up until 1979, since the advent of community care as a national policy. The first part presents an account of the background setting from which subsequent developments in community psychiatry developed in Battersea, South London. It briefly documents the policy planning environment that existed in London in 1979, describes the health service local organisation in the case-study area of Battersea, and presents an account of what existed in service provision for the long term mentally ill.

A discussion of local mental health service patterns that existed in 1979 is presented in the second part of the chapter, within the framework established in chapter three. The aim is to see whether the structural and philosophical interpretations identified in this earlier chapter can usefully be applied at the local level to give us a clearer understanding of the policy background for innovation. As will be seen in later chapters, innovation in service provision did occur in Battersea in later years in the form of a new CMHT service. The Doddington Edward Wilson Community Mental Health Team was established in Battersea, over a three and a half year period from 1982 to 1986. However, its origins and its ideologies lie further back in time and in order to fully understand them and evaluate the resulting form of care provision, it is important to consider the context in which they emerged during the 1970s.

The Policy Planning Environment- London Service Problems in 1979

The intention is to begin by looking briefly at the general political climate and the problems that were particular to London at the start of the study period in 1979. It is important to recognise that this case-study was carried out in London and results probably would not apply in rural areas and indeed in many other cities. The policy planning environment for health services in London was characterised by the following seven factors:

1) POPULATION CHANGES

In the 1960s it became apparent that the population of London was declining, one factor having been migration to the Home Counties after the war (Prochaska 1992). Expected population changes between 1971 and 1988 were large. The population of inner London was expected to fall by 1/5 and outer London by 1/10, while the numbers living in county areas outside Greater London were expected to increase by 6%. Central London was unusually well supplied with acute hospital beds (London Health Planning Consortium 1979), and this implied that there was a need for a shift of acute speciality resources to the outer fringes of Regions. The Tomlinson Report (1992) was later to restate this same problem in making recommendations for the re-shaping of London's hospital provision to provide a better balance of resources to the different care needs of the population.

2) ELDERLY SERVICES

The acute bed supply in hospitals was good, but London had always been poorly supplied with long stay beds for the elderly in particular (Ministry of Health 1954; DHSS 1981b). This meant that more elderly people were admitted to acute wards and stayed there longer. Many also stayed in their own homes or old peoples homes and this resulted in a great strain being exerted on social and health services. The numbers of frail elderly living alone in London was unusually high and likely to increase (Bebbington 1979). In 1977 the number of socially isolated old people per 1000 over 65 was 351 in Inner London, 226 in Outer London and 128 in the remainder of

England (Snow 1981).

3) PRIMARY CARE

Primary Care services were particularly unsatisfactory. In Inner London more residents were not registered with a General Practitioner (GP) than in the remainder of the Greater London area, there were more single-handed practices, more elderly GPs and they were more difficult to contact. The London Health Planning Consortium (1981) stated in the Acheson Report on primary health care in London that only 43% of GP practices in inner London were directly contactable during the working day.

4) COMMUNITY SERVICES

Other community services in London, such as community nurses and home helps were suffering recruitment difficulties due to alternative job opportunities and relatively poor salaries in an area where it was more expensive to live and work than the rest of England (Jarman & Bosanquet 1992).

5) FAMILY NETWORKS

The informal family support system was weak and movement of households was high. There was poor housing, poor health and a 50% higher rate of suicide in London than elsewhere in the country (Office of Population Censuses & Surveys 1982).

6) ADMINISTRATIVE COMPLEXITY

Community care services, particularly in the "Chronic Sector" were noticeably bad (Community Health Councils 1980) and "greater coordination" between agencies was frequently stated as the solution (London Health Planning Consortium 1981). In 1974, Local Government in England and Wales had been reorganised but London was left as it was, with a complexity of hospital provision. This resulted in a Byzantine system of health districts and areas being superimposed on the existing pattern of local authorities (Glennerster et al 1983). In London, few administrative boundaries and hospital catchment areas matched, whereas between 1974 and 1982 in the rest of the U.K., Area Health Authorities shared the same boundaries as Social Service Departments.

Consultant psychiatrists were clustered in London and the reasons for this were complex. The perception from within the psychiatric profession according to one respondent interviewed for this thesis, was that it was partly because that was where the rich patients were, but also the social power was there. The big psychiatric committees were all based in London and this, together with the strong link with private practice attracted the intellectual elite amongst consultants. London was the influential place to be for consultants, where they could keep abreast of and have influence on the development of the profession. Civil Servants and journalists rarely looked outside London for advice and information since such liaison was always of an urgent nature.

7) FINANCIAL CRISIS

Since the National Health Service was formed, London had done relatively well in terms of financial allocation. There was an uneven focus on the large Teaching Hospitals and cash tended to follow the existing pattern of services (Prochaska 1992). Between 1974-1979 the Labour Government tried to reverse that pattern, albeit gradually. The Resource Allocation Working Party (RAWP) (DHSS 1976c) provided an allocation formula that would give more resources to less wealthy regions and less to those who had most such as the Thames Regions. This formula was much criticised, especially in London (Avery-Jones 1976). The outcome was that the Thames Regions had a cash allocation that was virtually held static while other regions were to grow.

Regions had to allocate money to services knowing that they had to reduce services in London and extend them in outer areas. Cash limits and inflation eroded the value of allocations and by 1979 Wandsworth Health Authority was in deficit, like several others, and the deficits were growing. Cuts had to be made to get the authorities back in balance by 1981. Also a comparable situation existed in the Local Authorities, who had done relatively well under the Labour Governments Rate Support Grant (RSG) formula, but were treated more harshly under the new conservative legislation (See

Glennerster et al 1983). Sharp cuts in central government support were experienced also by other major urban areas.

The Health Service Local Organisation in Wandsworth

The policy planning environment in the inner city areas of London was affected by a number of quite dramatic service problems, as a result of general London-wide developments. The inner city areas had these problems in the most concentrated form. They were readily apparent in Wandsworth. Wandsworth was part of the Merton, Sutton and Wandsworth Area Health Authority (AHA)(Teaching) and was covered by two of the AHAs 3 health districts (District 1 covered 26% of Wandsworth and 22% of Richmond: District 2, 74% of Wandsworth and 27% of Merton).

Wandsworth was the second largest of the Inner London Boroughs. It bordered Richmond on the West, Hammersmith, Kensington and Chelsea and Westminster across the Thames, Lambeth on the east and Merton on the south. The borough covered a total area of 14 square miles. Despite its proximity to central London there were 160 acres of completely vacant land in 1972, mainly the result of declining traditional industries. By 1978 a quarter of this land had been developed with the completion of large projects such as the Nine Elms Market that replaced Covent Garden Market and much council housing. The majority of the remaining vacant land was concentrated in North Battersea and the Wandle Valley, along the Thames and around Clapham Junction. A considerable proportion of this land was derelict and polluted. The remaining industrial and manufacturing enterprises were also concentrated in the north and eastern parts of the borough.

Politically, the Borough of Wandsworth was created from the amalgamation of Battersea (solidly Labour) and Wandsworth (mixed). The Council had a Conservative majority in the 1968 election: it swung massively to Labour in 1971 (53-7) and back to Conservative in 1978 (on a bigger swing than the rest of London) leading to a 36-25 Conservative majority. So the Borough had a chequered political history and Glennerster et

al (1983) suggested that this was a reflection of its mixed social composition and the changes it had been undergoing.

Battersea remained the area of greatest deprivation in the Wandsworth Borough. In 1980 the Battersea population was estimated to be 68,000 adults and 10,000 elderly people¹. Battersea had and continues to have all the characteristics of the most difficult inner city areas: high unemployment (approx. 12.2% in 1985), a high proportion of the population from ethnic minorities (approx. 20.6% in 1985) and a large number of single parent families (approx. 5.81% of all families in 1985)². Using the Jarman criteria of social deprivation, which gives a composite score from eight demographic variables, the average score for the Battersea wards is 37 (range 22.59 – 57.11) putting the area within the most underprivileged 2% of all wards in England and Wales³. In relation to the rest of the Wandsworth borough, Battersea stood out as the most problematic area and the area most in need of significant service provision by the Local and Health Authorities.

Mental Illness Services in Battersea

Springfield Hospital⁴, London SW17, was a psychiatric hospital of approximately 1,000 beds and was part of the Wandsworth and East Merton Teaching District, closely linked with St. George's Hospital, SW17. It provided the catchment area services for the District's mentally ill population, which came from a total population of 280,000, together with services to adjacent local areas, and some residual areas North of the Thames⁵. In 1974 the first form of catchment areas was introduced in Battersea and on 1st April 1975, the Battersea catchment area, which had previously been under the care of Tooting Bec Hospital, was transferred to Springfield for administrative convenience.

From 1968 to 1975, one consultant psychiatrist was responsible for mental health services in Battersea. In 1975, a second consultant was appointed and the two consultants had half of the area each, with the Battersea catchment area of 85,000

being divided arbitrarily into North and South, using the railway line as the main boundary. In 1979, the catchment areas were altered slightly to cover a reduced catchment area of 81,000, with one of the above mentioned consultants being made responsible for North Battersea and one for South Battersea. Although the former had a smaller catchment area population, the work load was much heavier. In June 1979, a third consultant was appointed with special responsibility for the care of the elderly mentally ill, and although this did not at first include Battersea, when it eventually did, it meant that there was very little acute elderly work for the catchment area consultants.

a) In-patient Care

In 1979, the two consultants responsible for the mentally ill in Battersea, including the elderly, had access to six wards providing nominally 180 beds. However, for practical purposes the position was much less generous⁶. Three wards provided facilities for the elderly, but the majority of patients on one of these were admitted originally from Mitcham (out of the Area Health Authority catchment area) and on another one, about half of the patients came from North of the river (also out of the area). All the beds were occupied by long-stay patients, over 50% of whom had been resident for more than two years, and vacancies (estimated at about 2 a year) arose only on the death of a patient. This had a knock on effect in the acute and rehabilitation wards.

There were two rehabilitation wards, with 68 beds and one admission ward with 39 beds (Aster) that was the only ward with no "old long stay" patients that hence could be used as an active admission ward. However, it was accepted that when consultants were faced with an elderly patient in the community who was no longer able to continue without hospital care, then there were considerable pressures to use an admission bed. This had an adverse effect on the admission ward and was disturbing for patients and staff who saw themselves in an active therapeutic role. It was estimated in July 1979 that there were up to 4 elderly patients on the

admission ward at any one time⁷. This also had an effect on GPs who were reluctant to admit young patients to wards containing elderly long stay patients.

Using DHSS recommendations, the calculated bed needs for the Battersea populations (approx 80,000) in 1979 were for a total of 99 beds: 40 Admission beds; 26 New Long Stay Beds; and 33 Psychogeriatric beds. However, it was recognised that there was an argument that Battersea was an area of high morbidity and therefore provision should have been more generous than this⁸. Certainly indicators of social stress which had been shown to be associated with psychiatric morbidity, such as percentage of one-parent families, level of unemployment and severe financial problems were high in Battersea. An NHS service profile⁹ compared admission rates to Springfield Hospital for a three month period (April to June 1979).

Battersea admissions 55 – 80,000 population ==> 6.9
per 10,000

Remainder of catchment 167 – 270,000 population ==> 6.2
per 10,000

The Battersea admission rate was the highest of all the sub-catchment areas served by Springfield Hospital, demonstrating in part the weakness of community provision in the area.

The two Battersea consultants each had working with them a registrar or senior house officer appointed as part of the St George's Hospital 3-year training scheme and rotating to Atkinson Morley's Hospital, and also a part time senior registrar. They also had some support from clinical psychology, occupational therapy and a community psychiatric nurse, with an attached local authority social worker also involved with patients from the catchment area.

b) Out-Patient Clinics

The following out-patient clinics were provided for Battersea's mentally ill clients following the 1975 catchment area changes: one at St George's Hospital in Tooting (the District General Hospital); one at Bolingbroke Hospital in South Battersea (which was originally a private subscription

hospital that was taken over by St George's and run as a general adult hospital, before being turned into an in-patient geriatric hospital in 1980); and two at St James Hospital in Wandsworth (a general hospital which was originally a Poor Law Hospital serving the workhouse population). These clinics were considered sufficient at the time to meet the demands placed on them¹⁰.

Also at St James' Hospital, the consultant psychiatrists provided psychiatric cover to the general medical and surgical wards. One of the Battersea consultants saw surgical amputation patients there who were thought to be suicidal and would then take them into Springfield. The other Battersea consultant provided cover to casualty at the very active Accident & Emergency Department. Psychiatric liaison links were kept up with the other Tooting Bec consultants, who also held out-patient clinics there.

c) Psychiatric Emergency Clinic

The Psychiatric Emergency Clinic was a 9 a.m. to 5 p.m. walk-in service on the St George's Hospital site which was manned by nurses. Medical assessments were done by whoever was running the day's clinic. Later, the service improved from the consultants' viewpoint, as nurses were given more responsibility and became more selective in choosing the patients who necessarily needed a consultant's expertise. However, in 1979 the clinic was considered to be overstretched and for some long term mentally ill clients attendance at the clinic was inappropriate, but without adequate community services, the clinic was often their only option.

d) Day Hospitals

There were two Day Hospitals on the Springfield site providing facilities for the catchment populations. The Jubilee Day Hospital was a 25 place unit for the elderly (75+) mentally ill. There was no fixed allocation of places for each catchment area, but inevitably the limited nature of the provision influenced the referral patterns of consultants. In

July 1979 there were 4 Battersea clients attending this unit. Also at this time, this service was being seriously handicapped by the problems besetting the London Ambulance service and their inability to accept more commitments to transport day cases. This inadequate provision increased the demand for inpatient care and as described above, had an adverse effect on the care offered to the under 65 year olds.

The Cottage Day Hospital accepted up to 70 patients, many of whom were mobile and could get to the unit (though public transport to Springfield was not good). Again there was no rationing system for the catchment teams and in July 1979 there were 17 Battersea patients attending. The Cottage Day Hospital had never had much of a support role to long term mentally ill clients and no role at all in the activities of rehabilitation and resettlement. It had always been an acutely oriented service, with three main functions: to act as a bridge between being an in-patient on the ward and going back home (people could attend there for two weeks or so when they left the ward as a stepping stone to returning to their homes full time); to replace in-patient admission (it was doing this increasingly, particularly for depressives, neurotics, occasionally schizophrenics and a select few personality disorders); to serve "multiple problem" clients, who had social and housing problems and required liaison work. The number of these type of clients seen was very small and numbered may be two clients a year. The Health Authority Strategic Review indicated that the recommended provision for the total Springfield Hospital Catchment Area was 234 adult day places and 171 elderly day places¹¹. Actual provision fell far short of this and Battersea's quota was particularly low.

e) Community Psychiatric Nurses

A Community Psychiatric Nursing Service was established in North Battersea in 1975. This was a hospital based service and as such 99% of referrals came directly from consultant psychiatrists. Each of the hospital consultants had an attached community psychiatric nurse (CPN) who followed clients discharged from Springfield Hospital and cared for

mentally ill people living in the community. They attended ward rounds and then worked fairly autonomously in the community. Each CPN carried a case-load of between 30-50 clients, the vast majority of them having suffered with a psychotic illness. Approximately 40% of the CPNs clients were referred following a domiciliary visit by the consultant or a client attendance at the out-patient department in the local psychiatric hospital. The other 60% were referred for after care following hospitalisation¹².

The CPNs brief was basically to medicate and give family counselling, but very little was offered in terms of work towards social reorientation and their work was done with little formal supervision, though they did attend ward-rounds when relevant, and kept up a regular correspondence with the consultant and other professionals. It was a very stark form of chronic care. However, it had a very important role to play in keeping clients out of hospital. One consultant interviewed pointed out that for example, Hammersmith Health Authority had no CPN service at this time and had 3-4 times the number of in-patient admissions.

In addition, in 1978 a state enrolled nurse joined the CPN service and accepted responsibility for some of the more long term clients, to allow the CPN to accept new cases. This SEN was not full-time for the Battersea Teams but spent about one third of her time in other areas. Essentially then there were three staff, who between them carried a case load of over 90 community cases.

f) Social Services Provision

Social Services' facilities for mentally ill people in Wandsworth at this time were the following¹³: hostel accommodation in two ten place hostels in Putney and two twelve place hostels in Wimbledon and North Balham, with a further 29 place hostel under construction in Tooting ; one "Group Home" was operating, with six more planned to be opened in 1980-1981, two of which were to be specifically for Carr Gomm members; there was also a housing commitment of 20 units

per year for mental health purposes that was planned to be increased to 30 units, borough wide; and there were two Day-Centres, one in Bolingbroke Grove (between Balham and Wandsworth) that had 35 places, and one in Hazlewell Road (Putney) that also had 35 places.

It was apparent that the Hazlewell Day Centre provided a valuable service but at Putney it was not well placed to serve people living in Battersea. The Bolingbroke Grove Day Centre was better placed but its operational policy concentrated on the younger communicating clients, offering a social and therapeutic community rather than work rehabilitation programmes. The emphasis was very much upon a psychotherapeutic way of working. This day-centre was not fully used, and the day centre staff thought that referrers sometimes avoided making day centre referrals because of transport problems.

The consultant led psychiatric team at Springfield Hospital, comprising the consultant and the nursing staff also had a liaison social worker working between the hospital and community. This was a "joint appointment" social worker who was a half time member of the multi-disciplinary team in its earliest form. The Battersea Area Social Services Office at Lavender Hill had 14 social workers, 7 working in North Battersea, and 7 in South Battersea and this system continued from the early 1970s until the early 1980s when Social Services re-organised with an emphasis on generic working. Individual social workers were in contact with the consultant psychiatrists and there was a well established emergency service, where both would provide emergency home visits.

This system was being operated long before the catchment area teams were introduced, but not without problems. For example, a problem identified at a Joint Care Planning Team meeting in 1979, was that of social work support at the clinic at St James¹⁴. This was seen as a difficult problem to solve. At Springfield there was a social worker assigned to work with the Battersea teams and that worked well. If problems were

encountered in the out patient clinic at St James' then either this social worker had to be called across or a social worker from the wards in St James'. Referrals to community social workers at this time met with long delays, but the number of times such help was needed was not seen as sufficient to justify asking for a social worker to be present at the clinics. Similar problems were being experienced at Bolingbroke and St George's hospitals.

g) Non-statutory provision

Voluntary community based organisations were also in existence in Wandsworth in 1979. For instance, there was the Balham Action and Counselling Centre, the Family Welfare Association and the Doddington Family Centre, which catered for disturbed and depressed people who did not feel that their needs were met by the statutory services. They undertook a great deal of preventative work in the mental health field. In 1979, these organisations were considered to merit more support from the statutory bodies and as yet had no use of joint finance monies. Essentially in Battersea little account of these services already in existence was taken in any Health or Social Service planning briefs and there was no joint use of resources¹⁵.

h) General Practitioners

Responsibility for the mentally ill was sometimes accepted completely by the General Practitioner, but the extent to which this was possible reflected only the interests and abilities of the individual GP and also the range and accessibility of supporting services. An Emergency Service was provided for GPs, by the hospital consultants, where home visits were made within twenty four hours and usually on the same day. GPs could also make emergency referrals to the out-patient clinics or occasionally send clients up to the ward. In these days, referral procedures were very informal. More people were admitted to hospital directly without specialist assessment and much relied on the GPs word.

j) Rehabilitation and Other Services

In the early 1970s the Senior Hospital Medical Officer at Springfield took on the task of rehabilitating all those patients who he considered to be capable of leaving Springfield. This was a big and efficient rehabilitation push which ended around 1974. Therefore, those left in hospital were the very difficult "old long stay" patients and the "new long stay". Two hospital consultants started the rehabilitation work again in the early 1980s and very little was done in the intervening period. Therefore, there was no specific rehabilitation service in place in 1979. Clients needing rehabilitation had been maintained by the hospital ward nursing staff, which entailed very little in the way of rehabilitation work. There was an industrial therapy unit (ITU) at Springfield Hospital, but this was used mostly by long term hospital inpatients rather than community clients. Hence, rehabilitation work with long term mentally ill clients living in the community was almost non-existent. The sole provision was of a few client support groups utilised by Battersea clients such as a "Friday Club" and several luncheon clubs.

General Mental Health Service Problems in Battersea

The above account of the Battersea services in 1979 gives some indication of the gaps in services that existed. However, further consideration of interview material gives additional details of the key areas that were considered problematic.

1) QUALITY AND FOCUS OF EXISTING COMMUNITY PROVISION

What existed essentially was a skeleton community psychiatric emergency service with some follow up by community psychiatric nurses. The work was not multi disciplinary in the sense that the word is now most commonly used (see later discussion in chapter seven). Junior medical staff and nurses did not work out of the hospital and there was no community occupational therapy. Staff and management perceptions during this period were that the follow up of clients who dropped out of care was not rigorous and was usually left to Social Services or the GPs. Follow up was very sporadic and only the more articulate

and demanding clients were followed through and continued to be seen in the community. Many clients dropped out of care on discharge from the hospital and little support was available until the client's situation deteriorated to a level where they relapsed and were readmitted to hospital.

Therefore, the quality of the services provided was very variable, as much depended on the attitudes and commitment of individual GPs. There were more beds available in the hospital than under later arrangements, so more people were admitted for in-patient care than in the following decade, but there was a major problem with "revolving door" clients who were frequently admitted, time and time again. Admissions on the acute wards were gradually getting shorter. There was some successful work in rehabilitating some of the "old long stay" clients in the early 1970s, but there was no structured approach to rehabilitation after this time.

Out patient clinics and the work of the community psychiatric nurses were essentially the only form of community after care organised by the mental health service. There were many clients who were very long term attenders. There was no drop-in centre or formal crisis intervention and crises were dealt with mainly by hospitalisation of the person regarded as ill. One consultant interviewed pointed out that there was at the time immense pressure on hospital beds and a major instruction was to reduce length of stay, as well as admission rates, with little emphasis on developing alternative services. There was an increasing workload and this had to be coped with by the existing staff establishment. No extra staff were provided and inherently this situation was resulting in low morale among the staff group. Also it was recognised that the psychogeriatric population produced a great stress on the service.

2) NEEDS AND DISTRIBUTION OF LONG TERM MENTALLY ILL CLIENTS

An overwhelming feature of community care services as they existed was that there was no apparent matching of community provision with areas of particularly high morbidity. This was

the pattern in many other Health Authorities across the U.K. at the time. In relation to particular medical services and interventions, variations in service provision did not appear to correlate strongly with differences arising from characteristics of populations or geography. It was clear in retrospect that mentally ill people needed health services, social welfare, social security, housing, employment, training, rehabilitation, transport and social activities. Services were not adequately addressing these needs. Interviewees stated that from a client treatment view point, little attention was paid to preventing serious conditions from getting worse or to consistently maintaining helpful treatments. Traditionally, services had been based in the medical model of care and this continued to be the prevailing model, despite its perceived short comings.

3) CO-ORDINATION AND RANGE OF EXISTING SERVICES

It was clear that there was little co-ordination between or within services and such co-ordination would demand a tremendous psychological step forward. Joint working between the health and Social Services was very limited and there was little consultation with local voluntary initiatives. Also there was no assessment of need for services. Clients were generally being treated as an amorphous mass. No attention was paid to the differing needs of people with the more severe condition. There was no targeting of services to those who needed them most, such as the long term mentally ill. Little preventative or educational work was being done in the community. No provision was being made that was adapted to the needs of people from different ethnic backgrounds and social class and the range of community services was generally very limited.

4) CONCEPTUAL AND ADMINISTRATIVE BARRIERS

There were myths about the difficulties of providing services in the community rather than the institution. Those working in the hospital were reluctant to work outside the closed community of the hospital environment. It was thought that community work was more time consuming because all the

facilities were not provided on one site as in the hospital situation, and this may have led to the unwillingness of some to move more towards a model of community working. For community services that were provided, administrative structures were rigid and there was no flexibility. There were no common community psychiatric patient notes, only In-patient and Out-patient notes, and the community psychiatric nurses and social workers each kept their own individual notes as well. This caused much duplication of work and communication, link and liaison problems. However, the situation was inevitable due to the different office locations of the various workers and photostatting facilities were less accessible at this time, compared with present day arrangements. The CPN notes were spearheads for the multi-disciplinary notes that were later developed.

DISCUSSION

Before 1979, community mental health in Battersea was not a major issue on the planning agenda. The poor service provision detailed above mirrors the pattern that had developed in many other areas of the country at this time. There were general problems, many of which were not specific to Battersea but can be observed with hindsight in this area in a particularly acute manor. Despite the fact that community care had been officially enshrined in government policy eighteen years earlier, community services were weak, particularly those provided by the Local Authority. The social context of North Battersea was creating exceptional demands for services and the social fabric, in terms of family support, was too fragile to respond. The generalised accounts of the problems with community care policy presented in chapter three find echoes in the history of service provision in the case study area. It is now the intention to see which interpretations contribute in accounting for this pattern of provision at the local level.

Traditional/Pluralist Contribution

The first element of traditional/pluralist accounts of community care was identified in chapter three to lie in the "medical model" of care. Traditional/pluralist accounts suggested that adoption of the policy partly occurred as a result of an overall improvement in the treatment of mental illness brought about by advances in medical technology and increasing professional specialisation. It was claimed that, for the first time, decarceration of patients into the community was possible because they were being cured more quickly and effectively. However, while this may have been true for people with milder "acute" mental health problems, case study evidence suggested that there remained a pool of clients who were not and could not be "cured" (the long term mentally ill). The impression was that after eighteen years of community care policy these clients were as vulnerable and as "mentally ill" as they had ever been. There may have been improvement in drug therapies, but these were of little relevance when the social disablements of clients were so far reaching and when client management mechanisms for the long term mentally ill were so obviously poor. Only the most basic follow-up provision was being offered, and this was not the result of a deliberate policy developed to meet the needs of a changing client population, consisting of more clients who were generally "better" and required less further help. This suggests that one reason why community care for the mentally ill was so difficult to implement in the U.K. in the 1970s, was that the ideological foundation of the community services that were provided did not give adequate attention to addressing the social disablements of clients and too readily assumed that people with mental health problems formed a homogenous group. The "cure" focused model tended to provide too few services and to lead to "block treatment" which was particularly inappropriate to the needs of the long term mentally ill client group.

The second element noted in traditional/pluralist accounts of community care was that modern society had become increasingly humane and community care had developed out of the

institutions as part of a general moral advancement. Case study evidence suggested that it could only have been perceived as more humane if the services that had originally been provided in the institution had been re-provided in community settings. As highlighted in the literature presented in chapter two and in the account of services that existed in the case study area before 1979, community care offered little in the way of "asylum", long term maintenance or social and welfare support. This suggests that community care was also difficult to implement at the local level in the 1970s because community services provided were not comprehensive and was not a wide enough range.

The traditional/pluralist interpretations also suggested that the lack of central government directives regarding community care in the 1970s allowed enlightened thinking to develop. This may have been the case in some areas of the U.K., but there was no evidence that such enlightened thinking had developed in the case study area before 1979. People were aware that problems existed, but there were no formal plans to isolate and address them. Service provision was drifting. Any community services that did exist were there by default rather than by planning. Community psychiatric nurses had existed alongside the institutions since 1975 offering a minimal amount of support to those leaving hospital and little was being done to give new ideological emphasis, improved staff training or financial support to boost this service. Services were not naturally developing to supersede those that had previously been provided in Springfield Hospital.

In chapter three, traditional accounts were also noted to rest on the notion of a plurality of interests who contributed to the formation of local community care policy. Yet the description of community services that existed before 1979 in the case study area suggested that service structures were dominated by medical interests, Local Authority and voluntary sector input was minimal and the interests of clients and their carers were simply not represented. No evidence was found of any local pressure group activity. There was no

evidence that the service pressures resulted in any action to force change on the part of professionals, other community agencies, clients, carers or anyone in the political or management spheres. Therefore, at this time there was in no sense a pluralist response to the service problems. Also, decision making was not unpredictable and open-ended, as suggested by the pluralist position, rather it appeared completely dominated by the existing state of affairs. Changes that did occur were reactive, but did not to any degree spur real change in service provision.

In addition no evidence was found in any of the documents analysed to indicate a positive reaction to the deinstitutionalisation of the "old long stay" mentally ill from citizens in the community. Stories were found in the local press of local people protesting vehemently when they discovered that new tenants in their street had previously been occupants of Springfield Hospital. The "community", it seems, was not developing a new liberal attitude towards people with mental health problems based on growing knowledge and acceptance. In fact the same prejudices were still being attached to the mentally ill in the community as had been in the mental hospital. The stigma of mental illness had not diminished as far as the general public was concerned.

Sociological/Anthropological Contribution

Sociological and anthropological accounts of the move to community care suggested that the increasing recognition of the anti-therapeutic nature of institutional care, highlighted by a diverse range of studies, led to a re-conceptualisation of therapeutic activity towards treatment that focused on individual psychological and social approaches to care. Yet, there was little case study evidence that suggested this had occurred before 1979 at the local level. Community service structures still focused primarily on medical care and institutional provision. This suggests that a further reason for the problematic implementation of community care policy during the 1970s was that social models of care were not adopted across the board at the local level. Also, there was

little attempt to shift services away from the hospitals and the "institutional" attitudes of staff were transferred into the community.

The social control question raised in chapter three prompts a range of considerations in relation to the case study evidence. There was seemingly no formal attempt at social control of clients in Battersea, aside from the continued powers of consultant psychiatrists to section people in the community, legally requiring clients to be removed from that setting and returned to the institution for treatment. Then, as now, there was no community treatment order forcing people to continue to take their medication in the community. However, one could argue that the mentally ill were being socially controlled in another sense. They were being discharged into a largely hostile community, many with a reduced ability to take care of themselves, facing enormous problems with finances, housing and social relationships. They were not empowered in any way for their life "back" in the community and it was only the more vocal amongst them who were able to secure the help they needed with benefits, employment advice and on-going social support. In this sense they were essentially still controlled socially as it was virtually impossible for them to do anything much more than "scratch an existence" and they were hence indirectly encouraged to withdraw socially.

The sociological approach does appear to help us in our analysis in identifying a key problem illustrated in this chapter, namely the relationship between social structure (the prevailing socio-economic organisation of society) and social action (the behaviour of individuals and groups within that structure). This mismatch was one of the central problems in the case study area. The social fabric of the area was weak, housing provision was poor and Health and Social Services were minimal. Before 1979 there were no concrete plans to redress the obvious faults of the system. This chapter has illustrated how those suffering from mental illness in Battersea (particularly the long term mentally ill) were essentially

forced into a position of lower social status through environmental pressures and rendered politically powerless by the lack of any action to improve their position. Proponents of the sociological accounts would argue that mental illness is socially constructed and must be understood in terms of the interaction of sufferers with their environment. Consideration of this position further suggests that the model of mental illness utilised in community care policy formation at the local level before 1979 was too restrictive.

Also administratively, community services were hopelessly inefficient as there was little coordination between different services from the statutory and non statutory agencies. It has been shown that catchment boundaries between statutory services did not match and consequently it was difficult for these services to work together. There could not be a "whole person" response to individual clients within such a disjointed system.

Marxist Contribution

Marxist interpretations of community care suggest that it has been problematic due to a fundamental misconception about the ideological framework of mental illness, and its role to contain the stresses of the existing capitalist order under the control of the ruling classes. Material presented in this chapter suggests that at the local level, the Marxist position is too crude and mechanistic to contribute much to the analysis. The capitalist basis of service provision was not questioned in any of the documentary material studied or by any of the subjects interviewed. It may well be true to say that services had developed in such a way as to perpetuate the class-based divisions in society, but no definite proof for this position was forthcoming and it does not help us in approaching practical problems at the local level.

However, the account of services that existed before 1979 did generally highlight that there was a need to address social and political issues in relation to housing, employment, nutrition and education and underlined the lack of

coordination between different types of service agency. It seems responsibility for the care of the long term mentally ill was transferred from the state to informal community networks without a change in the fundamental concept of mental illness itself. Since in the case study area informal community networks were so weak, this provides a further reason why implementation of community care policy was so problematic. Responsibility was essentially transferred into a virtual social and political vacuum.

A further contribution of the Marxist interpretation may also lie in its emphasis on the need to politicise the nature and methods of service provision. Documentary and interview evidence from the period before 1979 suggested that clients and their carers were passive recipients of the services that existed. No attempts were made through the provision of services to empower them or to make them aware that anything could be done to change the mental health system. In addition, there was no case study evidence that the power structure amongst service planners and providers was being questioned or that any mechanisms existed whereby the professionals and service planners were made accountable to the public.

Economic Contribution

The economic interpretations discussed in chapter three suggested that the origin and problematic nature of community care can be explained solely in terms of economics and finance. It could be claimed that community care services at the local level were poor because insufficient financial support had been provided for the creation of new services. Yet case study evidence demonstrated that some community services existed, but the biggest problem was that they did not adequately cater for the needs of those with long term mental health problems. A purely economic analysis of this situation appears too simplistic.

The scale of the problem of financial control was growing rapidly before 1979. With the move towards community services, increased emphasis was generally being placed on the expanding

role of psychiatric treatment and there was growing concern regarding the financial feasibility of making psychiatric services more widely available. Services were being extended to serve a group of individuals with less severe problems and who tended to be more vocal about their needs (acute clients). This excluded from service provision those too socially chaotic to seek out services. Additional finance was obviously required to modernise existing services and to develop alternative new services in the community and although money could have been made available before 1979, there was no push to shift financial allocation from hospital to community services. It has been illustrated throughout this chapter that resources were still largely tied up in hospital based services. The underlying reason for this under-funding of community services appeared to be the lack of any political will to address the issue. Community mental health provision for the long term mentally ill was not at this time high on the political agenda. Staff and management were aware of the problems but no-one was promoting the cause and so there was no pressure for planners to seek out additional funding. Hence, it seems that the real contribution of the economic perspective is in highlighting the need to consider financial allocation problems. Service change was being prevented, not because the money was not available, but rather because the money was distributed in a bureaucratic system that did not allow for the use of joint finances in any way or for the free movement of money from one area to another area of higher need to allow new community services to be set up.

If cost reduction was the supposed motive behind community care, one would have thought attention would have been paid to keeping costs to a minimum. Interview evidence suggested that the local mental health system was in fact operating on a financially inefficient basis. For example, it would have cost the Health Authority more to accommodate "revolving door" clients who were continually in and out of hospital than to provide them with minimal levels of support to stay in the community. Keeping others in hospital for longer than necessary because they did not have adequate housing to return

to on discharge or because their self care skills were poor, was probably more expensive than providing services in the community. This however did not motivate service change at the local level before 1979.

Elitist Contribution

Elitist accounts of community care presented in chapter five suggested that policies were being dominated by the psychiatric profession who successfully resisted policy implementation through their monopoly control over service provision. Case study evidence demonstrated that before 1979, service provision in the case study area was very much in the control of the psychiatrists. For example, the account of the formation of catchment areas showed that these arrangements were largely based on the preferences of individual consultant psychiatrists, and other services were subsequently fitted in around them. It was the consultant psychiatrists who retained the power to determine how Health Authority services were shaped and since the majority of the community services listed in the first part of this chapter were health services, this gave the psychiatrists virtual elitist control over community mental health provision. GPs were noted to have had some power in acting as the main filter for clients to access these services and hence had some control over client eligibility criteria, but psychiatrists retained the final word. Social Services and voluntary sector services were minimal. Interviewees reported poor inter-service coordination, particularly between Health and Social Services, but also between statutory and non-statutory providers. Professionals worked along side each other, but there was no multi-disciplinary team working.

Interview evidence also suggested that, particularly amongst psychiatrists and nurses, there was a backlash against community care before 1979. Comments indicating an unwillingness to disperse services in the community were heard repeatedly during interviews about the situation before 1979, a common belief being that it was only when services were provided on one site that staff could organise themselves

effectively. Any changes that occurred were reactive and there was no specifically stated drive to develop new services or to shift the emphasis away from medical domination, rooted as they were in a fairly insular standard pattern of well-tried approaches. The policy planning environment had been somewhat stagnant for several years.

However, the evidence presented in this chapter is not extensive enough to be able to comment on the nature and extent of the psychiatric elitism that was observed. It does not demonstrate whether there were any internal divisions within the local group of psychiatrists and nor does it describe the manner in which the different professions and interested groups related to each other in the formation of policy. Therefore, it can be said that at first sight the consultant psychiatrists at the local level did seem to have an elitist control over service determination and because community services were so weak, it could imply that there was some resistance to developing a more community-oriented service from within the psychiatric profession, but it will be necessary to continue this theme in later case study chapters to determine its overall impact at the local level.

Feminist Contribution

Feminist accounts of community care presented in chapter three contended that the policy is rooted in the patriarchal control of women and the exploitation of women's labour, both as low-paid, low status professionals and as unpaid informal carers. Hence, in broad terms, feminists attributed the problematic nature of community care implementation to male social control over women as professionals, carers and clients resulting in the provision of inadequate community services that were overly reliant on informal social networks. In terms of professionals, those in positions of power in the case study area (the consultant psychiatrists) were nearly all men. Amongst other professionals, interview evidence suggested that there was a fairly even mix of males and females, but females were predominant at lower levels of all professional hierarchies. While this situation was undeniably unequal in

terms of gender, it is impossible to locate any evidence suggesting that male domination of the professions was the direct reason for the poor community services that existed, since no situation existed where the reverse was true.

In terms of women as carers, the description of service provision showed that women were given little specific community support, except through low profile voluntary sector projects like the Family Welfare Association. As clients, documentary evidence revealed that especially amongst the long term mentally ill, there was an over representation of young men rather than of women as clients. However, women were over represented amongst those suffering from neurotic based disorders. Perhaps the main contribution of the feminist interpretation here is to highlight that attention should have been paid to the differing needs of the various sub groups within the spectrum of mental health service users, as these were being grossly overlooked at the time.

This applied to minority and marginalised needs in general, not just to women. Services were not tailored in any way to the needs of the individual service user and the long term mentally ill clients were particularly poorly catered for. There was no attempt to target those from different ethnic backgrounds and to tackle the specific problems that they faced. The disproportionately high morbidity of the North Battersea area was not formally recognised as creating a greater strain on Battersea services than other areas. Neither had the presence of a high number of single parent families living in the Battersea area stimulated a change in services provision to meet their particular needs for child-care and social support. Social support services generally were lacking.

In Brief

This chapter has described the basis from which community services in the case study area evolved and has explored the initial contribution of the various structural and philosophical interpretations to an understanding of this

process. Several reasons were suggested to explain why community care for the long term mentally ill had been so difficult to implement at the local level during the 1970s. The ideological foundation of services that were provided did not give adequate attention to addressing the social disablements of clients and too readily assumed that people with mental health problems formed a homogenous group. Also, the quantity and range of community services was too restricted and they were not comprehensive. Financially, resources continued to be centred on the institution and there was an absence of any ideologically distinct new approach to service provision or political commitment to bring about change. Local consultant psychiatrists appeared to have monopoly control in determining local service structures and were resistant to change. In the following chapter the phases of development that occurred after 1979, that lead to the subsequent formation of a CMHT will be presented and discussed.

1. Wandsworth Health Authority Document- Services for the Adult Mentally Ill in Battersea, 1984.
2. Neighbourhood Study by Community Psychiatric Nurse Student in Wandsworth, 1979 (unpublished).
3. DEW Annual Report 1986-1987, dated April 1987.
4. For history see "Springfield: A Short History" -Booklet by Ian Lodge Patch, published by The Friends of Springfield Hospital 1992.
5. Data summarised in Job Description for Consultant Psychiatrist Post at Springfield and St George's Hospitals, March 1979.
6. Merton, Sutton & Wandsworth Area Health Authority- Services for The Adult Mentally Ill In Battersea, 25th July 1979.
7. Wandsworth & East Merton Teaching District, District Division of Psychiatry - Plans for psychiatric services in the 1980's Pamphlet, 1981.

8. Wandsworth & East Merton Community Health Council's Annual Report 1980.
9. Wandsworth Health Authority- Service Profile For The Mentally Ill, 1984.
10. Wandsworth Health Authority- Services For The Adult Mentally Ill in Battersea, 25th July 1979.
11. Springfield Hospital Steering Group- Day Hospitals, June 1981.
12. Neighbourhood Study by Community Psychiatric Nursing Student in Wandsworth, 1979 (unpublished).
13. Wandsworth Social Services - Background paper on Facilities Offered to Mentally Ill People By The London Borough of Wandsworth, 24th July 1979.
14. Minutes of the Joint Care Planning Team Meeting RE: Services for the Mentally Ill, held at Bolingbroke Hospital, 3rd August 1979.
15. For example, see Wandsworth Health Authority- Psychiatric Day Facilities for Battersea: A Planning Brief, 10th June 1982.

CHAPTER 6:

Innovation in Community Mental Health Service Provision in Battersea

The intention in this chapter is to consider how perceptions about potential gaps in services began to be formalised in the case study area and to document the actions and motivations of the actors involved in policy change. How was the issue of community provision put on the agenda and defined in the case study area? Where did the innovative ideas for reform come from and what factors shaped people's decisions about them? Why did it take so long before the CMHT model was taken on board and why was the implementation process so slow?

A detailed account of events will initially be presented. The predisposing factors for change in service provision will be drawn out and the debates that followed will be documented. This will encompass the positions of the main actors involved and the subsequent gelling of ideas towards an innovative idea being realised. In a discussion section in the second part of the chapter, the public policy framework established in chapter four will be used to analyse the origins of change and the institutional constraints within which the actors operated.

Perceived Gaps in Services

In August 1979 a meeting was held as part of the Wandsworth Joint Care Planning Team (JCPT) at Bolingbroke Hospital in Battersea, to discuss services for the mentally ill. This was the first such meeting that was organised in the area and signified a change in the forum by which planning aspects of services were to be discussed. It was attended by twenty one people: a range of senior psychiatrists, administrators, community physicians, the chairman of the division of Psychiatry, representatives from the Community Health Council, local General Practitioners, the Nurse Director, the Local Authority Hostels Manager, a senior registrar in Community Medicine and three Social Services representatives¹.

In preparation for the meeting, Wandsworth Social Services Department distributed a brief background paper on the facilities offered to mentally ill people by the Borough². The paper contained the suggestion that a day hospital should be provided for the mentally ill in Battersea. It stated that this had been in the plans for a long time, but had hitherto foundered on a lack of suitable premises and it was stated that during this time, the brief had been changed from offering a programme of rehabilitation to a range of people suffering from mental illness to long term containment of older mentally ill people. In addition, it stated that the social service's two existing day centres were not being fully used and it was therefore hard to make a strong case for increasing capacity.

A further paper was introduced at the meeting from the Health Service side that identified the problems in community mental health in Battersea³. It was suggested that if the need could be more clearly demonstrated for increased day provision in Battersea, this might be a joint health and Social Services venture, using capital from joint finance monies and then joint revenue funded by both Wandsworth and East Merton District and Wandsworth Social Services to build a new day hospital. It was hoped that such a venture would both provide a focus within Battersea for mental illness services and provide for the whole spectrum of day attenders by including some medical and nursing input and a work rehabilitation programme. There was no mention at this time of anything connected with a CMHT approach.

Pressure Points Under Discussion at the 1979 Meeting

At the 1979 JCPT meeting, arguments for and against the day hospital proposal were put forward. These can be summarised as follows:

Arguments For:-

- 1) Community provision at the time was inadequate leading to unnecessary admissions. Many wards were still occupied by clients from catchments outside the Merton, Sutton and Wandsworth Area Health Authority.
- 2) There were problems in services for the elderly mentally ill. The need for emergency admission of elderly mentally ill clients on to acute assessment wards had implications for both staff and clients, and had an impact on GPs readiness to admit young clients to the hospital wards.
- 3) The high morbidity in the area (as detailed in chapter five). It was accepted that the provision by both health and local authorities was below the norm for day hospital and day centre provision in relation to Borough population.
- 4) The inaccessibility of the existing day hospital on the Springfield site for residents of Battersea and accompanying poor public transport links.
- 5) The unwillingness of some clients to go to Springfield because of the stigma attached. It was thought that facilities on a separate site might well be more attractive.
- 6) The need for work-place experience for short stay clients in Springfield and those attending the Cottage Day Hospital. It was recognised that there was a need for Department of Employment support for any sizeable work rehabilitation programmes.

Arguments Against:-

- 1) Reservations were expressed about the staffing of a new day hospital. At the time, clients in the Cottage Day Hospital were seen by a consultant once a fortnight but more regularly by junior staff on the site. Also the junior staff were on call at all times if needed in the Day Hospital. To provide the same sort of cover in a Battersea day hospital would require an additional registrar on that site.
- 2) It was felt that much of the success of a new day hospital would depend on the nursing staff and it was questioned whether an outlying day hospital unit in Battersea would attract the right calibre of staff.
- 3) The revenue cut-backs faced by both health and local authorities at the time were perceived to preclude new developments.
- 4) It was recognised that there would be a problem in finding any site at all for a new day hospital in Battersea, especially in finding a site that was accessible to both the North and South Battersea catchment areas.

Resultant Plans for Action from JCPT Meeting

From the JCPT meeting, a plan was made for future action⁴. The Social Services Department would review the operational policy of the Bolingbroke Grove Day Centre and enter into discussions with the Area teams at Springfield Hospital about the clients considered to be in need of day centre referral and thought to be unsuitable for Bolingbroke Grove. The Area Health Authority would draw up a planning brief for the new day hospital project. A quantitative statement of need would be prepared, using information collected from attendants at the meeting. So in 1979, the idea of a new Battersea day hospital was back on the agenda after appearing in several planning documents over the previous few years, but the plans for action were tentative.

There were several people at the meeting who felt cynical about the idea and had reservations. Two of the local consultant psychiatrists pointed to the weak justification for the idea and the main objection that they voiced was on the grounds of staff shortages. They emphasised again that the medical registrars were already overworked and more junior staff were needed. They proposed that there was no way that a new day hospital could be run just with existing Springfield Hospital staff. No one put forward any ideas about how to resolve this issue and the day hospital idea was subsequently shelved on the strength of this objection.

With hindsight, one consultant suggested that there was also a hidden agenda. Consultant psychiatrists did not want a shared facility with Social Services, because of the bad experience at Bolingbroke Grove. This was a mental health after-care day centre which was run by some very good social workers but was managed by a person absolutely committed to the idea of the therapeutic community, who aimed to effect permanent changes in the lives of the clients. The centre eventually closed as it was felt that it was not catering to the client group who really required the service. A Social Service day centre was opened to replace it in Balham, but there was no question that this could have been a joint Health

and Social Services initiative.

Reflections on the First Planning Stage

These kinds of problems have been identified in the administrative literature, as one of the major failings of joint planning, as referred to in chapter four. For the mental illness services in Battersea, joint funding proposals served only to act as an impetus to think about required changes. The only joint funding money that was ever actually forthcoming for the mentally ill as a priority group was to fund one senior social work post in 1987. Yet it was through the joint planning machinery that increased provision for the mentally ill in Battersea was first raised as an issue. Hence, this new idea originated from proposals considered when it was thought that money might be available. The day hospital project was one of the many old projects drawn from existing plans that was given rather higher priority to be built sooner than it might have been in the absence of joint funding. This pattern closely resembles that reported by Glennerster et al (1983), who identified joint funding as "Face Money", untied to a service proposal, which allowed new ideas to take shape. However, the debates about medical cover to the proposed new day provision could not be resolved and no site was found for the proposed centre so the scheme was dropped. In essence, it was the local consultant psychiatrists who blocked the proposal, but the idea had been brought back into circulation.

Precipitating Factors that Helped Crystalise the Ideas

It was not until 1981, two years after the initial suggestion, that the issue of a new day hospital was again formally raised⁵. Five precipitating factors prompting its return to the agenda can be identified:

1) THE SUDDEN INTEREST OF A DETERMINED ACTOR

Between 1979 and 1981, one of the Battersea consultant psychiatrists had become more intrigued with the day hospital idea. She was beguiled by the way that the Cottage Day Hospital on the Springfield site was run and was starting to

explore ways that it could be improved. Her thoughts at the time were concerned with the philosophy of patient care and an awareness of the financial situation of service provision. She felt that the day hospital should be a more humane form of care and should also be cheaper than the existing provision. This consultant thought about the original meeting where she had decided not to have anything to do with the proposed day hospital and decided that it had been a mistake. Indeed she did want something to do with it, especially if she could have a major say in how it was run. And it was at this point that her ideas began to take shape. The sudden determined interest of this particular actor had a great impact on subsequent developments.

2) PERSONNEL AND PROFESSIONAL CHANGES

The Battersea consultant mentioned above had begun working in the Wandsworth District in 1976 and became a consultant in 1979. In 1982, while the day hospital negotiations were in progress she became Medical Administrator of Springfield Hospital. In those days this position held more planning power than it did later. Essentially there were three people who ran the hospital: Medical Administrator, Lay administrator and Chief Nurse. They made up the Unit Management Group who spearheaded all developments. Therefore, the consultant was suddenly in a very influential position. Also, a new administrator was appointed who demonstrated considerable ability and enthusiasm for new developments.

3) MORALE BOOSTS

By 1981, Springfield Hospital had been given control of their budget for the first time, which had previously been the responsibility of the District Health Authority. This did not have much to do with the day hospital itself, but meant that morale in the hospital improved, along with a feeling of management empowerment. Suddenly, some of the day to day frustrations of hospital life were ameliorated in terms of organisational efficiency. For example, one consultant interviewed recalled a time when she was a ward registrar when it took two years to get a new door put in. Such issues had in

the past been a significant drain on morale. When Springfield Hospital became budget holders they were able to improve their organisational efficiency and were also able to develop some new ideas. For instance, the hospital was allowed to put their obligatory 2% savings to fund a psychotherapist post for Springfield among other things, rather than feed it straight back into a Regional Health Authority account.

4) POLITICAL & FINANCIAL CHANGES

Also at this time, there was a lot of discussion and planning related to the closure of the South London Hospital for Women (one of only two women's hospitals in London). It had been a standard bearer, a place where a lot of women doctors could get senior jobs that were not made available elsewhere. As the first of the credit squeezes began to bite in the early 1980s, the Health Authority pinpointed it for closure as it was under utilised and was not being well run. This caused mass public outrage. Plans had been made to close it in four years time, but eventually a decision was made to close it in 1980 to save four years running costs. This money was to be safe-guarded - "ring-fenced" - for Springfield Hospital so that the hospital could build better accommodation for the elderly mentally ill at a ground floor level. There was also some money becoming available from the sale of other hospital land.

Needless to say, all the money disappeared into an account at Region and was subsequently given to other hospitals for other projects. However, the existence of this supposedly large amount of money, did spur the making of plans for a new day hospital. The previous Medical Administrator at Springfield in 1979 had been exploring the day hospital idea and had suggested that it should eventually become self funding in terms of capital expenditure. This was an added politically popular incentive for pursuing the day hospital project.

5) GOVERNMENT POLICY

The 1974 Government White Paper stated that "The day-activity area is the hub of the (psychiatric) unit" (p30). It put forward national norms with the accompanying adjunct that

these were "no more than a considered assessment of the requirement", and went on to suggest that "the day place ratio in particular may (have needed) to be raised" (p31). Given that the current provision of day places in Battersea was at least 150 short of the requirement, the increase in these facilities had taken on a considerable degree of priority for the management. The White Paper had suggested that

"where the hospital serves a large geographic area it may be appropriate to provide an additional separate day hospital..... a peripheral day hospital might be provided in association with a community hospital" (DHSS, 1974, p31).

Hence, the day hospital proposal fitted in with central government thinking.

The Gelling of Ideas – Down to Practicalities

In a report of a meeting held in December 1982⁶ there appeared an article by the Battersea consultant entitled "Getting the Psychiatrist Out of the Hospital". It embraced the Battersea consultant's thoughts and ideas at the time as to how she planned to tackle the task of addressing the needs of the mentally ill in Battersea. She wanted to change the focus of attention from getting patients out of the hospital, to associated changes required in the staffing establishment. She drew on the ideas that had been circulated previously and supported the setting up of a day hospital in a large building, where up to ninety clients could be cared for on a daily basis, provided families could care for them at night and at the weekends. It was the first time that anyone had started to talk about the practicalities of who the day hospital would be serving and in what manner. A persuasive argument supporting such a development was put together by the consultant. This argument was more specific than the general advantage points that had been raised in 1979.

It was argued that a day hospital would be a cheaper form of care than institutional provision in terms of expenditure on salaries. It was stated that 75% of health care costs went on salaries and if ninety people were cared for full time in a residential establishment, it would take four to six times the

number of staff. A list of 25 full time professionals, whom it was felt would be a necessary minimum for the proposed day hospital, was drawn up. This included: 13 Psychiatric Nurses; 8 Occupational Therapists; 2 Psychiatrists (with psychotherapy skills); 1 Psychologist; 1 Senior Social Worker; and 2 Full time Secretaries. Earlier objections to the day hospital plan on the basis of staff shortages were not considered and somehow assumed no longer to be relevant.

With sufficient care-taker staff, evening use of the new day hospital premises was also envisaged. For example, a club for ex-patients who had largely recovered but still needed some support was suggested. Therefore, the idea was that the centre would offer ongoing support to ex-patients; a service that was not provided by the Health Authority at this time. Full time use of the proposed building was hence being suggested, so maximising its utilisation and cost efficiency. At the same time, it was believed that a small unit would lead to better morale of staff than in the larger unit at the hospital, with obvious benefits to the clients. A group of individual activities for clients were outlined, some practical, some therapeutic. The centre would be a place to come to where people were interested in you. This would serve a similar function to that of people who go to work everyday. It would get them out of the house and give them an interest away from home. This was perceived to be potentially invaluable for people with no alternative, who were at great risk of breakdown such as mothers kept at home by pre-school children. No evidence was cited to support any of these claims.

Subsequent Planning Activity

In January 1982, the Battersea consultant initiated the setting up of a Battersea Day Hospital Project Team where draft terms of reference and a constitution were drawn up⁷. The membership of the project team was as follows: the three Battersea Consultant Psychiatrists, an administrator in planning and client services, the District Works Officer (Engineering Representative), the District Building Officer, the Divisional Nursing Officer in Psychiatry, a Senior Nursing

Officer from Springfield Hospital, an Occupational Therapy representative from Springfield Hospital and a Springfield Hospital administrator. It was agreed that the Project Team would also seek the views of other interested professions by co-option, including the District Catering Manager, District Services Manager, Principal Psychologist and Principal Psychiatric Social Worker. This project Team remained relatively stable in membership and continued to meet over the subsequent years.

By October 1982, a revised planning brief was drawn up with the objective of providing day services for the adult mentally ill and the elderly severely mentally ill in the Northern part of the Springfield catchment area on the principles stated below⁸.

Box 2: Wandsworth Health Authority Adult Psychiatry Principles-1982

- 1) A psychotherapeutic milieu in which problems of loneliness, bereavement, inappropriate patterns of making demands on friends and relatives, soft drug and alcohol abuse could be explored and support given during the therapeutic change.
- 2) More traditional rehabilitation procedures for institutionalised patients struggling out of a long illness.
- 3) The drawing together of community resources (often relating more to physical than to psychiatric illness) to help disabled people who are ill at home without appropriate support.
- 4) Assessment, subsequently allowing well informed referral to other agencies eg Henderson Hospital, the Regional Alcoholism Unit, Local Authority Day Care facilities.
- 5) Containment and treatment of neurotic and psychotic illness, avoiding the necessity for hospital admission.

It was envisaged that the planned day hospital would be newly constructed and would rely upon support from the District Health Authority and its hospital services as a whole. In

April 1983, a suitable name for the Battersea Day Hospital was researched, that would render it acceptable to local residents⁹. It was discovered that Edward Wilson (1872-1911); naturalist, artist, doctor and Arctic explorer had lived in Battersea when he came down to St George's Hospital in 1895 to study medicine. The Battersea consultant felt that the name "Edward Wilson House" was

"... extraordinarily appropriate combining as it does the St George's connection, the Battersea connection and the implied reference to the pioneering spirit which took Wilson to the Antarctic."

The naming of the proposed day hospital at this point raised the profile of the project. No longer was the day hospital part of an abstract plan.

Building Proposals

Throughout 1982, the Unit Management Group at Springfield Hospital became involved in a series of discussions at Regional level and negotiated with the Department of Health, who began to get very excited about the proposed day hospital development. It embraced the Thatcherite ideal of cooperating with the private sector and energy was put into planning and looking for a tender from a private company.

A site had been suggested on the corner of Battersea Park, where the former Battersea General Hospital had been¹⁰. The site was too big for what was required, and too small for half of it to be sold and the other half retained. Therefore, the idea was to offer the site to a private company for development with the payment being that at the same time that development must include the building of a new day hospital which would then be given to the Health Authority. With the acceptance of the day hospital plans in 1982, the DHSS in consultation with the District Valuer proceeded to arrange the allocation of part of the site for the construction of a psychiatric day hospital in partnership with a private developer. Under DHSS Circular HC (80)10 a private hospital development required planning permission and authorisation from the Secretary of State for Social Services if certain medical facilities were to be provided and the development was

to be of 120 beds or more.

The council stated their requirements for a successful planning application. It was keen to emphasise that in view of its history the site could be redeveloped for residential and or institutional uses, but in the predominantly residential area they would prefer residential use. The council also emphasized that the residential density and mix must meet certain council requirements (a high density of up to 100 h.r.p.a or 247 h.r.p.h. provided that more than 50% of the units were non-family units) and that the development must also meet certain design objectives to satisfy the demands made by its prominent location¹¹.

A joint day hospital and residential plan was drawn up by the DHSS, that proposed a building that would be a copycat of other buildings in the area in terms of design and an application for planning permission was submitted. In September 1983, the Development Control Committee of Wandsworth Borough Council met to consider the application. All agreed that the room density was excessive, the height and bulk of the buildings very much out of scale and the likely on-site congestion and on-street parking extremely damaging. The committee therefore unanimously opposed the application for planning permission. A letter from the Wandsworth Health Authority District Administrator stated:

"In all the circumstances, there really was no room for manoeuvre and, although both majority and minority party members would have liked to have cleared the way for these much needed extra day places, there was no alternative but to oppose the scheme"¹².

It can only be guessed why such a proposal was put forward in the first place. An interviewee stated that it was known that Wandsworth Council would have to give planning permission and there was no way the proposed room density would be acceptable to them. Whatever the reason, the result was that the project was proved not to be viable and ideas were set in motion to sell off the site as no other agency within the health authority wanted to utilise it and it was considered to be

surplus to health authority requirements. The day hospital plan was put back in limbo and alternative options had to be explored.

At a meeting in October 1983¹³, the Regional Capital Planning Services asked the Wandsworth Health Authority Planners to consider the alternative options listed in Box 3:

Box 3: Alternative Day Hospital Planning Options – 1983

1)	A smaller day hospital on the Battersea General site.
2)	A development on the St John's Hospital Site. It was pointed out that decisions on the disposal of this site could not be made before 1989. There was a geriatric day hospital already on the site which would probably remain there and psychiatric facilities could be housed in an existing block or be purpose built following demolition.
3)	Development on a new empty site to be designated within North Battersea.
4)	Development in domestic houses bought by the Health Authority.
5)	Adaptation of the day hospital scheme to make it suitable for operation from other existing properties that might become available.

None of the alternatives was considered suitable and in November 1983 it appeared that the whole proposal had been shelved yet again and the issue went quiet. In April 1984, the Health Authority then decided to conduct an option appraisal and cost-benefit analysis¹⁴. Explanations of the ranking of each option concentrated on staff environment, stigma concerned with large establishments, acceptability to the public who prefer the status quo but failing that favour smaller developments, staffing and timing. One consultant commented at interview that the scoring process of the cost benefit analysis was really a guessing game.

The question was still to explore the most appropriate site for the provision of the day hospital and Wandsworth Health Authority produced a further discussion document entitled "Services for the Mentally Ill in Wandsworth and Merton –

Review and Outline Strategy". The District Management Team recommended that the Authority choose the original option to develop the day hospital on the Battersea General Hospital site. The arguments had gone full circle. However, as an issue, the day hospital had gained organisational commitment.

A Committed Local Champion of Change? Salvage or Dump the Plan?

The Battersea consultant was not happy about the decisions that resulted in the stagnation of plans¹⁵, and on her own initiative contacted an old school friend who had married into a large building firm, and asked them to take a look at the site and comment on whether it really was financially viable to build a day hospital there out of the proceeds of a commercial share¹⁶. Permission was then obtained from the Health Authority for this firm to draw up a new proposal, which they did, and confirmed that the project could indeed be a financial success. This information was then taken back to the Regional administrators and planners stating that an opinion had been gained that it was possible to use the site for some kind of commercial share.

In April of 1984, a further meeting of the Battersea Day Hospital Team (now down to 8 people) was held¹⁷. Wandsworth Health Authority agreed to proceed with a new proposal to build a 60 place day hospital on the Battersea General site, and therefore the planning group had to go away and re-draft the planning brief. By the end of April, the alternative option was accepted at Regional level, and a tender was put out to see which private companies were interested in the deal. Two to three schemes were put forward and one was chosen- that of Servite Housing Association. The new building was to be smaller than the original 1982 proposal, providing thirty residential places for the elderly mentally ill with another seventy places for sheltered accommodation and two interconnected day hospitals, one for the elderly and one for the mentally ill.

It took eighteen months to complete the deal because after the

tender was accepted, the regional planners then proceeded to change the elements of the tender, greatly to Servite's disadvantage. There were many doubts expressed as to whether the contract would be retained. However, the confusion was eventually resolved and Servite remained interested. This brings us up to June 1985. It had originally been envisaged that the Day Hospital would open in 1986. Servite had already said that they would need half the preparation time to draw up plans, before construction actually began, so there was no way the Day Hospital was going to open in 1986 or even the following year as the plan was to construct a completely new development¹⁸. The old building had already been demolished but the vacant site was squatted by a second hand car dealer who had to be evicted by the Health Authority at great expense.

The Birth of the DEW Community Mental Health Team

Wandsworth Health Authority at that time made detailed plans for expenditure for the coming year and for one year ahead. Therefore, they had put aside money to open the Day Hospital in 1986 and it was quite clear that this opening was not going to happen. The plans were not even completed, let alone starting the building work. The Battersea consultant therefore approached the Health Authority with a completely new proposal¹⁹. She pointed out that the money had been earmarked for fifteen to twenty staff that was not going to be used and requested that in the intervening time, while the Battersea Day Hospital (EWH) was being built, she could use some of that money to set up a community support service in Battersea for the adult mentally ill. The Health Authority still stood to make a profit as only four members of staff were being requested.

Factors were put forward promoting the establishment of a community mental health team. Money had been earmarked for the staffing of Edward Wilson House (EWH). Also, training in the new way of working would be necessary if EWH was to provide genuinely new departures in client treatment. A pilot project in community occupational therapy had already been running in

the hands of an occupational therapist in the Battersea area and, therefore provided a starting structure for future work²⁰. The psychiatric out-patient clinic and consultations at Bridge Lane Health Centre were another root of community psychiatry to be built upon. Social Services had demonstrated their willingness to co-operate with the venture by the input they had made to the recently opened Garfield Drop-in Centre and the voluntary sector was providing important social support on the Doddington Estate through the family centre there. That centre was acutely in need of mental health support.

It was proposed that these factors together suggested the establishment of a CMHT as "a shadow day hospital team" which could draw on and develop initiatives to enrich the community aspects of their eventual work in Edward Wilson House. The brief of this team would be to experiment with ways of working in clients' homes and in community venues to treat and support both new referrals and existing clients with long-standing disorders. At this time there was also a proposal for a "Battersea Drop-In" Centre that would be staffed alongside the Shadow Edward Wilson Team. In December 1983, a discussion paper was drawn up for a proposed "Shadow Battersea Day Hospital Team". The aims of such a team were proposed as follows:

"The team intends to provide treatment in, or geographically near to, the patient's world including the major "family" figures from his world. They expect to provide group activities which will fulfil diagnostic, treatment and supportive roles. They expect to make assessments, as often as possible in the patient's home. They aspire to provide crisis cover either on a twenty four hour basis or on the basis of assessment early the next working day. They will need to meet at a secure and reliable base where information is held by a permanent secretary/receptionist. Team meetings must be such that enough information is exchanged and enough mutual support received. In addition to meetings which deal with current work there should be a structure of team meetings set aside for reviewing strategic issues. At the team base there must be a system of written reports such that recent information can be reliably retrieved. Time and facilities must be provided to foster communications with the patch Social Services and local GPs."²¹

A working pattern was suggested to be divided between group activities at suitable venues, home visits for planned or emergency assessment and management, team meetings, routine reporting to base and manning the emergency cover arrangements. The proposal was approved in principle and the minimum initial team was envisaged as one community psychiatric nurse, one occupational therapist, one junior doctor and a part time secretary. The importance of a central office base was also emphasised and it was pointed out that there would be major advantages in siting this office on the Doddington Council Estate to develop the mental health aspects of the Family Centre already functioning there. In April 1984, the Health Authority agreed to the shadow day hospital proposal and so the seeds of the Doddington Edward Wilson Community Mental Health Team (DEW) were sown.

Research Initiatives

The background research for both the day hospital development and the proposed CMHT was extremely sparse. At the time, the value of such research activities was not widely recognised. A small survey was carried out at Springfield Hospital on clients admitted from Battersea/Central Wandsworth over a six month period²². 66 in-patients (aged 16-70) were sampled and ten day patients (aged 16-54). It was found that 27% of clients could have been treated at a Day Hospital in Battersea instead of being admitted, and 73% could not. 42% could have been discharged earlier if a Battersea Day Hospital place had been available, (58% could not). 3 out of 10 Day Patients would have been treated at a Battersea Day Hospital if a place had been available. This survey was unstructured and set up by the hospital administration.

Also the consultant at the emergency psychiatric clinic at St George's Hospital was asked to record all clients referred from the Battersea catchment areas over a six month period, to provide suitable statistics for the likely emergency service required in Battersea²³. This was done from October 1985. The General Manager also passed to the Battersea consultant a policy document of Haringey Health District describing their

concept of a CMHT for information and this was used as a reference when compiling the DEW Team Operational policy.

The DEW Mental Health Team – An Innovative Idea is Realised

The DEW CMHT became a shadow day hospital team working in the North and South Battersea community from an office-base in a converted pram shed adjoining a health centre on the Doddington Council Estate. In the initial policy statement of the team²⁴, it was stated that they had two main aims as a new project.

Firstly, they wished to reach clients whose psychiatric needs were not being satisfactorily met by the existing service, and had already identified two such groups – people with long-standing mental health problems who had repeated admissions to hospital and were believed by the team to have had inadequate support between admissions, and depressed young mothers who did not wish to be registered as psychiatric patients. Secondly, they stated that they wished to explore ways of treating and supporting such people to minimise their use of institutions and maximise their use of voluntary and other resources available in the community and used by healthy people. A primary feature of the team was to develop a close working relationship with staff of the many Battersea projects who were already undertaking work with the mentally ill in the area.

At this time, it was a stated policy that the staff of the team aimed to teach themselves a genuinely community-based approach, with a view to the eventual opening of Edward Wilson House, when the staff would move in to become team leaders and teach their skills to the staff there. This was also one of the original justifications for the team having an office base only and it was requested of referrers that if the clients could not be seen in their own homes then the referrer should make available an interview room in which the client could be assessed.

DISCUSSION

The developments described in this chapter provide classic examples that illustrate and reinforce much of the literature on policy innovation and implementation discussed in chapter four. The aim now is to try and extract those that can further understanding of the issues involved and help us to explore the institutional barriers to innovation that the literature suggests are experienced all too often. The whole historical picture of the innovation in its implementation phase will be developed in the remaining chapters of the thesis, but this is a useful point to step outside the proceedings and evaluate key features that relate to the innovation process itself.

The Perception of The Problems of The Long Term Mentally Ill

The issue of how day hospital provision to the long term mentally ill was initially put on the agenda and defined, was described at the beginning of this chapter, but it is now our purpose to discuss how the CMHT proposal came to be accepted. Six main factors can be established. Firstly, the CMHT proposal was intimately linked to the day hospital plan, as it was to be a shadow team for the new day hospital. At no time was it suggested, independent of the day hospital project, that there was an explicit need for a separate CMHT development. The proposal was given political clout only because of its proclaimed link with the day hospital project.

Secondly, the CMHT proposal served the function of the "symbolic policy making" described by Edelman (1971). By 1983, the problems in service provision for the long term mentally ill had become a sensitive political area. Support for the DEW Team innovation was significantly connected with the idea that something was being seen to be done about these problems, without demanding the allocation of significant additional resources or initially expecting any dramatic successes in clinical care. Thirdly, the CMHT policy innovation partly came into being as a result of good timing. The historical account that has been presented so far has taken us through seven

years of discussion and planning about the day hospital and out of the frustrations with the length of time that such activities took conflict arose tied to operationalisation, timing and control of the day hospital project. The managers were not motivated to make the day hospital project time limited in the short term but the clinicians found it difficult to have to work to a received and constantly extending time-schedule which was managerially determined rather than professionally informed. By 1983, this conflict had become acute and the managers had to address the problem.

Fourthly, it was not until 1983 that one particular individual championed the CMHT idea and became dedicated to seeing it through, with the support of her fellow professionals. This was a vital turning point, as for the first time, the long term mentally ill issue invoked action and this element cannot be understated. Fifthly, the CMHT proposal also gained support because it was a fresh idea. It was the first time that any idea had been considered as to how to give additional support to the long term mentally ill outside a mental hospital or day hospital setting. The CMHT model was not put on the agenda earlier simply because no one had considered it as a possibility. All planning activity concerned with provision of services to the long term mentally ill group was for many years centred on bringing the day hospital plan back into circulation. The CMHT was a completely new idea in Battersea. It had not been part of any plans but was a new solution that initially was proposed as an interim measure. As a fresh idea, it therefore commanded attention, claimed legitimacy and invoked action, so passing Solesbury's (1976) three tests. Lastly, local senior psychiatrists indirectly controlled decision making activity and interview evidence suggested that initially their main goal was to resist change that would necessitate truly joint initiatives with the other concerned agencies, particularly Wandsworth Social Services Department. This was not formally stated at any point in the proceedings, but was identified by interviewees to be part of a significant sub-agenda and since the CMHT proposal was a Health Service led initiative, this factor aided its acceptance.

The Origins of Change

Where did the innovative ideas for reform come from and what factors shaped people's decisions about them? In Battersea, the innovative ideas for reform came from professionals working at the interface of service provision. As detailed in chapter four, Donnison et al (1975) and others, found that major initiatives for change often begin with the professionals working in a service. This is amply demonstrated in this case study. It was a professional who pushed through the day hospital proposal and then, more significantly for our purposes, came up with the later idea to establish a CMHT. There was a notable lack of hospital management involvement in the process of establishing ideologies for both these innovative ideas, and two reasons can be suggested for this, based on interview material collected from the actors involved.

Firstly the main policy innovator was herself not only a consultant psychiatrist and hence a professional working in the field, but she was also at the outset of discussions, the Springfield Hospital Administrator, and therefore in a strong management position herself. Secondly, the remainder of the management team wanted innovation in service provision, but were happy to let the consultant do the work while they occupied themselves with other facets of the mental health service based around the institution and concentrating on "acute" provision. They remained supportive of the consultant but contributed few innovative ideas themselves.

The Battersea consultant psychiatrist acted as a catalyst. The professional frustrations with inadequate service provision would probably not have borne any new development had it not been for her interest and dynamic thinking. She was a professional opportunist with a clear idea of the way she saw the needs and unusually put together feasible options. She fulfilled the role of what Williams (1980) would term a "top-level fixer". She moved the paper exercise into an actual project and the DEW story provides a good example of how a professional can do this in a way that results in innovation

in service provision.

Levin's contention that as a plan progresses, and is thwarted at various stages, so the drive to find alternative solutions and see them through increases proportional to the frustration (Levin 1976), is supported by the DEW Team example. The consultant had heard the day hospital plans being discussed for years and was familiar with the frequent pattern observable in all large organisations, but particularly in the Health Service in the 1970s and early 80s, of seemingly suitable projects never getting any further than the drawing board due to the amount of "red tape" involved and blocking by other vested interests. She knowingly took on the challenge to tackle these, and was in essence promoting the transfer of the vested interest of psychiatrists into the community sphere, as suggested by Holland (1988).

This fits in well with the Donnison notion of professionals taking the lead (Donnison et al 1975). However, the case study evidence is more specific than that. It does not suggest that any professional could have taken the lead. It was significant that it was a psychiatrist and this point gives us an indication of how the development of community care in mental health has been different from developments in allied disciplines such as mental handicap and services for the elderly. The developments described in this chapter suggest that in practice, at this time, policy change in community mental health could only be shaped by the consultant psychiatrists. It was no coincidence that the policy innovator in our example was a psychiatrist, and this demonstrates an elitist power at the local level in determining policy innovations. No alternative models of practice were considered, other than those promoted by the consultant psychiatrist.

The consultant, who championed the day hospital plan and later the CMHT plan became committed. Personal pioneering of a project gave a strong motivation to want to see it through for the sake both of the ideological reasons for starting it (in

this case the perceived failures of current services for the mentally ill and the seemingly obvious solution that providing a CMHT and giving people suffering from a mental illness ongoing community support would be both preferable to them and to the strain imposed on the current hospital services) and for personal reasons contingent on having a purpose in life and fulfilling personal goals to achieve job-satisfaction. These kinds of motive are absent from academic discussions of bureaucracy as Dunleavy (1981) has pointed out, but they are shown by our case study to be important.

The question of the degree of self interest of the key psychiatrist involved suggested by public choice theory, is a difficult issue to tackle. The interview material suggested that the consultant psychiatrist, in particular, was very eager to promote both the day hospital and CMHT developments on the grounds that she had a controlling interest, yet the impression gained was that this was not altogether negative. Altruism, professional ethics and the concept of public service most certainly featured significantly in dictating the actions of the consultant and the support of her immediate colleagues. Such issues were prominent in all the discussion documents produced by these individuals at the time and from becoming acquainted with them and working alongside them during the fieldwork research, the author was reassured that such proclamations were genuine. Yet, it cannot be denied that such evidence is highly subjective.

Government or Local Policy Determination?

The impact of government policy in the case study area during the period 1979 to 1986 was assessed in this chapter through documentary analysis and interviews with key actors. The overall impression was that central government directives had only a minimal influence on the decision-making process and innovative policy outcome. Only four direct references to central government impact were noted in the historical account presented in this chapter:

- a) In 1979, the Wandsworth Joint Care Planning Team played a consequential part in developments that followed. This factor is discussed in more depth below.

- b) In 1981, central government norms for day hospital provision stated in the 1974 Act were cited as one of five precipitating factors that helped to crystallise the Battersea Day Hospital proposal. The reference was used to make a case for the proposed day hospital plan, yet this was by no means the main impetus for the operationalisation of the day hospital idea. In all the 1979 documents prepared for the JCPT meeting, reference was made to the fact that the day hospital idea was being put back onto the agenda, having been proposed on several previous occasions. The 1974 Act had been previously used as a supporting argument for new day hospital provision yet no direct action had resulted.
- c) In 1982, the stated principles of Wandsworth Health Authority regarding psychiatric care (see Box 2) were loosely based on government community care rhetoric. Yet these statements were vague, ambivalent and not particularly relevant at an operational level. The only reference to the long term mentally ill was in stating the need to avoid hospital admissions for psychotic and neurotic clients.
- d) Later in 1982, the proposal to make the planned day hospital a joint project with a private sector company inspired interest and enthusiasm from the Department of Health, since it embraced the Thatcherite ideal of decreasing reliance on the public sector. This fitted in generally with central government policy.

These references all concerned the proposed day hospital project. Policy innovation in the form of the DEW CMHT development, involved no references to central government directives, other than as an offshoot of the day hospital proposal as a "shadow day hospital team". Evidence was hence found for the "bottom-up" policy determination described by Barrett & Fudge (1981). Certainly, no reference was made by any of the actors involved or in any of the documents analysed to the CMHT idea even being discussed at central government level, let alone causing a policy chain transmitted from the top of the organisation down to the frontline. In the case study area, the CMHT innovation was almost solely the result of local initiatives.

It is interesting to observe from the DEW Team example, that the CMHT model eventually utilised was not implemented from first principles. There was little research carried out into this working style, and the staff team were mainly experimenting with their own solutions to the problems that

they observed from having worked in the area for many years. The staff became increasingly aware that the style of service that they were trying to adopt fell into the realm of the CMHT model, but only vaguely set out with this model in mind. This supports the contention stated in chapter one that the CMHT model was not a widely known and recognisable model of service provision at the local level. It was being implemented in a patchy fashion across the country and the dissemination of information about the model was erratic. As far as the policy innovators were concerned, no model existed. They were pioneering a totally new approach based primarily on their own perceived needs of service problems that existed.

Decision Making

The concept of "non-decision-making" discussed in chapter four is a useful tool to invoke in considering the obstructive passage of the day hospital plan. As has been pointed out repeatedly, the day hospital issue had been discussed on many occasions prior to 1979, but no action had resulted. In 1979, it looked as though the same institutional barriers to change that had constantly been used to prevent the idea from taking shape were again going to cause the idea to dissipate. The arguments that initially prevented the day hospital plan invoking any action were listed at the beginning of this chapter. The first two related to staff input to the new day hospital. The problems envisaged concerned the organisational upheaval of relocating clinical staff and attracting the right calibre of nursing staff. Financial and site location problems were also stated. However, a consideration of these arguments with hindsight suggests that they had power because of the controlling interests of the psychiatrists who proposed them, rather than because of their content.

When the day hospital plan was finally accepted, the first two problems relating to staffing were solved by the sudden interest of the consultant psychiatrist and other personnel changes. It seems the arguments concerning staff originally put forward against the plan had either been wrongly perceived or they were deliberately presented with a sub-text. The

problems really concerned the perceived lack of commitment and motivation for staff to work in the community. The financial and site location problems were similarly misinterpreted. Later developments showed that the problem was not that finances did not exist, but that a reorganisation was needed to attach specific money to specific projects. The site was available too, but the series of flawed planning applications showed that the real problem was in planning rather than in resource scarcity.

The historical account of the way decisions were finally made in the case study area conveys the distinctive "yo-yo" style of proceedings. Decision-making was essentially based on a fairly haphazard and at times, unorthodox bargaining procedure between a key individual actor (the Battersea consultant) and the District Health and Local Authorities. Hence, there was evidence of incrementalism at work as suggested by Lindblom (1959).

The case study also supports the literature in observing that the decision making process was limited to a small elite. No attempt was made to gain a hearing from clients who were to receive the service at any stage of the planning of the new day hospital or the CMHT. The only concession was that a representative from MIND was invited to the Battersea Day Hospital Planning Meetings to speak for the interests of the non-statutory sector.

Joint Planning

In Battersea, the JCPT itself did not overcome any of the institutional barriers to implementation, but it did provide an opportunity for managers and professionals to consider where they were going and to look at the gaps in services. This was a positive direct result of the government framework. Out of it came a perceived need and an appreciation of the gaps in service provision. As observed earlier, this supports the evidence in the literature referred to in chapter four (Booth 1979; Glennerster et al 1983). The original central government model relationship was of two coterminous authorities sitting down together to decide the shape of

services in their areas. Webb & Wistow (1982) have pointed out that the complex organisational structures and lack of coterminosity presented by this idea caused considerable difficulties for many local planners. Yet, Merton, Sutton and Wandsworth Area Health Authority found a partial solution. It created bilateral planning by dealing with general allocations of joint finance separately and doing much of its work in specialist subgroups such as the Battersea JCPT.

However, the day hospital plan that resulted was not actually a joint initiative but was Health Service driven and the Social Services demonstrated no equivalent commitment or clout to follow through the project. This reinforces the contention put forward by both Glennerster et al (1983) and Ramon (1988) that Social Services operating in the 1980s found it difficult to interpret community care to innovate. In later chapters further evidence will be explored concerning the extent to which this dictated the style of service provision that resulted as being dominated by health service interests.

Conflicts and Constraints

The history of the DEW Team development emphasises that there were political and financial conflicts over both the day hospital and CMHT developments. For example, the council had clear ideas about the preferred residential use of the old Battersea Hospital site and the day hospital plans had to be adapted to this. Also, in considering the size of the proposed development, plans had to be redrafted from the original proposal for a ninety place facility to a smaller seventy place facility with lower room density. A good illustration of the political barriers is seen again in the consultants resort to privately consulting an old school friend about the building proposals that the council had condemned for being unrealistic.

Yet, there was a strong sense that all parts of the system were in some way ready for an innovation in service provision to take place. Gaps in services had been repeatedly demonstrated and discussed and there was a general sense that

resources could be made available. Two main interest groups were at work at the local level, namely the Health and Local Authority services, but differences in ideologies and organisation constantly prevented any new development actually crystallising and mobilising enough support to get it off the ground. Initially, everyone either wanted a controlling interest in a new development or no development at all, although no one was specifically stating this.

In addition, services were already over stretched and no one person would initially actually take on the responsibility, as it was but one part of their already very busy schedules. It seemed to many that there were just too many hurdles to be overcome, instilling a sense of lethargy and hopelessness with respect to the proposed day hospital plan. So while certain actors wanted to control the new development but did not perceive themselves to have the time to do it, they would rather prevent any new development taking place at all. This is reminiscent of scenarios described in the literature as "negative sum games". The literature suggests that such a situation results in conflict between those with policy interests that must be reconciled before an innovation can emerge (eg Donnison et al 1975). However, this case study gives rather a different picture. Conflict existed, but it was a very cynical kind of conflict. The actors involved were not fighting each other with action proposals, rather they were seemingly competing to destroy the policy proposals with reservations and general mistrust. When the day hospital proposal was finally accepted, it was not on the basis that different views had been recognised and reconciled. The innovation only became a reality when one individual "rode roughshod" over the objections and came up with new solutions to overcome problems that stood in her way.

In Brief

This chapter provides an account of one policy innovation in local mental health services during the 1980s, which supports much of the public policy literature. The issue of CMHT provision to the long term mentally ill was put on the local

agenda due to its direct link with the proposed day hospital project and it was one particular consultant psychiatrist who invoked action and together with her professional colleagues, defined the boundaries of the CMHT innovation. At this time, the CMHT model was not widely known about or explicitly understood as a coherent model at the local level. The next three chapters will now explore specific themes of the CMHT implementation process, initially considering the way that the team developed and the importance of personalities in team building.

1. Minutes of the JCPT Meeting RE: Services For The Mentally Ill held at Bolingbroke Hospital, 3rd August 1979.
2. Wandsworth Social Services - Facilities Offered to Mentally Ill People By The London Borough of Wandsworth, 24th July 1979.
3. Wandsworth Health Authority- Services For The Adult Mentally Ill In Battersea, 25th July 1979.
4. Minutes of JCPT Meeting RE: Services For The Mentally Ill In Battersea, held at the Bolingbroke Hospital, 3rd August 1979.
5. District Division of Psychiatry- Plans For Psychiatric Services In The 1980's. Wandsworth Health Authority, 1981.
6. Mental Health Services For Wandsworth, Annual Report. Wandsworth Health Authority 1986.
7. Psychiatric Day Facilities For Battersea: A Planning Brief. Wandsworth Health Authority, 10th June 1982.
8. Psychiatric Day Facilities For Battersea: A Planning Brief. Wandsworth Health Authority, 10th August 1982.
9. Correspondence between Springfield Hospital Medical Administrator and Professor Crisp RE: Naming The Day Hospital, 5th April 1983.
10. Wandsworth Borough Council Planning Department- Development Of The Former Battersea General Hospital Site, September 1983.
11. Wandsworth Borough Council Planning Department: Development Brief for the Former Battersea General Hospital Site, Prince of Wales Drive, SW11, 1983.

12. Letter to Wandsworth Health Authority District Administrator from Chairman of Development Control Committee RE: Battersea General Hospital Site, 6th September 1983.

13. Circular: Battersea Day Hospital- Further Options To Be Considered By The Project Team, 24th October 1983.

14. Wandsworth Health Authority Day Hospital Option Appraisal And Cost Benefit Analysis, 1984.

15. Correspondence to Principal Architect from Battersea Consultant RE: Development of Springfield Hospital, 16th June 1983.

16. Correspondence to School Friend from Battersea Consultant RE: Private Housing Joint Project For Battersea Day Hospital, 1st September 1983.

17. Minutes of Battersea Day Hospital Team Meeting held on 27th April 1984.

18. Minutes of a Battersea Day Hospital Planning Team Meeting To Discuss Progress with Edward Wilson House, 4th September 1986.

19. Draft Paper: Shadow Edward Wilson House Team, by E.K. McLean 14th June 1984.

20. DEW Discussion Paper by E.K. McLean, August 1983.

21. Discussion Paper: The Shadow Battersea Day Hospital Team, December 1983.

22. Springfield Hospital Survey Of Patients Admitted From Battersea and Central Wandsworth regarding the Battersea Day Hospital, Wandsworth Health Authority, 1983.

23. Correspondence between Medical Administrator and Consultant Psychiatrist and Charge Nurse at Clare House RE: Use Of Emergency Clinics By Battersea and North Wandsworth Patients, 24th October 1985.

24. DEW Outline, October 1986.

CHAPTER 7:

Implementing a Community Mental Health Team: Building the Team

The factors that shaped the formation of the DEW Mental Health Team have now been considered. The next task is to see how the plans were carried into practice. In this chapter, interviews with the main actors were used as the main source material, supplemented by further documents, reports and correspondence. In order to access key features in the implementation process, it was the intention to allow the actors themselves to identify the topics that they felt most important to discuss. Three key themes emerged which were, team building, service style development and barriers to implementation. These themes have therefore been used as a basis for the following three chapters.

This chapter concentrates on team building. It considers the development of the staff team and the involvement of other local actors. How was the DEW Team put together? What approaches to planning, management and staff participation were required for effective service development? How did the other key personnel working alongside the DEW service relate to the Team and to what extent did they perceive their own roles to have been eroded? Was there further evidence of the elitist practices of the psychiatric profession? What was the input of professionals from other disciplines and how successful was the team's multi-disciplinary approach? The discussion section at the end of the chapter further explores elements of this first theme, that add to those discussed in the previous two case study chapters.

The Setting Up of the DEW CMHT

It was assumed that office space for the new shadow day hospital team would be available in October 1985. On this basis, a scheme of phased recruitment was proposed, whereby each member of staff appointed would spend the first six months of their time working in a relevant induction setting. For nursing and occupational therapy staff, it was suggested

that this setting should be within Springfield Hospital in order to establish the community links that the workers would need at a later stage. The Battersea consultant planned to take her whole service out to the community base in February 1986, but building on the pram shed conversion was delayed and the team could not move until April 1986.

The briefing for staff¹ indicated that the shadow team members would aim to develop a carefully selected caseload of clients who would be representative of social, ethnic and age groups living in Battersea. This was thought to be an enabling factor in allowing the team members to familiarize themselves with local housing conditions, living standards and to assess the interaction of different cultural and social backgrounds with the delivery of mental health care. As far as possible, the new services provided by the shadow team would be those that could appropriately be moved to Edward Wilson House when it was opened. The shadow team would be involved in the planning and commissioning of the day hospital in conjunction with the project team members. Also the shadow team would be required to undertake certain research projects. These were identified to include a neighbourhood study, a directory of local resources and an exploration of transport arrangements.

The Initial Development of the DEW Staff Team

As explained in chapter six, the funding of the DEW Team came from revenue funding put aside for the staffing of the new day hospital, and the finance was deliberately tailored so that the DEW staff team was set up gradually over a number of years. When interviewed, the DEW Team Consultant stated:

"We were aware that it would not be a good idea simply to move staff from the institution straight into the community. Such an attempt would just have resulted in the transfer of the institutional framework into the community, rather than providing a new approach to care".

This phased development had implications for the way the service developed. It meant that there was no real opening date for the DEW service, rather a transitional period between 1985 and 1987 in which the team was built up. The team considered that they were not working from a borrowed

traditional pattern. The concept was that the staff recruited would gradually train themselves in a new non-institutional way of working. Therefore, the characteristics of team working that developed reflected the strengths and weaknesses of the key staff members.

As stated in chapter six, the original proposal for the DEW staff team, which was to act as a shadow team for the new day hospital, was put forward by the consultant psychiatrist. She requested eight initial staff: a full-time secretary, two nurses, 3 occupational therapists, one junior doctor and part time input of a consultant psychiatrist. She envisaged that there was also scope to eventually include two further staff members (a psychologist and social worker), once the Team had developed an identity². The following description of team building demonstrates that it received fewer staff than had been suggested as a minimum in this original proposal.

The team personnel evolved from a core group of three, all of whom had already had some experience of working in the community. The consultant psychiatrist was the first to take up her post in 1986 and an occupational therapist (OT) officially started a few months later, closely followed by the appointment of a community psychiatric nurse (CPN). A psychologist, clinical assistant and a senior registrar were appointed later that year, with additional input from a registrar on the hospital training rotation, and a social worker was appointed in 1987.

The Moving Spirits

1) The Consultant Psychiatrist

The DEW Team Consultant Psychiatrist had worked in Springfield Hospital for twelve years and had been running out patient clinics in General Practice since 1977. She became a consultant in 1979 and soon became aware of the reactive and "unthinking" style of service provision.

"While working as a consultant psychiatrist it is easy to loose ones thinking power. It is a high pressure position and there are so many things that should have been done yesterday, that one does not have a chance to stop and assess the situation".

She went on to take up the post of Hospital Administrator at Springfield between 1982 and 1986. In setting up the DEW Team, she drew on this experience. Her job as Medical Administrator made her realise that:

"...the people with the worst illnesses, people on the back wards and their equivalents in the community, received the least input".

She saw this as a direct result of the "unthinking" she described.

"They (long term mentally ill clients) may have had very faithful CPNs but these workers had very little supervision and no multi-disciplinary discussion at all. The serious solemn discussions of issues that took place at the hospital ward rounds were generally not available to the CPNs, as CPNs only attended when one of their community patients was in relapse and hence had become an in-patient".

This Consultant, therefore, became dedicated to involving CPNs and other staff more appropriately in client care. She was driven by her frustration with the hospital service and her perception of its seemingly obvious failings. Her personality and experience added to her controlling interest in the DEW Team project meant that she naturally became the DEW Team leader. In relation to team leadership, one management member commented:

"In the past Wandsworth teams have been nearly always set up to be led by consultant psychiatrists. This may seem unnecessary, in that the services are unduly dominated by one profession, but there are several good reasons why it has been the case. The psychiatrist is nearly always the most experienced member on the team and decisions about individuals require experience and generic knowledge. There is no reason intrinsically why other disciplines should not become team leaders, but it has to do with the career structures that other professionals seldom stay in one area for long periods of time. Anyway, I do not understand why it is such a big jealousy issue when most of the psychiatrists job is deadly boring - who wants to do those things?"

2) The Occupational Therapist

The Occupational Therapist (OT) was also a key figure in the DEW Team development. She stated:

"The Team was mainly initiated by the Consultant but since I was there and very interested, it soon became a mutual decision between the two of us to make the project work".

She had developed a keen interest in community working, previously having worked for eight years, part time, as the Battersea Ward OT at Springfield Hospital and prior to this, in day centres in community settings in Wales.

At Springfield, she felt that she was always seen as being very different by the other occupational therapists. She had strong views and frequently clashed with hospital OT policies. However, her head of department was very supportive of her community interest and she was left to get on with what she was doing and establish her own ways of working. She began work in the Battersea community several years before the DEW Team was started. In 1982, she started making a few home-visits to Battersea patients who were suggested by the consultant and then in 1983 she set up two community support groups in Battersea. She felt that such groups were a great help for the initial work of the DEW Team, because staff and clients could see the kinds of things that the team was trying to do.

First, together with a social worker who was the senior practitioner for mental health in North Battersea, she set up the "Garfield Group" which met once a week in a community centre in Battersea. This was a support group for people with long term mental health problems. Each week the group would meet and do an activity together. Such activities ranged from cooking and eating a meal together, playing games, holding discussions, inviting speakers and going on outings to places of interest. A second group was then started by the OT towards the end of 1983. She had been working with a number of very isolated young mothers and believed that there was a need to form a group to offer them the chance to meet others in a similar position and have some form of social support. So a "Mother & Toddlers" group was set up meeting once a week at a Family Centre.

3) The Community Psychiatric Nurse

The Community Psychiatric Nurse was the next staff member to join the DEW Team. She had previously been the Battersea Ward Sister and, like the OT had an interest in community work. She

also started setting up and running community groups in Battersea before the team officially existed. She was involved in the Garfield Group mentioned above and she also helped set up a "Relative Support Group", holding meetings in a Battersea church hall. She knew many of the Battersea clients and had already developed strong relationships with them in the hospital, before moving to work in the community setting.

Interviews with a member of the nursing management suggested that the local nursing hierarchy was not particularly supportive of the key DEW Team nurse, expressing concern about preserving the role of CPNs. By tradition, nurses had been very poor at defining the boundaries of their jobs and had tended to take on board any tasks that others were not prepared to perform. The nurse management sought reassurance that the DEW Team would protect the CPN role, but when interviewed later, the nursing management representative commented that the real intention in voicing this concern was to delay the scheme. Yet, the DEW Team CPN was prepared to act fairly independently, and this was of critical importance at the outset of the DEW Team development. The DEW Team forced the nursing managers to become more flexible. The DEW Team CPN commented that one of the more important achievements of the DEW Team was to achieve regular multi-disciplinary supervision of case-loads

"...particularly for the more chronic group, which traditionally had not been given to CPNs isolated in the community".

The Completion of the Staff Team

A senior psychiatric registrar working in the Cottage Day Hospital on the Springfield hospital site from 1985 to 1986 was approached by the Battersea consultant psychiatrist at the end of her year and encouraged to apply for a supernumerary part time senior registrar job created at the DEW Team at the time. She did so and worked for the DEW Team from 1986 to 1987. After a year, she had to go to work in Epsom as part of the senior registrar rotation. At the end of this placement, having completed her senior registrar training, she decided that she did not want a consultant job because of family

commitments and was attracted back to work at the DEW service as a Clinical Assistant. Her motivation was that the job was part-time, and she wanted to work in the community, seeing people in their own homes. Also, she had enjoyed her year working at the DEW service as part of the senior registrar rotation. In the intervening time, another Clinical Assistant had been appointed for a year who was also very able and committed to the DEW Team style of working.

The Clinical Assistant helped to set up and run a Women's Group on the Patmore estate in 1988 and was jointly responsible for writing the DEW Team operational policy with the psychologist, who was next to be appointed. The Clinical Psychologist joined the DEW Team in February 1986. Previously, she had been working in a day hospital in Kent, but had become frustrated with the journey time in travelling there from London. From her experience in the day hospital, she knew she wanted to work within a multi-disciplinary team and was excited by the idea of a newly developed project. She liked the DEW Team policy of concentrating on priority groups and not trying to provide everything to everybody, something that had been a failing of the day hospital where she had previously worked. Also, she was impressed by the commitment of the other team members.

Initially, she was the only psychologist working in Battersea, so she took some straight psychology referrals from the Hospital in addition to her DEW Team work and was never just working with the DEW Team. However, she made a great effort to research the team's work more thoroughly. She was primarily responsible for researching a client assessment and review policy and formulating assessment forms. Also she helped run the Garfield Group for a time, initiated the setting up of a "Befriending Scheme" and helped to run the Relative Support Group.

In July 1985 Wandsworth Social Services were approached to find out whether they wished to see social work contributing to the mental health services at Edward Wilson House. The

Department stated that they welcomed the idea but the difficulty in funding new posts was pointed out, and it was suggested that such a post would be appropriate for joint funding. Bearing in mind that only small bids that had no recurring consequences could be considered for the next financial year it was stated that it would be unrealistic to expect that an exception would be made for this post in 1986/7, but that it would be promoted in 1987/8 in the hope that the financial situation may have improved a little by then. By February 1986, the bid for the post had been working its way up the priorities of joint financing and a draft proposal was accepted. In the spring of 1987, after a long and delayed series of correspondence, the post was finally accepted for joint funding between the Health and Local Authority.

The Senior Social Worker who initially took up the DEW Team post, was making a sideways career move. Previously she had been working as a senior social worker in mental health in the South Battersea Area Office and was based at Springfield hospital. At the time the DEW service was increasingly making itself felt in the community. The Social Worker had been finding it difficult to work with children and families in a generic role and wanted to become more specialised and to do community work within a multi-disciplinary framework. The DEW Team presented such an opportunity and she remained working there for a year until she left on maternity leave. Another Senior Social Worker then joined the Team in August 1989, who had previously worked for six years as a mental health area social worker in neighbouring Lambeth, after completing her last six months training at Springfield Hospital. In Lambeth, she had constantly been involved in re-sectioning mentally ill people and was concerned about the frequency of this activity, caused by the lack of after care provision for people leaving hospital. She perceived that the DEW Team offered an alternative approach.

As part of the DEW Team, this Social Worker later helped to establish a "Doddington Estate Link", in which there were

community representatives from the library, the church, family centre and local college. The group met once every three to four months and offered an excellent forum for general discussions of problems on the council estate where the DEW Team was located. She also started the "Autumn Colours Group" for the elderly.

From the outset, the DEW service also became a split placement in adult general psychiatry for Senior Registrars and Registrars training at St. Georges' Hospital and throughout its development received such staff on a six month rotation. There were 16 senior registrar jobs on the St Georges rotation, only 5 of which were at Springfield Hospital. Senior Registrars tended to aim for the core jobs and of the 5, only 2 were in adult general psychiatry and one of these was the DEW Team job. The DEW Team was seen as the most desirable of these positions and hence benefitted from a stream of very able medical staff.

The Team personnel worked together as a multi-disciplinary team, to provide "patient-centred" care. In addition to their day to day clinical responsibilities to clients on their case-loads, each team member was also encouraged to involve themselves in innovative forms of care delivery ranging from the running of community support groups to the design of operational policy. Each person learnt from the people already in post, as well as bringing their own ideas. This principle was partly conscious and partly circumstantial.

Other Actors Directly Involved in the DEW Team Development

1) Hospital Ward Staff

The DEW Team had access to beds on one in-patient ward at Springfield Hospital. The ward manager pointed out that on a day to day level, their main contact with the DEW team was through the registrar, who came to the ward more often than any other member of team. He felt that the biggest problem for the ward was the fact that it was a shared senior registrar. Also, they felt "a bit out of it". The ward staff did not feel part of the community in any sense of the word. They felt

isolated in a very different sort of world. Problems with the hospital ward staff will be further explored in chapter nine.

However, some ward staff related to the DEW Team better than others. For example, the Charge Nurse on the Battersea Hospital Ward during 1982 and 1983 worked closely with the DEW Team from the ward. Before the Team was established he had helped set up the Relatives Support Group which started by meeting on the ward. Initially, relatives came to help out on the ward and occasionally organised social evenings, but there were a few problems with the ward being so busy and eventually the group moved out to the community.

2) Professional Hospital Departments

The DEW Team was formed with a multi-disciplinary structure. This meant that each professional on the Team was also answerable to their own professional department within Springfield Hospital. The Heads of the Psychology, Occupational Therapy, Social Work and Nursing Departments were therefore, also involved in the initial recruitment for the DEW Team and in supporting its on-going development. All of them were interested in the team's progress and remained flexible throughout the development period, allowing staff high degrees of independence. However, to some extent the DEW service created a need for department heads to challenge traditional work philosophies and staff management structures. An interview with a member of the nursing management suggested that the DEW service had been seen as quite threatening to the different professions, particularly nursing, but in fact no conflict occurred in this respect. One department head interviewed commented:

"Team building has proved to be an important issue, with the need for managers from different professions to agree on philosophies. One of the greatest blights of the mental health professions at the moment is increasing professionalisation. Numerous arguments are going on about what is whose job. For instance, in the psychology department there is an ongoing debate about psychologists ring-fencing their skills. People often seem to forget that what is really important is to look at the needs of patients. DEW seemed to be doing this more than other services at the time".

3) Hospital Management

The Wandsworth Services Manager was involved in the development of the DEW Team, although not at its inception. His role was as overall responsible manager for Wandsworth and the DEW service was a small part of this. After the initial day hospital plans were finalised, he saw his role very much as a servicing task, taking an enabling role and simply trying to respond to equipment requests. He also had involvement with all the catchment area teams with regard to ward reorganisation and the DEW Team was a part of this. He was consulted on assessment and referral procedures and tried to make these systems and styles of work consistent. He pointed out that

"There were some apparent tensions, particularly in the early days of DEW, as some managers felt that their role was being eroded".

The DEW Team was initiated by key local actors, the catalysts who mobilised innovative local professionals. The DEW Team staff were largely already in post working in Battersea with knowledge and experience. When they grouped together and wanted to do something new it was in the interests of management to support them, otherwise they risked losing high calibre staff or at least suffering a distinct slump in morale and possible movement to other jobs that were perceived to be more malleable to accepting new ideas and philosophies. The feasibility of recruitment and training was never a problem because the staff were already mostly working in Battersea, each with a personal interest in community working and were willing to experiment with training themselves. The Team was also willing to try to soak up the need for increased administrative capacity themselves, although this later proved to be a pressure point with which they would struggle.

The Wandsworth Nurse Manager, became involved with the Day Hospital plan on a very ad hoc basis in 1983. At this time she held the post of "Senior Nurse Projects" and had coordinating responsibilities for considering practices throughout the health service that needed to be updated or changed. She went to meetings when no other management members were available to

attend and at this stage was not well informed about the detailed plans and remained on the periphery. In 1985 she became more firmly involved and recalled a series of regular meetings occurring throughout 1986 when the Servite bid for a partnership in the new day hospital was accepted. She worked on themes such as the design of the building, contents of rooms and general details of the project. Regarding the DEW Team itself which evolved as an off-shoot of the day hospital plan, she had little direct involvement, except in safeguarding the interests of the CPN on the DEW Team.

4) Social Services

It was felt by many of those interviewed, that it was very positive to have people from Social Services working jointly with the Health Service as part of the DEW Team. Such joint working had been something of a rarity in the past. One social worker stated:

"DEW was unique in its multi-disciplinary aspect because it gave a joint consultative knowledge base between the Health and Social Services. There were advantages for DEW, for instance, in being able to feed into the social work information system about clients and in having easy access to consultative work about clients who had no past history of contact with the health services, but who were well known to Social Services".

Problems emerged later in the implementation phase regarding the involvement of Social Services in the DEW Team development and these will be discussed in chapter nine, but Social Services staff largely supported the initial work of the team. In a consumer satisfaction survey conducted in 1989 (MacDonald & Ochera 1990) 20 local social workers and community workers were interviewed about their views of the DEW service. All knew what the DEW Team was. 15 stated that they had never had any difficulty in contacting the Team, although 3 sometimes had difficulty in contacting specific DEW Team workers. 85% thought that their clients had a good relationship with the Team: and 90% felt that they themselves had a good relationship with the Team. 90% also identified that they felt the DEW Team had a positive effect on their own professional activities.

"My clients always speak very warmly about DEW staff and about how approachable they are. They appreciate that the staff seem to care. They appreciate that staff go and visit them if they don't turn up at groups."

One reported a poor client/DEW Team relationship:

"The patient was very angry. He felt he was badly treated by the psychiatrist. He was black. He was told he was mad and therefore didn't know what he was saying."

90% felt that they themselves also had a good relationship with the DEW Team and 90% felt that the DEW Team had a positive effect on their own professional activities.

"It's easy to co-work with them. We've stripped away stereotyped expectations of each other."

"It makes it much easier. I've got a referral point. Back-up, advice, supervision. Any difficulty with a mental patient and I can get them to visit."

15 of the 20 social workers interviewed thought that the DEW Team gave the best individual care possible in the circumstances. 2 said it was not helpful. Several felt that the DEW Team were restricted by a lack of resources and one felt that there were not enough black workers, particularly doctors. 8 social workers welcomed the Team's efforts to realise the principles of community care:

"I like best their willingness to liaise with us. They get away from the medical model and get involved in the social aspects of mental illness."

5) Local General Practitioners

The Team members made a particular effort to involve local GPs in their initial plans and to keep them closely informed of developments. Some GPs took a keen interest and developed close personal links with the team, regularly referring clients. Others did not use the team at all. A survey of GPs satisfaction with the DEW service carried out in 1988 showed that GPs use of the service varied and all those who referred were very happy with what the DEW Team could provide for clients. However, it was found that some did not have a clear conception of the value of multi-disciplinary assessment and preferred to refer cases only to the psychiatrists on the team. The survey was therefore additionally used to further

inform GPs about the DEW service, the referral system and the kinds of problems that they could best deal with.

MacDonald & Ochera (1990) also interviewed 28 GPs as part of their DEW service user satisfaction survey. 57% said that in general it was not difficult to contact the service in office hours. The majority were positive about their client's relationships with DEW Team staff. Just one was completely negative and consistently critical of the Team, saying:

"They're totally unhelpful, hopeless and unresponsive."

13 said the DEW service was supportive, reducing the GPs workload and stress of the job. 8 thought that the DEW Team provided a more appropriate service for the mentally ill than they could and 4 that it was somewhere for them to turn to in a crisis with a mentally ill client. Lack of knowledge about the Team's work was fairly widespread:

"I'm not sure of the scope of what they do. If I knew what they did I might be able to use them more."

4 GPs liked best that the DEW service's location meant that the Team were in touch with local conditions and the client's living environment. Several mentioned that they would like to learn more from the DEW Team and others suggested that they should help more with psychiatric emergencies and crises and should respond more quickly.

Features of the Team Building Process

Several key features of the team personnel were drawn out from the interviews, which contributed to the initial successful establishment of the DEW CMHT:

1) RECRUITMENT AND TRAINING

The DEW Team innovators were already trained and skilled before embarking on their innovative activity. The Team initiator essentially collected about her people that she knew she could work with and who shared her ideological convictions. The core team was formed from a group of individuals who were prepared to act independently of their

professional departments. They disengaged themselves gradually from the institution and manufactured their own organisational space, to replicate on a bigger scale community work that they had already begun individually in a small way. Together they operated in the "twilight world" described by Banting (1979), between the professional academic and political worlds. The three initial members of the team were all closely involved in choosing the remaining team members.

2) SENIORITY

Several team members commented at interview that it was important that all the staff were senior people, with confidence in their clinical training. It promoted a dynamic working environment. Also, each held a senior position within their own professional departments at Springfield Hospital, and could thereby influence the spread of information and the promotion of policies via this route. It was also considered by team members themselves, that it was an advantage that the team leader was Medical Administrator at Springfield Hospital, for it meant that the team was at the centre of discussions about planning and the team leader had access to some important administrative information.

3) STABILITY

Everyone on the core team was female and it was commented that they all had a certain kind of lifestyle in common, meaning that they were much less likely to move out of the area and change jobs. Senior registrars and registrars came and went on rotation but the core team remained incredibly stable.

"As a core team DEW works very well and there is a good atmosphere".

This was the representative view of most of the team members interviewed.

4) DEVELOPMENT OUT OF HOSPITAL SERVICE

The majority of staff (with the exception of the Clinical Psychologist and Social Worker) came from the Springfield Hospital service. They knew many of the clients, they knew the geographical area and had already had dealings with local

voluntary groups and Social Services. This was considered an advantage by most of those interviewed. For example, one of the Battersea consultants who had been working in Battersea for many years, referred many clients to the DEW Team at its inception. He saw it as a very useful resource that took some of the workload away from him and thereby did something to relieve his work pressure. He was well versed with the high morbidity of the area and had experienced the extremely heavy workload that resulted, so he saw the DEW Team as offering an opportunity to address quality of life issues for staff, in reducing the strain experienced by the over-stretched hospital based services.

5) MULTI-DISCIPLINARY WORKING

All the team members interviewed commented that the multi-disciplinary aspect of the DEW Team was one of the most rewarding features of the set up. One team member said:

"A major pro of the team is the community team spirit and camaraderie. In other teams, people remain too loyal to their own disciplines and this creates communication problems and duplication of work, with things put off until the team meetings. At DEW, discussions take place in a variety of settings and people really share things".

A management member commented that the DEW Team encouraged the development of multi-disciplinary team work in other areas of the mental health unit by presenting a strong, unified image. She added

"It has also made it apparent that although multi-disciplinary teams often like to think they are leaderless and there is true democracy, there always has to be a leader and if the team leader is weak, the team is weak".

There were some areas of multi-disciplinary working for which the DEW Team staff were criticised during interviews. One team member felt that the team had fallen down on the training function with regard to multi-disciplinary working. She felt that they ought to have been more structured in including students as part of the team. She felt that working on the team was a unique experience and it should have been proselytised to junior staff. The senior registrar and registrars on the team felt that they had a recognisably

different position from other team members. They recognised the camaraderie that existed within the team, but one interviewee commented that as a senior registrar he felt "peripheral to all that". The official policy of the team was that the Senior registrar and registrar were not part of the core team and so did not take part in team support meetings. This was seen as a disadvantage.

6) CULTURAL ISSUE

The CPN was a permanent black worker on the team and there was a black Clinical Assistant initially. Several team members commented that this was a tremendous advantage. However, interviewees stated that the issue of the need for more black workers was not addressed. Several felt also that there was a general lack of training of others on the team in how to deal with cultural issues and work with black people. Problems were dumped on the CPN and not shared by the team. It was felt that this was a general problem across the board in service provision, but Social Services tended to be better than teams like the DEW Team which were Health Service led. However, the fact that the Team had some black workers was considered a significant and positive feature of its development.

7) LOCAL CLIMATE

An immense advantage for the DEW Team was that other Battersea services welcomed the new team for the long term mentally ill. The general climate was very receptive, as previously services had been poor. Suddenly there was a new service that was bending over backwards to deal with the most difficult clients, while also consulting local organisations about their needs and making definite observable attempts to address relevant issues. For example, a DEW Team representative attended the housing forum and link-persons were set up with organisations such as the Family Centre on the estate and the team members also fostered less traditional links with institutions such as the local library. The ability of the DEW Team staff team to initially exploit receptive local feelings and to develop new service networks in this way was vital to their development.

DISCUSSION

Reflection on the team building process now provides part of the basis for analysing further the dynamics of learning and change in establishing a CMHT in the 1980s. The multi-disciplinary features of the team are particularly relevant to our earlier discussions of the source of innovation in service provision and the possible operation of an elitist policy. By extrapolation from this analysis, approaches to planning, management and staff participation required for effective service development can be identified in more detail.

Division of labour in mental health is such that client treatment entails drawing on skills of different practitioners, each organised in their professional specialisms claiming some right to control their own work. The literature discussed in chapter two, suggested that multi-disciplinary teams are needed where different professions recognise the interdependence of their respective roles in providing care to a particular set of clients and where participatory ways of working are established to ensure various contributions are appropriately mobilised and to encourage maximum commitment to realise objectives shared by the team. It was claimed that teams also need sufficient autonomy for staff to use their knowledge and initiative in responding to problems which arise and to establish collaborative ways of working with other services (Woof & Goldberg 1988).

The DEW Team example suggests that it is possible to establish such a multi-disciplinary way of working and this factor in itself contributed to the maintenance of the DEW Team as a cohesive group of service providers. It is interesting to note the features that made the success of the multi-disciplinary approach possible. The staff team were all committed individually to community working and to working together to achieve their jointly agreed aims. They were all highly motivated and respected each other's clinical abilities. They also shared a positive outlook. Other studies have shown that

this element is frequently lacking in team development. For example, Towell (1981) encountered a pessimistic climate in which staff were more aware of the constraints than the possibilities and opportunities. Examples can be seen in the DEW Team experience, where the Team were united in ideology and optimistic about their role.

Towell (1981) also noted from his evaluative study that there were several problems with a uni-disciplinary style of working. He observed different professions dealing with common problems in isolation or passing issues up the organisation, rather than confronting them on the spot. He also found that each individual could feel that a large institution would diffuse or nullify his or her personal efforts to make things better. The DEW Team case study shows that community care organised on a truly multi-professional basis appears to address some of these failings of the old institutional system. It is important here to describe what is meant by true multi-disciplinary working. The interview evidence suggested that it goes far beyond the realm of different professionals working together. In addition it embodies much which reflects a sense of collective worth. Collective action through shared concerns, set against the initial indifference and mistrust of the wider community of service providers gave the DEW Team a sense of the reaffirmation of the value of joint human experience and hence intrinsic worth. Key features of multi-disciplinary working will be further explored in the following chapter.

It was noted in the previous chapter that the main initiator of the DEW CMHT innovation was the consultant psychiatrist. However, the description of the development of the staff team in this chapter shows that other professionals also had a strong influence, particularly the occupational therapist. She had been trying to establish her own community mental health ideology for several years. For example, she had set up community groups and had separated herself almost entirely from in-patient work in the hospital. She was doing her own version of community care quietly on her own, without tackling

the establishment with a formal proposal for policy change. She had a strong personality and strong views, but as an occupational therapist was not in a position to instigate an innovation like the DEW Team. This further supports notions that psychiatrists formed an elite amongst mental health service providers in the 1980s, both in the hospitals and in the community. Other professionals simply did not have a countervailing ideology. The occupational therapist was doing innovative work in the community but this was not formally recognised by the management. An occupational therapist would never have had the power to innovate by forming a CMHT. However, interviews with the DEW Team OT also showed that she would not have wanted the political and administrative responsibility of setting up the team alone. She was interested in working with clients and not so much in taking management initiatives. It was a good partnership for her that the psychiatrist performed these tasks which were more distant from hands on work with clients.

However, the personality of the individual psychiatrist in the DEW Team example was also an important factor in the initiation of innovation and the implementation task that followed. There were other consultant psychiatrists working in Battersea who were well aware of the problems in service provision to the long term mentally ill group. For example, another Battersea consultant had worked in the area longer than the DEW Team consultant, knew all the clients and was very pleased that the DEW Team was developed as it eased his workload, but he would never have instigated it himself. He was nearing retirement and did not have the same academic interest and drive for change or the desire to make a name for himself.

The proposition about the elitist power of the psychiatric profession appears to be weakened. It is not as monolithic as Ramon (1988) suggests. The fact that the chief catalyst came from the psychiatric profession is important, but it is also significant that she had a strong personality, personal ambition, a commitment to exploring new ideologies of the CMHT

approach, and was already in a position of power as hospital administrator. Also she had a keen awareness of the practical problems that she would face, being familiar with the barriers traditionally expounded against change within the hospital system and an ability to constantly bargain for new solutions to these problems.

In Brief

The aim of this chapter was to extract from a detailed description of the development of the DEW staff team, factors that helped its implementation and defined it as a cohesive team. Features of the team building process that characterised the development of the case study CMHT were noted to lie in recruitment and training practices, seniority of staff, stability of the team personnel, development out of the hospital service, the establishment of true multi-disciplinary working and the receptiveness of the local climate. It was found that the psychiatrist was the most powerful actor in the DEW CMHT development, but other professionals had an important role and the elitist practices of the psychiatric profession were not found to be as monolithic at the local level as implied by the earlier case study evidence. The paramount importance of the personalities of the actors involved and their joint ambition to make the CMHT project succeed in a multi-disciplinary framework was noted. The next chapter will now explore how the team defined their activities.

1. Shadow Edward Wilson House Team Briefing For Staff, 10th March 1986.

2. Wandsworth Health Authority Circular: Staffing Proposals, November 1984.

CHAPTER 8:

Implementing a Community Mental Health Team: Service Style Development

This chapter aims to be primarily descriptive and to concentrate on the second theme identified by interviewees, that of service style development. What kind of service did the DEW Team provide? How was the team's operational remit defined and what were the key elements of the operational policy that was initially developed? How was this translated into practice and how did the users of the service respond to it? An account is given of the operational policy and team style that was developed, detailing clinical achievements during the first year of working. A brief discussion is presented at the end of the chapter.

Developing an Operational Policy

When the Team began work, they had no operational policy. They had an administrative policy¹, but it did not say anything about clinical care. They were given a brief to serve a population area of 68 000 across the Battersea catchment areas and were operating as a supernumerary team to the existing psychiatric services described in chapter five. The area included North and South Battersea and small areas of Balham and Wandsworth. This incorporated the catchment areas of three consultant psychiatrists, one of whom was the DEW Team consultant. At this time the team did not have any specific definition of their desired client population, but had set up with the broad intention to particularly concentrate on the problems of "revolving door" patients (and in practice the spectrum of long term mentally ill clients). Decisions about which clients came into this client group were made on a basis of personal knowledge of clients. Many of the long term mentally ill clients were already well known to the team from their work in the hospital service and were clients with whom the health services were having difficulty.

During 1986 an operational policy was written by the team psychologist and clinical assistant². The need for the writing

of the policy became apparent to the Team once all the staff had been appointed and they started extending their educational work with other mental health workers in the area. Also, it was not until then that they had the manpower to spare the time to develop the policy. The new policy stressed the DEW Team's intention to prioritise work with long term mentally ill clients and detailed aims in service development and clinical functions, and specific referral policies. Emphasis was placed on working closely with hospital departments and local community agencies, to promote a coordinated network of support services.

The DEW Team were keen for their work to be based on an assessment of local need and saw themselves as having an educational and support function to other service providers, clients and carers, investigating and improving quality of care. The multi-disciplinary nature of the DEW Team was highlighted and the policy stated that the Team aimed to be accessible and encourage use of community alternatives to hospital services. The referrals accepted were mainly to be second referrals. Initially also, referrals from GPs that were not strictly suitable were taken on in order to gain a reputation for the team and to allow GPs to adjust to the idea of the existence of a specialist team for the long term mentally ill.

Implementing the Key Elements of the Operational Policy

1) Clinical Service

The DEW Team aimed to develop an efficient procedure for dealing with referrals, case discussion and regular individual client reviews³. The key elements of this included the development of a key worker system, where each client was assigned a particular individual DEW worker who would coordinate their care requirements. Multidisciplinary notes were used to record all dealings with each client: workers from different professions did not have separate notes. Weekly multidisciplinary case-discussions were held when key-workers fed back information to the whole team about the clients on their individual key-worker case-loads and the team discussed

developments with the key-worker and offered advice, support and help where required, about the best way to proceed with a case. There was also an emphasis on improved information collection. Each key-worker was responsible for carrying out a detailed assessment for each new client referred and ensuring that this information was entered in the multi-disciplinary notes, together with data about the subsequent care planning arrangements. Many people interviewed commented that it was an important pillar of their work that the DEW Team specialised in work with the long term mentally ill. One comment was:

"Other teams end up with a never ending case-load and run the risk of attempting to do everything badly. Other teams get snowed under by people with minor complaints who attract a lot of time and attention. Those who can't shout get ignored or shout in a maladaptive way and are rushed into hospital. GPs prefer this as it lightens their workload, but it means largely that the people who should be being served are not".

The DEW Team was perceived by several interviewees as being in a position to do some serious work with people with long-term problems that had not been possible in the past. It was recognised that they had the time to set up community support groups, to work with other agencies and to support clients and staff in the group homes and hostels. Interviewees generally had a fairly clear understanding that very obvious (previously un-met) needs were starting to be addressed by the DEW Team, (although this statement will be qualified in chapter nine). The perception of one management member was that

"The DEW Team showed that you do not just have to work with the acute population in order to obtain job satisfaction. This was a good brick to build on for other teams and supported the management's philosophy of prioritising support to long term clients".

The DEW Team was also seen as having some impact on changing the way that the needs of the local population were perceived. One interviewee recognised that the DEW Team achieved a definite shift in the philosophical basis by which needs were addressed. For the first time, there was more than a purely medical input. Joint identifications of health needs being

related to societal issues was starting to be taken on board, such as the importance of ameliorating the conditions of tenants in poor housing as a crucial part of the DEW service. Another person mentioned that the DEW Team had very good strategies for providing continuity of care to clients and was successful in not allowing clients to slip through the net. Also, there were advantages for clients in that the DEW Team was seen by many as being very accessible, with its advantageous location right in the middle of the patch and its ability to reduce some of the client-staff barriers that traditionally exist in services. One team member commented:

"Stigma is a problem but self esteem is improved by seeing professionals outside in the community. You can pretend you are a family friend and people like this".

2) Duty System

A duty System was established in May 1986. It involved one worker being available each weekday, via a bleep, to answer queries and deal with new referrals, either seeing people within a few days or taking the referral to the weekly team multi-disciplinary team meeting for allocation. A record was kept of work done by the duty person and the results after eleven months showed very varied use of the system. A total of 85 queries were recorded altogether, 8 of which resulted in a visit by the duty person on that day. On 72% of days no queries were recorded⁴. The team felt that the system had been useful both to ensure that someone was available to discuss potential referrals and to help relatives, clients and other agencies find their way around the mental health system. The system could not have coped with too much of a workload for the duty worker but it was found that this was generally not a problem, and it was decided that the system would be reviewed again when the Team became more widely known and the possibility that the duty workload would increase could be assessed.

3) Information Collection

The Team decided early on that it was necessary to improve the collection of clinical data. After the first year, the DEW Team computer had been used to store basic information about

all the DEW Team referrals and Battersea admissions to Springfield since 1981. Copies of all Battersea Springfield Hospital discharge summaries were routinely sent to the DEW Team, and the team continuously collected all data available on local resources.

In 1987, the first DEW Team Annual Report was published. It concentrated on presenting long descriptions of the DEW Team way of working and presenting client data recording; total numbers of clients seen; referral rates (stated as 10-15 per month, with 42% referrals from the hospital service and 33% from GPs); demographic characteristics of clients (66% female and 33% non-white, half aged between 25 and 44); distribution of clients across the area served (Battersea); clinical characteristics; category of intervention offered; diagnosis (over 60% of clients were noted as having long term mental health problems); problems reported by clients; and inpatient data. The ability to provide such data marked an advancement for services in the district.

One management member commented that he thought this aspect of the DEW Team was exemplary. the DEW Team enabled the building of a better historic picture and improved information about demand levels became available, together with data about where the "heavy" areas were. One senior management member commented that he suspected that when the day hospital was first being planned there were very few reliable estimates of such demand levels. It was only in retrospect that it had been realised how such indices could be established.

4) Inter-agency Liaison

The team developed a link person system to liaise with relevant local authorities organisations and establishments. Where possible, appropriate other agencies were involved in joint projects with the DEW Team. These included the Battersea Befriending Scheme. This was set up with Social Services, Wandsworth Volunteer bureau, Wandsworth Association for Mental Health and other voluntary groups. Its aim was to train and support volunteers in befriending people with long-standing

mental health problems who were lonely and socially isolated. The DEW Team was centrally involved in initiating this scheme. Also a Housing Group was established. This was a liaison group with the Housing Department of the Local Authority, initiated by the DEW Team.

A further project was the "North Battersea Network". This was an attempt by a number of local groups including the DEW Team, to improve communications and increase joint working. Projects arising out of this group included a local exhibition of community groups and a training day on "Work and the Mentally Ill" for workers across agencies. Specialisation was perceived to offer the possibility to introduce new types of work that were greatly welcomed. One interviewee commented:

"The fact that they worked with staff too was very positive and on this front they provided a very good service to Battersea as a whole, particularly to the hostels and the housing department. The development and training function was very successful".

5) Community Group Philosophy

It became an explicit, verbally agreed policy of the team that each team member should be involved in the running of a community group. Every team member did this throughout the team's history, except for the junior doctors. In the April 1987 Annual Report, the principles behind the group philosophy were expounded. Priority was given to groups aimed at the needs of the long term mentally ill and their carers, reflecting the team's clinical experience that the needs of these people were poorly provided for. A number of these groups had a social and long term support function, reflecting the finding that for people with long standing mental health problems, loneliness and social isolation were very common reported problems (eg Wing & Morris 1982).

Wherever possible the groups were set up jointly with other organisations/ agencies. The groups were set up in response to perceived needs identified by the team and other relevant agencies in the area and were run in a variety of community settings such as community centres and churches, selected to

be as non-institutionalised as possible. So right from the very beginning the team saw themselves as having an educational and support function. This was high on their list of priorities. The Community Groups are listed in Box 4.

MacDonald & Ochera (1990) reported on users views of community groups related to the DEW Team. The most frequent response from clients was that they had the company of others who were understanding because they had similar problems:

"You talk to people. It's something you achieve. People outside don't understand but the people there have been in the same boat".

Several clients commented that they liked to have something to do in an informal atmosphere:

"It's something to do. It's not structured or disciplined. It's not therapy but more social".

"It's doing something interesting- occupying my mind - meeting people".

Some seemed unsure of what benefit they received or made comments such as:

"It passes the time."

"It's somewhere to go out to. It's the only time I ever go out."

Most of the more negative comments concerned the stigma of associating with mentally ill clients:

"I don't want to mix with mental people. I don't go to any mental places".

"I don't know. It was good. I liked it, but the people there were really sick and I didn't want to mix with them."

GPs and social-workers views of the community groups were also collected. Ten GPs said they did not know what benefits clients derived from groups or what they did there. The others said the main benefits were the social contact and support given to clients, and felt that the groups were more accessible to clients and less stigmatising than hospital groups:

"It's local. They can just pop in. It's not a hospital - there's no stigma".

"They're fantastically supportive. They prevent chronic relapses. If a patient is deteriorating, the group anticipates this. There is much closer control and contact".

Social workers interviewed gave similarly positive feedback about the community groups. It was thought that the groups provided a good way for clients to keep in contact with DEW workers and other professionals. Staff were able to monitor clients and help to avert crises and breakdowns. Five social workers said that participation at the groups gave some structure to the client's lives and four that they were a way of helping clients to integrate with the local community and to break down the stigma attached to mental illness:

"Their network of contacts builds up. They're not isolated. The clients know their health is being monitored in a relaxed way".

"It's a chance to move out of the mentally ill world. There are other groups going on here. They're part of the community."

Several social workers made the point that the groups were not liked by or suitable for all clients:

"They sometimes work well, sometimes not. In one case it was helpful for meeting others with the same problems. They also got information. Two others seemed ideal referrals but they fell apart. We couldn't understand why."

"(One client) was afraid that her affairs would be known all over the estate."

Box 4: DEW Team Community Groups -1987

GROUP	VENUE	LIAISON	ACTIVITY
Garfield Contact Group	Community Centre	Run jointly with Social Services	Social support and group activity for long term mentally ill clients
Black Carers Group	Health Clinic on Housing Estate	Run jointly with Social Services	Information and discussion about mental health issues relating to black people aimed at black people with long term mental health problems and their carers
Autumn Colours	Local Authority Day Centre	Run jointly with Community Elderly Team	Social support and group activity for elderly people with long term mental health problems
Relatives Support Group	Church Hall	Run jointly with Social Services	Information, discussion and support for the relatives of people with long term mental health problems
Sports Group	Leisure Centre	Run in conjunction with ILEA Youth Worker	Sporting activities primarily for young people with long term mental health problems (under 30s)
Out of Bounds Group	Church Hall	Run jointly with Psychology Department	Treatment and support for people with agoraphobia
Mother and Toddler Group	Social Services Family Centre	Run jointly with Social Services	Social support and activities for young mothers with long term mental health problems and their children

GROUP	VENUE	LIAISON	ACTIVITY
Befriending Scheme	Client Homes – Volunteer Training in Social Services venues	Joint project with Volunteer Bureau, Social Services, MIND & Psychology Department	Recruiting, training & supporting volunteers in befriending people with long term mental health problems
Patmore Women's Group	Community Centre	Run Jointly with Social Services	Information, discussion and support for women with long term mental health problems

Users Views on the DEW Service

The User Satisfaction study conducted in 1989 also aimed to find out which aspects of the DEW Team its users found most helpful or unhelpful and unnecessary (MacDonald & Ochera 1990). 110 DEW Team clients were taken from the DEW Team caseload and 103 successfully interviewed. 33 GPs taken from client case notes, were also interviewed together with 23 social workers. There was found to be a high level of satisfaction among clients, GPs and Social Workers and the majority found the team accessible and available when needed. The main reservation was that there was not enough care available, but that the DEW Team gave a good service within the constraints of their resources. Carers were generally less satisfied with the service, less aware of what it offered and how to use it.

About two thirds of clients knew how to contact the DEW Team and had never had any difficulty. Most were satisfied with the quality of communication. The main dissatisfaction was with information about and participation in treatment. Up to a third felt that the psychiatrist, CPN and OT did not give them enough information or encourage their participation in treatment. The prevailing themes of loneliness, isolation, and lack of support, while they may be inherent in the mental health of some clients, were felt not to be approachable without more staff and facilities. Clients also noted a need for more practical support. Lack of information about the service and its aims was reflected in the responses of all groups. A small minority of clients and carers could identify a named key-worker. Several GPs were unable to answer all the questions because they felt they lacked information about the DEW Team and would have liked to have known more. Both GPs and social workers requested more information and desired closer collaboration with DEW Team staff.

About two thirds of GPs knew how to contact the DEW Team and within certain constraints, such as that they would not use the service in an emergency or outside office hours, had experienced no difficulty in reaching a DEW Team worker. About

four fifths of the social workers knew how to contact the Team and had no difficulty. A large proportion of the people referred to the team's accessibility when asked what they liked most about the DEW service. Less than a third of carers (31%) knew how to contact the Team. In general, the users of the DEW service liked and respected the DEW Team staff. There were many references to staff shortages and the fact that staff were sometimes rushed and overworked. Nearly all the staff who had contact with the DEW Team had good relations with them.

A Review of Progress after One Year

In its formative years between 1986 and 1988, there was a lot of discussion about the DEW Team throughout the Mental Health Unit. The team was widely referred to in debates about different forms of service provision and retained a high profile. The DEW Team undoubtedly became the centre of attention for a few years and managers were supportive. They often quoted the practice as a model. Others became fed up with hearing about it. The development of the Team was stated to have played a significant part in formulating later perceptions about good practices in service provision, unit wide. In many ways, the DEW Team was part of a change in thinking and attitudes that was happening anyway, but it was seen as a testing ground for new ideas, new philosophies and the practical corollaries that accompany such change.

One management member said he thought people regarded the DEW Team very well because it was accessible and quick in giving a response. Their very nature of being out of the hospital was felt to mean that the team were more aware of other community facilities and were therefore able to "plug people in" better. The idea that evening classes could operate as an alternative to Day Hospital admission was very appealing. It avoided labelling and disability. It was slowly being realised from the management side, that professionals could be highly effective service initiators if they were given more autonomy and encouraged to make decisions without asking permission from management, but keeping them informed. The DEW Team was

considered to have encouraged professionals who were a bit more far-sighted, to look within their own catchment areas at how teams need to develop and what they can do. It had shown what it was possible to do and also highlighted the pitfalls.

A major section of the DEW Team 1987 Annual Report was devoted to future developments and longer term objectives of the service. The forthcoming opening of the day hospital in four years time was emphasized and various suggestions were made as to the planning that needed to be carried out in the mean time. At this stage the team still saw itself as developing a bridge to the opening of the day hospital and its objectives for the subsequent year related to further development of its research and evaluation components, liaison and training functions and ideas about the extension of the service.

Features of the Service Style Development Process

The DEW Team became a unique innovation in service provision in Battersea at the time for reasons that were intimately linked with its origins as a professionally defined initiative:

1) DISCRETION and AUTONOMY

The DEW Team were given considerable discretion and autonomy in the design and practice of their own work. Its ideology was initially established almost without any policy restrictions from management, political bodies or professional departments. The staff team were given a free rein in decision making regarding operational policy. the DEW Team introduced new forms of care based on community support, embracing practices of home visiting, community groups, liaison with families and networking in local community agencies. These forms of service delivery were loosely based on the CMHT model described in chapter two, but aside from broad ideological notions defined in the literature, the service was designed purely on the basis of professionally defined need.

2) DISTINCTIVE STYLE

The DEW Team style of working was very different from other

services, partly because it was the first community mental health service in Wandsworth to target the long term mentally ill population. Also, released from the strictures of comprehensive catchment area work, it had supernumerary status and hence was better able to respond to the individual needs of both the clients themselves and other service providers in the area. Whether or not the other actors affected by the development in the local area fully understood its role, they did perceive that the Team was offering something new and a style that was more personal and more indulgent than services that had existed previously. The extra time available to the team members also enabled them to establish new organisational patterns. They were able to develop an information system and establish multi-disciplinary case notes. They were able to account for their existence by preparing detailed annual reports and feeding back data to the Mental Health Unit and other local providers.

DISCUSSION

This chapter aimed to consider what kind of service the DEW Team provided and to establish the key elements of the operational policy that they developed. In this way, its function has been primarily descriptive and analysis is restricted to evaluating the extent to which the DEW Team's service style met with the broad constituents of CMHTs identified in chapter two and assessing the initial impact that the DEW Team had in changing service delivery patterns in the case study area⁵.

Returning to the service problems identified in chapter five, the pattern of community care service provision in Battersea, prior to the existence of the DEW Team, essentially constituted a skeleton psychiatric emergency service, with CPNs and the out-patient clinics forming the only means of client follow-up. With the setting up of the DEW Team, this pattern began to change. The DEW Team provided a specialist service that to some extent complimented services already in place and particularly addressed the problems of "revolving

door" long term mentally ill clients. The literature reviewed in chapter two identified a national need to concentrate more fully on how to ensure that long term mentally ill clients receive adequate services and to improve knowledge about models of practice within which such an ambition can be achieved. The DEW Team appeared to be addressing this need at the local level⁶. Their operational policy put into practice their commitment to prioritise the long term mentally ill group, proposing a defined range of options for staff to draw on when developing packages of care.

The DEW Team engaged in an active programme of service development. The key to this seems to have been that they began with a strong philosophical commitment to development and were granted the extra resources necessary to give life to this philosophy. Targeting the long term mentally ill group was a politically popular solution at the time. Other service providers generally noticed the reduction of strain on their own workloads that resulted and perceived that the DEW Team were doing something new in care provision for the long term mentally ill group.

The DEW Team operational policy fulfilled some of the typical values of a CMHT service identified in the literature presented in chapter two. Their service was undeniably local, accessible, reduced stigma to some degree and encouraged coordination between the Health Service, Social Services, GPs and other relevant local provider agencies. Their high profile served to change some of the myths about the difficulties of providing a community based service. For example, they showed that multi-disciplinary working between professionals from different disciplines was possible and indeed rewarding for both staff, clients and other professionals with whom they dealt. Key features of the DEW Team's multi-disciplinary style included their very high community profile, their commitment to work with a client indefinitely, the strong advocacy role that they adopted in working alongside rather than opposite clients and the sense that no job was "beneath their skills". The DEW Team also challenged administrative structures that

had previously proved problematic (This adds to the definition of true multi-disciplinary working developed in chapter seven). They developed a new information system and introduced multi-disciplinary client notes. The DEW Team had also gone some way towards challenging traditional treatment approaches, especially for the long term mentally ill clients. Their treatment philosophy emphasised the importance of social and environmental influences on client well-being and concentrated resources on providing on-going support and maintenance. The community groups were particularly well received by service users and as a team, the DEW Team presented a cohesive team identity and were well respected in the local community.

However, there was room for improvement, particularly concerning the empowerment of service users. The user group most dissatisfied with their service was the carers. Many service users, including other professionals, felt there was a need for improved information about the services that the DEW team could offer. Several also stressed the resource constraints under which the team worked and the fact that they often seemed rushed and short staffed. The DEW Team did not initiate any programmes run by clients or involve clients in planning and decision making in any capacity. They did not attempt to empower clients through the creation or direct involvement in sheltered work schemes and were unsuccessful in aiding many clients to enter open employment. Also, they offered little in the way of crisis intervention and missed a valuable opportunity by conceding to only operate in 9-5 hours on week days. The use of an "out of hours" answering machine was promoted by the team to forestall this criticism, but it could be surmised that with knowledge of this scheme, clients would merely have turned elsewhere for help or tried to deal with problems alone. The DEW Team's assertion that this was all that was needed could be questioned. The resultant impact of such pressures in sustaining the DEW service development will be described in the following two chapters.

In Brief

The key elements of the DEW Team operational policy were providing a multi-disciplinary clinical service, a duty system, an information and monitoring system, inter-agency liaison and client community support groups. The distinctive style of service that developed was defined by the professionals themselves, under conditions of high discretion and autonomy. The DEW Team was perceived to be distinctly different from what had existed in service provision previously as the team aimed to specialise in providing services to the long term mentally ill and to explore methods through which this aim could be achieved. They operated within a defined range of care options. The following chapter will now explore some of the barriers to implementation that were faced by the team in their early years.

1. Brief Outline of DEW, issued October 1986.
2. Doddington Edward Wilson Mental Health Team Operational Policy (Draft), February 1987.
3. DEW Annual Report 1986/87, circulated in April 1987.
4. DEW Annual Report 1986/87, circulated in April 1987.
5. The features of service provision will be reassessed in chapter eleven when the specialist DEW style of service will be compared empirically with the traditional service style that existed previously.
6. Empirical evidence to test the DEW Team's success in prioritising the long term mentally ill will be presented in Chapter Twelve.

CHAPTER 9:

Implementing A Community Mental Health Team: Barriers to Implementation

This history presented of the DEW CMHT has so far covered the positive aspects of team and policy development. Chapter six described barriers that were faced in setting up the team and in making a reality of the original innovative proposals. This chapter aims to explore further problems that were faced in the implementation stage. What were the constraints experienced in gaining resources and establishing territory? What impact did they have on the development of the DEW Team and from where did they arise?

As described in chapter four, policy is often discussed in an abstract sense, yet it is the practical problems of implementation that can tell a lot about the priorities within an organisation and the barriers to making innovations work. By again utilising interview and documentary material, this chapter will give an account of the problems that were of most significance to the actors themselves in sustaining the DEW CMHT development. Ways that the DEW Team dealt with criticism will also be described. It will be shown that barriers to implementation are often experienced as the flip side of policies that also have positive features. The constraints described here, range from the practical to the more fundamental, and although some problems described may appear minor at a first reading, hidden within them lie important structural problems that are often faced by policy innovators. These will be drawn out in the discussion section at the end of the chapter.

Practical Implementation Problems

1. Office Space

At its inception, the DEW Team were given use of a filing annexe in the top of the Cottage Day Hospital on the Springfield site, as their office space. Here, they held team meetings on a fortnightly basis, taking most of their referrals from the hospital ward round. However, it

increasingly became obvious that a team base in the community was required. The hospital administration were slow to respond. Finally, an individual administrator took on responsibility for this project. She found a small office space on the side of a health centre, on one of the high morbidity council estates in Battersea and proceeded to push the building work through.

The office was supposed to be ready in February 1986, but the team actually moved in on 1 April 1986. Due to this delay, the Consultant was left with three months extra time without a team in the community. The community staff could not officially be appointed until the office was ready. Resourcefully, she used this spare time to teach herself computing skills which later proved invaluable. However, she and the team to be found the delay extremely annoying and disruptive.

Even when the new office was opened, problems continued. The office consisted of three rooms; one small room for the consultant, a secretary's room and one room for all the remaining team members that was also used as a staff meeting space. At interview, everyone on the team mentioned that it was a valuable objective for the DEW team to be centrally located in the area of highest morbidity in Battersea. However, all team members recognised that there was a problem with the allocated office space being so small. For staff members who did not run out-patient clinics, space to see clients was lacking, when it was inappropriate, inconvenient or obviously dangerous to see them in their own homes. There was an associated safety issue about clients visiting the office base unannounced and there were occasional run-ins with staff in the adjacent health centre baby-clinic on occasions when disturbed clients turned up and created a scene.

The positive aspect of the lack of adequate office space was that it forced the DEW Team to work purely in an outreach style. Many commented that it also united the workers and provided good conditions for multi-disciplinary working. One

interviewee commented:

"I believe that the team office base is of tremendous importance as every team should be together. Communication is good as people are always around at the base and it gets around trying to find people in the hospital grounds, with loads of failed phone calls or having to write letters".

2. Secretarial Staff

The team had no secretarial staff until the office base on the Doddington Estate opened. The team were given extra funding for a half time secretary. The consultant combined this post with the funding for her personal half-time secretary at Springfield Hospital (a move that she later regretted as it cut her off from all secretarial support at Springfield Hospital). At this time a secretary was appointed, but she left to have a baby. Therefore, the post became vacant and despite constant advertising, was not filled for another eighteen months because it was funded at a low grade. Hence, the team had a series of temporary secretaries, which proved to be a very serious problem.

"Due to the nature of the outreach work with highly vulnerable patients, in conditions where staff were always very busy and working to full capacity, the role of such a person carried a high degree of responsibility and organisational ability as well as a veritable list of personal qualities."

From May 1988 to the end of July 1988 a long series of letters were sent by the consultant to the Unit General Manager bemoaning the situation of trying to run an effective community team with many months of changing and unsatisfactory secretarial/receptionist cover at the DEW Team base¹. The correspondence began when the consultant returned to work after a period of sickness partly caused by work pressures, and at this time she recognised that a significant contributory factor to her difficulties was the perpetual turnover of temporary office staff and the lack of a regular visual display unit in-putter to keep the computer up to date.

The consultant put forward a proposal which would in her

belief provide a way of keeping the office going without a regular experienced receptionist. It included a common telephone system between the DEW Team and the other Battersea mental health services, an ansa-phone and "fax" machines and a regular visual display unit in-putter for one half day per week. She suggested that the funds for such equipment might be obtained from a small vacancy factor in the DEW CMHT budget, represented by the two clinical assistant sessions not used by the current person in post.

The result of this correspondence was that the office did not receive any new equipment, but by mid-July the personnel department had advertised an up-graded Office Manager post. It was then possible to employ someone, so from 1988 the team had a full-time secretarial post in the community. The secretarial problem had lead to a revised proposed response, which in turn resulted in a compromise solution. It was felt by many at interview that the DEW Team had demonstrated the importance of having strong secretarial support.

Conflicts with External Interests

1) Hospital Services

The DEW staff were aware that they would have to make a case for their existence, separate from the hospital, but they did not find this easy to do. The first real signs of conflict came from the Springfield Hospital ward staff, when the DEW Team requested that they should come to do a secondment in the community, working as part of the DEW Team. This never happened, partly as a result of ward staff shortages but also because of resistance to the idea. There was an element of professional jealousy. Community workers were seen to have an easy time "swanning about around town", and teamwork was perceived to result in demarkation and role loss.

In July 1987, the ward staff and other Battersea CPNs stated that they did not know when and why the DEW Team worked with one client and not another. This occurred after a period when the team felt they had spent considerable time and effort explaining things to them and operating a very sensitive

liaison function. The DEW Team consultant was very upset. She said:

"I knew there would be splitting difficulties with the hospital and thought the team had done everything possible to stop it happening. For instance, it was always ensured that a DEW team member attended all ward rounds including those at the Cottage Day Hospital. But it was impossible to prevent such conflicts. All one could do was know when they were coming and be prepared to work on them, which is what the DEW team had to do".

When the issue came to a head, the consultant was told by management that she was demoralising staff and wasting valuable resources by offering an expensive service and the money would be better spent elsewhere. The importance of power relations became very obvious. The DEW Team consultant gave up her post as Medical Administrator in February 1986, resigning six months before the end of her official term of office. She stated that the reason for this was that she wanted to have an active part in the development of the DEW CMHT. However, she felt that had she still been Medical Administrator, the split with hospital staff would not have been so acute, as the management would not have faced her with such damaging comments.

The team decided to counter the attack and wrote a position paper for discussion, which stated a very clear vision of the difficult issues and the supporting philosophies². Again it was emphasized that the DEW Team was an attempt to work with the mentally ill in a new way and as such it was recognised that it was bound to encounter difficulties with existing services that had their set routines. It attempted to shift the emphasis from therapeutic places to therapeutic people and to reach some clients who were previously given a minimal service, namely, the revolving door "chronics" and the "social chaos" group.

Between February and April 1986 the consultant had spent her time learning how to use the computer. After the split with the hospital, she was able to take them lists of clients who had previously been in-patients and who were now doing well in

the community and she took hospital ward staff out to the community groups to see for themselves. Eventually the ward simmered down and even started to attend a few community Team meetings, which they had never done before.

The splitting problem was with the acute ward staff at the time (Heather Ward), who rightly saw themselves as very overworked and saw community work as the easy option. It is interesting to consider their opinions of the problems. They stated at interview that they were enthusiastic about the DEW Team and would have liked to have been more involved, but they recognised that there was "a bit of a communication problem" and thought this stemmed from the fact that the two services were situated on two different sites. They found it difficult to comment on what the good and bad aspects of the DEW Team were, because they were "too wrapped up on the ward". They claimed that they did not know enough about what the DEW Team actually did and could not accommodate its working pattern.

The ward staff were encouraged to attend the DEW Team weekly multi-disciplinary team meeting, but there were ongoing problems. They found it difficult to go to the meeting as they had the ward to run on a full time basis and had to be around when crises occurred. They constantly found that they were so short staffed that it was very difficult to spare a few staff to travel out to Battersea. Also, they felt that work was often duplicated in the monday ward round and even when they did manage to attend the DEW Team meeting, it was frequently just a matter of repeating the same things.

The DEW Team operated a nine to five service with each member of staff taking it in turns to run a duty system and with an answering machine operating when the office base was shut. The team members themselves perceived this to be a workable tactic and believed that the clients had adapted well to using the service in this form. However, the ward staff felt that it was they who silently suffered the consequences of this system:

"We fill in the gaps. We provide counselling and are always here if any patient needs to come for any reason. It is at the weekends and in the evenings that patients

most need support, particularly the ones who are working. We don't get credited for this work. We are budgeted for providing a service to the patients on the ward: we are not budgeted for giving an out-patient service. It is all extra for us".

The community support groups run by the DEW Team did take place outside office hours, which went some way towards addressing this problem, but several team members commented that this was not enough and constituted an added stress on the over-worked DEW Team staff.

The way that the working patterns had evolved for those in the hospital service working with the team, was also seen to be far from ideal. The problem for the senior registrar was that the remit was not to work full-time on the DEW Team, and consequent difficulties were found with juggling responsibilities. It was felt that the team set its commitments and often these did not fit into the senior registrar time slots. For example, the psychotherapy sessions that took place once a month at the multi-disciplinary team meetings, coincided with a time when the senior registrar found he had to be in a meeting with his other consultant who "shouted louder". The senior registrar's job was an accident in that sense.

The net result of all these "niggles" from acute ward staff was that there always remained some distrust and resentment of the DEW Team throughout their development. However, more success in achieving an innovative service in partnership with hospital staff was experienced in working with staff on Zinnia ward, which was the "homeward bound" ward at this time. The consultant had put a great deal of effort into establishing good links with Zinnia ward. She engineered that the nursing sister and the charge nurse positions on the ward were split positions, so these two staff members spent half their time on the ward and half their time following up people in the community.

There was also a very able charge nurse on Zinnia ward, who together with the consultant, initiated and organised what was

known as the "Zinnia Day Out". This was an arrangement whereby, one day each week, the ward was shut and all clients were taken out of the institution. The stimulating idea was that for many clients there was a high risk that they would become increasingly institutionalised, and rarely leave the hospital. It was decided that if a suitable venue could be found, there was no reason why both the clients and their nurses should not spend a day out of the hospital visiting their home community. The venue chosen was St Saviours Church Hall in Battersea. Generally the "day out" was planned the previous day and in the mornings the clients would go out to the shops and buy themselves some food. Everyone would then meet up and cook a meal together before spending the afternoon doing an individual task that they either wanted or needed to do. Some clients went back to their homes, some went to pay their electricity bills, while others went to the park or went shopping. This venture continued for about two years.

However, it was never an easy venture. Aside from the conceptual shifts required of institutional staff, management and even clients, in adjusting to this new idea, the main problem that constantly emerged was that of resources. Clients were given only thirty pence each per day to spend on their lunch and there was no flexibility to take extra clients. The consultant believed that there were a number of clients who would have benefitted from the day, who never had the chance to go. When relations were good, there was a good rapport between Heather and Zinnia ward, and if it was felt there was some reason that a Heather client should go and a Zinnia client not, then a swap was arranged. However, this did not work so well when relations deteriorated.

The issue of the money made it very difficult to keep the project going. Then the ward charge nurse left and the remainder of the Zinnia ward staff asked to stop the "Zinnia Day Out". The consultant commented that in many ways this was rather disappointing, but "these things always have a life of their own and it is important to let them die naturally so that other things can happen". However, no other such

innovations were instigated with the hospital ward staff throughout the remainder of the study period.

2) Social Service Department

The position paper presented by the DEW Team to smooth relations with the hospital service, argued that the Team was essentially an extension of the service offered by the Health Authority to areas that would ideally be practised by a well staffed Social Services department with abundant mental health skills and immediate access to medical, psychological and OT advice. It was stated that Battersea had long been deficient in such a service. However, in trying to supply it, the DEW Team also roused some distrust and incomprehension in existing hard pressed Social Services employees. They understandably felt that the effectiveness of their service was being impugned. The Team had attempted to nurture links by running groups jointly with other agencies and giving other professionals regular access to DEW Team workers at the point where handover decisions were made such as ward rounds and out patient clinics, but this was not enough. The different cultures of the Health and Social Services again aroused conflict.

During the interviews, further general problems with the DEW Team style of working were highlighted by Social Service Department workers, that demonstrated on-going distrust and criticism of the team. Social Services employees were critical of the DEW Team's referral procedures. One respondent from the Social Services side said that she believed "there is something about the NHS in general that consultants feel very beholden to respond to requests of GPs, over and above others". Another interviewee was also eager to highlight the bias that she could see towards accepting all GP referrals and constantly catering to the demands from GPs as fellow medical professionals. She pointed out that only 47% of those admitted to hospital have a GP involved. She felt that this point was not stressed enough and the DEW Team fell into the same trap. Mental health services often have very little to do with the GP as the first point of contact and it was quoted that only

20% of Springfield Hospital admissions come via a GP. This interviewee also mentioned that for example, in East Lambeth, a neighbouring borough, 40% of the mentally ill population, who are under 35 years of age, turn up by themselves at emergency clinics and 40% come via the police. The DEW Team did not do enough to recognise this and change its referral patterns. Therefore, it was perceived that there were certain areas of the population that they were not picking up quickly enough.

Ideologically, the DEW Team was also stated by one interviewee to be "very medical". She believed that the team model of working was based on the idea that schizophrenia was seen as an illness that required a drug. She stated that she saw the initial need to stabilise clients through the use of drugs, but did not always feel she could go along with this concept concerning certain individuals. She stated:

"I think there is an argument for drug use, but I also think people have a right to say no, with discussion. I believe we must be more imaginative with some people - they may need drug treatment but that is not the end of the story. Very often it is the very practical problems that need to be the centre for attention. DEW continues to reinforce the idea that continuous attention to drugs is the main challenge. They should particularly see neurotics in a much less medical framework".

Social workers working on the DEW Team commented that they felt the other team members did not fully understand their skills and training. They felt that the common understanding was that social workers only sort out money and housing, whereas their perception of the main skills of a social worker was in assessment, family dynamics, family relationships and individual counselling. At interview, there was a suggestion that the reason for the role confusion had historical origins in the way that social work developed as a profession. This conflict between Health and Social Services employees within the team also concerned policies of home visiting. The team policy was that any member of the team could appropriately do a home assessment visit unless a particular professional had been requested. They did discuss at the weekly multi-disciplinary meeting who might be the best member of staff to

go, but often the social workers interviewed believed that the reasoning seemed contrary to the needs of the client. For instance, one social worker questioned the appropriateness of a consultant psychiatrist going round to sort out someone referred with a housing problem. Essentially, professional demarkation was becoming blurred and there was a risk of role loss.

The first social worker who worked on the team stated that she was puzzled by the fact that she was working on the team for one year, but never had a real crisis on her case-load. She felt that this was not because she managed them well, but was more because of the way that different types of clients had been shared out and saw this as an area where there was a lack of clarity in team working. She recognised, for instance that the CPN probably had many crises on her caseload in this period. From a social work point of view, she felt that crises were picked up at other points in the Social Work Department.

The social workers who had worked on the team, felt that there were major problems with being part of Social Services and not the Health Service, which was the case for every other team member. Each organisation formed a distinctive bureaucracy with its own organisational policies and ideological approaches. For instance, the Social Services had a waiting list policy, whereas the Health Service did not. One social worker commented that she felt caught between the two and it was unclear for her whose policies she should be working by. In theory she was working by Social Services policies, but in practice these were unworkable when every other member of the team was working under a different organisational philosophy.

Another example stated was in working with long term mentally ill clients who expressly requested not to be seen by the team. The team had a policy of putting such clients on "Safety Net". This meant that no client was discharged from care unless they remained well for a very prolonged period or their circumstances changed. One social worker stated that by Social Services philosophy, people were seen to have the right to

reject team involvement if they wished. Health Service workers did not respect this right on clinical grounds and she believed this was an area of fundamental disagreement and concern. A further example stated was the issue of client's rights to access their own case-notes. The Social Services policy was that clients had right of access to files, while the Health Service had no such policy. (However, during the period of this case-study, the Health Service policy was in fact changed in this respect and they adopted the same rights for clients.) While it was recognised by the Social Services employees that clients hardly ever asked to see their files, the area office had apparently publicised the right. One social worker commented that she did not know of anyone who had actually asked to see them.

Another area of concern was that of duplication of administrative work. At the outset, the social worker working on the team officially had to duplicate all her work. This was very complicated. She had a workload management system whereby assessments and "one-offs" were filed at the community team, and although they probably did not realise it, clients had the right to see these notes. If the social worker then became the key-worker for a particular client, the notes had to be filed in the Social Work Department, while also being filed as multi-disciplinary notes at the team base. There was also a problem with referral forms, which was another demonstration of the different cultures between the Social Services and the Health Service. Social Services required much more detailed information. One of the most important things on the Social Services forms was whether or not the client was aware of the referral. In 1990, the DEW Team recognised this as a problem, but it took a long time and was certainly a difficulty for the social worker who was first working for the Team.

3) The Rehabilitation Team

In 1986, following a visit to Springfield Hospital by the Health Advisory Service (HAS)³, both the hospital and community services for long term mentally ill clients were criticised for being inadequate. This precipitated a major

rehabilitation initiative regarding the "old long stay patients" who had previously been living on the long stay hospital wards at Springfield Hospital. The majority of the long stay wards within the hospital were subsequently abolished and Wandsworth Social Services together with local Housing Associations and the hospital Rehabilitation Team developed a series of "Group Homes" across the Wandsworth Borough into which the long stay patients were gradually rehoused. The Rehabilitation Team offered a specialist service to support these new community clients in their new homes.

An interviewee from the hospital based Rehabilitation Team stated that she had a major qualm about how the DEW Team's specialisation with the long term mentally ill fitted in with this rehabilitation service. She felt it was unhelpful to draw distinctions between the hospital and the community. The Rehabilitation Team resettled hospital inpatients in the community and continued supporting them, while the DEW Team was also there, supporting a similar client population, but having nothing to do with the hospital based Rehabilitation Team or clients who were living in group homes. The respondent would have liked to have seen more of a blurring between the Rehabilitation Services and the DEW Team and stated that the Rehabilitation Team viewed the DEW Team as a "funny bit in the middle".

4) Health Service Management

Initially the Mental Health Unit management was very supportive of the DEW Team. Management members interviewed felt that in the implementation of the Team the main conflict that had been experienced concerned resentment from some quarters, because of the apparent amount of resources that were devoted to the Team. This resentment built up over time. One member commented that he saw the DEW Team as a maverick:

"It did things differently from the traditional model which was very powerful and continues to be, although its influence is diminishing. DEW was very significant in changing this, but there has undoubtedly been increasing pressure on that maverick to conform in certain ways."

Management members saw this pressure mainly coming from the necessity for the Mental Health Unit as a whole to be consistent in information systems and in service organisation. The DEW Team was seen as doing something different for a community team and was considered to have offered a good model for a catchment area team. It was fairly unique at its inception, but had become less so over the years. It was thought by the management side that as a model it would have a useful application in other inner-city areas, but they were not sure it could continue to be supported in Battersea in times of severe financial restriction.

5) Other Community Agencies

In general, the DEW Team links with community agencies were considered to be very good. However, there were inevitably some problems. Liaison with community agencies was felt not to be clear enough, and several people from the management side and from other local agencies questioned whether the Team's profile was high enough. The DEW Team was felt by workers in other local community agencies not to have convinced political bodies about the levels of service demands from the long term mentally ill population and the required response to that.

6) The Local Authority

When asked about decision making processes in community mental health, a management representative described a lengthy process involving discussions throughout the unit involving the catchment area teams, colleagues at ward level, community and Local Authority. But both in the evolution of the DEW service and in general across services, it was recognised that the role and involvement of the Local Authority remained unclear and their only real role was in terms of financial allocation. The interviewee commented that in Wandsworth there were pretty good links with the local authority, yet the Health Service were dealing with the mental health side completely.

Problems of Ideology: Specialisation in Work with the Long Term Mentally Ill

The interview material reported in the previous chapter suggested that on the whole, the DEW Team was well respected for its specialisation in work with the long term mentally ill. However, some people felt that although the Team was specialising in work with the long term mentally ill, they still took on a wide variety of work that did not initially really focus on the long term mentally ill. The team members themselves saw the initial taking on of some inappropriate clients as a necessary strategy to publicise their service. Through this approach they aimed to gradually educate referrers as to which were the more appropriate referrals and at the inception, they did not want to be seen to be refusing work. Yet, this was not a clear policy for some observers.

Several people interviewed, who were not team members, believed that the DEW Team had a problem with their referral policy, about which clients they took on and when. The staff on the DEW Team were extra to the inpatient staff and although this was seen as a good thing because it freed them to choose the areas of work on which they wished to concentrate, it also meant that it was incredibly unclear exactly who they were trying to serve across two and a half Battersea catchment areas. At the same time, other teams were increasingly doing a lot of work with the long term mentally ill client group as in-patients and as new community residents in group homes. For instance, one of the Battersea consultants said he used the DEW Team to off load his more troublesome clients, while others stayed with his catchment area team because they were well known and liked. This provides an example of how unclear the boundaries were.

Many felt that there were other areas relating to ideology where services tend to fail "across the board", in which the DEW Team was no more successful in finding solutions than anyone else had been in the past. One area mentioned was the danger of not relating effectively enough to the local population on issues such as ethnic minorities. One manager

commented that it was unclear how well the DEW Team responded to black groups and he suspected that the answer was no better than others.

"We need time and a model of intervention that we do not have and we are always caught in providing a priority service. DEW hasn't really contributed anything in this area".

The Team was also seen by some to have evaded some important issues of client care. By promoting their innovative policies, they were accused of ignoring and playing down other yawning gaps in service provision that were essential to providing an appropriate service to the long term mentally ill. For example, one interviewee said:

"People will always break down no matter how much support you give them. There remains a need for respite care, either in hospital or the new day hospital, but alternatives are scarce and DEW has not been able to introduce any strategies that highlight this to the necessary extent, because on one level they were sucked into pretending that this need was not there".

Problems in Service Provision: Gaps in Services Identified by DEW CMHT Staff

The 1987 DEW Annual Report identified serious gaps in the community service the team could offer⁴. There was a lack of work facilities for long term mentally ill clients, ranging from sheltered work places to support for people in open employment. The only permanent placement available at the time was in the Industrial Training Unit at Springfield Hospital. On several occasions, the DEW Team had tried and failed to employ one or two of their clients to do administrative work for the team, but such plans had not been successful. "Red tape" and confidentiality issues were given at interview as the reasons for the failed plans.

There was also a shortage of day places for long term mentally ill clients as at that time the only community facility offering day care was in Putney (4 miles away). The Cottage Day Hospital on the Springfield site only dealt with acute clients and the DEW Team view was that there was a need for placements with more of a long term rehabilitation function. The DEW Team also considered long term supported housing to be

in short supply, particularly for more disabled groups and understood that the Social Services Hostels provided no permanent homes and the supported housing provided by the Wandsworth Association of Mental Health only catered for those who needed low levels of support. This information conflicted with that provided by the hospital Rehabilitation Team member interviewed and serves to again highlight the tension and conflict between these two groups of actors.

The DEW Team recognised that evening and weekend social support for clients was needed. The only such service provided was the Doddington and Rollo Family Centre which ran an evening social group, but many more such groups were needed. The Team felt that they still had a gap in knowledge about the needs of long term mentally ill clients. They needed more information about the community agencies involved with clients and their input. Alcohol services in particular needed to be developed. The Team were aware that improved accessibility and appropriateness of services for ethnic minorities was also needed. Also the issue of transport needed investigation. The Team found that people would often only attend groups if they were taken there at least initially.

Computer skills training was needed for DEW Team staff and they also recognised that they needed to establish a register of all DEW Team referrals for service monitoring purposes. In addition, feedback from referrers about their views of the DEW service was required. With regard to improving liaison with Springfield Hospital, the joint appointment of two nurses each to work half time in hospital and half time in the community was again suggested.

DISCUSSION

The literature presented in chapter four suggested that attitudes to significant social change are characterised by ambivalence, even when supported. Several authors have pointed out that a great awareness is needed of the sometimes unrecognised aspects of tensions and relationships between

individuals and groups (eg Barrett & Fudge 1981). As can be seen, analysis of the DEW Team story supports many of these claims. The implementation problems experienced by the DEW Team have been described, starting with basic resource difficulties involved in trying to secure office space and secretarial staff and moving on to more fundamental misunderstandings of ideology and practice that were expressed by other actors affected by the team in the local area. All of these had an effect on the way that the team developed.

The implementation literature suggests that however strong the thrust behind a new policy, if there is a weak link in any part of the implementation process this can be seriously detrimental to the new policy. Donnison et al (1965) suggested that often it is a very elementary part of the service that constitutes such an implementation barrier. This idea is supported by the DEW Team case study. In the DEW Team example, secretarial cover was the major stumbling block in the initial phase of implementation. It is often a good test of organisational commitment to a project to analyse the limitations on practical resources that are supplied. The lack of adequate secretarial support and office base was a constant frustration for the Team and made it difficult for them to sustain their workload, achieve their aims relating to day to day clinical work and collect information. The secretarial issue caused significant stress in the work environment and the consultant spent a period on sick leave as a result.

More fundamental constraints were experienced by the team through conflicts with existing interests. These arose when the DEW Team attempted to carve out new territory. In Battersea there was a clear Health Service organisational structure and setting up a CMHT was like creating the State of Israel in an Arab world. It is well documented that organisational units do not like to give up resources or be pushed down in the pecking order; individuals in those units will not yield their power or prerogatives easily. What dominates thinking is the personal impact of changes on staff and their units rather than the intended substance of change

(see chapter 4). The main conflicts experienced by the DEW Team were with the hospital ward staff, Rehabilitation Team and Social Services employees working locally in Battersea. It can be seen from the description that although many of their criticisms and complaints had some substance, compared with the positive aspects of the team's work described in the previous chapter, some really concerned issues that any team would have had difficulty dealing with. In many ways, because the DEW Team was heralded as an important new innovative approach, there was pressure for them to solve every problem that had ever ailed mental health service provision. For some people, succeeding in some areas and failing in others was not good enough. Either the team had to get everything right or they were merely demonstrating how the new system could not work.

There were strong elements of professional jealousy involved. The hospital ward staff understandably resented the seemingly bountiful resources that the DEW Team community staff could initially utilise, when they themselves were stuck working in poor conditions. They would have liked a new office; they would have liked to work from nine to five; they would have liked to have received praise from management. However, at the same time, they were nervous about change, having worked in the institution for some time. The existence of the DEW Team did something to break up the "network" of hospital relationships. The hospital was no longer a self contained unit; outsiders would come and go and they had little knowledge of what they were up to. The new team did not appear to be restricted by the hospital organisational authority and the perceived autonomy was resented.

It took time for conflicts to develop. Initially there was anxiety about the new project, but it was only after a year or two that arguments against the team's existence began to really "take root". This is also well documented in the implementation literature. The team benefitted from a "honeymoon" period when they were perceived to be lightening the work-load of others and taking away their most troublesome

clients. However, after a time, it was realised that the team were not accommodating all such clients and arguments about which referrals they took and which they refused began to emerge. Other workers became unclear as to the boundaries of their work and perceived that they were "choosy" in their choice of clients.

Hospital staff and CPNs were unlikely to accept experimental working patterns easily, as the implementation of innovative approaches necessarily implied that the work they were doing could and should be improved. To some extent, the hospital staff had to defend the status quo to sustain a feeling of self worth. The DEW Team also sparked some rivalries between different staff members. For example, the Team developed a better relationship with staff on Zinnia ward than on Heather ward and this perceived favouritism was bound to cause resentment and a break up of the "family" unit in the hospital. As described by Lipsky (1980) service change was reliant on personal relationships between workers and was subject to "human emotion" and some degree of self interest. Several examples of mutual "scape-goating" and defensive rigidity where having someone to blame when things go wrong may become more important than trying to get something right, are illustrated in the DEW Team story.

In addition, the hospital wards did not become less overloaded with work. The team had done little to reduce the stress levels of workers and the hospital ward staff began to realise that the clients who were admitted to the ward were in many ways harder to deal with than before. What may have been happening was that while clients could be contained in the community, they stayed out of hospital where previously they would have been admitted. The ward staff only saw them now when they were in significant relapse. Their jobs were subsequently less rewarding as they rarely saw people through the recovery stages. So there were particular difficulties that they had with the new DEW Team that were connected with the long term mentally ill client group, as well as the usual institutional barriers to change that are cited in the

literature. However, the scenarios described support the literature in suggesting that such attitudes are more entrenched in a bureaucracy like the Health Service, and in a mental hospital.

Criticism of certain of the DEW Team policies were put forward. In particular, the referral system, working pattern and opening hours, response to crises, home visiting and safety net policy all came under attack. More fundamental doubts were expressed in the way that the Team fitted in with other mental health provision such as the hospital, CPN and rehabilitation service. The DEW Team was also criticised for not adequately addressing long running issues in service provision particularly concerning provision for clients from black and ethnic minorities. The Team members themselves identified the lack of complimentary community services to support their service philosophy. Yet, there was never really a political response to any of these issues from the DEW Team.

There were long standing differences between Health and Social Services policies that were never reconciled. Handicaps to joint planning initiatives were described in chapter six and have arisen from important differences between the Health and Local Authorities involved. The DEW Team research suggests that the idea that the government too readily assumes that shared goals and priorities can be arrived at locally is supported. The interviews with Social Services employees in Battersea show that an extensive organisational miss match between authorities is represented in: different structures; links with central government; financial and planning systems; administrative systems; and forms of professional involvement. Problems were also exacerbated by the latent tensions in the network of relationships between agencies and tiers involved in the total psychiatric services, as suggested by Korman & Glennerster (1990). The criticism expressed about the position of the DEW Team in relation to other local services was the most well founded and culminated in an appeal to management to review the team's functioning. The Team's position became increasingly unclear as the "old long stay" were moved out of

Springfield Hospital and the previously marked distinction between hospital and community services began to be more fluid. This had a considerable effect on the future of the team, as will be described in the following chapter.

In Brief

Constraints were experienced in the implementation phase of the DEW Team. These mainly arose in relation to practical constraints in gaining resources and establishing territory, and more fundamental criticisms of their ideology and operational practices highlighted through conflict with existing interests locally, namely hospital ward staff the Rehabilitation Team and Social Services employees. The barriers to implementation that were experienced did not prevent the Team from finding new solutions and battling for their own territory, but they had a considerable impact on the future development of the Team. The literature suggests that the interests of external bodies can eventually overwhelm innovative services. To see whether this was the case in the DEW Team example, the following chapter will relate the next part of the story. Consideration will be given to the lasting impact of the DEW service in retrospect and the likelihood that it would be sustained in future years, when the Battersea Day Hospital was finally built.

1. Letter to Dr Bolton from Dr McLean re:"No Secretary at DEW", 29th October 1987. Letter to Sue Gallagher from Dr McLean re:"Telephone and Receptionist Arrangements at DEW and Other Mental Health Team Offices", 17th May 1988. Letters to Sue Gallagher from Dr McLean re: Secretarial Staff, 27th June 1988, 4th July 1988, 12th July 1988.

2. Development of the Mental Health Service in Battersea, DEW, August 1987.

3. In 1960, the DHSS established a monitoring body entitled The Hospital Advisory Service. In 1976, it was renamed the Hospital Advisory Service and its procedure was to send a team of professionals, managers and Social Service inspectors to hospital and community facilities for the most deprived group of clients on an annual basis to monitor quality and

effectiveness of facilities. The resulting reports were sent to the District Health Authority concerned.

4. DEW Annual Report 1986/87, circulated in April 1987.

CHAPTER 10:

Sustaining a Community Mental Health Team: The Battle for the Future Model of Care

This chapter aims to give an account of the final part of the DEW Team story that will be described in this thesis, covering the period 1988 to 1992. It describes a battle that took place between interested parties in establishing the future model of mental health services on a Battersea wide basis and the subsequent process of redefinition that occurred in the development of the case study CMHT. What factors prompted the need for redefinition? Did compromises have to be reached? What form of service provision resulted? Did the DEW Team professionals succeed in sustaining the CMHT model that they had developed? Did it retain the essence of innovation that had been embraced in the original DEW approach? Which new issues emerged as important for the actors involved? How did the DEW Team fit in to the new local service structure involving the day hospital, which by 1992 was finally almost ready to open, and how did it relate to new central government legislation requiring the implementation of the Care Programme Approach by April 1991?

By considering these questions it is possible to describe the main features of the DEW Team that emerged as its identifying character and lasting impact after six years of development. No attempt will be made to comment on the effectiveness of the approach. Rather the intention is to briefly define the revised CMHT model and differentiate it from the specialist CMHT model that had existed previously. For the purposes of this thesis, it serves as a demonstration that innovative activity in the case study team did not dwindle but instead changed focus as new issues became predominant. The "professional and practice" literature presented in chapter two suggests that such background understanding is a vital step for the future development of good practice. The discussion presented at the end of the chapter further considers the influence of the variety of actors involved, the sustainability and flexibility of the CMHT model and the

degree to which the long term mentally ill remained at the forefront of local service planning.

The Need for Redefinition

In 1988, the DEW Team had officially been established for two years and the conflicts with existing interests at Springfield Hospital described in the previous chapter became extended. The hospital management declared that the DEW Team would have to redefine their role and activities. Five factors were stated to have stimulated this intervention:

1) A MOVE TO A CATCHMENT AREA PATTERN OF SERVICE PROVISION WITH ACCOMPANYING RESOURCE CONSTRAINT

Firstly, the character and established working pattern of the DEW Team as a specialist service operating across the Battersea catchment areas was questioned by the management. They decided that the DEW Team specialist model of care did not fit in with a planned change to a catchment area pattern of services¹ and questioned the extra resources that a specialist team would require in a catchment area model. A management representative stated that it was not that they did not see a place for a specialist mental health team for the long term mentally ill, but budgets were tightening and there was simply no money for it. The management proposed a blueprint strategy with a ten year perspective². The majority of Springfield staff were to be deployed in community work and only a minority involved in inpatient care. In such a model it was suggested that it would be possible for staff of all disciplines to rotate between community and inpatient work and shift the balance from its heavy bias towards inpatient care. It was envisaged that this would necessitate developing catchment area provision in Battersea and the possibility of a second CMHT was being discussed.

2) LOCAL MEDICAL INTERESTS AND PERSONNEL CHANGES

Secondly, predictions were being made about when the three consultant psychiatrists in Battersea might retire, as two were approaching retirement age at this time. St James Hospital was to be closed at the end of August 1988 and a re-

distribution of consultant psychiatric sessions was needed. In addition, a new consultant psychiatrist was appointed to work in Battersea in February 1988³. The service structure had to change to accommodate these actual and predicted personnel changes. One of the consultant posts that would be left vacant as a result of the forthcoming changes was part time and the DEW Team consultant was given the opportunity to take up this position. She did not want to move to another job, as many other consultants often did at her career stage, and so decided to accept this part time post. Such a move by the consultant had implications for the DEW Team as a whole.

3) RATIONALISATION

Management also wished to reorganise the catchment areas in line with social services boundaries to rationalise the populations covered. The Battersea community mental health services had not developed in a logical coherent fashion and it was felt that any reorganisation should necessarily be planned to overcome the mismatches in service provision that existed.

4) STAFFING

Fourthly, it was felt that the high calibre of staff on the DEW Team might decline with well earned promotions and natural movement.

5) JOINT WORKING

Lastly, the extent to which the strategic planning team, through its relevant locality sub-group was succeeding in setting up genuine joint community care with Social Services was questioned.

Conflict in the Process of Redefinition

The proposed redefinition of the DEW Team and reorganisation of services on a Battersea wide basis sparked off a further phase of conflict. It was a time when many hackles were raised and all professionals with a vested interest in the future pattern of services in Battersea were trying to assert their position. From the DEW Team's point of view, the worry was

that in the financial climate at the time, the DEW Team was perceived by some to be a luxury as on a catchment area distribution of resources, it received an unfairly large allocation. If the arguments about reorganisation were to be resolved on a strictly "fair" distribution of resources between the different catchment areas, the DEW Team would have to be dismembered. The DEW Team were very concerned about the proposed change and wanted to have an input into discussions about their fate. They were particularly concerned about the emphasis that they had been able to place on providing a specialist service to the long term mentally ill and felt that services to this client group could be eroded if the service was reorganised. The psychologist on the DEW Team, therefore, prepared a paper suggesting alternative models for dealing with the long term mentally ill group in Battersea⁴. She envisaged two main possible scenarios.

The first model would be to split the Battersea mental health service into three catchment teams, responsible for all the clients in their catchment including the long term mentally ill. It was pointed out that it would probably be more efficient to have two teams in the long run, coinciding as much as possible with catchment area boundaries. However, the problem with this scheme was in maintaining sufficient input to the long term mentally ill, as it was felt that the pressure of acute needs would overwhelm the catchment teams. It was also thought that such a model implied duplication of specialist resources for dealing with long term mentally ill clients as each team would have to develop their own. A second possible model was to have two or three catchment area teams plus one specialist "Continuing Care" team with input to the whole of Battersea. This would ensure input to long term mentally ill clients, spread resources and enable the formation of a Battersea-wide network without duplication of specialist links and resources devoted to long term mentally ill clients. It was felt by the DEW Team that the first proposed model of catchment area teams would only work well if the population of people with long term mental health problems was small, but since the long term mentally ill population in

Battersea was large, specialist input was thought to be needed.

Letters and draft documents were sent back and forth and over a three month period, many proposals were put forward in negotiating new staffing and responsibility in the proposed catchment area structure. The main body of correspondence was between the consultant psychiatrists in the area, with some input from the District Division of Psychiatry Executive Committee⁵. Complaints were also voiced from the department heads of Social Work⁶ and Occupational Therapy⁷ stating that they felt they had not been adequately considered in the reorganisation period. The DEW Team independently wrote a joint letter to the management expressing their concerns⁸. At the same time, the DEW Team consultant wrote to "Good Practices in Mental Health" (GPMH) requesting their support to prevent the dismemberment of the DEW Team⁹. This support was received and GPMH wrote to the hospital senior managers as asked¹⁰. GPMH also publicised the DEW Team's work as one model of good practice in their CMHT information pack.

These developments fit in with the Arab/Israeli analogy referred to in earlier chapters as the time of the "Seven Day War". For a short time, the conflicts with external interests caused the whole service structure to be thrown into confusion and different interest groups began fighting for their own perceived solution to be accepted. The long term consequences for the "surrounding nations" of the possible new models that were being proposed was being considered.

The Resolution

At the beginning of June 1988, a final decision was made. The DEW Team was seen as inconsistent, working in its supernumerary form and could no longer be funded to coexist with the other Battersea catchment area teams as a supernumerary service. From 1st October 1988, Battersea would be divided into three catchment area teams. The DEW Team, rather than being dismembered, would become the catchment area team for North Battersea East, and would be expected to

function as the other catchment area teams did, working with both "acute" and long term mentally ill clients. The eventual decisions that were reached were to some extent a compromise between the interested parties. However, interviewees stated that the overwhelming influence came from the District Division of Psychiatrists.

A meeting was convened to consider the implications of the reorganisation for all the Battersea mental health services and to identify and air issues needing detailed consideration, resolution or information sharing to ensure a smooth implementation of the new arrangements. It was attended by representatives from the UGM, Social Services, OT Department, the DEW Team, local Consultant Psychiatrists and a GPMH representative¹¹. At this meeting staffing input to each of the new teams was put forward and decisions made about who would inform other local service providers of the changes, particularly GPs and social workers. The planned transfer of clinical arrangements between consultants was discussed and agreements were reached as to how to transfer responsibilities for existing DEW Team clients to their relevant catchment area. It was agreed that the DEW Team community groups had become part of a Battersea wide service and as such remained open to appropriate clients from all three catchment areas. These groups would no longer rely solely on DEW Team staff for their organisation and functioning, but responsibility would be shared across teams.

Many painful discussions ensued within the DEW Team, who were not happy about the decision that had been reached. Finally they resolved that while accepting their new catchment area role, they would prioritise work with the long term mentally ill, presenting "acute" clients with rather different packages of care. Management accepted this compromise. The tension between carrying out the day to day demands of "acute" work, while giving priority to the long term mentally ill was to be the new DEW Team challenge. For such a small team, they effectively mounted a high profile campaign to ensure that they firstly were not dismembered and secondly, that they

would be able to continue specialist working with the long term mentally ill in some form. In the process, the DEW Team succeeded in retaining part of their former identity in a slightly transmuted form. The DEW Team became a catchment area team, dealing with all mental health referrals to their designated area, but they retained a say in how they worked with this situation and subsequently developed an approach through which they could continue to concentrate on work with long term mentally ill clients.

The Issue of Prioritising The Long Term Mentally Ill

The DEW Team realised that if the long term mentally ill were to be successfully prioritised, the team would need a clear way of defining this population. A search of the literature was made, looking for such a definition and several examples were found, mainly relying on the psychotic/neurotic distinction and past history of hospital use (see chapter two), but the DEW Team felt nothing really fitted their desired criteria. Therefore, the consultant and the psychologist published a letter in the Bulletin of the Royal College of Psychiatrists (McLean & Leibowitz 1989) requesting correspondence about this issue. No response was generated and so the team formulated their own criteria from a knowledge of the literature and their own experience. The criteria listed in Box 5 were chosen to distinguish between "acute" and long term mentally ill clients. If any one of these criteria was met the client automatically came into the long term mentally ill client group, and so would receive a different package of care than "acute" clients referred.

Box 5: DEW Team Categories for Defining Long Term Mentally Ill Clients

1. Two or more years continuous contact with psychiatric services, including out-patients.
2. Depot medication prescribed.
3. Three or more in-patient admissions in past two years.
4. Three or more day hospital admissions in past two years.
5. DSM III "Highest Level of Adaptive Functioning" in past year -rating is five or more.
6. Anyone with ICD diagnosis of 295 or 297.

DEW Team Care Planning Procedure for Long Term Mentally Ill Clients

In November 1990, the DEW Team changed their operational policy to adapt to their newly defined role as a catchment area team, to ensure a retained priority for working with long term mentally ill clients and to register Team policy changes gleaned from their early experience¹². They also devised and operationalised a care planning package for long term mentally ill clients. This involved an initial assessment detailing demographic and referral data (Form 1). During Team discussions and client visits in the first month after referral, two main "Aims of Intervention" were agreed with each client and recorded along with a problem checklist assessment and a brief record of long term aims (Form 2). At the same time a prediction was made of "best and worst" possible outcome that could be expected after six months of client care. A form of "Goal Attainment Scaling" was used for this process (Endicott et al 1976). A third form (Review Form) was used to review this care plan at six month intervals following the initial assessment. This recorded outcomes and revised aims. In this way a modified care plan for the next six months was established. If for any reason the client was discharged from DEW Team care, a discharge plan was made based on review information. Long term mentally ill clients were only discharged if they moved out of the catchment area, died or remained well for an extended period of time.

"Acute" clients were seen by individual key-workers and discussed with the multi-disciplinary team only when necessary. There was no planning and review programme for these clients. However, all clients defined as long term mentally ill were given a care plan based on the above, and this was reviewed regularly by the multi-disciplinary team as a group. It was in this way that the DEW Team managed to continue to prioritise work with the long term mentally ill and to retain the distinctive service style that they had developed over the previous two years¹³. Their other community activities, such as running community support groups and liaison meetings with other agencies continued, although their capacity to set up new community initiatives was much reduced. In relation to central government legislation requiring all community mental health initiatives to implement the Care Programming Approach by April 1991, the DEW Team merely continued with their existing system and replicated some of the information collected and monitored on new Care Planning forms distributed by the Mental Health Unit.

The Outreach CMHT Model

In November 1990, the DEW Team also published a reflective paper on their experience as a CMHT to serve "revolving door" clients (McLean & Leibowitz 1990). This paper included an analysis of the advantages and disadvantages of the outreach model from the DEW Team experience. Advantages identified included the following:

- 1 Outreach allowed more productive and flexible use of staff time because no staff were tied up in "covering" a Centre which may have had varying occupancy.
- 2 It allowed workers to provide short periods of very intensive input when crises occurred and, having attached the client to other support, to return equally quickly to a position of occasional contact.
- 3 Outreach did more to reattach the client to normal activities within his/her community.
- 4 It produced more opportunity to foster links between the CMHT and other voluntary agencies.
- 5 Outreach minimised stigma.
- 6 It was cheaper in capital costs and as cheap or cheaper in non-pay revenue costs.

Against this, the disadvantages were found to be:

- 1 Clients valued having a place to go that was "their own".
- 2 Working in the outreach model provided no safe and convenient place for the emergency assessment of a noisily disturbed client.
- 3 Staff wasted time in travelling and parking.
- 4 Rent costs varied with activity and were not fully predictable.
- 5 Outreach work was impossible in the absence of a secretary/coordinate at the team base who was both knowledgeable and reliable.

The unresolved issues for debate within the outreach CMHT model for the long term mentally ill were identified to include:

- 1 Problems of "sitting up" in providing long term maintenance and support to all long term mentally ill clients (the DEW Team operated a "no discharge" policy for long term mentally ill clients unless they died or moved out of the area, meaning that the team caseload of long term mentally ill clients could potentially become full).
- 2 Concerns about how intrusive staff felt they were justified in being in their efforts to "keep tabs" on their clients (again the "no discharge" policy meant that all long term mentally ill clients were contacted on at least an annual basis to follow their progress and check that all was as well as could be expected and clients were not discharged when they refused contact with staff or tried to drop out of care).
- 3 Links with the hospital service and the prevention of "splits" (referring to the maintenance of good communication with hospital services and the avoidance of conflicts).
- 4 Interface problems with other agencies concerning good communication, particularly with GPs.

Plans to Reconcile the DEW Team with the New Day Hospital

By 1992, the building of the new Battersea Day Hospital (Edward Wilson House) was almost complete and the centre was due to open later in that year. The DEW office base was to be moved to the new building, but the plan was for them to continue working in the catchment area CMHT model. When the DEW Team was originally created, the issue of EWH was dominant. It was then almost forgotten about for three years and it was only in early 1990, when building work was almost complete that the issue was again brought up. By this time ten years had passed since the idea of the day hospital was first conceived. The big question was whether the day hospital idea

had become a "white elephant". When the original plans were made, there was no conception of setting up a CMHT in the meantime and the DEW Team's existence had negated some of the original purposes of the day hospital project. For instance, they had shown that it was possible and even preferable to set up community support groups and structured activity groups in a variety of community venues, rather than in a "mental health" facility. They had also demonstrated the value of a community outreach style of working (McLean & Leibowitz 1990).

Logically the identification and analysis of a problem precedes proposals for a remedy, but in reality the sequence is less tidy. Many authors have pointed out that solutions may become detached from the problems which originally prompted them. The DEW Team example demonstrated this process at work. The DEW Team began life as a specialist shadow team for the day hospital that was in the process of being built. Over time, the emphasis shifted towards it becoming a model comprehensive catchment area team, prioritising work with the long term mentally ill. The Battersea Day Hospital essentially became a separate venture.

DISCUSSION

Evidence presented in this chapter goes some way towards supporting the contention put forward by authors like Ramon (1988) that in the 1980s, psychiatrists continued to be major stake-holders in the determination of community mental health service patterns at the local level. However, in earlier chapters it was suggested that this control was not as monolithic as Ramon suggested. This theme can now be expanded upon, as later case study evidence suggested that the elitist influence of psychiatry varied at different stages and levels of service development.

The different stages of development will be considered first. It was at the vital juncture of service redefinition that the monopoly power of the psychiatric profession to control the

drawing of new catchment area boundaries again became important in defining local service structures. The sense that consultant psychiatrists legitimately "owned" areas and shared out clients amongst themselves was a strong feature of the description of service development presented in this chapter. However, in the late 1980s, a new challenge to this psychiatric elitism appeared to be emerging from the management side. Final decisions on catchment organisation and team structure came from the management group. This could suggest that management were to some extent emerging as a challenging local elite. They did not act simply as allies of the dominant medical interests, but exploited competing subdivisions within the consultant psychiatrist group to resolve issues of local resource allocation to the new catchment area teams.

Concerning the influence of various interests at different levels of service development outside basic determination of resources and organisational structure, other professionals were observed to have a significant role. The multi-disciplinary DEW CMHT insisted on retaining their commitment to prioritise the long term mentally ill and worked out a specific operational procedure to achieve this within their catchment area responsibilities. They did not respond by abandoning their previous work, but drew up an alternative proposal to accommodate their established care practices for the long term mentally ill within their new role. The DEW Team accepted a compromise solution that retained their priority work with long term mentally ill clients and hence continued to embrace the essence of their innovative style of working in a muted form.

It has been a constant theme of the case study, that professionals possess the potential for exercising considerable discretion in the way they provide services within the frameworks laid down by the Health Authority. As "street level bureaucrats" (Lipsky 1980) they were able to shape the way in which the service operated and also to decide who should and should not receive it. The DEW Team were not

given any choice about becoming a catchment area team, but were allowed to establish their own working pattern, the clients they were to prioritise and the packages of care that different groups of clients would receive. Hence, the DEW development continued to be heavily dependant on the personal strengths and experience of the staff in the team.

The DEW Team were in a strong position to bargain with management on issues of service style because of the multi-disciplinary team identity that they had developed. A major influence on the management's decision to keep DEW as a team and not split up the staff amongst different new teams, was provided by the increasingly confident and coherent group of professional staff. Another asset to the DEW Team's bargaining position was gained by seeking the support of outside bodies such as Good Practices in Mental Health. However, it is notable that again such an influence was successfully exerted over service style but not over service structure.

In addition, due to the development of a computer data-base, the DEW Team were able to produce statistical evidence of their clinical record and this aided their case. This is also interesting from another point of view. It demonstrates a shift in the nature of local issues in local community mental health care. In the late 1980s and early 1990s, issues of monitoring and evaluation were taken up by the case study team and became a major feature of their work in a way that they had not been in the past. Yet the associated concern with effectiveness and clinical quality was entrusted exclusively to the local professionals in the DEW CMHT. No real attempts were made by management during the study period to impose external evaluations on community services, except when care planning forms were introduced unit wide in April 1991 in accordance with new government legislation. However, this had little impact on the case study team except in increasing the quantity of paperwork dealt with by the staff team, since the DEW Team were already operating a care planning procedure and just had to duplicate some of the data that they routinely collected on the new care planning forms introduced across all

services within the Mental Health Unit. No feedback arose from the introduction of the "Care Programming Approach" during the study period. So professionals essentially retained control in determining and developing service monitoring criteria and evaluation of clinical quality.

There was also undoubtedly an institutional element to the DEW Team's process of adaptation to the catchment area change. Wildavsky (1972) suggested that any organisation that produces a single product or engages in a limited range of activities, is unlikely to abandon them willingly. Its survival is dependent and bound up in its programme. If the programme goes the organisation dies. Wildavsky observed from his studies that agencies are often encouraged to differentiate their products and diversify their outputs. The DEW Team was observed to be involved in this process. As a catchment area team prioritising work with long term mentally ill clients, the Team had retained their essential innovative character, but also broadened their range of activities.

There was also a strong financial influence observed in the DEW Team story. To secure the growing volume of resources it needs, the implementation literature suggests that those providing a service are compelled to enter into commitments that command the approval of those whose support they seek in competing with other potential users of the resources. In order to grow a service must both meet a demand and maintain its creditworthiness among those controlling the resources that it needs. The DEW Team was initially set up with money that was standing idle from the delayed day hospital project. By 1988, this surplus funding was no longer available as there were credit squeezes within the Health Authority. Therefore, the DEW Team had to compete for funding with other local services and as such, was logically compelled to offer a service style on a catchment area basis like the other Battersea CMHTs that were being developed. Hence, there was a strong element of cost-efficiency motives dominating quality of care motives in the change to comprehensive catchment area status.

The DEW Team professionals were the only party to raise issues concerning specialist versus comprehensive models of care. The service wide problems of long term mentally ill clients in Battersea that had prompted the DEW Team development initially, still existed at the time of the DEW Team reorganisation. Yet, it appeared that the scope and purpose of the DEW service as a specialist team, caring for the long term mentally ill population, never really emerged clearly enough. The DEW story suggested that the Team did not convince those involved in service planning that a case could be made for such a specialist service in addition to the Rehabilitation Service that had since been developed. The value of new liberal approaches as embraced by the DEW service was questioned. The DEW Team had legitimised its existence initially as the Unit had to be seen to be trying to do something to address the problems of people with long term mental illness. Later, management were not convinced that the DEW Team had found the right method to do this and with the change in central government legislation in 1991, all community teams were made responsible for prioritising their catchment's long term mentally ill population. After the reorganisation, the team became more specific about their outreach working model and a stronger ideological commitment to the long term mentally ill was perceived by the management and other local service providers. The DEW service had evolved to re-formulate priorities left unclear in the original blueprint. They had defined more precisely the type of clients for whom they intended to offer a priority service.

The reorganisation prompted extreme discontent within the DEW Team and a growing awareness that this was not going to be the only time that such service change would occur. This had considerable implications for their ability to provide continuity of care to their clients. In addition, they no longer had the status of being a unique team. Other CMHTs were being established in Battersea and mental health policy in the area was being planned on a Unit wide basis. Rationalisation had reduced the DEW Team's own potential for innovation while giving other local professionals the opportunity to take up

and experiment with some of their early ideas. This indicates that an important feature of the CMHT model lies in its flexibility and adaptability. The new catchment area teams were modelled on the CMHT approach and so we can conclude that the DEW Team had helped foster local acceptance of the CMHT model. The model itself had gained legitimacy and aspects of the model that the DEW Team developed had been shown to be sustainable in practice.

Many authors have commented that CMHT research is often marred by its concentration on time limited model programmes (Bachrach 1980) and that it is important to wait and see if efforts acquire sufficient potency to be self-sustaining in the face of material deficiencies and wider political constraints. This retrospective look at the implementation of a CMHT model by the DEW Team over a six year period allows such an opportunity. It has shown that the DEW Team did not succeed in sustaining its role as a specialist CMHT serving the long term mentally ill population, but it did promote the adoption of a comprehensive CMHT approach on a Battersea wide basis.

In Brief

This chapter considered the final part of the DEW Team story. Prompted by conflicts with existing interests, the team were forced to change their status and redefine their activities. Changes in personnel amongst the Battersea consultant psychiatrists, rationalisation of catchment populations, the adoption of a comprehensive catchment area CMHT model, and resource cutbacks all played a part in this redefinition. The DEW Team retained the essence of their innovative roots by developing a CMHT model that would prioritise work with the long term mentally ill. However, the political profile of the long term mentally ill did not pass beyond the realms of professional concern to enter the wider local political agenda until central government legislation implemented in 1991 required all teams to operate within the care programming approach and to monitor their long term clients. At the end of the thesis study period in 1992, it was not at all clear what

impact this new legislation had had and CMHTs in the case study area were all operating with different organisational systems, yet the CMHT model itself was observed to be acceptable, flexible and sustainable over a six year period in the case study area.

As described in the latter part of the account presented in this chapter, in its later years, the issues of monitoring and evaluation became prominent in the case study CMHT. The DEW Team set about the task of evaluating their work. The aim in the next two chapters is to extend the thesis evaluation to consider some of the process data that resulted from these efforts. Chapter eleven aims to evaluate aspects of the DEW Team's work as a specialist service working only with long term mentally ill clients and chapter twelve will evaluate their work when they changed focus to function as a comprehensive catchment area service.

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2. Wandsworth Health Authority- Adult Mental Health Services: Strategy for future provision within Wandsworth & Merton 1988-1994. WHA- Services for People with Mental Illness in Wandsworth, Interim Report of The Strategic Planning Team, amended October 1988.
3. Consultant Job Description: Kitson/McLean Replacement, May 1988.
4. Some Options For The Care Of Long Term Patients In Battersea, J. Leibowitz, February 1988.
5. For example see Letter to Dr McLean from Dr J Hollyman, Unit Management Representative, Springfield RE: "Second Thoughts" On The Proposed Job Description, 15th March 1988. Memo from Dr J Bolton, Consultant Psychiatrist, Springfield to Unit Management Group RE: Kitson/McLean Replacement Consultant Post, 15th January 1988. Letter to Dr A Forrest, Tutor in Psychiatry, Netherne Hospital from Dr J Bolton, 3rd June 1988.

Letter from Dr J Hollyman, Unit Medical Representative to All Members of the Division of Psychiatry Executive Committee, 17th March 1988.

6. Letter to Sue Gallagher, Unit General Manager, Springfield from H. Dobson, Principal Officer Mental Health, Wandsworth Social Services RE: Battersea Consultant Changes, 20th May 1988.

7. Letter to Nick Georgiou, Wandsworth Services Manager, from J. Manley Head III Occupational Therapist, Wandsworth Division RE: Plans For The New Wandsworth Catchment Teams, 16th May 1988.

8. Letter to J. Hollyman, Unit Medical Representative from A. Dennis, H. Haynes, A. Hoar, J. Leibowitz, R. Parsons & K. Scrimshaw RE: New Consultant Post To Replace Dr Kitson's Catchment Area Work And Half Of Dr McLean's Post, 16th February 1988. Letter to S. Gallagher, UGM, Springfield from the DEW Team, RE: Draft Proposals For Kitson/McLean Replacement Consultant Job Description, 18th March 1988.

9. Letter to R. Echelin, GPMH from Dr McLean RE: Future Of The DEW Mental Health Team, 28th March 1988.

10. Letter to Dr E. Vincent, District General Manager, Dr J. Bolton, Chairman District Division Of Psychiatry & S. Gallagher, UGM Springfield from R. Echelin, Senior Information Officer GPMH RE: DEW Team, 26th April 1988.

11. Notes of Meeting To Consider The Implications Of The Reorganisation Of The Battersea Catchment Areas held on Tuesday 21st June 1988.

12. DEW Report 1988-1990.

13. See Rickard W., Leibowitz J., McLean E.K. & Glennerster H.- A Prospective Outcome Study Of The DEW Care Planning Procedures, Wandsworth Health Authority Monograph, April 1992.

CHAPTER 11:

Community Care for the Long Term Mentally Ill in a Specialist CMHT Model

- Was it any Different to Services That Existed Previously?

The DEW CMHT approach has so far been evaluated in terms of whether it could sustain itself over time and retain its identity and particular service style. It has been suggested from documentary evidence that differences between the DEW Team and the "traditional" styles of after-care provision described in chapter five, existed on paper and interview evidence suggested that in their early years, the DEW Team was perceived by DEW staff and other local service providers to be offering an alternative model of service. However, as described in chapters nine and ten, neither the management nor hospital ward staff and social service staff were entirely convinced that the DEW service was actually very different from the "traditional" service style that had existed previously.

In this chapter, a retrospective empirical study is presented, which questions whether any difference between the "new" and "traditional" style of service was evident in practice in terms of the service offered to long term mentally ill clients. The DEW CMHT service was compared with the Community Psychiatric Nursing (CPN) service, which was the established "traditional" community aftercare service that existed in Battersea prior to the DEW Team's development and continued operating alongside the DEW service. The CPN service style was briefly described in chapter five.

Rationale of First Empirical Study

The DEW CMHT claimed to have developed a treatment service that was distinctive to and an improvement on the existing CPN service in Battersea. To study differences that existed between the two service styles, a CPN service was selected that was responsible for the needs of a similar set of clients. At the time of the study, the DEW Team was operating as a specialist service supernumerary to existing services,

working with long term mentally ill clients across the whole of Battersea (including the South Battersea population). The CPN Team chosen for comparison was the CPN service covering South Battersea, as defined by Health Service catchment area boundaries at that time.

The study was retrospective, looking at an eighteen-month period from 1st April 1987 to 30th September 1988. This period was chosen since it represented a time when the DEW Team were still operating as a specialist team and also there were no catchment area changes in Battersea during this period that would have confused the profile of clients. The study aimed to test whether DEW Team care differed from CPN care in terms of process factors. Essentially, two research strategies were combined:

- a) PERFORMANCE MEASUREMENT of the two teams on some of the goals and principles stated in the CMHT operational policy (termed "goal-directed evaluation" in the literature).
- b) NETWORK ANALYSIS which documents the client contacts with agencies in a service system. Inferences are drawn from the total number of contacts and different patterns of agency contact regarding improved social functioning and alleviation of social problems.

The two services were compared on indices of whether clients were seen in a greater variety of locations, whether there was really greater continuity of allocated primary worker and whether DEW Team clients were successfully linked to more community-based activities and a wider range of community agencies. The effect of each service on the overall number and duration of In-patient Hospital admissions during the study period was also measured. A retrospective case-note study method was used to compare the service offered to two matched samples of long term mentally ill clients: 50 CPN and 50 DEW clients. First, the contrasting characteristics of the DEW and CPN styles of service delivery are summarised in Box 6.

Box 6: The Contrasting Service Styles of the DEW and CPN Approaches

	DEW	CPN
WORK ENVIRONMENT	Whole team & administrative staff located in community base	CPNs located in community base, but working with predominantly hospital based team
STAFF	Team is multi-disciplinary Team comprises a Consultant Psychiatrist, a Clinical Assistant, a CPN, a Psychologist & a Social Worker. Team of 4.5 whole time equivalent workers, each with an approximate case-load of 26 per whole time equivalent staff member	Similar training backgrounds and largely uni-disciplinary team. Team of 5 whole time equivalent workers, each with an approximate case-load of 25 per whole time equivalent staff member
REFERRALS	Team dealt only with referrals of clients with long term mental health problems from across catchment areas, from a variety of referral agencies	Team took any NHS mental health referrals from catchment area, but almost exclusively these were referrals of people with long term mental health problems from hospital consultants
CARE POLICIES	A high degree of case responsibility with a formal key-worker system, multi-disciplinary assessment, individual care planning and regular review	Case responsibility, assessment, individual care planning and review left for the most part to individual worker. No multi-disciplinary working as such but "networking" arrangements with other professionals. No formal key-worker system.
MONITORING OF CLIENTS & WORK OF TEAM	Monitoring via computer data-base, multi-disciplinary community case-notes and multi-disciplinary community team meetings.	Monitoring confined to separate case-notes held by CPNs, social workers, consultants with out-patient clinics & psychologists.

	DEW	CPN
PHILOSOPHY	Emphasis on long term support to clients through setting up & engaging clients in community groups.	No stated emphasis on long term support for clients. No community groups set up, but some client use encouraged of existing groups in area.

Method

The sample comprised 100 subjects, who were considered to be long term mentally ill, based on the joint clinical judgement of senior clinical personnel from each team. A matched sample was drawn from the case-lists of the two services under comparison. This consisted of: 50 DEW clients (including 20 discharged and 30 who had been in DEW Team care for at least eighteen months); and 50 CPN clients matched for age, sex, diagnosis, ethnic origin, length of history and discharge. A form was designed to collect data (see Appendix 4) about:

- 1) BASIC DEMOGRAPHY
:-sex, age, marital status, living situation, diagnosis.
- 2) PREVIOUS PSYCHIATRIC HISTORY
:-type & length of past contact.
- 3) CONTACTS IN PROPOSED PERIOD
:-referral data, key-worker & team details
- 4) DETAIL OF CONTACTS IN PROPOSED PERIOD
:-number & location of staff-client contacts, medication compliance, attendance records at day centres, community groups and hospital-based activities; client contacts with other community agencies.
- 5) CARER DETAILS
:-number of carers, number of staff contacts with carers, support offered.

Data was collected from the case-notes of each client in the sample. Discussion interviews were set up with members of the professional staff from each service to clarify data. Out-patient consultation contacts were also recorded where possible from out-patient notes. Attendance records for the period at structured day-activities including day centres, community groups and hospital-based activities were collected and staff ratings of regularity of client attendance were obtained. A coding system was designed to categorise the data regarding client contacts with community agencies into those dealing with problems in different areas of functioning. Ten senior clinicians from different professions were given a list of the twenty-seven agencies identified from the case-notes as having been used by clients in the sample. Each was asked to formulate their own list of up to ten sub-categories according to the nature of the help that each agency offered. Seven consensus categories emerged and the data was coded.

The information extracted was used to establish whether care

given by the DEW Team differed in any measurable way from CPN care and whether the DEW Team was doing what it set out to do as compared with its stated operational policy (see Appendix 3). It was hypothesised that the DEW service would be more flexible and accessible in terms of direct contacts with clients and new elements of long-term community support would be evident, such as better support to carers. There was an expectation that fewer clients would be discharged because they "remained well" as the DEW Team saw themselves as offering long term support, with a policy of not discharging clients between relapses. Care from a wider range of community advice agencies would be interwoven and more DEW Team clients would be expected to be linked into structured day activities.

Results

The study samples drawn from each service were found to be well matched in terms of demographics and diagnosis (see Table 1). The majority of each sample lived in Council accommodation and the proportion of clients who moved house during the eighteen-month study period in each sample was high (22% in the DEW sample and 17% in the CPN sample). 24% of each sample were noted as having some form of employment, but during the study period only 4% DEW and 2% CPN were working continuously.

Table 1: Comparative Demographic Characteristics

DEMOGRAPHIC VARIABLE	DEW	CPN
SEX	29 Female, 21 Male	28 Female, 22 Male
AGE on 01-04-87	Mean=42yrs, SD=17.7	Mean=42yrs, SD=15.8
MARITAL STATUS	62% Single 10% Married 20% Divorced/ Separated 8% Widowed	52% Single 20% Married 22% Divorced/ Separated 6% Widowed
ETHNICITY	50% Caucasian 42% West Indian /African 4% Asian, 4% Other	48% Caucasian 46% West Indian /African 2% Asian, 6% Other
LIVING SITUATION	48% Alone 24% With Parents 8% Alone with children 8% Spouse & children 6% Spouse /Cohabitee 6% With Friends	48% Alone 18% With Parents 8% Alone with children 14% Spouse & children 10% Spouse/ Cohabitee 2% With Friends
DIAGNOSIS	78% Schizophrenia, Affective Psychosis or Paranoid States. 22% Neurotic, Personality Disorder or Alcohol Dependence Syndrome.	84% Schizophrenia, Affective Psychosis or Paranoid States. 16% Neurotic, Personality Disorder or Alcohol Dependence Syndrome.

The majority of each sample had been in contact with psychiatric services for more than 7 years and 86% of each sample had been in contact with services for more than two years. 66% DEW clients and 64% CPN clients had one or more in-patient admissions in the two year period immediately prior to the beginning of the study period and 28% of each sample had one or more previous day hospital admissions. There were notable differences between the two cohorts in original referral sources; in the CPN sample most of the referrals had originated from hospital-based services, whereas in the DEW Team sample there was a wider variety of sources. The majority of each sample were seen at home for their first assessment

(72% DEW: 70% CPN).

The DEW Team had a multi-disciplinary "Key-worker" system operating during the study period. The CPN service had no such explicit "Key-worker" system, although each client did generally have a regular primary nurse. In the DEW Team sample key-workers were allocated as follows: 58% of clients had a Community Psychiatric Nurse; 12% Psychologist; 10% Clinical Assistant; 8% Occupational Therapist; 4% Consultant Psychiatrist; 4% Social Worker; 4% Registrar or Senior Registrar. 21% DEW and 72% CPN clients had a change in their allocated primary worker during the study period. Three clients in each sample had a second primary worker change.

Table 2: Staff Contacts with Clients and Continuity of Personnel During Study Period

VARIABLE	VALUE	p	DEW		CPN	
			MEAN	SD	MEAN	SD
Total No. Visits Attempted	t=-1.81	p=0.07	22.7	14.1	28.0	15.4
Total No. Visits Successful	t=-1.81	p>0.05	20.5	14.0	25.0	15.2
Total No. Different Locations *	t= 3.40	p<0.001	2.3	0.8	1.8	0.7
Total No. Different Staff Members Seen *	t= 4.95 F= 2.04	p<0.001 p<0.05	2.3	0.9	3.6	1.5
Total No. Visits Where Medication Prescribed	t=-1.68	p>0.05	18.1	14.7	23.3	15.9
Total No. Visits Where Medication Taken	t=-1.67	p>0.05	16.2	14.9	21.3	15.6
Total No. Staff-Carer Contacts *	t=-0.74 F= 2.04	p>0.05 p<0.05	5.1	7.1	6.6	10.2

* = Significant Difference

Some differences were found in the number of staff contacts with clients. Table 2 shows that there was a trend towards CPNs attempting more visits than DEW staff. There was a highly significant difference in the number of different places individual clients were seen -DEW staff saw clients in significantly more different locations than the CPNs. Significantly fewer different staff members were seen by DEW Team clients than CPN clients and there was a greater variance in the number of different staff members seen in the CPN service than in DEW service. There was no difference between the two groups in the total number of staff contacts with carers, although in the CPN service there was greater variation in number of contacts. There was no significant difference between DEW and CPN in the proportion of clients with known carers ($\chi^2=0.81, p>0.05$) or the proportion of clients with known carers where staff support was offered to the carer ($\chi^2=2.80, p>0.05$).

Table 3: Client Use of Structured Day Activities and Attendances at these Agencies during Study Period

VARIABLE	VALUE	p	DEW		CPN	
			MEAN	SD	MEAN	SD
Total No. of Structured Day Activities Used *	t= 0.80 F= 2.27	p<0.01 p<0.01	1.1	1.3	0.5	0.8
Total Day Centre Attendances	t=-0.85	p>0.05	38.3	63.6	80.3	107.6
Total Community Group Attendances	t= 0.70	p>0.05	18.2	23.4	11.2	12.3
Total Hospital-based Activity Attendances	t= 1.00	p>0.05	47.1	79.4	25.0	39.4
Proportion of Clients Using Day Centres	$\chi^2=0.75$	p>0.05	18%		10%	
Proportion of Clients Using Community Groups *	$\chi^2=8.78$	p<0.05	40%		12%	
Proportion of Clients Using Hospital-based Activities	$\chi^2=0.43$	p>0.05	34%		26%	

* = Significant Difference

Analysis of client use of structured day activities revealed further differences. Table 3 shows that DEW Team clients were involved in significantly more structured day activities in total than CPN clients. There was a significant difference in the proportion of DEW Team and CPN clients using Community Groups. There were no significant differences between DEW Team and CPN clients in total number of attendances during the study period at any of the structured day activities used or

in the staff ratings of regularity of attendance.

Table 4: Client Use of Other Community Advice Agencies

VARIABLE	VALUE	p	DEW		CPN	
			MEAN	SD	MEAN	SD
Total No. Helping Agencies Client Had Contact With *	t= 4.28	p<0.001	3.16	1.62	1.82	1.50

* = Significant Difference

Analysis of client use of community advice agencies such as the local counselling service, job centre and citizens advice bureau revealed further differences. Table 4 shows DEW Team clients were in contact with significantly more community advice agencies during the study period than CPN clients. When agencies are categorised into those providing help in different areas of functioning, Table 5 shows a significant difference between the proportion of DEW and CPN clients in contact with agencies providing social support and agencies dealing with work or day-time occupation.

Table 5: Client Use of Other Community Agencies sub-categorised into Agencies Dealing with Problems in Different Areas of Functioning

VARIABLE	VALUE	p	MEANS	
			DEW	CPN
Daily Living	$\chi^2=0.43$	$p>0.05$	34%	26%
Social Support *	$\chi^2=7.77$	$p<0.01$	46%	18%
Housing/Legal	$\chi^2=1.01$	$p>0.05$	60%	48%
Family/Relationships	$\chi^2=0.00$	$p>0.05$	4%	2%
Work/Day Occupation *	$\chi^2=7.53$	$p<0.01$	48%	20%
Specialist Services eg Anorexia Clinic	$\chi^2=0.85$	$p>0.05$	16%	8%
Physical Health	$\chi^2=0.06$	$p>0.05$	22%	18%

* = Significant Difference

Table 6: Number of In-patient Hospital Admissions per Client in Study Period

NUMBER OF ADMISSIONS	DEW		CPN	
	Count	Percentage	Count	Percentage
0	25	50%	26	52%
1	11	22%	16	32%
2	9	18%	5	10%
3	5	10%	2	4%
5	0	0%	1	2%
Total Clients	50	100%	50	100%

Table 6 shows that there was no significant difference between the DEW service and the CPN service in the proportion of clients who had in-patient admissions during the study period ($t=1.58, p>0.05$); approximately half of each cohort had one or more in-patient admissions and there was no significant difference in the length of the admissions (see Table 7).

Table 7: Duration of Study Period In-patient Hospital Admissions

DURATION OF ADMISSION	DEW		CPN	
No Admission	25	50%	26	52%
Up to 1 Month	2	4%	5	10%
1 – 3 Months	8	16%	11	22%
4 – 7 Months	7	14%	6	12%
8 – 13 Months	8	16%	2	4%
Total Clients	50	100%	50	100%

There were very few sample client admissions to Day Hospital during the study period: 2 DEW Team clients and 4 CPN clients had Day Hospital admissions. Table 8 shows reasons for client discharge or drop-out. There was a significant difference between the two services in the proportion of clients discharged for different reasons ($\chi^2=8.63$, $p<0.05$). This finding must be interpreted with care due to small sample numbers.

Table 8: Reasons for Client Discharge/Drop-out

REASON FOR DISCHARGE	DEW		CPN		TOTAL
Catchment Area Change	7	37%	1	5%	8 21%
Moved Out Of Area, Died, Referred On or Readmitted	4	21%	8	38%	12 30%
Client Refusal	6	32%	5	24%	11 28%
Client Remained Well	2	10%	7	33%	9 21%
Total No. Clients Discharged	19	100%	21	100%	40 100%

DISCUSSION

The findings suggested that community care by the DEW CMHT was different to the traditional CPN service in practice. DEW Team care was found to differ from CPN care in the following ways.

i) Number and Location of Visits /Staff-Client Contacts

The DEW Team saw clients in a greater variety of locations over time. This suggests that the DEW Team may have been more flexible at responding to the varying needs of clients in terms of where consultations took place and has implications for the acceptability of services to clients. Assuming that part of the accessibility of a service can be judged in terms of the variety of location of contacts, the DEW Team had gone some way towards supporting a stated aim of their operational policy in providing a more accessible service.

No differences were found between the DEW and CPN services in terms of the total number of client visits made. This finding has implications for the form of the care delivery system. It may just have been a demonstration that the two services studied had similar sized case-loads per whole time equivalent staff. Alternatively, it could have had two further implications. It could mean that both services were adept at responding to the needs of clients in terms of the number of visits they made, but it could also mean that both services studied offered a block response in the number of visits they were prepared realistically to make. It was not possible to resolve this question without further analysis of client need for visits.

ii) Continuity of personnel

It was hypothesised that there would be greater continuity of personnel in the DEW service by virtue of their key-worker system. This hypothesis was supported. In the CPN sample 72% of clients had a change in their allocated primary care worker during the study period as compared with 21% of the DEW Team sample who had a change in their key-worker. In addition it was found that in the CPN service some clients saw very few staff members while others saw very many. In the DEW service

there was less variation between clients in terms of the number of staff members seen. In this context it is interesting to consider the results with respect to the key-worker function and the role of the multi-disciplinary team.

As stated in chapter two, research evidence suggests that good quality community psychiatric care requires teamwork (Test 1979; Intagliata 1982; Woof et al 1988). Although staff may be allocated to individual clients and work with them over months or years, they should work as a member of a team (Holloway 1991). The above finding suggests that the multi-disciplinary team approach as embraced in the DEW service did facilitate continuity of personnel. The team thus provided continuity of care. Individual team members were apparently protected from the burden of sole responsibility (Stein, Diamond & Factor 1990).

In the DEW Team it was judged that the key-worker system was operated relatively efficiently in line with team policy. Every client in the sample was assessed and allocated to a key-worker responsible for overseeing the clients total care and for being the personal worker in all general matters to that client. Where the key-worker was absent for a period, cover arrangements were made at the weekly team meeting and precisely described in the notes and also caseloads were monitored on a three monthly basis at the team meeting with any resulting planned changes in key-worker discussed and noted.

The CPNs did not have a key-worker system and evidence taken from the notes suggested that client allocation was considerably more haphazard. In general there was a high staff turn-over of CPNs during the study period, with several CPNs leaving. The "key-worker system" as such was operated on a very informal and flexible basis and clients were handed over to colleagues for a variety of reasons (rarely recorded in the notes). Examples of reasons for client hand-over were gained from interviews with the CPNs. It was found that:

1. CPNs negotiated amongst themselves, swapping clients who lived in certain areas to rationalise their travelling times and distances.
2. When one worker left the CPN Team, often a new primary care worker was not appointed for some time and the client was shared among colleagues for this period.
3. There was no specific forum for the making of these decisions in the form of a team meeting and no practice of recording the decisions in notes.
4. Such decisions were up to the discretion of the particular CPN involved and may have been discussed at the hospital ward round, but no records were available.

iii) Medication Administration on Visits

It was hypothesised that the CPN service would be more likely to discharge clients who refused medication or for whom visits did not involve the administering of medication. However, there was no evidence that there was any difference between the DEW and CPN services either in the total number of visits on which medication had previously been prescribed or in the total number of visits on which medication was taken. If the above hypothesis were correct, one would expect that the DEW Team would have a higher number of visits to clients who were not complying with prescribed medication. This was not the case.

iv) Use and Extent of Use of Day-time Activities

The results suggested that the DEW Team were more effective at initially linking clients with structured day-time activities than the CPN service. When the types of day-activities were sub-divided into day-centres, community groups and hospital-based activities (such as the industrial therapy unit, and art therapy), it became apparent that this difference was mainly due to the DEW Team linking clients to a much higher percentage of community groups than the CPN service. It is also interesting to note that it seems as if community groups were not substitutes for day centres and hospital-based activities but were an additional support service.

There were no apparent differences between the DEW and CPN services in terms of the total number of client attendances or the staff-rated regularity of attendance at structured day activities. These results, however, should be interpreted with a considerable degree of caution due to the small sample size and the poor quality of the attendance data obtained. It does suggest that while DEW Team staff may have been more effective at initially linking more clients to structured day-time activities than CPN staff, the DEW Team were no more successful than CPNs at ensuring that clients attended the centres on a regular basis. One might have expected attendances to be higher for DEW Team clients due to closer monitoring arrangements through support visits and closer liaison with the organisations involved, but evidence suggests that this was not the case.

v) Use of Other Community Advice Agencies

The DEW Team were found to be more effective than the CPN service at linking clients with a range of community advice agencies, particularly with agencies concerned with work or day-time occupation and agencies providing social support. This suggests that the use of resources by the DEW Team did show greater sensitivity to the care network as a whole and care from a wider range of community sources was interwoven in the client care package.

This supports the "enabling role" of the CMHT. In the US with development of case management services, the concept of the core agency that brings together all local mental health services is becoming increasingly influential (Intagliata 1982; Santiago 1987; Lehman 1989; Stein, Diamond & Factor 1990). The DEW Team stated in their operational policy that they aimed "to work closely with other locally based agencies to promote the development of a co-ordinated network of support services." The above result suggests that the DEW Team had some success in this respect.

vi) Discharge and Drop-out

The reasons given for client discharge were found to be

quantitatively different between the DEW and CPN services. 37% of the clients discharged from the DEW Team were discharged due to the pending catchment area change that occurred in October 1988, the month after the end of the study period; whereas only 5% of the CPN discharged sample were discharged for this reason. The other striking difference was in the number of clients who were discharged because they "remained well". Only 10% of the sample discharged by the DEW Team were discharged for this reason compared to 33% of the CPN sample. The DEW Team's different approach regarding the long-term support function to clients was, therefore, reflected in the discharge data. However, it was not possible to assess this difference without a knowledge of the pattern of future relapses of clients in the sample who were discharged because they "remained well". Also, differences in morbidity between the two services, despite the matching process needed to be compared.

This discharge data showed the interesting effects of continual organisational change in the local Health Service administration. The particular study period was chosen because it was hoped that it represented a time when the services were not being affected by such organisational changes, but it is evident that there was an effect due to the pending catchment area change. Such a finding has implications for any assessment of continuity of client care and suggests that it is not only connected with individual team practice but also closely linked to Mental Health Unit organisational practices and the effect of changing local and government policy.

vii) In-patient Admissions

The results demonstrated that the DEW Team had no significant effect on reducing either the frequency or duration of in-patient admissions and DEW Team clients displayed a similar admission pattern to that of the CPN service. This suggests that the DEW Team were not as successful as they might have been at reducing the need for in-patient admission. However, research evidence on this issue is contentious and largely equivocal, as described in chapter two. Studies of "case

management" services focused on out-patient populations deemed to be at high risk of readmission have shown a decrease in hospital utilisation in clients receiving "case management" services (eg Jerrell & Hu 1989; Bush et al 1990), although some centres have not shown such expected improvements (eg Bond et al 1988). However, "case management" in these studies often referred to the provision of an intensive twenty-four hour support service, similar to that used in the Stein & Test studies (1980) and very different to the much less intensive input offered by both the CPN and DEW services.

viii) Staff Contact with Carers

No significant differences were found in the number of staff contacts with carers on visits between the DEW and CPN services, but a greater variation in the number of carer contacts was found in the CPN service. This may indicate that in the CPN service, staff contacts with carers might have been more dependent on the practice of the individual CPN, whereas in the DEW service, different members of the staff team had similar numbers of contacts. There was no significant difference between the two services in the proportion of clients with carers where support was offered to the primary carer.

Research suggests that community psychiatric services have not been very effective in the past at offering good services to the carers of people with mental health problems. The DEW Team operational policy stated that the DEW Team aimed to "provide a service of support and advice to users of the service and their relatives" and hence one would expect that DEW Team staff would have made more attempts to contact and support carers than the CPN service. There was, however, no evidence to suggest that this was the case. A similar result was found in the client satisfaction study of the DEW Team conducted by MacDonald & Ochera (1990). They discovered that less than a third of carers (31%) knew how to contact the DEW Team. It must be stressed that as a direct result of the client-satisfaction study findings, the DEW Team consequently attempted to address the issue by adding an additional part to

their initial assessment of clients. This ensured that the DEW Team staff found out about carers and made carer support more widely available and accessible. Such developments were not picked up in this study due to its retrospective nature, but effects of this policy change were found in a later prospective study (described in chapter 12).

A Note on the study sample

The process of matching clients from the DEW and CPN services to allow comparison between them, meant that the samples obtained did not diagnostically reflect the total caseload of these services. This is particularly important with respect to the DEW service, as it had a much more heterogeneous caseload in terms of diagnosis than the CPN service. If demographic data from Table 1 were compared to prior data on the total DEW Team caseload for the year 1987-88 (McLean & Leibowitz 1990) there are differences in ethnicity ratios (the present sample had more afro-caribbean clients than the total DEW Team caseload) and in living situation (48% of the present sample lived alone compared to only 25% of the total DEW Team caseload). Lastly, a higher percentage of the present sample had a diagnosis of schizophrenia, affective psychosis or paranoid state compared to the total DEW Team caseload.

An Overview of the Service Style Comparison

Essentially, this study has served to demonstrate that in practice, the "new" CMHT and "traditional" CPN style services were found to be different in terms of most of the process factors considered, but they were not as different as would have been expected. The previous chapters detailing the history of the DEW Team gave the impression that the DEW Team were aiming to provide a radically different style of service provision, but the differences in practice were noted to be largely organisational. The DEW service was found to be distinctive in three main aspects of service provision that were not present in the CPN service:

- 1) The multi-disciplinary teamwork approach as opposed to the largely uni-disciplinary CPN approach.
- 2) The key-worker system, procedures for assessment, clarification of aims and client review system established by the team. This allowed them to work effectively with clients and monitor progress in a way that was not possible for the CPN service.
- 3) The emphasis on developing improved methods of co-ordinated care with other community agencies.

However, as regards measuring an improvement in care to clients, results were less easy to interpret, and few apparent differences emerged. The most striking feature was that no differences were found between the two services in number or duration of hospital admissions between the two cohorts. One of the main precepts of the original proposal proposing the establishment of the DEW Team was that they would alleviate the problems of "revolving door" clients and decrease the pressure on the hospital services. In practice, this did not happen. The team may have ensured that while clients were living in the community they were more closely monitored and should the need for hospital admission arise, this may have been better coordinated than in the more "traditional" service style. Yet the actual need for hospital admission did not notably diminish.

In Brief

With the implementation of the CMHT model of care, doubts remained about whether this approach really provided an improved service for long term mentally ill clients compared to the established after care services that existed previously. The overall findings of the first empirical study presented in this chapter suggested that on the indices measured, the service offered to long term mentally ill clients by the DEW CMHT did differ from that given by the CPN service and did potentially improve service quality for clients. Yet the differences were noted to be largely organisational in nature in improving the support role to clients rather than having any significant impact on reducing the need for in-patient admissions.

The next chapter now presents a prospective study of the DEW

Team style of working when it changed to operating as a catchment area service after 1988. It considers whether the team succeeded in their stated aim to prioritise working with the long term mentally ill within their redefined remit to serve all mental health clients within a catchment area.

CHAPTER 12:

Prioritising Long Term Mentally Ill Clients in a Catchment Area CMHT Model: Is it Feasible?

This chapter will present a second empirical study of the DEW Team style of working. One way that the implementation literature in public policy is driven is to consider whether or not a service achieves the objectives that it sets itself. This is the principle that underlies organisational audit. Using this theme, this chapter aims to present a study of the DEW CMHT when they changed to become a comprehensive service, serving all the mentally ill clients within a newly defined catchment area of North East Battersea. As described in chapter ten, it was agreed within the team that the long term mentally ill clients required a different style of service, with emphasis on preventing inappropriate discharges or drop-out and providing a flexible and accessible service with regular multi-disciplinary reviews (at least every three months) at weekly team meetings, designed to provide support to key-workers and facilitate the involvement of different disciplines in care programmes as appropriate. The aims of the study presented in this chapter were to discover whether the DEW Team's policies of prioritising the long term mentally ill were observable in practice and whether the team were succeeding in their effort to provide a different type of service to the two groups defined (Long Term Mentally Ill and Acute clients).

Rationale of the Second Empirical Study

Details of studies concerning the aims and principle services offered by CMHTs in the U.K. were presented in chapter two. It was noted by Sayce (1989) and Patmore & Weaver (1991) amongst others, that in many parts of the U.K., even where CMHTs specifically claimed to prioritise work with the long term mentally ill group within the catchment area team model, few actually succeeded in serving more than a small proportion of their catchment area's known long term mentally ill population. It was also noted that there was a conspicuous absence of active, effective case-load monitoring systems that

would allow such an aim to be evaluated. Hence, the study presented in this chapter focused on two aspects of DEW Team service provision. First, it aimed to discover whether the DEW Team definitions of two different client groups were reflected in the characteristics of clients. Were there any differences between the two groups of clients defined as "long term mentally ill" and "acute"? What were the proportions of "long term mentally ill" and "acute" clients in DEW Team care? How did the two groups compare in terms of discharge and period of time spent in the care of the DEW Team? What differences were there between "long term mentally ill" and "acute" clients relating to variables such as sex, diagnosis and source of referral?

The second aim was to focus on staff input to clients in the two groups. How far did the "long term mentally ill" and "acute" clients receive a different kind of service? How were the DEW weekly multi-disciplinary team meetings weighted in terms of the amount of time spent discussing clients from each of the two groups? What proportion of the case-load had contact with more than one team member? What differences were there in terms of key-worker allocation? A major consideration in designing the methodology of this study was an additional aim to develop a simple methodology that avoided making extra demands on staff and which could be used by other CMHTs with little access to research staff or complicated computer monitoring systems. Maximum use was therefore made of data routinely collected by the team.

Method

Data was collected from three different sources:

1) Data-base

As described in chapter eight, the team ran a computerised case register of all DEW Team clients. Details were obtained from this about how many "long term mentally ill" and "acute" clients DEW Team workers had on their case-load over time. Information was collected about the case-load on four specific dates spread at six monthly intervals over an eighteen month period (from December 1988 to May 1990). This was used to

assess the balance of such clients on the DEW Team case-load at any one time. Comparisons were made across the two groups on the four discrete six monthly "slices", looking at the following variables:

- a) Numbers of long term mentally ill and acute clients in care at discrete six monthly intervals.
- b) Differences in race and sex between the two groups at each interval.
- c) Differences in source of referral between the two groups.
- d) Differences in key-worker allocation between the two groups.
- e) Number of clients in each group who continued in care over two six monthly periods (Dec 1988-May 1989; Dec 1989-May 1990).
- f) Numbers of clients newly referred and seen at each interval.
- g) Number of clients discharged between each interval.

2) Team Meetings

Records were kept of the time spent discussing different clients at the DEW multi-disciplinary team meetings over a period of three months (12 meetings). These records were made by direct observation, with the researcher using a stop-watch to time discussions. Team members gave their permission for recordings to be made and were asked to continue meetings in the normal fashion. Discussion times for individual clients were recorded, classified into "long term mentally ill" or "acute" and "in-patient" or "community" client.

3) Staff Contact with Clients

An analysis was made of estimated DEW Team core staff contact with clients listed on the computer as "currently in care" over a six month period. A "current in care" list for the month of January 1991 was presented to team members with a request for each team member to indicate each client they had contact with over the last six months and the type of contact this was. There was no requirement to detail the actual number of contacts, as this was intended only to be a crude measure of approximate type of contacts and to identify any differences between the "long term mentally ill" and "acute" groups. The categories of contact were defined as follows:

- a) Face-to-Face -planned meeting between staff and client
- b) Informal Face-to-Face -unplanned meetings between staff and client (eg on the local Council estate, at mental health social events)
- c) Telephone -telephone calls between staff and client
- d) Letter -letters written to or about or by clients to staff (excluding referral letters)
- e) Consultation -staff consulted by another professional about client
- f) Carer -any contact by staff with relatives/carers (face-to-face, telephone or letter)

Results

1) Data-base Study

Table 9: Size of DEW Team Case-load over time: Number of DEW Team Clients in Care at Discrete six monthly intervals

MONTH YEAR	DECEMBER 1988	MAY 1989	DECEMBER 1989	MAY 1990
TOTAL	132	164	152	137
LONG TERM MENTALLY ILL CLIENTS	116 (87.88%)	125 (76.22%)	117 (70.13%)	98 (71.52%)
ACUTE CLIENTS	16 (12.12%)	39 (23.78%)	35 (29.87%)	39 (28.87%)

The total number of DEW Team clients in active care rose over the first six months of the study and declined again over the next year reflecting a reduction in the size of the team's catchment area in August 1989. The proportion of clients classified as "long term mentally ill" declined slightly over the first year of the study following the change to catchment area status in October 1988. It then remained stable at about 70% of the DEW Team case-load. A corresponding increase in the proportion of "acute" clients (doubling from 12% to 24% in the first six months) stabilised to approximately 30% of the case-load.

Table 10: Diagnostic Breakdown of DEW Team Case-load over time: Diagnosis of DEW Team Clients In Care At Discrete Six Monthly Intervals

MONTH & YEAR	DIAGNOSIS	LONG TERM MENTALLY ILL CLIENTS	ACUTE CLIENTS	TOTAL
DECEMBER 1988	200s	82 (71%)	0 (0%)	82 (62%)
	300s	32 (27%)	15 (94%)	47 (36%)
	0	2 (2%)	1 (6%)	3 (2%)
MAY 1989	200s	86 (69%)	4 (10%)	90 (55%)
	300s	33 (26%)	28 (72%)	61 (37%)
	0	6 (5%)	7 (18%)	13 (8%)
DECEMBER 1989	200s	84 (72%)	2 (6%)	86 (56%)
	300s	30 (26%)	27 (77%)	57 (38%)
	0	3 (2%)	6 (17%)	9 (6%)
MAY 1990	200s	69 (70%)	5 (13%)	74 (54%)
	300s	25 (26%)	27 (69%)	52 (38%)
	0	4 (4%)	7 (18%)	1 (8%)

Key: 200s = ICD9 No 290.0 to 299.9,
 300s = ICD9 No 300.0 to 310.0,
 0 = Other -Including No diagnosis, Not Mentally Ill, Doubt or Missing Data.

Clients with a psychotic diagnosis (ICD 290.0 to 299.9) remained at about 55% of the total case-load and about 70% of the "long term mentally ill" group.

Racial Mix

The racial mix of the DEW Team case-load also remained relatively stable over time. For the "long term mentally ill" group the proportions were: 64% Caucasian, 26% African/Afro-Caribbean, 6% Asian, 4% Other. The "acute" group showed a slightly different distribution. From May 1989 (when the numbers of "acute" clients had built up on the case-load) the proportion of caucasians declined over the next year from 77% to 69%, with a corresponding increase in the number of

African/Afro-Caribbean clients from 21% to 26%. There were no Asians in the "acute" group over the period of the study.

Movement of Clients from Case-load over time

Table 11: Changes in Number of Clients on Case-load over time

Between December 1988 & May 1989	LONG TERM MENTALLY ILL CLIENTS	ACUTE CLIENTS	TOTAL
Continuing In Care	93 (81%)	3 (19%)	96 (75%)
Number Discharged	20	13	35
Number of New Referrals	30	36	66
Between December 1989 & May 1990	LONG TERM MENTALLY ILL CLIENTS	ACUTE CLIENTS	TOTAL
Continuing In Care	88 (75%)	22 (63%)	110 (72%)
Number Discharged	27	13	40
Number of New Referrals	7	17	24

Between December 1988 and May 1989, 81% of "long term mentally ill" clients remained in care, compared to only 19% of the "acute" group. The six months from December 1989 to May 1990, showed a similar proportion of "long term mentally ill" clients continuing in care (75%), but an increase in the proportion of "acute" clients (63%). The number of new referrals decreased between the two periods, reflecting the decrease in the size of the catchment area.

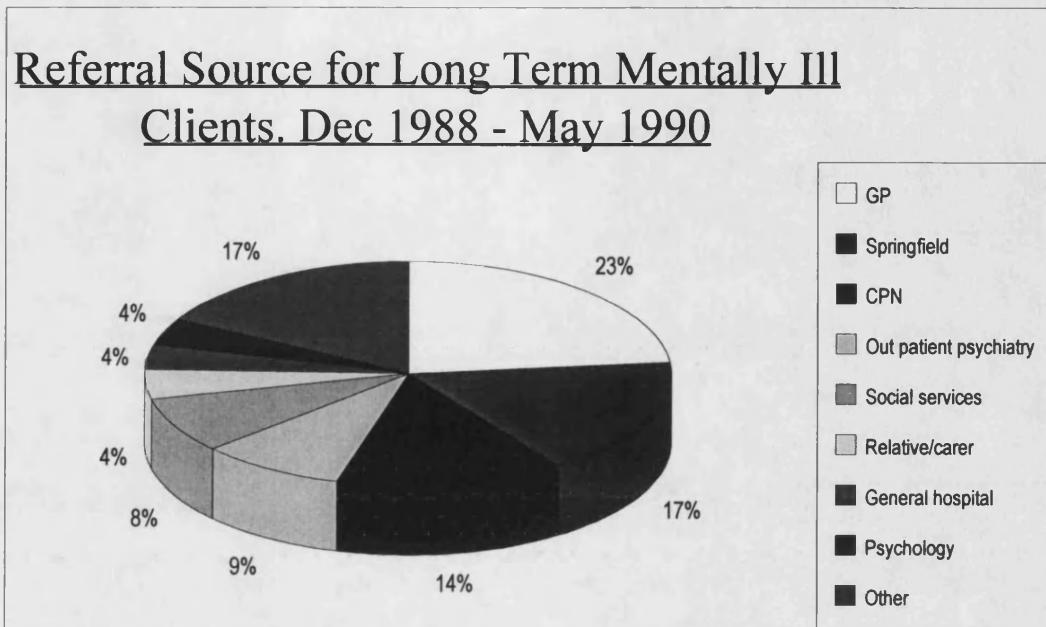
Key-worker Case-loads

Results showed that over time the "long term mentally ill" group continued to have key-workers from a wide distribution of professions, but the majority had a CPN, consultant or clinical assistant key-worker, with the CPNs consistently having the largest group (30-40%). The range of professions being key-worker for the "acute" group was very limited in December 1988 (only the consultant, clinical assistant and

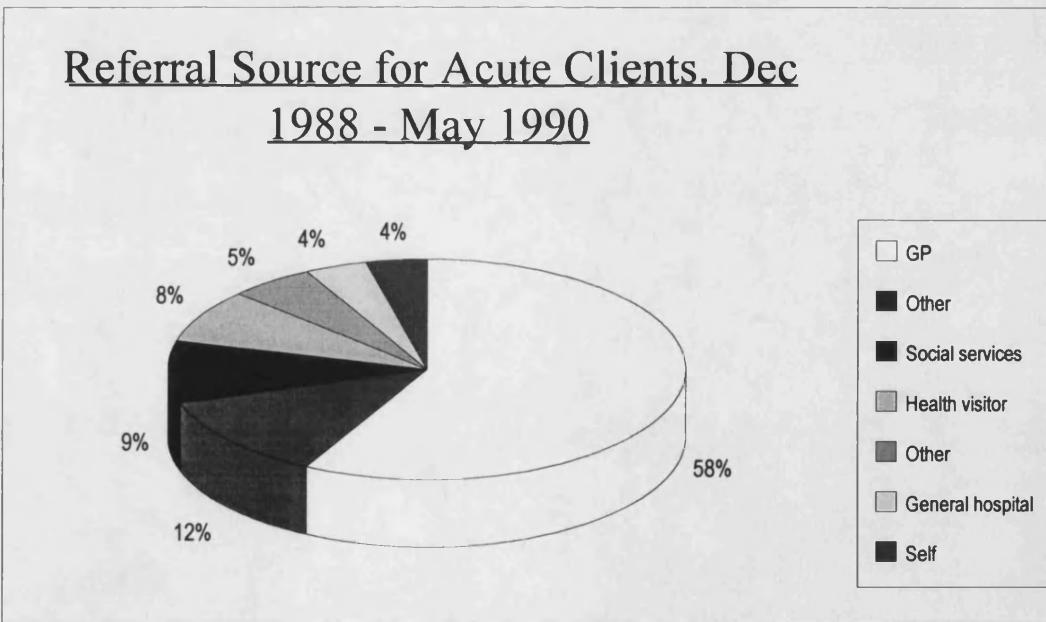
psychologist), but the distribution became wider after that date, although these three staff still carried the majority of the "acute" case-load. Interpretation of these results is complicated by the inevitable staffing changes that occurred during the study period (eg vacant OT post, psychologist on maternity leave, new social worker) and by the different number of sessions each professional group worked for the team.

Referral Sources

Graph 1:



Graph 2:



Results showed a much wider range of referral sources for the "long term mentally ill" group than the "acute" group, with the majority of the "acute" group (58%) referred by GPs.

2) Multi-disciplinary Team Meetings Study

The average duration of the weekly team meetings was three hours (range 4 hours 5 minutes to 1 hour 40 minutes) and they were well attended by the core staff team with various others attending less regularly. Approximately 62% of the whole meeting each week was devoted to discussion about individual clients. About 81% of this total client discussion time was spent talking about "long term mentally ill" clients, with 19% spent talking about "acute" clients. The remaining 38% of the team meeting was concerned with business matters, ranging from policy discussions to information dissemination and the organisation of groups run by team members.

There were no significant differences in the amount of team discussion time each client received, whether they were in the "long term mentally ill" or "acute" group, or "in-patients" or "community" clients (average of about 4 minutes). However, of the clients discussed each week, 78% were in the "long term mentally ill" group and 22% were in the "acute" group. This roughly matched the proportion of clients on the case-load from each group, with a slight bias towards the "long term mentally ill" group.

3) Staff-Client Contacts with "Current" Case-load

Tables 12a & 12b: Staff-Client Contact for six months prior to January 1991

Clients in care in January 1991= 149 - 92 "LONG TERM MENTALLY ILL"
57 "ACUTE"

(Percentage figures stated in this table relate to total contacts in each column, for the two study groups, eg CPN was involved in 17% of the face to face contacts experienced by the team as a whole in the long term mentally ill group, but only 2% of the face-to-face contacts in the acute group.)

a) Long Term Mentally Ill Clients

STAFF MEMBER	FACE TO FACE	TEL. CONTACT	LETTER CONTACT	CONSULTATION	CARER CONTACT
CPN	34 8INF 17% 31%	30 26%	5 6%	26 27%	26 41%
Clinical Assistant	23 5INF 11% 19%	14 12%	7 9%	10 10%	12 19%
Consultant Psychiatrist	33 3INF 16% 12%	3 3%	8 10%	19 20%	2 3%
Social Worker	20 4INF 10% 15%	5 4%	4 5%	5 5%	6 10%
Psychologist	13 6INF 6% 23%	5 4%	7 9%	10 10%	9 14%
Registrar	16 8%	4 4%	1 1%	2 2%	3 5%
Senior Registrar	23 11%	13 11%	11 14%	25 26%	5 8%
Office Manager	18 9%	37 28%	12 15%	0	0
Research Psychologist	22 11%	9 8%	24 31%	0	0
TOTAL CONTACTS	202 26INF 100%	115 100%	79 100%	97 100%	63 100%

INF= Informal Contacts (included as separate variable)

b) Acute Clients

STAFF MEMBER	FACE TO FACE	TEL. CONTACT	LETTER CONTACT	CONSULTATION	CARER CONTACT
CPN	1 2%	1 5%	0	1 6%	1 7%
Clinical Assistant	6 10%	4 20%	2 5%	5 28%	4 29%
Consultant Psychiatrist	16 26%	0	12 30%	0	0
Social Worker	4 7%	2 10%	2 5%	1 6%	2 14%
Psychologist	21 34%	2 10%	18 45%	6 32%	3 21%
Registrar	7 11%	1 5%	1 2%	0	0
Senior Registrar	6 10%	5 25%	5 13%	5 28%	4 29%
Office Manager	0	5 25%	0	0	0
Research Psychologist	0	0	0	0	0
TOTAL CONTACTS	61 100%	20 100%	40 100%	18 100%	14 100%

The results showed that the "long term mentally ill" group had a much wider variety of types of contact with DEW Team staff than the "acute" group. None of the "acute" group had "informal" contacts with staff during the six month period, compared to 30% of the "long term mentally ill" group. The proportions of "long term mentally ill" clients about whom staff reported telephone consultation or carer contact were much greater (67%, 72% and 56% respectively) than those reported for the "acute" group (31%, 31% and 24% respectively). It is notable that, of all of the staff, the CPN had by far the most contact with carers and this was mainly in the "long term mentally ill" group. The "long term mentally ill" clients were generally in contact with higher numbers of DEW Team staff than the "acute" group. This was particularly striking for "Face-to Face" contacts where only 15% of the "acute" group had contact with more than one core staff member over the six month period, compared to 54% of the "long term mentally ill" group.

DISCUSSION

i) Proportion of Long Term Mentally Ill Clients on Case-load

A major purpose of this study was to evaluate whether the DEW Team were giving priority to the "long term mentally ill" group of clients. From an analysis of the case-load over an eighteen month period it appeared that, despite a build up of "acute" clients following the change to a comprehensive catchment area service, the proportion of "long term mentally ill" clients stabilised at about 70%, with the other 30% being "acute" clients. The only comparable data to this is from the evaluation of six comprehensive CMHTs carried out by Patmore & Weaver (1991). Their definition of long term clients which was closest to the DEW Team definition was anyone with a psychotic diagnosis or three previous admissions to a psychiatric hospital in the last five years, or an admission lasting one year or more in the last five years, or any compulsory admissions. They found that in all except one of the teams less than half of the case-load was made up of long term clients. The one exception showed only 59% long term clients.

The DEW Team were therefore carrying a significantly higher proportion of long term clients (70%) on their case-load than any other of the CMHTs studied by Patmore & Weaver (1991). Part of the explanation of these differences could be the socio-demographic nature of the different catchment areas. The DEW Team covered a deprived inner city area with a correspondingly high level of psychiatric morbidity. These figures do however suggest that the DEW Team were successfully prioritising the "long term mentally ill" group in terms of client numbers on the caseload.

ii) Racial Mix

The racial mix of the "long term mentally ill" clients on the case-load was fairly stable over the time period studied. The "acute" group showed a gradual increase in the proportion of African/Afro-Caribbean clients during this time. This suggests that the team was becoming more accessible to African/Afro-Caribbean "acute" clients over the time period. The lack of

Asian clients in the "acute" group supports the widely recognised contention that Asians do not tend to seek psychiatric help with neurotic type disorders.

iii) Referral Sources

The "long term mentally ill" group were referred to the team from a much wider range of places than the "acute" group, in which over half were referred from their GP. This suggests the need for links with a wider number of agencies when working with the "long term mentally ill" group, whereas links with GPs are much more central for the "acute" group.

iv) Proportion of Team Discussion Time Devoted to Long Term Mentally Ill Clients

Another aspect of prioritisation that was investigated was team discussion time. The difficulty of controlling and structuring review systems was described in Patmore & Weaver (1991) and the authors expressed concern that discussions focused on current problems of new clients or dealt with crises, leaving very little time for reviewing long term mentally ill clients who may not have been causing major concern at the time. The DEW Team actively tried to avoid this by ensuring regular review of "long term mentally ill" clients and the results suggested that this strategy was successful. The amounts of team discussion time spent on "long term mentally ill" and "acute" clients were roughly in line with their proportion on the case-load, with a slight bias towards the "long term mentally ill" group.

v) Period of Time that Long Term Mentally Ill Clients Spent on the DEW Team Case-load

The second major focus of the study was to investigate whether differences in the type of service provided could be demonstrated between the "long term mentally ill" and "acute" groups. The results showed differences in a number of areas. One important expectation from the DEW Team policy of providing long term support to the "long term mentally ill" group was that they would stay on the case-load for longer periods of time than "acute" clients. Two six month periods

were looked at and in both cases 3/4 of the "long term mentally ill" group were still in care at the end of six months. This suggested that the DEW Team were providing long term care to this group. If team policies were being adhered to, one would expect that a lower percentage of the "acute" clients would still be in care after six months. This was the case, although there was a large increase from 18% still in care after the first six months, to 63% after the end of the second period. This suggests an increasing tendency for the "acute group" to stay in care for longer than six months. Therefore, the distinction between the two groups was getting less marked over time.

It is worth noting that about 25% of the "long term mentally ill" group were discharged during both of the six month periods. This study did not investigate reasons for discharge (see Rickard, Leibowitz & McLean 1992b), but the results of the study presented in chapter eleven suggested that quite a high proportion were accounted for by the significant amount of population movement which occurred in Battersea as an inner city area and also in response to changes in catchment area boundaries which put surprising limitations on attempts at continuity of care.

vi) Key-worker Allocation

Both "long term mentally ill" and "acute" clients had key-workers from a range of professions, with CPNs and psychiatrists most likely to take on this role with long term mentally ill clients. Psychiatrists and psychologists were most frequently key-workers for the "acute" group.

vii) Staff-Client Contacts

Major differences in the types of contacts made with clients were indicated from these results. From the nature of work with long term clients, one would expect that a wider variety of types of contacts would be required to support them. This was in fact the case, with the "long term mentally ill" group receiving more telephone contact and only "long term mentally ill" clients having "informal" contacts with staff (eg

unplanned meeting in the local area). The importance of carers for this group was reflected in the larger proportion of contacts with carers for the "long term mentally ill" clients. The proportion of "long term mentally ill" clients about whom staff reported "consultation" contacts was also much greater than for the "acute" group, reflecting the involvement of a lot more agencies in the care of the "long term mentally ill" clients. The results also showed that more members of the multi-disciplinary team were involved in the care of the "long term mentally ill" clients than the "acute" clients, with over half of them being in "Face-to-Face" contact with more than one team member over a six month period, compared to only 15% of the "acute" group.

An Overview of the Feasibility of Prioritising Long Term Mentally Ill Clients in the Catchment Area CMHT Model

Patmore & Weaver stated in their study of six CMHTs that:

"A system to monitor representation of sufferers from serious mental illness needs at least three components. It needs an operational definition of "sufferers from serious mental illness". It needs a record system which can show how many people with these defined characteristics are on the case-load. It also needs some means of evaluating whether their number is sufficient, praiseworthy or too low - maybe a target quota to be achieved...." (Patmore & Weaver, 1991, p60)

This study showed that the DEW Team had been successful in the first two of these tasks - producing a meaningful definition of the long term client group and developing a monitoring system that could identify their numbers on the case-load. What was still required was the last point concerning clear target quotas to be achieved. In comparison with data from other teams (Patmore & Weaver 1991) it can be concluded that the DEW Team were giving priority to their "long term mentally ill" clients in terms of proportions on the case-load. The study also looked at differences in what the team offered to the two groups of clients ("long term mentally ill" and "acute") once they were on the case-load. The results suggested that the distinction was a meaningful one in that the DEW Team did offer a different kind of service to the two groups.

The parameters used in this study were relatively quick and easy to access and required very little direct input from team members: characteristics which made them very useful as part of a regular monitoring system. In terms of looking at what was offered to different types of clients, the sample method described above for looking at types of contacts each team member had in relation to clients over the previous six months, provided a simple alternative methodology to the very time-consuming diary studies often used in this type of research. It was easily utilised without any extra "research time" and provided useful information as part of an overall review of team functioning.

In Brief

Overall the results of the study presented in this chapter suggested that it is feasible for a CMHT to give priority to long term mentally ill clients within the comprehensive catchment area model, both in terms of overall numbers on their case-load and in terms of the type of input they receive. The move by the DEW Team towards catchment area provision from specialist provision to the long term mentally ill was not as destructive as the team had foreseen and the model of working that they had devised while working as a specialist team was successfully transferred to the catchment area model.

PART 3: SYNTHESIS

This thesis has been concerned with community care services for people with long term mental health problems. It has concentrated on one local experimental team using the CMHT Approach. It was argued at the outset that the existing literature was poorly adapted to answering the research questions, as it fell into largely separate discourses. It embraced macro political and sociological theory, narrowly professional commentary, micro political science approaches and in-service evaluations with little inter-change between each. An attempt will therefore be made in this final section of the thesis to synthesise material from each approach.

The thesis methodology was based on the idea that a synthesis of theoretical and practical material would allow us to gain a better understanding of what is really happening in community care policy development for the long term mentally ill at the local level. Chapter 13 will be concerned with answering the first of the research questions stated at the outset, and chapter 14 will deal with the other major question. Some comments on the relevance of such work with the current changes in national policy will be presented at the end of chapter 14.

CHAPTER 13:

The Structural/Philosophical Interpretations Reconsidered

The first of two central research questions that stimulated this thesis was:

Why has community care of the "long term mentally ill" been so difficult to implement in Britain?

The aim in this chapter is to answer this first question by reconsidering the case study evidence in the light of structural and philosophical interpretations put forward in chapter three. The intention is to start to draw together the threads of analysis that can be gleaned from the discussion sections presented throughout Part Two. In so doing, it is hoped that it will be possible to see to what extent the broad theoretical interpretations help us to understand the structural and philosophical problems experienced in the implementation of the CMHT model for long term mentally ill clients at the local level during the 1980s. An initial discussion of the contribution of these interpretations prior to the introduction of a CMHT model in the case study area was presented in chapter five. For the sake of clarity, in this chapter each set of interpretations described in the framework will be considered again in turn, building on previous discussion.

a) Traditional/Pluralist Interpretations:

The first element of the traditional accounts discussed in chapter three was identified to lie in the medical model of care and in chapter five it was suggested that one reason why community care for the long term mentally ill was so difficult to implement in the case study area was that the ideological foundation of community services that were provided in the 1970s, did not adequately address the social disablements of clients. Chapter six described how the CMHT approach was partly embraced in the case study area as a recognition of this fact that services needed to depart from relying only on a medical input, specifically aiming to promote a more social and environmental perspective on the aetiology and treatment

of mental illness. This new emphasis was reflected in the establishment of a multi-disciplinary CMHT, drawing on the skills of a range of professionals (described in chapter seven) and in the service style and operational policy of the CMHT (described in chapter eight). The fact that the CMHT approach was sustainable throughout the study period and that these basic parameters were later adopted by other CMHTs later developed in the case study area, suggests that the change of ideology towards ideas based in developmental social psychiatry played a significant part in the successful implementation of the CMHT approach during the 1980s.

The second element of the traditional/pluralist set of interpretations was that community care developed as part of a general moral improvement. However, case study evidence suggested that the CMHT model was not initiated as a result of a collective appreciation that the CMHT approach was superior to institutional care. There was no process evident of gradual enlightenment, rather an attitude of reserved distrust of service innovation. The institutional system was initially only being actively challenged by a few isolated individuals within the hospital, who formed an alliance as part of the new DEW CMHT. Others had a general sense that community services were to become the emphasis of future service provision, but not all professionals supported the new DEW Team initiative on liberal grounds of the possible improvements in quality of care for clients. Many did so on the basis that the new CMHT relieved their own workload or at least dealt with some of their more difficult patients. Hence, case study evidence suggested that professional self interest also played a significant part.

As discussed in chapters eleven and twelve, even in the DEW Team's later years, many were not convinced that the CMHT approach actually offered anything new in service provision or that it successfully prioritised work with the long term mentally ill group. The empirical study described in chapter eleven comparing the DEW service with the CPN approach to care, showed that some of these reservations were well

founded. In the traditional way in which service quality was measured, little improvement was evident. There was no decrease in long term mentally ill patient need for hospital admissions, no decrease in the duration of admissions and the number of visits that staff in the two services were able to offer to patients did not differ.

However, the DEW Team did demonstrate other improvements relating mainly to ideology, the style of service delivery and the process of care. The DEW Team had some influence in changing staff attitudes to the goals of service provision. They emphasised a "maintenance" rather than "cure" approach to care and highlighted the importance of social support to the long term mentally ill group. The value of care planning was shown, as a structured, well thought out and monitored approach to care. The importance of multi-disciplinary input to care and the improved support to staff and development of a coherent staff identity was highlighted. Also, there was improved liaison with community agencies and the DEW Team undertook some forms of educational work. Yet there was no traditional way to measure such inputs and their value was underplayed by those staff who had never been exposed to them in their own working environment. Hence, the traditional interpretation of events is unhelpful as it contends that such improvements are noted and accepted by the plurality of interests. Yet, opinion remained divided on fundamental aspects of the structure of services at the local level.

The third element of traditional pluralist interpretations was noted to be the emphasis placed on the activity of a range of interest groups, who were said to exert pressures commensurate with their degree of influence to jointly determine policy. Case study evidence presented in chapter six showed that change in the provision of community care services to the mentally ill was initially prompted by the setting up of a Joint Care Planning Team (JCPT) in 1979. The representatives on the JCPT did represent a plurality of interests to some degree, but were heavily dominated by medical interests and the psychiatrists effectively blocked the initial proposal for

joint day hospital provision. The potential for dialogue between the different interest groups was in fact very limited.

Innovation in service provision in the formation of the DEW CMHT later occurred, but this was not the result of productive discussions and bargaining between interested parties. Hence, the traditional pluralist position does not adequately explain the process of innovation and how change was instigated. Neo-pluralist writing emphasises the imbalance of power between interested groups but continues to stress the vital role of debate between a diverse range of interests in developing policy. Evidence presented in the later case study chapters regarding the reorganisation of catchment services demonstrated that there was heated debate between different Health Service professional departments and management representatives at the local level, but still no representation of client and carer interests. During the 1980s, pluralist input into the process of local mental health policy formation was widened to some extent, but was dominated by professional and managerial interests and was influenced by a wider general trend for each professional group to assert and distinguish their particular skills and draw strict boundaries between themselves and other professionals. This "professionalisation" contributed to the difficulties of successfully implementing innovative care approaches for the long term mentally ill, as arguments did not just centre on which care approach was best, but were instead used as a forum to settle wider disputes about professional boundaries.

There was no balancing input from carers, service user groups or local voluntary groups, aside from consultation through a user satisfaction survey conducted in 1989 and this was never considered as a major tool for policy change. Local MIND and NSF groups were not involved at all and the DEW Team development did not arouse any interest from these bodies. The input from the Social Services side was reduced to the recruitment of one social worker to join the new team. All these interests were to some extent involved in highlighting

the extent of community care problems for the long term mentally ill, but organised groups of particular interests were not observed to be putting forward proposals resulting in a balanced solution in which each interest had played a part.

Some traditional pluralist accounts of the problems with community care policy emphasise the administrative inadequacies, bureaucratic mismatches and disorganisation in providing the structures necessary to successfully implement the policy. Evidence from the DEW Team case study suggested that while these barriers existed, problems in initiating and implementing change in service provision were deep rooted and reflected personal, political, ideological and professional issues. Administrative difficulties were reported in chapter nine regarding the problems with establishing office space and secretarial cover, and it was suggested that the root of these problems lay in organisational obstructiveness. The traditional interpretation, while giving important emphasis to these difficulties attributes them to structural flaws in the administrative system and does not adequately address their complex origins.

b) Sociological/Anthropological Interpretations:

From a sociological/anthropological perspective, community care was said to have been adopted due to the recognition that institutions were anti-therapeutic, as demonstrated by a diverse range of studies in the 1960s and 1970s. The idea was that mental illness institutions perpetuated a form of social control. This interpretation was initially considered in chapter five in relation to services that existed before the DEW CMHT was initiated in 1979. It was suggested that the social control function that institutions previously served had become almost inverted in the community at this time. Clients were being discharged from the institution with very little follow up in the community. In particular, they received little help in tackling the welfare benefits system, had few sheltered work opportunities, often had poor housing, little social support and generally chaotic lives. It was suggested that institutions had changed since the days of

those described by Goffman and his contemporaries. They no longer had a long term asylum function and clients were not interned for life. Most clients were treated for short periods within the hospital and then returned to their homes. Long term mentally ill clients often became "revolving door" cases and the main function that the institution was serving was in temporary crisis containment. The element of the social control function that the institution still fulfilled at this time was hence for the long term mentally ill. They were being controlled in the sense that it was virtually impossible for them to escape this "revolving door" cycle.

In 1986, the DEW CMHT was set up to particularly address these institutional "revolving door" problems for the long term mentally ill and the apparent neglect to which they were subjected in trying to survive in the community. Hence, the DEW Team could be said to have been attempting to tackle the two associated issues of social control in the institution and social withdrawal in the community. The DEW Team formally made some attempts to embrace an environmental and social approach to care and this was reflected in its operational policy described in chapter eight. For example it promoted home visiting, community support groups, the maintenance of client support even when clients were not in relapse, and networking with other community agencies. As such, the DEW CMHT appeared to go some way towards addressing the social withdrawal imposed on long term mentally ill patients in the community, but as demonstrated in chapter eleven, did little to break the cycle of "revolving door" hospital admissions. This suggests that a further reason why community care policy for the long term mentally ill was difficult to implement in the 1980s was that service providers did not acknowledge and accept that clients would still require some form of asylum that could not be provided by CMHTs, away from the harsh realities of the community.

However, the DEW Team aim to stabilise and support the long term mentally ill in the community could also in another sense be perceived to be a return to the social control function

with the motive of maintaining societal stability. In terms of their direct impact on clients, the DEW Team were to some extent attempting to "normalise" the long term mentally ill and to make them more like other clients; compliant, receptive and less troublesome. Yet, few of the clients interviewed for the user satisfaction survey referred to in chapter eight recognised this as a problem and the majority welcomed and came to rely on the support offered by the team. Proponents of the sociological/ anthropological schools of thought may argue that the clients did not realise they were being socially controlled and were passive recipients of the new CMHT system of care. It seems the only evidence that can be drawn from this study was that clients were not found to be experiencing extreme personal and social discomfort as a result of the way that the CMHT was working, on a par with those observed in the past by authors considering the plight of people institutionalised for long periods in mental hospitals. The CMHT clients had their individuality, limited freedom and ongoing social, emotional and practical support from the CMHT. Hence, it is suggested here that the negative implications of the idea of social control in the community are not necessarily valid in terms of the direct perception of the majority of clients at the case study CMHT.

Yet the DEW approach did not really allow for much liberalising of patient rights and nor did it give any power to service user and voluntary groups. Efforts to empower clients through the provision of jobs within the DEW organisation were never successfully carried through and although the team members saw this as a frustration they were never able to make it a reality during the thirteen year study period. The impression gained was that professionals on the team came to believe that such aspects as service user empowerment were overly ambitious and largely impossible to achieve. Gradually the CMHT model was used to challenge some of the old principles of care but not to challenge them too radically and as such was to some extent imported into the local service and gradually modified by it at the same time. It is suggested that in this way, CMHTs implemented in the

1980s acted as a stepping stone by which hospital psychiatry moved into the community and adopted a more social approach to care but retained some of its former ideological allegiance to the medical model of care. From this it could be implied that community care for the long term mentally ill during the 1980s was problematic because the required social and environmental approaches to care were only partially adopted.

Social workers, in particular, were critical of some aspects of the DEW approach to care, including the intrusive nature of their "no discharge" policy, home visiting and multi-disciplinary assessment. This demonstrated fundamental ideological differences between Health and Local Authority professionals. Some social workers also criticised the CMHT for remaining too medical in their approach. Certainly, the DEW CMHT model whilst introducing newer methods of care as described above, also continued to emphasise the importance of medical intervention, institutionalisation when relapses occurred, drug treatments, electro-convulsive therapy (ECT) and other medical based therapies. Thus the sociological theories are helpful in pin-pointing ideological and philosophical differences that exist between different agencies operating at the local level, which partially explain why community care for the long term mentally ill has taken so long to be implemented and why it continues to be problematic.

The sociological interpretation was important in questioning the philosophical and political basis of care in the institutions. With the move to the community, it remains a valuable framework for considering the ideological foundation upon which services are based and for assessing the appropriateness of individual care policies. In the DEW CMHT, such a framework was used by the professionals on the team to consider the on-going appropriateness of the DEW Team's "outreach" style of service provision and the merits of different sections of the operational policy (see chapter ten). Hence, consideration of the sociological position helps us to remain aware of the mistakes of the past and gives a critical framework to assess the merits of new policies. It

raises critical questions about where the boundaries of therapeutic involvement should be drawn in a move towards social care rather than social control or withdrawal.

c) Marxist Interpretations:

In terms of a Marxist perspective, community care is seen as having failed because it does not address the social, financial and political inequalities of a class based society and is used by the state as a way of marginalising the needs of people who suffer the consequences of chronic deprivation in a capitalist system. The mental health care system is considered to trade in protecting individuals from discovering the true causes of their plight.

The DEW Team case study serves to highlight the complexity of social and political issues that underlie community care services. The motivation for the DEW service to be set up lay partly in a recognition by existing service providers that the long term mentally ill were particularly concentrated in the Northern part of Battersea, where they experienced poor housing conditions, where social networks were particularly weak and where their mental health problems were exacerbated. In terms of the social class and economic power of long term mentally ill clients in the case study CMHT, very few clients had jobs, most were living amongst the working classes and were essentially lowest in the pecking order and highly vulnerable as a result. A Marxist analysis might explain this situation as reflecting capitalist control over mental health care expenditure which was kept to a minimum since the long term mentally ill did not register on the political agenda. Neglect of this marginalised group would have no electoral consequences and therefore they were not accorded any priority. Case study evidence showed that it was only professionals who forced the issue of long term mental illness onto the local political agenda during the 1980s. This suggests that a further reason why community care for the long term mentally ill was so difficult to implement was that the long term mentally ill did not gain sufficient political priority.

The DEW approach did attempt to address some of the problems described above. Chapter six and eight described how the DEW Team located their office base in the middle of the Doddington Housing Estate and designed their working practices to start to address social, environmental, cultural, educational and employment issues. They started to consider clients individual needs in many different areas, not just in relation to medical needs. The DEW Team set up joint working with the housing department, they organised a network group of community representatives on the housing estate and ran social support groups and sheltered workshops. The DEW CMHT could be said to have been trying to set up more effective and accountable local projects that reflected a need for a response across the broad spectrum of social welfare.

However, the DEW Team members were never explicitly political. They were able to help clients tackle the benefit system and improve their financial situation, for some to be moved to better housing, for help in getting furniture and necessary household items and the team negotiated with the gas and electricity board on behalf of clients to settle debts. Yet they never aimed to campaign to change the structural inequalities that had caused clients to be living in such deprived conditions in the first place. This would demand a political reaction to challenge social structures. A Marxist consideration, therefore appears to be helpful in locating a source of problems for the long term mentally ill group in the environmental and political arena, but there was no evidence from the case study area that the suggested solution for professionals, clients and the wider community to become politically active was considered on any level other than within the narrow professional arena. The Marxist analysis hence loses some of its potency in explaining local policy because no large scale political struggle ensued during the case study period and the case study team slowly lost political momentum rather than widening its remit into local political activity.

The Marxist interpretation also suggests that change can only

come about through crisis and conflict rather than debate and planning. In 1988, conflict did arise in the case study area over whether care for the long term mentally ill was to continue to be provided by a specialist CMHT or within a new comprehensive catchment area service. The conflict essentially resulted in a "luke warm" compromise rather than the radical and escalating organised pressure desired by Marxists. In this sense, the Marxist interpretation appears unrealistic regarding mental health service change at the local level, because it implies the need for constant dynamic struggle which is virtually impossible to generate and cannot be sustained. The lack of such political activity was indicative of further implementation problems with community care policy, as it suggested that with the government emphasis on moving towards reformed Health and Local Authority functioning within a market structure, the collectivist ethos of groups like the DEW Team was undermined at the local level.

The Marxist framework does have considerable drawbacks as an interpretation of the move towards innovation with the CMHT approach at the local level. In terms of case study evidence, the dynamic of class struggle was not found to be informative and the DEW CMHT was not seen to be part of any kind of dialectical process. Poor inner-city communities like those in North East Battersea accumulate the long term mentally ill for reasons of housing policies and the tendency for poor, inner-city areas to become transition zones. A Marxist consideration can only help to emphasise that tackling these problems is all part of the community care solution and any programme that does not accept this will not start to address important needs. Where a Marxist interpretation may have more to offer at the local level is when considering the economic basis of the care system. This will be explored in the following section.

d) Economic Interpretations:

The economic interpretations discussed in chapter three suggested that the origin and problematic nature of community care can be explained solely in terms of economics and

finance. In relation to the thesis case study, no cost data was sought for the period studied, as the research design could not be extended within the limits of this thesis. The contribution of the economic interpretation at the local level is hence restricted for our purposes to a consideration of the influence that assumed costs and financial expediency had on the case study CMHT at different stages of its development.

The DEW service was initially set up with funds from the delayed development of the new day hospital in Battersea. The money for this venture had been set aside when the situation was not as financially restricted as it became later in the decade. The CMHT was not aiming to replace institutional care or the meagre after-care community provision that had existed previously. It was initially proposed as an additional service to act as a "shadow day hospital team". The DEW service, therefore, constituted a new cost, although the capital investment was relatively small and the money had been set aside for the day hospital project anyway.

However, this evidence discounts any argument that the DEW CMHT was accepted purely on the grounds that it was thought directly to provide a cheaper form of care than the institution. There was no direct financial gain to the Health Authority in allowing the practitioners to set up the DEW Team, but indirectly financial savings were hoped for as a result of the Team reducing the need for "revolving door" hospital admissions. Hence, there was an indirect financial motive based on speculation about the DEW Team's ability to act as a cheaper substitute for other costly services. With hindsight, the data presented in chapter eleven showed that the DEW Team did not significantly reduce the need for hospital admission, but while the hope was there, the motive of potentially saving money was a powerful influence on policy.

It was a politically expedient move for the DEW service to be allocated extra funding at the outset, for the Mental Health Unit was under pressure to be seen to be doing something to

address the problems of the long term mentally ill. The DEW CMHT was a professional led initiative, and as such, the Unit was achieving policy objectives at a minimal cost, without having to invest extra time and resources in researching how to fulfil such objectives, training new staff and creating new administrative structures to facilitate a new development. They were to some extent getting service innovation on the cheap and hence achieving further indirect financial gain. Therefore, an economic interpretation is quite powerful in accounting for local developments concerning the reasons why innovation using the CMHT approach was permitted to take place.

However, the economic interpretation has less weight in explaining the process of innovation. It does not account fully for the initial motivation to innovate on the part of professionals involved. Therefore, it only gives a partial account of events. The DEW Team were both lucky and clever to locate and exploit the additional funding required to set up and the economic interpretation does not offer any explanation of the important role of this aspect of the DEW Team story.

In the late 1980s, financial squeezes began to have a significant influence on the future development of the case study CMHT. The Mental Health Unit's decision at this time that it could no longer support a specialist service for the long term mentally ill across the whole of Battersea was partly based on the fact that the team was continuing to use additional resources, and yet had grown to be a development in its own right, that was rather separate from the day hospital plan. Also, it was not seen to have effectively reduced the burden on hospital services. Therefore, the DEW Team's continued existence as a specialist service was rejected partly on the grounds of fiscal constraint. They became subject to the same monetary constraints as other local services when the need arose to rationalise financial allocation in the cost cutting climate of the late 1980s.

The DEW Team effectively worked on the principle that long

term mentally ill patients needed to be supported and maintained even when they were well. No such maintenance service had been provided in the past and hence, implied the need for the continued development of the DEW Team as a new, additional service with the associated increase in costs. This became apparent to management after the Team's first two years of working and they refused to continue to financially support the Team in this role when the Rehabilitation Service had also been developed with a remit that over-lapped the DEW Team's responsibilities. This suggests that another reason why community care for the long term mentally ill was difficult to implement during the 1980s was that innovations were encouraged with the hope that they would result in financial savings, but when these financial savings were not perceived to be forthcoming, the innovative activity was curtailed rather than being developed.

Interview and documentary evidence suggested that the strengthening of the managerial position in 1988 represented a strategy by the state to control and contain the amount of local service provision that was seen to be absorbing too many resources. However, other motives, such as the desire to make mental health services across Battersea more consistent and rational by introducing a catchment area model, also played a part and these considerations are marginalised by economic theorists, who attribute cost to be the sole determining factor. Hence, as suggested in the critique presented in chapter three, the economic interpretations appear too deterministic, but consideration of the financial aspects of CMHT provision was important in explaining such developments at the local level.

e) Elitist Interpretations:

Those who adhere to an elitist interpretation of community care policies attribute its problematic implementation to an unhealthy domination of mental illness policy by the psychiatric profession and their unwillingness to give up established medical empires within institutions to enable new community approaches to develop. Consideration of whether such

psychiatric elitism existed at the local level of community mental health service development has already been referred to throughout the account presented in part two and this section aims to draw together the evidence.

In chapter five it was noted that before 1979, psychiatrists in the case study area had elitist power across the whole range of service organisation, from planning and the determination of service ideology right through to direct clinical provision, and were resisting change. In chapter six, one of the reasons quoted at interview for the failure of the initial day hospital plans was that the psychiatrists did not want a joint project with Social Services staff in which their clinical autonomy would be challenged. Joint provision did not exist and was being resisted. The psychiatrists were observed to have had the power to prevent the plans from becoming a reality.

However, the fact that the DEW CMHT was initiated by a psychiatrist, who was initially supported by her psychiatric colleagues, showed that not all psychiatrists were resisting community care developments at the local level. Yet, the early historical account of the DEW CMHT presented in chapter six showed that the innovating psychiatrist initiated change in community services on the grounds that she had a controlling stake and could keep joint provision to a minimum. She did wish to encourage joint working with other professionals and organisations outside the Health Service as long as she had clear responsibility for initiating and managing the work of the DEW Team, retaining an elitist influence. It could be argued that the DEW service proved to be a sustainable approach to community care, because it did not disperse the power base of the institution among multiple interests, being a primarily Health Service driven initiative. From the suggestion that the medical profession was resisting the implementation of community care in the 1970s on the grounds that they would lose monopoly control over care for the mentally ill, it logically follows that implementation was only accepted in the 1980s because it was realised that the

essence of this monopoly control could merely be transferred into the community. The case study evidence demonstrated this process at work and suggests that a further reason why the implementation of community care policy for the long term mentally ill in the 1970s had not been made possible, was that psychiatrists had not yet discovered the potential to exploit such a move.

The elitist interpretation is hence useful in emphasising the importance of this feature, but gives little or no consideration to other accompanying factors such as the genuine altruistic concern on the part of the innovating psychiatrist to improve services for the long term mentally ill or her personal qualities and motivation to instigate change. She was committed and out-spoken and this was found to be an important element in her ability to sustain the innovation through the planning process. The elitist position does not adequately account for the importance of this individual's determination and strength of personality.

The case study showed that psychiatrists are in a good position to instigate service change within the mental health field. There are several reasons for this, that were highlighted by interviewees. For instance, psychiatrists generally have years of experience in one geographical area, with associated authority vested by their professional responsibilities. The professional hierarchy and promotional system amongst psychiatrists also encourages the championing of new projects. This point was emphasised in chapter seven in discussing the OTs involvement in the DEW Team innovation. The OT essentially co-founded the CMHT with the psychiatrist. She had strong ideological convictions on a par with the psychiatrist and her ideas were respected. However, she stated at interview that she would not have wanted the sole responsibility for instigating the new service and was not in a position to do so. The DEW Team initiative was only possible because the consultant involved was an experienced and powerful agent within the hospital organisation and was initially able to mobilise the support of both the management

and her psychiatric colleagues. No representative from another profession was in a position to do this. Hence case study evidence suggested that in the early 1980s in service innovation at the local level, psychiatrists were in an elitist position over other professions, both in terms of influencing planning activities and initiating action.

The consideration of team building within a multi-disciplinary framework that was presented in chapter seven showed that the psychiatric elitism described may have been true of service innovation in the case study area, but in the early years of CMHT implementation and day to day working it was less apparent. Other professionals on the DEW Team played a significant role in the development of the CMHT service style, particularly the OT and the psychologist. This observation gave rise to the suggestion that while the key psychiatrist did draw on elitist power in order to achieve the required authority to innovate, this was not as destructive or as monolithic as the literature suggests because it enabled other professionals to begin to exert considerable influence over the style and direct provision of CMHT services to the long term mentally ill in the following two years. This is illustrated by the fact that the key elements of the DEW Team operational policy described in chapter eight were jointly defined by all the members of the multi-disciplinary team.

With the catchment area reorganisation in 1988, the Mental Health Unit management were partly motivated by the movement between posts of other local consultant psychiatrists in Battersea and the DEW Team consultant psychiatrist's decision to go part time. Hence, at the time of major service reorganisation, the psychiatric profession again exerted a considerable influence over future service provision. Yet, by this time, local management members had to some extent formed a challenging local elite and forced elements of cost containment and rationalisation of catchment populations onto the planning agenda. The extent to which management actually challenged the psychiatric elite is open to interpretation, for in some ways they acted as allies of the dominant medical

interest, but they did exploit competing sub-divisions within the psychiatric profession locally to resolve issues of resource allocation. Hence, by the late 1980s, the psychiatric profession was certainly no longer the only interest group to have power in determining local service structure and distribution of resources.

Other professionals on the DEW Team reacted strongly to the proposed catchment reorganisation and fought independently of their psychiatrist team leader to retain their identity and continue to prioritise the long term mentally ill. They won this battle and were able to negotiate a compromise. Therefore, these non-psychiatric professionals, although unable to have any control over service structure, retained an influence over the style of the new service and succeeded in keeping the long term mentally ill on the local policy agenda. Between 1988 and 1992, they continued to exercise this power in determining the CMHT programme for the monitoring and evaluation of service quality. They also retained considerable autonomy and discretion in their day to day clinical work. Hence, psychiatric elitism was not observed to be prevalent at these levels of service provision.

In conclusion, a further reason why community care for the long term mentally ill took so long to be implemented during the 1980s was that it initially threatened the elitist position of psychiatrists in determination of service structure and it took the profession time to work out they could transfer some of their influence into new social psychiatry initiatives such as the DEW CMHT. At the same time, local management were creating new rivalry as a challenging elite and it took time to overcome the tensions that this new challenge posed in establishing new working relationships.

f) Feminist Interpretations:

The feminist interpretation suggests that community care policies maintain an existing structure of social organisation that is sexually biased and disadvantageous to women as professionals, carers and clients. It is suggested within this

perspective that community care cannot work until these ideological foundations are challenged. The aim in this section is to determine whether such challenges were apparent in the progress of the case study team. In chapter five it was noted that in 1979, before the DEW CMHT existed, women were under represented in the mental health planning structure and very few of the consultant psychiatrists were women. The Battersea JCPT was significantly male dominated. Whether such features affected the slow process of community care development locally can only be surmised.

The hospital consultant psychiatrists were predominantly male throughout the study period, and in line with earlier contentions regarding the elitism of the psychiatric profession, this was almost tantamount to male elitism. Within this structure, the DEW CMHT was progressive from a feminist perspective due to the fact that it was initiated by one of the few local female consultant psychiatrists at the time. In so far as the DEW CMHT was a "women led" initiative, it was a great success. Most of the core members of DEW staff that worked on the team throughout the thesis study period were women. Hence, on a day to day basis the DEW Team did something to champion the abilities of women as professionals within the health service, but had no real need to embark on debates about the questioning of equal opportunities between the sexes, as in the latter part of the 1980s they were increasingly privileged to work with women at all levels of the profession from management through to the voluntary agencies. It is noteworthy that Springfield Hospital became a particular centre of excellence when it came to women being given substantial responsibilities within their professions and many of the higher management positions were also held by women.

At least initially when extra resources were available, the DEW Team were able to identify work with young mothers and toddlers as one of their priorities and more generally to be sensitive to the needs of women with long term mental health problems, particularly those who were suffering from

depression. By developing a definition of the long term mentally ill that was not restricted to a psychotic diagnosis, the DEW CMHT were able to extend their prioritising policies to more women, who were over represented in the long term mentally ill client group suffering from severe neurotic disorders, a diagnostic category that was excluded from most definitions of the long term mentally ill used elsewhere in the country at the time. Through linking in with other community agencies and doing some advocacy work with clients, the Team also did something to address issues relating to the provision of welfare services and benefits in relation to the family, conferring benefits particularly on the female members. Attention was given to women in the caring role supporting relatives and dependents with a mental illness, particularly through the Relatives Support Group, but this was not confined to women. However, evidence from the client satisfaction survey suggested that carers were the most dissatisfied group interviewed and hence it can be concluded that during the study period, the DEW Team's work with carers was not extensive enough.

The case study evidence therefore suggested that a feminist interpretation is not useful in accounting for why community care for the long term mentally ill has been so difficult to implement. However, it does demonstrate that feminist issues can play an important part in the move towards community care that has only before been considered on the fringes of the academic debate. Feminist issues were certainly an element of the DEW Team success story, although they were never formally recognised as a contributing factor to their achievements. Maybe this fact in itself is instructive when considering some of the areas where as a team they could have done better. For example, the initial group work with the mother and toddlers group and the Patmore Women's group had to be gradually phased out in the team's later years due to other work pressures. This was regretted by the team and because this fact was never highlighted as an issue in itself it was left to fall by the way side.

In Brief

An important part of the thesis methodology was the idea that the literature has not gone wide or deep enough to give a clear overall view of the dynamics of the policy process at the local level regarding implementation of the CMHT approach. It was therefore thought necessary to introduce a selection of broad theoretical interpretations designed to afford this broader perspective. The case study evidence discussed in this chapter could arguably be claimed to be inconclusive in not suggesting an explanation of events located solely in terms of one theory. On the contrary, it is argued here that all contribute something to an understanding of the local policy process. In combination, they suggested a spectrum of reasons why community care for the long term mentally ill was difficult to implement during the 1980s, which are summarised below.

However, to fully understand the difficulties involved in implementing a CMHT model at the local level, we need to also look more closely at the role of professional and political conflicts and organisational complexity. It is to the implementation literature found in the realm of public policy and the professional and practice literature that we need to return to consider these additional features and this is the aim of the final chapter.

A Summary Of Case Study Evidence For Why Community Care For The Long Term Mentally Ill Was So Difficult To Implement In Britain During The 1980s

1. It was not until the 1980s that the required ideological shift towards more social and environmental approaches to client care was introduced at the local level, yet professional opinion remained divided on the value of these approaches. Also, during the 1980s, new community services based in the CMHT approach were often introduced without regard for the full range of client needs. Emphasis was placed on trying to keep clients out of hospital without providing an alternative to the asylum function of the hospital in a community setting. The required social and environmental approaches to care were only partially adopted.
2. During the 1980s, pluralist input into the process of policy formation was widened to some extent, but was dominated by professional and managerial influences and clients themselves were not consulted or given opportunity to contribute to planning or service development. Discussions about innovative community services based in the CMHT approach became a battleground to settle more general disputes about professional boundaries. This detracted from the drive to improve community services for the long term mentally ill.
3. Administrative inadequacies and bureaucratic mismatches also impeded the implementation of new community service approaches during the 1980s. However, these difficulties were not solely structural in origin, but deeply rooted in personal, political, ideological and professional issues and consequently less readily resolved.
4. Ideological and philosophical differences between different agencies operating at the local level were often unreconciled, particularly between Health and Social Services. This contributed to the implementation problems of the CMHT approach during the 1980s which was predominantly Health Service driven.
5. At the local level, the long term mentally ill did not gain a sufficiently high political profile to promote community initiatives that genuinely met their needs.
6. The collectivist ethos of CMHTs developed during the 1980s was undermined by wider central government moves to reform the Health and Social Services within a market structure. This had an adverse effect on the morale of staff who pioneered CMHT ventures.
7. During the 1980s it was hoped that CMHT approaches would result in financial savings but when such savings did not become apparent, these new initiatives were curtailed.
8. The implementation of new community approaches was dependant on acceptance of these approaches by the psychiatric profession, due to the elitist influence of the psychiatric profession on mental health services. During the 1980s it took time for the psychiatric profession to realise that CMHTs offered an opportunity to extend their elitist influence from the hospitals into community services and this further accounted for the slow implementation of new CMHT policies.

CHAPTER 14:

Are CMHTs the way forward?: An Innovation that will stick?

The second major research question of the thesis was:

"Does the Community Mental Health Team (CMHT) Approach provide a viable model of service provision?"

The aim in this final chapter is to answer this question in the light of case study evidence. To undertake this task, the intention is to synthesise the main findings from each of the case study chapters in turn and generate conclusions from each that were supported by the case study evidence. The case study chapters drew on the professional and practice literature described in chapter two and the public policy literature presented in chapter four. Hence, these have been used as a basis to evaluate the CMHT approach and identify issues that are crucial for the future development of community care services for the long term mentally ill.

A few ideas about the relevance of the research findings in the current national context of change will then be presented. Since the work for this thesis began, the community care agenda in the UK has moved on, with new legislation in force and more promised. Yet, the central issue remains, however financed and administered, what viable models for care exist? This thesis has concentrated on one highly pertinent innovation in health and social care for the long term mentally ill, that was developed and tested in the field during the 1980s. Drawing on the case study findings, this chapter aims to discuss some of the important issues that those on the front line of the reforms continue to grapple with in the changing climate.

What Kinds of Issues Prompted The Introduction of the CMHT Model at the Local Level in the 1980s?

In the case study area, the key issues to which the CMHT potentially afforded a solution were identified in chapter 5 to be:

1. The variable quality of existing services and their focus on hospital provision
2. Particular unmet needs of the long term mentally ill client group in distinct areas of the inner city borough and the resultant strain that they presented to existing services
3. Poor coordination and limited range of existing services
4. Conceptual and administrative barriers

These broadly reflected the kinds of issues identified as important at the national level, which were described in the overview of the professional and practice literature presented in chapter 2. However, local evidence presented in chapter 6 suggested that, with hindsight, these issues could only be tackled within certain constraints of the local policy environment, which were explored by reference to the public policy literature reviewed in chapter 4. These were:

1. The CMHT solution had to be closely linked to existing plans for new day hospital provision.
2. The CMHT was to serve the function of symbolic policy making- expectations were not high, but something had to be being seen to be done.
3. The timing of the CMHT proposal was auspicious as delays with the day hospital project had been extensive.
4. A particular individual had to champion the CMHT project and take full responsibility for its development.
5. A fresh idea was required about how to provide community services to the long term mentally ill, which inherently suggested that the planned day hospital solution was not seen to offer a coherent model for community services, although this was not formally identified.
6. Local power relations dictated that the CMHT project was to be health service lead and there was a sub-agenda to keep joint provision with social services to a minimum.

Therefore, case study evidence suggested that in the 1980s, the CMHT model was introduced at the local level within fairly rigid criteria dictated by the local policy environment and not specifically driven by the ideological appeal of the CMHT model itself or an imperative to structurally change the balance of service provision on a long term basis towards

better catering for the needs of the long term mentally ill. It would be foolish to suggest that the precise restrictions faced in the case study area are generalisable across the country, but case study evidence does serve to illustrate that significant sub-agendas underlay attempts to implement the CMHT approach.

Two imperatives flow from this perspective. Firstly, the central task of the case study CMHT was to be developmental. Covering a comparatively large geographical area, it was given the task of developing new forms of care, originally with the intention that these would then be transferred to the day hospital when it was finally completed. Secondly, it was to have a specialist remit of only working with long term mentally ill clients, protected from the every day pressures of routine case work with acute clients, but from the outset no long term financial or organisational commitment was extended to support this work. Hence, both the concept of the CMHT model and the priority afforded to long term mentally ill clients were introduced as a temporary, experimental solution.

This evidence supports our hypothesis that the CMHT model was not initially widely known about at the local level in the early 1980s and any changes that were being considered to shift the emphasis from hospital to community provision were of narrow scope, relying on the resurrection of old ideas supplemented by small, temporary, experimental projects. This, in turn, supports the incrementalist notion of decision making proposed by Lindblom (1959) and others. Central government directives had little local relevance or impact and the introduction of the CMHT model at the local level was part of a "bottom-up" policy process.

The CMHT model used to achieve innovation in the case study area was an ad hoc local response, not an evaluated demonstration undertaken in a way that could be replicated elsewhere. Other research has shown that this has been the pattern across much of the UK for a range of client groups (Davies 1993). In this sense, it was disjointed from any

system wide process of planned change and therefore vulnerable to being dismantled or corrupted at a later stage, when it ceased to be protected as a special project.

Under What Conditions Did The CMHT Model Act As A Vehicle to Achieve Innovation in Service Provision in the 1980s?

The CMHT model that was used to achieve change in the case study area was moulded by a definite set of conditions. Firstly, the innovative ideas for reform in adopting a CMHT approach came solely from the professionals involved. The factors that shaped people's decisions about them included a consideration of economic and political factors, and the appeal of a new model of service provision that could be championed by management, but relied primarily on the abilities of the DEW Team staff group to engender support for their ideas and activities. Professionals had an important role in not only defining and responding to the perceived needs of long term mentally ill clients, but also in the vital process of transmitting this need to the resource controllers. This largely supports the positive contention stated in the public policy literature that professionals play a critical role in innovation within public services (eg Donnison et al 1975).

Secondly, innovation demanded professional leadership which was provided by the Battersea consultant psychiatrist. To return to our military analogy, a team from an army trained in conventional manoeuvres was converted into a guerilla force, and at least at the outset, the team's success depended on the skill of its local commander. She fulfilled a vital role as a "top-level fixer". Professional status gave her the required authority to innovate, and case study evidence suggested she drew on elitist power as a psychiatrist to push through her innovative proposals. This gives a strong indication that throughout the 1980s, without the support of local psychiatrists, no care model could have been successfully implemented. However, the opportunistic approach, dynamic thinking and personal commitment of the particular psychiatrist also played a critical role, in the way she was

able to "ride roughshod" over obstructions that presented rather than await resolution of conflicts.

Thirdly, as a result, decision making was haphazard and at times relied on unorthodox bargaining between key local actors. No accountability was initially sought from clients, carers or other local service providers and the CMHT model was introduced with a purely "service-led" approach to planning and provision. Leading on from this, the task to convince other local service providers of the value of the CMHT approach was fraught with tensions and maintaining the delicate balance which gave sufficient sanction for action and avoided outright opposition was a considerable task. The ideologies that were proposed as a basis for the DEW CMHT model were alien to what had existed in service provision previously and gaining an understanding of this amongst other service providers locally was a frustrating and on-going battle for the case study team. Success depended crucially on getting the politics right and establishing a broad consensus of approval. In this sense, the DEW CMHT case study does not tell us much that is new about the way that social policy innovations are developed more generally in health care (Haywood & Alaszewski 1980; Hunter 1980; Ham 1981; Klein 1983; Hunter 1988), but it does add to that limited literature.

Fourthly, case study evidence suggested that what was lacking in the local mental health policy arena before the CMHT existed, was the will to effect change. The lack of enthusiasm, meant that it was only a few isolated "alliances of ideological zealots" who tried to influence the decision makers to experiment with new approaches. The case study team were one such alliance. Nothing of significance would have happened at that time without their determination and commitment as a group to effect change. All parties to the change also drew on an enthusiasm flowing from the challenge of doing something against the trend. This supports other case study evidence from local level studies, such as King's study of deinstitutionalisation in the Exeter service (King 1991). He attributed overwhelming importance to the part that group

effort played, on the part of existing staff, in effecting the move from hospital to community based services.

Lastly, a further condition for the acceptance of the CMHT model locally was the "personalisation" of the cause of people with long term mental health problems by a small group of isolated individual professionals. "Personalisation" is used here as a term to describe how it was a closed network of local field level professionals who wanted to get something done that led to the definition of the long term mentally ill as a priority group and it was they also who followed this with action. Hence, the long term mentally ill were chosen as a distinct client group at the local level for whom professionals pushed for new services. In so doing the long term mentally ill were targeted and the CMHT model was used as a tool. There was no research evidence sought locally in the early 1980s to establish that it was the best possible tool and confusion followed later in the decade about the relationship between this model and the Care Programme Approach and case management which were legislated for by central government. This confusion will be discussed in our later sections about service style development and sustaining the CMHT approach.

What Features of the Team Building Process were Important in Implementing a CMHT Approach?

Case study evidence suggested that the features of the team building process that characterised the development of the CMHT were:

- 1) staff recruitment (staff who shared an ideological conviction and positive out-look mainly recruited from within the existing hospital service) & staff training (the team was committed to training itself and researching new care approaches).
- 2) seniority of staff (only experienced, far-sighted professionals were recruited).
- 3) stability of core staff (individual professionals had similar life-styles, were committed to working together and had all reached stages of their careers where they wanted longer term jobs).
- 4) use of staff already employed locally (largely from existing hospital service).
- 5) development of multi-disciplinary team working (more than just professionals from different disciplines working

within the same team. It embodied a sense of collective action through shared concern and implied the subtle achievement of a dynamic between professionals from different disciplines).

- 6) staff reflecting cultural diversity of local client group (employment of black workers).
- 7) ability of staff to initially engender support amongst other local service providers and develop new service networks.

These features have implications for the planning and management of CMHTs. Emphasis on developing the multi-disciplinary approach has also been a strong feature of other research at the local level and cannot be over emphasised (eg Powell & Lovelock 1992: Patmore & Weaver 1991). The case study material showed that the area where there was most difficulty in achieving multi-disciplinary work was in the internal Social/Health Service interface within the CMHT, which was described in chapter seven. The social workers on the team encountered difficulties in working as part of a health service led team as they had a different organisational and disciplinary background compared with their colleagues from the health service. This feature is already well documented in the literature (eg Webb & Wistow 1986: Towell 1981). The DEW Team's policy of setting aside "team support" days on a regular six monthly basis helped in this respect and proved to be an important forum for airing disagreements and grievances, but fundamental differences remained. From this, we can conclude that successful working within the multi-disciplinary CMHT model is dependent on the recognition of different organisational practices and ideological stand-points between Health and Local Authority professionals and a willingness to address these differences with specific action policies, both in terms of training and on-going inter-professional support.

Case study evidence also suggested that the cultural backgrounds of staff recruited were important. It was considered crucial that the cultural backgrounds of staff members recruited to a CMHT reflect the ethnic diversity of the surrounding community and for adequate support and training to be directed towards this issue. The fact that mental health professionals continue to be mainly white and

middle class has to be radically challenged and recruitment practices and access to courses changed to ensure that clients needs in the community are really addressed.

It is difficult to extract how much of the DEW Team's sustaining ability arose because of the CMHT model of working and how much was dependant on the enthusiasm and commitment of individual workers involved regardless of the service model that they adopted. The two are inextricably connected and this gives us further insight into the nature of the CMHT model itself and the reasons why people have had so much difficulty in trying to formulate definitive statements about it. The conclusion is that the CMHT model is a useful vehicle to establish service change, but is not in itself a solution to the problems of the long term mentally ill, as so much is dependent on the quality of staff putting the model into effect and the actual methods that they choose to utilise.

What are The Important Features of Service Style Development In Implementing A CMHT Model?

The CMHT model by its very nature implies a high degree of flexibility, inter-professional collaboration and regard for the specific needs of a local area. As such, it constitutes a major experiment in social policy. As stated in chapter two, the goals, principles and ideals referred to in the CMHT literature are to establish services which are local, accessible, acceptable (non-stigmatising), focused and coordinated, and enable empowerment of clients. These goals are not absolutes; they are broad themes of good practice open to the interpretation of those who plan and put them into effect. As such, case study evidence suggested that they are not sufficiently robust to ensure provision of a good quality community service.

As stressed above, in the case study area, interpretation of these service goals by a handful of innovative staff resulted in a sustainable model of care. Hence, the service style developed using a CMHT approach is heavily dependent not only on the quality of the staff and the high degree of discretion

and autonomy afforded to them, but also on their ability to interpret the model and adapt it to reflect local needs. The CMHT model that was developed in the case study area began life as a clinical model and essentially metamorphosed into a system of care. Its characteristics grew to be:

1. the multi-disciplinary clinical service embracing care planning
2. the duty crisis system
3. the development of an information system
4. inter-agency liaison
5. assertive outreach
6. dynamic social support through the introduction of community support groups for clients and carers.

The repertoire of possible ways of developing the service style was vast and the approach adopted for the long term mentally ill by the case study team was formed from permutations of many detailed local arrangements. This pattern of provision allowed the team to start to address the broad range of needs of the long term mentally ill which included health services, social welfare, social security, housing, employment, training, rehabilitation, transport and social activities. Hence, the DEW CMHT as a system of care, did appear to be intellectually viable and coherent when the features of the previously poor service provision noted in chapter five are considered. The case study team attempted to address deep seated problems in service provision that had existed for a long time and contributed to a change in thinking about the needs of the long term mentally ill. It can be concluded that the CMHT approach can be used as a basis from which to change the ideological foundations of service provision, but it does not constitute a model of clinical care.

Assessment of need for services and a clear care planning approach within a defined range of options was a major feature of the DEW Team's development. This helped to achieve co-ordination between and within services and enabled attention to be paid to the differing needs of people within the long term mentally ill group. This new style of service embraced the key elements of what later came to be termed the Care Programme Approach, first proposed in Caring for People (Cm

849, 1989), but in the case study area it was implemented from a bottom up rather than a top down perspective. From April 1991, care programming was introduced as a national system. The development of the DEW system pre-dated this. This supports literature suggesting that national policy often simply recognises and formalises policy worked out at humbler levels of the providing group (Barrett & Fudge 1981) and that professionals are important power brokers in the determination of policy (Dunleavy 1981).

The elements the Care Programme Approach that were embraced by the case study team included assessment and review of client need, the agreement of service provision levels by other local service providers and monitoring of these levels and the formation of care plans in consultation with clients and their carers. These features attributed coherence and generalisability to the CMHT model developed. It is therefore suggested that it is the Care Programme Approach, that is precisely the model that has been lacking in community mental health care rather than the CMHT approach which has been the subject of this thesis.

Unresolved issues for debate within the outreach CMHT model for the long term mentally ill which apply equally to any consideration of the Care Programming Approach were identified to include problems of "sifting up" in providing long term maintenance and support to all long term mentally ill clients; concerns about how intrusive staff felt they were justified in being in their efforts to "keep tabs" on their clients; links with the hospital service and the prevention of "splits"; and interface problems with other agencies concerning good communication, particularly with GPs. Such concerns are broadly similar to those that have been noted in several recent evaluation studies published in response to the national implementation of the Care Programming Approach (eg Schneider 1993).

Part of the reason for the DEW Team's success was the team's ability to set boundaries to the work that they were going to

try and do. As it developed the DEW Team staff selected a few issues from a multitude and created specific policies to address them. In this way their ideology, based on the CMHT model was sustainable as they retained a clear focus. Doubts about the effectiveness of the DEW CMHT that were expressed in later years concerned areas where there was a blurring of this clarity. This point will be further explored in the following section.

What Barriers to Implementation are Faced in Implementing a CMHT Approach?

Barriers to implementation initially faced by the case study CMHT were manifest in practical constraints and establishing physical territory. The controllers of resources had stated that they were committed to supporting the DEW CMHT development, but when it came to supplying them with adequate office space and secretarial staff there were considerable delays and the Team was effectively prevented from getting established as quickly as had been planned. As described in chapter nine, this was very frustrating for the new team. Such political ambivalence reflected in constraints imposed on the implementation process has been well documented in the literature (eg Hill 1980; Bardach 1977). It can be concluded that organisational commitment to an innovative CMHT approach is essential. The importance of good secretarial staff and physical work space is paramount to the setting up and continued smooth functioning of a CMHT.

More fundamentally, the DEW Team also had problems in establishing professional territory and on-going resource and management commitment. Conflict with existing interests locally, namely hospital ward staff and social services employees was apparent. This occurred partly as a reaction to movement away from the status quo in service provision and a dislike of general change on behalf of some workers. Professional jealousy also featured, particularly concerning the extra resources that the DEW CMHT initially received. The DEW CMHT maintained the long term mentally ill group of clients in the community and because of this, hospital ward

staff felt that their jobs were less rewarding as they only saw clients who were in a chronic state of relapse. Also, there was some conflict over the ownership of new policies that were introduced by the CMHT. For example, social services staff disputed the DEW Team's claim to be running all the long term support groups in the Battersea community. It can be further concluded that strong resistance driven by professional self interest, job satisfaction, levels of morale and the goals of individuals become apparent in setting up new CMHT services and a great awareness of tensions and relationships is needed (Barrett & Fudge 1981).

However, it is not suggested that case study evidence supported notions put forward in the literature that professionals are purely motivated by self interest that can be shaped by maximising the size of the departmental budget and little else (eg Niskanen 1971). Ultimately, the success or failure of the DEW CMHT was dictated by the efforts and dedication of individual professionals who, interview evidence suggested, were also motivated by genuine altruistic goals and a concept of public service. Hence, the positive line of Donnison (1965, 1975) is supported.

The interview material presented in chapter nine showed that many of the criticisms expressed about the DEW service were connected with aspects of service provision that the Team expressly stated they would not tackle, such as working outside regular nine to five office hours or providing respite care. This suggested that there were aspects of the DEW Team's model that were not practically robust. The service was not comprehensive. It was inconsistent to provide such a partial local service without equivalent good quality services to cover the aspects of care that the DEW Team could not address. In the original blue-print the DEW CMHT was to be the shadow team for the new day hospital. It was the intention that it would be part of a whole new service provision structure. However, this was considerably delayed. In the meantime, the Team could not develop a full range of specialist services for the long term mentally ill which included sheltered work

placements, respite care and drop-in facilities. This was beyond their remit and capacity. The conclusion is that the CMHT model can be powerful enough to mobilise professional support, but must itself either be comprehensive or be initiated within a mental health care system that offers quality complementary services.

Can the CMHT Model Provide a Sustainable Model for Change?

There can be no single judgement of the achievement of the CMHT approach at the local level. It could be viewed as a roaring success, a qualified success or an expensive diversion, depending on the definition of success employed. However, case study evidence suggested that the CMHT approach did provide a sustainable model for change during the 1980s. Firstly, the creation of the CMHT galvanised the health authority into further action based broadly on CMHT ideologies. Secondly, few would deny that the CMHT was precipitated into a virtual policy vacuum and was in effect successfully used as one means to develop a broader framework of service provision. However, it had little impact in influencing the direction and future definition of the boundaries of this broader framework.

Two years after the initial implementation of the specialist CMHT approach in the case study area, a battle took place for the future model of mental health care. The subsequent reorganisation was stimulated by a variety of factors: movement of consultant psychiatrist personnel in Battersea, a need for the CMHT to better define their service model and the clients that were to be served, a need to reorganise services on a Battersea wide basis with the development of other CMHTs and inevitable resource constraints. A catchment area model of service provision across the district was imposed and it was planned that each new catchment area team would be formed as a comprehensive CMHT. Hence, the CMHT system itself had taken hold in the case study area and proved to be sustainable, but it had been adopted in a comprehensive form rather than the specialist form developed by the case study CMHT. In line with this new policy, the DEW CMHT was also forced to change to

become comprehensive.

These changes took no account of the problems of the long term mentally ill to which the initial DEW CMHT innovation had been a response and this has been the experience of many local initiatives across the UK in a wide range of client groups (Davies 1993). It was only the professionals themselves who pushed to retain a priority role for long term mentally ill clients within their new role. This suggests that in terms of local policy, even after the intense effort that the DEW CMHT had tried to exert in putting the long term mentally ill firmly onto the planning agenda, they remained marginalised and dispossessed. Quality of care motives in caring for the long term mentally ill group were deemed to be too expensive given the resource constraints and this highlights a major dilemma and area of confusion for those who develop social policy. Encouraging the development of a specialist innovative service clashed with the conception of district wide planning that was later embraced and was not deemed financially feasible. This tells us a lot about why it has taken so long for viable models of community mental health service provision to be developed in the UK. It is not that hopeful new models have not been developed, but rather that they have been marginalised in the formation of district wide plans.

In the late 1980s and early 1990s, community care policy became what Palmer (1985) would describe as a "strategic high" and central government legislation started to dominate the local agenda. It seems that local professionally driven service innovations, such as the case study CMHT were largely swept aside and it was only the determination of local professionals that retained lessons that had been learned. After six years of development, the DEW CMHT did have some lasting impact on other local services, as various of its policies were later adopted by other new CMHTs that were established locally, but their specialist knowledge of the long term mentally ill was significantly down played. The DEW Team's sustaining ability had its origins in successfully championing policies that were to become a feature of service

provision across the country following national implementation of the Care Programming Approach in the early 1990s, not in the development of improved services specifically for the long term mentally ill group. This suggests that CMHTs can play an important role in experimentation and setting service standards, but it is the whims of planners and managers and resource constrictions that actually determine service structure and resource distribution. Far from the oversupply of services suggested by some public choice theorists (eg Niskanen 1971), the case study demonstrated how restricted resource allocation has been at the local level. Hence, there is no obvious connection between Tory rhetoric and the reality of local experience.

The team themselves recognised that the DEW CMHT approach as a whole would probably be applicable only in inner city areas: to Central Birmingham, but probably not rural Yorkshire. Hence, the case study CMHT model was geographically localised and there were some facets of the way that the DEW Team's work developed that meant it would be difficult to replicate elsewhere. For example, its catchment area was always far smaller than that normally required of a CMHT in order to be economically viable and most of its staff were part time. In addition, the DEW Team were never able to approach all of the required shifts in thinking about service provision. For example, the team remained largely health service dominated in their practices. They never really carried through the more revolutionary parts of the original scheme. They never had any client involvement in day to day caring activities or the management structure and they were unable to actively seek out clients once their caseloads grew. They were subject to the same work pressures as any one else when it came to quality and quantity of interactions with clients and inter-agency communication. Their initial training efforts were gradually eroded. Hence, it is concluded that while the CMHT model was considered flexible and sustainable there are institutional barriers within the UK mental health system which prevent certain aspects of the model from taking hold. Particular difficulties revolve around empowering service users and

involving them in decisions about service planning.

Do CMHTs provide a service that is distinctly different from traditional services that existed previously?

In recent years, many questions have arisen amongst service providers and planners about whether the CMHT approach results in services that are really different from what existed previously. On paper, the claims for the new CMHT services appear startlingly different, but it is important to consider whether they actually imply a different kind of service provision, or just an intellectualised accountability, dressing up old-style services in fancy new terminology. Interview evidence at the local level suggested that many believed the CMHT model merely mimicked services that existed previously and that it was only the language used to describe the service delivery process that had changed.

The DEW Team claimed that their CMHT approach would result in improved standards of care for the long term mentally ill population. Chapter eleven specifically questioned whether the new service was really any different from the CPN after-care provision that had existed previously. It was concluded that the service offered to the long term mentally ill clients by the DEW CMHT did add something to what was provided by other established care models. DEW Team care differed from CPN care and offered an improvement in terms of seeing clients in a greater variety of locations, greater continuity of allocated primary worker and linking clients to more community-based activities and a wider range of community agencies. So it seems that the CMHT model is different in practice in terms of accessibility, effectiveness and coordinated working with other agencies.

However, the DEW CMHT study showed no differences from the point of view of hospital usage by long term mentally ill clients. The DEW Team had no effect on reducing the number or duration of In-patient Hospital admissions, the admission pattern being similar to that of the CPN service. A classic example of the confusion in the on-going reform in mental

health care has been that it has largely been guided by goals such as the reduction of in-patient activities that are often laid down as operational objectives. Indices of in-patient treatment have become the most frequently used outcome criteria and readmission to hospital a synonym for "relapse" or "recidivism" (Falloon 1984). There is an economic rational for such measures, as in-patient care is the most expensive form of care. However, the DEW Team study highlights the fact that, for the long term mentally ill population, prevention of readmission is probably not a realistic goal and certainly not the only one that should be measured as a "success". These wider goals include supporting chronic clients in their dependence on the asylum and improving the quality of life that they can sustain in the community.

At the local level, the improvements that were discovered in this respect were mainly attributed to three components of service provision by the DEW Team that were not present in the CPN service:

- 1) The superiority of the DEW Team multi-disciplinary approach over the largely uni-disciplinary CPN approach.
- 2) The advantages of the DEW Team key-worker system and clarification of aims as set out in the DEW CMHT operational policy. This allowed the DEW Team to work effectively with patients and monitor progress in a way that was not possible for the CPN service.
- 3) The development of improved methods of co-ordinated care with other community services by the DEW Team.

From an ideological stand point, while accepting that the CMHT approach did appear to be different to what had existed in service provision previously, it could be questioned whether it was really different enough. When the plight of the long term mentally ill described in chapter two is reconsidered in terms of the case study evidence, it appears to the author that there are vast areas of need that simply were not addressed within the CMHT approach at the local level. The clients who the author met during the completion of field work for this study, constantly stressed that many of their problems arose from feelings of chronic loneliness, sexual frustration and spiritual dissatisfaction. Whether meeting

these needs lies within the remit of Health and Social Services is another matter, but if the CMHT model can be as flexible and locally accountable as some claim, such needs must be considered. Perhaps part of the Department of Health should be replaced by a Ministry of Loneliness.

Is It Feasible to Prioritise the Long Term Mentally Ill in a Catchment Area CMHT Model?

Throughout their development the DEW Team worked with a brief specifically to target the long term mentally ill, first as a specialist team and later as a catchment area team. The DEW CMHT service was targeted on those who needed it most, concentrating resources on the long term mentally ill, and in this sense, it operated with the "vertical efficiency" described by Challis & Davies (1986b). Despite much rhetoric, the literature presented in chapter two suggested that few CMHTs have succeeded in the task of providing care to the long term mentally ill client group. The case of "revolving door" patients was a nationally recognised problem and all the literature on the topic advocated a need to prioritise work with this group. In developing a working definition of people with long term mental health problems (see Box 5), the DEW Team made an original contribution to service development that was published in national academic journals (McLean & Leibowitz 1989).

People with long term psychiatric problems had often previously been defined by psychotic diagnosis, numerous lengthy compulsory hospital admissions or the presence of a "perceived risk of re-hospitalisation". However, the team felt that theoretical guidelines published by Bachrach (1988) which referred to definition along the three axes "Diagnosis, Duration and Disability" were more suitable for day to day practice than research criteria developed for exclusive purposes. The DEW Team definition that was developed was used in every assessment of long term mentally ill clients to determine eligibility for CMHT priority services.

It is recognised that a common problem of CMHTs in the UK has

been a failure to distinguish targeting criteria clearly enough (Patmore & Weaver 1991). However, although the DEW Team seemed to avoid this failure, a note of caution is required. The development and use of alternative and widely differing criteria between CMHTs implies problems relating to evaluation of efficacy and a monitoring nightmare that negates the usefulness of any comparative studies. There is a need for standardisation of criteria that are used to define the long term mentally ill population.

The results of the study presented in chapter twelve suggest that it is feasible for a CMHT to give priority to long term mentally ill clients within the catchment area model, both in terms of overall numbers on the case-load and in terms of the type of in-put that they receive. This study was carried out in 1992, a time when the DEW Team had been in existence for a period of six years and they were no longer operating as a pilot project, so it seems that the positive effects found do actually indicate the existence of a community mental health service that is adapted to the realities and possibilities of local care provision to the long term mentally ill group.

The above discussion suggests that the DEW service as a specialist CMHT was intellectually sustainable in a world where there were relatively ample resources, but the ultimate test was whether this could be translated into practice in the longer term. The story of the DEW Team development described in this thesis suggests that the catchment area team model adopted in the Team's later years was practically more realistic than the specialist model adopted earlier, but it was less ideologically convincing. It is when practical considerations are taken into account that one realises to what extent it is not enough for a service just to be intellectually viable. The DEW Team as a specialist CMHT was seemingly preferable for long term mentally ill clients but in the long term was politically and economically unsustainable. This demonstrates that it is not enough for a CMHT just to be professionally sustainable -it must also be economically and politically sustainable.

A Way Forward for Community Services for the Long Term Mentally Ill: The Relevance of Thesis Findings in the Current National Context

The White Paper Caring for People (DH 1989b) appeared just at the beginning of the fieldwork period of this study and the NHS and Community Care Act (DH 1990) followed shortly afterwards. These developments indicated a recognition of the problems experienced in setting up community services, problems that motivated the formation of the DEW CMHT a decade earlier. In 1990, for the first time, the policy directives were firmly located in new legislation. The DEW Team research had already been planned and so the specific content of the new legislation and guidance could not directly influence the thesis itself. However, a number of key points emerged from this research which might usefully inform the implementation of current national policy changes and reference to the experience gained in field programmes has been one aim of recent government documents. For example, Griffiths stated:

"I have the occasional sinking feeling that there is nothing so outdated as to provide today's solution to today's problem. It is however a necessary preliminary to thinking ahead and a precaution against ensuring that nothing is recommended which is inconsistent with tomorrow's scene." (Griffiths, 1988, para 39)

1) Finance

The cost of services and the critical relationship between resources, needs and outcomes has become a major research topic in recent years (eg Knapp et al 1993). Thesis evidence suggests that to provide quality community services and the motivation for service providers to seek out new initiatives, extra money is needed. Innovative good quality services for the long term mentally ill are expensive and largely additional to services that have existed in the past. It is suggested that a separate budget and departmental management division is needed, devoted purely to services for the long term mentally ill. This would create a group politically committed to and accountable for the long term mentally ill and "ring fenced" funding should be provided to ensure that the long term mentally ill receive the amount of funding required.

The "Mental Illness Specific Grant (MISG)" has been operative since April 1991, but some authors claim that the sums of money it entails are too small to effect any lasting change on service provision (eg Sayce 1989). The recent monitoring exercise carried out by the Social Services Inspectorate (SSI) suggested that the MISG has funded creative initiatives in mental health care and has had considerable impact (SSI 1993). The case study material suggests that in order for service innovation for the long term mentally ill to come about and to be sustained in a cohesive form an ongoing financial commitment is required, that extends beyond the three year period of the MISG.

2) The CMHT Approach and Care Programming

Case study evidence suggests that there is a risk of duplicating much of the work about appropriate local care models because of obvious confusions between the different solutions that are being proposed and the problems of defining boundaries and differences between them. The Care Programme Approach (CPA) was only implemented just before the end of the thesis study period, so observations regarding its effectiveness at the local level cannot be made. However, case study evidence did suggest that the CPA policy is being adopted selectively and in some cases (as in the case study area) this is because existing systems of care almost fulfil the requirements of care programming. The CPA offers an opportunity to standardise such systems, but considerable care must be taken to implement the CPA so as not to alienate staff who have already developed effective local care planning packages and so that it adds more to existing services than additional paperwork.

3) Lead Responsibility for Service Planning and Joint Working

Another major element of the new legislation is the proposed partnership between Health Services, Local Authorities and independent sector services. It was legislated that from April 1993, Local Authorities would take a lead role in the development of mental health services, working jointly with

these other interests. The DEW case study material strongly suggests that Social Services are not well equipped to deal with the new responsibilities imposed upon them (described in Caring for People and the considerable implementation guidance from the DH that has followed). This is supported by other research evidence (eg Hunter 1992). Davies (1993) stated that the community care reforms have been led by the Department of Health and evidence about how far behind the Local Authorities have been during the early 1990s is now beginning to appear. In monitoring the community care reforms he noted that among Social Services staff,

"In almost all instances, the grasp of issues was unsophisticated even among top managers in the first period of implementation: and much less lower down the organisation." (Davies, 1993, p27)

Achieving pluralism in service provision in the new "mixed economy of care" has also become a major aim of community care policy in recent years. However, thesis evidence suggests that gaining the voice and involvement of the service user is one of the biggest challenges to services in the U.K.. In this respect, lessons can be learnt from progress in CMHTs in the U.S. (eg see Perkins 1993). Clear acknowledgement is also needed of where lead responsibilities for the long term mentally ill group rest. This study suggests that community care of the long term mentally ill should be firmly placed in the hands of the Health Service. Professional expertise, appropriate service models and money do not appear to exist in Local Authorities. Good practices in multi-disciplinary working are now being developed after a very slow and fraught start and the elitist domination of policy by the psychiatric profession has begun to lose its hold. The positive features of joint working that are now developing at the local level are encouraging a reflective and considered approach to care that was difficult to instill in the institutional framework.

4) Emphasis on Policy and Organisational Change

This case study also raises genuine concern that the emphasis on policy and organisational change embraced in recent legislation could lead to the dissipation of progress already

made in local contexts like Battersea towards innovation in service provision that is adapted to the local context. This case study has demonstrated the extent to which service development can be initiated and driven by professionals themselves. The new legislation seems to overlook such a valuable resource. A key determinant of success in community care policies for the long term mentally ill, as for many other client groups, is the recognition of this will, determination and commitment.

Also, if local projects never lead to actual change in long term service provision, the professionals themselves will lose faith and because of the power that they hold in defining needs at the local level, any nationally dictated policy will be perverted. Similarly, with the recent hive of activity in developing monitoring systems, quality targets and evaluation, results must be used to inform policy and this information must be fed back to the people at the front line of service provision. The potential for conflict in ideology between the collective view of service provision being promoted at the front line of service provision and the individualist ideal of government, cannot be ignored.

The new legislation implies rapid and extensive change. The case study material suggests that in the face of this, it is important that services do not become so pressurised that they cannot take time for reflection as to where developments are going. The DEW Team's ability to sustain itself over time was based in a constructive use of the reflections of individual professionals on the team. It was important that staff played a distinctive role in developing their own policy and regularly collectively made sense of their experience in order to learn from it during team support days and general multi-disciplinary working. Ignoring such a feature could have a significant effect on further front-line service development.

5) Targeting Resources on those with the Greatest Need and the Degree of Concentration of Resources

With current changes in community care policy, it is being

questioned whether CMHTs can bear the whole burden of client care that the mental hospitals once carried, especially in the case of the long term mentally ill. Thesis evidence suggests that prioritisation of the long term mentally ill in local services is essential and although specialist services are ideologically preferable, prioritisation within the catchment area model is possible if the service is supported by a comprehensive range of other quality local services. However, there appears to be a continuing need to concentrate resources on those most in need and to monitor progress in priority working.

6) Future Research and Dissemination of Ideas

The Griffiths Report (1988) highlighted the principle of learning from local innovations to inform mainstream practice. Ultimately, the case study example presented in this thesis offers a positive example of what can be achieved in community care of the long term mentally ill and indicates some areas that require future attention. It is contended that a number of case studies are required, of which this study is but one, in order to match the amount and quality of data that was amassed about institutions. In short CMHTs have provided a vital source of energy for future development, but knowledge about CMHT developments throughout the 1980s and early 1990s remained very localised and patchy and there was little reference to the CMHT approach at the central government level. A clear national policy needs to be adopted about the role of CMHTs in the current decade.

In Brief

Case study evidence suggested that the CMHT approach does provide a viable model of service provision to the long term mentally ill as a system of care. However, the development of CMHTs during the 1980s was bedeviled by ambiguity about the precise nature of the approach and its relationship and relevance firstly to district wide planning at the local level and secondly to new legislation implemented from central government in the early 1990s promoting the Care Programming Approach. Case study evidence suggested that policy makers

need to address the lack of real commitment that was extended to the long term mentally ill group during the 1980s and to sharpen their focus about specific models of care. The British CMHT movement could be improved upon with determination to address the complexities involved in enhancing service provision.

APPENDICES

APPENDIX 1 - DOCUMENTS CONSULTED (Chronological Order)

APPENDIX 2 - INTERVIEWS CARRIED OUT

APPENDIX 3 - THE DEW TEAM OPERATIONAL POLICY (1987)

APPENDIX 4 - STUDY 1 DATA COLLECTION AND CODING FORM

APPENDIX 1: DOCUMENTS CONSULTED

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APPENDIX 2

INTERVIEWS COMPLETED

DEW Consultant Psychiatrist

DEW Clinical Psychologist

DEW Occupational Therapist

DEW Social Worker

DEW Clinical Assistant

DEW Senior Registrar

DEW Community Psychiatric Nurse

Central Wandsworth Community Psychiatric Nurse

South Battersea Consultant Psychiatrist

Central Wandsworth Consultant Psychiatrist

Rehabilitation Team Consultant Psychiatrist

2 Area Social Workers

Principal Social Worker

Head of Social Services Department, Mental Health.

Head of Springfield Psychology Department.

Principal Clinical Psychologist, Springfield Hospital
Rehabilitation Team

Yew Ward Manager, Springfield Hospital

Wandsworth Mental Health Unit Services Manager

Wandsworth Nurse Manager, Springfield Hospital

Community Worker, Doddington & Rollo Family Centre

Social Responsibility Missioner, Association for the Pastoral
Care of the Mentally Ill

Local Battersea General Practitioner

APPENDIX 3

THE DEW TEAM OPERATIONAL POLICY – Feb 1987

1. PHILOSOPHY AND AIMS

1.1 Service Development Aims

- 1.1.1. To promote the development of a comprehensive mental health service in Battersea, which incorporates both hospital and community based facilities and is based on an assessment of local needs.
- 1.1.2. To work closely with other locally based agencies to promote the development of a co-ordinated network of support services in the area for people with mental health problems.
- 1.1.3. To develop methods of investigating and improving the quality of care provided by the service.
- 1.1.4. To educate people in the area about mental health issues and promote a less stigmatising attitude towards people with mental health problems.

1.2 Clinical Service Aims

- 1.2.1. To provide an easily accessible, locally based service which is responsive to local needs and takes into account the fact that Battersea has a high level of social deprivation (which is known to contribute to mental health morbidity) and also that it is a multi-racial area.
- 1.2.2. To make the needs of people with long-standing mental health problems living in the area a priority and attempt to minimise the effects of long term mental illness and prevent inappropriate admissions to hospitals for this group.
- 1.2.3. To encourage, where possible, the use of locally based alternatives to the existing out-patient, day patient and hospital facilities.
- 1.2.4. To improve the continuity of care between hospital and locally based mental health services.

2. FUNCTIONS

2.1 Direct Clinical Service Functions

2.1.1. To provide treatment, rehabilitation and support programmes as appropriate. These will vary with identified needs and may include work with individuals, families and groups.

2.1.2. To provide a multi-disciplinary assessment service which is responsive to local needs and which can refer people on to appropriate agencies as necessary.

2.1.3. To provide regular monitoring of cases by multi-disciplinary reviews and also by the development of a computerised case-register of all DEW referrals.

2.1.4. To provide a service of support and advice to users of the service and their relatives.

2.2 Indirect Clinical Service Functions

2.2.1. To liaise closely with all NHS services involved in the provision of mental health care in Battersea (including psychiatric hospitals and GP's) to improve co-ordination and continuity of care.

2.2.2. To liaise closely with non-NHS agencies working with the mentally ill in Battersea (including Social Services and voluntary organisations) to improve co-ordination and continuity of care.

2.2.3. To provide a consultation and advisory service for locally based groups working with mentally ill people in Battersea.

2.2.4. To allocate to each relevant establishment, organisation or institution in the area one member of the team as Link Person to liaise between that group and the DEW Team to improve communications and bring back information about any unmet needs. (The Link Person is not responsible for meeting those needs).

2.3 Service Development and Monitoring/Evaluation Functions

2.3.1. To monitor the work of the Team and evaluate the service on the basis of its stated aims and to develop changes in policy and practice in the light of these findings.

2.3.2. To collect up to date information on local resources in

the area relevant to mental health.

2.3.3. To contribute to the further development of mental health services in Battersea by developing methods for investigating the effectiveness of the service, pointing out gaps in existing services and identifying needs for resources.

3. OPERATION OF THE CLINICAL SERVICE

3.1. Target Patient Group

3.1.1. Patients will be from amongst the adult population of Battersea (covered by the catchment areas of Drs McLean, Gundy and Kitson, which includes all of SW11 and some of SW8 & SW4). They will predominantly be between the ages of 16 and 75.

3.1.2. A priority group will be people with long-standing mental health problems living in the area.

3.2. Exclusions

3.2.1. The team will not normally provide a direct clinical service to the following groups, but will provide an advisory/consultation service where appropriate:

- a) People over the age of 75. (see Appendix for comment)
- b) Children & adolescents under the age of 16.
- c) People for whom alcohol or drug abuse is the primary problem.
- d) People suffering from senile dementias.
- e) People who have a mental handicap.
- f) People who have a significant forensic history or a history of violence.

These groups will usually be referred on to the appropriate part of the service.

3.3 Referrals

3.3.1. Referrals will generally be accepted from any professional person or body (such as GP, Social Worker, CPN, Psychiatrist, Psychologist, Voluntary Organisation) seeking the advice of the team concerning people living in the area.

3.3.2. At present the Team will not normally accept self referrals, but flexibility will be maintained and individual cases will be dealt with as appropriate.

3.3.3. Referrals (by telephone or letter) will be responded to

by one member of the Team who is on duty each weekday from 9am to 5pm. The duty worker will either deal with the referral herself if it has to be responded to quickly (within a few days) or will bring it to a weekly multi-disciplinary meeting for allocation to an individual worker on the basis of individual skills and case load.

3.3.4. The Team is not a Crisis Intervention Team and emergency referrals should be sent direct to the emergency clinic at St Georges Hospital or to the appropriate consultant for an urgent domiciliary visit.

3.3.5. If appropriate an assessment is made by a member of the Team and this is discussed at a multi-disciplinary meeting and a key-worker is allocated as appropriate.

3.3.6. For each person taken on by a key-worker an individual care plan is drawn up which specifies the aims of intervention. The key-worker is responsible for co-ordinating this and keeping records up to date.

3.3.7. Cases are reviewed at regular intervals, the next review date being decided each time the case is discussed.

3.3.8. The person's GP will be informed when a referral is made to the DEW Team and the GP and/or referrer will be kept informed of progress.

3.3.9. Where a psychiatrist is involved, medical responsibility will transfer to the appropriate consultant psychiatrist. In some cases where another mental health professional has the major clinical involvement, medical responsibility remains with the GP.

4. SUPPORT SERVICES

4.1. The secretary/receptionist is available at the DEW office for clerical support and to take telephone messages from 9-5 on weekdays. She can contact the duty worker via a bleep if necessary. A 24 hour answering machine takes messages while the office is closed.

4.2. A computerised register of all DEW referrals and Battersea Hospital Admissions is kept at the DEW office. (The information stored complies with the requirements of the Data Protection Act, 1984).

4.3. Individual files are kept on all DEW patients at the DEW

office. The key-worker is responsible for keeping these up to date.

5. SITE AND LOCATION

- 5.1. The DEW Team has an office base at 311 Battersea Park Road, London. SW11 4LU (at Doddington Health Clinic).
- 5.2. Patients are not generally seen at the office base. They are seen in a variety of settings as appropriate including their homes, community centres and health centres.

6. THE CORE DEW Team

6.1. The DEW Team is a multi-disciplinary Team of professionally qualified personnel.

6.2. The core Team establishment consists of:

Whole-Time Equivalent

Community Psychiatric Nurse	1.0
Senior Community Occupational Therapist	1.0
Consultant Psychiatrist	0.5
Clinical Assistant	0.9
Senior Clinical Psychologist	1.0
Senior Social Worker	1.0
Secretary/Receptionist	0.5

7. POLICY DEVELOPMENT GROUP

7.1. A policy development group will be set up which meets at regular intervals to update the policy and working practice of the Team and define objectives.

7.2. The group will be initially composed of the core DEW Team and an administrative representative for the Adult Mental Health Unit (probably the Manager of Wandsworth Services). The membership of the group may be modified as necessary, but will include representatives from all senior professionals involved in the DEW Team.

7.3. This group could function as a pilot scheme for a similar Policy Development Group looking at the whole of the Battersea Service.

Appendix: Comment on 3.2 Exclusions, Part a

When the DEW Team was originally planned it was envisaged that

it would provide a limited service to the elderly (over 75 years). The experience of the Team, however, has shown this to be impractical and the elderly get a more effective service via the community elderly Team. The inclusion of people over 75 in the list of those for whom the DEW Team does not generally aim to provide a direct service reflects this change in policy.

APPENDIX 4

CASENOTE STUDY DATA COLLECTION & CODING FORM

Completed for 100 subjects for the period 01-04-87 to 30-09-88

=====

CARD 1

1. Study Code Number:
Code last 2 digits

2-3

2. Sex:

0=Male, 1=Female

4

3. Age on 01-APR-87:
Code actual age

5-6

4. Marital Status:

a) Married/Cohabiting - 0 b) Single - 1
c) Divorced - 2 d) Widowed - 3
e) Separated - 4

7

5. Ethnicity:

a) Caucasian - 0 b) West Indian/African- 1
c) Asian - 2 d) Other Europe - 3
e) Other eg Mixed Race- 4

8

6. Living Situation:

a) Alone (inc Hostel) -00 f) Lone Adult with child-05
- Any 18 or older
b) with Friends -01 g) with Parents/Siblings-06
c) with Spouse/Cohabitee -02 h) Other -07
d) with Spouse & child(ren)-03
e) Lone Adult & child(ren)-04
-Any under 18 yrs

9

7. Type of Housing:

a) Owner-occupied House/Flat -1
b) Private Rented House/Flat -2
c) Council House/Flat -3
d) Housing Assoc. House/ -4
Hostel (with Residential Staff)
/Group/Shared Home/Sheltered House
e) Hospital Ward -5

10

8. ICD9 Diagnosis:

a) 295.* -1
b) 296.* -2
c) 297.* -3
d) 300.* -4
e) 301.* -5
f) 303.* -6
g) 309.* -7

11

9. Employment Status:

12-13

a) F/T Employment	-00	f) Off Sick- has Job	-05
b) P/T Employment	-01	g) Student	-06
c) Occasional Employment	-02	h) Retired	-07
d) Sheltered Work	-03	i) House-Wife/Carer	-08
e) Not Working	-04	j) Other	-10
		k) Voluntary Work	-11

10. Duration of Past Psychiatric Problems

-Year Onset of Problems:(last 2 digits)

14-15

11. Total Past Psychiatric (Code actual Number)

In-patient Admissions:

16-17

12. Type of Past Contact:

18

a) None	- 0
b) Continuous since first referral	- 1
c) Intermittent for long periods (More than 6 months contact at a time)	- 2
d) Intermittent for short periods (Less than 6 months contact at a time)	- 3
e) One previous contact only	- 4

13. Admissions in Study Period: (Code actual Number)

No. In-patient Admissions:

19-20

14. Total Duration of Study Period

Admissions

21-23

(List no. of days as in-patient in study period)

15. Type of Patient:

24

1= Discharged 2= Continuous

16. Discharged/Drop-out:

25

a) Not Discharged	-0
b) Moved Out of Area	-1
c) Catchment Area Change	-2
d) Patient Refusal/Failed Appointment	-3
e) Patient Remained Well	-4
f) Patient Died/went on long holiday	-5
g) Patient Referred on to Specialist	-6
h) Carer Refusal	-7

17. Total Number of Attempted Visits in Whole Period:	<u>26</u> - <u>27</u>
18. Total Number of Successful Visits in Whole Period:	<u>28</u> - <u>29</u>
19. Total No of Different Places each Person was seen:	<u>03</u>
20. Total No of Different staff seen over period:	<u>13</u>
21. Total No of Visits on which there was carer contact:	<u>32</u> - <u>33</u>
22. Total No of Visits on which medication Prescribed:	<u>34</u> - <u>35</u>
23. Total No. visits medication was being Taken:	<u>36</u> - <u>37</u>
24 Total No. Day Centres Used:	<u>38</u>
25 Total No Community Groups Used:	<u>39</u>
26 Total No. Hospital Activities Used:	<u>40</u>
27 Average Reliability Rating for Day Centres:	
a) None	- 0
b) Once Only	- 1
c) Very Erratic	- 2
d) Regular for Part Period	- 3
e) Regular for Whole Period	- 4
28 Average Reliability Rating for Groups:	<u>42</u>
29 Average Reliability Rating for Hospital Activities:	<u>43</u>
30 Total No. Day Centre Attendances in Period:	<u>44</u> - <u>45</u>
31 Total No. Group Activity Attendances in Period:	<u>46</u> - <u>47</u>
32 Total No. Hospital Activity Attendances in Period:	<u>48</u> - <u>49</u>
33 Total No. Community Agencies Client in Contact with:	<u>50</u> - <u>51</u>
34 Total No. Agencies Staff Involved with on behalf of Client:	<u>52</u> - <u>53</u>

Total No Agencies Client in Contact with in each Category:

35	DAILY LIVING	54-55
36	SOCIAL SUPPORT	56-57
37	HOUSE/ADVICE/WELFARE	58-59
38	FAMILY/RELATIONSHIPS	60-61
39	WORK/DAY OCCUPATION	62-63
40	SPECIALIST TEAMS	64-65
41	PHYSICAL HEALTH	66-67

42 Carer Data:

68

0 = None,
1 = Yes & Not Live With
2 = Yes & Live With

43 Type of Support Offered to Primary Carer:

69

a) None	-0	f) Liaise Through SW	
		Department	-5
b) Telephone Contact	-1	g) Letters	-6
c) Relative Support	-2	h) Family Therapy	-7
Group			
d) Advice on Alcohol	-3	i) Help contacting	-8
Services		other agency	
e) Seen with Patient	-4		

44 Total No. Non Mental Health Carers:
(0=None)

70

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