



Where's the Heart in Community Care ?

Introduction

“Naming the Beast” is what poets do. It's as if the poet is Society's whistleblower, working craftily, through words full of music and magic. That is why in totalitarian Societies, poets lead risky lives and have to be especially light-footed if they want to keep their tongues. But ultimately it is totalitarian Societies that value their poets most. In acting against them, governments show recognition of the poets' power and danger, the danger of free truthful words. Defiant crowds chant those words in football stadiums.

In Societies where speech is free, and where all beasts can be freely named, the poet has a less clear role and maybe rather less impact – a paradox.

In free Societies, naming Beasts is an easy matter and everyone is able, willing and even keen to share in it. Yes ?

There are many Beasts about, and some of them are kindly and mean nothing but good. However, it is always terribly important to name and know them, draw them into the light so to speak, and see how they relate to each other. Sometimes, together, they form something new and unexpected and their nature can change.

This piece will aim to name some Beasts. It concentrates on the mental health services. That is the sphere in which I have operated for most of my waking adult life and the issues I'll cover here seem important in terms of that sphere alone.

But I think the issues also has a wider significance and application. There's something in them that's relevant to Community Care as a whole, and beyond that to Community as a whole - what Community means, how it happens, *whether* it happens.

Besides, I do think that mental health is anyway and in itself a central issue for our Society. How our culture deals with mental ill-health has something to do with how all of us connect - connect with Self, with Other, with Order and Disorder, with Control and the loss of Control, with Reason and Other than Reason... And in turn this is inevitably an indicator of our Society's true value, our communal capacity to survive and thrive through the strains of our time without scapegoating, without the need to burn witches.

And we'll start with some potted history, for reasons which I hope will come clear. I am restricted to UK history in this, although quite a few countries share a similar story, since theory, policy and practice have become ever-increasingly interchangeable and common.

Potted History - Ancient

In the UK, “Community Care” in mental health had its beginnings in the Mental Health Act of 1959. Before that, Society treated those of its citizens who suffered from serious mental ill-health largely by putting them away in large Victorian Hospitals in the country. There was precious little else available.

Consequently, there was a phenomenon called the “revolving door” – people were discharged from hospital, but having received no preparations for their return to the community, and having insufficient support within it, soon returned to hospital again.

As a way of addressing the “Revolving Door” problem the ’59 Act made it legal to open hostels in and out of town for ex-patients who needed time to prepare themselves for life in the community again.

And those individuals and organisations who moved in to fill this new function and opportunity, looked for a model of practice that would be suitable. They found it in the “therapeutic community,” developed in the Second World War at the Henderson Hospital.

The model was quite radical for that time. It was non-medical. It treated people as individuals not as cases, and their problems as soluble. People were expected to recover. The therapeutic community seemed the best and maybe only model available and, in the 60’s and 70’s, hostels run along these lines became fairly common around the country. At first they were managed and staffed by the Voluntary Sector but soon local authorities were imitating the model, or adopting elements of it.

However, it was discovered that for many people that model wasn’t sufficient or suitable. Often it served less as cure than as interlude, a mere extension of the revolving door circuit and, following discharge from the hostel, people would too often and too easily end up yet again in hospital.

A more complex and varied system of community supports were gradually set up, including much longer term and less intensive interventions and agencies and day-support and supported-housing arrangements.

Then the big hospitals were closed and for while the community services were reeling and failing. Significant numbers of ex-patients fell through the net, exchanging one set of degradations on the long-stay ward for another set on the street. But improvements came, never sufficient, never well enough resourced, but increasingly pertinent and realistic with regard to range, variety and extent of need.

By the mid 1990’s much larger numbers of people with long term mental health needs were being supported with reasonable success in the community, within multi-disciplinary support networks whose long-standing liaison problems were at last being significantly resolved. The networks served as anchorages, monitors and mediators for individuals struggling to keep a place for themselves in the community.

A decision was made about funding priorities. I remember a manager I was fond of and respected hunching his shoulders to take the flack as he said (to a potentially hostile audience) that the budgets he had at his disposal would be deployed henceforward in favour of people with severe and enduring mental health needs. These were people otherwise certain of being rejected by the community and falling away from it altogether, without any real foothold, or humanising recognition - unless a whole support package was painstakingly put together - decent housing, supportive workers, some meaningful and rewarding daily activity, a reasonable income from State benefits. I was present with the manager during those particular local moments and I felt something significant had just happened, an advance had been made, a moment of hope and binding for more than just those present or those directly affected.

Potted History Modern

New Labour came to power in the UK with promises of major new money for mental health services and a plan for a more comprehensive and regionally equitable spread of resources (called the National Service Framework). This seemed in many ways commendable. The argument was that, if it’s been established by research that a particular service or approach works, then we have no right to restrict its practice to the place where it chanced to begin, or places to which it has spontaneously spread. We must ensure and insist that everyone in all parts of the country get the benefits of a similar range of good quality provision. Hard to argue with that, though of course implementing it would mean a much more centralised system, fiercely top-down management hierarchies, and a very different role for managers - no reduction in responsibility but much less scope for personal initiative, much tighter compliance with fixed and centralised indicators of achievement.

So, for instance : Crisis response teams to keep people out of hospital ; early intervention teams to help at risk youngsters who might otherwise fall into a “mental health” way of life ; assertive outreach teams to ensure people particularly isolated and maybe chaotic stay in touch and received treatment.

Though few admitted it, the promised extra money did not actually materialise in several areas, yet still the new services were required there. It seems also that these services turn out to be more about equity and “minimum sufficiency” than about flair and excellence and we can wonder whether excellence can ever be associated with the amount of top-down duress and centralised control which this major exercise has required.

I don't think my last point applies just to managers. I think it's true as well for practitioners and clinicians at ground level. The human skills and qualities needed to offer excellence in any mental health setting are exceptional and maybe require a sense of vocation, as well as excellent recruiting and supervision. (These last essentials are usually emphasised far too little). But excellence and vocational urgency are rare in themselves ; and in turn are rarely attracted by, nor do they flourish under, centralised duress.

Now we must prepare for the entry of the Beasts.

I have said before that some Beasts are entirely benign and well intentioned. It's merely helpful to name them.

Other Beasts are benign and well-intentioned in their purposes, but then change their nature in the rush and squeeze of the large and pressured system which adopts them. They emerge in the work-place very different in practice from the intent they promised in the power-point presentation. Or they are used by their host for very different purposes from those the policy-makers had in mind. Or maybe all along the Beasts had their own plans and just got away ; and out on the prairie they join other Beasts and merge with them and slowly a different Beast altogether rises above the horizon and comes lurching back to Bethlehem to be born...

A feature shared by most of these Beasts is the constant and worthy search for means by which services can be attuned as closely as possible to different individual needs and situations. The principle of Choice.

Enter the Beasts

The Recovery Model

The Recovery Model suggests there is always hope, always the possibility of advance and personal development, and these should be constantly sought and worked for. This philosophy is reminiscent of the therapeutic community approach of the 60s, sharing both its virtues and possible limitations (mentioned above). It is a long-standing principle of social work and of medicine. In a sense it is nothing new.

But it carries a shadow with it - the danger that “Recovery” as Policy will come to mean or be understood as being total “cure” in all cases. Therefore failure is implied if “cure” is not achieved. Thus community services that once were open-door and non-judgemental resource-centres begin to shift their focus, with a tendency, which might even be explicit - to judge, condemn, select...”Only people we can be confident will Recover may enter Here...”

I am not saying that this might happen. I am saying it *has* happened. It *is* happening. So where will the others go ? And how will they feel about themselves ?

Social Inclusion

There has been creative thinking under this heading over the past decade.

But one proposal that has emerged from the Social Inclusion “nexus” has pressed policy buttons to major

effect - namely that buildings which offer specialised services in the community to disabled groups of one kind or another merely reinforce a segregation, an “exclusion”, that’s unhealthy.

So that open-door non-judgemental centre in the community, must not only start to judge and “cure” people as a matter of top-down policy, and create a sense of anxiety and potential failure in so doing, it must now justify its whole existence. Maybe it’s not needed at all.

Employment

Research has found that people with mental health problems can and should and in the majority of cases want to be employed. It’s their right, (but might it also perhaps be their responsibility ?) Mental health services should therefore offer training to prepare people better for employment. They should run campaigns to encourage and support employers to offer work to people with mental health problems.

But please remember here the other Beasts just mentioned, jostling for attention, shaking the ground of people whose footing in the world is anyway not very firm. And remember as well that there are some for whom getting to the Support Centre once or twice a week is a major achievement in itself, requiring its own form of heroism.

Disability Benefits

A further related campaign : let’s get “tough” with people on long-term Disability Benefits. Let’s strongly question, in various ways, their right to remain unemployed, sponging off the State. A policy borrowed from Mr Clinton ? A policy to please the Daily Mail ? A very large proportion of the people on Long-term Disability Benefits just happen to have long-term mental health problems. Who’s talking about that ?

What the Beasts have been getting up to

Below are some results that I have witnessed. I have every reason to believe that they are typical examples :

The Catering Project

There was a café down the road, giving long-term sheltered employment to people with severe and enduring mental health problems. It offered fresh food on the spot and also a catering services for sandwich lunches etc. It was hugely valued by its employees - they would talk about it with true joy and exultation. And its food was famous for miles. It attracted a loyal clientele from the local community and as an example of good PR for mental health in the community, it was a star turn. Funding problems forced it to close. The commissioning manager concerned said she wouldn’t be able to fund a similar project again - she could only support a strategy that worked with people individually to obtain jobs in open employment. No blame to the manager for that. Directives/signals keep hitting the managerial desk.

But the people who had literally gloried in working for that project, and had found a valued social role there, would never cope in open employment, whatever the training, whoever the employer.

Quantitative Measures

Independent agencies are being commissioned to help people with mental health problems into employment. At least one I know pays its staff a bonus each time they get someone into a job. A powerful incentive to be hasty and careless and put the needs and pace of the individual second...

Day Services for Recovery

Day services for people with mental health problems are being quietly transformed. I used to run one such place and saw it as a kind of parish centre for the disconnected, offering stability, a choice and range and weekly rhythm of valued activities, a social role and acceptance to people who otherwise lacked all those things. It provided links and bridges to the wider community and a constant sense of non-threatening possibility, a belief in people. It was a vibrant close-knit place that was somehow life-enhancing. Individuals and groups from its community made extensive use of local community resources ; in turn the local community used the building as a resources as well – the local MP held a surgery there ; GP's sent patients to an evening stress clinic that took place there, offering group sessions and massage. It was based on high quality and highly motivated staff, well supported and supervised, and in my opinion it carried and put into good practice lessons learnt over a period of nearly twenty years.

But once judged to be segregationist, such places are everywhere being “modernised” and having to justify themselves in terms of “through-put.” They are becoming time-limited treatment centres for “recovery” and “social inclusion” and indicators for their success must now include the numbers of people they have discharged within quite a short space of time. In a sense they are taking on some of the elements of the old and largely superseded “Therapeutic Community” - but without the skills or knowledge-base of that model being applied. Inevitably, there is a growing incentive not to admit people who may not be capable of moving on afterwards. Across the care system people are absorbing the news that the whole idea of buildings in the community allocated and specialising in support for needy groups is in question and under threat (And Consultation and Involvement ? What does the user movement say about this ? Oh come on, Bruv. Some slogans matter more than other slogans. Let's move on)

Chasing the money, Mabel

Local voluntary sector mental health services have to go to local NHS commissioners for their funding. They know the buzz-words and it's the way of the world that funding will yield to them if they buzz on the right frequency . The valued drop-in centre ? Or another employment initiative ? The Chair of one such organisation checked with me. She was going to plumb for the employment initiative, she said. She re-assured herself with the thought that the local NHS would continue to provide the drop-ins locally for people with long-term problems. But no, she was wrong. *All* the local day services were being “modernised” - obedient to the buzz-words, dancing to the tune, chasing the funding.

What's the meaning of this ?

I can't be sure but I fear the worst. I fear that what's happening is that various strands of superficially persuasive dogma, driven by people who believe in them with an almost religious fervour, have come together and are serving to justify the steady withdrawal of ongoing specialist and skilled support from people with long-term mental health problems. I cannot believe that's intended but I am watching it begin to happen.

Even in the early stages of this process, the ripples running across the service user communities have been doing damage. There is dread and a sense of betrayal. There is already less supported activity in the week to sustain and re-assure. There are less experienced support workers available (it is anyway being questioned whether professional support is really needed). There is fear of the next letter from the DSS Dept, requesting another assessment interview, challenging unemployment status, questioning how you are, requiring you to justify yourself....

I fear that service funding and selection processes will favour and follow those people whose mental health problems are less serious, people more employable, people easier to “include”. For years now, managers have been required to work to tick-in-the-box paper measures of approved practice, forced into a mould, forced to

work separate from their own genius, their own flair. Here is another tick that will attract funding and win approval from centre.

The lessons of the 80's and 90's are being ignored. The tangible developments that followed the learning of those decades, and ensured a better and more sustainable life in the community for significant numbers of people with long-term mental health problems, are being unpicked. And under the banner of "Modernisation" we are actually rushing backwards through a blur of denial and sloganising. Where will we stop ? In the Life and Times of Charles Dickens ? Before they learned better and faced facts, many Victorians talked in terms of personal immorality and fecklessness as the cause of the miserable lives of the Victorian Have-nots. I am beginning to hear the first hints of similar talk, among senior mental health managers, as they think blue-sky thoughts about a building-free socially inclusive person-centred recovery model-driven mental health support service. "The reason these people have long-term needs," said one manager recently, "is that services have made them dependant." Have we at last discovered, then, the cause of mental illness ? Ladies and Gentlemen, the cause of mental illness is mental health services. At a stroke we have resolved a problem centuries old. All we have to do now is get rid of the services altogether and mental illness will just disappear. Or let's give the whole business over to the Faiths, the User movement and to Volunteers. And the odd Agency Nurse. And the odd overworked policeman. Let them sort it. Easy.

The Victorians had an excuse. They were learning pretty well from scratch. If I am right about the present shift, this is an altogether different thing, a deliberate rejection of learning painfully achieved over years, in favour of slogan, dogma and denial. There is no excuse for wantonly going backwards.

People with long-term mental health problems will remain part of the community. They belong in it and in truth add to it. But their acceptance by the community can't be conditional on whether they've "recovered" or whether or not they have jobs. Many will be difficult company, inviting rejection, and will continue to fit only uneasily into the common social shapes and transactions. They will need for respite the company of people in similar situation, because there is always going to be less judgment and less fear there. "I feel more at home here in this place" said one such person, describing a mental health community centre she attended, "than ever I feel at home." That won't change, however much money is pumped into mental health promotion, however many celebrities come out.

And people with long term needs will continue to turn to and rely on workers especially trained, closely supervised and themselves skilfully supported, to act alongside them, sustaining, mediating, advocating and, yes, on occasion defending. To deny that necessity and just leave it vaguely to the Community's natural "Inclusiveness" is a frightening and irresponsible denial of reality. It is a denial of the facts and difficulty of mental ill-health. It is a denial of the "Skills of Love" - their complexity, their art and their power, their centrality to the success of community. That is perhaps the real beast here, named at last : a rejection of the connecting Skills of Love. They must be nurtured and treasured for Community Care to work, for human life to work. They must be strengthened and must advance. Instead they are being weakened, belittled, set at naught. Rights, Equality and Choice have replaced them, the new godhead. There is no such thing as Society. There is only Rights, Equality, Choice, Me and Mine, past the point of no return.

"Humankind cannot bear very much reality" sings the poet, cautiously, craftily. For the poet knows that all too readily humankind hunts down and sets at naught that which it cannot bear, even to the point of complete and final self-destruction.

*Rogan Wolf
February 2009*