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Needs and Wants and Fairy Tale Wishes: A Scottish Impression of Care in the Community

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Summary

This paper provides an impression of care initiatives within Scotland which emphasise 'community-based' services. Only mental health services are featured in the description, partly for simplicity, but also in recognition that wide differences in operational policy do not exist for different 'populations'. The mini-perspective is presented against the backdrop of consideration of some of the critical elements discussed in Baldwin's (1987) overview of neighbourhood services. Finally, a project-in-progress is discussed in greater detail as an example of an 'alternative' service designed around a 'needs-led' philosophy.

Résumé

L'article vise à présenter une image des services sociaux qui, en Ecosse, placent l'accent sur la 'communauté'. Il se limite toutefois à une description du domaine de la santé mentale, dans un souci de simplification d'une part, mais aussi parce que les institutions concernant différentes 'populations' fonctionnent selon des principes très semblables. Cette perspective est présentée par rapport à certains des éléments critiques discutés par Baldwin (1987) dans son aperçu des services fonctionnant par quartier. Finalement, un projet en cours est discuté plus en détail; il doit servir d'exemple d'un service 'alternatif', structuré en fonction des besoins de ses usagers.

1. The Context

Scotland is part of the United Kingdom and comprises nearly 30000 square miles with a population of approximately 5.5 million. The country is one-third the size of Britain overall, but represents only about one-tenth of the total population. Much of the northern Highlands and Islands, and the southern belt, is thinly populated. Four fifths of the Scottish people live in the narrow belt of the Central Lowlands with a population of 1000 per square mile, compared with 20 people per square mile in the Highlands. One half of the population is located within a strip 5 by 20 miles long on the West coast in the Strathclyde region, stretching from Clydebank on the coast, through Glasgow inland to Motherwell.

Although governed by the British parliament from Westminster, in London, Scottish affairs are dealt with by the Secretary of State for Scotland who is responsible

for four departments based in Edinburgh: the Scottish Home and Health Department (SHHD) and Departments of Development, Education and Agriculture. Questions concerning, for example, teachers' morale, hospital closures, 'mad cow disease' (BSE) or ethnic representation in the police force, would be dealt with separately by Ministers of Education, Health, Agriculture and the Home Secretary respectively, if they arose in England or Wales. In Scotland, however, all such issues are directed at the Scottish Secretary. Although Scotland is influenced by the British political agenda, specific policies are framed in relation to their implementation within Scotland. Traditionally, Scotland has had, for example, its own Mental Health Act, Hospital Advisory Service, and Mental Welfare Commission. At present, the implementation of the Community Care Bill is influenced by specific Scottish guidelines. Demands for a separate Scottish Parliament, (or at least a Scottish Assembly), have grown in the past 20 years. At the time of writing, the British Government has witnessed a steady decline in support: less than 10 per cent of the Scottish Members of Parliament represent the Government in London, England. In some respects, therefore, Scotland is fortunate to possess its own legislature. This continues, however, merely to *modify* seminal pieces of legislation which have been issued from Westminster.

2. Mental Health: Hospitals and Community

The concerted transfer of people from 'hospital care' to 'community care' which has characterised English mental health services over the past decade, has not been evident to the same extent in Scotland. Between two-thirds to one-half of the residents of psychiatric hospitals are over 65 years of age, more than a quarter of these suffering from dementias. Opposition to widespread closure of hospitals appears to be stimulated by awareness of the relative 'failure' of some English closure programmes and, more appropriately, the weakness of pre-existing community services (Drucker, 1987). People with the burgeoning emotional problems of stress, anxiety and depression are treated by General Practitioners, with only 5% of such people referred to psychiatric services, and these predominantly on an 'out-patient' basis. People with more severe disorders, such as schizophrenia and manic depression, spend shorter periods in hospital, and are supported by 'out-patient' services and domiciliary services run mainly by Community Psychiatric Nurses (Pollock, 1988). Although a reduction of 4000 beds over the past 20 years has been achieved in psychiatric hospitals, equivalent services within 'the community' have not been developed. In operational terms, although no Scottish psychiatric hospital has been closed down, it could be argued that many people have been effectively 'closed off' from gaining access to services by reducing the size of hospitals, whilst failing to fund alternative initiatives.

'Community care' is not working well in Scotland: Scotland has almost twice as many people, per head of population, in mental hospitals compared with England; 'dowry' payments which facilitate transfer from hospital to community care in England, do not exist in Scotland; between 1981-1986, mental health expenditure fell, as a proportion of overall NHS expenditure; joint planning between health and social services has proven ineffective (and, unlike Wales, no central leadership, or co-ordinated strategy, exists). Against the background of inadequate funding for community-based projects, much money continues to be spent on upgrading hospital facilities and, at least in the Highlands, to total rebuilding programmes.

3. Goals of Mental Health Care

It is difficult to define explicitly the aims of mental health services in Scotland. An indication of the expectations of central government for the development of community-based services is contained in various 'official' reports (e.g., SHHD, 1985). These tend, however, to focus on 'the community' as some nebulous concept which is rarely defined, other than negatively. The proposals in the recent White Paper (Cm 849) identify the importance of providing care which allows people with mental illness *(sic)* "to live in the community wherever possible" (para 10.25). These proposals also recognise that Health Boards and local authorities need to work together to ensure the "availability of the relevant community-based health services and social work services (which) will allow the individual concerned to live in the community" (para 10.27). The community is, perhaps, everything other than hospital services.

A philosophical commitment to some of the fundamental principles of a 'neighbourhood-based' system of service delivery, however, does appear to exist within Scotland. Clarke (1987) described the goals of mental health care shared by the Scottish Association for Mental Health (SAMH), a charitable body committed to political lobbying and some service delivery. In Clarke's view, people with mental health problems have an:

> "inalienable right ... to be valued and to participate in and experience those things which sustain, express or accord value" (Clarke, 1987, 2).

He acknowledged furthermore that the person's expected 'access' to treatment, care or support should be characterised by several elements, which include being:

> "dignified and appropriate in both setting and manner of delivery ... (preserving or developing) social roles and relationships in the community" *(ibid.).*

Because of the pervasive presence of institutionalised services in Scotland, 'positive' voices, such as SAMH, often articulate their message in negative terms. The SAMH response to the White Paper on Community Care (SAMH, 1990) noted, however, that 'community care' needed to be based upon:

> "locally based and multi-disciplinary community mental health teams who would work closely with voluntary organisations and self-help groups and other support networks such as primary care services, health visitors and home helps" *(ibid.:* 7).

Aside from SAMH, few 'official' organisations emphasise the need for specific 'locally based services'. Although not explicitly stated, the emphasis upon a specific 'locality', and the mobilisation and coordination of locally available services, are at least suggestive of the neighbourhoods described by Baldwin. More often, however, the exact nature of alternative forms of service delivery rarely is agreed. Often, 'community care' involves providing traditional clinical (hospital) services outside of hospital. Typical examples are: community psychiatric nurses running depot medication clinics in health centres; psychiatrists, social workers and nurses 'screening' people for services at psychiatric day hospitals; various 'therapists' offering various forms of 'therapy' at out-patient clinics, day hospitals, and health centres. To describe these as 'health services' involves some manipulation of the language: they are 'health-oriented' only by virtue of their almost exclusive efforts to reduce 'illness/disorder/ problems';

and the model is primarily a 'servicing' one, requiring users to be passive recipients of care and treatment.

Clarke (1987) acknowledged, however, the *constituents* of a more appropriate 'pattern of care'. People need at least:

- an extensive *menu of advice and information.* This should identify services, facilities and benefits;
- a range of *'talking therapies' (sic).* This should embrace traditional psychotherapies as well as a range of counselling approaches;
- access to *medical assessment and medication.* New patterns of care, in Clarke's view, also need to recognise the value of traditional medical services;
- practical, financial and emotional *support in daily living;*
- integration into the network of wider mainstream community life through *organised social contact and support;*
- *employment and rewarding activity;*
- in particular cases *supported accommodation and housing;*
- in other cases *'asylum and security';*
- identified workers to promote *self-help and mutual aid;*
- to ensure maximum effectiveness, all projects should be subjected to *evaluation* and *networks* established to promulgate effective systems of service delivery.

Clarke's 'recipe' emphasises a balance between services stemming from 'ordinary living' environments and 'extraordinary living' environments, such as special care or residential settings. It is a recipe which is, however, in conflict with much of the typical mental health programme, which is either highly specialised in terms of its 'treatment aims', or expressed through variants of hospital outreach services.

4. A Scottish Impression

Examples of Scottish services which conform to Baldwin's concept of 'neighbourhood' systems are elusive. Six examples are provided here of services which are typical of current 'community care' provision. The first two represent extensions of traditional institutional care: they are, in effect, 'outreach' services. The second two represent 'flexible responses', emphasising the use of 'general' health services or carers and sufferers themselves. These four together fail to meet Baldwin's criteria for 'neighbourhood systems'. The latter two examples are strong examples of 'alternatives' both to institutional services and medically-oriented forms of mental health service provision.

4.1. Current Community Care Provision - I

The *Borders Psychiatric Service* (Jones, 1987) has developed over more than 20 years, and represents an extension of the 'therapeutic community' developed at Dingleton Hospital by Maxwell Jones in the 1950s (Jones, 1952). The service is provided to the total population of the Borders: 100000 people within an area 70 miles by 50.

Most of the larger towns in the area have populations of around 17'000. The service is sympathetic to the view that in

> "most psychiatric illness there is a very significant degree of regression to a more childlike state of feeling and behaviour" (Jones, 1987, 75).

The model of service provision emphasises, therefore, the encouragement of people "to take back responsibility", also using crisis intervention and systems theory approaches.

This service provides not only an after-care service to people who have been discharged from hospital, but also assessment and direct treatment in 'the community', by a multidisciplinary team which liaises between the hospital service and various general practice teams. Jones (1987) acknowledged that some people might view hospital (institutional) and 'community' psychiatric services as mutually exclusive. He suggested that the Borders psychiatric service balances the maintenance of in-patient and community services by use of a common therapeutic community philosophy, and by the "permeability of the institutional boundaries" (Jones, 1987, 75).

4.2. Current 'Community Care' Provision - II

All institutional mental health services have developed *out-patient psychiatric services.* Pullen (1987) described how these services for Edinburgh (the Scottish capital city, population: 440000) were sectorised into four catchment areas, each comprising 85-124000 people. All four sectors share inner city housing, 'middle class suburbia', outer city housing schemes and a further band of middle-class housing on the city periphery. Pullen described three different models of provision: (i) in 'replacement', the psychiatrist at the clinic relieves the general practitioner of responsibility for a specific 'case'; (ii) in the 'educative' model, the psychiatrist aims to support and train the general practitioner to cope with mental health problems; and (iii) in the 'liaison' model, collaboration between general and specialist practitioners is encouraged. His out-patient service, based at a health centre rather than a District General Hospital, allows promotion of the 'liaison' model of collaboration between specialist and general practitioner.

4.3. Flexible Responses - I

Traditionally, *Community Psychiatric Nursing* (CPN) has been provided as an 'outreach' services from large psychiatric hospitals. Within the past decade, some of the services have experimented with the provision of CPN services from health centres within 'the community'. Ryce (1987) described one such experiment at Livingston, a 'new town' in West Lothian, mid-way between Edinburgh and Glasgow. All referrals to the service are vetted by the general practitioner (GP). The CPN provides a direct counselling role or implements medical treatment prescribed by the GP. In a smaller proportion of cases, the CPN refers people on to other counselling or therapeutic services.

4.4. Flexible Responses - II

The growth in the provision of support by *voluntary groups,* to people with various mental health problems - phobias (Crichton, 1987); schizophrenia (Crocket,

1987); manic depression (Kanis, 1987) and addiction to tranquillizers (Moss, 1987) - is probably one of the major success stories of the 1980s. Many of these groups are supported by health and social services staff, but the main ethos is on self-help or mutual support in a 'non-clinical' setting.

4.5. Review

These four examples are typical of general mental health services within Scotland. The Borders service struggles to contact people scattered across a wide area, whilst maintaining contact with the 'base hospital'.

Similar geographical problems in the Highlands played a part in encouraging the building of a new £16 million hospital in Aberdeen: this action appeared to go completely against the nationally-agreed plan of reducing the size of large institutions. Although neither the Highland nor Borders community services could be described as reactionary, the contrast between highly specific hospital services and nebulous, dispersed community foci, run counter to Baldwin's concept of neighbourhood services.

The concept of providing services from an out-patient department is typical of the 'specialist group' described by Baldwin (1987, 44). Whether intentional or not, Pullen's description of the Edinburgh service reinforces the central, linchpin status of the consultant psychiatrist; all other professionals appear subordinate, if not peripheral to his *(sic)* influence. Ryce's description of CPNs and Pullen's description of psychiatrists both focus on health centres, and both virtually ignore each other's contribution. As such services are evaluated, the enormous disparity of cost between CPNs and psychiatrists should become a central issue. Finally, despite the contribution made by various self-help and mutual support groups to the welfare of various clients, these continue to represent the relative isolation (and continued stigmatisation) of people with 'specific' disorders.

4.6. Two Neighbourhood-based examples - Alternatives to Institutional Services I

The Craigmillar Social Welfare Workshop in Edinburgh (Greenwood, 1987) allows a wide range of individuals to discuss and debate existing and desired services. The Workshop attracts representatives from health visiting, community education, social work, church, schools, child and family centres, police, housing, sheltered accommodation wardens, community workers, community psychiatric nurses, home care, voluntary workers and the DHSS. The workshop focus is on issues which are of local importance. Emphasis is given to exerting 'collective pressure' on local politicians or the local population. Although this interagency workshop has been chaired by a psychiatrist, Greenwood asserted that she had not seen it as partisan, or with any vested interest in specific institutions (Greenwood, 1987, 21). She also acknowledged that

> "probably the easiest way to effect change (in the nature and organisation of services) would be to set up a network of local counselling and advice centres (Community Mental Health Centres sounds too hygienic!)" (Greenwood, 1987, 18).

4.7. Alternatives to Institutional Services II

The *Greater Easterhouse Mental Health Project* began in 1984 in the East End of Glasgow, in an area of multiple deprivation with approximately 50000 people. A 'core group' set up a number of working groups to examine specific service areas: primary care, home support, day care activities and research and evaluation. The core group comprised representatives from: senior medical, nursing, administrative and research staff from the Health Board; and senior Social Work Department staff, including a research officer, a university lecturer, the Director of the Scottish Association for Mental Health, the local branch of SAMH, consumers, the area housing manager and the area community education officer. The Project, which has been described in detail by Millar (1987), offers neighbourhood-based services to people experiencing mental health problems for the first time (Primary care) and who have longer-term mental health 'needs' (the Crescent Project).

5. A Neighbourhood Service - Pheonix: A Project-in-Progress

The neighbourhood-based service described briefly here is focussed on a specific population of women living in an area of 'urban deprivation'. The professional support for the project is referred to as Service X: the project is referred to hereafter pseudonymously as *Pheonix.*

5.1. Subjects

The groups comprised women (all single-parents) who previously had been supported by community workers with a single-parent charity 'action project'. All the women had a background of alcohol and tranquillizer abuse: both practices appearing to serve as 'coping strategies' against a background of relative poverty, social isolation, and histories of past and/or ongoing physical abuse. The single general practitioner for the neighbourhood (pop. 7000 approx.) had diagnosed anxiety, depression and/or various psychosomatic complaints in the group, but had not referred any of the women for a psychiatric consultation. In the health visitor's view, this was due partly to the women's refusal to see a psychiatrist: they did not see themselves as 'loonies' *(sic)* or otherwise 'crazy' *(sic).* More practically, they feared that such a referral would stigmatise them further: some of the women had experienced their children being placed on the social work department's 'at risk' register and viewed psychiatry as a related 'controlling/penalising' agency.

5.2. A Traditional Precedent

Service X had been involved previously with a similar group in a less deprived neighbourhood on the opposite side of the city. This group had been identified as experiencing a variety of 'depressive' disorders related to childbirth and domestic or financial crises. This project was problem-led: each woman was assessed in terms of her specific psychological problems; a 'treatment package' was subsequently developed, centred on a 'therapy group' held in the health centre. The constituents of the package were identified by the service providers: a community psychiatric nurse, a community occupational therapist and a health visitor. The key constituents and providers were:

- information about 'anxiety' - community psychiatric nurse and health visitor;
- basic assertiveness training - community occupational therapist;
- aroma therapy and mood - community psychiatric nurse;
- yoga breathing as a relaxation aid - local yoga teacher;
- self-hypnosis - local hypnotherapist.

The project was evaluated by the anecdotal 'self-report' of the participants, all of whom 'enjoyed' the sessions and generally 'felt less anxious and depressed'. This project appeared to represent a typical 'specialist' group service (Baldwin, 1987). The women were defined mainly as suffering from 'post-natal depression': the treatment package was 'designed' independently of the group, who were essentially passive recipients of a 'coping' advice and information service.

5.3. Sample Group

The women who subsequently formed the Pheonix group were offered a short structured 'course' of eight one-hour sessions, held in the single-parent charity headquarters, based in the ground floor accommodation of a late 1960s four-story 'maisonnette' block. The block, which was otherwise empty, was scheduled for demolition as part of a general refurbishment of the neighbourhood. Some of the 'answers' to the women's problems were 'housed' in buildings soon to be knocked down to build something more architecturally appropriate. The sessions were offered by two Clinical Nurse Specialists from the mental health unit.

The women were encouraged initially to describe their 'problems' from their own perspective: the nurses then provided information about 'anxiety' and mood disturbance (their perspective) by way of 'clarifying' and 'validating' the group's experience, finally discussing with them practical ways of managing everyday difficulties. Throughout the sessions, nurses avoided all psychiatric terminology and made no attempt to 'classify' the women's experience in any 'psychopathological' sense. The 'strategies' explored with the group were discussed simply in terms of their 'potential problem-solving effects'. Although the nurses were 'informed' by specific psychotherapeutic strategies and theories, no attempt was made to introduce concepts such as 'anxiety management' or this-or-that 'therapy'.

The nurses negotiated eight sessions with the group; when these ended they said their goodbyes and left. One month later, the community worker in the neighbourhood contacted the Team Leader of Service X: the women were 'anxious' to have further contact, "another group" or "more of the same". Intentionally, no evaluation of the pilot group had taken place. The request, however, represented a measure of the motivation within the group, who at first were hesitant and suspicious, and now were 'asking for more'.

5.4. Assessment

Pheonix was developed by two community workers from the neighbourhood and two (different) Clinical Nurse Specialists supported by the Team Leader from Service X. Having established that a genuine 'need' for help was being expressed by the group, they aimed to assess this further before beginning any intervention. The women were informed that another group was 'pending', and were invited to participate in the pre-

liminary stage of planning the group. The community workers agreed to invite all women in the neighbourhood who expressed similar needs to the 'pilot' group to join Pheonix.

The first stage in the exercise involved an 'assessment' conducted by the community workers at their base: this involved completion of three self-report measures of depression, 'anxiety' and self-esteem; all were valid and reliable instruments, appropriate for completion by the women. Where literacy presented a problem, the community workers assisted in their completion, in accordance with the original research guidelines. The anxiety and depression scales were selected to 'locate' the women within the psychopathological norms embraced by the mental health unit. Typically, people with no history of hospitalisation, or without a formal psychiatric diagnosis, were described as the 'worried well': the assumption was that they suffered negligible (clinically insignificant) levels of psychological disturbance. All the women who joined Pheonix registered levels of 'anxiety' or depression which placed them in the 'moderate to severe' categories on both scales. The self-esteem measure had no normative criteria, but was helpful in assisting the women to describe their view of themselves: it was an invaluable measure of 'personal' change, concurrent with any other observable change.

5.5. Objectives

From the outset the participants in the project were encouraged to set their own 'agenda': what did they wish to deal with, in what fashion, how often, etc. In the early sessions the professional input involved exploring options, facilitating discussion, keeping notes, charting decisions, etc. The temptation to offer 'packaged' solutions ("you could deal with your anxiety like this" ... or ... "we could try some assertiveness training") was strong: it seemed almost perverse to avoid prescribing solutions which were of acknowledged value. The group soon began to generate their own preferred options which, surprisingly, approximated the ideas being carefully avoided. Group members' suggestions that "we need to do something different: every day is just the same..." led to a session on 'life-planning' where the group brainstormed optional activities, their potential value, and practical costs.

The work of the group is focussed within Pheonix, but extends out to connect with other services and agencies within the neighbourhood. Although as yet in its infancy, it has 'connected' with the health visitors at the general practice, the social work 'fieldwork' team, the two local primary schools, the community police and the community councillors. These 'connections', which involve either individual group members meeting with the agency or inviting the agency to address the group, appear to be the beginnings of a network which will link Pheonix with relevant support services in the wider neighbourhood.

5.6. Process

Pheonix operates as a 'rolling' or open-ended group. The group is open to any woman resident in the neighbourhood who feels that she needs help with any one of a wide range of 'problems of living'. The professionals who participate are regarded as members: they are expected to share their life experiences, as appropriate, and exercise no authority within the group. Women joining the group are oriented to its aims and operations by the existing members, rather than the professionals involved. The rules governing behaviour within the group, revision of aims and selection of

alternative options for managing the group, are decided by consensus. Women leave the group whenever they decide this is appropriate.

To date the group has examined a diverse range of 'needs', all 'prioritised' by consensus. These have included: relationship problems; managing and avoiding debt; dealing with anger and aggression; managing tranquillizer and alcohol abuse; parenting problems. Dealing with problems has been a top priority. In addition, however, the group have begun to consider more 'positive' options: life planning, personal development, extending social networks, increasing membership of other groups and organisations.

5.7. Future Developments

After six months the group continues to be focussed on women with life problems with a strong emotional content. In this sense the group represents a 'specialist group'. The reason for maintaining the original composition is simple: the women were unwilling to consider participation in any exercise which did not, realistically, reflect their immediate needs. Six months later, the group has attained an identity and may now be willing to open its doors to other women and, ultimately, men with related needs. The low expectations of the women at the outset can be summarised in a comment which was used in the title to this article. The group met with no difficulty in listing outstanding 'needs' not being met by existing agencies. When asked what they would *like* done, on a purely personal level, one women observed: "this is like talking about fairy tale wishes".

5.8. Conclusion

Pheonix is a 'work in progress' which is attempting to implement some of the principles of the neighbourhood systems approach with special reference to unmet mental health needs. For the professionals involved, the project offers significant challenges in terms of revising some of their traditional roles: committing themselves more rigorously to collecting data about the population, its setting, and the general infrastructure in the neighbourhood; and taking a more facilitative line in their dealings with the project participants. The project is unashamedly a 'bottom up' exercise: it is acknowledged that a 'sleight of hand' was used in terms of tempting the participation of the women through a time-limited sampling exercise. This strategy appeared to be justified and carried no covert controlling mechanism. The key features of the project appear to be its commitment to demystifying and deinstitutionalising mental health services; and to develop alternative systems of meeting mental health through active collaboration with the recipients of the service.

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