The College

A Carer's Perspective

A Consensus Statement on Caring for the Mentally Disordered in our Communities prepared at a Meeting held on 2 April 1987 at The Royal College of Psychiatrists

(A list of participating organisations is attached, see Appendix I)

On 2 April 1987 the College invited representatives of national organisations directly concerned with patients suffering from mental disorder and their families to a meeting at 17 Belgrave Square. The aim was to attempt to reach a consensus with representative members of the College on what constitutes a good community mental health service. The College had drafted and circulated in advance a document which was debated, amended and expanded on the day. The outcome necessarily reflects the need for compromise between optimism and reality. It can nevertheless serve as an agenda for discussion of the development of district mental health services which includes the point of view of users and carers.

1. Introduction

In any community there are a number of people who suffer departures from normal mental health. It is the structured response of the community as a whole to these which constitutes its mental health service. A satisfactory community mental health service arises out of partnerships between different agencies and particular individuals and a clear vision of a comprehensive service and its objectives. A good community service is therefore one in which all the elements are planned and coordinated against a background of information of need provided by anyone having concern for mental disorder in the community. This statement is concerned with mental illness and mental handicap in its varied forms affecting all ages and including dependence upon alcohol and other drugs whether obtained through illegal or legal channels.

2. Characteristics of mental health services

Disorders of mental health may be minor or severe, brief or very prolonged, occur repeatedly or in single episodes and affect the whole age range, from childhood to great old age. Some may lead to permanent disability and dependence; others may need only brief intervention or support at times. The mentally disordered are to be found anywhere in the community but mostly in their own homes living with their relatives and other carers. A service must therefore put a major part of its efforts into providing treatment and care for the mentally ill or handicapped in a domestic or local setting and strong support for the relatives or carers. It must, of course, provide a range of services for the seriously mentally ill. Apart from providing the resources for diagnosis and assessment, a comprehensive service has also to provide health education and prevention, training and research. It must be organised and managed efficiently and be capable of demonstrating its comprehensiveness, effectiveness and quality.

In a summary a good mental health service for communities is recognised as:

COMPREHENSIVE—meeting the whole range of disturbances of mental health and of handicap wherever they are to be found.

ACCESSIBLE—readily available locally and easy to consult.

ACCEPTABLE—to patients, their carers and the community as a whole.

EFFECTIVE—demonstrating the capacity to bring about improvements in health both in magnitude and duration.

EFFICIENT—good value for money.

A good service is also marked by its STYLE which embraces good communication, responsiveness, flexibility, innovation and advocacy on behalf of the mentally ill and handicapped.

3. The partners in mental health services

The main partners in mental health services in the UK are:

(i) the mentally disordered themselves;
(ii) their families and friends, sometimes in formal groupings;
(iii) the specialist psychiatric services, including psychiatrists, nurses, psychologists and occupational therapists;
(iv) other medical services, notably general practice, but including other specialist services of professions allied to medicine;
(v) the personal social and welfare services;
(vi) provision of educational service by the Department of Education;

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(vii) voluntary and community mental health organisations;
(viii) private care;
(ix) local and central government
(x) housing associations.

4. **Service needs**
(i) housing and accommodation;
(ii) employment and occupation other than social activities;
(iii) health education for general public including the young;
(iv) provision of continuing education for carers and professionals;
(v) advice and information;
(vi) social activities and leisure;
(vii) income support;
(viii) transport.

5. **Objectives**
(i) *Treatment and care should be delivered where possible with the least disturbance to the normal life of the patient.*
Services have to be as available in the house, in local day care settings as in hospitals. They must therefore have both local and central components.

(ii) *The conflict between the needs of the patient and the needs of the carer should be addressed.*
There are situations in which because of the nature of the disorder a satisfactory solution for all parties cannot be found and there must be a balance between what is provided for the carer and what is provided for the patient and the community at large.

(iii) *People with disorders of mental health should be offered the least restrictive alternative.*
A good service is made up of a wide range of housing provision, staff networks, community groups and opportunities to remain in an environment which preserves self determination as far as disability allows and which will also allow support to be given. Housing provision should enhance the dignity of the individual.

(iv) *Specialist services should be of the highest quality and should be available in sufficient quantity.*
Where hospital and in-patient care is required, it must be provided in well staffed and well equipped modern hospital buildings in close contact with general medical and community services. The specialist services should also be readily available at all times, for example, to respond to psychiatric emergencies in the community at large. Continuity of care must be provided. Services should be capable of an easy, flexible and smooth transition between different settings. Some provision should be made either at district or regional level for patients with special needs such as young people who are drug dependent or those with Huntington's Chorea.

(v) *Specialist services should work in partnership with other statutory and voluntary organisations in advising and encouraging them in their work in mental health.*
Where mental health professionals see the need for complementary services, they should initiate, encourage and advise on their development within their community.

(vi) *All community mental health services should have access to a place of safety for a minority of the mentally disordered.*
For the small group of mentally disordered people who require longer term sanctuary, there should be a well designed comfortable environment and high quality life, e.g. residential 'hospital home' facilities for some mentally handicapped people. This category may include patients who exhibit behaviour problems, progressive mental and physical disability and those who may need intensive nursing care or asylum in suitably spacious settings.

(vii) *Community mental health services should provide a wide ranging and flexible support system for carers recognising the nature of their role and providing above all else adequate relief and respite care.*

(viii) *Community mental health services should be subject to external assessment at regular intervals.*
All services should account for their performance to external independent bodies, compare their practice with others and seek to imitate good practice and innovative ideas demonstrated by others. The availability of adequate statistical information concerning patients movements is paramount. Also the search for satisfactory performance indicators should be pursued. An important factor in any evaluation must be an objective estimate of the level of consumer (user) satisfaction.

6. **Integration and co-ordination of services**
Few of the partners listed are exclusively concerned with mental health. The majority have wider responsibilities and their contribution to mental health is set against other priorities within their budgets and organisation. Ideally the answer is to have a strong consortium of interest in which representatives from each agency including relevant voluntary organisations can take responsibility for the contribution of their agency to the partnership. The responsibility for co-ordinating this initiative should lie with the Health Service as should the monitoring of the total service. The identification of gaps, plans and initiatives can be fitted together against the recognition of the total needs of the community. The separate executive function of each agency is not compromised by each acting in concert. It is enhanced by knowing the common purpose.

7. **Ideals and realism**
Ideal services are nowhere to be found but some communities are further along the way towards their vision of an ideal service than others. In any event there can be no universal formula since each district has its unique

geography, social structure, history and personalities. Development is as much to do with overcoming restraints to progress as having good ideas and the resources to implement them. Nevertheless, the vital importance of adequate funding for mental health services is imperative. It is much more likely that progress will be made if all involved have a common purpose and make the contribution towards the whole which is uniquely theirs to contribute.

Overhasty closure of existing mental hospitals without providing suitable alternative resources both in the community and other hospital settings should be deplored.

The policy of realisation of assets from the sale of psychiatric hospital buildings and land returning to the mental health services must be enforced.

Examples of good practice are found in every health district in the UK. Many are recorded in the reports of the Good Practices in Mental Health project* and others by the Health Advisory Service† which keeps an information file on good practice. Both bodies may be consulted on specific issues.

*Good Practices in Mental Health, 380–384 Harrow Road, London W9 2HU (telephone 01–289 2034).
†Health Advisory Service, Sutherland House, 29–37 Brighton Road, Sutton, Surrey (telephone 01-642 6022).

April 1987

Appendix I

Attendance List

Al-Anon Family Group
61 Great Dover Street
London SE1 4YF

Alzheimer's Disease Society
3rd floor, Bank Buildings
Fulham Broadway, London SW6 1EP

Anorexic Family Aid
Anorexic Aid and National
Information Centre
Sackville Place, 44 Magdalen Street
Norwich NR3 1JE

Association to Combat
Huntington's Chorea
34a Station Road
Hinckley, Leicestershire LE10 1AP

Association of Carers
London House
243–253 Lower Mortlake Road
Richmond, Surrey

Depressives Associated
PO Box 5
Castletown, Portland, Dorset

Drug Line
9a Brockley Cross
Brockley, London SE4

Ex-Services Mental Welfare Society
Broadway House
The Broadway
Wimbledon SW19 1RL

Families Anonymous
88 Caledonian Road
London N1 9DN

Mental Health Foundation
8 Hallam Street
London W1M 6DH

National Autistic Society
276 Willesden Lane
London NW2 5RB

National Council for Carers and
their Elderly Dependents
29 Chilworth Mews
London W2 3RG

National Schizophrenia Fellowship
78 Victoria Road
Surbiton, Surrey KT6 4NS

National Society for the Prevention
of Cruelty to Children
67 Saffron Hill
London EC1N 8RS

North West Fellowship
46 Allen Street
Warrington, Cheshire WA2 7JB

RESCARE
Lindens
Chichester Road
Dorking, Surrey RH4 1LR

The Royal College of Psychiatrists