Community Mental Health

Historically, the management of mental illness was about restraint and segregation. Nowadays, it's completely about the opposite, it's about engagement and integration. So what brought about this change?

Community mental health is a concept which internationally started in the 60's and 70's, and was instigated by what is known as the process of de-institutionalization (Barton, 1976). Russell Barton had noted that patients who were treated in hospital for long periods of time, developed symptoms which were beside the symptoms of mental illness. These were characterized by a loss in personal abilities and functions, and manifested in loss of individuality, apathy, and loss of interest in activities which are considered part of the daily life of every human being. This was named by Barton as "Institutional Neurosis". Although it is unclear how much of these symptoms were the result of the illness itself, it was evident that long periods of hospitalization were, if not causing, maintaining and exacerbating these very dilapidating symptoms. The causes of Institutional Neurosis were factors which were associated with large psychiatric hospitals (or asylums as they were known at the time). These included loss of contact with the outside world and lack of activities associated with daily functioning, which most often were catered for by the institution itself. Other factors which contributed towards institutionalization were lack of daily structured activities, loss of friends and personal possessions, poor ward atmosphere and an authoritative approach by the hospital staff (Barton, 1976).

Interestingly, the Second World War was a major influence towards community care. Mental health care became highly valued when it was a major aid for soldiers who were returning home suffering from the effect of combat, now known as Post – Traumatic Stress Disorder (PTSD). Most people were much against high regarded soldiers being treated in rundown asylums and most care was given into what was known as therapeutic communities. This promoted soldiers helping themselves, which had similarities to what today is recognized as support groups. Moreover, any measures were taken to prevent these soldiers from being admitted to hospital, and so, most of the care was provided in the community.

Another factor which contributed towards community care, was medication (Burns, 2006). Chlorpromazine was founded in the 1950's by a French anesthetist who noticed that it had a calming effect on patients post-operatively. This was consequently used in psychiatry, and its effect on symptoms of mental illness was remarkable. For the first time in the care of mental illness, there was an effective medication which had an effect on the agitation experienced by the patients. Psychiatric hospitals became less daunting and the atmosphere in wards less chaotic. It allowed for human conversation and opened the way for patients to be eventually sent out of hospital and even discharged. However, one problem which was occurring was the relapse of the illness. This was triggered by patients not taking their medication, which resulted in symptoms to reoccur. This was dealt with, by closer follow up outside the hospital, in out-patient clinics, and the patients' own home and communities.

All these factors contributed towards the move to care in the community, where initially, large psychiatric hospitals were closed down. However, community care is not just about that, but about providing the care outside of the hospital environment. The first publications referring to the first community psychiatric nurses in the U.K. dates back to the mid-1950's (Bowers, 1992). As Burns (2006) stated, the development of community mental health services in the U.K. was made possible by

community psychiatric nurses. These were the main force behind community mental health teams and other specialized teams like Crisis intervention and Home Treatment, Assertive Outreach and Early Intervention Services.

The Community Care Act in 1991 had a huge influence of how mental health care was delivered in the community. This was not only as a compliment to hospital but as an alternative. Patients, who were in the past admitted, were now maintained in the community, and the care provided in hospital, was transferred to the patient's home.

The Community Care Act in the U.K., introduced the legislation of the Care Program Approach (CPA), where people suffering from mental illness were allocated a key worker, who was responsible in the formulation of a care plan and regular reviews with the mental health team (similar to the 2012 Mental Health Act and the Community Treatment Order in Malta).

The move towards care in the community has revolutionized mental health care. It has lessened the stigma associated with mental illness, leading to a positive effect, not only on the patients, but also on their families and the professionals working with them.

Community care is about providing the service to those who need it the most, since the people most vulnerable to mental illness are usually the most reluctant to seek help. Therefore, a good liaison with the local communities is essential, including G.P.'s, police and the local support nucleus. Community care is a move towards normality. However, this is not just about being normal (since normality is a very broad term and open to interpretation), but about the community accepting what it's not, what is diverse and understanding our differences, needs and issues. It is about receiving mental health care outside of hospital, while continuing to face life's daily challenges. Hospital stays remain a necessity in mental health, however those stays can be kept brief and to the minimum, so that the individual can continue dealing with life and learning to cope with its difficulties and the symptoms of mental ill health.

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