Arch. & Comport. / Arch. Behav., Vol. 6, no. 3, p. 211-224 (1990)

Introduction: Deinstitutionalisation and the Myth of "Community Care"

Steve Baldwin
Neighbourhood Networks Project
TACADE
1 Hulme Place
Salford M5 4QA
United Kingdom

Polytechnic Southwest
Plymouth
United Kingdom

1. The 1950s-1980s

Since the late 1950s, attempts have been made to deinstitutionalise people with a learning difficulty, elderly people and people with rehabilitation problems. Also, the inappropriateness of hospital-based services for people with disabilities, handicaps and impairments was brought into focus in the 1960s, when mental health organisations began to develop rights-based perspectives. During the 1970s, especially in Europe and North America, some initiatives were made to develop parallel alternative services to hospital-based provision for a range of client groups. In the 1980s, many non-government agencies and organisations flourished, and the 'client' perspective was promoted, via development of advocacy and other consumer organisations.

At the beginning of the 1990s, however, some fundamental questions have remained unanswered. In Europe, the UK and North America, much time, effort, energy and resources have been invested in the development of so-called 'community' resources. Since the 1960s the term has been used extensively in health and social services planning to describe non-hospital, decentralised services. In the 1970s and 1980s, it has been viewed as the main alternative model to traditional institutionalised service provision. In the UK and USA, it has become the *zeitgeist* in human services planning and implementation. Despite major unresolved conceptual, ideological, and methodological problems, the so-called 'community care' model has remained unchallenged as the main rival to traditional hospital services.

2. The 1990s

In the 1990s the emphasis in human services design, planning, implementation and evaluation will be on provision for individuals. Instead of a focus on groups of people who have been identified as 'similar' by virtue of their disability or impairment, the new focus will be on individuals. This focus will be a needs-based perspective, with a generic overview, rather than an obsession with specialist groupings and the elimination of problems.

3. Background to Special Issue

A renewed interest in the meaning of 'community care' and 'care in the community' models has occurred, following increased interest in operational definitions associated with deinstitutionalisation. In the UK and North America, the planned and actual closures of hospitals has required staff and workers to become more precise in their terminology. In particular, for clients who move out of institutions, it has become essential to know what is meant by 'the community' *(sic).* For many professionals, being in 'the community' has become synonymous with 'not being in a hospital'.

The range of problems associated with this loose and woolly thinking have become clear during the 1980s. In particular, many clients have been 'lost' from institutional case registers and statistical records, due to manipulation of data. Thus, high success rates have been claimed for some deinstitutionalisation initiatives in the UK and USA, following closure of hospital-based services. In reality, however, tens of thousands of disadvantaged and at-risk clients, previously resident in state hospital facilities, have been discharged into 'the community'. For many of these people, the reality of this 'community' existence has been homelessness, incarceration or death.

Paradoxically, many of the 'community care' exponents have been well-meaning professionals, genuinely seeking a new model to challenge traditional hospital-based services. Whilst some deinstitutionalisation initiatives may have concealed other agendas of 'rationalisation' *(sic)* and reduction, the stated aim of many 'community' services has been to provide alternatives to large hospital services.

Sadly, 'community care/care in the community' models have failed to achieve their potential. The multiple meanings of this vague model have allowed wide variation for interpretations. Reviews in this area have indicated a wide range of responses to the call to develop 'community' services. Worst of all, many such services have been mini-institutions, with many features of hospital services: a focus on groups not individuals; services directed at problems not to meet needs; priority on quantity not quality.

This special issue of *Architecture & Behaviour* is devoted to an examination of a rival model to outdated 'community care/care in the community' concepts. In particular, a focus is made on the reality of non-institutionalised care for a range of client groups. This emphasis on mental health themes is particularly relevant in the current climate of human services. In the UK, the implementation of central government 'care in the community' initiatives recently was delayed by two more years until at least 1992. Implementation of an unworkable 'community' model continues to prove difficult.

4. A Focus on Neighbourhoods

In 1987, a paper "From Community to Neighbourhoods I", was published in *Disability, Handicap and Society,* **2** (1) 41-59. In 1988, an international symposium was convened at the BABP World Congress in Behaviour Therapy in Edinburgh. Following that symposium, three mental health practitioners and one architect were invited to comment on the original paper, from their own national perspective. A short resume of the paper is reproduced below.

5. From Communities to Neighbourhoods I: Resume

Increasing confusion and dissatisfaction with so-called 'community care' and 'care in the community' initiatives has prompted a search for greater clarity and efficiency in mental health services. An attempt has been made to specify some of the means and ends required to establish local comprehensive services for a range of client groups.

In particular, staff working in learning difficulties services, services for elderly people, rehabilitation services and physical handicap have examined traditional ideas. The transfer of clients to so-called 'community care' from large institutions has been flawed by many problems, which have recently reached crisis proportions. Many attempts to transfer clients into non-hospital settings have failed to take account of clients who already live in these local settings. In such instances, local neighbourhoods have become swamped by too many clients targetted at too few services and resources. Moreover, the term 'community care' has been used to convey meanings which are opposite: in the UK, one government administration has been committed to service expansion and diversification, another has been committed to contraction and unification. Both administrations, however, have used 'community care' concepts.

'Community care' also has been viewed as an ideology which is both reactionary and conservative. Some observers have suggested that the concept is flawed by concealed values of capitalism and sexism.

In contrast, the concept of 'neighbourhood' may offer a unit of analysis which is precise, measurable, definable and open to evaluation. To achieve a neighbourhood perspective, a multi-level approach is required, to provide a focus on clients, staff and the wider physical environment.

In particular, a neighbourhood approach requires the identification of physical aspects of the environment to establish local boundaries. In addition, the creation of a Resources Directory and a Workers Directory is necessary to plan effective services for a range of client groups. This approach requires an examination of *all* clients who inhabit a neighbourhood, to make informed decisions about optimum placements for individuals.

The neighbourhood perspective also requires a full appreciation of the built environment. When planning services for clients with disabilities or impairments, an appreciation of ergonomic considerations is a design imperative. The significance of architecture on the behavioural repertoire of individuals is inherent in the neighbourhood perspective.

The approach requires a commitment to the identification and development of relevant skills by a range of workers. Common training curricula are identified, to assist the development of core skills for staff from different backgrounds. Moreover, the neighbourhood perspective requires a fundamental review of concepts such as 'teamwork': interdisciplinary approaches, which value competence, performance and relevance are recommended for generic work in small, local geographic areas.

One fundamental shift which would accompany a transition to a neighbourhood perspective would be a parallel realignment towards client-oriented services. This would require the implementation of needs-based services, with a 'bottom-up' (consumer) philosophy. Needs assessments would be required to achieve a flexible approach to service provision for individual clients. The aim of service provision for a range of groups should be to enhance the 'goodness of fit' between individual clients and their

physical environments. All neighbourhoods are *not* equal: some clients should not be exposed to some settings.

6. Articles in this issue

6.1. England

Barefoot creates an exciting vision of the degree of specificity possible in future services. He observes how the smallest group of dwellings may be a dozen residences; this degree of precision could be adopted by service planners who are interested in providing quality housing options for clients. The use of concepts such as 'community', 'neighbourhood', 'district', 'region', 'parish' and 'areas' without precision could produce confusion. It is a timely reminder of the need to operationally define these terms.

The proposition of 'neighbourhood' as the area covered by a primary school fits well with contemporary definitions, and is a useful contribution to the debate. On a different note, Barefoot asserts that many architects enjoy the privilege of living and/or working in environments they have designed. It remains a truism, however, that no known UK architects live in the 1960s high-rise housing stock of their own design; this remains the dubious 'privilege' of many disadvantaged and at-risk populations.

6.2. Scotland

Barker notes how the confusion between 'neighbourhood' and 'community' is exacerbated by the vague and nebulous nature of policy documents. He observes how the meaning of 'community' has become defined by everything which is 'not hospital'; as he states, service provision should involve something more than the relocation of traditional hospital-based medical/clinical services in different settings.

Within nursing, however, as in many other professional groups, the retention of 'community' and 'psychiatric' prefixes have slowed the development of innovative services. The advent of 'neighbourhood nursing' (Cumberledge, 1986) will be predictive of how such services might be developed in the future, given that such growth is permitted by the medical hegemony.

A £16m capital investment in new psychiatric hospital buildings in Aberdeenshire is singularly depressing; it is retrogressive, repressive, conservative, and represents a stifling institutional blindness. In a cultural ethos of "learning from England's mistakes" *(sic)* it is a particularly disturbing development. This medical stranglehold on service planning and implementation is a worrying predictor for the 1990s.

In contrast, the projects of Easterhouse in Strathclyde and Pheonix indicate the seeds of some innovative neighbourhood services. The Easterhouse Mental Health Project, although not planned to match design principles of neighbourhood services, includes many desirable features at the point of delivery. It illustrates how appropriate services may develop naturally, without strong 'top-down' systemic pressure. The Pheonix Project is an excellent paradigm example of how collaboration between service providers and consumers may truly achieve quality provision in the local neighbourhood. Data from effectiveness evaluations of Pheonix will be eagerly awaited.

6.3. Switzerland

Meier and Rezzonico report from a local setting which also retains many features of neighbourhood services. It is clear from this report of the *Pro Malati* Foundation that services can be fully developed, with retention of key design principles. The real commitment to hypothesis-testing and data collection for ongoing service evaluation is particularly refreshing.

The arrival of a neighbourhood model may well create new tensions for established 'community' staff and workers; this may produce positive benefits, as well as uncertainties, within the system. The flux required to shift paradigms (i.e., from 'community' to 'neighbourhood') may thrive on such tensions.

The failure to close old psychiatric hospitals is a common problem highlighted by the services described in Ticino. Paradoxically, whilst such traditional services are allowed to remain 'open for business', the transfer of much-needed funds and staff into new, alternative settings cannot occur. Where psychiatric hospitals are allowed to remain open, the old interprofessional battles will continue.

Meier and Rezzonico state that many sources of sabotage exist, where rivalries occur between professionals (and/or clients). The lack of clarity about 'community care', however, contributes to the conceptual vacuum in which woolly thinking can flourish. It is, moreover, stretching a point to describe 'community care' as "an already good job". In the UK, at least, many non-hospital services are an appalling hit-and-miss patchwork, based on *ad hoc* responses to previous crises and/or scandals.

The neighbourhood model, as noted by Meier and Rezzonico, is open to adaptation, and will change with time. As they observe, it may well be rejected eventually, in favour of a more specific, precise model with a smaller unit of analysis. Putting the concept 'on the line' for subsequent analysis and dissemination seems important.

The flaws and limitations of advocacy are well illustrated by Meier and Rezzonico. Whilst neighbourhood systems do not rely exclusively on advocacy services, this additional tier is most certainly integral to the future template. The problems identified by Meier and Rezzonico raise the question of external monitoring, to ensure quality services. In addition, their critique has produced other challenges for the neighbourhood model, which will advance the debate about choice of paradigm for service delivery.

In sum, whilst the neighbourhood model is *not* synonymous with a return to "village life" *(sic),* it does require a focus on smaller units of analysis. The neighbourhood approach is not problem-free, but it is infinitely less flawed than 'community care'.

6.4. Holland

Berger outlines a generic/special needs model for local provision which fits well with design principles of neighbourhood services. The input of generic 'coaches', to work with the special needs of troubled adolescents in their own environment, is an imaginative, innovative alternative to the usual, predictable institutionalising responses. The Coaching Project, as described by Berger, is consonant with key features of neighbourhood services, and is a further demonstration of how non-psychiatric,

non-hospital services can be developed to meet the local special needs of individual clients.

On one axis, however, Berger's assertions should be strongly challenged. In the context of innovation of the Coaching Project, her faith in 'community' is surprising. Certainly, her claim to its indispensability should be rejected. 'Community' is completely dispensable, as a concept, and as a service. Neighbourhood is but one possible alternative model.

7. Conclusion

Any challenge to the *status quo* will be met with resistance. This is understandable, and may even be appropriate; too-rapid changes in model of service delivery can be catastrophic for both staff and clients alike. Experiences of *psichiatria democratica* in Italy have regenerated the debate of 'evolution not revolution'.

Whilst there is no single route to necessary reforms in human services delivery, evidently some paths are more attractive than others. Equally, the circuitous nature of other routes may eventually be revealed as their true form - a circle. Thus, any route which leads back to institutions should be rejected: 'community care' has a very long history of leading clients (if not staff) back into hospitals and hostels.

Internationally, 'neighbourhood' has currency in human services. More local services should be developed and evaluated, which meet the needs of individual clients. Community care is dead.

BIBLIOGRAPHY

CUMBERLEDGE, J. (1986), "Neighbourhood Nursing - A Focus for Care" (HMSO, London).