Finding the right place for mental health care: it's not about postcodes

Despite a 2019 definition based upon population size by NHS England, 'place' still appears to mean all manner of things to all manner of people and in all manner of contexts.

Guest blog by Tony Warne, Professor Emeritus of Mental Health Care at the School of Health and Society, the University of Salford

It's a somewhat ambiguous concept hijacked from the regeneration initiatives of the 1990s. Today, its meaning is so ill-defined that it is perhaps no wonder the recent White Paper setting out reforms to the NHS barely mentions it at all, despite its obvious importance to bringing about transformational change.

For the purpose of this piece, I'm going to consider place to mean what we think of as the community we live, work or spend our leisure time in and also those communities our families might consider home. A home is more than a postcode, however.

When I first arrived in the North West it was to work at a newly-established forensic mental health service for adolescents. In those early days my focus was on managing the in-patient secure unit. The challenges were many. Were the behaviours we saw from the young people due to a mental health problem, or because they were simply going through the process of adolescence? Likewise, there was always the need to balance security with creating an environment that supported therapeutic relationships. While the young people were in the unit (and this was often for extended periods), this was their place. Like young people everywhere, they sought ways to make their space individual; something that helped them connect with themselves or with their past. In some cases, they tried to create a space that projected an image of the person they wanted to be.

Resettlement initiatives

At the same time, in another part of the hospital, a great deal of work was going on to resettle people back into the community. The regional health authority (RHA) – think ICS in modern parlance – wanted to reduce the number of patients in what were large psychiatric institutions. Indeed, the hospital I worked at was, at one time, one of the largest in the UK with some 3,000 patients. Even in the 1980s, when I started, there were over a thousand patients. It was a large, sprawling place, set in 58 hectares with plenty of green space, but situated adjacent to a busy motorway. The RHA scheme was well funded. Every 'resettled' patient received a 'dowry' that provided an annual payment of £15,000, which was guaranteed for life. Generous funding was also available to help prepare patients for resettlement, and to work with the communities they were resettled into. And that, for me, was the rub.

Many of these patients had been in hospital for much of their adult lives. Choosing where they should be resettled was a challenge. The patient's place of birth or last known address were used as proxies for choosing the place of resettlement. I no longer have access to the numbers of people successfully resettled, but it was in the relatively low hundreds. Even so, by 1988 there were still 100 patients who, for various reasons, were thought to be too difficult to resettle. The late 1980s was also a time of economic instability and 'resettlement funding' was becoming scarce. It would be fair to say the ambitions of developing care in the community were proving difficult to achieve.

Progress continued to be slow in developing a sustainable approach to care in the community. There was a great deal of political rhetoric which didn't always translate into action. There were, however, heroic efforts by locality-focused health and social care professionals in bringing about change. Assertive outreach teams, community mental health centres, mental health liaison services, crisis intervention teams were all developed and clearly did make a difference to the experiences of many people living with mental health challenges.

Ambitious plans for mental health

In 2016, the independent Mental Health Taskforce published a report for NHS England setting out its ambitions for mental health services over the following five years. The rhetoric was truly ambitious. By 2020/21 it was envisaged that local communities would focus on addressing the social determinates of mental health, mental health promotion, and the targeting of at-risk groups through a blend of health and social care and user-informed interventions.

The NHS Long Term Plan (2019) more clearly articulated these ambitions. Contained within it, the mental health implementation plan, again with an ambitious set of outcomes backed by increased funding, clearly set out how these ambitions might be realised by 2024. It was a welcome commitment to ensuring parity could be reached in addressing both physical and mental health needs.

Fast forward to Spring 2021 and our post-pandemic world. How realistic are the NHS Long Term Plan ambitions now? I would argue they are more important and critical than in pre-pandemic times. The psychological trauma experienced by many people – particularly those working in health and care services – is almost inestimable and will need addressing for many years to come. And there's the damage to people's mental health caused by the pandemic restrictions on those who were isolated, shielding and distanced from their families.

Much can and should be done at a system level, but not at the expense of neglecting the importance of place to people. For all of us, place will forever be more than just a postcode.