Need in community psychiatry: a consensus is required

Frank Holloway

The government's community care White Paper *Caring for People* assured us that assessment of need is a "cornerstone of community care". Unfortunately there is a lack of clarity over the nature of severe mental illness and the problems and needs of the mentally ill, with no conceptual framework agreed by all the stakeholders in community care. The model of need adopted by management and direct care staff will determine both the priorities of the services and the treatment and care that is actually provided. Familiar concepts of diagnosis, impairment, disability and handicap, which are central to psychiatric thought (Wing *et al*, 1992), are simply not accepted by the majority of those working within community mental health services. This is particularly true for staff in social services departments and the voluntary sector, who will increasingly become the major purveyors of community mental health care.

Conceptual approaches to need in mental health services

The terminology used to define long-term mental illness may be seen as devaluing and excessively medical (hence the substitution of 'mental health problem' and 'mental distress' for mental illness in many contemporary planning documents). Psychiatry is often associated with a crudely biological model of mental illness instead of the contemporary biopsychosocial approach to major mental disorders, which are seen as the result of a complex interaction between biological, environmental, cultural and behavioural factors.

There are many possible approaches to understanding the needs of the mentally ill. The MRC Needs for Care Schedule (Brewin *et al*, 1987) takes a narrow view. Need exists when "a patient's functioning falls below or threatens to fall below some minimum specified level" and "this is due to some remedial, or potentially remediable, cause". Identification of a need is therefore a "recommendation for action" by the services to address symptoms, behavioural problems and impairments in social functioning that are specific to mental illness. Other commentators have emphasised the importance of client-identified needs and goals (MacCarthy *et al*, 1986); the intrapsychic needs of people with chronic and disabling mental illness (Harris & Bergman, 1987); and specific difficulties that must be addressed for patients with long-term mental illnesses to remain in the community (Stein & Test, 1980).

The concept of 'normalisation' (or 'social role valorisation' as it was subsequently re-christened) has been exceedingly influential among planners and providers of community services for people with a disability. This perspective identifies social stigma as the key problem for people with a disability, who are traditionally treated badly both by society and service systems. Consequently the central goal for services is defined as "the creation, support and defense of valued social roles" (Wolfensberger, 1983) for service users. This entails steps to enhance people's "social image" and their "competencies". Normalisation theory draws on the sociological concept of stigma, deviancy theory and social learning theory. The importance of the environment in determining behaviour is strongly emphasised in normalisation literature and training. Despite their empirical trappings, normalisation and social role valorisation principles are statements about values rather than facts, with a strong ethical component that is untestable.

Another way of approaching need is embodied in Maslow's (1954) hierarchy of needs, which is claimed to have universal relevance. According to Maslow, the hierarchy extends from basic physiological needs through needs for safety, love and self-esteem to "self-actualisation" needs. Basic needs must be met before higher order needs can be addressed. The empirical literature on quality of life identifies life domains, such as occupation, social relationships and health, that are relevant both to people with severe mental illnesses and the general population (Lehman, 1983). These generally applicable life domains may then become the focus for interventions by the mental health services, with the aim of maximising the quality of life of service users.

Table 1. Contrasting models of mental disorder in community care

'Implicit' model	'Psychiatric' model
Ordinary human needs	Needs for treatment and care
Normalisation theory	Biopsychosocial model of mental illness
Focus on strengths	Focus on problems/weaknesses
Non-professional care staff	Reliance on professional interventions
Aim to provide an 'ordinary life' within a pseudofamily	Aims to minimise symptoms and maximise social functioning
Focus on individual user	Epidemiological perspective
Commitment to user involvement and empowerment	Attempt to gain adherence of patient to treatment
Problems located in society	Problems located within individual
Emphasis on 'holistic' approach	Emphasis on biological treatments
Attractive and fashionable	Unattractive and unfashionable
Basically optimistic?	Basically pessimistic?
May lead to staff burnout	May lead to staff cynicism
May lead to 'rotting with your rights on'	May be coercive and confining

The 'implicit' and 'psychiatric' models of need

Schemes developing as part of hospital reprovision programmes and innovative community services tend to adopt the rhetoric of normalisation and focus on the ordinary human needs of service users. This approach may offer a sharp contrast to the sometimes weary cynicism of nurses working on long-stay wards within psychiatric hospitals. There is an 'implicit' model of need that is held by many community workers (and by user groups and some senior managers within social services departments and social care provider agencies). This model is superficially attractive and is currently fashionable. It can be compared with a standard 'psychiatric' model of need. Table 1 sets out some elements and possible consequences of the two models in a schematic fashion.

The 'psychiatric' model is often dismissed as reductionistic and excessively narrow in focus, potentially ignoring ordinary human needs while focusing on the pathology of the individual. However, the 'implicit' model cannot provide a plausible account of the nature of psychiatric disability. It is inadequate as a basis for an effective mental health service. Because of the fundamental ideological differences between these two models (for example on the legitimacy of 'professional' knowledge, on the proper location of service users' perspective on their problems and on the primacy of the individual's stated wishes) dialogue between community staff and psychiatrists can at times be very difficult.

Developing a consensus

More than 20 years ago Bradshaw (1972) produced a taxonomy of social need. He identified four separate definitions of need as used by service managers and researchers. These were 'normative' need (i.e. what the experts define as need); 'felt' need (i.e. the wants or desires of service users); 'expressed' need (i.e. demand for service); and 'comparative' need (the gap between service provision in one area and another, with weighting for differences in local morbidity).

Even at the 'expert' level there is confusion and conflict about the needs of the mentally ill. Psychiatric concepts currently lack credibility within community mental health services. It is important that the psychiatric profession regains the intellectual initiative if it is to have an impact on the evolving system of community care. Experience of the community mental health movement in the United States of America indicates that deprofessionalisation of community services results in an abandonment of patients with the most severe disabilities in preference to a more superficially attractive client group.

The development of a generally agreed statement of the needs of people with a mental illness and a simple but methodologically satisfactory method of assessing these needs are urgent priorities. Any pronouncement about these needs will have to take into account the rise of the mental health services user movement, which is at last expressing the wants and demands of users.

When these tasks have been completed, staff working with people who are severely disabled by their mental illness will continue to be faced with a dilemma that is inherent in psychiatry; the problem of balancing the necessity to make decisions for people who are severely mentally ill (who might, for example, choose to harm themselves or sink into apathy because of their negative psychotic symptoms) with the importance of promoting individual choice and autonomy.

https://doi.org/10.1192/pb.18.6.321 Published online by Cambridge University Press

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https://doi.org/10.1192/pb.18.6.321 Published online by Cambridge University Press