Mental Health Community Care in Great Britain: Idealism and Reality

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Introduction

Community care is the term given to the British policy of deinstitutionalising people with long-term physical or mental health problems and caring for them within their own homes. It became official government policy under Margaret Thatcher following a report by the Audit Commission in 1983 entitled *Making a Reality of Community Care*. The idea of caring for mentally ill people in the community was not, however, a new one. The 1930 Mental Health Act allowed for the admission of voluntary patients to the county lunatic asylums leading many hospitals to adopt an "open-door" policy, albeit one that was not well publicised, and which relied heavily on the personality of the superintendent and his willingness to allow patients to access hospital care only when they felt they needed it (Clarke 527). The idea of community care was first debated as an idea in Parliament during the second reading of what was to become the 1959 Mental Health Act, when the Health Minister, Derek Walker-Smith, stated that "One of the main principles we are seeking to pursue is the re-orientation of the mental health services towards care in the community" (Martin 5). However, despite this apparent interest in a new form of care for the mentally unwell, the Act itself imposed no obligations on local authorities in the matter of community services.

It was not until two years later that a politician was to argue publicly in favour of replacing the asylums by care in the community. In 1961, the Health Minister, Enoch Powell, was invited to open the annual Conference of the National Association of Mental Health and, in what has now become known as the "Water Towers Speech," he claimed that under his fifteen-year hospital plan for the NHS the total number of hospital beds needed for mental illness could be reduced by half. What people remember primarily about this speech today was the emotive language that he used to convince his audience that closing the lunatic asylums was a necessity:

> There they stand isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside—the asylums which our forefathers built with such immense solidity—to express the notions of their day. Do not for a moment underestimate their powers of resistance to our assault. (Powell)

This appeal to people's emotions is characteristic of the way community care has been approached both by politicians and by the media over the past fifty years. The second half of Powell's speech, in which he specifically states that it is not sufficient to simply close down the asylums, and that the closure must be accompanied by the creation of some sort of "community services" has long been forgotten:

> A hospital plan makes no sense unless the medical profession outside the hospital service will be able progressively to accept responsibility for more and more of that care of patients which today is given inside the hospitals. It makes no sense therefore unless the medical profession outside the hospital service can be supported in this task by a whole new development of the local authority services for the old, for the sick and for the mentally ill and mentally subnormal. (Powell)

Even Powell did not dwell on practicalities and his speech gives no precise indications of what form these new community services might take. Powell merely identifies that their development would necessarily include both "human" and "physical" aspects; that is to say that the new services would need both a range of qualified staff and adequate community buildings. Interestingly, given what actually happened when the asylums started to be closed, Powell believed that it would not be cost but inertia amongst those working in the asylums which would prove to be the main difficulty in setting up community care: "It would be more than flesh and blood to expect [the hospital staff] to take the initiative in planning their own abolition, to be the first to set the torch to the funeral pyre" (Powell).

Closing the asylums took far longer than Powell had anticipated but, almost sixty years later, they have all been closed or completely renovated as psychiatric hospitals. An effective system of community services has, however, failed to materialise. Community care for the mentally ill is currently in crisis: waiting lists for treatment are long, there is a national shortage of beds for the most severely unwell, and despite all the prevention campaigns, suicide rates have started to rise again.[1] Often referred to as the Cinderella service of the National Health Service, mental health care has undoubtedly suffered from a lack of funding but, as this article will argue, this lack of funding has been exacerbated by the inability among politicians to agree on what the word "community" actually means in the expression "community care."

Removing the insane from the community

For many people, including Powell, community care is defined primarily by its opposition to hospital care, thus emphasising the place in which the care happens, and making the word "community" primarily a geographic term. This is, however, a simplistic opposition which ignores two important facts. The first is that the mentally unwell have always to some extent been cared for in the community by their families. The second is that a small proportion of

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[1] 2018 saw the first increase in overall suicide rates in the UK since 2013. See Office for National Statistics www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations>

severely mentally ill people are always going to need the sort of intensive care which can only be provided in a hospital setting.

Without wishing to get into a Foucauldian debate about mental illness, it is important to remember that what is termed a mental disorder is cultural, and a result of society's expectations. There is often a fine line between illness and criminality. What is acceptable in one society may be thought of as a psychiatric problem in another and a crime in a third (Jones, "Society Looks" 328). Attitudes also evolve over time. Suicide, for example, was a crime in England until 1961 and, prior to its decriminalisation, there were regular discussions about whether the costs of putting a hospital patient on one-to-one suicide watch should be borne by the police because it was attempted murder or the hospital because the person was sick (Millard 40).

The word "care" in the expression "community care" appeals to people's emotions, and ideas of altruism. There is a tendency to forget, however, that the asylums were set up in the second half of the nineteenth century not so much to ease the burden of those individuals caring for their severely disordered relatives within the community, as to enable the parishes to save money by making workhouses cheaper to run. It had become apparent that a small group of people within the workhouses were simply incapable of holding down any sort of job and required permanent support for food and accommodation. In 1845 the County Asylum Act and the Lunacy Act made counties legally obliged to build asylums in order to remove the insane from the workhouses, thus making the insane the financial responsibility of the counties.

The asylums were built away from the towns, partly because it was believed that the lunatics needed fresh air and contact with nature, partly because the asylums had to serve the whole county and it was deemed fairer to share transport costs by situating them at an equal distance from all the main towns, and partly because no one wanted an asylum on their doorstep (Jones, "Asylums" 61). Their isolated location, however, meant that it was easy for the rest of the community to forget that mentally unwell people existed.

Moving the mentally unwell back into the community

While cost was an important consideration in setting up the asylums, the initial impetus for closing the asylums was not financial but the result of two unrelated developments. The first was the discovery of the anti-psychotic drug chlorpromazine in the 1950s (Martin 1). Until then, no medical treatment had existed for the most severe pathologies (in particular schizophrenia and what was then known as manic depression). This was the principal reason why, once people entered an asylum, they were likely to remain there for the rest of their lives. The discovery of chlorpromazine meant that for the first time it was possible to provide schizophrenics with a form of treatment that actually worked and enabled them to live a normal life provided they complied with taking their medication. At the time it was expected that chlorpromazine would have as big an impact on mental illness as the discovery of antibiotics had had on the treatment of tuberculosis, and that consequently the need for asylums would disappear completely the way the need for sanatoriums had.

This has, of course, turned out to be an over-optimistic view. Anti-psychotics did not work for all schizophrenics, and even when they did work, they often had problematic side-effects which made their long-term use complicated and rates of non-compliance high. Although it was not the panacea that had been hoped for, the new idea that mental illness has a biochemical origin did go on to play an important role in the development of community care policies; in particular in the belief that secondary mental health services would become redundant because community GPs would be able to manage the mentally ill simply by prescribing medication.

The 1960s saw the growth of civil rights movements in Britain and America. The fact that people could be locked up indefinitely against their will began to appear shocking and organised anti-asylum movements began to develop. There were several different trains of thought within the movement. On the one hand, radical sociologists saw asylums as a symbol of capitalism and claimed that they were the result of the breakdown of the family and the destruction of communities during the industrial revolution. The anti-psychiatry movement, on the other hand, saw repression as originating in the power imbalance between doctor and patient and used as evidence the historically dangerous treatments which had been common in the asylums, such as insulin shock therapy and lobotomies (Martin 33-34). It is important to note that what both groups had in common was a focus only on getting people out of the asylums. No real attention was given by either group as to what help the former patients might need once they were back in the community (Jones, “Scull’s Dilemma” 221).

Thus, by the end of the 1960s, politicians, human rights activists and some, but not all, psychiatrists were promoting the idea of community care but without ever defining what exactly they meant by the term. Did community care mean care *in* the community or care *by* the community? Did it mean a change in the place of care or a change in who funded the care? What did the word “care” even mean? And how would it be possible to decide who needed, or who was entitled to this “care”?

Asylums as a community

Surprisingly given that human rights movements claimed to be empowering the patients in the asylums, the patients’ own views on the closure of the asylums were never sought. Although everyone outside the asylums seemed to see a simplistic opposition between “hospital” and “community care,” it is undeniable that by the middle of the twentieth century, whatever the asylums’ failings, they were fully functioning communities in which many patients led relatively active and fulfilling lives. The asylums were designed to be as self-sufficient as possible. The patients grew the fruit and vegetables and tended the cows and chickens on the asylum farms. The asylums had furniture workshops for the male patients, and the male patients were also responsible for minor repairs. The female patients were employed in the laundries and the kitchens and could attend needlework workshops (Jones, "Asylums" 146). Most asylums also had leisure facilities—Harperbury Hospital in Hertfordshire, for example, had tennis courts, a sports building, a well-stocked library and a recreation hall. Many of the patients lived their whole adult lives inside the asylums and became friends. This was particularly true of the older patients who no longer had any living relatives outside, and who had long since ceased to have visitors.

When the beds in the asylums began to be closed, the first patients to leave were the least unwell, those who should have been able to live within the outside community without too much trouble; and yet right from the start there were problems. Accommodation was provided for those who had no family to return to, but no attempt was made to resettle friends together. Instead, patients found themselves living by themselves in a neighbourhood where they knew no one. Having been institutionalised for so long, many of them found it impossible to hold down a job. Some found the outside world to be a bewildering and frightening place and left their house as infrequently as possible. As Hawks has pointed out: "The sum of any patient's effective community has proved difficult to calculate and in some cases its members are not more numerous than those paid employees of the institution which discharged him" (278). Furthermore, there was no systematic follow up of the discharged patients and inevitably many stopped taking their medication. Sometimes this was because they did not really believe they were ill, but often it was because they were incapable of organising themselves to get hold of it. Without medication their health deteriorated, some ended up homeless and others accumulated short stay admissions in general hospitals. For many patients, the geographical isolation of the asylums was replaced by social isolation. By 1973, the British Medical Association was expressing concern about the indifference of the community stating that: "It was difficult to believe that an existence of aimless destitution is preferable to the organised and structured life in a well-run mental hospital" (Anon.).

One of the major failings of the human rights' groups who campaigned for community care was to have underestimated the complexity of mental disorders. It is now recognised, for example, that it is the result of the progression of the illness, and not institutionalisation, which causes schizophrenics to withdraw from others and lose contact with reality (Murphy 11). It is also now widely understood that one of the characteristics of all severe mental illnesses is that the mentally unwell person becomes unable to function without support but does not recognise that they need help. While it is important to protect patients' rights, there are times when treatment needs to be imposed either because the patient is a risk to others or, more often, because they are a risk to themselves.

An unfortunate aspect of the influence of the human rights movement can be seen in the 1983 Mental Health Act, which makes it possible for a patient to be sectioned for compulsory treatment. The terms of the Act focus on the right of an individual to live in the community rather than the sick person's need for care and treatment (Murphy 105-6). Moreover, by focussing on the moment when someone is sectioned, the Act takes attention away from what happens afterwards. Straightjackets and chains may be a thing of the past, but today patients can be sedated medically. A person who has been sectioned has no right to refuse treatment and can be sedated against their will. Successive government cutbacks have meant that a lot of in-patient units can no longer afford to employ full time therapists with the result that hospitals have become little more than holding pens in which patients are kept almost permanently sedated because there are not enough staff to manage them safely.

While most specialists agree that some form of hospital care will always be needed for the most severely unwell (Thornicroft et al. 423), no studies have been undertaken to determine the optimum length of an in-patient stay. All too often patients are released back into the community too early. Without any proper follow up, many patients relapse and are readmitted becoming what is known as "revolving door patients." The sense of community that patients had in the old asylums both with other patients and members of staff has gone. The national shortage of beds means that they are often readmitted to a different hospital, sometimes hundreds of miles away. Funding cutbacks means that hospitals rely increasingly on agency staff (Pilgrim and Ramon 280). This is particularly a problem with the health care assistants who are the ones in permanent daily contact with the patients. Many agency health care assistants have little or no training in mental health, turnover is high and they have no sense of being part of a hospital community.

Care by the community

As David Hawks points out, "Basic to the recommendation that the mentally ill should be treated in the community is the assumption that the community is therapeutic or that the community cares" (Hawks 277); in other words, implicit in the term "community care" is that the community is more than just a geographical entity. However, the severely mentally unwell behave in ways that differ notably from society's expectations and care within the community has always depended in part on what the community can tolerate.

Even before the idea of community care had become popular, the President of the Royal Medico-Psychological Association noted in 1957 that psychiatric care "depends not only on current medical theories regarding the causation of mental illness, the latest product of the drug houses and the skill of the neurosurgeon, but also on the degree of toleration to its deviants and the sympathy towards its more helpless members shown by society" (Rees 306). Since the 1960s, society has gradually become more tolerant of difference, but there is still considerable stigma attached to mental health. When planning permission is sought to build sheltered housing for the mentally ill within residential areas, for example, neighbours often launch appeals, claiming that it will alter the nature of the area, and could be dangerous for the existing residents (Murphy 109) even though most severely mentally unwell people are more of a danger to themselves than to others.

The main problem, however, is that the real burden of community care falls on the families who have to look after the mentally disordered. The difficulty of caring for a severely unwell relative had not been anticipated by any of those campaigning in favour of community care. Not only can caring be extremely time-consuming—supervising the meals of someone suffering from anorexia, for example, can take up most of the day with the result that some carers are forced to give up their job—, but it is also emotionally draining. In many cases, the toll of caring can lead to the carer developing mental health problems of their own, albeit of a more minor nature (Hawks 281). As early as 1975, critics of community care were pointing out that: "The fact that relatives do not complain cannot be interpreted as justification for such a policy, rather it is to be taken as evidence of the obligation they feel and the low expectation they have of the services available" (Hawks 281).

The cost to the community

Following the oil crises in the 1970s, the political motivation for community care became less about patients' rights and more about cost. In 1986, twenty-five years after Powell's speech, it was estimated that hospital care still accounted for 90% of the mental health budget (McCarthy 392). The transfer of short-stay patients to general hospitals had been relatively successful (Peck and Parker 243) but no major psychiatric hospital had been fully closed (McCarthy 392). The former asylums were becoming increasingly expensive to run since the same overheads now served for a much smaller number of patients and, moreover, discharging the more able patients had unexpectedly led to increased staffing costs as these patients had often helped to look after the more unwell (Social Services Committee).

From the Thatcher years onwards, politicians have actively promoted community care as a way of saving money. Accurately costing community care, however, is complicated. Care for the mentally unwell has three main components: medical care (both in general hospitals and in community mental health teams); what is often termed "hotel care" (the bed in a hospital or a place in sheltered housing), and social care. A 1994 study found that a service user could use up to 40 different services and that the funding for these came from a range of different sources

(Hallam et al. 304). Interestingly it was not the clinical diagnosis which determined the number of services a particular patient would need but their personal characteristics with older males who had never married requiring the largest number of services (Hallam et al. 308). It is outside the scope of this article to examine the effect of the various reforms of the NHS and the DHSS that took place in the 1980s and the 1990s on the organisation of mental health care. Suffice it to say that they resulted in splitting still further the number of organisations responsible for mental health, and in an increasing marginalisation of mental health care in the various budgets.

Over the past ten years, the need to reduce the cost of mental ill-health to the community has become a constant theme in government speeches and policy documents. In 2014 Jeremy Hunt, the Conservative Health Secretary from 2012 to 2018, claimed: “Mental health costs the country £100 billion each year—including 70 million lost working days, additional welfare benefits, lost tax receipts and the costs of treating avoidable illness. Investing properly in mental health is not just good for individuals, but good for the economy and good for society” (Hunt). In 2015 Nick Clegg, the Liberal Democrat Deputy Prime Minister stated: “Treating psychosis rapidly not only dramatically improves someone’s chances of recovery, it could also save the NHS £44 million a year in reduced hospital admissions” (Clegg, “Conference Speech”). What politicians fail to acknowledge in their speeches is that severe mental illness is both chronic and unstable; there are times when a chronically mentally ill person can hold down a job, but there are also periods of relapse, often with no apparent trigger. Unlike physical health, mental health rarely follows a linear path from hospital back to normal life.

Conservative and Liberal Democrat politicians have tried to encourage not just care *in* the community but care *by* the community. Nick Clegg for example claimed in 2014: “You don’t need to be a health expert or politician to do your bit. A quick chat over a cup of tea, a supportive text or phone call or a friendly word to ask if everything’s okay today, all these things could make a massive difference” (Clegg, “Priority”). Three years later, in 2017, Theresa May sought to promote a similar message: “A chat over a cup of tea; a heart-to-heart over the phone; a text message to check someone’s OK—[…] can help free people from the prison of their own thoughts [… and] end the suffering that blights so many lives” (May). Admirable as the wish to remove the stigma around mental health may be, such statements carry with them the risk of diminishing the seriousness of mental disorders, and even more importantly the need for trained specialists to treat them.

It is equally worrying to note a recent tendency in Liberal Democrat and Conservative policy documents to present mental ill-health as a problem for which the individual holds much of the responsibility. In 2013, Norman Lamb, the Liberal Democrat Spokesperson for Health, and the Minister of State for Care and Support under the Cameron government, clearly laid some of the blame on the patient when he reproached the mentally ill for having a lack of will-power by saying that: “we need to ensure people have the support—and *the aspiration*—to recover” (Lamb, my emphasis). The 2015 Liberal Democrat manifesto contained a paragraph about “doing more to promote healthy eating and exercise, making people aware of the dangers of smoking and excessive consumption of alcohol and other drugs, and helping to improve mental health and wellbeing.” Aligning mental health problems with obesity, smoking, alcohol and drug use implies that mental ill-health is a life-style choice; it therefore becomes the responsibility of the individual, and not the responsibility of the community as a whole.

Even the Conservative Party promise to establish parity between physical and mental health within the NHS is not as laudable as it might at first seem. Psychiatrists have pointed out that:

> This illness discourse removes the focus [...] away from the social conditions that are so strongly associated with mental health difficulty (poverty, poor housing, social exclusion. [...] Consequently, the impact of social policies associated with austerity [...] becomes obscured as increasing rates of psychological difficulties are re-read as disorders of the brain.” (Callaghan, Fellin and Warner-Gale 112)

One of the well-known paradoxes of setting up any community service is that it creates a need which did not exist before. As mental health services have become more visible in the community, so more people have begun to want to use them. As the media constantly remind us, over the past thirty years, rates of anxiety and depression have risen steadily in the United Kingdom (Brown and Triggle). The demand on services has been further exacerbated by the various “Stop the Stigma” campaigns which have been running since 2007. As Simon Wessely, the former head of the Royal College of Psychiatrists said in 2017: “Every time we have a mental health awareness week my spirits sink. We don’t need people to be more aware. We can’t deal with the ones who already are aware” (Arie). People suffering from mild anxiety and depression are, however, both well enough to demand to be treated and well enough to vote in elections. This has led successive governments to put in place various forms of short-term therapy under the Improving Access to Psychological Therapy programme (IAPT) with the aim that all patients should start treatment within eighteen weeks. Waiting times have been largely respected for IAPT, but the more seriously unwell are not eligible, and there are no targets for how quickly they should be seen by more specialist services. In 2018, 1,500 severely unwell adults in England had waited for longer than a year to access talking therapies (Cooper).

Conclusion

The vast majority of those suffering from mental health problems are today treated within the community, but does the community actually care? The answer would seem to be “it depends.” As one of the first government reports on mental health care pointed out: “The demands which the mentally ill make on the community must not be more than the community can accept”

(*Better Services for the Mentally Ill*, 1975). Whilst those with more minor problems are no longer stigmatized, and can usually access some form of help, the severely mentally ill remain largely invisible, unless they murder someone or kill themselves in a particularly spectacular way. There is no proof that community care is less effective than hospital care for the severely unwell (Thornicroft et al. 426) but what has become clear is that simply expecting members of the community to look after the mentally disordered is not sufficient.

Care for the mentally unwell has always been very low on everyone's list of priorities but without specific national policies, and adequate public funding, the severely mentally disordered will be unable to live a fulfilling life within the community, and suicide rates will remain unacceptably high. It would seem that the term "community care" is all too often a red herring; as David Hawks points out, it is easier to create a therapeutic community within a hospital than to create a community that provides hospital level care for those that need it (284). Debate should be centred around the standard of care, not where it is delivered.

Works Cited

Anonymous. "Rootless wanderers." *British Medical Journal*, vol. 3, July 1973, pp. 1-2.

Arie, Sophie. "Simon Wessely: Every Time We Have a Mental Health Awareness Week My Spirits Sink." Interview, *British Medical Journal*, vol. 358, Sept. 2017.

Better Services for the Mentally Ill. HMSO, 1975.

Brown, David and Nick Triggle. "Mental health: 10 charts on the scale of the problem." *BBC News*, 4 Dec. 2018, www.bbc.com/news/health-41125009

Callaghan, Jane, Lisa Chiara Fellin and Fiona Warner-Gale. "A critical analysis of Child and Adolescent Mental Health Services policy in England." *Clinical Child Psychology and Psychiatry,* vol. 22, no. 1, 2017, pp. 109-127.

Clarke, Liam. "The opening of doors in British mental hospitals in the 1950s." *History of Psychiatry,* iv, 1993, pp. 527-551.

Clegg, Nick. "Making Mental Health a Priority." 20 Jan. 2014. Deputy Prime Minister's Office, www.gov.uk/government/speeches/nick-clegg-making-mental-health-a-priority

---. "Mental Health Conference Speech." 19 Jan. 2015. Department of Health and Social Care, www.gov.uk/government/speeches/nick-clegg-at-mental-health-conference

Cooper, Keith. "The devastating cost of treatment delays." *British Medical Association*, 5 Feb. 2018, www.bma.org.uk/news/2018/february/the-devastating-cost-of-treatment-delays

Edgley, Alison, et al. "The politics of recovery in mental health: A left libertarian policy analysis." *Social Theory & Health*, vol. 10, no. 2, 2012, pp. 121–140.

Hallam, Angela, et al. "The costs of accommodation and care Community provision for former long-stay psychiatric hospital patients." *Psychiatry and Clinical Neuroscience*, vol. 243, no. 6, 1994, pp. 304-310.

Hawks, David. "Community Care: an Analysis of Assumptions." *British Journal of Psychiatry*, vol. 127, no. 3, 1975, pp. 276-285.

Hunt, Jeremy. "Providing better help and support for mental health services." Department of Health and Social Care, 2014, www.gov.uk/government/speeches/providing-better-help-and-support-for-mental-health-services

Jones, Kathleen. "Society Looks at the Psychiatrist." *British Journal of Psychiatry*, vol. 132, no. 4, 1978, pp. 321-332.

---. "Scull's Dilemma." *British Journal of Psychiatry*, vol. 141, no. 3, 1982, pp. 221-226.

---. *Asylums and After: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s*. Athlone Press, 1993.

Lamb, Charles. "Achieving parity of esteem between mental and physical health." 19 June 2013. Department of Health and Social Care, www.gov.uk/government/speeches/achieving-parity-of-esteem-between-mental-and-physical-health

Liberal Democrat Manifesto. Tim Gordon, 2015.

Martin, F. M. *Between the Acts: Community Mental Health Services 1959-1983*. Nuffield Provincial Hospitals Trust, 1984.

May, Theresa. "Time to Talk Day." 2 Feb. 2017. Prime Minister's Office, www.gov.uk/government/news/time-to-talk-day-2017-prime-ministers-message

McCarthy, Mark. "Community Care." *The Lancet*, 15 Feb. 1986, p. 392.

Millard, Chris. *A History of Self-Harm in Britain A Genealogy of Cutting and Overdosing*. Palgrave Macmillan, 2015.

Murphy, Elaine. *After the Asylums: Community Care for People with Mental Illness*. Faber & Faber, 1991.

Peck, Edward and Elizabeth Parker. "Mental health in the NHS: Policy and practice 1979-98." *Journal of Mental Health*, vol. 7, no. 3, 1998, pp. 241-259.

Pilgrim, David and Shulamit Ramon. "English Mental Health Policy under New Labour." *Policy & Politics*, vol. 37, no. 2, 2009, pp. 273-288.

Powell, Enoch. "Address to the National Association of Mental Health Annual Conference." 9 Mar. 1961, www.nhshistory.net/watertower.html

Rees, Thomas. "Back to Moral Treatment and Community Care." *The Journal of Mental Science,* vol. 103, 1957, pp. 303-313.

Social Services Committee. *Community care with special reference to adult mentally ill and mentally handicapped people*. HMSO, 1985.

Thornicroft, Graham et al. "From Efficacy to Effectiveness in Community Mental Health Services." *British Journal of Psychiatry*, vol. 173, no. 5, 1998, pp. 423-427.