The Mental Health Matrix

A Manual to Improve Services

There have been major changes to mental health services internationally in recent years, revolving around the concept of care in the community. Although speed of change and precise service mechanisms differ between countries, there is nevertheless increasingly widespread consensus on key components essential to adequate care provision. This in turn provides an opportunity to develop a widely acceptable framework to direct future developments. This book proposes a simple model that can be used as a guide to increased clinical effectiveness through focused evidence-based reform. Using a time/space framework, it is intended to act as a practical manual to assess strengths and weaknesses in services, and to be useful to care providers, trainees and planners.

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The Mental Health Matrix

A Manual to Improve Services

GRAHAM THORNICROFT
& MICHELE TANSELLA

Foreword by
PROFESSOR SIR DAVID GOLDBERG

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We dedicate this book to

AMALIA THORNICROFT
CALUM THORNICROFT
HEIDI LEMPP
CAROLE TANSELLA
CHRISTA ZIMMERMANN-TANSELLA

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Foreword

PROFESSOR SIR DAVID GOLDBERG
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This volume represents a watershed in writing about the mental illness services, in that the authors are proposing a model that brings together a public health concern with the health of populations, with an insistence on remembering that services must also be judged by their effectiveness in dealing with disorders at a patient level. It was all there before they wrote it, but no-one has previously put it together so elegantly. Space and time are fairly obvious dimensions to choose for a model; what they have achieved is to produce a simple model that neatly serves as a framework for comparisons between different services, and illuminates the way in which planning at different levels of the model relates to events at other levels. It is especially ingenious to use the 'time' dimension to indicate time with respect to the treatment of illnesses, rather than merely indicating the historical passage of time. This gives the whole model greater power, which the authors have exploited brilliantly. Nothing will ever be quite the same again; it is a book certain to be widely read and quoted.

One point needs further clarification. Models can be predictive, they can be explanatory, they can be heuristic, or they can be descriptive. In Chapter 17 misgivings are expressed from the Nordic countries that the model is not specific, which implies that no predictions follow from it. First and foremost, this is a descriptive model, which helps to ensure that like is compared with like, by carefully disentangling the nine divisions in the proposed matrix. However, as the authors point out, the model can also be used as a tool to improve services in a particular place, so that features of a mental health system become better understood, or lead to priorities for improving services. However, the model is here being used as a tool: it makes no predictions or suggestions itself. It may even be that the present vogue for community care will pass, and that we will return to a more institutional approach in the future: even if that were to happen, the present model would serve as a framework for considering changes in the system.

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Older readers of the book may be faintly troubled by the implication (in Chapter 3, the historical context) of unbroken progress towards more desirable services, with the achievements of the 'middle period' being seen as mere preludes to the great symphony now occurring. The rehabilitation services that were set up in that period should not be seen as a transitional step – merely a way of emptying the asylums. The principles that were set up then are good now, even if time has moved on, and they now need to be adapted to a changed world. The widespread closures that have occurred in rehabilitation workshops, in day centres and facilities for those with long-term disability in England, were carried out to save money and to balance budgets – not because they were no longer needed.

Towards the end of the book the authors leave their metaphor of the 3×3 matrix, and use another from the card table. The three ACEs are highly desirable aspects of each level of their model (see Table 11.4). However, three ACEs disturbed me somewhat, and I fell to brooding about what the fourth ACE might be. It was clearly something that the authors preferred not to think about.

With diffidence – as befits someone whose function in the deck is to be a mere joker (surplus to requirements, or simply replacing a missing card?) – let me suggest that the fourth ACE is Austerity, Criticism and Enmity. It is worth saying a few words about each.

Austerity is the main force opposing change and improvements to the mental health services. Unlike the old asylums, the budgets of community-orientated services are fatally easy to prune; and it is difficult to be innovative when your service is facing progressive reductions to its budget with each succeeding year. Criticism stands for the criticism that is made of junior staff when things go wrong: in England blame is now habitually devolved downwards, so that planners at both national and local levels are rarely or never held to be responsible for individual disasters, even though their decisions have often resulted in situations that cannot be handled well at patient level, given the level of resources available. This devolution of blame makes life easy at the top; but it is at the expense of a demoralised, burnt out work force, which in deprived inner city areas cannot attract staff in sufficient numbers. Judicial enquiries into homicides by patients consider only the 'patient level' of the present model – never the decisions made at national or local levels that have made work at the patient level so difficult. Enmity exists, in suitably muted forms, between workers working for different masters, or between different disciplines. Another kind of enmity is represented by sometimes ill-informed criticisms of the service in the media. In England, there are often tensions between health and social ser-

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vices; between managers and the work force, and between different professional groups. The British government asks for partnerships, but it is doubtful whether real common ground can be found between those working for different organisations with separate budgets. The best examples of well-functioning mental health services are to be found in those American cities where there is a common purchaser of both health and social care – able to commission services from either, as well as from NGOs and user groups.

However, these are minor points. This book fizzles with excitement, as familiar concepts and findings are shown in a new light, by being measured against the framework now described so clearly. Readers will find Figure 13.3, 'Well targeted services', a good example of this facility that the authors have to throw new light on old problems.

The model is timely, as broadly similar events are occurring in many countries. The new model provides a language for comparisons between regions of the world – and these are demonstrated by the ease with which it has been applied in the five chapters that bring the book to a close.

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Preface

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Graham Thornicroft and Michele Tansella have written an altogether remarkable monograph. *The Mental Health Matrix* is lucid, written in such simple and spare language as to make its concepts transparent, free of cant and of special pleading. For all these reasons, it should have a profound impact on the provision of mental health services; that is, *if* it is read by the practitioners, the policy makers and the politicians who need to understand its basic principles. Thornicroft and Tansella present no new data; what they provide are new ways to determine what data are needed across domains and to assess available data to permit evidence-based, integrated conclusions.

Amidst the clamour of cost-containment, they have managed to do the unique. They highlight the importance of a *population-based* approach to mental illness, because of its health benefits, at the same time that they make the care of the *individual patient* the focus for clinical planning. In the United States, at least (and I suspect, this is not solely an American disease), 'population medicine' is a slogan often used to rationalise cost control by limiting services that might have benefited individual patients. Such rhetoric is absent from this volume. Better care can be less expensive care when ineffective high cost procedures and episodic interventions are replaced by integrated services, but the goal must be the provision of care that benefits patients rather than investors or managers (or mental health workers!).

Indeed, so profound is the proposed way of looking at services and so different is it from what each of us is accustomed to, whether we be clinicians, public health workers or designers of social policy, that I urge its use as a study guide for interdisciplinary working groups. The subtitle of the book is *A Manual to Improve Services*; that is precisely what it provides. Its concluding sections set forth illuminating case studies that apply the matrix model to areas as different as Australia, Canada, Eastern Europe, the Nordic countries and the United States.

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The authors suggest the model can help in 'understanding the possible causes and effects of episodes of severe violence committed by psychiatric patients'. They contrast a narrow focus on the clinician, on the one hand, with a more inclusive analysis of case load, staff training and national investment in services, on the other. Let me pursue this typology through a specific illustration of misplaced blame and its social consequences.

The tragedy in question took place in July 1986 on a ferryboat between Staten Island and New York City. A homeless 43-year-old Cuban refugee, responding to command hallucinations, slew two passengers and wounded nine others. The tragedy was transmuted into public outrage when the newspapers discovered that Gonzalez had been seen four days earlier in the emergency room of a teaching hospital. Although the psychiatric house officer who saw him recognised that he was wildly psychotic, he was unable to find a bed for the patient at his own university hospital or any of the seven other in-patient units he telephoned. The patient was uninsured and without funds. The news report of an inability 'to find a bed' was an inability to find a *free* bed. The state agency piously concluded that the house officers performance 'did not meet professional standards' and that there had been 'inadequate supervision'. The diagnosis of clinical failure obfuscated the real problem: pathology in national and state policy.

The public consequences were enormous; within two weeks, the number of patients brought to psychiatric emergency rooms in New York City increased by 50%; the number admitted led to such overcrowding that patients had to be transferred by bus and van to remote backup state mental hospitals. Despite that manoeuvre, psychiatric emergency admissions spilled over into unused medical and surgical beds in municipal hospitals. The crisis did not abate until almost a year later when public services settled back into their ante-bellum status.

Were the ferry murders a sentinel event in an epidemic of homicidal psychoses? Clearly not. The 'epidemic' was panic among the gate keepers. The police brought verbally abusive homeless persons to emergency rooms, no longer willing to gamble on their harmlessness. House officers on emergency duty would no longer sign out potentially violent patients without evaluation by a senior physician, resulting in long queues in the emergency room. Staff psychiatrists opted to be on the 'safe side' by hospitalising patients they would have sent back to the streets before the ferry murders.

The fundamental problem did not lie with the resident's clinical judgement, but with the failures at the national, state and local levels. Because the United States is the only country in the world without universal health insurance, lack of coverage precluded private hospitalisation and placed

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the patient in a queue for public care. State/federal fiscal relationships had made it advantageous to states to downsize public hospital capacity in order to shift payments for the mentally ill from state to federal budgets. At the local level, the pathology included the homelessness of thousands of mentally ill patients because public housing is inadequate and because after-care and rehabilitation services are insufficient. Preventing avoidable hazards to ordinary citizens demands an address to these issues.

If the principles of *The Mental Health Matrix* are widely understood, the groundwork will have been laid for comprehensive public mental health services. However, understanding will not in itself suffice. To actualise what is possible 'in principle' requires a social strategy and the political will to make change happen.

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