The 1970s are seen now as the 'glory days' of social work when there was both ideological and legislative support for social work as a profession in its own right, and when numbers of social workers increased from 10,346 in 1971 to 21,182 in 1976 (NALGO, 1989). This was not to last however, and the glory days were soon over with social workers facing a new anti-welfare Conservative government that came to power in 1979, and finding themselves on strike during the latter part of the decade. The Barclay Committee was set up in 1980 to examine the crisis that social work found itself in. It reported in 1982 stating that:

> Too much is expected of social workers. We load upon them unrealistic expectations and then we complain when they do not live up to them. Social work is a relatively young profession. It has grown rapidly as the flow of legislation has greatly increased the range and complexity of its work. (Barclay, 1982: vii)

Langan argues, 'the Barclay Report attempted to reconcile Seebohm and the new right, and inevitably failed' (cited in Clarke, 1993: 63). Furthermore, the two minority reports that accompanied the main report both assumed the demise of the generic social worker as the dominant force in the provision of social support. Nevertheless, in the middle of this period the DHSS White Paper *Better Services for the Mentally Ill* confirmed the importance of the social worker's role in working with the mentally distressed when it stated, 'the unifying element ... is the professional skill of the social worker, whether deployed in fieldwork, in primary care, in residential or day care, or in hospital' (DHSS, 1975: 23).

The Mental Health Act 1959 had governed the process of admission to psychiatric hospital for 24 years, but, as Davies maintains, 'it came under increasing attack partly because of the way the facility for emergency admissions was abused and partly because of the ambiguous role of the social worker in the process' (1981: 114). The Mental Health Act 1983 was designed to improve matters with a statutory requirement for 'approved social workers' (ASWs) to be properly trained, and in order to fulfill their role they would be required to carry out professional assessments. The minimum requirement to become an ASW was two years relevant post-qualifying experience and the completion of a specialist training course. Thus, the specific role assigned to Mental Welfare Officers under the 1959 Act was made clearer for Approved Social Workers under the 1983 Act, albeit with their powers controlled by strict time limits stated in the legislation and supervised by the courts, subject to medical collaboration, and with the rights of patients and their families protected. This nevertheless created an important and specific role for one group of social workers at a time of nervousness in the profession.

THE TRANSITION TO COMMUNITY MENTAL HEALTH CARE

As outlined earlier the major move toward care in the community came with the emptying of the asylums. The number of residents in the asylums peaked at around 150,000 in 1955, but by 1992 this figure had plummeted to just 50,000. Much has been written concerning deinstitutionalization of the mentally ill with various

commentators speculating as to the primary motivating force(s) underpinning th process of change (Busfield, 1986; Jones, 1993; Scull, 1977). Four main drivers hav been identified, as follows.

The Drug Revolution

It is widely believed that it was the 'scientific breakthrough' in the development o the major tranquillizing drugs in the 1950s that enabled large numbers of menta patients to be discharged into the community. However, many of these drugs were not widely used until some years after patients had already begun to be transferred to the community. Scull (1977) argues that while drug treatments may have facilitated the management of mental patients discharged into the community, they were not responsible for community care policy as such.

Therapeutic Optimism

After the Second World War many psychoanalytically oriented army psychiatrists such as Tom Main, Maxwell Jones and David Clarke led the way in pioneering new approaches to mental distress. 'Therapeutic communities' were developed and the same pioneers set about unlocking the doors of the traditional mental hospitals in an effort to humanize the care and treatment of the institutionalized insane. By the 1950s most hospitals had open door policies.

Anti-institutional Critiques

From the 1950s onwards a growing body of critical work emerged that reflected profound disenchantment with institutional care in all its forms. Writings on the sociology of deviance, phenomenology, ethnomethodology, labelling theory and symbolic interactionism (for example Goffman, 1961; Laing, 1959; Scheff, 1966; Szasz, 1961) not only represented a powerful critical literature around the nature, causes and responses to mental distress but also contributed to the call for deinstitutionalization

Economic Crisis

Scull's (1977: 1) preferred explanation for what he refers to as the 'state sponsored policy of closing down asylums' is an economic one. He argues that the social control mechanism of segregation that epitomized the nineteenth-century approach to managing the mad became an increasing financial burden to the state that could no be sustained; therefore propelling patients from segregation in the asylum to neglect in the community. Busfield (1986) suggests that Scull's argument fails to account for increases in expenditure on mental health services during this period – especially in relation to primary care. However, she does acknowledge that this expenditure was skewed towards services for people with less severe mental health problems at the expense of the chronically mentally distressed.

It is likely that deinstitutionalization was, to a greater or lesser extent, a consequence of all of the above. Regardless, the expansion of state medical and social services meant that the institutional setting became less significant and no longer represented the ideal location for psychiatric practice. Yet if the intention was that with the closure of the large institutions patients would find themselves in a new, less institutionalized, more therapeutic environment, the reality was that many of the theories and practices of the asylum transferred with them (Rogers and Pilgrim, 2001). Moreover, by the late 1970s it was clear that the state's interpretation of community care was changing.

In the broader context of fiscal crisis and economic recession a 'New Right' Conservative government had come into power in 1979 with an 'anti-welfarist agenda' high on its list of priorities. The stated objective of Margaret Thatcher's government during the 1980s and early 1990s was to roll back the 'nanny state'. As far as social workers were concerned, Cochrane quotes a senior Minister (John Patten) reported in *The Times* in 1991 as arguing that, 'municipal armies of social workers should be disbanded and responsibility for caring for the vulnerable and inadequate transferred to smaller community-based groups' (1993: 73). Sir Roy Griffiths was given the task of reviewing the efficiency of public organizations, and his Report, *Community Care: An Agenda for Action* was published in 1988. The Report proposed ways of introducing community care linked to reducing levels of public expenditure, and, as Clarke notes, 'the Griffiths Report acknowledges that the new arrangements are likely to change the ways in which professionals – and social workers in particular – will have to operate' (1993:79).

The government's White Paper *Caring for People* followed and incorporated Griffiths' ideas on the purchaser/provider split, encouraging local authorities to construct care packages that should 'make use wherever possible of services from voluntary, "not for profit" and private providers insofar as this represents a cost-effective care choice' (DH, 1989: 22). As Means and Smith (1998) argue, the White Paper was not received favourably and some criticized it as part of a Thatcherite strategy to introduce the market to public services. The NHS and Community Care Act 1990 that followed, 'changed the traditional territory of the mental health professions' (Rogers and Pilgrim, 2001: 89), and brought with it new funding regimes which social workers were required to re-orientate themselves to. The Act heralded a shift away from the post-war pattern of welfare services where the state played the central role, to a 'mixed economy of welfare' in which the voluntary, informal and private sectors would play a greater part. As Clarke maintains, it signalled the 'end to the social services department as a 'monopolistic provider' of services' (1993: 151). Services would be 'needs led' and 'clients' would become 'customers'; social workers would become 'care managers', assessing customers' needs and purchasing services on their behalf from the local mixed economy of care. Means and Smith argue that 'these were under-funded regimes ... that had new complex assessment and fee payment systems which depended upon the willingness of social workers and other field-level staff to take an increased role in the means testing of clients' (1998: 107). Social workers became uneasy with their new role as budget managers, with Langan and Means (1995) finding that many social workers resented the 'money role' being passed on to them. The care management approach changed the very nature of social work. The primary objective of achieving a trusting,

caring and supportive relationship with clients was replaced with a customer–servic provider relationship. That social workers in mental health services put together 'car packages' within a community care framework within set budgets, in what Harri describes as 'the social work business' (2003: 1), is the subject of Chapter 3.

CHAPTER SUMMARY

The development of the modern mental health system has a complex and convolute history. Accounts of that history are inevitably tainted with the subjective meaning and interpretations of those contributing to it. There are therefore *multiple historie* reflecting the legacy of ideas, institutions and practices of each generation. Given this the simplicity of the summary of the early development of mental health provision i Britain offered by Kathleen Jones has an obvious appeal: 'In the eighteenth century madmen were locked up in madhouses: in the nineteenth century, lunatics were sent t asylums; and in the twentieth century, the mentally ill receive treatment in hospitals (1955: ix). To which may be added that in the late twentieth and early twenty-firs centuries the mentally distressed were cared for in the community. Whether the ideal o 'community care' has actually been achieved remains a matter of significant debate an is the subject of the next chapter.

Further reading/resources

Coppock, V. and Hopton, J. (2000) *Critical Perspectives on Mental Health*. London: Routledg
Porter, R. (2002) *Madness: a Brief History*. Oxford: Oxford University Press.
Rogers, A. and Pilgrim, D. (2001) *Mental Health Policy in Britain*, 2nd edn. Basingstoke: Macmill

3 CARE IN THE COMMUNITY

Policy ideals and practice realities

This chapter can be used to support the development of knowledge and skills in professional social work as follows:

National Occupational Standards for Social Work

Key Role 1: Prepare for and work with individuals, families, carers, groups and communities to assess their needs and circumstances

- Prepare for social work contact and involvement
- Work with individuals, families, carers, groups and communities to help them make informed decisions
- Assess needs and options to recommend a course of action.

Key Role 2: Plan, carry out, review and evaluate social work practice, with individuals, families, carers, groups and communities and other professionals

- Interact with individuals, families, carers, groups and communities to achieve change and development and to improve life opportunities
- Prepare, produce, implement and evaluate plans with individuals, families, carers, groups, communities and professional colleagues
- Support the development of networks to meet assessed needs and planned outcomes
- Work with groups to promote individual growth, development and independence.

Key Role 3: Support individuals to represent their needs, views and circumstances

- Advocate with, and on behalf of, individuals, families, carers, groups and communities
- Prepare for, and participate in decision making forums.

Key Role 4: Manage risk to individuals, families, carers, groups, communities, self and colleagues

- Assess and manage risks to individuals, families, carers, groups and communities.