

**COMMUNITY-BASED MENTAL HEALTH CARE IN BRITAIN AND
ITALY: GEOGRAPHICAL PERSPECTIVES**

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**Thesis submitted in partial fulfilment of the requirement for the degree of
Doctor of Philosophy**

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September, 1996

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ABSTRACT

This thesis examines the implementation of mental health reforms in Britain and Italy since the 1950s from a geographical perspective. Both countries have experienced the policies of deinstitutionalisation and community care, yet the timing, methods and outcomes of implementation have varied considerably, both between the countries and within them. This situation suggests that underlying social, political, economic and cultural differences have been important influences on the implementation of the respective mental health reforms, and this is a theme that is considered throughout the thesis.

The research was conducted at three levels of enquiry: firstly by comparing the implementation of mental health reforms at the national scale in Britain and Italy, looking in particular at the influence of politics and place; secondly by focusing upon the implementation of the reforms in two cities, for which Sheffield and Verona were selected; thirdly a case study approach was adopted in order to study in greater detail one community-based mental health service in each city. It was at this level of enquiry that the more intensive research was carried out, in the form of two local resident questionnaire surveys, one in each city, and semi-structured interviews with mental health professionals from the two case study services.

This research illustrates that the implementation of mental health reforms in Britain and Italy has led to a geographical unevenness in the distribution of community-based services at all spatial scales. However, the social, cultural and political contexts in which the reforms have occurred in the two countries have been quite different and therefore when contemplating direct comparisons between mental health reforms in Britain and Italy, the argument that 'place matters' is highly pertinent.

DEDICATION

This thesis is dedicated to my parents: thank you for your unfailing support and encouragement throughout my educational years and beyond. With much love.

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PREFACE

This doctoral research project developed out of an undergraduate dissertation which examined an example of NIMBYism in St. Albans, Hertfordshire, where local residents bought a house in order to prevent the local Health Authority from purchasing the property for five people with learning difficulties who were being resettled from a long-stay hospital. This extreme example of reactions to community care 'got me hooked' on the whole topic area, particularly as I was brought up in St. Albans where, until the late 1980s, there were five long-stay hospitals for people with mental health problems and learning difficulties.

The idea of comparing Britain with another European country was suggested to me by Dr Paul White, whilst on an undergraduate field trip in Paris. As I was enjoying my week abroad it all seemed like a good idea. Paul suggested a comparative study with Italy, with the comment that "Italian is really easy to learn anyway". From such a simple conception this research project has become complex in ways I would never have imagined and has quite literally re-directed my life.

When I began this research a straight-forward comparative study was proposed, to compare 'like' with 'like'. However, when I arrived in Italy I realised that such an approach was simply not feasible because of the specific national and cultural contexts in which mental health reforms had been applied. This realisation called for a radical re-design of the whole research project and to adopt a cross-national and cross-cultural perspective for the research. This is the reason for the format of the thesis, addressing the Italian and British situations separately in Sections Two and Three and then drawing conclusions from the thesis as a whole in Section Four.

ACKNOWLEDGEMENTS

There are so many people to whom I am indebted, both in Britain and Italy:

Most importantly, Dr Paul White, for encouraging me to do this research in the first place and for being such an excellent Supervisor, especially for encouraging me to keep going in the final year. I also wish to thank Professor Robert Haining for his help and advice at the initial stages of this research.

I wish to thank all my friends at the Department of Geography for their help and support: Kay Graham, Juliet Carpenter, Kate Day, Aglaia Barraclough, my fellow members of the Sheffield Medical Geography 'Pack' Judith Bush and Dawn Thompson, Paul's infamous coffee morning group where we regularly exchanged ideas and gossip, and all the staff and postgraduates for providing such a supportive and friendly environment in which to work. Also a big thank you to all the people who have had to share a house with me and my research for the last four years, so thank you Rachel, Kay, Kate and Hazel. Thanks also to my brother Adrian, who has helped me move house on occasion and who continues to ensure that my feet remain firmly on the ground.

I would like to extend my thanks to all my colleagues at the Royal College of Nursing Institute where I have been working for the last year as a Research Assistant with the Mental Health Programme, especially Martin Ward, Jenny Reed, Ingrid Goodman and Sophie Staniszeweska. Thank you all for your support and for sending me home when I looked too stressed!

In Sheffield I am indebted to a number of people for their help and co-operation in my research, in particular Janet Williams, Helen Parkin, Frank Thorne, Clare, the staff and tenants of the Lister Avenue Project and all the people who answered my questionnaire survey and agreed to be interviewed.

In Verona I am indebted firstly to all the staff at the *Instituto di Geografia Economia* at the University of Verona for allowing me to work in the department for my six months of fieldwork. Particular thanks go to Professoressa Claudia Robiglio and her husband Professor Guiseppe Rizzo, who very sadly died earlier this year. I also gratefully acknowledge the kind assistance of the staff and patients of the South Verona Community Psychiatric Service, who permitted me to work in their facilities. Particular thanks go to Professor M. Tansella and Ernesto Guerriero. I would also like to thank Roberto Mezzina and the mental health workers at Barcola for taking time to show me around some of the mental health facilities in Trieste. Thanks are also due to all those who assisted me in my research in Verona by responding to my questionnaire.

Grazie mille to Angelica Peruz and Sonja Logiudice for their help with translations and transcribing in Verona and a very important thank you to Walter Palazzin, who has helped and supported me so much in the last two years and who has deepened my love for Italy.

I acknowledge the financial support for this research from the Economic and Social Research Council (Award no: R00429234155). A special thanks to Dawn Hill at the Postgraduate Division for all her assistance, especially when I was in Italy.

NOTE:

Published work derived from this thesis:

Jones, J. 1996. Community-based mental health care in Italy: are there lessons for Britain? *Health and Place*. 2, (2), 125-128.

SECTION ONE

INTRODUCTION

CHAPTER ONE

THE CONTEXT OF CHANGE IN THE CARE OF PEOPLE WITH MENTAL HEALTH PROBLEMS IN BRITAIN AND ITALY.

1.1 INTRODUCTION

All European countries (and many beyond) share the legacy of the asylum system. But the search for alternative systems of care for the mentally ill in Europe over the last thirty years has produced considerable variations in what is on offer outside the mental hospital (Mangen, 1994). Britain was one of the first countries to introduce reform legislation in 1959, with a policy to relocate mental health care services from institutional to community settings. The Mental Health Act of 1959 has been followed by a succession of legislation, culminating in the 1990 NHS and Community Care Act.

Italy, in comparison, was much later than Britain to introduce mental health reforms; legislation was not passed by the government until 1978 when Law 180, a single piece of legislation, was introduced. Law 180 called for radical and rapid reforms, in a country where mental health care was provided predominantly by long-stay psychiatric hospital system, with no major mental health legislation having been passed for fifty-nine years. The aim of Law 180 was to dismantle the Italian psychiatric hospital system and to replace it with community-based mental health services within two years. This reform law has been called 'revolutionary' and 'the most comprehensive community-oriented mental health act in the Western industrialised world' (Mosher, 1982, p.1).

Since 1978, the 'Italian experience' as it has been termed, has played an important role in the discourse on mental health internationally; as an innovative model it has

attracted much interest, particularly amongst those searching for 'lessons for the homeland' (Mangen 1994). In Britain, in the early 1980s, some mental health professionals cited the 'Italian experience' as a model to emulate for Britain (Lacey, 1984; Heptistall, 1984). Yet others describe the reforms as a failure, with success confined to a few locations, and have issued dire warnings against copying the 'Italian experience' in Britain (Jones and Poletti, 1985;1986).

In response to this debate, this doctoral research project has had the purpose of investigating the consequences of temporal and spatial changes in mental health care provision since the 1950s in both Britain and Italy, but from a geographical perspective. As stated by Thornicroft and Bebbington (1989) 'the recent history of the treatment of those with severe and chronic mental illness must be one of the most significant social changes of our time' (p.739). But the way in which Britain and Italy have experienced this change has varied considerably, both temporally and spatially.

Britain and Italy have both experienced the policies of deinstitutionalisation and community care, yet the timing, methods and outcomes of implementation have varied considerably, both between the two countries and within them. This situation suggests that underlying social, political, economic and cultural differences have been important influences on the implementation of the respective mental health reforms, and this is a theme that is considered throughout the thesis.

It is clear from this research that geography does matter and can make an important contribution to the understanding of the impact of the implementation of deinstitutionalisation and community care policies for the mentally ill in different places. Yet the changes to mental health care systems in Europe have received surprisingly little attention by geographers to date. This 'gap' in current geographical research is an important reason for this piece of research.

1.1.1 Overview of research project

The focus of this doctoral research project has been to investigate the impact of deinstitutionalisation and the implementation of community care policies in Britain and Italy. These two policies can be defined as the closure of long-stay psychiatric hospitals, which have been the 'sites' of care for people diagnosed as having a mental illness (see 1.1.2) since the second half of the nineteenth century throughout Europe, and their replacement by alternative systems of community-based mental health services. A major theme of this research has been the decision-making process behind the location of new community-based mental health services and facilities, predominantly in urban and residential environments, and the impact that this relocation has had on the 'host' communities of these new 'sites' of care.

By focusing upon the implementation of mental health reforms in Britain and Italy, this research has been concerned with the temporal and spatial consequences of relocating people and resources from 'out' of the community to 'within' it in the two countries, as most of the nineteenth century asylums were built on the outskirts of towns and cities, with the mentally ill being both socially and spatially marginalised from the rest of the so called 'normal' population (Philo, 1987a). The challenge of community care policies is therefore whether the historical problem of the marginalised and excluded mental patient can be, in part, resolved by the relocation of the 'sites' of care (Barham, 1992).

A focus upon the implementation of community care policies, bring attention to the concept of 'community,' with the associated the cultural implications of the use and meaning of this term in different cultures and languages. With the use of the term 'community care' to describe the new system and location for this care of the mentally ill in both Britain and Italy, it is important to consider the expectations of the 'host community' which are implied by the ideology of community care policies. These issues will be addressed within the thesis.

The policies of deinstitutionalisation and community care in Britain and Italy have had a huge impact on the lives of a number of different groups of people: people with mental health problems who have been spatially relocated from the large psychiatric hospitals to smaller community-based facilities; the families and carers of the mentally ill; mental health professionals who have also faced spatial and professional change from working in an institution to working in a community setting; the 'host' community of people who live or work near to a newly opened community-based mental health facility. Not all these groups can be considered in depth within a single PhD project, although all warrant attention. For this PhD, the views of mental health professionals working in community-based services and local residents living close to community-based residential mental health facilities in the two case study services are the main focus of research concern.

This research was carried out using a case study approach. This strategy was adopted because it became clear at an early stage that a direct comparative study would be inappropriate; the implementation of mental health reforms in Britain and Italy had occurred at different timescales, from different starting points and within different social, economic, political and cultural contexts. In Britain, the policy of community care has been implemented by the national Government, with the introduction of statutory requirements for community care provision by Local Authorities and health agencies in every town and city in the country.

In Italy, the implementation of Law 180 has had no statutory enforcement or co-ordination by the national Government. Subsequently the introduction of community-based services and facilities in Italy has been patchy and is certainly not comparable to the situation in Britain. Thus it was not going to be possible to compare 'like' with 'like'. So it was decided that the most appropriate approach for this piece of research would be to use case studies, as will now be discussed.

The research was organised at three levels: firstly by comparing the implementation of mental health reforms at the national scale in Britain and Italy, looking in particular at the influence of politics and place; secondly by focusing upon the

implementation of the reforms in two cities, for which Sheffield and Verona were selected (see 1.2.1), with the 'mapping' of the community-based mental health facilities in the two cities, as will be discussed in Chapters Four and Seven; thirdly a targeted case study approach was adopted in order to study in greater detail one community-based service in each city. It was at this level of enquiry that the more intensive research was carried out, in the form of two local resident questionnaire surveys, one in each city, and semi-structured interviews with mental health professionals from the two case study services. This component of the research is discussed in Chapters Three, Five, Six, Eight and Nine. The data collection for the research was carried out during Year Two of the three years of PhD funding, which consisted of six months in Sheffield (1993-94) followed by six months in Verona (1994).

Throughout the thesis, these main themes of enquiry have been considered within the relevant cultural context - the national and regional cultural contexts in the two countries and also the cultural context of the mental health field. The unique institutional way of life experienced by patients and staff in the long-stay institutions, a phenomenon documented initially by Goffman in his famous study 'Asylums,' first published in 1961, has created a culture unique to mental health. As patients and staff have moved out together from the hospitals into the community, aspects of this culture remain and this is something that will be discussed further in Chapter Ten.

1.1.2 Some definitions of mental illness

It is important to define briefly what is meant by 'mental illness'. Just like physical illness, mental illness involves a wide range of problems and complaints. There are many different types of mental illness which can range from common forms of stress and depression to more chronic and serious forms of illness such as schizophrenia. Mental health professionals use classification systems in order to diagnose the type and severity of mental illness; in the UK, Italy and most other countries (apart from the USA which uses its own system known as DSM IV) The International Statistical Classification of Diseases and Related Health Problems (ICD-10), developed by the

World Health Organisation (1992) and now in its tenth edition, is used. This system includes a detailed classification of over three hundred mental and behavioural disorders which are organised into ten main categories, each with clinical descriptions detailing the principal signs and symptoms of each disorder (Cohen and Hart, 1995).

Such definitions of mental illness are based upon a medical or biological model, by which mental disorders are viewed as a disease or illness. This way of viewing mental illness remains dominant amongst medically trained mental health professionals. But this is not the only model used for the understanding of mental illness; Mangen (1982) discusses seven alternative models, as devised by Siegler and Osmond (1974) which offer different perspectives on the understanding of mental illness. Two of the most relevant models for this type of research are the moral and the social model: the moral model questions the validity of the concept of mental illness as a disease and suggests that instead it is used as a label which is attached to individuals' behaviour that the society in which they live regards as 'abnormal'; the social model regards the individual as part of a social system in which mental disorder evolves in response to difficult life events such as bereavement, divorce, unemployment and poor housing conditions. According to the social model of mental illness, 'elements of the fabric of society, and especially rapid social change, are perceived as pathological and in a radical version of this model, it is society itself that is sick' (Mangen, 1982, p.14)

Individuals can suffer from a mental health problem at any time in their life; it is estimated that one in ten adults and one in five children suffer from a mental health problem at some time (Department of Health, 1993). However, many people suffering from stress, depression or a nervous breakdown will make a full recovery from their illness. It is also very important to make the distinction between mental illness and 'mental handicap', now called 'learning difficulties'. People with learning difficulties, which includes mental disabilities such as mental retardation or Down Syndrome, have disabilities that occur normally from birth and are medically non-reversible (MENCAP, 1990). The mentally ill and people with learning difficulties are sometimes collectively called the 'mentally disabled'.

This research focuses upon changes in care for people with a 'diagnosed mental illness'. People with learning difficulties have also been affected by the policies of deinstitutionalisation and community care, but health service provision for the two client groups has been separate since the beginning of the twentieth century and the decision was taken at the beginning of this PhD to concentrate on the provision of services for the mentally ill only. By focusing on the relocation of people with mental health problems from the psychiatric hospitals into the community, this research has also concentrated on the situation for what is termed the 'old long-stay' clients, a term that describes individuals who have previously lived in long-stay institutions rather than the 'new long-stay' clients who are the younger generation of the mentally ill who have never experienced long-term institutional care.

In the previous paragraph the term 'diagnosed' mental illness was used. This is an important distinction to make because the definition of mental illness has varied considerably over time and between different places and cultures. Rosen (1968) traced the treatment of those deemed to be 'mad' from the time of antiquity showing how the definitions and care of the mentally ill have always been influenced by what society at a given time has defined, interpreted and classified as deviant or 'social misfits'. A good example of such temporal changes is given by the work of Scull (1979; 1981) who traces the treatment of the 'mad' between the mid-eighteenth and mid-nineteenth centuries in England and this is discussed further in Chapter Two.

Definitions and treatment of mental illness have not only changed over time but they also vary spatially. Helman (1994) suggests that definitions of 'normality', 'health' and what it is to be mentally ill vary widely throughout the world. Behaviour which may be considered 'normal' in one culture, may equally be considered to be wholly 'abnormal' in another. Helman gives the example of the experience of 'hearing voices' in different cultures. In a western setting, individuals who claim to be 'hearing voices' and to be 'possessed by a spirit' (or by God) would be likely to be diagnosed as being psychotic and probably 'schizophrenic'. But in other parts of the world people freely admit to being 'possessed' by supernatural forces and to having spirits speak and act through them. Helman argues that in most cases this is not

considered by their communities to be evidence of mental illness and that in some societies in parts of Africa, 'possession' is a normative experience (p.250).

Perceptions of health and ill-health also vary amongst individuals who may live in the same place but have very different cultural backgrounds. Donovan's (1988) study of health and illness in the lives of black people in London illustrates how culture affects people's perceptions and different ways of dealing with illness. With regard to mental illness, a recent study conducted in Bedford with Sikh and Hindu Punjabi and white British psychiatric patients (Krause, 1994) found that the Punjabis reported more somatic symptoms than the white British patients in a health questionnaire. But the author suggests that such a finding cannot be taken at face value as it hides important cultural differences between the two groups. Additional qualitative research revealed the importance of cultural construction and 'modes of thought' regarding definitions of health and illness by the Punjabis, for whom physical symptoms are intricately bound up with their psychological, biological and social well-being. Such differences between different cultural and ethnic groups living in the same locality highlights an increasing need for mental health services to be sensitive to different needs within local populations, as discussed by Lefley (1984).

So in conclusion to this section, definitions of mental illness are fluid rather than static, changing constantly over time and space in response to changing societal norms and values. Every culture has, and has had, its 'madness' and it is clear that mental illness does not exist in a social vacuum and that changing ideas and practices with regard to how the mentally ill should be treated are generated by changes within society itself. Butler (1993) suggests that the development of mental health services has been reflected by societal change and has, as such, emerged in a rather ad hoc manner - 'not as the gradual unfolding of a shared vision of policy and provision for people with mental illness, but rather as a variety of strategies which have swayed for a period and have in turn been challenged by alternative approaches' (p.2). Some would even argue that it is society itself that has socially produced mental illness (Scull, 1979; 1981).

1.1.3 My interest in mental health

For an appreciation and understanding of any research, I believe that it is important to be aware of the researcher's own agenda and perspective on their chosen topic area, their personal background and the 'baggage' that they bring to the research process. I was brought up in the city of St. Albans in Hertfordshire, during which time there still remained within the city boundaries five long-stay mental hospitals, three for the mentally ill and two for the mentally disabled. Two of the hospitals, Hill End Hospital for the mentally ill and Cell Barnes Hospital for the mentally handicapped, were located within a mile of my home. Friends of my parents worked at the hospitals, as did parents of schoolfriends and seeing people who were visibly mental disabled walking around in the neighbourhood was an everyday experience during my childhood; it was a situation that was 'normal' and acceptable to me and my contemporaries.

However, when it was announced that the hospitals were to close and that patients were to be resettled in residential neighbourhoods in St. Albans, the attitudes of some local residents changed. My undergraduate dissertation looked at the opposition of some local residents in St. Albans to the location of community care homes to resettle former patients from Cell Barnes Hospital. In one case, four families actually joined together to buy a neighbouring house in order to prevent the health authority from purchasing it for five elderly people with learning difficulties. Such extreme action caught my interest and made me want to know more about why the relocation of mental health facilities in an urban residential setting has the potential to create such reactions. I also became increasingly interested in why reactions seemed to vary in different places and amongst different groups of people, and this led to my interest in doing some research in a different country.

1.2 A CROSS CULTURAL PERSPECTIVE

This research project has been a cross-cultural and cross-national comparative study, as it has examined the same phenomena, the implementation of mental health reforms, in two separate countries, each with its own respective culture. Cross-national comparative research differs from other comparative research as data is collected within a specific national and cultural context. Such an approach facilitates the discovery of 'where and why social occurrences in one nation differ from those in another, and how context, social conditions, policy and culture shape the manifestations of specific social phenomena' (Hantrais, Mangen and O'Brian, 1985, p.vii). This perspective can also 'establish or sharpen the parameters of national uniqueness or societal specificity' (ibid., p.vii).

This research has not been a strictly systematic comparative study because of the differing outcomes of the implementation of mental health reforms in Britain and Italy, as already mentioned (1.1.1). The country of Italy was selected for this research project because the policies of deinstitutionalization and community care there have had perhaps the most rapid and radical history of any country that has introduced such reforms. However, because of differing historical, social, political, economic and cultural contexts and the timescale in which the reforms have been introduced in Britain and Italy, the outcomes 'on the ground' vary considerably. But this situation is in itself an important research finding, as the fact that reforms with similar aims have been introduced in the two countries yet the outcomes are significantly different, indicates that it is in fact the national and cultural contexts which require important emphasis in this research.

By adopting a cross-cultural perspective within this research, the importance of the cultural differences between two different countries has been recognised and considered. But what is meant by the term 'culture'? Keesing (1984) has defined this concept as 'systems of shared ideas, systems of concepts and rules and meanings that underlie and are expressed in the ways that human beings exist' (quoted by Helman, 1994, p.2). Helman continues to state that from this definition, one can see culture as

‘a set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to *view* the world, how to *experience* it emotionally and how to *behave* in it in relation to other people’ (p.2).

Helman suggests that such a concept can be thought of as an inherited and culturally specific ‘lens’ through which the individual perceives and understands the world around them. An aspect of this ‘cultural lens’ is the division of the world and the people within it into different named categories, for example, ‘social categories’ such as: ‘men’ or ‘women’; ‘children’ or ‘adults’; ‘rich’ or ‘poor’; ‘able’ or ‘disabled’; ‘normal’ or ‘abnormal’; ‘healthy’ or ‘ill’. Different cultures have different criteria for inclusion to these ‘labels’ of identity and such definitions have been seen to change over time. Such an understanding of the influence of culture on the way individuals perceive themselves and others is important when considering the treatment and care of those labelled ‘mentally ill’ in different cultures.

It is also important to recognise that virtually all societies are not culturally homogeneous and contain within them various sub-cultures which are aligned to a group of people sharing similar positions in society or similar experiences, for example sub-cultures belonging to particular ethnic groups and/or particular age groups (see Hall and Jefferson, 1976). Helman (1994) also describes a further subdivision of culture within advanced industrialised societies with the various professional sub-cultures that exist such as the medical, nursing, legal or military professions and that each professional culture contains its own concepts, rules and social organisation, with unique and distinctive features of its own. This is certainly the case for the mental health profession and this issue will be developed further in Chapter Ten.

Pedersen (1984) states the importance of being aware of the dangers of imposing the perspective of one’s own culture on another when applying a piece of cross-cultural research. This is particularly relevant when making a study of mental health services in different countries because of the dominance of western psychiatry, its definitions and theories regarding the causes and treatment of mental illness. Although the

'outsider' perspective is unavoidable because of a researcher's background, it is important to 'learn' or at least become aware of the 'local' perspective on mental illness, health care, societal values and so on. It is essential to assess social phenomenon in the appropriate local and cultural context, which is what I was able to do by conducting fieldwork in both Britain and Italy, in the cities of Sheffield and Verona.

1.2.1 Why Sheffield and Verona?

As already mentioned (1.1.1) the majority of the data collection for this research was conducted in Sheffield and Verona. Sheffield was the obvious and practical choice as I was based at the University of Sheffield for this PhD. My choice of Verona was due to a number of factors:

1. Verona is located in the north of Italy where the implementation of Law 180 has been the most rigorous (Bollini, Reich and Muscettola, 1988; Tansella, De Salvia and Williams, 1987). I also knew from relevant literature that in South Verona a new community-based mental health system had been developed since the late 1970s (Mosher and Burti, 1989; Tansella, 1991) and that there was a research unit within the Institute of Psychiatry at the University, that was linked to the South Verona Community Psychiatric Service (Tansella, 1993).
2. Verona and Sheffield are both large regional cities, with University-based hospital systems. Both cities have had a large mental hospital at the centre of the mental health care system prior to the implementation of mental health reforms. Since that time, both cities have been geographically divided to provide a more localised service for people with mental health problems. Sheffield had recently been split into five major geographically-based sectors, each with its own specialised mental health team and facilities (Sheffield City Council, 1991). In 1978, Verona was split into three geographical sectors for mental health. One of these sectors, South Verona, came under the responsibility of the Institute of Psychiatry of the University of Verona (Mosher and Burti, 1989).

3. The Department of Geography at the University of Sheffield had an ERASMUS student exchange link with the Department of Geography at the University of Verona, which offered to support me during my six months in Italy. Such practical support cannot be underestimated when living and working in a different country, especially for the first time.

1.2.2 Sheffield and Verona - a few facts and figures

Sheffield

The city of Sheffield is located in the county of South Yorkshire in the heart of Britain. With a total population from the 1991 census of 425,000, Sheffield is the fifth largest city in Great Britain. Sheffield has twenty-nine electoral wards, amongst which there are wide variations in social status and health; there is a clear east-west divide in the city, with the population in the west of the city being of a higher social class and also being more 'healthy' (Watts, Smithson and White, 1989). Sheffield has an ageing population structure; whilst the population of the city decreased by three per cent between 1981 and 1991, over the same decade the proportion of adults aged between 75 and 84 increased by twelve per cent and the over 85 age group increased by sixty per cent. According to the 1991 census, approximately 5% of the city's total population consisted of black and minority ethnic groups, with almost half of this population living in four inner city.

In the past, Sheffield was a major industrial centre, especially in manufacturing and mining activities. But since the 1970s, like much of central and northern England, Sheffield has been hit by economic decline, with high levels of unemployment which have increased from 11.5% of the economically active of the total population in 1981 to 18.8% in 1991. In the 1990s, the city has been attempting to revive its economy with a new focus on the service and leisure sector, examples of which are the creation of a regional shopping centre on the site of a former steel works, the development of new sports and leisure facilities, many of which were built for the World Student Games in 1992, and an emphasis on office relocations into the city.

Politically, the city of Sheffield has a long history as a Labour Party strong-hold, relating to the dominance of heavy industries and the associated trade union activity until the economic decline from the 1970s onwards. Despite the effect of economic restructuring, Sheffield remains a city with left wing allegiances and following the 1993 General Election, five of the six constituencies for Sheffield are presently represented by Members of Parliament from the Labour Party. Like the variations for social status and health, the city also shows a clear east-west divide according to its voting patterns with the east of the city voting predominantly for the Labour Party (Watts, Smithson and White, 1989). Sheffield City Council is Labour controlled and has, in recent years, suffered financial difficulties which has led to substantial cut-backs in Local Authority spending.

Verona

Verona is located in the north-east of Italy in the region of Veneto. Veneto consists of eight provinces, the province of Verona being one of them which encompasses the city of Verona and nearby towns and villages as far as Lake Garda to the west and San Bonifacio to the east. The city of Verona itself is split into eight administrative sectors called '*circonscrizione*', which are subdivided into a further twenty-three smaller administrative zones called '*quartiere*'. The 1991 census showed that the city of Verona had a total resident population of 255,824. Like Sheffield, there are variations between the different parts of the city according to social status and health (Comune di Verona, 1994).

The population of Verona decreased between 1981 and 1991 by almost four percent (3.8%) (Comune di Verona, 1994) and like Sheffield, Verona also has an ageing population structure; between 1981 and 1992 the proportion of adults aged between 75 and 84 increased by twenty-seven percent and the over 85 age group increased by forty-eight percent. Another important feature of population change affecting Verona is a decrease in the 0-4 age group of twenty-eight per cent between 1981 and 1992 (data calculated from the 1981 census and 1992 annual statistics for Verona, Comune di Verona, 1993 and Comune di Verona, 1994 respectively). This reflects a nationwide phenomenon of a decreasing birth rate, where Italy now has the lowest birth rate

in the world and is described as becoming 'ever more adult, elderly and sterile' (King, 1993, p.69).

The percentage of ethnic minority groups in Verona was recorded by a local census conducted in 1992 as one per cent of the total population, which is lower than the figure for Sheffield. However, this figure may not be accurate as it is estimated that the number of non-Italians recorded is only about half of the total thought to be living in the country (King, 1993). Verona experienced considerable in-migration from the 1950s onwards, both from other parts of Italy and elsewhere, as new industry developed, locating in the south of Verona. Before that time, Verona's economy was based predominantly on agriculture but since the 1950s, as in most of Veneto, new activities in the manufacturing and service sectors have brought new employment and new wealth to the area. For example, Verona is the second largest marble exporter and third biggest footwear producer in Italy (Azienda di Promozione Turistica Verona, 1994).

The political situation in Verona is far more complex than in Sheffield, reflecting the instability of the national political system (see Chapter Seven). Local politics in Verona is equally complex, with many different political parties represented within the city council of Verona ('*Consiglio Comunale*'). From 1946 until 1992, the 'right-of-centre' Christian Democratic Party ('*Democrazia Cristiana, DC*') dominated Italian politics at the national and local level. In Verona the Christian Democrats dominated the local political system; Verona was known as the 'white city', white being the colour of the Christian Democratic Party.

From the 1970s, Verona was governed by a coalition Local Government, formed by the Christian Democrats and the Socialist Party (*PSI*), the latter having increased its share of national power from this time onwards. But since 1992 in Italy, corruption investigations have dominated the political scene with many politicians and business people being investigated and imprisoned. This campaign, known as the 'cleaning of hands' campaign ('*mani pulite*') has led to the break up of the Christian Democratic

and the Socialist Parties and the demise of their power in Italy, leaving a political vacuum and providing the opportunity for new political movements to emerge.

In 1994 the political situation in Verona, as in the rest of Italy, changed dramatically with the birth of a new 'centre of right' party called *'Forza Italia'*, led by the entrepreneur businessman, Silvio Berlusconi. Nationally, at the 1994 elections, *'Forza Italia'* took control of a coalition government (although this government only lasted a few months). In Verona, a new alliance of *'Forza Italia'* with the Northern League Party (*'Lega Nord'*), a party which campaigns for the separation of the north from the south of Italy and which is particularly strong in the north-east of Italy, took 48% of the votes for the House of Deputies (*'La Camera'*) and 41% of the votes for the House of Senate (*'Il Senato'*). The *'Forza Italia-Lega Nord'* parties formed a coalition council in Verona with the other main right-wing parties, including the National Alliance Party (*'Alleanza Nazionale'*). 'A *Forza Italia'* candidate became the newly elected mayor (*'sindaco'*) (L' Arena, 27th June, 1994). Thus the political situation in Verona in the 1990s has changed considerably, as it has in the whole of Italy.

This picture reflects the complexity of the Italian political system, something that is discussed in greater depth in Chapter Seven. The mental health care services in Sheffield and Verona will be discussed further in Chapters Four and Seven respectively.

1.3 MAIN OBJECTIVES OF RESEARCH

This doctoral research project has had three main objectives which will now be discussed:

1. *To compare and contrast the geographical implications of spatial changes in mental health care services in Britain and Italy.*

This first objective represents the first level of investigation, as discussed in 1.1.1. The purpose of this part of the research has been to compare changes to the mental health care services in Britain and Italy from the 1950s onwards and in particular, following the implementation of the respective mental health reforms. This research was carried out at the national and local scale, and only services for the mentally ill were considered. At the local scale, maps were produced (see Chapters Four and Seven) that show the location of the new community-based mental health facilities in the two cities in 1994. The purpose of these was to consider the geographical locations of facilities across the city and to look for any concentrations or gaps in service provision across the cities. Finally, in order to investigate the geographical consequences of this relocation of services at a deeper level, a case study was made of a mental health service in each city (see Chapters Three, Four and Seven).

2. *To identify neighbourhood profiles/characteristics associated with levels of acceptance of the location of community-based mental health facilities.*

This second research objective focuses upon the responses of the local ‘host’ community who have been defined for this research as those people living in the vicinity of a community-based mental health facility. Much of the previous geographical interest in this field has focused upon the actual and potential reactions of ‘host’ communities, with an interest in the spatial and neighbourhood conflict aspect of community-based mental health care (Dear, 1976; Dear, Taylor and Hall, 1980; Dear and Taylor, 1982; Smith, 1980; Smith and Hanham, 1981a and 1981b). By conducting local resident attitudinal surveys in both Sheffield and Verona (discussed in Chapters Five and Eight) this part of the research has carried on from geographical research that has been done before in this field. The decision-making processes behind the siting of community-based mental health facilities has also been investigated through interviews with health managers and planners, as previous research suggests that perceived or actual opposition by ‘host’ communities may influence this process (Dear, 1992; Gleeson and Memon, 1994).

3. *To investigate the interpretations of 'success' of community care by the different groups involved.*

The third objective represents some new directions of geographical research into mental health care. By making contact with different groups involved in community care, professional city and health planners and professionals who make decisions regarding where to locate community-based facilities and how to manage them, the mental health professionals who work in the community-based facilities and services and the local 'host' residents who live in the vicinity of a community-based mental health facility, I have attempted to gain different views and perspectives on what makes community care a 'success'.

This route of enquiry has had two main purposes - firstly, it was postulated that 'success' to one individual or group may not be seen as a 'success' to another, in fact it may be seen as a failure. For example, the siting and development of a community-based mental health facility in a residential neighbourhood may be considered as 'successful' implementation of community care by health care planners and professionals, but local residents of the facility may have opposed the siting and be unhappy about such a development 'in their backyard'.

Secondly, most of the current geographical research in this field has focused upon the actual or perceived reactions and attitudes of the 'host community' to the location of community-based mental health facilities (Dear and Taylor, 1982; Smith and Hanham, 1981a and 1981b; Moon, 1988) with less attention given to the locational decision-making made by health and public planners or the impact of community care policies upon the mental health professionals who have moved with the long-stay mental patients from institutional to community settings. By using a triangulation strategy, the views of different groups involved have been explored within this PhD, with the overall aim of contributing to a greater geographical understanding and perspective on the changes in mental health care in Britain and Italy.

CHAPTER TWO

CONTEXT AND LITERATURE REVIEW

2.1 INTRODUCTION

“Madness cannot be abolished by relocating it, renaming it, or redefining it as social alienation, political oppression, or an idiosyncratic way of being in the world. Its effects can be modified by treatment but it is seriously distressing and disabling.”

(Robertson, 1991, p.131).

This chapter provides a review of relevant concepts and literature, creating the context for this thesis. The above quotation from Robertson, a consultant psychiatrist who made this comment during a debate on the continued need for asylums, encapsulates some key themes that are to be discussed within this chapter: the changing definitions of ‘madness’ over time and how this has determined the type and location of treatment of those ‘deemed to be mad’; the social and political context within which the treatment of the mentally ill needs to be considered; the fact that mental illness is a chronic and disabling illness which will continue to exist in society, despite attempts in the past to eradicate it.

This research is concerned with the impact of the closure of mental hospitals and the implementation of community care policies in Britain and Italy. As a cross-national study, the research has adopted a cross-cultural perspective which is considered throughout the thesis and within this literature review. Because of the topic area covered by this research, it has been necessary to consider a diverse range of literature, multi-disciplinary in nature, in order to gain a good understanding of the issues involved. The main ‘umbrella’ themes that have been identified form the section headings of the literature review the rest of this chapter.

2.1.1 The development of a geography of mental health

Until recently, research on mental illness and mental health services has been highly specialised and predominantly ‘discipline bound’, with books and articles written generally around single specialisms, notably psychiatry, psychology, sociology, law and so on. However, over the last twenty-five years there has been a growing trend of interdisciplinary analyses of both mental illness and mental health care (Smith and Giggs, 1988, preface). This ‘opening-up’ of mental health research has undoubtedly created a broader and more encompassing arena for a greater understanding of an undeniably complex subject-matter.

The contribution of geographers to this debate has also been relatively recent. Mental illness and mental health service provision cross the research interests of social, political, urban and medical geography with, very broadly speaking, a number of areas of interest. These include the social and spatial exclusion of the mentally ill as ‘outsiders in urban societies’ (Evans, 1978; Sibley, 1981; Philo, 1986; Winchester and White, 1988); a concern with the spatial implications arising from deinstitutionalisation, with the potential for locational conflict and community opposition to the location of community-based mental health facilities (Dear and Wittman, 1980; Dear and Taylor, 1982; Taylor, 1988; 1989) and the ‘ghettoisation’ of the mentally ill in certain parts of cities, along with other ‘service dependant’ groups (Dear and Wolch, 1987; Wolch, 1980; 1981; Wolch and Gabriel, 1984; Wolpert, Dear and Crawford, 1975); an interest on the geographical perspective of mental ill-health and the provision and location of services for sufferers from mental illness (Eyles, 1986a; 1988a; Giggs, 1973; 1991; Smith and Giggs, 1988) which comes under the ‘domain’ of medical geography, now being called the ‘geography of health’.

These different aspects of geographical interest are intricately bound together and it is common that much of the existing research literature on mental health care has combined more than one perspective of enquiry. Geographers with research interests in mental health care have been contributing to the development of a ‘geography of mental health’ (Dear and Wills, 1980; Smith, 1978; Smith and Giggs, 1988) since the

late 1970s, and more recently they have developed the potential of contributing towards a 'geography of and for disability' (Golledge, 1993). So far interest in this field has focused upon vision impaired and blind populations (Butler, 1994; Golledge, 1993); disability and the urban environment (Hahn, 1986); implications for planning and the built environment (Imrie and Wells, 1993a; 1993b); and a theoretical debate concerning what and for whom such a geography should be constructed (Gleeson, 1996; Golledge, 1996; Imrie, 1996).

Philo (1986) traces the development of the geography of mental health from the work of Faris and Dunham, sociologists from the Chicago 'school', published in 1939, with their mapping of the 'urban distribution of insanity rates' from records of admissions to psychiatric hospitals in Chicago. Faris and Dunham's research found a concentration of individuals with mental illnesses, and in particular schizophrenia, in central parts of the city with a discovery that more of these individuals were living alone rather than with their families. Philo comments upon the 'allegiance of this text to the 'human ecology' of Ernest Burgess and Robert Park' (p.34) and that their work introduced ideas of the social isolation of the mentally ill (p.35).

Faris and Dunham's ecological approach of studying mental illness led to the establishment of an 'ecological tradition' in medical geography, with geographers pursuing this particular 'pattern of analysis'. Examples include Timms' examination of 'social defectiveness' in Derby and Luton (1963, cited by Philo, 1986), Giggs' study of the distribution of schizophrenics in Nottingham (1973), and the study by Dean and James (1980) of the spatial distribution of depressive illness in Plymouth. These studies, and a number of others, have contributed in putting 'madness on the map' of geographical enquiry, but alternative approaches have also emerged in the investigation of mental health issues and these will now be discussed.

In the mid-1970s, geographers in North America began to pursue research that investigated the impact of deinstitutionalisation and the introduction of community-based mental health facilities. Work from geographers such as Christopher Smith,

Michael Dear, Martin Taylor, Julian Wolpert and Jennifer Wolch (discussed further in 2.6) placed mental health care firmly on the geographical research agenda, with the 'empirical high point' being reached by Dear and Taylor's study 'Not on our Street' published in 1982 (Moon, 1988). However, Moon (1988) states that the existing geographical research had been 'curiously deficient in two respects. First, in spite or because perhaps of a singular success in generating empirical research, there has been a comparative lack of theoretical underpinning to published work. Secondly, whilst extensive research has been conducted in Canada and the USA, there has been little comparable work elsewhere' (p.203). Adding a third deficiency from Philo (1986), most geographies of mental health have 'entertained a search for general laws'(p.39), whilst neglecting 'the lives and thoughts behind the numbers' (p.41).

2.1.2 The relevance of medical geography

Changing perspectives in medical geography, as detailed by Curtis and Taket (1996), have led to an interest in the socio-cultural construction of health and illness, with a realisation of the importance of culture, drawing upon the new cultural geography, and a growing interest in 'concepts of space and place and how these influence and affect health, health policy and health services provision' (Curtis and Taket, 1996, p.4). Curtis and Taket call this 'fifth strand' (p.18) of medical geography perspective 'the cultural turn,' as it has been informed, in various ways, by the concerns of cultural geography, representing a new interest in the experiences by individuals of their health and ill-health and how these is bound up with the concepts of space and place.

Kearns and Joseph (1993) state that place and space are firmly embedded in urban studies of mental illness (Faris and Dunham, 1939; Giggs, 1973) and that the 'geography of deinstitutionalisation,' with the spatial concentration of the mentally ill and facilities that service them in inner cities constitutes 'an extreme place-specific manifestation of a social restructuring process (i.e. deinstitutionalisation) unfolding over space' (p.713). Philo (1987b; 1989; 1992) has also contributed to this reconsideration of the importance of place in medical geography with his work

exploring the historical geography of the 'mad-business' in England and Wales. Drawing upon the work of Foucault, Philo asserts that the segregation of 'mad' people from the 'normal' round of rest and play was 'an impulse that is at once social and spatial' (1992, p.288). Philo also explains the siting of the majority of the nineteenth century asylums away from centres of population in isolated locations as 'a straight forward exercise in overt social control' (1992, p.292) and that such a practice of socio-spatial exclusion can be viewed not as a natural process but as a social construction that has been 'conceived of and enacted (albeit in different ways, for different reasons and with different effects) by certain societies in certain times and places' (1992, p.293-294).

'Research on the geography of mental health and mental health care can serve to illustrate the changing expression of place and space concepts in medical geography' (Kearns and Joseph, 1993). At a time when medical geography is 'making space for difference' (Kearns, 1995), with an ongoing debate as to the future direction of the sub-discipline (Dorn and Laws, 1994; Kearns, 1994a; 1994b; Litva and Eyles, 1995; 1996; Mayer, 1994; Paul, 1994; Philo, 1996) it appears that socio-medical geographers, with research interests in mental health care, have the potential to make an important contribution to a medical geography.

2.2 CONTEXT OF CHANGE IN CARE FOR THE MENTALLY ILL

'The wheel seems to have turned full circle from community care in the 17th century, through private asylums in the 18th, public asylums in the 19th, and community care again in the 20th century'

(Hall, 1991, p.43)

Changes in the way that people with mental health problems have been cared for over time have been significant, particularly in the way that changing social, political and economic conditions have influenced societal values, social policy and definitions of madness. The public asylum system did not emerge in Europe until the middle of the nineteenth century; before that time it is believed that the majority of people with

mental health problems were care for by their families (Jones, 1993). Thus the idea of putting people who were 'deemed to be mad' away from their families and 'normal' society in an institution is a relatively modern practice. Yet within a hundred years, professional and lay opinion has again swayed away from this practice, with policy now advocating the care of the mentally ill without institutions, with community care. Thus, as suggested by Hall (1991), ideas and practices regarding the care of the mentally ill have now gone full circle. But reversing the process of institutionalisation has proved a major task, with the policies of the nineteenth century having left a powerful legacy (Butler, 1993).

Therefore, before considering changes within contemporary mental health care in Britain and Italy, it is important to reflect upon the historical, social, economic and political context to these changes, for as noted by Tomes (1988) 'mental health care is one area of social policy where the burden of history lies heavy and obvious' (p.3).

2.2.1 The history of mental health care in Britain and Italy (before 1900)

The early social history of mental illness is well documented by Rosen (1968), who traced societal attitudes and care for the mentally ill as far back as the period of classical antiquity in Greece and Rome. Rosen states that even until the sixteenth century in Europe, for the most part, care of the mentally ill was left to family and friends. Therefore the mentally ill were a visible part of everyday life, who were tolerated and remained at liberty as long as they caused no public disturbance (Dear and Wills, 1980).

In Britain, the first hospital set aside exclusively for the insane was London's Bethlem Hospital, known as 'Bedlam', founded as a priory in 1247 and which began to provide care for 'lunatics' about a century later. Up until the middle of the seventeenth century, Bedlam beggars were given a licence to beg and were a common sight in towns and villages in England. In the eighteenth century, 'pauper lunatics' frequently ended up in workhouses or poorhouses of the local parish, particularly if mentally ill individuals became vagrants and had become a 'public nuisance' (Jones, 1993). In

these institutions the 'lunatics' were generally treated just as other vagrants, although the amended Vagrancy Act of 1744 did make a step towards distinguishing lunatics from other social outcasts, legislating for some form of specialised 'care' for them. However, as this was to be provided for locally, the extent of 'care' varied widely and many pauper lunatics simply remained in the parish workhouse (Murphy, 1991).

The situation in the eighteenth century was different for the middle and upper classes in Britain. Wealthy families with mentally ill relatives obtained private care by consulting the growing number of physicians with an interest in insanity; some patients were treated at home and others were cared for in the increasing number of small private hospitals or 'madhouses.' These private madhouses were unregulated until 1774 and many were reported as having appalling conditions with cases of brutality against patients (Murphy, 1991). These 'entrepreneurial' establishments flourished in what Parry-Jones (1971) has described as the 'trade in lunacy'.

Within the pre-unified states of Italy, there is a long history of the Catholic Church providing care for the insane and 'feble-minded', although such provision was relatively small and local in scale (De Bernardi, 1980). More formal provision for lunatics varied hugely from place to place; in 1774 the Grand Duchy of Tuscany introduced one of the earliest laws in Europe to regulate the 'condition of the mad' (Donnelly, 1992) and in 1788, the first hospital specifically for the 'mad' was established in Florence (Mosher and Burti, 1989). In 1813, a 'model' lunatic asylum was established in the Kingdom of Naples; other Italian states also opened institutions for the insane, but it was on a fairly 'ad hoc' basis.

Tagliavini (1985), who has traced the history of psychiatry from the beginning of the eighteenth century, notes how different psychiatric traditions had developed in different places before the political and administrative unification of the country in 1860. Therefore, even at this time, 'it is difficult to refer to an 'Italian psychiatry' as a national enterprise, a unique body of knowledge, a definite and homogeneous profession' (Tagliavini 1985 p. 177). A more systematic provision for the insane did not occur until after 1860, following the unification of the country (Donnelly, 1992).

Mosher and Burti (1989) attribute the fact that the establishment of hospitals specifically for the mentally ill occurred much later and on a smaller scale in Italy compared to other European countries, to 'a more tolerant, somewhat archaic society, based on agriculture and handicraft' as well as 'the influence of the philanthropic attitudes towards the poor and the marginal propagated by the Catholic Church (p.187). In the pre-asylum years then, different countries in Europe were treating the mentally ill in different ways at different times.

The introduction of 'moral treatment'

In the later years of the eighteenth century, new doctrines of 'moral treatment' of insanity emerged in Europe, focusing upon more humane treatments of the mentally ill. In France, at the time of the French Revolution, a physician called Pinel ordered the removal of chains from his patients at the Bicêtre Hospital, introducing *traitement moral* (treatment through emotions) in preference to physical restraint (Jones, 1993). In England, medical practitioners also began to experiment with more humane methods of care and treatment for the insane in particular cities where new hospitals were set up by public subscription, such as St Luke's Hospital in London (1751) and the Lunatic Hospital in Manchester (1752) (Jones, 1993).

In 1792, a charitable asylum called the 'York Retreat' was established by a group of Quakers, led by a merchant called William Tuke. The Retreat was set up as a direct response to what the Quakers perceived as the harsh and brutal care in asylums, following the death of a Quaker woman in the public asylum in York. At the Retreat, a regime of 'moral treatment' was implemented, based not upon medical practice of the time but on 'gentle Christianity,' treating the inmates with dignity and respect (Busfield, 1986; Jones, 1993).

Mosher and Burti (1989) discuss the fact that Vincenzo Chiarugi, the medical director of the first Italian mental hospital, established in Florence in 1788, also practised according to 'enlightened and philanthropic ideas' translating these into new hospital regulations in 1789. However, it is not known whether there was any contact between Chiarugi and other 'moral reformers' elsewhere in Europe.

The birth of the asylum system

In Britain, a combination of recurring madhouse scandals (see Jones, 1993), new 'moral treatment' philosophies and changing societal attitudes led to the introduction of new legislation concerning the mentally ill. The Country Asylums Act of 1808 provided for Local Authorities to build asylums for those unable to afford private treatment. This law was the beginning of an increasing involvement by the state in the institutionalisation of the insane (Barham, 1992). But the motives of the early lunacy 'reformers', who campaigned for further legislation, were humanitarian rather than custodial; public opinion had changed such that the madman was no longer seen as someone just to be locked up but instead as a wayward individual who, if placed in the appropriate moral regime, could eventually be restored to the world of good citizens (Scull, 1981).

The creation of the asylum system in Britain had begun; by 1828 there were nine county asylums in operation and by 1842 a further eight had been constructed. Commissioners, appointed by the 1828 Madhouse Act, regularly inspected the asylums and the increasing political and public interest and concern for the treatment of the mentally ill led to the Lunatics Act of 1845. This law directed the compulsory construction of asylums in every county and established a new Lunacy Commission to regulate all public and private asylums (Jones, 1993).

However, as the nineteenth century progressed, Victorian reformers' good intentions were lost as within a very short period of time the populations in the asylums increased rapidly. Instead of small caring institutions the asylums had become vast custodial institutions, described by Barham (1992), as 'gigantic warehouses for the chronically insane' (p.67). In England and Wales, the number of asylums in 1860 was twenty-four; by 1900 there were seventy seven asylums; and by 1910 there were ninety-one, with an average population of a thousand patients. Between 1859 and 1909 the general population in England and Wales doubled, yet the number of 'people of unsound mind' in institutions more than quadrupled, from 15,845 patients in 1860 to 97,580 patients in 1910 (Jones, 1993).

The design of the new asylums was telling of prevailing public opinion of the time, as discussed by Philo (1989). High walls and long drives kept patients away from the outside world and long straight corridors made for easy surveillance (Jones, 1993). The prevailing attitude of 'out of sight, out of mind' was reinforced by the 1890 Lunacy Act in Britain which permitted people to be certified to an asylum without their consent. The 1890 Lunacy Act remained the primary legislation for mental health care until the Mental Health Act of 1959.

According to Tagliavini (1985) mental health care in Italy in the nineteenth century was greatly influenced events in by France. In 1838, the French Lunacy Act was passed; France was the first European country to institute the practice of 'mental medicine', with the Lunacy Act providing for the establishment of a national network of asylums and defining a legal status for the insane and for the doctors caring for them (Mangen and Castel, 1985). Following the French experience, in the second half of the nineteenth century, every Italian state established lunatic asylums (public and/or private) with physicians to supervise them.

In the second half of the century, with the emergence of the new Italian state, a new 'national consciousness' of psychiatry developed, with psychiatry emerging as an autonomous discipline with a distinct professional identity. From the 1870s onwards, psychiatrists organised themselves as a professional body, independent, as a separate profession, from medicine (Tagliavini, 1985). During the second half of the nineteenth century in Italy there was an increase in the number of public and private asylums and the population in asylums increased enormously, from about 12,000 in 1894 to 40,000 in 1907; this was the age of 'the great confinement' in Italy (Tagliavini, 1985). The rate of confinement was, however, only roughly half that in England and Wales at the same period.

The increase in madness - alternative perspectives

The emergence of asylums in Britain and Italy therefore was part of an international phenomenon, with the development of new 'sites' and new methods for the treatment of the mentally ill occurring right across Europe and North America. But this new social phenomenon was occurring at different timescales in different places. As stated by Tagliavini (1985), the age of 'the great confinement' in Italy was between 1894 and 1907, whereas in England and Wales the timescale was between 1860 and 1910, a much longer period.

Scull (1979; 1981), has traced the changes in the treatment of the 'mad' between the mid-eighteenth century and mid-nineteenth century in England. He attributes the increases in the numbers of certified mad to the expansion of the boundaries of definitions of madness, in response to the changing economic and social conditions of nineteenth century England, with industrialisation, urbanisation, an increase in the urban poor and changing moral values. Asylums became the dumping place for dependant, economically useless and potentially troublesome family members who became 'inconvenient' in the eyes of families, neighbours and the authorities. Such individuals had not changed over this time but society's perception and treatment of them had; in Victorian society there was no longer a viable social place for such individuals and thus they were socially and spatially excluded from it.

According to Tagliavini (1985) the situation in Italy was quite similar. The majority of the asylum population was made up of the lower classes and Tagliavini attributes social and economic reasons for this, in response to rapid social change at this time with widespread poverty and hardship. Boundaries of madness broadened and sufferers from alcoholism and 'pellagra' (a physical disease caused by poor diet) were frequently found in asylums at this time (Tagliavini, 1985).

After its consolidation as a nation in 1860, Italy faced social problems relating to industrialisation, that more advanced European countries (England, Germany and France) had experienced decades before. The flow of large masses of people to rapidly expanding cities led to a deterioration of the lives of the urban lower classes,

with large increases in unemployment, poverty, homelessness and vagrancy (Galzigna and Terzian, 1980). These 'uprooted and vagrant people' posed serious problems of public order and many of them were incarcerated in institutions 'suitable to contain and manage them in a disciplined way' (Mosher and Burti, 1989, p.188). During the second half of the nineteenth century, the numbers of institutions and patients increased only in the northern, more industrialised regions, whilst there was little change in the south of the country (Galzigna and Terzian, 1980). The consequences of this development, with the establishment of public asylums mainly in the north of the country, would be seen a century later, as discussed in Chapter Seven.

Foucault (1967) attributed the emergence of 'houses of confinement' across Europe from the seventeenth century onwards, to the state of the contemporary political economy at that time, linking changes in social policy to times of economic crises. At such times, the asylums absorbed and contained the unemployed and vagabonds, guarding against agitation and unrest, thus fulfilling a function of repression and social control. 'Throughout Europe' stated Foucault, 'confinement had the same meaning, at least if we consider its origin' (1967, p.49). These 'enormous houses of confinement' were designed for the social segregation of a wide ranging collection of social 'misfits', as defined against the context of mainstream society at that time. At this time, the mentally ill were treated no differently to other 'deviant' groups. However, by the nineteenth century the mentally ill had been clearly and sharply distinguished for specialist treatment throughout Europe, finding themselves incarcerated in a 'specialised, bureaucratically organised, state organised asylum system which isolated them physically and symbolically from the larger society' (Scull, 1979, p.14.)

Foucault saw the mentally ill as replacing the lepers as society's social outcasts; he wrote 'the asylum was substituted for the leper house, in the geography of haunted places as in the landscape of the moral universe' (1967, p.57). This socio-spatial segregation to which 'the Same' (mainstream society) banished their mentally disordered 'Other' to the outskirts of towns and cities, implies a careful manipulation of space in order to separate 'normality' from 'deviancy' (Philo, 1992). The mentally

ill were therefore banished into what Wolpert (1976) termed 'closed spaces'. Despite the declared intentions of asylums to reform or cure the 'lunatic', Philo (1989) argues that this method of care not only had the purpose of social control but also effectively led to the socio-spatial reproduction of madness.

The role of psychiatry

The changing definitions of 'madness' over time are also strongly linked to the evolving role of the psychiatric profession. Since the emergence of the asylum system in Europe in the nineteenth century, psychiatrists have become the 'experts' on mental illness. 'Madness' was re-defined as 'mental illness,' becoming a diagnosed illness which therefore only doctors were qualified to treat (Scull, 1979). The 'medicalisation' of madness reflects a similar situation of general medicine, with reference to the work of Illich (1975; 1977), who contends that the professionalisation of medicine has created a culture of dependency on the medical profession, giving doctors a great deal of power which they have used to enhance their own interests and perpetuate that power. Therefore the increases in those diagnosed as insane could be considered as a deliberate policy by psychiatrists to further the status of their profession.

In Britain, in 1841 the asylum doctors sought to establish professional autonomy by creating their own professional organisation, the Association of Medical Officers of Asylums for the Insane. However, as the medical profession evolved during the nineteenth century, the position of the asylum doctors remained vulnerable as they were frequently attacked both by mainstream doctors, for lacking medical knowledge, and by the legal profession, who realised the increasing power and status of the asylum doctors and subsequently took new interest in lunacy law. Thus the asylum doctors were under constant attack (Jones, 1993) and spent the rest of the century consolidating their position of monopoly over the mentally ill by securing control over the asylums (Scull, 1979).

As already mentioned, in Italy, it was not until the 1870s that psychiatrists organised themselves as a professional body (Tagliavini, 1985). However, it was not until the

first national mental health legislation in 1904 that Italian psychiatry was ratified as a defined scientific discipline (Mosher and Burti, 1989). But in Italy, psychiatrists already had greater political and professional power than their counterparts in Britain. Tagliavini (1985) states that some psychiatrists in the nineteenth century were active in politics, some of them were even senators in the Kingdom of Italy. These psychiatrists were influential in the construction of new asylums in the second half of the nineteenth century and were also instrumental in determining the flavour of legislation, passed in 1904, which gave psychiatrists total power over the public and private asylum systems and established the concept of the danger to society from madness and of the need for juridical and psychiatric control. The political involvement of the psychiatric profession in mental health in Italy is something that has been perpetuated into the twentieth century, as will be discussed further in Chapter Seven.

By providing a means of disposing of society's undesirables, the discipline of psychiatry provided a well-refined, scientifically sound and therefore acceptable means of social control of the mentally ill, the group that became the socially constructed 'outsiders' of western society . Psychiatrists were well paid for their services and given a lot of power, which has been another important factor of resistance to the process of deinstitutionalisation in the twentieth century.

2.2.2 Mental health care in the twentieth century

The history of the establishment of the asylum system has been a shared European experience, but the twentieth century has seen a departure from similarity to a situation of difference and diversity. The reason for this, according to Mangen (1985) has been the varied speed at which different countries have recognised the need for change and then put policies into practice. For example, Britain and France (as well as the USA) were the first countries to make moves away from institutional care from the 1950s onwards. Other countries were not actively seeking alternatives to the hospital until relatively recently, for example Italy, Belgium and Germany. It is therefore important to consider why the trend of dissatisfaction with institutional care,

which has now changed the focus from institutional to community care for the mentally ill in all western industrialised countries, reached different places at different times, over a thirty year timescale.

Until the second world war, there were many similarities between the mental health systems in Britain and Italy, with a sharing of the clinical-somatic approach to mental distress and the dominance of the large asylums with custodial and regimented systems (Ramon and Giannichedda, 1991). However, in post-war Britain the regime of the hospitals started to change, with open wards, some therapeutic communities, more occupational therapy, the introduction of psychological approaches towards mental illnesses and the emergence of psychotropic drugs in the 1950s. This did not happen at this time in Italy.

The complexities of Italy's experiences during the second world war left the country with problems of famine, destruction and corruption. A new republic was declared in 1946, with attention in the post-war years focused upon industrialisation and the development of the Italian economy rather than social and political reforms. With the industrialisation of northern Italy, the period 1945-1968 saw a period of massive south-north migration, creating economic, demographic and social changes. The Italian health care system received less attention and the psychiatric service saw few changes during the post-war years. Until the late 1960s, most wards were locked and many people were still restrained in straightjackets or chained to their beds (Ramon and Giannichedda, 1991).

In Britain, provision for the move towards community care was first made in the 1959 Mental Health Act. In Italy, despite the fact that some psychiatrists were becoming dissatisfied with a lack of progress, compared to elsewhere (see Chapter Seven) the closure of mental hospitals was not put forward in legislation until 1978. Clearly, as with the establishment of the asylums in the nineteenth century, social, economic and political factors were crucial factors determining these temporal differences.

Changing ideologies

It is relevant also at this point to briefly discuss ideological influences which contributed towards changing attitudes towards mental illness in the 1960s. In 1961 three influential academic studies were published: Goffman's sociological study of the effects of institutional life in the United States (*Asylums*), Szasz's critique of the role of psychiatry in mental health (*The Myth of Mental Illness*) and Foucault's historical study of madness, published in French (*Madness and Civilisation: A History of Insanity in the Age of Reason*) which was not translated into English until 1965 (published first in the USA and then in Britain in 1967). It is important to appreciate the timing and context of these publications, at a time in Britain when further community care provision was being planned (Jones, 1993) and the contribution made by these publications to new ideas and philosophies that were spreading rapidly internationally, influencing practitioners and policy makers alike.

The developments in the mental health care systems in Britain and Italy from the 1950s onwards are considered in greater detail in Chapters Four and Seven respectively. From the current review of the changes over time in the treatment of the mentally ill in Britain and Italy, two things are clear. First, there are some similarities of experience, with the establishment of asylums in the nineteenth century in both countries and with the development of the psychiatric profession to run them. But secondly, the timing of changes and the way in which they have occurred has varied considerably between the two countries. The legacy of this situation is perpetuated and also repeated with the implementation of mental health reforms in the latter part of the twentieth century, as will be addressed later in the thesis.

2.3 PERCEPTIONS AND ATTITUDES TOWARDS THE MENTALLY ILL

Much of the existing geographical literature on mental health has considered local community attitudes towards the mentally ill and the facilities being provided for them, for as Dear and Wittman (1980) state:

'attitudes of the host neighbourhood towards the mentally ill are major determinants of the success of a community based mental health service' (p.354).

This is because successful opposition to the siting of a facility can effectively exclude the mentally ill from many residential areas, which can accordingly contribute to a geographical unevenness of the distribution of mental health facilities within an urban system. Clearly, therefore, the reactions of local residents to these facilities have an important influence on the evolving geographical distribution of community-based mental health facilities and the people with mental health problems that they serve. (Geographical attitudinal studies are discussed in greater depth in Chapter Five).

2.3.1 Attitudinal research

There has been a great deal of research over the last forty years on public attitudes towards the mentally ill. Much of this has been summarised and classified by Rabkin (1980). One of the common findings of most of this research is that the general public has apparently become increasingly more tolerant towards the mentally ill. Yet a number of studies (Dear, 1992; Smith, 1980; Smith and Hanham 1980a; 1980b; Wall, 1986) and media reports (The Sunday Express, 12/8/90; The Independent, 22/11/90; The Guardian, 28/7/93) suggest that although the public may in theory accept the benefits of those with mental distress living within a 'therapeutic' community, they do not want the facilities or the people that they serve living within their own residential neighbourhood.

The authors of a recent mental illness survey carried out by the Research Surveys of Great Britain Omnibus (1993), funded by the Department of Health, claim from its findings that ninety-two per cent of the two thousand respondents believed that 'society needs to adopt a more tolerant attitude towards people who are mentally ill' and seventy-seven per cent of respondents agreed that 'mental health services should be provided through community-based facilities'. However, only nineteen per cent of the same respondents agreed that 'most women who were once patients in a mental hospital can be trusted as baby-sitter'. Clearly and perhaps understandably, when mental illness comes 'closer to home' the general public's true perceptions and attitudes overtake their general sympathy for the mentally ill.

Another recent attitudinal survey conducted by the mental health charity MIND (1994) had similar contradictory findings. The survey, which was conducted with 1,000 adults, found a high level of endorsement for the policy of community care for people with mental health problems, although many thought that insufficient resources were being made available for it. At the same time, over half those questioned were concerned about risk to the public from dangerous mental patients. According to the authors of the report, this general support for community care, accompanied by the continued perception of risk, demonstrates how confused the general public is about mental health.

Compared to North America, there has been relatively less research on attitudes towards the mentally ill in Europe. Hall, Brockington, Eisemann and Madianos (1994) provide a useful summary of the results of some existing studies and give more detailed results from four studies conducted in Sweden (Umea), Italy (Naples), Greece (Athens) and Britain (Worcester). The four studies were carried out independently and only eleven questions were more or less comparable. With a number of the questions, there seemed to be a clear north/south Europe divide, with the British and Swedish respondents appearing more informed and tolerant of the mentally ill (results from the British and Italian studies will be discussed further in Chapters Five and Eight). However, it is important to note that these studies selected their samples differently, had different sample sizes, used terms which may mean

different things in different cultures and languages and were conducted in quite different places. As stated by the authors, 'clearly one should not read too much into these studies, as it difficult to compare Naples or Athens with a small English town or with Sweden' (p.179).

This point is also make by Taylor (1989), who suggests that there are problems with accepting the findings of attitudinal research at face value, which may help explain such contradictions in findings. Firstly, when asked about attitudes towards mental health facilities, many respondents report their attitudes towards a hypothetical facility rather than one that is actually proposed or existing in their neighbourhood. Secondly, different surveys will have used different methods to collect their data, asked different questions, used different ways to measure and analyse attitudes. Therefore it is difficult to generalise on the findings of these surveys.

2.3.2 Perceptions about mental health facilities

Dear and Taylor (1982, pp.116-118) discuss the fact that frequently opposition to mental health facilities is limited to a 'small vocal minority'. But it has to be recognised that if the minority have political power and influence, then they can succeed in opposing a facility location, particularly if the non-opponents remain neutral and do not voice their support. Such a scenario does not seem to be uncommon and can explain the claim that as many as half of all mental health facilities planned for residential areas may have been blocked by community opposition (Piasecki 1975, cited by Rabkin, Muhlin and Cohen, 1984) and Dear (1992) fears that such opposition seems to be increasing.

According to Dear and Wittman (1980), if opposition arises from local residents regarding the siting of a community-based mental health facility it is frequently based upon: fears for personal and property safety; a concern about anti-social and possibly violent behaviour from the users of the facilities; the expectation of property value decline; increased traffic and noise in the vicinity. They make the distinction between the qualitative or intangible effects and quantitative or tangible effects; the

intangible effects relate to perceptions and expectations with regards to the behaviour of the clients of the facility whereas the tangible effects relate to the facility itself and its operation (p.353). They suggest that in many cases of conflict, what begins as intangible opposition quickly transfers into tangible opposition. The explanation given for this is that such a shift seems necessary to gain credibility in public debate.

The role of the media can also be seen to play an important part in the formation and reproduction of people's attitudes towards the mentally ill. Taylor (1989) stresses the importance of 'the exaggeration of opposition due to conflict situations that become media events' (p.321) and the fact that 'situations in which facilities are introduced without conflict do not attract media and thereby public attention' (p.321). With few exceptions, media coverage tends to concentrate on the failures and difficulties of community care deemed as sensational and sellable (Ramon and Giannichedda, 1991). The successes of the policy are rarely mentioned. So headlines such as *'The tragic scandal of a schizophrenic killer nobody stopped'* (The Independent, 19/7/93), *'Mentally ill people kill 32 in a year, study finds'* (The Independent, 14/8/93) and *'Psychiatric unit linked to deaths of 32 patients'* (The Independent, 5/12/94) do not assist in improving the public's perceptions of people suffering from mental health problems.

However, a recent study in Britain by Wolff, Pathare, Craig and Leff (1996) suggests that the key to improving the general public's perceptions and tolerance of the mentally ill and facilities that serve them may be to be more open about new developments and provide more information about them. This research conducted a 'controlled' study of residents in two neighbourhoods prior to the opening of community care homes for former mental patients. Local residents in both areas were interviewed using Taylor and Dear's (1981) community attitudinal scale (CAMI) before the opening of the facilities and in one area, a public education campaign was conducted. This involved providing the local residents with information packs about mental illness and invited them to social and information-giving events at the new facilities. The researchers found that two years after the initial interviews, a greater integration of the mentally ill had occurred in the experimental neighbourhood, where

the mentally ill living in the facilities had made social contact and even friendships with neighbours, whilst in the control area, this had not happened.

2.3.3 Profiles of opposition

Many studies have shown significant relationships between various personal characteristics and attitudes towards the mentally ill. Rabkin (1980) in her summary of the research literature, comments that demographic variables such as age, education, social class and ethnicity have been studied in this context. Some consistent findings have shown that people found to be less tolerant towards the mentally ill are generally male, older, less educated and of lower occupational and social status. With respect to ethnicity, the more established ethnic groups expressed greater tolerance than the most recently arrived. Also personal acquaintance and experience with the mentally ill is associated with greater acceptance (pp. 23-24). Other characteristics taken into account by studies reviewed by Rabkin include the type of facility, its location in relation to other facilities and private households and the characteristics of the facility's users, in that more disturbing behaviour from the clients will attract greater attention to the facility and therefore there is greater potential for negative attitudes and opposition.

Dear and Taylor (1982) carried out research in Toronto on community attitudes towards mental health facilities and the mentally ill. In their conclusion, they suggest a methodology for predicting typical profiles of accepting and rejecting neighbourhoods. Although their results provided no strong relationships, they tentatively conclude that 'rejecting neighbourhoods are those where there are young children, low education levels and non-English speaking groups, where the population is relatively stable and population density is low and where the land use is predominantly residential. It follows therefore that accepting neighbourhoods are those in which residents have few children, are well educated and predominantly English speaking, where the population is relatively transient and there is a mixture of land uses with commercial development and public open space in addition to residential areas' (p.153).

Dear and Taylor admit that these predictions are not rigorously proven. It is clear therefore, from this study and others (see Rabkin, 1980) that public attitudes towards mental health facilities and the mentally disabled are, as discussed Dear and Wittman (1980), multi-dimensional in nature and difficult to predict.

2.3.4 Beliefs, norms and values

As already mentioned, recent surveys suggest that tolerance of the mentally ill is improving. One of the reasons given for this is the greater acceptance of the medical model of illness, with an understanding of mental illness as being like any other illness; accordingly people have adopted a more compassionate, non-judgmental attitude towards the mentally ill (Jones, 1993). But others have suggested, on the basis of labelling theory, that with the increase of de-institutionalisation, public opinion may harden because of greater contact between those labelled as mentally ill and the general public (Rabkin, 1980; Taylor, 1988).

Social scientists such as Goffman (1961; 1963), Lemert (1951), Scheff (1966) and Szasz (1961) are prominent figures in promoting the labelling theory of deviancy with regard to mental illness. Scheff, for example, regards mental disorder as a type of behaviour which is judged by the dominant norms and values in society as 'deviant' and therefore socially unacceptable. According to this view, mental illness does not so much 'exist', rather it is a social construction specific to a particular culture and time (Mangen, 1982). For example, terms such as 'madness', 'lunatic' and 'insanity' in our language are far more socially created words than medical terminology.

According to labelling theory, once the label of 'mentally ill' is attached to an individual, the stigma of this label is continually re-reinforced by 'significant others' until the individual's social identity and concept about themselves is organised around the label. Such a process Goffman describes as a 'moral career', where an individual learns to cope with the responses and attitudes of the 'normal' majority and eventually accepts the identity as his/her own.

2.4 COMMUNITIES AND CARE

'What kind of care? What community?' (Derricourt, 1983).

The aim of the community care policy in Britain is to give people needing care the opportunity 'to live as independently as possible in their own homes or in homely settings in the community' (DHSS, 1989, p.3). This is the ideology of community care in Britain, yet in practice such ideals seem far from reality and as far as Ramon (1991) is concerned, community care has been 'bedevilled by a conceptual muddle, a policy muddle and a practice muddle' (p.x). Some commentators even argue that the policy has been a failure as it was a completely inappropriate model of care in the first place (Baldwin, 1993).

According to Derricourt (1983), a particular source of confusion about community care is the prefix 'community'. The term community is one of great ambiguity with a variety of definitions and interpretations attributed to it. The discussion that follows provides a brief review of the complexity of debates over the concept, since the focus in this thesis is on the implementation rather than the conception of 'community care'.

2.4.1 The concept of community

Some of the key questions that the research literature addresses concerning the concept of community are the following: do communities actually exist? If they do, are there then different types of communities? Does localism still have significance in the community debate or is the social organisation of society based upon different criteria? Is the whole concept simply an ideology, as suggested by Eyles (1986b), or just a myth (Stacey, 1969). Can the term community be synonymous with 'neighbourhood' or 'social networks' and in what circumstances (Knox, 1987)?

There is a vast amount of literature on the subject of communities that attempts to address some of these questions, yet definitions and explanations of the term vary greatly, as illustrated by the following quotation from Pereira, 1993:

'The word 'community' is, nowadays, a ubiquitous term. It crops up in all kinds of situations though its meaning remains elusive. 'Community' has been used in senses that include the personal, political, cultural, geographical, historical, national and international.' (p.5)

A useful definition of 'community' is given by Eyles (1986b) in 'The Dictionary of Human Geography, edited by Johnston, Gregory and Smith, as the following:

'A spatially delimited set of interacting face to face groups with common elements such as area, common ties and social interaction, suggesting that much of the everyday life in a locality is underpinned by shared values'.

This definition continues to describe the concept of a community as an:

'evocative idea, used to refer to a place or sense of calm, refuge and harmony in an increasingly individuated and competitive world'.

In this way then, Eyles continues by stating that:

'community as ideology becomes superimposed on the reality'.

Knox (1987) gives a summary of different literature and viewpoints in respect to communities. He classifies the literature according to three main categories: 'community lost', 'community saved' and 'community transformed':

'Community lost'

According to classic sociological theory, communities should not exist at all in cities and if they did it would be a very weak existence. Tönnies (1887) presented two basic forms of society, *Gemeinschaft* and *Gesellschaft*. The former described a pre-industrial set of social relationships based on kinship networks with 'cohesion and continuity'. The latter is seen as a product of urbanisation and industrialisation that led to the breakdown of family ties and has resulted in relationships purely based on social and economic terms. The work of Tönnies has been reinforced by Wirth (1938) and Webber (1964).

'Community saved'

Studies, again from sociology, give empirical evidence to support the existence of socially cohesive communities in cities. Gans (1962), who studied the Italian quarter in Boston, suggests that 'urban villages' exist within the inner city. Another classic study is Young and Willmott's study of family and kinship in Bethnal Green in 1957, who found a 'sense of community' amongst a working-class community in East London. But these two studies found this 'sense of community' among ethnic and working class neighbourhoods respectively, in segregated 'social areas' where neighbours are likely to share similar experiences and therefore consider each other as 'social peers'; social homogeneity is perhaps the greatest force in creating 'community spirit' (Cater and Jones, 1989, p.172). Young and Willmott have also been criticised for giving a romantic and one-sided picture of Bethnal Green and of 'community' in general, highlighting only positive elements of the lives of the people that they studied (Cornwell, 1984).

'Community transformed'

Suburban life, in contrast to the urban village, is characterised by more loose-knit networks. Mumford (1940) wrote that the suburbs represent a collective attempt to lead a private life. Yet further research shows that many suburban neighbourhoods do contain localised social networks, for example Gans's study of Levittown (1967). Such communities, according to Knox (1987), should perhaps be considered in the terms of breaking down (instead of breaking up) into an ever-increasing number of

independent sub-groups, only some of which are locality based. Another important issue, discussed by Cornwell (1984), is that different people living in the same place have different experiences of living in a 'community' according to their gender, age and occupational status. To illustrate this point Cornwell discussed a married couple who experience 'the community' quite differently as 'the spaces they occupy - socially as well as geographically - are different' (p.50).

In conclusion then:

'community as a concept is multi-dimensional in nature and does mean different things to different people; its meaning will vary from time to time and from place to place, even within the lifetime of an individual'

(Davies and Herbert, 1993, p.184).

2.4.2 A 'caring community'?

The concept of a 'caring community' is an ambiguous and vague term which can be seen to contribute to the ideological confusion surrounding community care. Such a concept suggests firstly that such a community actually 'exists', which as previously shown, is not something that is universally agreed upon. Secondly, it assumes that the community is prepared to participate, with care in the community also being implied as care by the community (Bayley, 1973).

Philip Abrams (1977) suggests that 'a convenient and in some ways useful definition would see community care as a matter of the provision of help, support and protection to others by lay members of societies acting in everyday domestic and occupational settings' (p.125). However, Abrams stresses that such 'community care' should be a complement rather than an alternative to other forms of social care. In this way then, Abrams sees community care, in theory at least, as a meeting ground between formal and informal care. But Abrams acknowledges the reality of the situation that the majority of informal care is in fact provided by kin and most of this is by women.

Walker (1989) suggests that the reality of the community care policy in Britain, with the promotion of a 'mixed economy of welfare' by the government, has in fact led to a huge and deliberate growth in the informal care sector. With a reduction in resources for the provision of services by the state, this has led to the greater reliance on families and particularly on women as carers. This latter burden is discussed further by Finch and Groves (1983), Williams (1993) and Graham (1993). According to Walker (1989), these shifts in community care policy have been paralleled by a push from the New Right of the Conservative Government to transfer the responsibility for care from the state back to the institution of the family. Such a policy shift is interpreted by Walker as an attempt to adopt a cheaper option of care for dependent groups in the British population.

In Britain, the debate regarding community care focuses upon the demise of the welfare state and the increasing burden of care not on the 'community' as a whole but on the families and carers of those requiring care and support. In Italy, however, the situation is rather different with the family still playing a primary role in caring for its members. There is a tradition of care being provided by the institutions of the church, the family and by private charitable organisations and these have perpetuated an alternative to state provision, which is certainly less developed in Italy than in Britain. Community care services are designed to supplement family care, enabling dependent people to remain at home. Dependence on care by women in the family system is high (Means and Smith, 1994) and with a much lower percentage of women in employment compared to Britain, it must be assumed that Italian women face an even greater obligation than their British counterparts to provide a caring role for dependent relatives.

2.5. PUTTING THE TOPIC INTO A GEOGRAPHICAL CONTEXT

The changing locational pattern of mental health services has been described by Moon (1988) as an 'urbanisation of care'. This description reflects the fact that there has been a change in emphasis from care out of the community to care in the community (Bayley, 1973), which has resulted in a spatial relocation of people (staff and clients) and resources from long-stay hospitals, frequently located on the outskirts of towns and cities, into a predominantly urban environment.

The introduction of new mental health facilities within an urban environment has the potential to be the cause of urban neighbourhood conflict, which is one of the reasons why the issues surrounding de-institutionalisation have become a subject of geographical inquiry (Philo, 1987). This view is further emphasised by Burnett and Moon (1983) who stated that '*locational conflicts involving residential and day facilities for dependent and deviant groups are evidently now firmly fixed on the research agenda of urban political geography*'. This is because the spatial relocation of people and resources into the community has added these community based facilities to the list of so called 'noxious' facilities, the siting of which are frequently the subject of community resentment and opposition (Cox and Johnston, 1982).

Community based mental health facilities were found by Smith and Hanham (1978a; 1978b) to be perceived as one of the facilities people least want to live close to. Smith (1980) has transferred these results into diagrammatic form, which shows that respondents group community mental health facilities with facilities such as prisons, mental hospitals and rubbish dumps, as the most noxious of facilities, which they would choose to locate elsewhere in the city (see Chapter Five).

Such attitudes have been popularly called the *NIMBY syndrome* (Not In My Back Yard), or *NOOS* (Not On Our Street), where local residents want to protect the 'quality' of their residential environment by resisting attempts to locate an undesirable facility in the vicinity of their home. When local residents organise themselves

against an actual or perceived threat of a noxious facility, such a response is referred to as *neighbourhood activism*, an example of *locational conflict*.

2.5.1 Locational conflict and neighbourhood activism

'The local residential environment provides the most common locus of conflict within the city not simply because residential areas comprise the largest land use, but because of the strong commitment that people have to the immediate area in which they live.'

(Robson, 1982, p.45).

Locational conflict is geographically concentrated in a specific place and almost invariably focuses on public decision making (Dear and Long, 1978). Such conflicts are typically between residents and a group in authority like local authorities, planners and developers (Kirby, 1982), as evident in many examples of geographic research on spatial conflict (Collison, 1963; Dear and Long, 1978; Robson, 1982; Rowley and Hayes, 1990). But could it be that underlying such 'residents versus officials' conflict, there is a deeper social conflict in operation, as suggested by Robson (1982)? He describes the conflict of his case study as, on the surface, being motivated by the problem of extra road traffic in a residential area. Yet the 'hidden agenda' of the problems were 'basically concerned with the socially motivated cleavage between private and public households' (p.46).

Cox and McCarthy (1982) describe neighbourhood conflict as a 'politics of turf', a type of social conflict that is spatially based. Neighbourhood activism is a response by residents to a real or perceived threat to the 'quality' of the environment in which they live. The households involved may come together and organise opposition against a commonly felt threat because of their set of common interests, their same place of residence. Such activism is 'spatially variant, at any one time activism will be apparent in some neighbourhoods but not in others' (Cox and McCarthy, 1982, p.196).

There has been a great deal of geographical research on the subject of neighbourhood activism, particularly in N. America. Much of this concentrates on identifying particular characteristics of the activists, for example, house-ownership, socio-economic class and presence of children, to see whether these characteristics make individuals more aware of neighbourhood problems and prepared to do something about it.

It is suggested by the literature that owner-occupiers are more likely to become involved in activism than tenants (Agnew, 1978; Cox, 1982). But Cox and McCarthy (1982) question whether such a 'house ownership effect' may in fact be disguising the effect of socio-economic status, as individuals of a higher status are more likely to own their own homes. Marshal (1968) states that activists are likely to be of a higher socio-economic status and are better educated. Pinch (1985) argues that the middle and upper income groups are better organised to resist the location of unwanted facilities.

More affluent households can afford to locate themselves in desirable residential neighbourhoods that avoid negative externalities like football grounds (Bale, 1980), roads or airports (Kirby, 1982). They locate instead where there are favourable positive externalities like access to 'salutary' facilities such as parks, good schools and libraries (Burnett and Moon, 1983). Therefore, if a perceived 'noxious' facility, such as a community mental health facility, threatens to locate in close proximity to such households, the potential for conflict is evident and clearly spatial. However, the suggestion that affluent and educated individuals are more likely to become activists contradicts research reported in 2.3.3. that suggests that individuals with such characteristics are more tolerant of the mentally ill. Clearly the whole issue of who opposes what is not at all straight forward.

Neighbourhood activism therefore can be seen to be 'fired by self-interest' (Kirby, 1982) and to represent the response by particular groups of residents wanting to protect their own territory and financial interests that are fixed in location, particularly if they are homeowners (Agnew, 1978). Cox and McCarthy (1982) go

further by putting such activist behaviour in a historical context, that of advanced capitalist societies. They explain neighbourhood activism as an outcome of class conflict and state that 'people are what they are because of the relationships in which they stand to others' and that 'the problems to which neighbourhood activism is a response, therefore, seem to be situated within the urban development process as it occurs within advanced capitalism' (pp.211-2).

2.5.2 The social geography of the city

To explain urban spatial processes, geographers have increasingly turned to a paradigm based in conflict theory, conceptualising the social geography of the city as an outcome of a power struggle amongst various competing groups (Castells, 1977; 1978; 1983; Harvey, 1973; 1982). Knox (1987) summarises the work of urban theorists and suggests that the spatial structure of the city cannot be understood without reference to group competition and group conflict which occurs over the organisation of city neighbourhoods and the location and allocation of services and amenities. In addition, socio-spatial processes such as gentrification, polarisation and marginalisation are creating a new 'social order' in the inner cities and leading to constraints on the residential location and activity spaces of marginal groups (Winchester and White, 1988).

Dear and Wittman (1980) refer to the work of Harvey (1975) on the 'theory of residential differentiation' in order to try to explain the mechanisms of community exclusion of the mentally ill. They suggest that just as the processes of residential differentiation create separate neighbourhoods based on class and ethnic divisions, so similar processes can be seen to isolate and exclude the mentally ill and other marginalised groups from these neighbourhoods. The outcome of these underlying socio-spatial processes in many inner cities is the rise of the concentrated 'service-dependent population ghetto' (Wolch, 1980, 1981; Wolch and Gabriel, 1984). The mentally ill have also been affected by the social process of deinstitutionalisation which, according to Dear and Wolch (1987), has led to the ghettoisation of the mentally ill in the core areas of North American cities.

In conclusion then, if one accepts the conflict approach in order to explain the social and spatial organisation of the city, and that individuals and interest groups are basically self-interested and will constantly compete for space within the urban environment, then community exclusion can be seen as a predictable response to de-institutionalised mental health care (Taylor, 1989).

2.6. GEOGRAPHICAL STUDIES OF COMMUNITY-BASED MENTAL HEALTH FACILITIES

As already mentioned (2.1.1) most of the geographical research to date concerning mental health care, has been conducted in Canada and the USA. Legislative and academic history perhaps provides the reasons for such a N. American domination of the research on this topic. Legislation in both countries in the early 1960s has meant that the geographical impact of the closure of asylums was seen much earlier than anywhere else (Moon, 1988).

One particularly interesting finding of the North American studies has been the tendency for mental health facilities to become geographically concentrated in low income, inner city communities in major cities, for example in Toronto, San Francisco and Winnipeg (Dear and Taylor, 1982; Dear and Wolch, 1987; Currie, Trute, Tefft and Segall, 1989). These studies have suggested that a 'ghettoisation of the mentally ill' has developed and that the isolation of the asylum is in danger of being replaced by an 'asylum without walls' (Wolpert, Dear and Crawford, 1975). Therefore the spatial isolation of the mentally ill is still occurring, but a new spatial partitioning has been devised, situated in the community (Dear and Wittman, 1980).

As far as I am aware, there have only been three geographical studies on the provision and location of facilities for the mentally disabled in the UK. The studies have been based on services in the cities of Northampton, Nottingham and Portsmouth by John Eyles (1986b), John Giggs (1990) and Graham Moon (1988) respectively. All three studies, like the North American ones, have found a geographical concentration of facilities within 'disadvantaged' neighbourhoods in the cities that they studied.

2.6.1 Geographical concentration of mental health facilities

The tendency for new community-based mental health facilities and their clients to be clustered in geographically limited parts of many inner cities has attracted increasing attention in the geographical and psychiatric literature (Dear, 1981) and there are a number of factors that have been suggested which may contribute towards an understanding of such a geographical concentration.

Giggs (1990) found such a pattern in his study of the location of facilities for the mentally handicapped and the homeless in Nottingham and he contributes three main factors to explain this. Firstly, a 'structural' influence due to the urban geography of the city. As the financial resources of charity and private organisations that provide hostel accommodation in Nottingham are limited, they have generally bought large, old and relatively cheap houses for conversion; such houses are mainly located in the centre of the city. Eyles (1986a) found a similar concentration of private homes and hostels in old and relatively cheap terrace housing, located in the east and north-east of Northampton, close to the town centre.

Secondly, Giggs (1990) accounts for the influence of the attitudes and responses of community residents to both the facilities and their clients, for as already discussed, successful opposition in other residential areas can lead to an unevenness in the spatial allocation of such facilities. Eyles (1986a) differentiates between differences in reactions to the public and private sector, 'mainly because the former engages in full consultation and planning procedures whilst the latter often locates without due fuss and attention' (p.59). Such differences, it could be suggested, are determined by the public sector's requirement to operate according to official planning regulations and because of their 'accountability' to the general public, whilst private organisations are not always required to adhere to such strict controls and are perhaps more likely to adopt a 'fly-by-night' strategy, as suggested by Wolpert, Dear and Crawford (1975).

Thirdly, Giggs (1990) states that the clients of these facilities are dependent upon a substantial array of public and private services provided by the NHS, the local Social Services and numerous voluntary organisations that are concentrated in and around the city centre, along with various meeting places such as cafes and other facilities like shops and libraries. So therefore, 'given their very limited financial resources, the clustering together of both the hostels and the relevant services for their clients makes very good sense' (p.243). So, from this point of view, the formation of a ghetto of deinstitutionalised patients can also be considered positively, as it creates a supportive environment that may help people survive without the formal support of the hospital (Dear, 1981).

2.7 CONTRIBUTIONS OF THIS RESEARCH

Returning to the comments quoted from Moon (1988) in 2.1.1, there is a considerable 'gap' in current geographical research on this subject area, as the majority of existing research has been conducted in North America. Changes in mental health policy in Britain have received some attention (Eyles, 1986a; Giggs, 1990; Moon, 1988) yet mental health reforms elsewhere in Europe have received surprisingly little interest from geographers to date. Giggs (1990) suggested that there is 'a real need for sustained empirical and theoretical geographical work in this field' and at the time of writing he claimed that it is an issue that 'British geographers have scarcely begun to address' (p.237). Therefore this thesis, and others forthcoming from British postgraduates also researching into mental health care, have an important contribution to make to the greater understanding of the spatial outcomes of mental health reforms outside North America.

Within the mental health field there is also a scarcity of studies which focus upon the implications of mental health reforms in Europe. As discussed by Ramon (1996) 'the majority of publications with a comparative perspective on mental health care either originate in the United States, or look to it as their ideal' (p.1). Ramon continues by stating that as 'Europe is moving towards becoming a single political entity within the European Union (EU) it is becoming increasingly urgent for Europeans throughout

the EU and outside to know what is taking place in different countries so that they may learn from each other and collaborate in the development of an improved system' (p.2).

The social, economic and political context in Europe regarding health and social welfare is very different to that in North America. For example, whereas in the USA most social services, benefits and health care are provided by the private sector, in Europe the role of the state as 'provider' predominates, although this is clearly changing in Britain, as discussed in Chapter Four. There is therefore a need for research to take into account the different social, political, economic and cultural contexts in which mental health reforms have been decided upon and implemented. Furthermore, this should be approached from a European perspective rather than comparing events to those in North America, which as commented by Ramon (1996), has led to an 'overexposure' to North American influence and a considerable 'underexposure' to what is happening much closer to home.

With the increasing pace of hospital closure since the late 1980s in Britain and in some regions in Italy (see Chapter Seven), the realities of deinstitutionalisation and community care have begun to emerge only in the last ten years. Thus 'contemporary' research is required to account for the outcomes of these changes in the 1990s. The dominance of the North American geographical research in the 1970s and 1980s has led to an impression that the experiences of Canada and the USA, with the ghettoisation of the mentally ill in the inner cities and exclusion by suburban communities, will be duplicated elsewhere. It is therefore important to re-address this balance and show, with empirical evidence, that this may not necessarily be the case.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

'Alice tried another question. "What sort of people live around here?"

"In that direction," the Cat said, waving its right paw around, "lives a Hatter, and in that direction," waving the other paw, "lives a March Hare. Visit either you like, they're both mad."

"But I don't want to go among mad people," Alice remarked.

"Oh, you can't help that," said the Cat, "we're all mad here. I'm mad. You're mad."

"How do you know I'm mad?" said Alice.

"You must be," said the Cat, "or you wouldn't have come here."

(From Lewis Carroll's *Alice's Adventures in Wonderland*).

The preparation for and actual 'doing' of fieldwork, has been perhaps the most essential learning experience gained from this PhD. As for Alice, the experience has certainly been a personal adventure, especially whilst conducting fieldwork in a country and culture that was different to my own. It has also been a great challenge researching as a 'geographer' in the field of mental health where other disciplines dominate and where others thought that it was perhaps me that was actually 'mad'! This issue will be explored further in 3.7.

The field researcher relies upon learning first hand about 'a people and a culture' (Burgess, 1982, p.1). Personal fieldwork has the great advantage of providing a range of insights and understandings of different places and people by actually having 'been there'. To carry out research in another country and in one's second language, it is

essential to 'be there' for a substantial length of time. This is not only to develop the language skills to be able to talk to people at the level required, but also to gain an understanding of the culture and everyday life in that place. This process of 'semi-acculturation' is fundamental for fieldwork abroad; as stated by Burgess (1982) 'the main instrument of social investigation is the researcher, who has to learn the local language, live among the people and participate in their activities over relatively long periods of time in order to acquire a detailed understanding of the situation under study' (p.1).

As already mentioned in Chapter One, the fieldwork component of this research consisted of six months in Sheffield followed by six months in Verona. In reality, this was a very short length of time to carry out all the fieldwork that had been planned. Having already lived in Sheffield for four years before starting the research, working in the city was not too problematic once access had been achieved to the 'case study' mental health facility, as will be discussed in 3.3, although it is important to recognise that researching in a more 'familiar' setting has its own disadvantages and pitfalls (Burgess, 1984).

As described by Burgess (1984), the experience gained from this PhD shows that field research is as much about research processes, such as planning the research, gaining access, finding and selecting people to interview and coping with ethical and other difficult issues, as it is about the actual research methods involved in the collection, analysing and writing-up of the data. This chapter will therefore discuss both the research processes and methods of this PhD, as I consider them to be of equal importance.

3.2 A CASE STUDY AND MIXED METHOD APPROACH

The choice of research methods for this PhD was very much tailored to the three main objectives of the research, as discussed in Chapter One, and to the context in which the research was to be carried out. To meet these requirements, a mixture of different methods was applied: two questionnaire surveys (one in each city); semi-structured interviews; ethnography; census analysis; literature and document reviewing.

These methods were implemented under the ‘umbrella’ of a case study approach, by focusing on the mental health services in two cities, Sheffield and Verona, and two community-based facilities, one in each city. Case studies focus on one or a limited number of settings and, as stated by Yin (1994), are ‘the preferred strategy when “how” or “why” questions are being posed, when the investigator has little control over events and when the focus is on a contemporary phenomenon within some real-life context’ (p.1). Case studies are often used for the evaluation of health services and policy as they can accommodate the use of multiple methods required to address broad, complex questions in complex circumstances (Keen and Packwood, 1995).

Yin (1994) discusses the advantages and disadvantages of case studies, stating that the case study approach has ‘long been stereotyped as a weak sibling among social science methods’ (p.xiii). Traditional prejudices against the strategy include a lack of rigour, the inability to make generalisations and the length of time the method can take. Yin addresses these criticisms (p.9-10) and suggests that case studies, like any other type of qualitative or quantitative method, can be carried out rigorously or not, according to the rigour applied by the researcher. As suggested by Mays and Pope (1995), it has to be recognised that all research is selective to an extent and that the validity of all research ‘will depend upon the judgement and skill of the researcher and the appropriateness to the question answered of the data collected’ (p.109). In response to the argument that a limited number of case studies provide little basis for scientific generalisation, Yin suggests that ‘case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes’ (p.10). Finally, in response to the argument that case studies are too time intensive, Yin

argues that this may have been the situation in the past, but that this is not necessarily the way that case studies should be done in the future. This is a sentiment that this research reflects.

The ‘mixing’ of methods and in particular the combination of quantitative and qualitative approaches has become increasingly acceptable and popular within the social sciences (Brannen, 1992) and such a strategy is also being more frequently used by human geographers (for example, see Meegan, 1989). As all research methods have their advantages and disadvantages, by using a multiple-method approach from a variety of different sources, the methods compliment each other and strengthen the validity of the research. This strategy can also facilitate a process of triangulation, where a particular phenomenon is examined on several different levels and from different sources (Pope and Mays, 1995). Triangulation has been used where possible in this piece of research.

3.2.1 Answering the research questions

How the research methods were applied in order to answer the three main research objectives will now be addressed. A more detailed discussion of the objectives is found in Chapter One (1.3).

- 1. To compare and contrast the geographical implications of spatial changes in mental health care services in Britain and Italy.*

First of all, it was important to establish what temporal and spatial changes had actually occurred within the mental health care services in Britain and Italy. This was researched primarily in the first year of the PhD, by reviewing relevant literature, government documents and reports. The literature searching was carried out by searching databases such as BIDS, MEDLINE and PSYCHLIT, making manual searches of non-electronic indexes and abstracts, following-up references from relevant books and articles, visiting specialist libraries and consulting ‘experts’ in the fields of interest for guidance at the initial stages of the research process. The

subsequent reviews of the literature and background information which provides the context of the thesis are detailed in Chapters One, Two, Four and Seven.

The first task at the beginning of the six months fieldwork, in both Sheffield and Verona, was to establish the temporal and spatial changes to the mental health care services in each city since the implementation of mental health reforms. In Sheffield this task was made easier because of a greater availability of relevant policy documentation. For example, Sheffield City Council had a written policy for community care services in the city (Sheffield City Council, 1991) and the different health agencies in the city had a joint strategy for mental health care services in the city (SHA/FHSA/F&CS Joint Strategy for Mental Health Services, Inventory of Services (Draft), 1994). A number of meetings with my 'key contact' in Sheffield (see 3.3) gave final clarification and an 'on the ground reality' of the situation before the more intensive research got underway.

Such policies and information were not in existence in Italy; there was no written national policy for mental health and at the local level, each of the three sectors in the city of Verona were working quite independently from each other (see Chapter Seven). This situation certainly made the task of finding out what was actually happening in the city for mental health care rather problematic. So in Verona, information about the mental health services in the city was obtained from published research literature from the staff at the Institute of Psychiatry at the University of Verona (see 1.2.1) and interviews with mental health professionals working in the different mental health sectors, in particular, two of the three heads ('*Primario*') of sector services (both psychiatrists) and my 'key contact,' with whom I had numerous meetings during the six month period.

I then set about producing a map of the community-based mental health facilities for each city. In Sheffield, this was a relatively easy task; my key contact was at the time compiling an inventory of all the mental health services and facilities in the city. We collaborated on the production of the maps which are shown in Chapter Four (figures 4.6 and 4.7). In Verona, the process was not so easy. In order to establish what

mental health services and facilities were in existence in the city, I had to ask mental health professionals from the respective sectors what services they provided and then compile my own maps (see Chapter Seven, figures 7.1 and 7.2) which undeniably lack the sophistication of the Sheffield maps. But it was also very difficult to locate and obtain good quality base maps of the city. This problem will be discussed in relation to the questionnaire survey in 3.5.

The next step was to choose one case study mental health service in each city, on which the more intensive research would be focused. In Sheffield, this decision was made in collaboration with my 'key contact' and my supervisors. From the research point of view, I had three main criteria for this choice: firstly, I wanted to choose a community-based residential facility located in a suburban residential 'neighbourhood' which would therefore provide a sample of local residents for the questionnaire survey. Secondly, as the focus of this research was to investigate the impact of deinstitutionalisation and the implementation of community care policies, I felt it important to focus upon a service that served clients who had been moved out of a long-stay institution and into the community, i.e. the long-stay client group.

Thirdly, I was keen to select a service that had been established relatively recently on a 'new' site for a mental health service, so that I could interview health planners and professionals involved with the development of the service as well as local residents living in the vicinity who would also have been living there when the service was first introduced and would hopefully provide a 'before' and 'after' perspective on the service. The community-based residential facility that was chosen fitted all these criteria and it was also a service where my 'key contact' had good relationships with the staff. However rigorous the research, without the access to and the good will of the people that you want to 'research', the research will not happen. The importance of negotiating access cannot be stressed enough and the excellent co-operation of the staff at the case study facility in Sheffield certainly made the 'doing' of the research there much easier. The characteristics of the Sheffield case study service are detailed in Chapter Four (4.5).

In Verona, as discussed in Chapter Seven, the community-based services are far less developed at a city level compared to Sheffield. The most developed community mental health services are found in the sector served by the South Verona Community Psychiatric Service. As already mentioned in Chapter One, this service has strong links with the Institute of Psychiatry of the University of Verona. As I went to Italy partly as an ERASMUS student on an inter-university exchange, as well as having an introduction to the '*Primario*' of the South Verona service from a mental health academic in Britain, I was able to negotiate access to the staff and facilities of the service following meetings with the '*Primario*' and his team. As the service only has two small residential facilities, which are integrated with a community mental health centre, three community mental health teams and an in-patient service, it was decided to make the whole service my 'Verona case study' in order to gain access to enough people for the more intensive research. The characteristics of the South Verona Community Psychiatric Service are discussed in Chapter Seven.

Thus it was not possible to compare 'like' with 'like,' but as already discussed (1.1.1) it had become clear by this time in the research process that a direct comparison would not be possible or appropriate because of the huge differences in community mental health care provision between the two countries. However the interviews and particularly the questionnaire surveys were replicated within the two case studies as much as possible, allowing for the different contexts in which they were carried out.

2. *To identify neighbourhood profiles/characteristics associated with levels of acceptance of the location of community-based mental health facilities.*

As already discussed in Chapters One and Two, the second research objective focuses upon the responses of the local 'host' community who live in the vicinity of a community-based mental health facility. There has been considerable geographical interest in this topic with a tradition of research looking at the potential for opposition or conflict over the location of mental health facilities attempting to uncover characteristics and 'types' of neighbourhoods which are likely to be more or less tolerant of such facilities. This research question therefore has the purpose to follow

on from previous geographical research which has focused upon public attitudes towards mental health (see 2.3) but in new places, at a different time and within two different social, cultural and policy contexts. This part of the research therefore addresses Moon's (1988) claim that one of the deficiencies of the study of geographical aspects of deinstitutionalisation is that most of the research has been carried out in North America with little comparative work elsewhere (p.203).

This research question was investigated at the case study level, by focusing upon the characteristics and attitudes of local residents living in vicinity of the two case study facilities which were selected, one in each city. A number of research methods were used including some basic census analysis and fieldwork in and around the case study facilities using three main methods - interviews, questionnaires and ethnography.

Previous research (see 2.3.3) has suggested that tolerance towards the mentally ill and the facilities that serve this group, can be related to certain personal and neighbourhood characteristics. Such characteristics are considered as internal factors or variables, already in existence in a neighbourhood before any proposal for a mental health facility is made. Previous research has investigated the socio-economic and demographic characteristics of the residents of neighbourhoods under study, considering the influences of variables such as age, gender, education, social class, occupation, ethnicity, housing tenure, the existence of children in the household, the existence of 'key' individuals living in the area who are prepared to organise opposition, and so on.

For this study, in order to provide a relevant context, census analysis was carried out firstly at the city level, to provide some background information regarding the demographic and socio-economic characteristics of the populations of Sheffield and Verona, as reported in 1.2.2. Then analysis was undertaken at the more local 'ward' level in Sheffield, as discussed in Chapters Four and Five respectively and at the '*quartiere*' level in Verona, as discussed in Chapters Seven and Eight respectively. The purpose of this was to provide further contextual information regarding the wider population of the areas in which the case study facilities were located and from where

the sample of local residents for the questionnaire surveys were drawn. As will be discussed in 3.5, the residents selected for the questionnaire surveys were not selected to be representative of the wider ward or '*quartiere*' populations but because of their closeness to the case study facilities. Socio-economic and demographic details of the sample populations who participated in the questionnaire surveys were requested at the end of the questionnaire and this information is detailed and discussed in Chapters Five and Eight respectively.

Census data were much easier to obtain in Britain than in Italy. In Britain, the 1991 Census data at the national, city and ward level were widely available relatively quickly and I was able to access all the information required 'on-line' from computers at the University of Sheffield. In Verona it was not possible to obtain information in the same format or via computer and it was not available in the University of Verona library. After a great deal of time contacting different local government departments, I was able to ascertain that local census information was available from the City Council's Statistics Department.

I was eventually able to obtain local census data for the city of Verona from a local census taken on 31/12/92, which was published in report format by the City Council's Statistics Department in 1994 (Comune di Verona, 1994). This report gave a variety of data from the local census in 1992 and the national census in 1981; only the population total from the 1991 national census was available at this time. This report was also very difficult to obtain; it was not until my 'key contact' telephoned the relevant department and explained that I was a visiting 'academic' working with the '*Primario*' of the service, was I allowed a copy of this census report. To gain more detailed information from the 1991 Italian Census, I would have had to have travelled to Rome; the dissemination of such information in Italy is far less developed than in Britain.

I also gave some consideration to external factors which previous research suggests may influence people's attitudes towards a community-based mental health facility. Such factors include: the nature of the development of the actual facility; the location

of the facility; actual or perceived increases in traffic or noise in the vicinity; a fear of a reduction in property values; the existence of other health and social facilities or buildings in the area, for example another nearby mental health facility, a hospital or a school. The influences of such external factors were investigated in the two case studies through the questionnaire survey, interaction with local residents who completed the questionnaires and often wanted to 'chat' about the issues raised by the questionnaire, the semi-structured interviews (see 3.4) and ethnographic observation in the localities of the case study facilities, from which fieldnotes were kept.

Related to this research question is the suggestion from existing research (see 2.6) that policymakers, health service and city planners are often confronted with a dilemma when making siting decisions for new mental health facilities in residential environments and may allow the potential for community opposition to influence their locational decision-making. This issue was explored in the interviews with the managers for the two case study facilities in both cities and in Sheffield, with the health and city council planners who were interviewed for this research. (In Verona, as discussed in Chapter Seven, the location of mental health facilities was not planned by any health or city council planners). The results of these interviews are discussed in Chapters Four and Seven respectively.

3. *To investigate the interpretations of 'success' of community care by the different groups involved.*

As discussed in Chapter One (1.3) this research question aimed to explore the views and attitudes of different groups who were involved and affected by the implementation of community care policies, which for the purpose of this study was the development and operation of community-based residential facilities for people with mental health problems. The most appropriate method considered for this part of the research was semi-structured interviewing as I wanted to understand the respondents' personal views, allowing them to speak freely and in their own words about their attitudes and beliefs. I also wanted to ask all respondents, from the different groups, a certain number of questions on the same topics in order to

facilitate ‘triangulation’ and validation of information; therefore a semi-structured format with a flexible interview schedule was applied. Such a strategy enables the researcher to structure the interview to be relevant to the research questions as well as providing adequate flexibility to enable the respondent to introduce issues not anticipated by the researcher (Whyte, 1982). The interviews will be discussed in greater detail in 3.4.

3.3 GAINING ACCESS

Burgess (1984) states that gaining access is not a straightforward procedure, with different approaches having to be made to different individuals. One must also be aware of the fact that the process of gaining access raises fundamental ethical issues. For example, there are dichotomies over covert and overt research and the gaining of access to groups or individuals with less power than the ‘gatekeeper’ of an organisation who may have granted access to those individuals. Power relations between the researcher and those ‘being researched’ must also be recognised as part of the research process, with a consideration of how these may influence the results of a study.

With this piece of research, gaining access was an ongoing and progressive process. In gaining initial access to the relevant mental health services in both cities, the phrase ‘it’s not what you know but who you know’ was quite appropriate. The introductions to the two main ‘gatekeepers’ for each case study were gained from contacts made via the Department of Geography at the University of Sheffield and from the small but tightly knit Sheffield ‘Italian speaking community’, who either teach Italian in the city, attend an Italian language class or are indeed Italian. This use of ‘formal’ and ‘informal’ networking proved to be highly effective, as will now be discussed.

Burgess (1984) describes ‘gatekeepers’ as ‘those individuals in an organisation that have the power to grant or withhold access to people or situations for the purpose of research’ (p.48). It was essential for this research to gain access via gatekeepers as I

required information about the mental health services in each city to address research question one and also to gain access to the facilities and mental health professionals working in them, in order to carry out the interviews to address research question three. It was information and access that I wanted to obtain overtly and officially. Although there are, of course, ethical issues surrounding the practice of gaining access from someone in charge or in a position of authority, as discussed by Burgess (1984), it was considered to be easier, quicker and more appropriate to 'get in' from the top.

First of all in Sheffield, the Department of Geography had research links with what was then Sheffield Health Authority (SHA) (see Chapter Four) and one of my supervisors had contact with a manager at SHA who was responsible for research in the Authority. She was the 'official' gatekeeper as it was her decision to allow me, as an 'outside researcher', to carry out my research within the organisation. She then put me into contact with a Planning Manager with the Mental Health and Disabilities Strategic Planning and Purchasing Group, who became my 'key contact' for the Sheffield case study.

After an initial meeting with this manager and my two supervisors to discuss my proposed research, the manager's agreement to allow access to information regarding the mental health services in the city and access to members of staff within the organisation was perhaps more appropriately described as the role of a 'gatekeeper', as defined by Burgess (1984). But this manager subsequently became a 'key contact' as she continued to provide information and assistance throughout the research period as well as negotiating, on my behalf, access to the case study facility and a number of mental health professionals in the city who I subsequently interviewed.

The use of 'key contacts' or 'key informants' in research has an established tradition, in the social sciences, particularly in Sociology. As discussed by Hornsby-Smith (1993) when the researcher is an 'outsider' in the research setting there can be some problems of distrust amongst those being researched, therefore the acquisition of an 'appropriate 'sponsor' who acts as a 'bridge', 'guide', and 'patron' with the group to

be researched' (p.54) can be very useful. Having a 'key contact' not only assists with practical arrangements like arranging times to interview people but it also very useful 'politically'; if the key informant is well liked and respected within the organisation and they say that you (the researcher) can be trusted, then people will generally co-operate with the research.

My key contact negotiated access to the mental health facility which was used as my case study facility. She accompanied me to an initial meeting with the manager of the facility, who then passed responsibility for my research in the facility to a member of staff who became my 'facility key contact'. She was a qualified member of staff who organised all my interviews with the staff of the facility. I also initially attended a staff meeting to explain who I was, what research I was doing, why I was doing it and so on, and to answer any questions people might have.

Every time I was working at the facility, I would join the staff in their common room when invited and have coffee with them; this enabled me to get to know people and gain a greater understanding of everyday working and living in the facility. My purpose was also 'to be available' to staff if they had any questions about the work and how it was progressing as well as letting the staff get to know me more and hopefully this made them less suspicious of me as an 'outsider'.

In Verona, access was gained via contacts from the Department of Geography again and also from the 'Sheffield Italian Set'. I went to Verona on an inter-university exchange as there are links between the Geography Departments at the Universities of Sheffield and Verona. The head (*'Primario'*) of the South Verona Community Psychiatric Unit was also the head of a research unit of the Institute of Psychiatry at the University of Verona and so as I was already attached to the University, this gave me a stronger position. I also had a contact from Sheffield Hallam University, via the 'Sheffield Italian Set', who had met the *'Primario'* a few months previously in Verona and had mentioned me and said that I would be coming to Verona for my PhD research. This contact also gave me an introduction to mental health professionals in Trieste where I subsequently visited for background information for the thesis.

(Trieste was the city where the leader of the reform movement *Psichiatria Democratica* (PD), Franco Basaglia, 'closed' the first Italian mental hospital in the 1970s, as is discussed in Chapter Seven).

Thus when I contacted the '*Primario*' of the South Verona Community Psychiatric Service he already knew that I was coming to Verona and what I wanted to do. For my initial meeting with him, one of the Lecturers from the Department of Geography accompanied me to show that I had support from that department. At this meeting the '*Primario*' agreed to allow me access to the facilities and staff of the service for my research. He was therefore the Verona 'gatekeeper', as he was in charge of the whole service and his co-operation literally 'opened up' all the information and sources of research that I needed. If he had withheld access it would have severely restricted what I would have been able to achieved in Italy.

Access then continued to be negotiated with the staff of the service; the '*Primario*' invited me to on of the staff meetings which occur every morning at 9am (see Chapter Seven) where he introduced me to the staff and explained what I wanted to do and asked for their co-operation. This situation could perhaps have been ethically 'unsound' as he was their superior and they may have felt obliged to co-operate. However, I did not get this impression as people were very friendly and seemed intrigued and interested that I, a geographer from England, wanted to talk to them about mental health care in Verona and Italy. This issue will be discussed further in 3.7. The staff were very welcoming and co-operative and often invited me to have lunch with them or have coffee in their staff area.

In Verona my 'key contact' was a social worker who worked with the South Verona Community Psychiatric Service. The '*Primario*' asked the social worker to help co-ordinate my research and, despite a very busy workload, he gave me an enormous amount of time and support whilst I was carrying out my research. During regular meetings throughout the research period he first gave me much of the background information about the organisation of the service, which is reported in Chapter Seven,

and then helped me identify who I needed to interview and then contacted people on my behalf to explain who I was and ask for their time for an interview.

My Verona 'key contact' also contacted officials when I was having difficulty obtaining information, for example when I was trying to obtain census data from the City Council and for the planning of the questionnaire (see 3.5), maps of the *quartiere* of Borgo Roma from the *circostrizione* (local government administration) office. I was very fortunate to have such assistance. Newby (1977, cited by Hornsby-Smith, 1993, p.56) describes such success in gaining access and co-operation as 'strokes of luck' in research; I certainly realise that I was most fortunate.

In conclusion to this section it is important to discuss briefly the responsibilities of the researcher undertaking such a study. Two important concerns for researchers who undertake research involving 'people' is that of informed consent and confidentiality. I made every attempt to be completely open about the research with everyone I came into contact with, informing them who I was, why I was doing the research, what it was for and always made a point of asking people whether they had any questions at the end of an interview or questionnaire. I also ensured confidentiality with respondents and have therefore used coded identities instead of people's real names. I have also offered feedback to research participants and this is ongoing and will continue following the completion of this PhD.

3.4 THE INTERVIEWS

'Qualitative methods are most useful and powerful when they are used to discover how the respondent sees the world'

(McCracken, 1988).

Qualitative methods have been gaining increasing recognition in geography (Eyles, 1988b; Pile, 1991). Human geographers interested in people's experiences of health and ill-health, are also finding that qualitative methodologies can be the most appropriate in such a context (Cornwell, 1984; Donovan, 1988; Dyck, 1995; Wilton,

1996; Young, 1996). The method of interviewing is the most widely applied qualitative technique. According to Burgess (1982) 'conversation is a crucial element of field research' (p.107) and the use of interviews, which Burgess (citing Webb and Webb, 1932) describes as 'conversations with a purpose', are now widely used by human geographers as a way of investigating individuals' attitudes, experiences, values and beliefs, when these issues are the subject of the research enquiry.

Interviews can take many forms and vary according to the degree of structure imposed on the format (Fielding, 1993). The uses of interviews, different types of interview structures and interview techniques are discussed comprehensively in the research methodology literature (Burgess, 1982;1984; Whyte, 1982; Fielding, 1993; Silverman, 1993) and thus will not be discussed further here. Instead this section will focus upon how interviews were used in this research in order to address the three main research objectives of the PhD, with a discussion of who was interviewed, how, why and where they were interviewed and the advantages and disadvantages that I experienced from applying this research method.

3.4.1 The interviewing process

The interviews undertaken for this research varied in structure, content, length of time and the method of recording the interview, according to who I was interviewing, the purpose of the interview, the location of the interview and how much time the respondent could spare. All the interviews that were conducted in Sheffield and Verona are detailed in Appendix One of the thesis. The information provided in Appendix One states who the respondents were (their status, position or job title), how they were interviewed, whether an interview schedule was used (which are detailed as Appendix Two), the location of the interview and the code given for the respondent, as used in the result chapters. No names are given for the respondents in respect for confidentiality. Those respondents whose posts and organisations have been detailed were happy for me to state this, but only in this thesis.

The respondents interviewed were all selected according to the role that they played within the situations and organisations of research interest. I conducted both semi-structured and unstructured interviews and depending upon who the respondent was and what information I was seeking from them, this determined the interview format and also whether I recorded the interview with a tape recorder or by taking notes during and after the interview.

The interview process also had to be very flexible and some interviews were tailored to the needs and/or wishes of the respondent. For example, some respondents whom I had planned to interview using a particular interview format and method of recording, were unable to either offer me the time or a suitable location for such an interview. For example, I would have preferred to have interviewed 'Sheffield Planner 2' using a semi-structured format and recorded the interview with a tape recorder in a quiet room, as I had done with the other four health professionals and planners in Sheffield. But the Planner was extremely busy and could only talk to me over lunch in the staff canteen and thus it was totally impractical to interview her as I had intended. Instead I had to adapt the interview schedule and just cover the most important issues in the thirty minutes available, taking a few notes during the 'interview' and then writing-up the interview afterwards.

I made a decision to tape record only the semi-structured interviews, of which there were thirty (eighteen in Sheffield and twelve in Verona). Transcribing is a very time consuming activity and as the interviews were not the sole source of data of this piece of research, I decided to conduct tape-recorded semi-structured interviews only with the groups whose views I was interested in, in order to answer research objective three. For the remaining thirteen interview respondents, whom I wanted to interview for more general and background information for the thesis as a whole, I generally used a more informal strategy with less structured interviews. However, some of these interviews conducted in Italian were tape recorded when I felt less confident of understanding all that was said. Most of the interviews that I have called 'unstructured', as indicated in Appendix Two, were recorded manually by taking notes during and after the interview.

The unstructured interviews

The interviews which I have called 'unstructured', but which have also been termed 'focused' or 'non-standardised' interviews (Fielding, 1993), involved respondents from whom I wanted specific information and where I had a simple list of topics which I wanted to cover. This strategy was adopted mainly for the 'Key Individuals' who were interviewed for the research (see Appendix One) from whom I required specific information regarding their particular status or experience that was unique to them. These interviews were carried out particularly at the beginning of the research period in each city, when I was still trying to gain more general background information in order to tighten the focus of the research questions. As stated by Fielding (1993), this type of interview is valuable as a strategy of 'discovery' (p.136).

The semi-structured interviews

Semi-structured interviews were conducted, whenever possible, in Sheffield with the health professionals and planners, the mental health professionals working in the case study facility and the Basegreen residents; and in Verona, with the mental health professionals working in the South Verona Community Psychiatric Service. The semi-structured interviews were conducted using five different interview schedules, as indicated in Appendix One and detailed in Appendix Two. I had a number of difficulties with the tape recording of the interviews and some of the interviews were more or less 'lost' due to very poor recording quality, as indicated in Appendix One.

All the 'useable' interviews were transcribed in full, using a transcribing machine, and verbatim transcripts produced. The interviews in Sheffield were all conducted in English, and in Verona all but one of the interviews were conducted in Italian. The interviews conducted in Italian were transcribed in Italian and then translated into English with the help of Italian speakers who spoke good English. The question of validity that such a practice raises will be discussed in 3.4.2.

The importance of the location of interview

The interviews undertaken for this research were conducted in a variety of different places. The majority of the interviews with mental health professionals who worked in the case study facilities in the two cities, as reported in Chapters Six and Nine, were conducted in quiet rooms or offices in the facilities. However, the 'quietness' of these locations varied considerably and there were various occasions when interviews were interrupted by telephones or bleeps going off, other members of staff or clients coming in, the respondent being called away for an urgent call or enquiry and then returning a few minutes later. Such interruptions had the potential to affect the continuity of the conversation, as the interview could have been at the point of a 'deep' discussion which would then be lost following such an interruption.

Interviews with policymakers, health service and city planners were undertaken either in the respondents' offices or an interview or meeting room at the building in which they worked. These interviews usually had fewer interruptions. These interviews were predominantly more formal and business-like, with a specific time allocated by the respondent which was negotiated when the interview had been arranged. In contrast, interviews with people in their own homes were usually less formal and normally lasted much longer. These interviews were often preceded and concluded with general conversation about the issues being discussed and my research in general.

I have paid attention to the 'place' in which the interview took place as I found that the environmental setting of an interview was an important issue in a number of respects. Firstly, the geographical context of the interview location, whether in public or private space, neutral territory to both parties or familiar to one, are factors which can influence the content of the subsequent interview. For example, it can determine the power relationship between the researcher and respondent.

Interviewing people in their own homes also raises issues concerning the role and skills of researchers. Parkman and Bixby (1996) discuss how interviewing someone in their own home can be both beneficial and detrimental to the quality of the

interview. They give examples from their research which involved interviewing people with mental health problems and suggested that interviewing people in their own homes often put people at ease by being in their own 'familiar territory'. The researchers believed that this led to the respondents being more able to relate their experiences and opinions openly and honestly. However, they also discussed the fact that other people may find being interviewed at home an invasion of their privacy or that the interview may prove difficult to conduct if other members of the household are present, in which situation the respondent may be less willing to speak so freely.

Another very important issue raised by Parkman and Bixby (1996) was the issue of the personal safety of researchers entering people's homes. This aspect of 'doing research' is one rarely addressed in the literature yet is of fundamental importance, particularly for female researchers, an issue to be addressed later in this chapter. This issue is of equal relevance when conducting door-to-door surveys, as I did for this research, knocking on people's doors and talking to people on their doorstep. Although I took precautions when out alone 'in the field' of always telling someone where I was going and carrying an alarm, such research can undoubtedly be 'risky'.

The role of the researcher

The role of the researcher is an important and integral part of qualitative research. As discussed by Burgess (1984), overt characteristics of the researcher, for example their age, social status, race and ethnicity, will create an immediate impression of the researcher. Donovan (1988) adds that dress, appearance and accent of the researcher are also important characteristics. For this research, I was certainly younger than most of the people that I interviewed, I was an 'outsider' to mental health in both countries and in Italy I was also a 'foreigner'. I acknowledge that my personal characteristics may have influenced different interviews in different ways; I was a white, English woman in my twenties, I was a geographer working in a mental health environment, I spoke with a southern accent in a northern city in England and in Italy my accented Italian probably sounded very strange to the Italian respondents. It is perhaps not surprising that some respondents were perhaps a little wary of me at first.

However, I believe that one's personality and ability to talk and get on with people of any age, gender, social background or profession can over-ride many of the possible negative effects from one's personal characteristics. I strongly believe that it is one's personality that builds up a good rapport with respondents in an interview situation and contributes greatly to whether the researcher gets a 'good' or 'bad' interview. As discussed by Donovan (1988), biases exist in all types of social interaction and by documenting and dealing with these possibilities, the effects of the researcher's personal characteristics can become an integral and beneficial part of the research. In fact, in many instances I found that my personal characteristic of being an 'outsider' in a number of different ways was a definite advantage, as will be discussed in 3.7. The only effort I made to create a good initial impression was by paying some attention to my appearance and dress when I conducted the interviews, and this will be discussed further in 3.6.

The interview analysis

As already mentioned, written notes were taken from the unstructured interviews and verbatim transcripts were produced from the tape recorded, semi-structured interviews. The semi-structured interviews were analysed thematically, as detailed by McCracken (1988), by identifying themes and patterns within the individual transcripts and then bringing together overall topics, similarities and contradictions. As these interviews were conducted with fairly detailed schedules, with the respondents in each case study being asked questions around similar topics, this helped greatly to 'order' and organise the emerging themes which are reported in the result chapters.

It is acknowledged that this method of recording interviews and then analysing the resulting transcripts also loses any non-verbal language that occurred during an interview. However, during the interviews I did try to be aware of body language and take note of gestures, the nodding of the head and so on in order to judge how comfortable and at ease the respondent appeared in what can be quite an artificial and intimidating situation, particularly with the presence of a tape recorder. If I felt the

respondent to be ill at ease, I would ask more general questions for longer and to try to establish a better rapport with the respondent.

3.4.2 Conducting the Italian interviews

As already mentioned, the majority of the interviews conducted in Italy were conducted in Italian, my second language. The interview with 'Psychiatrist 1' in Verona was conducted in English; the respondent spoke excellent English and he offered to speak in his second language. The interviews with Key Individuals 5 and 6 in Trieste were conducted half in English and half in Italian.

For the Italian interviews, it was important to be very well prepared. One of my first tasks on arriving in Verona to commence the fieldwork was to learn some specialist vocabulary that I would require for the interviews. The lecturers at the Department of Geography in Verona and 'Key Individual 1' gave me assistance with this. Not only did I need to learn vocabulary relating to mental illness but I also needed to learn words specific to the Italian mental health profession, as will be discussed further in 3.6. I then designed the interview schedule for the Italian interviews which was more structured than those used in Sheffield (see Appendix Two). Although still semi-structured with particular themes, I prepared some 'set' questions in Italian so that I asked all the main questions in grammatically 'correct' Italian to ensure that I was clearly understood by respondents. I then asked further questions 'ad lib' to probe or follow-up particular lines of enquiry.

Interviewing in one's second language obviously has limitations; one is less quick to 'pick up' particular points made and to develop them further; respondents may speak with accents or use colloquial terms which are unfamiliar. These can equally occur in one's own language but in another language, such problems are intensified. Sometimes it is possible to miss something completely that may be important and not realise its relevance until hearing it again when transcribing, which of course is too late.

I then transcribed the interviews in Italian and then had to translate them into English. The fact that I had to translate the Italian transcripts into English, with the help of Italians who spoke English, has undoubtedly introduced the potential for bias and questions the resulting validity of the interviews' analyses. However, it was essential to gain assistance for the translation because my language skills were still not completely fluent and a few of the respondents used words in local dialect, which is spoken widely in Verona and is very different from standard Italian. For these transcripts, the assistance of a Veronese (someone born in Verona) had to be sought.

The translation process was very time consuming and difficult; many words in a language are colloquial and many concepts have specific meanings in one culture that are not directly translatable to another. As Smith (1996) has commented 'translation often does not quite convey 'original' meanings and associations.' This is because so many concepts and meanings are culturally specific. An example to illustrate this point was the use by the Italian mental health professionals of the term '*mentalità*' when they talked about variations in the implementation of mental health reforms in different regions of Italy (see Chapter Nine). A number of respondents said they believed that the reforms had not been implemented in the south of Italy because of reasons of '*cultura e di mentalità*' which translates directly as reasons of 'culture and of mentality'.

The term mentality in English is defined as a 'type of mind' and 'a way of thinking' but is not used to describe a group or 'region of people' as it is in the Italian language. In Italian, the usage of the term is value laden; Italians are loyal to their home town or region rather than their country (apart from sporting events). Northern Italians do not think highly of the southern Italians; they call them '*terrone*' which is a highly derogatory and insulting term. Many northerners support the Northern League political party that is against supporting the poorer south with taxes from the hard working northerners and is campaigning for a separate northern state (Richards, 1994). This is the context in which the term was being used; one respondent told me that the reforms hadn't been introduced in the south because "they [people in the south] leave things as they are, they lack rigour or common sense" (quotation from

section 9.4.1). Therefore the term '*mentalità*' in this context does mean 'a way of thinking' as a direct translation would suggest, but such a direct translation in fact omits the multiplicity of the intended meanings and understandings, as suggested by Smith (1996).

3.5 THE QUESTIONNAIRE SURVEYS

In both Sheffield and Verona, questionnaire surveys were conducted which targeted local residents living in close vicinity to the selected case study facilities. The purpose of carrying out the questionnaire surveys was to address the second research objective of the PhD which focuses upon the reactions of local residents towards mental health facilities and the mentally ill people that they serve (see 3.2.1). Many previous studies on this topic have conducted research using questionnaires (Dear and Taylor, 1982; McConkey, 1987; Moon, 1988; Currie, Trute, Tefft and Segall, 1989; RSGB General Omnibus Survey, 1993, a survey commissioned by the Department of Health as part of the Health of the Nation initiative). These studies are discussed in Chapter Two.

The choice of questions and actual design of the two questionnaires used for this research are discussed comprehensively in the two result chapters; Chapter Five for the Sheffield survey and Chapter Eight for the Verona survey. For the Verona survey the Sheffield questionnaire was translated into Italian and most of the questions were replicated where possible, so that some comparisons could be made. However, some parts of questions and terms used had to be changed to be culturally and locally specific and this is discussed further in Chapter Eight, as is the process of translation which was completed with the assistance of local Italian speakers. Copies of the two questionnaires can be found in Appendix Three of this thesis. In this Chapter, the more practical issues of how the questionnaires were actually implemented and how this varied in the two countries will be discussed.

In both Sheffield and Verona the questionnaire respondents were selected randomly according to the distance of their homes from the case study mental health facilities.

Maps in Chapters Five (Figure 5.1) and Eight (Figure 8.1) illustrate how the questionnaire samples were drawn according to the distance away from the case study facilities. Four concentric rings were drawn around the case study facilities, at two hundred metres apart, and an allocated number of households were selected randomly from each of the four zones. This achieved a stratified random sample of questionnaire respondents. This 'zoning' strategy was adopted in order to evaluate a 'distance decay effect' on people's awareness of the existence of the facility, as had been done by previous research (Dear and Taylor, 1982; Rabkin, Muhlin and Cohen, 1984).

In Sheffield the questionnaire was a door to door survey; I physically knocked on people's doors and would ask the person who answered the door to complete the questionnaire for me. Very few people refused, in fact the greatest problem was actually finding people at home. I would try a house on three different occasions before giving up and selecting a different house. After failing to find many people at home during the day I started to go out at weekends and during the evenings which was more successful. Most people answered the questions for me at the time and I would read the questions out to them; if people were busy but offered to complete the questionnaire, I left it with them to collect a couple of days later. On collection, I went through the questionnaire with the respondents to ensure that the questionnaire had been completed correctly. In total I collected the target of eighty questionnaires, twenty from each of the four zones.

In Verona the strategy was slightly different; because of problems envisaged in knocking on people's doors and explaining the purpose of the questionnaire in my second language, it was decided to use the 'drop and collect' method of 'posting' the questionnaire, with a covering letter (a copy is in Appendix Three) through letter boxes of the selected households. The covering letter explained: the purpose of the questionnaire; how the information given would be used; that I would then return seven days later to collect the completed questionnaire; asking the respondents to leave the questionnaire out in an accessible place so that I didn't need to knock on their door. I also gave the telephone number of the Department of Geography at the

University of Verona if anyone had any queries and one lady did contact me just to clarify that I was bona fide. Following the experience of conducting a survey in Sheffield, I delivered and collected the questionnaires at consecutive weekends. I chose not to work in the evenings because I did not have a car in Italy and buses became infrequent in the evenings.

Two hundred households were targeted, fifty in each zone, but only forty nine correct and fully completed questionnaires were collected. This was rather a low and disappointing response. On reflection, there were a number of problems with this method; a number of questionnaires had not been fully completed or were not filled in correctly and this reduced the number of questionnaires which could be used for analysis. Very few completed questionnaires were left in an accessible place to be collected on the day stated on the covering letter, as had been requested. In fact most of the questionnaires were retrieved following a number of calls to the household, which was what I had tried to avoid by adopting the 'drop and collect' strategy. The fact that the questionnaires were left in the post-box also gave greater opportunity for non-response.

Another problem, as I was later informed by more knowledgeable local people, was that Italians are not accustomed to door to door surveys as we are in Britain and it is possible that many people may have been confused or annoyed to be asked to cooperate in such a way. So in retrospect, the survey would have probably have had a better response rate had I used the same method as in Sheffield. But this was my first attempt at conducting such a survey abroad and many of the problems were caused by a lack of experience in conducting research in another country. As discussed by Hantrais, Mangen and O'Brien (1985), problems of doing cross-national research can be the same as in one-nation studies, 'but they are often compounded by the 'cross-national factor' and additional problems are created, mainly associated with cultural differences' (p.viii).

The questionnaire analysis

The data from the two questionnaires were treated as two separate data sets for the analysis. Thus the following description of the analysis process was completed separately for each two data set. When the questionnaires were designed, the possible responses were pre-coded and boxes were put at the far right of each questionnaire page in order to enter these codes at the beginning of the analysis process (see Appendix Three). A 'coding frame' was developed where each question from the questionnaire was converted into an appropriate number of variables, with each response given a code. Each questionnaire was given an ID number and when all the questionnaires had been coded, the data were entered into a computer. The statistical package used to analyse the data was SPSS for Windows.

Once all the data had been entered, the frequencies were checked for each variable to check that the data had been entered correctly and to show up any inconsistencies. Analysis of the data sets was then undertaken, with some results presented as frequencies and then more detailed analysis being conducted to examine relationships between variables. The major problem with the questionnaire analysis was that the sample sizes were relatively small and this caused some problems with gaining significant relationships where the cell sizes were just too small. However, the two surveys produced some interesting results, as detailed in Chapters Five and Eight.

3.6 DOING CROSS-CULTURAL RESEARCH

'Culture is invisible and taken for granted. People are so used to their own ways that they may not be aware of cultural issues until they come into contact with different cultures.'

(Baumberg, 1995)

Some of the difficulties of conducting research in a different culture and language have already been discussed in this chapter regarding the interviews and questionnaire survey that were carried out in Italy. This section will discuss further how working in a different culture and language influenced the practicalities of actually 'doing' the

research in Italy. When I first arrived in Italy, I was not prepared for the more 'underlying' cultural differences of Italian life which quickly became apparent when I started to live and work there. As commented by Baumberg (1995), I was very used to my own ways of working and living and it was not until I became 'exposed' to a different culture that I became aware of cultural differences in everyday life, both in Italy and Britain.

Levine (1987) discusses how some of the most dramatic differences between people from different cultures occur in the pace of life. Citing Hall (1959) who describes time as a 'silent language', Levine states that after language, the two most difficult matters for cross-cultural researchers to deal with are both temporal: 'the general pace of life' and 'how punctual most people are' (p.27). Learning this 'silent language' was certainly very important when conducting my research in Italy. Italian life 'ticks' at a different pace to what I was used to; it operates according to a 'sense of time' characteristic of Mediterranean cultures which seems much slower and almost lazy compared to the more frantic pace of life in urban Britain. The daily timetable is quite different, with a 'siesta' between 12.30pm and 3pm, when all offices and shops close down and the streets become quiet and deserted, then shops and offices stay open until 7.30pm and then people go out and socialise until late in the evenings. Definitions of punctuality are also quite different; it is almost expected to be late for an appointment or to be kept waiting; even the television news is three or four minutes past the hour.

'With no formal definition for customs like 'early' or 'late', it is little wonder that this silent language can pose as many difficulties for cultural adaptation as differences in formal language itself' (Levine, 1987, p.32). For the first few weeks in Italy I tried to work the way that I was used to in Britain which achieved little and caused much personal frustration. I then decided to adopt the 'Italian pace' and soon realised that I could still achieve my research objectives by working at a different pace and worrying less about how things would work out; in Italy they just do. The Italians themselves also appreciate that you are accepting an Italian way of life, as stated by Parks (1992) in his commentary about living in Italy as an Englishman: 'while Italians usually seem

to like foreigners, the foreigners they like the most are the ones who know the score, the ones who have caved in and agreed that the Italian way of doing things is the best' (p.19). By accepting the 'invisible' culture with its 'silent' language and 'rules' of behaviour, then the research and living itself becomes easier and one's confidence of 'coping' increases.

Every culture has its own norms and values that dictate what it considered as the correct way to live and behave (Levine, 1987) and it is very important to learn these quickly when conducting research abroad. In Italy, knowing and using the correct 'etiquette' is very important in social interaction, which is much more formal than in Britain. For example, in the Italian language one always addresses a person who is not known well or is older with a polite third person pronoun which also has a different verb ending to the more familiar 'you'. It was very difficult at the beginning of my time in Italy to remember to always use the correct and polite third person; not to do so could cause offence. Formal handshaking is also the norm when meeting people who you do not know well, both in formal and informal settings.

Another aspect of learning the 'rules' of Italian life is using contacts in order to gain access to information or to get things done. Few Italians rely on 'official channels' to get something done or fixed, like arranging for a telephone line or electricity to be connected quickly. These things are all arranged via contacts, often relations or family friends. As Richards (1994) has commented 'it may be well-nigh impossible to get something done or fixed without what the Italians call a 'saint in paradise' or a patron, but once personal contact is established, doors will be thrown open' (p.xvii). I also experienced this with my research; I made a number of visits to Local Government Departments in Verona to try to get census information and detailed maps of Borgo Roma in order to plan my questionnaire survey. I had great problems obtaining both so I asked my Verona 'key contact' for assistance. He contacted the relevant Departments and explained that I was 'Dottoressa Jones', working with Professor 'X' and needed this information for the research etc. and the 'doors' to the respective departments were literally 'thrown open' to me. Whether one likes this system or not, it is part of the Italian way of life.

3.6.1 'Dressing up' and 'dressing down'

As already mentioned when discussing the 'role of the researcher' in 3.4.1., I did pay attention to my dress and appearance when conducting the research in order to give a 'good impression' where required and also to 'fit in' to the environment within which I was working. For example, in Sheffield I 'dressed up' for more formal interviews with health professionals as I felt that I would be taken more seriously if I appeared to be smart and professional in appearance and manner. This 'dressing up' also gave me more confidence in entering formal working environments and for interviewing professional managers. However, in other research settings in Sheffield I chose to 'dress down'; in the case study facility the staff all dressed very informally in jeans etc. as did the tenants and I felt more comfortable dressing the same when I visited the facility. I felt that if I had 'dressed up' in such an environment people would be more suspicious of me as an 'outsider' and the tenants may have felt uncomfortable with me around dressed differently to the staff.

In Italy, people generally dress more formally and smartly than in Britain and it is very important to dress and behave appropriately if you want to 'fit in' and be accepted (as a foreigner) by Italians. This is something that I had to accept and accommodate in the way that I presented myself and conducted my research whilst in Italy. Italians take appearance seriously; the importance of appearance or 'image' for Italians is known as *'bella figura'*, a concept which means to give a good impression at a particular time and place, to appear smart and clever to others. This was obviously the impression that I wanted to portray for my research and thus in Italy I 'dressed up' considerably. I wore suits and jackets daily for work at the University, when I worked in the case study facility and for all the interviews and meetings. It wasn't just that I wanted to 'fit in' and be taken seriously, dressing more formally also gave me greater confidence and helped me to feel more comfortable in the environments in which I worked.

3.6.2 Being a female researcher

I found it more difficult being a young female researcher in Italy than I did in Britain. Perhaps part of this is because I am aware of the 'silent' language of gender roles in Britain and felt more comfortable working in a culture with which I am familiar. Also, in the field of mental health care in Britain, there is an enormous amount of research being conducted and mental health professionals are used to being the 'subjects' of research. There are undoubtedly more educated women in professional occupations in Britain than in Italy and thus, whilst conducting my research in England, people did not seem particularly surprised that, as a young female researcher, I was conducting this level of research.

Italian society is far more patriarchal, even in the 'progressive' north, and this raised quite a few issues for me as a female researcher. First of all, people with whom I came into contact could not understand why I had come to Italy, on my own and so far away from my family, to do this work. It was beyond people's comprehension. In Italy, young women do go to University and it is becoming more acceptable for women to have careers but the family still comes first and most women remain living at home until marriage. Italy is certainly very much a male dominated society with the women still expected to carry out the domestic tasks in the home. Therefore I was concerned that in such a culture, I was not going to be taken seriously in my work. This was one of the reasons for my 'dressing up', in order to appear 'professional' and for using the title of 'Dottoressa' which all female holders of a first degree are entitled to use in Italy.

However, I was very fortunate that I was working in a health care environment as although men predominantly are still 'in charge' there are a number of women in positions of responsibility as doctors, psychologists and nurses and therefore the 'educated' woman was not a complete oddity. The fact that the case study facility was integrated with the University and that I was based at the Geography Department also helped. Although I think people probably thought that I was strange, the fact that I was a young woman was in many ways actually an advantage. As discussed by

Easterday, Papademas, Schorr and Valentine (1982), if a young female researcher is not taken particularly seriously because of her age and gender, this can often be to the researcher's advantage. She is considered 'harmless', powerless and non-threatening and therefore people speak more openly than they might to a man or older researcher. The fact that I was English and not a mental health professional I think also contributed to this situation.

3.7 SOME ADVANTAGES AND DISADVANTAGES OF BEING A GEOGRAPHER

There is a great deal of research being conducted in the mental health field internationally, both from a clinical and social perspective, by a number of different disciplines. But as discussed earlier in this thesis, geographers do not have a reputation of contributing to the mental health debate. Thus I rather suspect that the mental health professionals with whom I worked, did not really understand why I, as a geographer, was interested in mental health.

However, in many ways this situation worked to my advantage. Mental health professionals did treat me as an 'outsider' but in a positive way; they assumed that I knew nothing about mental illness and mental health care (which I didn't at the beginning of the research) and thus they explained things to me very clearly and in detail, and this is something that I experienced both in Britain and in Italy. This 'depth' of detail that I gained would perhaps not have been offered to someone who worked in mental health and would therefore be expected to know about 'how things were' in mental health.

Being an 'outsider' to mental health I think gave me the advantage of objectivity and 'distance' as the mental health environment was quite new to me. As stated by McCracken (1988), 'scholars working in another culture have a very great advantage over those who work in their own. Virtually everything before them is, to some degree, mysterious' (p.22). Working in a mental health environment was like being in another culture, with a whole different set of norms and values and 'language' to

observe. This experience was intensified in Italy when I was 'exposed' to two different cultures.

In Italy, as already mentioned, I think people were rather curious about this 'mad English geographer woman who wanted to talk about mental health' which also worked to my advantage. When I started to conduct interviews in the mental health facility, my 'key contact' had to ask the mental health professionals to talk to me for my research. However, after a few interviews word had got about concerning what I was doing and people starting coming up to me to ask when I was going to talk to them. People became interested in the perspective which I was 'coming from' as it was not an area that people had thought about before and, being Italians, they all had opinions about the issues I was concerned with, which was very useful for the research and assisted further with being 'accepted' by the staff.

The main disadvantage of being a geographer, apart from having to justify being one so much, was not having a background in mental health for this particular research. It was necessary to gain a good understanding of mental health issues; I had to learn a great deal about mental illness, medication, legislation (in Britain) and the mental health specialised 'vocabularies' in Britain and Italy. This was achieved not only from the literature but also by talking to mental health professionals and visiting mental health facilities and some mental hospitals, all of which were at various stages of closure. Seeing for myself the old and new 'sites' of care has certainly given me a clearer understanding of the extent of change that is occurring in the mental health systems in the two countries.

SECTION TWO

CHANGES IN CARE FOR PEOPLE WITH MENTAL HEALTH PROBLEMS IN BRITAIN AND SHEFFIELD

CHAPTER FOUR

MENTAL HEALTH CARE IN BRITAIN: THE IMPACT OF TEMPORAL AND SPATIAL CHANGE.

4.1 INTRODUCTION

"There they stand, 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 solidity. Do not for a moment underestimate their power of resistance to our assault..."

Enoch Powell, (1961).

This extract is taken from the then Minister for Health's famous 'water-tower' speech which was given as an address to the annual conference of the National Association of Mental Health in 1961. Legislative changes to the mental health care system had already been initiated by this time, in the form of the 1959 Mental Health Act. Enoch Powell's dramatic speech announced a further radical shift in mental health policy, by announcing the closure of the mental hospitals and a reduction in the number of hospital beds for the mentally ill by half in the following fifteen years. The closure of the large mental hospitals, from the time of Powell's speech onwards, has become a major component of the British government's national health policy and has created enormous changes for people in Britain suffering mental health problems as well as for those people that care for them, in both formal and informal settings.

Since 1959, a series of mental health and community care legislation has reshaped the organisation of mental health care services throughout the U.K. This chapter will evaluate the consequences of these temporal and spatial changes to mental health care provision in the U.K., with a particular focus on how these policy changes have

affected the lives of the 'old long-stay' client group, the former mental hospital patients, many of whom have now been resettled into the so called 'community'. An overview of the consequences of these changes to mental health care will be given at the national scale and then the impact of these reforms will be considered at a city level with the discussion of the changes to mental health care provision in Sheffield. Finally in this chapter, the impact of the reforms will be illustrated at an even more local scale, with an account of the planning, development and operation of a single residential facility, built to resettle twenty-five former long-stay mental hospital patients from the closing psychiatric hospital in Sheffield.

4.2 THE 1959 MENTAL HEALTH ACT AND BEYOND: TOWARDS CARE IN THE COMMUNITY

"One of the main principles we are seeking to pursue is the reorientation of the mental health services, away from institutional care towards care in the community." (D. Walker-Smith, Minister of Health, House of Commons Debates, 1959:598,719).

The Mental Health Act of 1959 was the first major mental health reform of the twentieth century; throughout the first half of the twentieth century, mental health care had been based upon the provisions of the 1890 Lunacy Act (see Chapter Two). However, changes were occurring from the 1930's onwards in the mental hospitals in Britain, with some wards becoming open and some patients being allowed to leave the ward and walk in the hospital grounds or the local neighbourhood, depending upon their degree of illness. But until the second world war, mental health services outside the hospitals were patchy and sporadic (Jones, 1993).

Following the Second World War, the National Health Service was established and all public mental hospitals were transferred from the responsibility of Local Authorities to the new Regional Health Boards. There were many administrative problems, particularly in that most of the mental hospitals were in the wrong places as they were often in country areas, distant from the populations of their new catchment areas. In

the early 1950's, a debate concerning the future of mental health care began; there had been no major changes in mental health legislation since 1890 and there were growing concerns regarding a shortage of nursing staff and junior doctors, of serious overcrowding in outdated buildings and the realisation of the expense of maintaining the buildings of the vast hospital system (Jones, 1993).

But perhaps most influential in the calls for change were new developments in the medical world, with the introduction of new psychotropic drugs in the early 1950's, which revolutionised psychiatric practice by being able to control many forms of mental illness. Also the introduction of the 'open door movement' in many hospitals, pioneered by Maxwell Jones, which saw the development of the 'therapeutic community' approach, an ideology which was later to influence Franco Basaglia in Italy (see Chapter Seven). This 'British experiment' strove to break down the barriers between the hospital and the outside world and was an important step towards community-oriented psychiatry (Jones, 1993). In a step further from Maxwell Jones's work, in different parts of Britain innovative and even radical alternative approaches to in-patient care were being developed; Butler (1993) discusses examples of such developments in Worthing, York, Oldham and Birmingham. In Worthing for example, from 1955 onwards the district mental health service provided day treatment and out-patient services, resulting in a marked reduction in the use of in-patient care. So by the 1950's, alternatives to the mental hospital were beginning to emerge, although restricted to particular localities.

In addition to the pharmacological and social 'revolutions' in mental health care in the 1950's, there was a third legislative 'revolution' (Jones, 1993). From 1954 to 1957, the Royal Commission on Mental Illness and Mental Deficiency met with the purpose of reviewing the existing law, the 1890 Lunacy Act, as it affected admissions to and discharge from hospital for people 'who are or are alleged to be suffering from mental illness or defect'. The Commission was limited to legal and administrative issues and its recommendations made called for sweeping changes to the mental health system. It was upon these that the 1959 Mental Health Act was based (Jones, 1993).

It is important to appreciate that the combination of these 'three revolutions' as Jones (1993) calls them in the 1950's, effectively swayed public opinion and importantly influenced the politicians from all sides. The first parliamentary debate on mental health for twenty-four years was initiated on a Private Member's Bill by a Labour M.P., Kenneth Robinson, in 1954. Mr Robinson expressed his concern for the overcrowding in mental hospitals and the shortage of medical staff and highlighted the advances in medical treatment, calling for change. This debate initiated the re-emergence of mental health onto the political agenda, with the setting up of the Royal Commission and the subsequent acceptance of the Commission's recommendations by the Conservative Government of the time, that adopted the policy of community care and asylum closure as part of the Government's health policy.

The main features of the 1959 Mental Health Act were the following:

- The act replaced all previous mental health legislation and provided for four different types of patients: the mentally ill, the subnormal, the severely subnormal and those diagnosed as psychopathic.
- New routes for hospital admission were introduced which included: informal admission, where informal patients could discharge themselves at any time; compulsory admission for observation and separately for treatment and emergency admission.
- The Mental Health Review Tribunal was created, giving patients new rights to appeal against their continued detention.
- Local health authorities took over responsibility for the inspection and review of mental hospitals and were encouraged to provide community-based services.

The 1959 Act was seen as a considerable legislative advance for the care of the mentally ill. However, although this act embodied the principle of moving towards care in the community, it failed to demand commitment from the Local Authorities and shortly after the law was passed the earmarking of special grants for community services, which had been strongly recommended by the Royal Commission, was replaced by block grants, giving Local Authorities greater freedom in how they

allocated the money. In this way, the 1959 Act failed to give financial commitment to the development of community services, as the allocation of resources through block grants meant that with some Local Authorities giving a greater priority to mental health services than others, geographical disparities in community provision increased (Jones, 1993).

After the passing of the 1959 Act, mental health policy swayed again both radically and rapidly. In 1961, the new minister for Health, Enoch Powell, announced his policy to close the mental hospitals and to reduce psychiatric beds by half. This was news to mental health professionals who had not been consulted on the matter (Jones, 1993) and although many believed that it was indeed time to move on from institutional care, there was widespread concern that services in the community were not yet adequate to replace the mental hospitals. One such critic was Professor Titmuss of the L.S.E., who asked the government for three acts of policy as an assurance that the government 'really meant business': a specific earmarked grant to Local Authorities for mental health services, funding for the training of social workers and a Royal Commission on the training of doctors. Of these, only the third actually materialised (Jones, 1988).

Research by Tooth and Brooke (1961), published three weeks after Powell's announcement, gave credibility to the government's plans as the research showed that inpatient numbers in the mental hospitals were dropping sharply. But the researchers predicted also that there would still be a demand for some form of institutional care in the future, with the possible increase in senile dementia due to lengthening life expectancy, chronic patients who may always require acute care, the uncertainty of public tolerance and so on. However, these secondary predictions seemed to carry less weight than the primary trend (Jones, 1993).

Table 4.1 Timetable of Mental Health and Community Care Reports and Legislation (1959 -1992)

Year	Legislation
1959	Mental Health Act
1962	Hospital Plan for England and Wales (<i>Ministry of Health, Report</i>)
1963	Community Care Blue Book - Health and Welfare: the development of community care (<i>Ministry of Health, Report</i>)
1975	Better Services for the Mentally Ill (<i>DHSS, White Paper</i>)
1976	A Review of the Mental Health Act 1959 (<i>DHSS, Report</i>)
1983	Mental Health Act
1985	Community Care with special reference to Adult Mentally Ill and Mentally Handicapped People (<i>Social Services Committee Report</i>)
1986	Making a Reality of Community Care (<i>Audit Commission Report</i>)
1988	The Griffiths Report - Community Care: Agenda for Action
1989	Caring for People: Community Care in the Next Decade and Beyond (<i>DHSS White Paper</i>)
1989	Working for Patients (<i>DHSS White Paper</i>)
1990	NHS and Community Care Act (fully implemented in April 1993)
1992	The Health of the Nation (<i>DOH Report</i>)

Table 4.1. lists the series of government publications and legislation which have followed the 1959 Mental Health Act, each contributing to the re-shaping of the mental health care service since 1959. The numerous reports between the pieces of legislation do not form a complete list; there have been many more, for example studies and reports published by mental health charities and mental health professional bodies. The main policy changes determined by these reports and laws are summarised in 4.2.1.

4.2.1 Mental health policies in the 1960s and 1970s

Following the 1959 Mental Health Act, at the turn of the 1960's there was relative optimism in mental health, with the government committed to community care and mental hospital closures (Murphy, 1991). The *Hospital Plan* (1962) launched the official hospital closure programme, with a policy to reduce the number of psychiatric beds in half by 1975 (Murphy, 1991) and restricting the remaining beds for acute and short term services, with chronically ill patients to be provided for by community services, funded by the Local Authorities.

This new policy called therefore for a reversal of previous practice with the transfer of responsibility for long-term patients to the Local Authorities. The acute psychiatric services were to be located in new District General Hospitals, which would provide acute treatment in all medical specialisms. The companion document to the Hospital Plan, *Health and Welfare: The Development of Community Care* (1963), stated the desirability of community care but little else, leaving those hoping for a positive lead from the government disappointed (Jones, 1993).

The process of reducing mental hospital beds continued, but at the same time admissions continued to increase and subsequently most hospitals developed two parallel services; short-stay acute care and long-term care for the elderly chronic patients who were more difficult to discharge (Jones, 1988). During this period the long-stay patients became an issue of public and political concern, as allegations of maltreatment towards chronic patients in some hospitals were made, frequently receiving media coverage.

A number of 'Hospital Enquiries' were set up to investigate allegations in different hospitals. One particular book by Robb (1967), which contained detailed and specific allegations concerning abuse of elderly patients, was the subject of a Government enquiry (Ministry of Health, 1968). This period in the mental health service was marked by scandals, with low morale and disillusionment amongst mental health workers. However, one result of the hospital enquiries was the setting up of a

government complaints procedure, the Hospital Advisory Service in 1969, which led to regular visits to mental hospitals by interdisciplinary teams of senior staff.

In the 1960s there was also the impact of a change of government when the Conservative Macmillan and Douglas-Home Governments were succeeded by six years of Labour Government, led by Harold Wilson. Both parties supported the reduction of mental hospital beds but each placed a different emphasis on the importance of hospital and social services provision of care. The Conservatives thought in terms of the dominance of the medical profession and the role of specialist medical services, whereas the Labour ministers talked of 'health service professionals' and saw an increasing responsibility for the social services (Jones, 1993). The Conservatives and Labour parties therefore differed in their views regarding which agency should hold the major responsibility for mental health.

Under the Wilson Government, the Seebohm Committee on Local and Allied Personal Social Services (1965-8) was commissioned to set up a new managerial framework for Local Authority social services departments. On reviewing the mental health system, the Committee reported that 'the widespread belief that we have 'community care' of the mentally disordered is, for many parts of the country, still a sad illusion' (1968). The Commission recommended that mental health services should be included with other social services and within the subsequent Local Authorities Social Services Act (1970), a greater responsibility for community care was passed to social workers in preference to medical and nursing professionals.

These changes led to the break up of a single specialist service for mental health with a new focus on genericism, with social workers taking on a greater role for caring for the mentally ill in the context of a community and family setting. A new political divide had been created, with the creation of separate health and social services 'empires', each with its own different responsibilities, patterns of organisation, different styles of management etc. (Jones, 1993). This major reorganisation in mental health care is an important example of how a change in government

determines changes to the way that community care has been managed and implemented.

In 1974, the National Health Service was reorganised, with the establishment of Regional Health Authorities, Area Health Authorities and District Management Teams (Jones, 1993). These changes were again related to the policies of the Labour Government of the time, with an emphasis on deregulation and a reduction in public costs. Psychiatry became simply one medical specialism amongst many, with decision-making increasingly being transferred from psychiatrists to professional 'health managers'. As a result of all these changes during the 1970s, particularly with the loss of a single specialist organisation for mental health and an increasing divide between social services and health, it became increasingly difficult to organise and co-ordinate community care, particularly for mental health (Jones, 1993).

By 1975, it had been predicted by Enoch Powell that the domination of the asylum system in mental health would be over, with a cut by half of in-patient beds. In fact not one hospital had closed and although inpatient numbers continued to decrease, the admission rates were still increasing. In the white paper *Better Services for the Mentally Ill* published that year, under a Labour Government, the government admitted that there had been 'successes and failures' but held firm to the 'philosophy of community care', stating:

"We believe that the failures and problems are at the margin and that the basic concept remains valid. We believe that the philosophy of integration rather than isolation which has been the underlying theme of development still holds good and that for the future the main aims must continue to be the development of more locally based services and a shift in the balance between hospital and social services care" (DHSS, 1975).

However, from the mid-1970's it had become obvious that the expected replacement of hospital beds by community facilities and services was simply not happening. The worsening economic situation in the country with rising unemployment added to the problems of resourcing mental health. Despite the fact that within the 1975 White Paper, specific targets were set for the development of community care facilities, notably residential and day services to be provided by the Local Authorities and day hospital places by the NHS, the increase in these services was nowhere near matching the reduction in mental hospital beds. This mismatch is detailed by Murphy (1991, p.63) who stated that between 1974 and 1984, hospital beds reduced by 25,000 to around 80,000 in total, yet only 3,500 Local Authority residential places were created in this time and day care places also fell short. Clearly urgent action was required.

4.2.2 Mental health policies in the 1980s

In 1979 there was again a change of government with Margaret Thatcher becoming the new Conservative Prime Minister. The review of mental health care services in the 1970's led to new legislation in the early 1980's with the *Mental Health Act*, passed in 1983. This piece of legislation marked a return to legalism (Jones, 1988) with a heavy legal and prescriptive emphasis which replaced the more liberal and 'enabling' 1959 Act.

The main points of the law were the following (Jones, 1993):

- Definition of mental disorder - The definition of mental disorder was narrowed and removed nearly all mentally handicapped people from the provisions of the act, apart from those also suffering some mental illness, who were categorised as suffering 'severe mental impairment'. The act also removed the possibility of using the act against people according to their sexuality or because of drug or alcohol abuse.
- Compulsory admission to hospital - the three principal forms of compulsory admission (assessment, emergency and treatment) in the 1959 Act were amended.

- Discharge from hospital - provisions for discharge were extended and all patients now had an automatic right to regular review by a Mental Health Review Tribunal, when previously patients had to apply.
- Consent to treatment - this was a new clause. Patients detained under Assessment or Treatment Orders could be treated without their consent for the first three months after their admission. 'Treatment' referred primarily to ECT or medication.
- The Mental Health Act Commission - an independent inspectorate was established to monitor the stay of detained patients.
- Social work responsibilities - Social Service Departments of Local Authorities were required to appoint a 'sufficient number' of Approved Social Workers (ASWs) 'having appropriate competence in dealing with persons suffering from mental disorder'.

Butler (1993) described the 1983 Act as a missed opportunity to put right problems which had been identified decades before. A major failure of the law is that it gave little attention to the details of further development of community care; most of the law focused upon inpatient care which actually affected a relatively small proportion of patients, with many patients being discharged and less than ten percent of all mental health patients being in mental hospitals at any one time (Jones, 1988).

Although the rhetoric of community care was emphasising the shift of services from hospitals to the community, in practice this was not occurring and government legislation continued in its failure to support this transfer, in legislative and financial terms. Mental health services remained fragmented between Local Authority provision and the NHS, with no structure or process to ensure that the complex needs of individual patients were jointly discussed, let alone met. The Act also failed to provide the means to develop standards of good practice, especially in the area of preventative work (Butler, 1993).

Until 1985, the policy of reducing hospital beds and transferring the focus of care into the community went relatively unchallenged in Britain, despite the fact that behind the scenes, community provision was proving to be inadequate. The realities of community care, however, came to the surface when two reports were published which were both very critical of community care provision.

In 1984, the House of Commons Social Services Committee conducted a survey of community care, taking evidence from many organisations and individuals and in their report, published in 1985 (*Community Care with special reference to Adult Mentally Ill and Mentally Handicapped People*) the committee emphasised the fact that community care involved much more than reducing hospital beds and believed that the Government's 'hands-off' approach, giving minimal assistance, in terms of policy prioritising or resources for community care, was an abdication of responsibility (Jones, 1993).

The report contained many strong critical statements, for example, that the phrase 'community care' had become '*virtually meaningless.....it had become a slogan, with all the weaknesses that that implies.....*' (HCSS, 1985: para. 8), and that '*the pace of removal of hospital services for mental illness has far outrun the provision of services in the community to replace them.....putting pressure on authorities to close or run down hospitals without similar incentives or resources to develop alternative services is putting the cart before the horse*' (HCSS, 1985: para.30), and stating that '*the stage has now been reached where the rhetoric of community care has to be matched by action*' (HCSS, 1985: para. 27)

This publication was swiftly followed by a report by the Audit Commission for Local Authorities in England and Wales (1986), entitled '*Making a Reality of Community Care*'. This report was also highly critical of the implementation of the community care policy, highlighting the 'mismatch' of resources between funding for hospital and community care, with a failure adequately to shift resources between the two sectors, resulting in a massive underfunding of community care provision. The Audit Commission report revealed that although mental hospital beds had been reduced by

some 25,000 since the 1950s, only 9,000 places had been provided in community-based facilities. The Audit Commission also found great disparities between different Local Authorities in their expenditure on mental health, which had led to different types and qualities of services in different locations. The report concluded that community care services were 'in disarray,' with money being spent in the wrong places (Jones, 1993).

4.2.3 The Griffiths Report : an agenda for change

It was clear that some strong action was required by the government; a businessman, Sir Roy Griffiths, who was deputy Chairman of the Sainsbury's food chain and Chairman of the NHS Management Committee, was appointed to review the way in which community care was being managed and to report his findings to the Secretary of State, with his recommendations for action. The appointment of an industrialist was a reflection of the political changes in Britain in the 1980's, with the development of 'Thatcherism', and the country being increasingly run on the lines of an industry in a laissez faire market place. It was clear that the government's intention was for the NHS to become more business-like and the architect was to be one of Britain's top businessmen (Butler, 1993).

However, Griffiths' recommendations were blunt and forthright and were received with little enthusiasm by the government (Jones, 1993). The main reason for this is that Griffiths accepted the evidence from the Social Services Committee Report (1985) and the Audit Commission (1986), endorsing the view that there was a wide gap between political rhetoric and the reality of the situation. He confirmed the failures of central government to give real financial commitment to community care and stated that they could not opt out of responsibility, commenting that the central problem with community care was that it was 'a poor relation: everybody's distant relative, but nobody's baby' (Griffiths, 1988, Letter to Secretary of State, para.9, p.iv.).

Griffiths reiterated the fact that much of the care in the community was fragmented and uncoordinated with the result being uneven and confusing patterns of service provision. Griffiths argued for a greater role for Local Government to co-ordinate community care and enable 'packages of care' to be delivered to each individual in need, with the provider of services coming from one of a number of agencies.

The Griffiths Report (1988) made four main recommendations, addressing important central problems with community care: the appointment of a Minister of State who would be clearly and publicly identified as being responsible for community care; the transfer of all community care, for the mentally ill, mentally handicapped, physically handicapped and frail and infirm elderly, to Local Authorities; the provision of earmarked grants by central government for community care; the Local Authorities to be empowered to buy in services from other agencies, including hospitals, voluntary homes and the private sector.

But these recommendations ran into a political minefield (Jones, 1988) with a major conflict being that the Thatcher Government was strongly opposed to giving greater powers to the Local Authorities. This had already been demonstrated by other policies, for example the break up of the GLC and other metropolitan councils and the rate-capping of councils. Therefore a proposal to hand out extensive powers and large sums of money to the Local Authorities was an extremely unwelcome suggestion. The publishing of the Griffiths Report uncharacteristically had no press conference and it was prefaced by a statement from the Secretary of State, saying that the DHSS would put forward its own proposals in due course (Jones, 1993).

The DHSS proposals arrived in 1989 in two white papers: *Caring for People: Community Care in the Next Decade and Beyond* and *Working for Patients*. The latter was the result of a government review that examined the funding and management of the NHS. The report recommended major changes in the organisation of health care, with a separation between those agencies which purchased services and those which provided them. For the past forty years, health authorities had taken on both roles (Butler, 1993). In *Caring for People*, while paying

tribute to Sir Roy Griffiths' 'valuable work', the preface letter from the four Secretaries of State (Health, Social Security, Scotland and Wales) defended the achievements so far of government policies and proceeded to outline how services would be organised in order to serve the different client groups included within community care policies.

These two reports set out the intentions for new legislation, adopting some of Griffiths' recommendations, for example by giving local authorities the responsibility as 'arrangers and purchasers' of care, but failing to provide specific funding for these services and not appointing a Minister for Community Care. These proposals resulted in the National Health Service and Community Care Act, passed in 1990 and implemented in three stages over two years from April 1991.

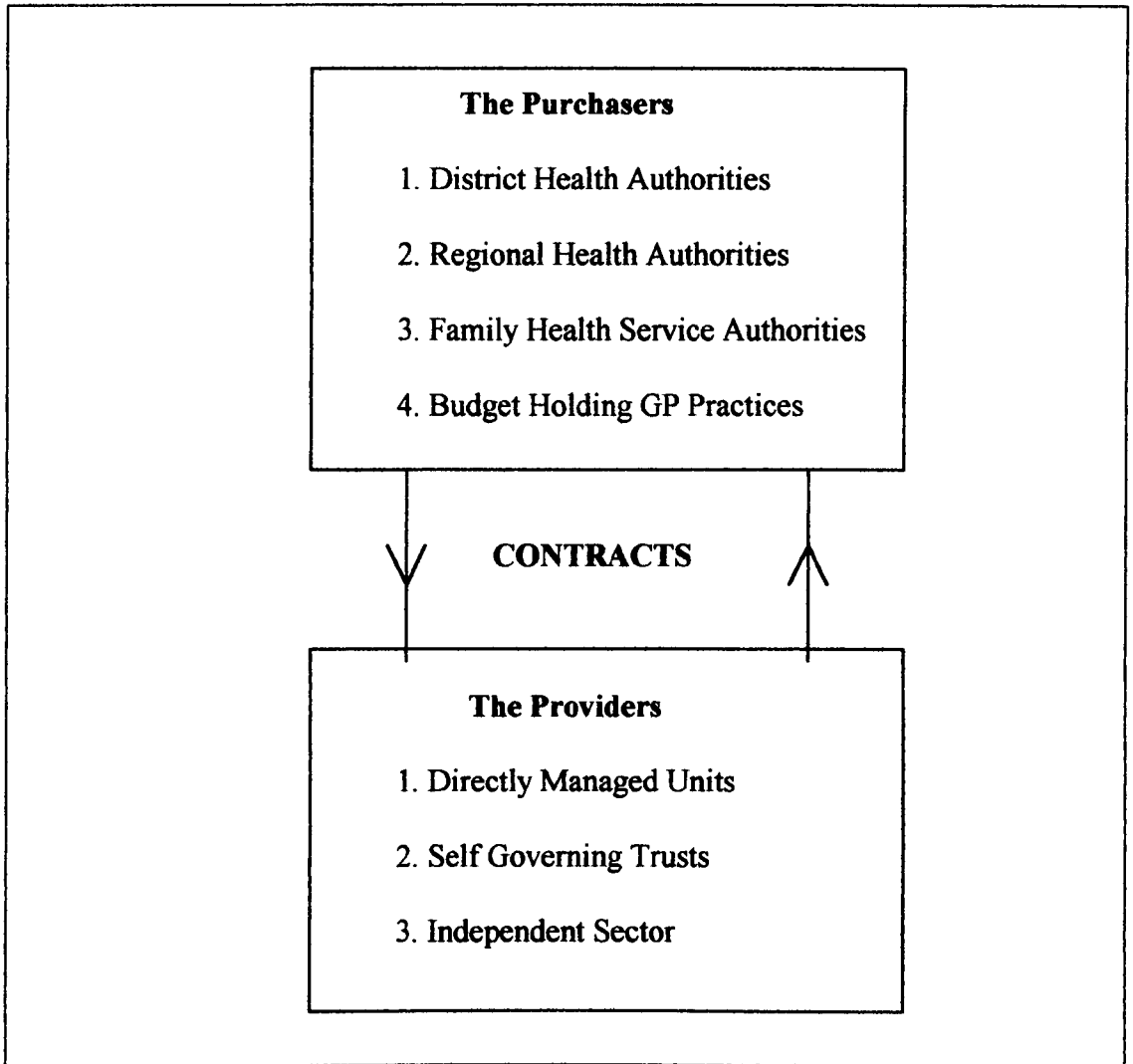
4.3 THE REORGANISATION OF MENTAL HEALTH SERVICES IN THE 1990s.

The 1990 NHS and Community Care Act is a wide ranging reform law, with the aim of transforming the management of health care in Britain. The purpose of this act has been the reorganisation of the NHS from a single organisation into two distinct and separate functions of purchasing and providing patient services. The Act has facilitated the emergence of a new 'contract culture' formalising relationships between the new purchasers and providers, as shown by Figure 4.1. This approach has been adopted from the world of business and is radically different from the traditional way of providing care within the NHS (Butler, 1993).

This new health care culture has brought with it a new language. The *purchasers* are the agencies with funding from central Government to spend, with the emphasis on obtaining 'good value for money'. The purchasers decide what services are required and then put out a call to tender to the *providers*, who can be health or social agencies from the statutory, voluntary or private sector. Patients have been renamed *clients* as they are supposedly like customers, being supplied with the services they require. Health administrators have become *managers*, with their numbers increasing

enormously during and since these reforms. Many hospitals have obtained self-financing status and have become *Trusts* and many GP's have also taken advantage of being able to manage their own finances and have become *GP fund-holding practices*.

Figure 4.1 The Purchasers and Providers in the new NHS (from Butler, 1993).



The 1990 NHS and Community Care Act has the following key objectives (Rao, 1991):

- To promote the development of Domiciliary, day and respite services to enable people needing care to live in their own homes whenever feasible and sensible.
- To ensure that service providers make practical support for carers a high priority.
- To make proper assessment of need and good case management the cornerstone of high quality care provision.
- To promote the development of a flourishing independent sector along side high quality public services.
- To clarify the responsibilities of agencies and so make it easier to hold them to account for their performance.
- To secure better value for money by introducing a new funding structure for community care.

In order to achieve these objectives, a number of changes have been introduced. Firstly, as recommended by Sir Roy Griffiths (1988), Local Authorities have been given the major responsibility for providing and/or organising the social care for the elderly and for people who are mentally ill or have physical or learning disabilities. The funding of residential care for these client groups has also been transferred to the Local Authorities from central government. A greater use of the independent and voluntary sectors as providers of care has been promoted within this legislation, with the Local Authorities and Health Authorities becoming primarily the purchasers of services, as shown in Figure 4.1.

Hospital services and GP's have been 'enabled' by the legislation to 'opt out' from direct control of the local Health Authority and become self-governing. Many hospitals have become *Trusts* and GP's have had the option to become *fund-holders* and purchase services for their clients from providers like the local district hospital Trust, with whom they have made a contract. Finally, a care management and assessment system has been established, with all people thought to need community care services entitled to an assessment of their needs. If deemed to be entitled to

service provision, they should receive an individual 'care plan' to be co-ordinated by a care-manager or key-worker who will act as a 'broker' and arrange the provision of required services. In this way, the funding follows the client from the purchaser, who is responsible for the client, to the service provider.

This reorganisation of services was originally scheduled to come into force in April 1991. But the timescale was tight for such enormous changes and the Government announced its decision in 1990 to phase implementation in three stages over two years from April 1991, with full implementation by April 1993. The hospital and GP elements of the Act were implemented immediately in 1991 but most of the community care changes were not brought into effect until April 1993. Therefore, the Local Authorities did not become the 'lead agency' for community care until that date.

The NHS and Community Care Act has dramatically restructured mental health services. In essence, local Social Services Departments (SSDs) and Health Authorities (HAs) have become the purchasers of health and social care and are responsible for providing jointly agreed community care plans for their locality. For mental health, these plans should clearly indicate the local implementation of needs-based individual care plans for long-term, severe and vulnerable people with mental health problems (Thornicroft, 1994). Such 'packages of care' can be purchased from a mixed economy of services, provided by statutory, private or voluntary agencies. Since the implementation of the Act, services have been increasingly provided by the private and voluntary sector; a number of mental health charities like MIND and the NSF have increased their stake in the share of services, particularly residential services. There has also been an enormous increase of service provision by the private sector, a development which Walker (1989) calls the 'marketisation' and 'privatisation' of care.

The Health of the Nation - A Strategy for England, a government White Paper published in July 1992, has added further policy changes and targets for mental health. This report was a national response to the WHO's *Health for All by the Year*

2000 Initiative (1984). Health of the Nation sets out a national plan of action for achieving health gains in five selected priority areas: coronary heart disease and stroke, cancers, mental illness, accidents and HIV/AIDS and sexual health (Department of Health, 1992). Following the publication of the White Paper, in 1993 the Key Area Handbooks were published, outlining the government's health targets for the five different priority areas. The Mental Illness handbook, published in 1993 with a second revised edition published in 1994, is the first comprehensive document on mental illness for health professionals and managers since 1975. It gives detailed guidance to both health and social service managers on the range of services they should be providing for people with mental health problems (Jenkins, 1994).

The mental illness key area has three health 'outcome' targets (Department of Health, 1994, p.11, 1.1): to improve significantly the health and social functioning of mentally ill people; to reduce the overall suicide rate by at least 15% by the year 2000 (from 11.0 per 1,000,000 population in 1990 to no more than 9.4); to reduce the suicide rate of severely mentally ill people by at least 33% by the year 2000 (from the life-time estimate of 15% in 1990 to no more than 10%).

These mental health targets are expected to be achieved by the promotion of the following three strategies: the improvement of information and understanding; the development of comprehensive local services; the continuing development of good practice. The development and use of good practice guidelines has become an important priority for mental health services. A central strategy for achieving 'good practice' is the Care Programme Approach (CPA) introduced in April 1991. The CPA is designed primarily to improve delivery of care to people with severe mental illness and should be applied to all people accepted by specialist psychiatric services and all psychiatric patients considered for discharge from hospital. The main aim of CPA is to ensure that 'vulnerable' people with severe mental illness (SMI) are not likely to 'slip through the safety-net of care'. The CPA has been further strengthened by the introduction of Supervision Registers, which cater for patients diagnosed as suffering from a severe mental illness who are considered to be at significant risk of

suicide, severe self-neglect, or of seriously harming other people (Department of Health, 1994, p.116-17, 9.8-11).

4.3.1 The impact of these changes on mental health care services

Recent Government policy and legislation concerning the delivery of general health and social care and more specifically mental health care, has had an enormous impact on the way that mental health care services are provided and subsequently, on the lives of people with mental health problems. The restructuring of mental health services has affected: how people receive a service, where they receive it and who provides it. The type of mental health service received is also determined by where in the country an individual lives; there is a geographical unevenness in the provision of mental health care services across the country, with some districts being particularly well endowed with services whilst others are poorly provided for (Faulkner, Field and Muijen, 1994).

This situation has also been highlighted by the latest Audit Commission report on mental health services, published in 1994, which states that local need for service provision varies and that 'some districts need four times as many mental health resources as others but the allocation of resources to districts does not match the pattern of local needs' (Audit Commission, 1994, p.9). There is great concern regarding the adequacy of service provision in the community for the mentally ill (Mental Health Act Commission, 1993), particularly in the light of the fact that despite the constant policy emphasis on 'care in the community', most of the money allocated for mental health remains in the hospital sector; in 1992/3 two thirds of the funding was spent on in-patient care (Audit Commission, 1994).

But despite the majority of funding being concentrated in the hospital sector, there is growing concern regarding the lack of acute psychiatric beds for people requiring urgent treatment and care, particularly in the inner-cities (Lelliot, Audini and Darroch, 1995; Powell, Hollander and Tobiansky, 1995). This problem is being compounded by patients being unable to leave the hospital system because of

insufficient appropriate community-based residential facilities (Lelliot and Wing, 1994).

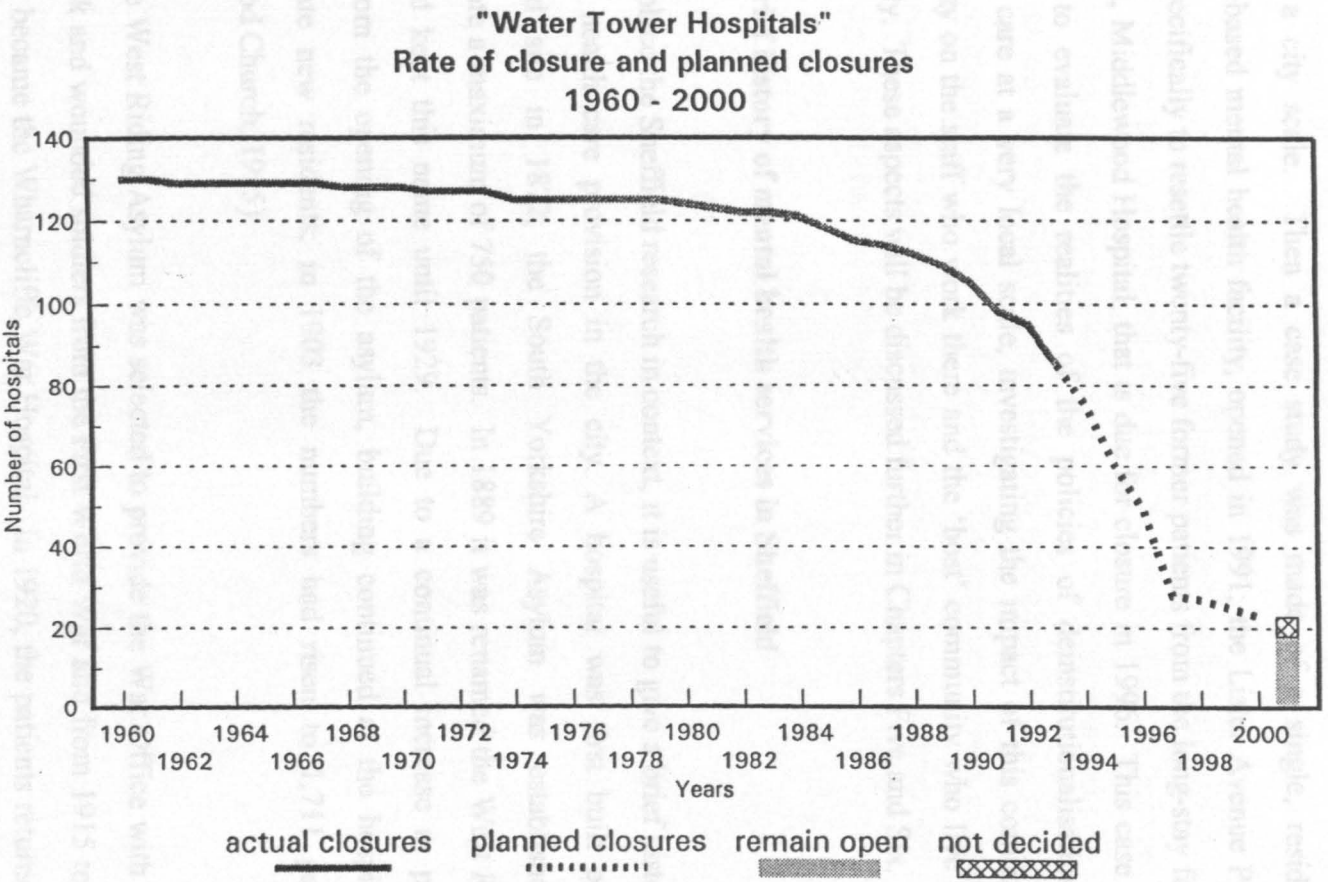
Added to this, it is evident that different ways of working between purchasers and providers have developed across the country (Ward, 1994) so that in some places, good collaboration has developed between the different agencies, but in others a more distant relationship applies. The relationship between purchasers and providers undoubtedly influences the efficiency and comprehensiveness of local services and is likely to be dictated by past relationships between the different services. For example, the historical legacy of a large psychiatric hospital in a district has been cited as one of the underlying causes of a mismatch between resources and needs in an area, with districts used to running a large hospital still spending more on mental health care (Audit Commission, 1994, p.13).

The closure of the old psychiatric hospitals has played a central role in community care policy since the 1960s. The Hospital Plan in 1962 introduced proposals to close the long-stay hospitals as discussed in 4.2.1. But twenty years later, no hospitals had closed although many had been gradually 'run-down' as the number of inpatient beds had declined steadily (a trend that has continued into the 1990s). In 1960, there were one hundred and thirty of the old mental hospitals in England open; Figure 4.2 illustrates the very slow closure of these hospitals until the mid 1980s, after which time the closure programme speeded up considerably, in line with the flux of legislation detailed in 4.2.2. However, in 1994, there were still eighty five of these hospitals open, although sixty-two of these are scheduled for closure by the year 2000 (Davidge, Elias, Jayes, Wood and Yates, 1994). As shown by Figure 4.2, the psychiatric hospitals in England did not start closing until the late 1980s onwards and thus the major impact of the mental health reforms is a relatively recent experience in Britain.

This is the national picture up to the first half of the 1990s. The second part of this chapter focuses upon the local picture, examining the impact of mental health reforms in the city of Sheffield from 1959 to the 1990s.

Figure 4.2 Rate of Closure and Planned Closures of Mental Illness Hospitals in England (1960-2000)

(source: Inter Authority Comparisons & Consultancy)



4.4 THE RESTRUCTURING AND RELOCATION OF MENTAL HEALTH SERVICES IN SHEFFIELD

The research component in Britain for this project was undertaken in the city of Sheffield between 1994 and 1995. The organisation of the mental health services in the city was examined in order to evaluate the impact of the national mental health reforms at a city scale. Then a case study was made of a single, residential community-based mental health facility, opened in 1991; the Lister Avenue Project was built specifically to resettle twenty-five former patients from the long-stay facility in Sheffield, Middlewood Hospital, that is due for closure in 1996. This case study was made to evaluate the realities of the policies of deinstitutionalisation and community care at a very local scale, investigating the impact of this community-based facility on the staff who work there and the 'host' community who live in the same locality. These aspects will be discussed further in Chapters Five and Six.

4.4.1 A brief history of mental health services in Sheffield

In order to place the Sheffield research in context, it is useful to give a brief history of the mental health care provision in the city. A hospital was first built on the Middlewood site in 1872; the South Yorkshire Asylum was established to accommodate a maximum of 750 patients. In 1889 it was renamed the West Riding Asylum and kept this name until 1929. Due to a continual increase in patient numbers from the opening of the asylum, building continued at the hospital to accommodate new residents; in 1903 the numbers had risen to 1,711 patients (Middlewood Church, 1995).

In 1914, the West Riding Asylum was selected to provide the War Office with 1,500 beds for sick and wounded soldiers from the First World War and from 1915 to 1920 the Asylum became the Wharnccliffe War Hospital. In 1920, the patients returned but to a newly named 'hospital'; according to a government directive, the use of the term 'asylum' was to be replaced by 'hospital' and in 1930 the Wadsley Asylum became

known as the South Yorkshire Mental Hospital, Wadsley. In the 1930's, a new era in mental health legislation saw changes in the mental health hospitals, with the Mental Health Treatment Act. With changing professional ideas about outpatient treatment and the community care movement developing, in 1935 a new Admissions Hospital was opened close to the Middlewood Road (see Figure 4.3, p.144). The new hospital was named The Middlewood Hospital, with the aim to distinguish itself from the main institution (Middlewood Church, 1995).

By the time of the Second World War, in-patient numbers had increased to 2,200 patients. Following the end of World War Two, the National Health Service Act of 1946 saw great changes for the mental health service. Wadsley Hospital came under the responsibility of the Sheffield Regional Hospital Board and the name of the whole institution was changed to Middlewood Hospital. The hospital served a geographical catchment area covering Sheffield, Rotherham, Doncaster and other parts of the West Riding, a population of over one million.

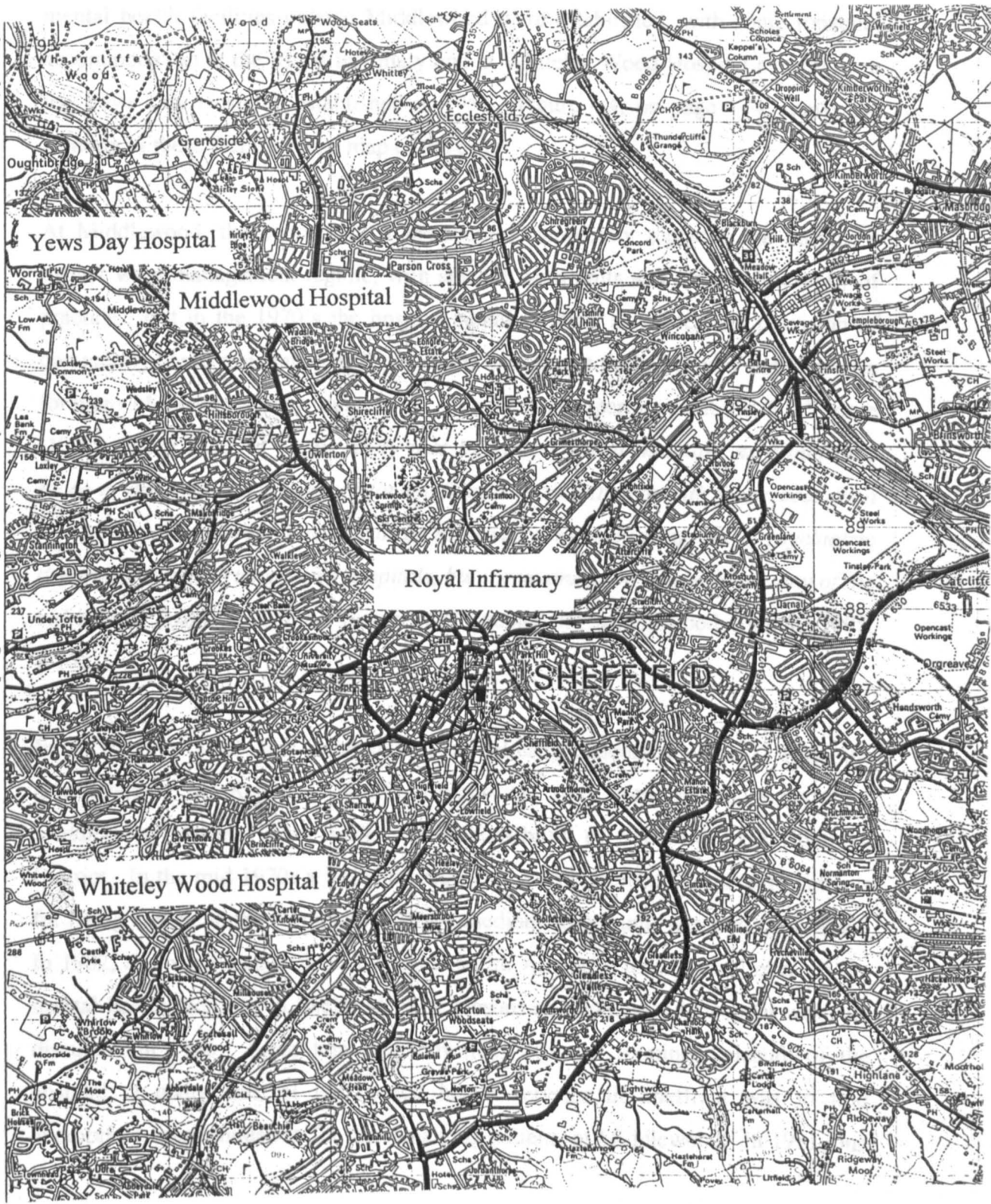
Figure 4.3 The Middlewood Hospital Site

(source : OS Sheet SK 39 SW Scale: 1: 10 560)



Figure 4.4 The City of Sheffield showing the Locations of Middlewood Hospital, the Royal Infirmary, Whiteley Wood Hospital and Yews Day Hospital.

(source: OS Sheet 111 Scale 1: 10 000)



As already discussed (4.2) the 1959 Mental Health Act brought about great changes to mental health care in Britain. With new medical treatment available, new admissions were discharged more quickly following effective treatment and with the move towards community care, in the 1960s rehabilitation to prepare long-term patients for life in the community began at Middlewood in earnest. In the 1950s and 1960s some mental health facilities outside Middlewood were established, with some inpatient accommodation at the Royal Infirmary and at Whiteley Wood Hospital as well as at the Yews Day Hospital, established in 1958. Figure 4.4, on page 144, shows the location of these facilities on a map of the city.

At Middlewood, the concept of a therapeutic community replaced the hospital's former ward management regime, with smaller ward units and a new philosophy of practice. But in the 1970's the hospital remained busy as inadequate provision of community-based residential facilities in the area meant that there was nowhere else for many of the long-term patients to go. The medical superintendent, Dr. F T Thorpe (1972), stated that: *"it seems likely that Middlewood will maintain its established place in the psychiatric services for the Sheffield area though with fewer beds than heretofore....the present decade will be marked by the increasing use of psychiatric departments in district general hospitals, but it remains to be seen whether any of the old mental hospitals will be superseded"* (quoted in, Middlewood Church, 1995, p.10).

In 1974, the NHS was reorganised, as already discussed (4.2.1), with the establishment of Regional Health Authorities and Area Health Authorities. Middlewood Hospital came under the responsibility of Sheffield AHA Southern District. In the mid 1970s a Rehabilitation Unit was established to prepare patients for living outside in the 'community' and a medium secure unit was also established. In 1982, the newly established Sheffield Health Authority took control over all the mental health facilities in Sheffield. The closure of Middlewood Hospital was first discussed in 1986. From this time onwards, with the imminent closure of the hospital, a major task of the mental health services in Sheffield was to find appropriate accommodation for the remaining patients at Middlewood. In 1991, one

such facility was opened in Lister Avenue, in the south-east of Sheffield, to provide a new home for twenty-five Middlewood patients.

4.4.2 The restructuring of mental health services in Sheffield

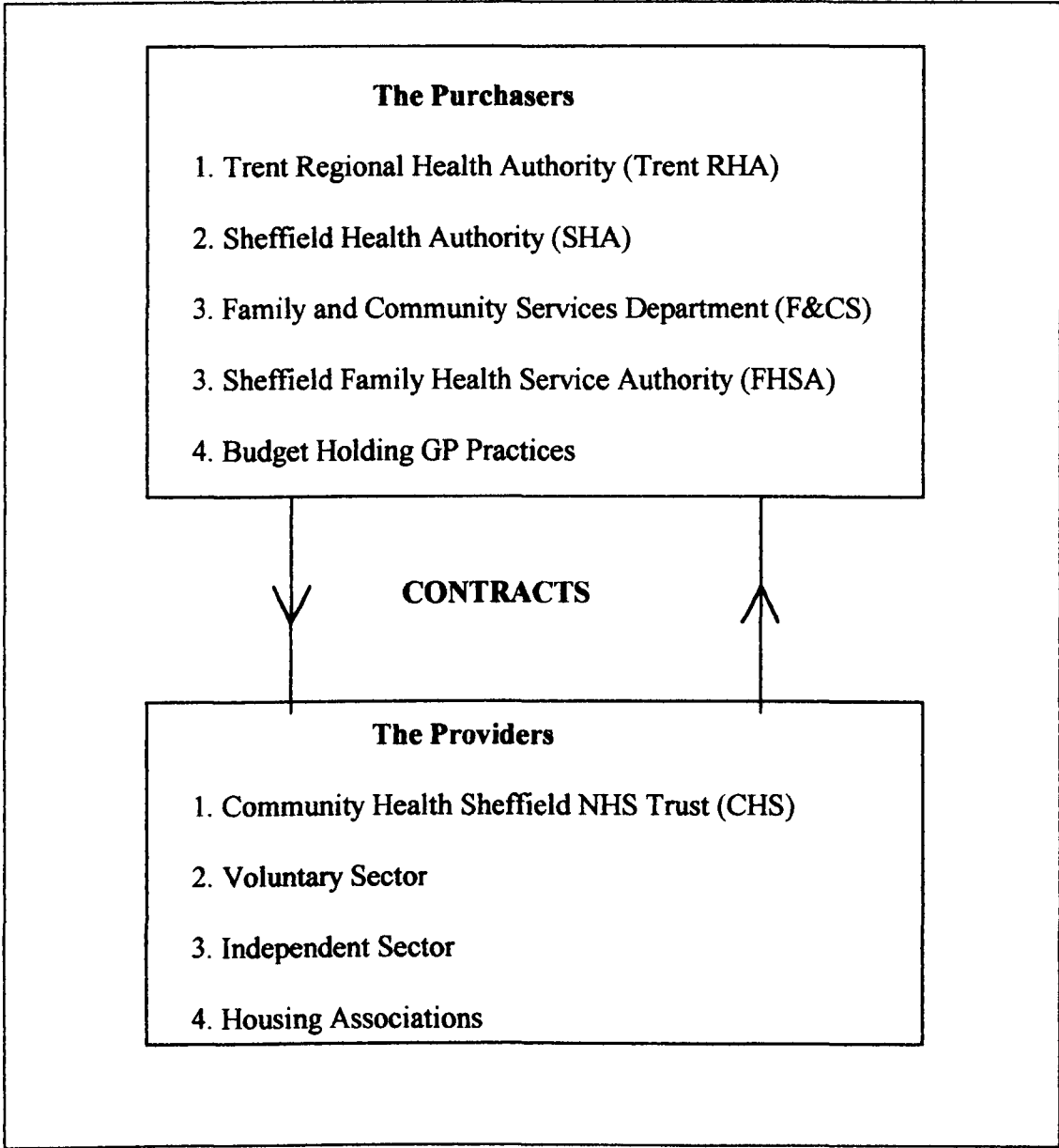
This section will discuss the reorganisation of the mental health services in Sheffield in the 1980s and 1990s as an outcome of government legislation, as detailed earlier in this chapter. The information given in this section has been derived from a number of sources: interviews with mental health professionals in Sheffield and documents and reports from different health agencies.

From 1982 until 1993, the mental health care services in Sheffield were a separate entity, under the responsibility of Sheffield Health Authority (SHA), who funded and provided the majority of health care for the local population. According to Government legislative changes, with the NHS and Community Care Act in 1990 coming into full effect in April 1993, the former Mental Health, Learning Difficulties and Community Health Services were all incorporated into a new organisation, Sheffield Community & Priority Care Services. This organisation acquired Trust status in April 1994 and was renamed Community Health Sheffield. This NHS Trust is now the major provider of mental health services in Sheffield. So in Sheffield, as elsewhere, a single health organisation has been replaced by different agencies, some that purchase services and others that provide them. There is also greater collaboration between health and social care agencies. In Sheffield, the new purchaser/provider split is illustrated by Figure 4.5.

Trent Regional Health Authority is the major health purchaser in the Trent region, allocating money, received from central Government, to Sheffield Health Authority and Sheffield's Family Health Service Association (FHSA) for health services in Sheffield. Trent RHA is still the agency responsible for secure mental health units for the Sheffield population, although there is currently not a secure unit in Sheffield. The service provision in this area is detailed in Table 4.2.

Sheffield Health Authority acquire services from providers in the statutory, voluntary and private sectors. The management of SHA has been reorganised, according to the national health reforms, to enable a greater focus on the provision of services to a locality. SHA is responsible for services covering a wide spectrum: acute in-patient services; specialist services such as intensive treatment; day hospital services and community mental health care. The FHSA is responsible for primary health care.

Figure 4.5 The Purchasers and Providers of Mental Health Care Services in Sheffield from April 1993.



The Family and Community Services Department (F&CS) is part of Sheffield City Council and therefore represents the Local Authority, who took over the responsibility for co-ordinating community care in April 1993, according to the changes introduced by the NHS and Community Care Act 1990. The F&CS is now a purchaser in the new market structure, responsible for ensuring that people with mental health problems in the city are provided with a wide range of social care services and accommodation services. (Although at the time of this research, F&CS were still undergoing a period of transition, still providing some mental health services). The new role for F&CS, in accordance with the new legislation, is the responsibility for co-ordinating joint strategies and development plans for mental health care in the city, together with a number of other agencies, including SHA, FHSA, representatives from the voluntary sector, mental health users and carers.

The major provider of community health services in Sheffield, funded by SHA and FHSA, is Community Health Sheffield. In 1994, when the research in Sheffield was carried out, SHA had three major contracts with Community Health Sheffield for mental health, learning difficulties and general community health services.. For mental health, as for the other two service types, the health providers in Sheffield (SHA, FHSA and F&CS) in 1992/3 decided on their priorities and the needs for service provision and then devised a longer-term strategy for mental health services. Therefore the contracts that they place from year to year are made to meet the aims and target objectives of their Mental Health Strategy.

The purchasers commission providers to 'provide' these required services, for example by saying that so many residential beds for a particular type of client group are required in a particular geographical sector. The 'winner' of the contract tender will then decide where and how to provide that service (sources: interviews with SHA mental health services manager and SHA/FHSA/F&CS Joint Strategy for Mental Health Services, Inventory of Services (Draft), 1994).

Services provided by the voluntary sector in Sheffield include residential facilities managed by mental health charities and campaigning groups such as MIND (National Association for Mental Health), Sue Ryder and NSF (National Schizophrenia Fellowship) and drop-in centres run by these groups and also by mental health users organisations. The majority of voluntary sector facilities are now purchased by F&CS. The voluntary sector has been providing mental health services in Sheffield for many years, but from 1993 their source and route of obtaining funding has changed, having to compete in the market place with other service providers, of which an increasing number are from the independent sector. However, in Sheffield the voluntary sector still provided the greatest number of residential facilities for rehabilitation and continuing care, although not the greatest number of beds; the independent sector provided the highest number of beds for this type of purpose (SHA/FHSA/F&CS Joint Strategy for Mental Health Services, Inventory of Services (Draft), 1994).

The independent sector has become more prominent as a mental health service provider in Sheffield, following the promotion of this sector within the National Health Service reforms. In 1994 in Sheffield, this sector was only providing residential services for the continuing care client group; in 1994, there were nine, twenty-four hour support residential facilities provided by the independent sector in Sheffield, providing a total of 195 beds. Some of the new independent facilities have emerged to provide accommodation for former Middlewood patients. The F&CS, in line with the emphasis of community care policy, are moving more and more towards purchasing all their residential services from the independent sector (source: interview with mental health professional from F&CS).

Services provided in the community, particularly for people in their own homes, are funded and provided by a range of different agencies, as shown by Table 4.2. An important development in community mental health care is the implementation of community mental health teams. This is a nationwide development and in Sheffield community mental health teams began to operate in 1993, with five teams, each serving a geographical sector, operating to provide a community-based mental health care service. Nationwide, more and more Community Mental Health Teams (CMHTs) are becoming multidisciplinary in nature and this is also the case in Sheffield, with the CMHTs composed of Consultant Psychiatrists, Psychologists, Occupational Therapists, Social Workers, Approved Social Workers (ASWs) and Community Psychiatric Nurses (CPNs).

With an increasing emphasis on the importance of Primary Care, GPs are working in greater collaboration with the mental health services and in Sheffield there are now also GP and Primary Care Mental Health Teams that are based at GP practices, right in the heart of the community. With reference to Table 4.2, it is important to explain that with the community and home-based services, some are still funded and managed by a single agency, for example the Primary Care Mental Health Teams are the responsibility of FHSA who are responsible for primary health care, but they also still employ the specialist trained mental health professionals required by such teams. Such arrangements may well change in the future.

Table 4.2 Mental Health Services Provided for the Sheffield Population (1994)

Source: SHA/FHSA/F&CS Joint Strategy for Mental Health Services, Inventory of Services, 1994.

Type of Service	Acute/Crises Accommodation	Rehabilitation and Continuing Care	Specialist
<u>Residential Services</u>	-Crises Accommodation -Acute Units <u>Funded by SHA</u> <u>Provided by CHS</u>	-Ordinary Housing -Unstaffed group homes -Adult placement schemes -Residential care schemes -Mental nursing homes -24 hr NHS accommodation <u>Funded by SHA and F&CS</u> <u>Provided by CHS, F&CS, voluntary and independent sector.</u>	-High Security <u>Funded by Department of Health</u> <u>Provided by Special Hospitals Authority</u> -Medium security <u>Funded by Trent RHA</u> <u>Provided by Leicester Mental Health Services and private secure facilities.</u>

Type of Service	Acute/Crisis Accommodation	Rehabilitation and Continuing Care	Specialist
<u>Day Services</u>	-Day Hospitals <u>Funded</u> by SHA <u>Provided</u> by CHS	-Drop in services -Employment schemes -Day care <u>Funded</u> by F&CS <u>Provided</u> by F&CS (temporarily) and voluntary sector	
<u>Community and home-based Services</u>	-Intensive home support -Emergency response team <u>Funded</u> by SHA <u>Provided</u> by CHS -Primary care teams <u>Funded</u> and <u>provided</u> by FHSA	-Out-patient services -Community mental health care services <u>Funded</u> and <u>provided</u> by SHA -Domiciliary services -Community groups -Community rehabilitation services <u>Funded</u> and <u>provided</u> by SHA, F&CS, voluntary and independent sector	

Figure 4.6 Sheffield Mental Health Services - Residential Services (1994)

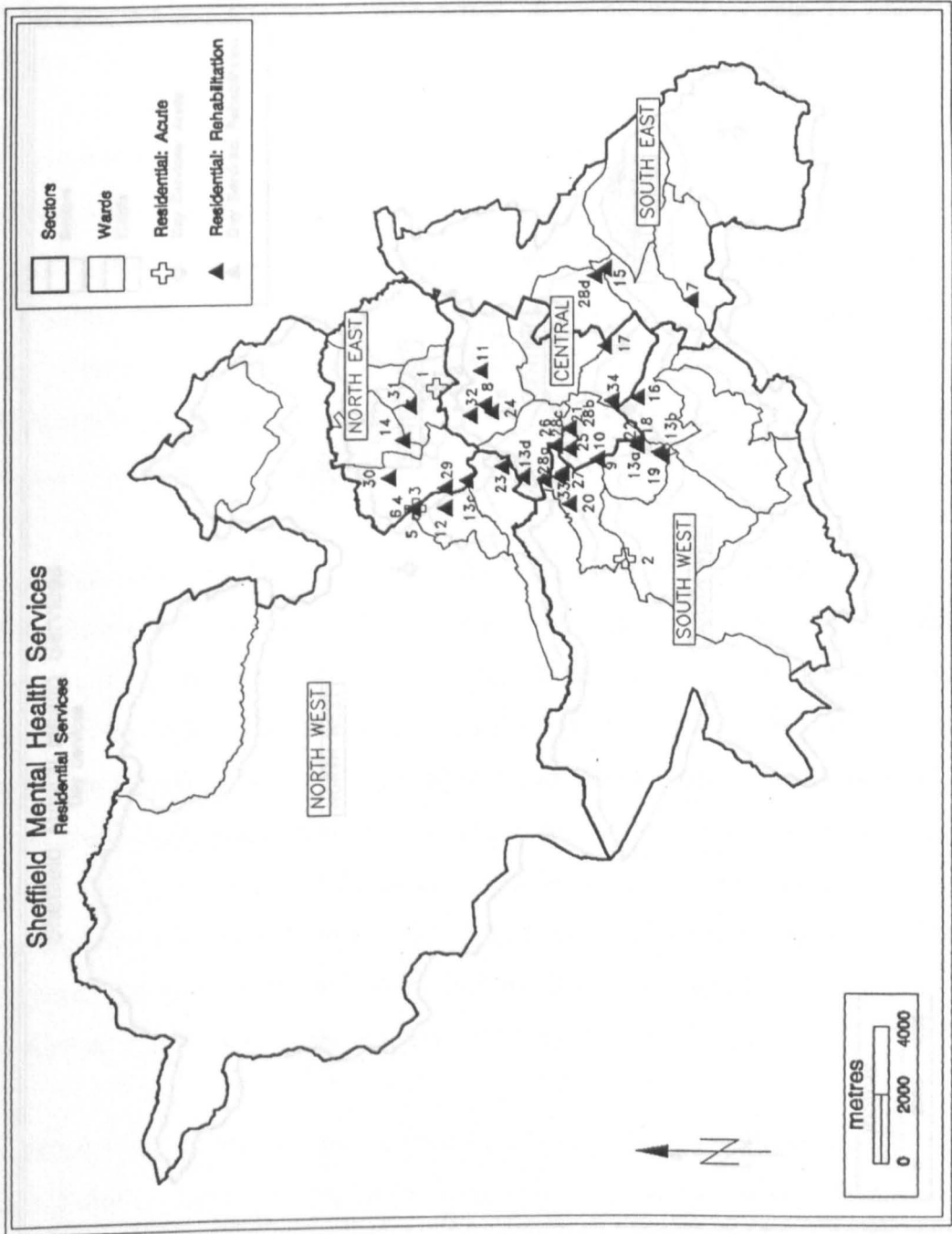
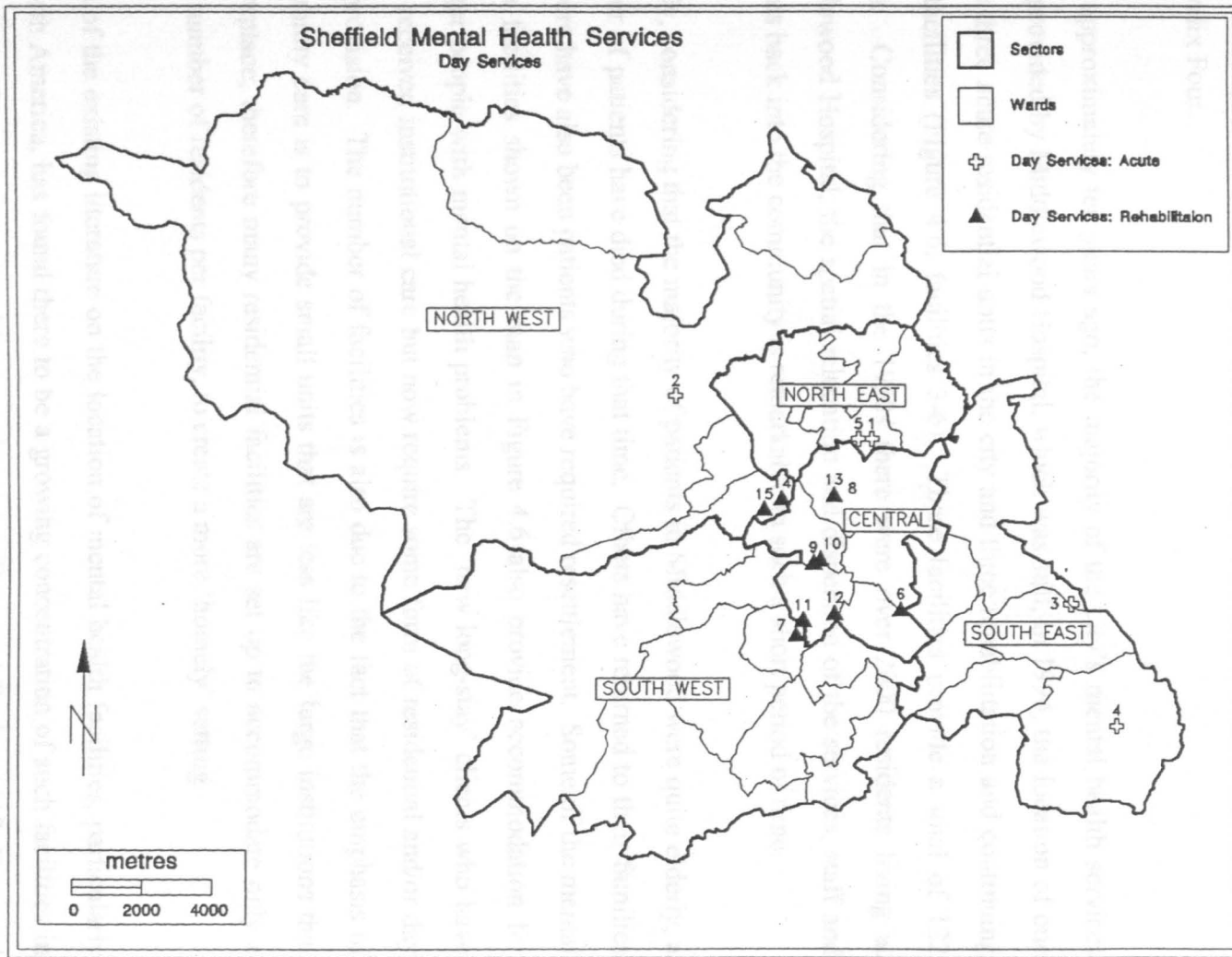


Figure 4.7 Sheffield Mental Health Services - Day Services (1994)



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4.4.3 The spatial relocation of mental health services in Sheffield in the 1990s.

Figures 4.6 and 4.7 show the five geographical sectors that have been designated for mental health services in Sheffield. They also show the city's ward boundaries and the location of the residential and day mental health care services and facilities, as of April 1994. Each facility is numbered and the details of each facility are given in Appendix Four.

Until approximately ten years ago, the majority of the city's mental health services were provided by Middlewood Hospital, which was still, in 1994, the location of one of the three acute residential units in the city and three rehabilitation and continuing care facilities (Figure 4.6, facilities 3-6). These facilities provide a total of 122 places. Considering that in the 1950s there were over 2000 residents living at Middlewood Hospital, the spatial relocation and dispersion of the services, staff and patients back into the community is remarkable in such a short period of time.

Clearly, considering that the majority of patients in Middlewood were quite elderly, a number of patients have died during that time. Others have returned to their families but there have also been patients who have required resettlement. Some of the mental health facilities shown on the map in Figure 4.6 also provide accommodation for younger people with mental health problems. The 'new long-stay' clients who have never received institutional care but now require some form of residential and/or day care provision. The number of facilities is also due to the fact that the emphasis of community care is to provide small units that are less like the large institutions that they replace; therefore many residential facilities are set up to accommodate only a small number of residents per facility, to create a more 'homely' setting.

Much of the existing literature on the location of mental health facilities, particularly in North America, has found there to be a growing concentration of such facilities in low income, inner city communities in major cities (Dear and Taylor, 1982; Dear and Wolch, 1987; Currie, Trute, Tefft and Segall, 1989); a situation described by Dear and Wolch (1987) as the "ghettoisation of the mentally ill". A similar experience has

also been found in the few studies carried out in Britain, for example in John Giggs's study in Nottingham, published in 1990.

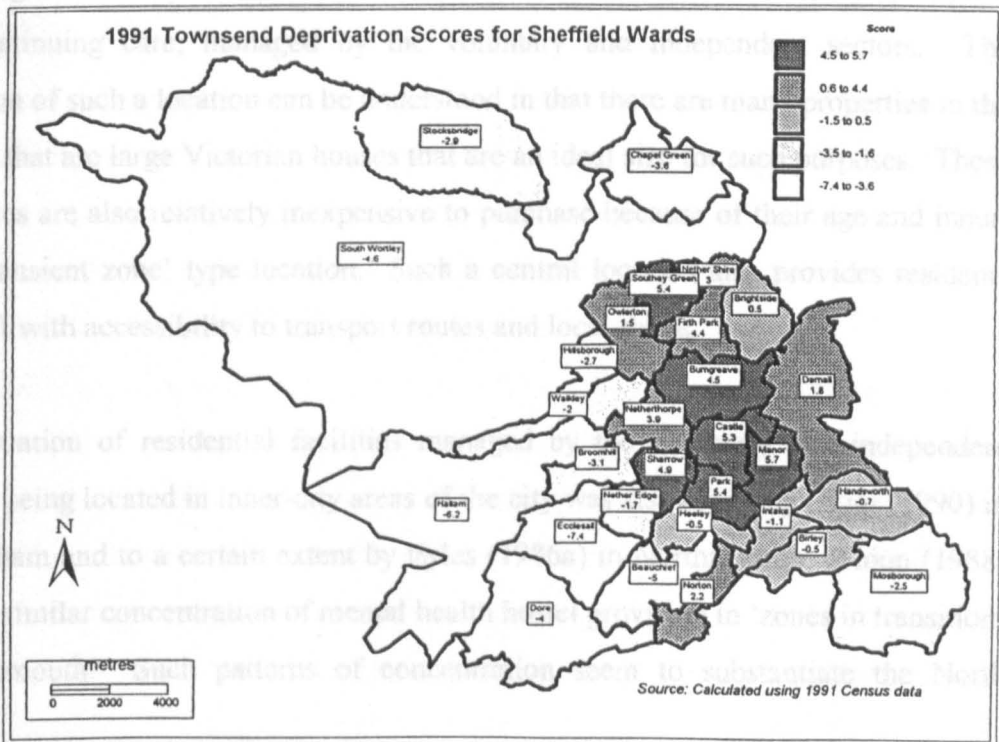
In Sheffield, as can be seen from the two maps (Figures 4.6 and 4.7), the distribution of mental health facilities appears to be more widely dispersed throughout the city. There is a slight concentration of facilities around the boundary of the central and south-west sectors. This area is covered by four wards: Broomhill, Nether Edge, Sharrow and Netherthorpe, as can be seen in Figure 4.8 which shows also the 1991 Townsend Deprivation Scores for Sheffield Wards. Table 4.3 shows that Sharrow is the fifth most 'deprived' ward in the city and that the ward of Netherthorpe is the eighth most 'deprived'. If all the city's mental health facilities were concentrated in all the most deprived inner city areas, then the 'hypothesis' suggested by previous research, that mental health facilities and the mentally ill will naturally become concentrated in the 'poorest' areas of a city, would also apply for Sheffield.

Table 4.3 Ranked Townsend Index and Deprivation Indicators for Sheffield Wards 1991

RANKED TOWNSEND INDEX AND DEPRIVATION INDICATORS FOR SHEFFIELD WARDS 1991							
Quintile	Electoral Ward	1991 Townsend Deprivation Index		1991 Census % economically active unemployed*		1991 Jarman Underprivileged Area Score	
		Index	Rank	%	Rank	Score	Rank
Most Deprived	Manor Park	5.7	1	24.9%	1	41.5	3
	Southey Green	5.4	2	24.5%	2	40.3	5
	Castle	5.4	3	21.4%	7	31.3	8
	Sharrow	5.3	4	23.9%	4	42.6	2
	Bumgreave	4.9	5	23.0%	5	40.8	4
	Bumgreave	4.5	6	24.5%	3	44.7	1
Above Average	Firth Park	4.4	7	19.3%	8	36.7	6
	Netherthorpe	3.9	8	22.5%	6	34.3	7
	Nether Shire	3.0	9	16.2%	9	21.8	11
	Norton	2.2	10	15.1%	10	22.3	10
	Darnall	1.8	11	15.0%	11	25.8	9
	Owerton	1.5	12	13.9%	12	21.8	12
Average	Brightside	0.5	13	12.3%	14	14.6	14
	Heeley	-0.5	14	12.8%	13	15.9	13
	Birley	-0.5	15	11.2%	16	4.3	19
	Handsworth	-0.7	16	10.5%	18	5.4	17
	Intake	-1.1	17	11.5%	15	5.3	18
Below Average	Nether Edge	-1.7	18	11.2%	17	13.5	15
	Walkley	-2.0	19	9.1%	19	3.2	20
	Mosborough	-2.5	20	8.7%	20	1.0	22
	Hillsborough	-2.7	21	8.5%	21	1.6	21
	Stocksbridge	-2.9	22	8.4%	22	-0.1	23
	Broomhill	-3.1	23	8.0%	23	5.4	16
Least Deprived	Chapel Green	-3.6	24	7.7%	24	-6.3	26
	Dore	-4.0	25	7.3%	25	-3.7	24
	South Wortley	-4.6	26	6.2%	27	-10.5	27
	Beauchief	-5.0	27	6.8%	26	-5.3	25
	Hallam	-6.2	28	4.7%	29	-10.8	28
	Ecclesall	-7.4	29	4.8%	28	-12.8	29
	Sheffield	0.0		12.4%		13.8	

*Unemployment rate for the economically active population aged 15-59/64

Figure 4.8 1991 Townsend Deprivation Scores for Sheffield Wards



However, in the four most 'deprived' wards of Manor, Park, Southey Green and Castle, there are very few mental health facilities. Where there is a slight concentration of mental health facilities in the wards of Broomhill and Nether Edge, these areas are both 'below average' according to the Townsend Deprivation scores. This evidence suggests that the North American experience is not necessarily applicable in all cases and certainly not in Sheffield in the 1990s. This suggests that other forces may be more influential in determining the spatial distribution of mental health facilities, as will be discussed shortly.

There are also large areas of the city without mental health facilities, particularly in the north-west, south-west and south-east sectors; wards such as Hallam, Dore and Beauchief, which are all quite prosperous areas of the city, but also in Darnall, Brightside and Norton, wards that are more 'deprived' (Table 4.3). These are less populated parts of the city and subsequently have a more sparsely distributed transport network and are less suitable than the urban areas of the city for community-based mental health facilities.

As one can see by comparing the map of residential facilities (Figure 4.6) and the list of facilities detailed in Appendix Four, the majority of facilities clustered in this area bordering the south west and central sectors are residential facilities for rehabilitation and continuing care, managed by the voluntary and independent sectors. The attraction of such a location can be understood in that there are many properties in the locality that are large Victorian houses that are an ideal size for such purposes. These properties are also relatively inexpensive to purchase because of their age and inner-city, 'transient zone' type location. Such a central location also provides residents and staff with accessibility to transport routes and local shops.

This situation of residential facilities managed by the voluntary and independent sectors, being located in inner-city areas of the city was also found by Giggs (1990) in Nottingham and to a certain extent by Eyles (1986a) in Northampton. Moon (1988) found a similar concentration of mental health hostel provision in 'zones in transition' in Portsmouth. Such patterns of concentration seem to substantiate the North

American research. However, in Sheffield the inner-city districts are not the only 'deprived' areas of the city as shown by Figure 4.8. Therefore it is perhaps the central location that is more important. Giggs (1990) suggests that the clustering of residential and other services for this client group 'makes good sense' as a central location increases accessibility to services and meeting places frequented by this group and also reduces travelling expenses for people, who will usually have limited resources (p.243).

In Sheffield there are further structural influences which have acted to prevent an increasing concentration of facilities for the mentally ill and other dependent groups in the inner-city areas. In Sheffield, as in other British cities, the City Council has a Department of Land and Planning that is responsible for ensuring acceptable land uses in the city. The Department publishes a policy document with plans for the city every ten years in a plan called the Unitary Development Plan (UDP). The UDP outlines a strategy for the city for the following ten years and beyond. Of relevance to this discussion is that the UDP states what is acceptable and unacceptable land use for different areas of the city. The City Planners work in consultation with health and social care agencies to assess the implications for community care and housing needs for people with special needs and particular groups of people, like the mentally ill (Sheffield City Council-Directorate of Planning and Economic Development, 1993).

Due to a concern that the areas of Nether Edge and Broomhall, in the ward of Broomhill, have developed the greatest concentrations of care and nursing homes in Sheffield, these areas are now 'blocked' according to a 'red-line' policy, where literally a red line has been drawn around those areas on the map, preventing future similar facilities being located there. Hotels, hostels and residential institutions are unacceptable uses for further development in these areas. What is permitted in those areas are offices used by the public, food and drink outlets, some small shops, community facilities and open space. The reason given for this policy is that the concentration of these land uses in these areas is beginning to undermine the residential character, with problems of inadequate parking, noise, traffic and general disturbance and, because of these factors, the City Council has decided to treat these

areas differently from other Housing Areas (Sheffield - A City for People, H11, p.175-177; Appendix 1, 1993).

The UDP has an additional impact on the development of housing for people in need of care; it will only allow new and refurbished housing in the form of supportive accommodation, sheltered accommodation, care homes and nursing homes to be permitted in 'suitable' areas providing that certain circumstances apply; that the situation would allow all residents to have a pleasant outlook, it would be within easy reach of a shopping centre, it would be suitable for people with disabilities, it would provide a reasonable area of accessible private open space or be immediately next to an area of public open space, it would not involve extensions which would remove essential open space and finally that it would comply with other Departmental policies (Sheffield - A City for People, 1993, p.169-170). This policy complies with the aims of the UDP to provide a better, more accessible and more caring environment for the people of Sheffield and specifically to meet the objectives of the Council's Community Care Policy by enabling residents in accommodation for people in need of care to enjoy a good quality of environment (p.170).

Clearly then, in the city of Sheffield a process of strict planning control is being undertaken to determine the geographical location and standard of accommodation for community care homes. This action is preventing a 'ghettoisation' of the mentally ill from emerging in the city, with an attempt to re-shape the future development of the areas of concern by encouraging other types of land use. As particular areas and streets now have restrictions concerning the establishment of such facilities, Planners from the community care providers must look elsewhere. The role played by the City Council and the Planning Department can be considered therefore to be an important one in explaining the distribution of community-based mental health facilities in Sheffield (sources of planning information: reports and documents as cited and interview with Planning Officer of Directorate of Planning and Economic Development, Sheffield City Council).

4.4.4 How the locations for new community-based mental health facilities are selected

In Sheffield, a number of recent developments of mental health facilities for the resettlement of former Middlewood patients, particularly by the statutory sector, have been purpose-built facilities rather than the re-development of existing buildings. Many of these new facilities are now located in suburban, residential parts of the city rather than in inner-city locations, partly due to the planning restrictions already discussed. The existence and public 'tolerance' of newly developed mental health facilities in suburban residential areas in Sheffield contradicts the tradition of previous research (Dear and Taylor, 1982; Taylor, 1988) that suggests that inner-cities are seen as more tolerant and accepting and that residents of higher status neighbourhoods and homeowners are more likely to oppose such facilities (Taylor, 1988, p.324).

There is also the implication that with a fear of neighbourhood opposition, Planners can be deterred from locating mental health facilities in suburban neighbourhoods; Dear (1992) discusses how the NIMBY syndrome can influence everyday land use decision-making by city Planners. But from the interviews that I carried out with Health and City Council Planning Department Planners in Sheffield, a concern about potential local community opposition has certainly not been an important factor in influencing the siting of new mental health facilities. Firstly, all the Planners that I spoke to told me they believed that people with mental health problems, providing that they presented no risk to themselves or others, had the same right as anyone to live in an ordinary house, in an ordinary street. For example, **Health Professional 1 (HP1)** told me:

HP1 "unless you are actually introducing a risk into that community and that's a known risk or a very high and likely risk, I don't think it's anything (stressed) to do with anybody else. Just like you or I, we don't have to ask neighbours permission to buy a house and I think it's rich that we treat other people in the same way.. (pause) if neighbours don't like it

they can come and talk about it, come and educate themselves, they can discuss their concerns with the people who are in the facility and the bottom line is that they have a choice to move house, these people don't."

Another Health Professional (HP2) had the same view point and told me:

HP2 "we [health agency] have always taken the line that people with mental health problems or what have you, have as much right to live in the community as anybody else and in the same way, when I move into a new estate or what have you, my neighbours do not have the right to have my life history. We've always taken the same line and I think that is..... that has often, you know, been one of the difficulties with placing projects there..... that because people that will be living there have mental health problems, the neighbours think they have the right to know, sometimes very intimate details, of their (pause) past, their new neighbours past histories. Now I think we have to strike a balance between..... obviously informing people about what's going on, but also protecting the right to privacy of the people who will be living there and as far as possible, not treating the development as anything other than that."

One of the Planners interviewed, **Planner 1 (P1)** told me that he believed that Planners had a responsibility to stand against community opposition for housing for all groups that are discriminated against in society and made an interesting comparison between the mentally ill and the black population in a city. When I asked him whether he thought residents had the right to exclude the mentally ill from their neighbourhood, he replied:

P1 "there has to be a fundamental principal that people have a right to live anywhere (pause)it might be interesting to do this at a kind of philosophical level which is slightly where we are, to do some comparisons... you could do some comparisons for example of where black people live. There are parts of this city where black people are

effectively excluded by the activities of the residents.. where white people will harass people out very quickly, bricks through the window, etc. etc. and I think that there's a danger of what that leads to, which is the effective ghettoisation of black people being forced back into the ghettos, unable to choose whether that's where they want to live, because of the reaction they get and I think that in that instance... for example Housing Associations and others have got a responsibility to take that on and do something about it. So in a sense there is a comparison, because people with mental health problems have been victimised, discriminated against so that notion in communities, thinking that they've got the right to exclude people who they perceive as not fitting and being different or whatever....it's not on."

In fact, consideration for local community reaction is relatively low on the list of priorities for the Health Professionals and Planners that I spoke to, when looking for a new site to locate a mental health facility. Factors such as site availability and size, distance from local shops and transport routes and other characteristics detailed in the UDP are far more important. In most cases, it appears that the choice of a site is more opportunistic than anything else, for as one Health Professional explained:

HP2 "there's a particular problem with Sheffield in site availability ... there are only a few sites available in Sheffield, so you never, in these situations, never start with like, the ideal, by any means, it's dictated by site availability..... I think you have to have a suitable size of site, depending on... so you can put in, you know, the right facilities with sufficient density, things like the garden area and that sort of stuff, all those things are ...ought to be important. So the site size is very useful."

The need to provide a range of services across the city is another factor as well as the influences of many different groups and organisations involved in the siting of a service, as highlighted by one of the Planners:

P1 “ There is a national position about the spread of services that we need around the city, sectors and such like... but even then you see, I used the word opportunistic before and opportunity is a huge factor in developments. Thinking about who’s actually involved in, in this, the stake holders, the users and carers, the purchasers and the providers, the F&CS, the Health Authority, the Housing Associations, the voluntary sector organisations, a small number of private sector organisations, the housing department housing corporation etc., etc., you write a rather long list of people who influence this and, in a sense, what happens within that mass of organisations is opportunity. So, opportunity arises because the Housing Department wants to sell a piece of land or opportunity arises because the Housing Department has a housing strategy with respect to a particular part of the city.... so I don’t think there is a plan that says we want to have this number of mental health units in this number of neighbourhoods and... we’d actually prefer it to be..... um, in Broomhall rather than over the road in Sharrow... or we’d like it to be in this sort of street rather than that sort of street. You’re just not able to be nearly as sophisticated as that. Now part of the reason why we’re not able to be as sophisticated as that is because the amount of work that has to be done to develop that kind of very sophisticated model of services is huge and this Department for example [F&CS Planning Dept] is in the process of knocking £4 million pounds of its budget so, um..... we’re a bit stretched, yeah?”

This final quotation raises several important issues. Firstly, there are a number of different agencies involved in the mental health system in a city and that any development is therefore an outcome of a complex process of decision-making by a number of different people and organisations. The influence of funding also is a factor, where a provider is competing in a market where often the lowest bidder wins and therefore there is not always the finance or time available to find the ‘best’ location but instead a site that is available at the right time and that fits the necessary

criteria. This point will be returned to when discussing the choice of location for the case study facility (4.5).

However, the type of community or neighbourhood is taken into consideration when siting a new facility and the Health Professionals and Planners did have their personal views, often based on experience, about particular areas in the city where they believed the siting of a mental health facility would be likely to be more successful, in terms of greater tolerance from host communities and subsequently, less isolation for the mentally ill. The main point to be made regarding this issue is that the health agency and City Council Planners that I spoke to all admitted the fact that they would expect greater community opposition to the siting of a mental health facility from a neighbourhood of a more middle class and owner occupied type.

However, as illustrated by the quotations just given, even though they sometimes expected and had recently experienced opposition from middle class local residents because of problems of finding suitable sites in the first place as well as believing that people with mental health problems have the right to live anywhere and not be ghettoised, they chose not to let this factor influence their decision-making. They would go ahead with a project wherever it was in the city. But, if community opposition did arise, they then reviewed their strategy only if they felt that the hostile atmosphere would act against the interests of the mentally ill who would be living there.

This commonly felt belief by the Health Professionals and Planners, that they were more likely to have opposition from middle class residents and owner-occupiers, does in part ratify previous research carried out on this issue. But what is different in Sheffield, is that Planners would still go ahead and propose projects in where they thought would be the best location, irrespective of whether they anticipated community opposition. If opposition did arise, then they would deal with it. Whether this situation is unique to Sheffield or to Britain, is something requiring further comparative research.

4.4.5 Examples of community opposition to the siting of mental health facilities in Sheffield

It is useful to consider briefly some examples of situations of community opposition to mental health facilities that occurred during the period of my research in Sheffield. One Health Professional, after telling me that the availability of suitable land and space was always the most important initial factor in choosing a site, said that once a site decision had been made, the type of neighbourhood was taken into consideration and a different approach to the development was often required in higher status neighbourhoods. So the neighbourhood character did not influence the decision but may have influenced the detailed outcome.

HP2 “I think, increasingly (pause).. we have learnt by experience that umm, the sort of social mix of the area of Lister Avenue [case study facility], is a good social mix to try and put facilities in. In more middle class areas, with a high proportion of owner occupiers, then I think you have to do it in such a way that... the only way that I think it can work in those circumstances is where the site is somehow separate or somehow isolated from the main housing environment..... and even then, I think... our biggest problem is in areas of higher,..... higher owner occupied, higher owner occupation. So I think you have to look at both, I think you have to look at both really and, you know....umm there'll be a few sites, ...you know... you plan your project and there will be two or three sites probably, in the city, that are available and possible and it's about balancing what the advantages itself of the site are, and the advantages of the community around it, really.....”

JJ “So are you, you sort of saying that in the higher owner occupation areas, then it's better to have sites slightly isolated but that, that is surely defeating the object of community care.....?”

HP2 “Yes, yes I think it is. I'm just”

JJ “But these are the realities?”

HP2 “Yes”

JJ “I see”

HP2 “Yeah...I mean I think (pause).. people are (pause).... I have to say as well,my prejudice coming out.... is that I've actually found that more middle class people have been, on average, less generous in their acceptance of people than, than more socially mixed areas. The first work I did really was on Hyde Park [a council high rise housing estate, most of which has now been demolished] you know, at the top there, it was bigger than Kelvin [a council high rise estate which has been demolished]..... and I think that (pause)...the acceptance of people at Hyde Park to people coming out of Middlewood I think was far greater than with any community I've ever worked, any area I've ever worked in since then..... I think that's quite (pause)... yeah, I found that pattern you know repeated...”

Another Health Professional, when asked how important the anticipation of community opposition was in relation to siting a mental health facility told me:

HP1 “Well not as important as you might think. Um (pause) I think because we are prepared, increasingly prepared to take the public on, um and I think we feel a bit more confidence. I can say that now because of what's been going on around the Rivelin Valley development, the Stockarth Close development and the Yews in Hillsborough [new mental health facilities subject to controversy at the time of this research]. All those three came on stream almost at the same time and it's been a lot of um, public opposition to, well to all those three developments and I think that you come to a point where if you consider the public in too great a detail or you place the communities um (pause) it depends on what you expect that facility to do, um (pause) ... I have to say, but if you consider the reception of the

community too much then you'd literally never move a thing, um, because there is no... the only tolerant areas for mental health are ghettos and there is no way on God's planet that any of us are going to start building or offering services in ghettos, unless it's appropriate and that's where people live so the only thing that would make life easy would be to place everything in places like Pitsmoor [a deprived area of the city], you know..... I certainly (words stressed) wouldn't allow the public view to, or the community view to colour not purchasing a facility somewhere.....”

This last quotation highlights very clearly the commitment of the Health Professionals and Planners in Sheffield not to allow community opposition to change siting decisions. However, the interviews with the Planners showed that their decisions can sometimes be overridden by political interventions. It was suggested to me by a number of interviewees, that this was the case in a recent situation when it was believed that a particular new facility development did not go ahead because of local opposition from a particular sector of the community and a forthcoming local election. However, this information was anecdotal and cannot be substantiated.

The remaining part of this chapter will focus upon the case study facility, the Lister Avenue Project, which opened in 1991 with minimal local opposition. The material discussed in 4.5 has been compiled from a number of sources: interviews with health Planners and health professionals involved in the project; interviews with 'Key Individuals' - the local vicar, Base Green Tenants Association, a councillor of Birley Ward; interviews with local residents, facility staff; relevant reports and documents; ethnographic observation within and outside the facility (as discussed in Chapter Three and detailed in Appendix One).

4.5 THE SHEFFIELD CASE STUDY

The mental health facility selected for the Sheffield research is a residential, rehabilitation and continuing care facility that was built to accommodate twenty-five people with long-term mental health problems, who were resettled from Middlewood

Hospital. The majority of the staff also came from Middlewood Hospital. So this facility is a 'classic' example of where patients, staff and resources have been relocated from a long-stay psychiatric hospital to a small community-based mental health facility.

This facility was also selected because at the time of the research it was one of the newest mental health facilities in the city, being opened in March 1991 and because it is located in a stable and suburban neighbourhood, a type of neighbourhood that previous research would suggest would be more likely to reject such a facility rather than tolerate one (this issue is addressed further in Chapter Five). The Lister Avenue Project is located in the south-east sector of the city and can be found on the map of residential facilities (Figure 4.6) as facility number seven. It is located in the neighbourhood of Base Green, in Birley ward; Figure 4.9 shows the area, showing the location of the facility on the corner of Lister Avenue and Base Green Road.

The population characteristics of the Birley ward, where this area is located, is of a 'skilled working class' area. The total population of the ward, according to the 1991 Census, was 18,817. Only 1% of the population was from an ethnic minority group, whereas the average for the city as a whole is approximately 5%. In 1991 Birley ward ranked 'average' according to the ranked Townsend Index and deprivation indicators (SHA/SFHSA, 1994); 58.5% of the households in the ward were owner-occupied (an increase of 22.2% since 1981) and 11.4% of the economically active were unemployed (the ward range in Sheffield for unemployment was from 4.7% (Hallam) to 24.9% (Manor)). There was quite a high percentage of the Birley population that were over the age of sixty-five, with 16% of the total local population, which was the third highest ward level in the city. The population of the ward was also very 'stable' with the second lowest figure in the city for individuals having moved a year before the census in 1991.

Figure 4.9 Base Green and Surrounding Area, Showing Location of Case Study Facility.

(source: OS Sheet SK 38 SE. Scale 1:10 000)

Location of case study facility ●



An interesting characteristic of the Lister Avenue mental health facility is that it was built on a completely new site for health care services. The site had previously been a green-field plot, adjacent to the local parish church and belonging to the church. The whole corner site was originally purchased by the Church of England in the mid 1950s and the church of St. Peters was built to serve the rapidly increasing local population, resulting from the development of a large council housing estate being built at that time, between the main roads of White Lane and Hollinsend Road (see Figure 4.9). The church was built on the corner of Lister Avenue and White Lane, with the rest of the site, on the corner of Base Green Road, being left a green-site. This spare piece of land was sold for the Lister Avenue Project rather than a commercial use because the Sheffield diocese made a conscious decision to sell the land for a social and community use (source: interview with 'Key Individual 2').

The project was developed as a partnership between three different agencies: Sheffield Health Authority (SHA), Sheffield City Council (F&CS) and a Housing Association, South Yorkshire Housing Association (SYHA). This type of partnership was the first of its kind in Sheffield, with SYHA building the facility and acting as landlord, SHA acting as advisors and providing support and assistance and F&CS managing the facility. What is also unique about this project is that the residents of the facility have become, and are always called, 'tenants' rather than 'patients,' 'clients' or 'residents'. With this status, the tenants pay rent which is derived from their welfare benefits to SYHA, and they are entitled to full tenant rights according to an assured tenancy agreement. The tenants are ensured a home for life and in return they are expected to contribute to their daily living needs, as much as their disability allows them; they are expected to be involved and contribute to such things as cleaning and shopping in their group house and so on.

FIGURE 4.10 TWO OF THE HOUSES OF THE
CASE STUDY FACILITY



FIGURE 4.11 THE CASE STUDY FACILITY: PHOTOGRAPH
TAKEN IN BASEGREEN AVENUE, LOOKING
TOWARDS LISTER AVENUE



The development consists of five separate houses, each house being shared by a small group of tenants. Each tenant has his or her own furnished bedroom and there are communal living areas, a kitchen and bathroom. One house is designed for people with additional physical disabilities, as are two bedrooms in two of the other houses. The five houses are interlinked at the back by a communal garden area. Each house also has its own front entrance with a driveway and garden fence, so that the housing looks like any ordinary Housing Association accommodation, as one can see in the photographs of the facility, Figures 4.10 and 4.11.

4.5.1 Why was this site selected for a mental health facility?

I was fortunate that the Health Professional who was the Planning Officer for the health agency responsible for the site selection and development of the Lister Avenue Project was still in Sheffield and willing to talk to me about his role in the project. In his own words, this is how the facility was located in that particular place:

HP2 “Yes, I managed the development of that project as an operational planner at the time. In terms of how we chose the location, it was partly (pause)opportunistic. (stressed)....what we did was we identified the sort of service that we felt we wanted and researched into what it might look like, and how many people it would be for, what design the building might be, those sorts of things. We worked with a Housing Association and they started then to look for an appropriate site that would fit that category. At that time, because it was a project, it wasn't a project to serve a particular area of the city, it was a project to resettle people from Middlewood, so in effect it could be anywhere. We didn't actually have..... you know, guidelines to where abouts in the city that might be, just wherever an appropriate site would be available. I think that when looking for an appropriate site, one of the things was land mass, that would be of an appropriate size and shape of site, we were also looking for a site that was part of an ordinary housing.... community, a community of ordinary housing. Not one so deprived that.... it was going to create

additional problems... and what we were extremely fortunate about, one of the reasons why Lister Avenue went so well was that... it was an ordinary housing area, the housing stock around, much of it was council housing, it wasn't essentially a private housing estate, it was quite a good estate though, it wasn't run down or deprived, but I think what assisted Lister Avenue the most is that the site was actually owned by the local church and they were actually looking for a socially useful use for that site. So they were very much in support of what we were proposing to do.....”

This description of events by respondent **Health Professional 2** reiterates a number of points and factors already discussed in this chapter. Firstly, the planner explained that his agency decided what sort of service was required, for how many people etc. and then the Housing Association started looking for a site to fit these criteria. As the facility was to resettle Middlewood patients rather than serve a geographical area (although the remit of the project is to do so from 1996 onwards as places become available), the most important thing was finding an ‘appropriate’ site, that in this case was a suitable size and shape of land. The Planners were also looking for a type of neighbourhood which they thought would provide an ‘ordinary housing’ environment.

As already discussed, ‘opportunity’ played an important part in the selection process, with the land for sale at the same time that SYHA were looking for a site. However, the role of the church in this development appears also to have been crucial and highly influential in the success of the project surviving the planning permission stage and with minimal negative community reaction, although there was some community response as will be discussed in a moment. The Health Professional involved with the development, **Health Professional 2**, described how important he thought the role played by the local church had been:

HP2 “effectively it was a partnership between the Housing Association and the church and so what that meant was that the church got involved in terms of shaping local opinion... you know, because obviously people knew the church were local people and because they were so much in support they actually, you know, we had that sort of people in place in the community who were supporting the project, and I think, ...I think Lister Avenue is almost, certainly in my experience of eight, nine years in Sheffield, has been almost unique in that respect. We've had opposition to virtually everything else that we've done... having the help of the local church, within the local community sort of arguing the case and being supportive towards the project made all the difference in the world.... now we've not managed to do that again in Sheffield.”

This last quotation highlights the ‘uniqueness’ of the Lister Avenue Project, having the local church supporting the project in the local community. The Health Professional, at the beginning of the project, gave the impression that the introduction of the facility to the local community went smoothly and without any negative reactions. However, because I had used the method of triangulation during my fieldwork, I had already spoken to other people involved with the development: the local vicar, the Base Green Tenants Association, local residents, and from these interviews I had obtained a slightly different ‘interpretation’ of how the local people were introduced to the facility.

It was true that the local church had been enormously influential in explaining the development to local residents, but there was discontent at the way the Housing Association and Planners gave information to the local residents about the project. One resident, (**Resident 3**) who lives on the same street to the facility and who is also a member of the church, told me in an interview that church members were initially shown a plan of the facility and that they approved of these plans. But then when they started building, something different appeared:

Resident 3: “The original plan showed that they [facility buildings] were going to be single storey developments, with a landscaped site and with some more parking spaces for the church goers.... I was delighted with it, it didn’t bother me at all as I’ve said, no reservations, in fact I don’t think anybody really objected.... (pause) I think probably the thing that upset us [the church members] the most was that the development in actual fact, turned out to be structurally very different to what had been proposed and what we had all agreed.... (pause) the other point was, that was the church’s concern rather than mine, not only did they not get more parking space, they actually got less. So I felt very sorry about it all.... (pause) I think we all felt that we had been conned”

Another event to cause misunderstanding and distrust amongst the local residents was that the local community were not told at first that the facility was being developed to resettle former Middlewood patients. When planning permission was being applied for, the Housing Association put leaflets through the letterboxes of the surrounding houses, saying that they were planning to build on the site, but apparently with no mention of Middlewood. Then a sign was put up on the proposed site, saying that the site was intended for housing for the ‘elderly and infirm’ with no mention of mental illness.

A local resident then found out by some means that this information was incorrect and that in fact the facility was for Middlewood patients. According to the local vicar (**Key Individual 2**), this revelation caused ‘a stink’ and a petition was begun, although it failed to be effective. The vicar believed that the people creating the most fuss were homeowners who had bought their council houses and were concerned about their house prices, although this information is purely anecdotal. The misleading sign was removed and the vicar put up a notice on the church noticeboard, giving information about the proposed facility, explaining that it was for people with mental health problems.

When interviewing local residents, I asked them about how they first heard about the facility development and a number of them told me about the sign going up and told me that they thought that they had been misled. One resident (**Resident 2**) who lived opposite to the facility told me:

Resident 2: “We weren’t told all the facts about it and that’s what annoyed people, that we weren’t told the truth..... (pause) we were told it was going to be an old folks’ home, but then we found out that they were really from Middlewood. A lot of people were really angry about it, you know...”

Clearly, the whole situation could have been handled better; the Health Professional responsible for Lister Avenue, when I asked him about this, told me that there had been ‘an administrative error’ with the Housing Association not being clear enough with their planning permission application and the City Planners misinterpreting the fact that because the planning permission had been applied for as a registered care home, which it is, they had assumed that it was for the elderly and infirm. Obviously there was a break-down in communication somewhere along the line which was wholly unintentional and very unfortunate. In no way was I attempting to ‘catch out’ this planner during the interview, but it was interesting that after he knew that I had ‘done some homework’ he seemed to give me a very honest account of what happened, that tied in with information that I had received from other sources. This episode was an example of how by triangulating one’s research strategy, the complete picture of a situation can be revealed, as discussed further in Chapter Three.

Previous studies (Wall, 1986; Reynolds, Pitts-Brown and Thornicroft, 1996), illustrate that the approach taken by agencies in introducing a new mental health facility to the host community can be very influential in the resulting acceptance or rejection of that facility by its neighbours. The manager of the Lister Avenue facility told me that this episode did cause bad feeling amongst local residents when the facility first opened and he thinks that he should have been in post earlier, to explain what the facility was about and so on. He did attend some meetings of the local tenants’ association and

talked to anyone who wanted to find out more information. When the facility opened in March 1991, an Open Day was held to which members of the local church and other local residents were invited, to meet the staff and tenants and see the facility. A number of people attended (source: interview with the manager of the Lister Avenue Project).

Considering the amount of bad feeling in the neighbourhood about the way local people had been misinformed, one would perhaps be surprised that the facility went ahead. Some local residents felt that the project had been pushed through so quickly and secretly that they had little time to do anything about it. Two of the local residents that I spoke to didn't hear about what the facility was for until the building had started and then they found out unofficially from friends and neighbours:

Resident 4 "They were well on the way of building it before we discovered what it was going to be.... it was just done and that was it..."

Resident 1 "We watched them build it.... it went up ever so quick... (pause) and then it was the guessing game, 'I wonder what it's going to be?' and then we heard from a friend of ours that it was going to be for people from Middlewood"

Despite the lack of public consultation, apart from the local church members, and the subsequent discontent from local residents, the development did go ahead and the tenants and staff moved in. As far as the Planners are concerned, this is therefore a successful project; the planner responsible for the development told me:

HP2 "I'm sure there were some concerns, I'm not trying to say that everyone down Lister Avenue was hunky dory about it, but on balance we had the support of the local community, of, of the local church (correcting himself), that's enough to balance out so it was not..... there were no major eruptions with lots of protest at that time. I don't know what people's

experience is since then but I suspect they would not have problems with people living there”.

This quotation is interesting as it shows how the Health Professional felt that the church represented the views of the local community and because the church was in favour of the development, that ‘over-rode’ any other opposition. The last sentence also reinforces the fact that the main role of the Planner is to get the development operational and then he simply assumed that everything would smooth over in time. Previous research has shown that tolerance does increase over time (Moon, 1988; Dear, 1992) and Chapter Five addresses this issue as far as the Lister Avenue Project is concerned. Therefore, the role of the Planners is to get the facility established, with minimal opposition that does not succeed in preventing the facility being located in the selected place. The Health Professional responsible for Lister Avenue had this to say about why he thought the siting was a success:

HP2 “All the things that went for Lister Avenue, we hit on by chance, I have to say, I couldn't say that they were all planned. The partnership with the church, the fact that it wasn't a high degree of privately owned property around it, for example, all little things that I think make for a more successful placement. Having the help of the local church within the local community, being supportive towards the project, made all the difference in the world..... now we've not managed to do that again in Sheffield.”

Previous research has shown also that the design and appearance of the facility is also an important factor. Dear (1992) suggests that facility characteristics have a direct impact on community perceptions and that a facility ‘should blend into its context to obtain a good fit with its setting’ (p.293). The photographs of the case study facility, Figures 4.10 and 4.11, show the appearance of the Lister Avenue Project. The Health Professional who managed the development of the project spoke in his interview about how well designed he thought the facility was:

HP2 “I have to say, that I think that the design of Lister itself is, is very good in that you know..... it does in fact look very much like ordinary housing from the outside, they went into a lot of detail with the planning, having the closed garden at the back and even, you know, even having the drives, individual drives and stuff to make it look very much, well, it blends in, I think, very well with the community... I think it is a particularly well designed project.”

This chapter has discussed the implementation of mental health reforms in Britain at the national, city and local scale. In Sheffield, the spatial relocation of mental health services has resulted in a considerable dispersion of facilities, with the provision of services in a small number of sites being replaced by a greater number of smaller, community-based facilities across the city. Interviews with Health Professionals and Planners has shown that the decision-making processes behind the siting of these new facilities is complex and involves a number of different people and organisations. It also appears that a consideration for the reactions of the potential ‘host’ community to new facilities is not of primary concern, with other criteria being more important.

According to the Health Professionals and Planners interviewed, the location and development of the Lister Avenue Project in Base Green has been a successful example of community care. The following two chapters investigate the views and attitudes of the ‘host’ community and the staff working in the case study facility with regard to this, and other issues.

CHAPTER FIVE

THE QUESTIONNAIRE SURVEY IN SHEFFIELD: INVESTIGATING REACTIONS OF LOCAL RESIDENTS TO THE LISTER AVENUE PROJECT.

5.1 INTRODUCTION

“The deinstitutionalization of mental health care has meant that demands are placed on selected communities to act as host to a group which has traditionally been excluded by society in general. The reaction of the local community in its role as host is regarded as fundamental to the success of community-based care. Rejection of the mentally ill by local residents is likely to undermine any therapeutic benefit of being part of a ‘normal’ environment.”

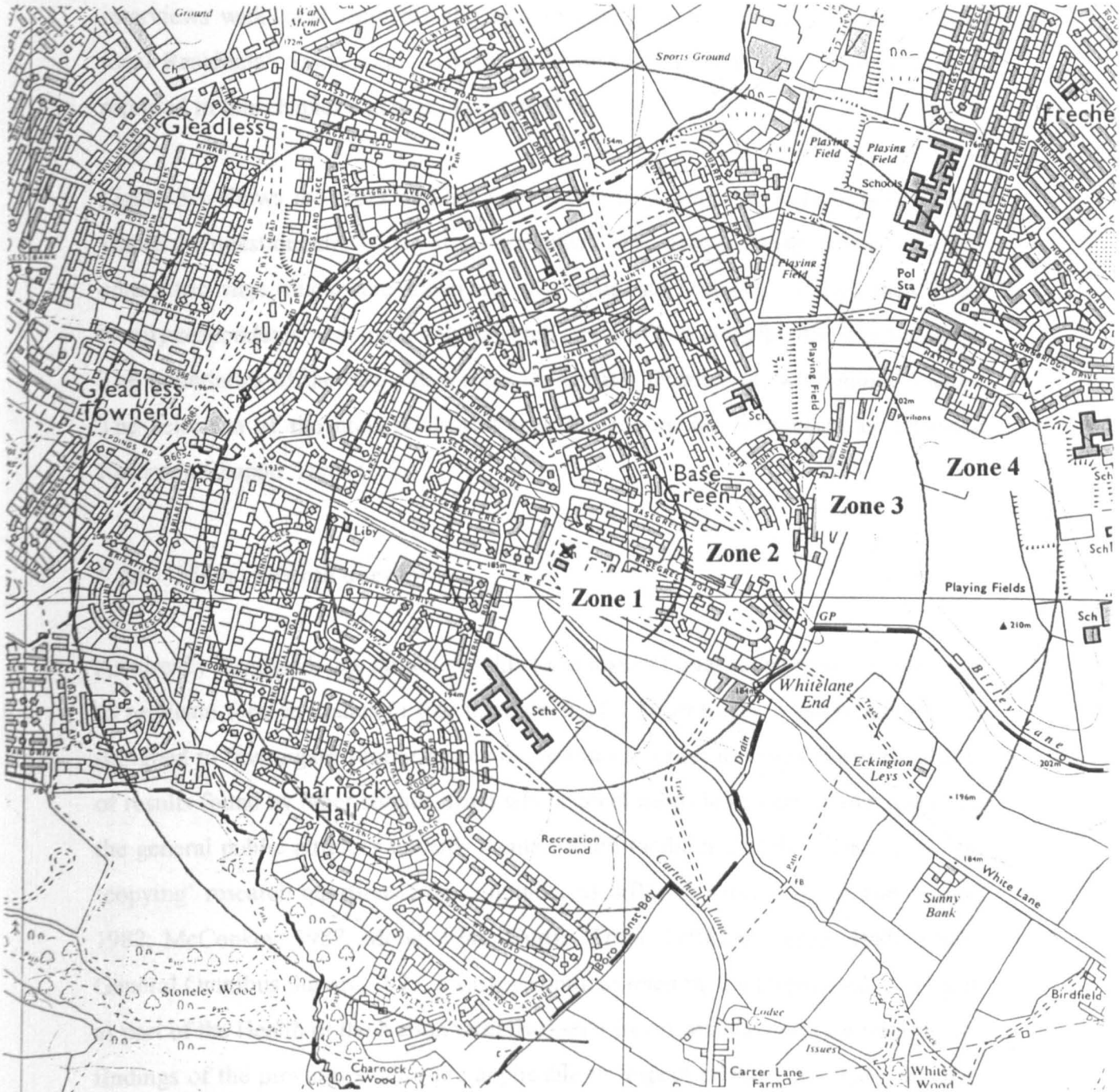
(Dear and Taylor 1982, preface)

This chapter discusses findings from a questionnaire survey conducted with eighty residents who lived in close vicinity to the Lister Avenue Project. As discussed in Chapter Two, much of the geographical research on mental health in the 1970’s and 1980’s has focused upon an ‘urban conflict’ and ‘neighbourhood activist’ approach, in an attempt to gauge the attitudes of local residents towards the location of a mental health facility in their locality. Such an approach has assumed that members of a local community will have some kind of response, almost as a matter of course, to the possible or actual location of a type of mental health facility in their neighbourhood.

Figure 5.1 The South-East of Sheffield, Showing the Zoning Method used to Recruit the Sheffield Local Resident Survey Sample

(source: OS Sheet SK SE Scale 1:10 000)

X Location of case study facility



5.2 THE LOCAL RESIDENT SURVEY

The aim of this part of the research has been to assess the impact of the location of the case study mental health facility from the point of view of the local residents living in proximity to the facility. The main method applied was a door to door questionnaire survey of eighty local residents, as has been already discussed in Chapter Three. This questionnaire was further complemented by five semi-structured interviews with local residents and an interview with a committee member of the local Residents' Association. The information gained from these six interviews is reported in this chapter and also in Chapter Four.

Figure 5.1 shows the areas of Base Green, Charnock Hall and Gleadless Townend, where the questionnaire survey was conducted. Also shown on the map are the four concentric rings which were drawn around the case study facility. Within each 'ring', twenty respondents were randomly selected and asked to complete the questionnaire. The boundaries of the concentric rings represent a distance of two hundred metres. The selection of the households and how the survey was conducted is discussed further in Chapter Three (3.5).

5.2.1 Main research questions

As already discussed, one purpose of this local resident questionnaire survey has been to replicate former studies in this research field. Accordingly, a questionnaire was designed to investigate similar research questions in order to assess the applicability of results found by other studies, from which conclusions have been drawn regarding the general public attitudes towards mental health facilities and the mentally ill. By 'copying' research questions from a number of different surveys (Dear and Taylor, 1982; McConkey, 1987; Moon, 1988; Currie, Trute, Tefft and Segall, 1989; RSGB General Omnibus Survey, 1993, a survey commissioned by the Department of Health as part of the Health of the Nation initiative), this survey aims to consider whether the findings of the previous studies are applicable in respect of this case study, whether

any general trends can be identified or whether this case study is unique to the place, time and specific conditions of the locality.

Following from the aims of the survey, the questionnaire was designed with the following research objectives in mind:

- To measure the extent of the existence of social networks in the neighbourhood. How 'stable' is the local neighbourhood? Does this give an indication of whether this neighbourhood is a suitable place for the location of a mental health facility?
- To assess perceptions of 'noxiousness' of mental health facilities in comparison with other public facilities and services and to investigate whether there is a 'distance decay effect' on people's attitudes towards the location of facilities.
- To investigate the potential for 'activism' amongst the local residents if they oppose the siting of a particular facility.
- To investigate local residents' awareness of the mental health facility in the neighbourhood.
- To assess the influence of personal characteristics on individual's attitudes, perceptions and behaviour.

To this end, the questionnaire was constructed within sections, as discussed in 5.3.

5.3 THE QUESTIONNAIRE

In order to explain the rationale behind the design of the questionnaire used in this research and how the questions relate to the defined objectives, the questionnaire will now be examined section by section, with the purpose of explaining where the questions came from in terms of previous studies and how each question is related to the main research objectives.

5.3.1. Extent of 'community' in locality

The aim of the questions in this section has been to assess to what extent there is a 'community' in this locality. According to the rhetoric of community care, the government assumes that some sort of a community exists to 'care' for the groups targeted by the community care policy. The concept of a 'caring community' is a highly ambiguous one, as discussed in Chapter Two (2.4). The first four questions in this questionnaire aim to assess the degree of 'social cohesion' within the local community which is in the vicinity of the mental health facility. Previous studies (Dear and Taylor, 1982; Currie, Trute, Tefft and Segall, 1989) suggest that the extent of social cohesiveness of a community can influence the acceptance or rejection of a mental health facility. To investigate these enquiries, the following questions were asked at the beginning of the questionnaire:

Q1 How long have you been living in this neighbourhood?

- Less than a year
- 1 to 5 yrs.
- 6 to 10 yrs.
- 11 yrs. or more

Q2 How many people do you know in this neighbourhood?

- None
- 1 or 2
- 3 to 5
- 6 to 15
- 16 +

Q3 What activities are you presently involved in this neighbourhood?

Are you involved in.....	No	If Yes do you go		
		Occasionally	Regularly	
sports clubs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
other clubs (e.g. bridge)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
bingo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
the local residents association	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
voluntary work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
political organisations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
evening/day classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
a local church	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*
going to local pubs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
going to a working men's club	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*
using the local shops	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*
meeting other parents from children's school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*
other 1.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

(The starred activities are those added to the list taken from McConkey's questionnaire (1987). Attending the local church replaced McConkey's activity of 'prayer groups' and also removed was the activity 'discos/dances'.)

Q4 Do you feel as though there is a strong sense of local community in this neighbourhood?

- Agree strongly
- Agree slightly
- Neither agree or disagree
- Disagree slightly
- Disagree strongly
- Don't know

Questions 1-3 were adapted from a questionnaire survey used by McConkey in Dublin (published in 1987), which investigated community involvement with handicapped people. **Questions 1 and 2** and the un-marked sections of **question 3** were taken directly from McConkey's questionnaire. Some of the activities were changed in **question 3**; for example, involvement in working men's clubs was added as these organisations are widespread in the north of England, as part of its industrial heritage. Using the local shops and meeting other parents from the children's school were also added as there are both local shops and schools within the defined area of the survey and it was anticipated that both activities were examples of participation in the local community. **Question 4** was added as a question not asked by McConkey but one considered to be important for this study.

The term 'neighbourhood' used in **questions 1-3** was chosen deliberately instead of 'community'; it was considered that the concept of a 'neighbourhood' has a more geographical dimension to it and also would be a more comprehensible term for the respondents in light of the questions being asked. However, both terms are highly problematic and it is readily accepted that different respondents would have made their own definitions according to their interpretation of their 'neighbourhood'. But it was decided that it was preferable for the respondents to apply their own definitions rather than the question prescribe the concept, allowing them less freedom. The wording for **question 4** was equally problematic but, for this question, any way of asking the question would have had its drawbacks, so this compromise was reached. Finally, **questions 1-4** came first in the questionnaire as it was considered to be better to begin the questionnaire with general and less sensitive questions.

5.3.2 Comparative 'noxiousness' of facilities

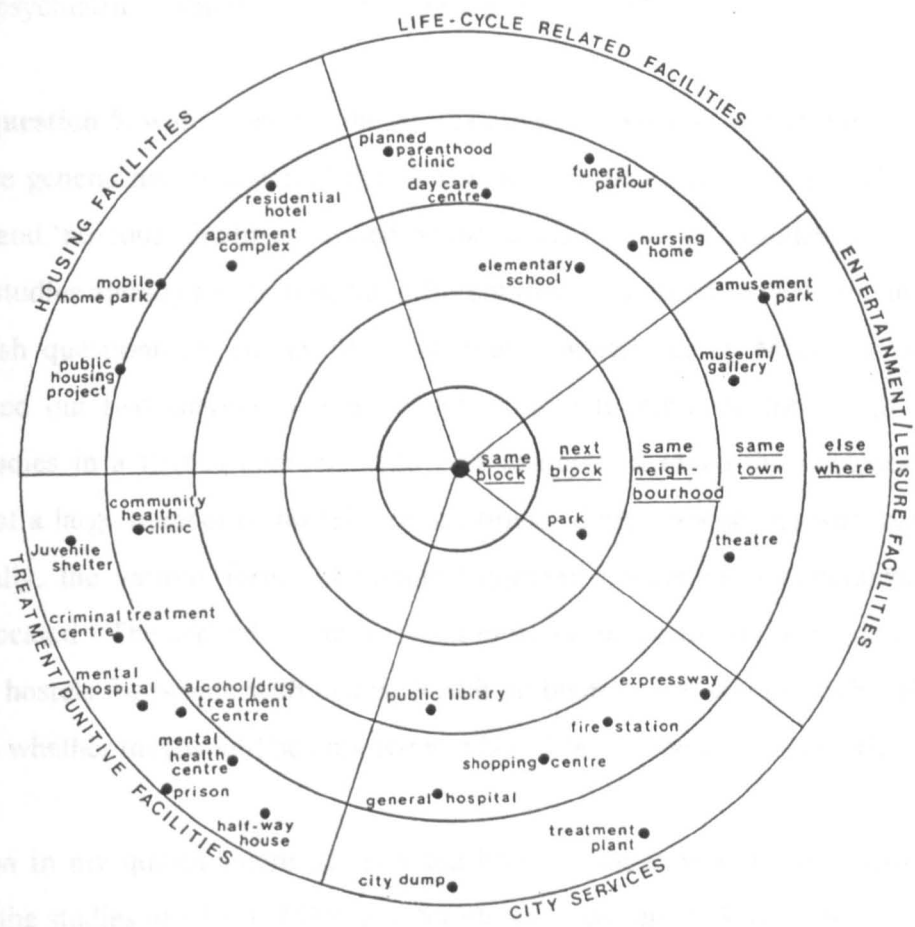
Previous studies have shown that mental health facilities can be classed as part of a larger group of 'noxious' facilities that have the potential to arouse substantial community opposition whenever locational decisions need to be made (Smith and Hanham, 1981a; 1981b; Burnett and Moon, 1983). Smith, Hanham and Chang (1978, as quoted by Smith, 1980), investigated the perceived 'noxious' and 'salutary' nature

of different public facilities and found that the most noxious of facilities, for example prisons, city dumps and psychiatric hospitals, were grouped together as equally noxious even though they are different types of facilities. The respondents of this study were asked their preferred location of these facilities in relation to their home; respondents chose to locate the most noxious facilities 'somewhere else'. Smith (1980) translated these data into diagrammatic form, shown as Figure 5.2.

This distance decay effect on people's attitudes to the location of such facilities, with respondents choosing to locate extremely undesirable facilities as far away as possible from their own home, has also been reflected by studies conducted by Dear and Taylor (1982) and Moon (1988). Dear, Taylor and Hall (1980) discuss how community mental health facilities generate externality fields which include such effects as the negative impact on property values, traffic volumes and residential satisfaction. Three distance zones were used in their study to provide a measure of the extent of the externality field and the results of the study included the fact that the impact of a facility was spatially very confined. Generally, as proximity to a potential facility increases, so does the perceived undesirability of that facility.

The most negative responses were found to exist within one 'block' (this research was carried out in Metropolitan Toronto) of a facility location and beyond six blocks a more tolerant attitude appeared to prevail. However, it should be noted that an awareness of a facility and the type of facility had some effects on the results and that the majority of respondents were relatively favourably disposed towards community mental health care. The authors suggested that it may be the case that 'opposition to such facilities is limited to a vociferous minority whose views are not necessarily representative of the wider community' (1980, p. 342).

Figure 5.2 Preferred residential distance from different public facilities (Smith, 1980)



The type of facility also affects attitudes and Dear (1992) drawing from previous studies (Dear and Taylor, 1982; Segal and Aviram, 1978) notes that generally six dimensions of a facility influence perceptions; type, size, number, operations, appearance and reputation (p.292). For the purpose of my questionnaire, I considered a distinction between smaller residential facilities, like residential homes for the mentally ill or the elderly and larger, more general facilities like schools and libraries (although two of the facilities used in the questionnaire are residential institutions; a prison and psychiatric hospital) to be an important one to make.

Therefore **question 5**, which assesses the comparative noxiousness of facilities, lists a mix of more general and residential facilities which are also a mixture of 'salutary' (desirable) and 'noxious' facilities. Based on the 'distant decay of attitudes' idea of a number of studies already mentioned, the different distances asked were based on the single British questionnaire survey of these issues carried out by Moon in 1988. Moon carried out two surveys in Portsmouth, aiming to replicate the Smith and Hanham studies in a British context. The first exercise involved the comparative evaluation of a large number of hostel type facilities, where respondents were asked where, ideally, the various forms of community-based residential accommodation should be located. The second survey focused more on probation hostels, women's refuges and hostels for people with mental health problems. The second study asked respondents whether they would be opposed to a hostel being opened in their street.

The question in my questionnaire has adapted Moon's question and used facilities included in the studies of Moon (1988) and Smith and Hanham (1981b) ; some 'new' facilities have been added to reflect the specificity of the 1990's and the locality where the survey was carried out; these different facilities have been started. In Sheffield, a refuse dump is commonly known as a 'dumpit site'. I included an AIDS hostel in my list of facilities as the spread of the HIV virus and AIDS had been a growing phenomenon since the 1980's and some hostels are now being established for sufferers. I also included a hospice as the hospice movement is now widespread in Britain, as an organisation supported by donations which cares for the terminally ill.

Q5 If you had the choice, how close to your home would you like the following facilities:

	Same Street	Same N'hood	Elsewhere in Town	As far away as possible	
(General)					
Park	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prison	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Primary school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Library	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dumpsite (refuse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*
(Residential)					
Home for elderly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hostel for homeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
AIDS Hostel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*
Home for mentally ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hospice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*

5.3.3 Potential for involvement in opposition to proposed location of a 'noxious' facility

The purpose of question 6 was to assess how actively people may get involved in opposing a 'noxious' facility. By considering the eighty responses to the questionnaire, this study aims to investigate whether or not this particular community has the potential to 'join together' and organise opposition to a perceived or actual threat to the 'quality' of their local environment (depending on whether the respondent is aware that there is actually a facility in their locality). The distance dimension also comes into effect again in this question, as proximity to a facility which people have negative attitudes towards may make them more likely to be prepared to oppose 'actively' a facility.

Question 6 was taken directly from Dear and Taylor’s behavioural intentions index (p. 113, Figure 7.13) as detailed in Table 5.1. Dear and Taylor (1982) included this question to test the relationship between attitudes to facilities and behavioural intentions. They also investigated whether proximity to a facility had any positive relationship to behavioural intentions; their research found that in general, the nearer the potential location is to a respondents’ home, then the more likely that it will be rated as undesirable.

Table 5.1 Dear and Taylor’s Behavioural Intentions Index (1982)

Category	Actions
Intend no action	oppose but do nothing
Intend group action	oppose and sign petition oppose and attend meeting oppose and join protest group oppose and form protest group
Intend individual action	oppose and write to newspaper oppose and contact politician oppose and contact official
Consider moving	oppose and consider moving

I slightly adapted this question; firstly by adapting the wording of the question and by combining the three actions which Dear and Taylor have under ‘intend individual action’. I also deliberately mixed the possible forms of action so that they didn’t get progressively more or less ‘active’.

Q6 Thinking about a facility that you would choose to locate as far away as possible, if there was a proposal to locate such a facility close to your home, for example in the same street, what action do you think you might take?

Do you think you would do one or more of the following:

	Yes	No	Don't know
Attend meeting about facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Write to newspaper or councillor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Form protest group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do nothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organise a petition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Join protest group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consider moving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sign petition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organise a meeting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Question 6 was also used with the purpose of comparing the potential for 'neighbourhood activism' from local residents, as compared to findings from research carried out by Kevin Cox and his colleagues (Cox 1982; Cox 1983 and Cox and McCarthy 1982). In these studies Cox and his colleagues investigated the context for activists' behaviour, which leads them to take some form of action in order to protect their 'turf'. By investigating the independent variables of housing tenure, children and neighbourhood problems, the researchers found that housing tenure was a key determinant of activism, as homeowners had more of an investment in that locality and were less likely to consider moving than renters would be. Households with children were also more likely to be concerned about issues of neighbourhood change (Cox, 1983). This finding corresponds to the findings of Smith and Hanham (1981a) who found that homeowners were more likely to reject the mentally ill, regardless of their proximity to a mental health facility (p.160). So this question had the potential for some very interesting comparative findings.

However, it is important to note that the respondents answer to this question was determined by their response to **question 5**; people were asked to respond to **question 6** by thinking about a facility that they would choose to locate as far away as possible. Therefore it would depend on which facility (or facilities) people would choose to locate as far away as possible from their own home in **question 5**. It is likely, therefore, that different people will be thinking about a different facility when responding to this question. But the purpose of this question was to investigate the potential for 'activist behaviour' against a perceived noxious facility and it is unavoidable that different people will have different perceptions concerning different types of facilities according to previous and personal experiences, life-stage, gender and the list goes on. This component to **question 6** is taken into account when the results were analysed.

A further consideration with regard to **question 6** was the influence of an opposition movement to the Sheffield Supertram which was being build along main roads in the locality just prior to the time when this questionnaire was carried out. The route of the Supertram goes along White Lane and Ridgeway Road (see Figure 4.9 on page 175). A number of respondents mentioned being actively involved in the opposition to the Supertram, particularly residents who lived on the roads where the Supertram was being built and were directly affected by the building work and redirection of traffic. Some people said, in response to **question 3**, that they had been actively involved with the opposition group to the Supertram and therefore included this as an activity that they had recently been involved in the neighbourhood. Then at **question 6**, a number of people said "well we did all that for the Supertram". So it is possible that the event of the Supertram could have made people more likely to oppose noxious facilities in the future from the experience it had given this particular neighbourhood and it could also have brought the community closer together as some residents joined together in order to oppose a commonly perceived threat to their 'turf'. But none of this was measured by this survey and therefore no concrete statements about the effect of the Supertram can be made except that it happened and there may have been some effect on the general potential 'activism' of the community as a whole.

5.3.4 Awareness of the mental health facility in their local area

Previous studies have found a low level of awareness among local residents of a mental health facility in close vicinity to their homes (Dear and Taylor, 1982; Rabkin, Muhlin and Cohen, 1984). Both these studies expressed surprise at this result; the first sentence of the discussion of results from the Rabkin, Muhlin and Cohen study states that “the most striking of our findings is the remarkably large number of people living in the same building or on the same block as a facility serving chronically disabled mental patients who were oblivious to the presence of the patients or the facility serving them” (p.311). Only 24% of respondents living near a facility were aware of its existence; the authors state this fact to be probably their most noteworthy finding (p.309).

A similar experience was found in Dear and Taylor’s study (1982); of the 388 respondents selected by Dear and Taylor’s sample who lived within 400m of a facility, only 33 were aware of its existence which is only 8.5% of the sample. Due to this unexpectedly low number the researchers then included respondents of the sample who were aware of any facility in their neighbourhood, although this only increased the respondents who were aware to 15% of the total sample (p.99). Obviously an awareness of the chosen facility in any study is an important factor in testing people’s attitudes towards mental health facilities and assessing their experience of having a facility in close proximity. Dear and Taylor stated that because of the very low level of facility awareness they had to revise their analytical approach accordingly, as such a low awareness level severely limits any assessment of the effects of facility characteristics on beliefs about the facility’s impact.

As for other studies, in McConkey’s study (1987), in the two neighbourhoods chosen on the criteria that there was a facility for people with learning difficulties there, less than half the sample knew that the facilities existed. It was from McConkey’s questionnaire that I based my question on whether people were aware of a facility for people with mental health problems in their neighbourhood, and as explained in 5.3.2, the spatial dimension of this awareness was tested by stratifying the sample at

different distances away from the facility. If people were aware of a facility, I then asked them whether they had had any contact with the people who live there, as McConkey had done. The purpose of this follow up question was again one of triangulation, to assess the visibility and social acceptance/integration of the facility tenants within the local community; this aspect was followed up in the interviews with local residents and staff of the facility.

Q11 Do you know whether there is a residential home for the mentally ill in this neighbourhood?

Yes

No

Don't know

If answer is YES, go to Q12, if answer is NO or don't know, go to Q14.

Q12 Where is it?

Q13 Thinking of the people who live in the residential home, have you:

	Yes	No
Seen them walking around the neighbourhood?	<input type="checkbox"/>	<input type="checkbox"/>
Talked to them? because of your job	<input type="checkbox"/>	<input type="checkbox"/>
other	<input type="checkbox"/>	<input type="checkbox"/>
Visited where they live?	<input type="checkbox"/>	<input type="checkbox"/>
Invited any of them to your home?	<input type="checkbox"/>	<input type="checkbox"/>
Other.....		

5.3.5. General attitudes towards the mentally ill and community care policies

In July 1993, the Department of Health issued a press release to announce the findings of a mental illness survey (RSGB General Omnibus Survey 1993). Virginia Bottomley, the Secretary of State for Health, was seen on TV news announcing that “over three people in four are in favour of the policy of caring for people with a mental illness in the community.” Mrs Bottomley said that “this survey includes

some very encouraging signs of developing positive attitudes towards the mentally ill.....90% of the population believe that people with mental illness are deserving of our sympathy and that society should adopt a far more tolerant attitude towards them. This is indeed good news. We should not forget that mental illness is three times as common as cancer” (Press Release H93/851, The Health of the Nation, 8/7/93).

The “90% of the population” claim was based on a representative sample of 2,000 adults, selected over 130 sampling points all over Great Britain. Respondents were asked over 40 attitudinal questions concerning mental illness and community care policy. As this was a national and recent survey, I decided to replicate four questions for my own questionnaire in order to compare my local study to a national one (which also gave regional information) and also to compare attitudes from my sample area where there is a facility to a survey which was testing more general and perceptual attitudes. The four questions I chose involved a mixture of positive and negative attitudes about tolerance (**question 7**), the “risk factor” of the mentally ill (**question 8**), community facilities (**question 9**) and the rights of local residents verses the rights of the mentally ill (**question 10**). The questions asked by this survey appear to have been taken directly from Dear and Taylor’s attitudinal questions used in their research in Toronto (Dear and Taylor, 1982, pp. 88-89). Therefore I am able to compare my results to two studies:

The next few questions are about mental illness and community care. Can you tell me whether you would you agree or disagree with the following statements:

Q7 We need to adopt a far more tolerant attitude toward people with mental illness in our society

- Agree strongly
- Agree slightly
- Neither agree or disagree
- Disagree slightly
- Disagree strongly
- Don't know

Q8 Having mental patients living within residential neighbourhoods might be good therapy, but the risks to residents are too great.

- Agree strongly
- Agree slightly
- Neither agree or disagree
- Disagree slightly
- Disagree strongly
- Don't know

Q9 As far as possible, mental health services should be provided through community based facilities.

- Agree strongly
- Agree slightly
- Neither agree or disagree
- Disagree slightly
- Disagree strongly
- Don't know

Q10 People should have the right to exclude people with mental illness from their neighbourhood.

- Agree strongly
- Agree slightly
- Neither agree or disagree
- Disagree slightly
- Disagree strongly
- Don't know

5.3.6 Influence of personal characteristics on individual's attitudes

Much of the literature takes into account the influence of an individual's personal characteristics on their attitudes towards the mentally ill and the location of a mental health facility in their locality (Dear and Taylor, 1982; Rabkin, 1980; Rabkin, Muhlin and Cohen, 1984; Smith and Hanham, 1981a). For example, Dear and Taylor (1982) 'tentatively' suggest that rejecting neighbourhoods are those where there are households with younger children, low education levels and non-English speaking groups present, where the population has been relatively stable over the past five years and population density low and where the land use is predominantly residential (p.153). Rabkin (1980), who summarises the findings of twenty-five years of research, states that respondents likely to be less tolerant towards the mentally ill are likely to be: male, older, less educated, less skilled occupational workers, of lower class, members of recently arrived ethnic groups and those who report less social contact with the mentally ill (p.28).

The research by Cox (1982;1983) already discussed, which suggests that homeowners are more likely to become 'active' to protect their 'turf' from any threat of a noxious facility, is of particular interest for studies undertaken in the U.K. This is because there is such a high percentage of owner-occupied dwellings compared to other forms of housing tenure in Britain; for example, in 1989, 68 per cent of the housing stock in England and Wales was owner-occupied (Power, 1993). This figure has risen progressively during this century and particularly since the 1950's when, according to Power, "post-war affluence fuelled the desire to own" (Power, 1993, p.212). In 1953, 35 per cent of dwellings were of an owner-occupation tenure.

A contributory factor towards recent increases in owner-occupation has been changes in housing policy and legislation. Of particular interest to this study, because of the selected target area, is the Right to Buy policy which was introduced as part of the 1980 Housing Act. This legislation was part of the wider privatisation policy of the Conservative government, under the leadership of Mrs Thatcher, which pursued a housing policy to extend the opportunities for privatisation and home ownership. The

Right to Buy policy gave most Local Authority tenants the opportunity to buy their homes (as long as they had been living in them for longer than three years) at discounts of up to 50 per cent; between 1980 and 1989, 1.2 million council dwellings were sold to sitting tenants (Power, 1993). The privatisation of council housing has therefore generated a considerable increase in the level of home ownership, although the sale of council dwellings has been heavily concentrated in certain regions: the South East, South West and in the East Midlands. Another important factor is that sales have been disproportionately higher amongst better-off tenants on better estates (Forrest, Murie and Williams, 1990).

This final point is of relevance to this piece of research. Approximately half of the households included within the target area of the survey are located within a large post-war council estate which was built in the 1940's to relocate working class families from other areas of the city (the first residents moved onto the estate in 1949, source: 'Key Individual 1'). Base Green is one of the 'better off' council estates in Sheffield and it was therefore assumed, in the planning stages of this survey, that many owner-occupied dwellings in the area may have previously been council owned. To account for this possibility and to investigate whether house-ownership can affect householder's attitudes, question 17 was introduced to identify residents who were former council tenants and then purchased their homes according to the Right to Buy policy.

The questions in this final section comprised the following:

These last questions ask for some brief details about yourself. These are just for statistical purposes and are treated in the strictest confidence.

Q14 Respondent's gender

Male

Female

Q15 Which is your age group? .

18 - 29

30 - 49

50 - 69

70+

Q16 Which type of accommodation do you live in?

Rented (council)

Rented (housing association)

Rented (private landlord)

Owner occupied (inc. mortgage)

Other

If an owner occupier go to Q17, if not go to Q18:

Q17 If owner occupier, were you an owner occupier in this property when you first lived here?

Yes

No (tenant first then bought house)

Other

Q18 Do you have any children?

Yes

No

If yes go to Q19, if No go to Q21

Q19 How many children do you have living at home under eighteen?

- 1 to 2
- 3 to 4
- 5 to 6
- 6+
- No children at home under 18

Q20 What are their gender and ages?

	M	F	0-11yrs.	12-18yrs.
Child 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child 6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Q21 What is your occupation?

.....

Q22 Can you tell me the occupation of the person who acted as head of household in the 1991 census?

.....

(Question 22 was asked to compare the sample to the 1991 census data, in particularly if the respondent is a woman as the head of household occupation is normally taken to be male)

Q23 Can you tell me at what age did you leave full time education?

- under 16
- 16-17
- 18-20
- 21+
- still in full time education

5.4. RESULTS FROM THE SHEFFIELD QUESTIONNAIRE SURVEY

Despite the fact that the sample was quite small, some strong and interesting findings have emerged from the questionnaire survey. The main research findings will now be discussed, particularly in relation to the findings of previous studies which have been discussed in this chapter. The questionnaire findings will also be complimented, on particular topics, by quotations from the interviews carried out with local residents who live close to the mental health facility.

5.4.1 The survey respondents

As already discussed in section 5.2.1., the sample was made up of 80 cases which represents 80 householders, selected according to a stratified random procedure as illustrated by Figure 5.1. The profile of the respondents in the sample is shown in Table 5.2 and will now be briefly discussed.

Table 5.2 Profile of Sheffield Questionnaire Respondents

Characteristic	% of sample (n=80)
Gender	
Male	39
Female	61
Age structure (pop. 18+)	
18-34 years	25
35-49 years	26
50-69 years	31
70+ years	16
Household Tenure	
owner occupiers	85
renters (private and public)	15
Households with children at home (0-18 years)	35
Economic position (residents 16 years +)	
Economically active (in employment)	54
Economically active (out of employment)	2
Economically inactive	44
Occupational structure (economically active)	
Professional/Intermediate	37
Skilled (3N & 3M)	51
Partly/unskilled	12
Age left full time education	
under 16 years	52
16-18 years	38
18+	10
Ethnicity	
White	100

Gender: there was a higher proportion of women compared to men who responded to the questionnaire. The male/female ratio of my survey is purely a result of the random sample of households, which was dependent on who answered the door of the selected household and agreed to complete the questionnaire. On some occasions a man would answer the door and say his wife/partner would complete the questionnaire and vice versa. As I was totally dependent on the goodwill of the householder to complete a questionnaire in the first place, I allowed the respondents to make their decision (if one was to be made) about who completed the questionnaire. McConkey (1987) also had an excess of females in the sample; the researchers explain this as being a result of more males being uncontactable or unwilling to be interviewed than women.

Age structure: the age structure of the sample's respondents matches fairly well the population of Birley ward, as discussed in Chapter One. According to 1991 Census data, Birley had the third highest ward total in Sheffield for the number of retired men and women. One reason for this, drawing on information from interviews with the local residents, is that many people moved into the area in the 1950's, into newly built council properties which were designed for 'young families'. Many of these people, as the information on the length of time living in the locality shows, have stayed in the area and have now reached retirement age.

Household tenure: the housing tenure in Sheffield has changed quite considerably in recent years, particularly in respect of an increase in homeownership and a decline in the availability and renting of Local Authority owned accommodation. As already discussed in 5.2.3, the Right to Buy housing policy, where Local Authority housing tenants have been given the opportunity to purchase their local authority home, has clearly had a significant impact on the housing tenure structure in Sheffield. In Sheffield as a whole, homeownership has increased from 45% in 1981 to 57% in 1991; the figure for owner-occupation in Birley Ward in 1991 was 58%. At the same time in Sheffield, the number of Local Authority owned households declined from 45% in 1981 to 33% in 1991.

In the sample area the ratio of owners to renters was much greater. Of the 85% owner occupiers, 20% stated that they had originally been tenants and subsequently bought their properties. The figure of 20% was lower than I had anticipated, although I believe that a number of the owner occupiers are actually living in homes that had been bought from the local authority by the previous occupiers and then sold, therefore the new residents would have always been owner occupiers and thus responded to the questionnaire accordingly.

Households with children: the sample figure of 34% of households with children at home under eighteen is lower than the figure for the ward which is 42% and the figure for Sheffield of 47%. As already discussed, one reason for this below average figure must be due to a large proportion of older people living in the locality; 49% of the adult population in the Birley ward are aged 50 years and over. From my observation in the locality and the people I met whilst carrying out the questionnaire, I would also tentatively suggest that there is a spatial concentration of young families in the area dominated by private housing, which broadly speaking is the Charnock Hall area (where there is an infant and primary school) and a concentration of the older age groups in Base Green, particularly in the housing which remains public renting tenure.

Economic position and occupations: the figures from the sample reflect the basic pattern of the ward as a whole. The majority of the respondents who were classified as 'economically inactive' were in fact retired; 71% of the 'economically inactive and 31% of all of the respondents. The high percentage of percentages employed in 'skilled' occupations reflects the local population composition which is predominantly 'skilled' or 'upper' working class, as already discussed.

Age left full time education: just over half of the respondents left school before the age of sixteen and only 10% of the respondents stayed in education over the age of eighteen. These figures are perhaps not too surprising when one considers the age and occupational structure of the respondents. Many of the older respondents told me that they had left school at fourteen or fifteen and sent to work as apprentices, in

shops or factories. It was mainly the younger respondents who left school at a later age.

Ethnicity: all of the respondents were British and white. This reflects the ethnic composition of Birley ward when, according to the 1991 Census, 99% of the ward population were reported to be white.

5.4.2 Extent of 'community' in locality

Question 1 asked respondents how long they had been living in the neighbourhood; 65 % of the respondents in the survey had lived in the area for eleven years or more which indicates quite a stable population. The social networks in the neighbourhood also appear to be strong; in response to **question 2**, 66% of respondents stated that they knew (to speak to) sixteen or more people in the neighbourhood. Only 8 per cent of the sample stated that they knew five or fewer other people, although as one would expect, there is a clear relationship between the length of time people have lived in the neighbourhood and the number of people they know (*Pearson chi-square = .00000*). These results indicate that the neighbourhood as a whole is well established and 'stable', with the majority of residents having lived in the locality for a considerable length of time.

Responses to **question 3** show that there is also a relatively high use of amenities in the neighbourhood; 93% of respondents stated that they use the local shops and 52% frequented local pubs. 21% of the respondents said that they were involved in meeting other parents from their children's' schools, which accounts for approximately two thirds of the respondents who have children under the age of eighteen living at home (34% of the sample). Participation in other activities was lower, as found in previous surveys, for example McConkey (1987). The results to **question 3** are given in Table 5.3.

Table 5.3 **Participation/involvement in local activities**

Activity	% of respondents
Local shops	93
Local pubs	52
Meeting other parents	21
'Other' clubs	21
Local church	15
Working men's clubs	14
Sports clubs	13
Voluntary work	10
'Other' activities	9
Day or evening classes	6
Political organisations	4
Local resident's association	2
Bingo	1

The level of participation in such activities is determined to some extent by availability within an area (McConkey, 1987, p.52) and also to the fact that many people will socialise and be involved in clubs or other activities outside the immediate locality, as was indicated to me by respondents verbally. But the level of involvement in activities in the locality as a whole, by which I mean using local shops, pubs and/or other activities, are considered to be very high; 97.5% of the respondents use or participate, but with 51% of these only 'using' shops and pubs.

Question 4 investigated whether respondents consider there to be a 'strong sense of community' in the neighbourhood. This question was problematic, as already discussed in 5.3.1, as people were not given any guidance as to what was meant by the ambiguous term 'sense of community'. This lack of guidance resulted in 32% of the respondents giving a response of 'neither agree or disagree' or 'don't know'. But 49% of respondents did agree that there was a strong sense of community in the

neighbourhood and 19% disagreed. There was no relationship between this finding and the results of questions 1, 2 or 3.

The main relevance of the results from questions 1-4 is that they suggest that the local community surrounding the case study mental health facility is well established and relatively stable. Many residents have lived in the locality for a great length of time and have good social networks in the area, including contact with their neighbours. This evidence from the survey was supported by local residents who were interviewed:

Resident 4: “We’ve lived here since 1952 [in Base Green], so that’s 42 years... we were all young, all with young children and starting out, so we’ve all grown up together and now we’re getting old together.....we’ve known most people, you see, to be on speaking terms and it hasn’t altered much at all. We all moved in together and we sort of know that Mr and Mrs ‘So and So’, across there, if we needed assistance, you’ve only got to knock on the door, you see”.

The impression of people knowing each other in the neighbourhood was also discussed by **Key Individual 1** although he also talks about how things have changed over time:

JJ: Do you think that a lot of people know each other here?

Key Individual 1: “Yes, they’ve all got a word for me, how are you and that... but they don’t come into houses like they used to, they don’t do that, but they like to socialise and it’s nice to know that your neighbour is looking out for you

JJ: “Are there many newcomers, many younger people now in this area?”

Key Individual 1: “Not so many, it’s a bit surprising, but it’s an estate where they don’t really leave as it’s ‘top of the tree’ as regards as getting on to Base Green [council estate], you’ve got to be lucky as it’s classed as one of the best”

This last comment re-inforces the point already made that Base Green is a pleasant residential neighbourhood, where many people stay once they’ve moved there. The findings from questions 1-4 indicate, therefore, that the neighbourhood of Base Green and Charnock Hall consists of a relatively stable population, where residents have good social networks within the same locality and use and participate in local services and amenities. These features are some of those that Dear and Taylor (1982) listed as being characteristic of a ‘rejecting’ neighbourhood to a community-based mental health facility. But the following findings from this research appear to suggest that this particular neighbourhood, on the whole, is actually a tolerant neighbourhood, as will now be further discussed.

5.4.3 Comparative noxiousness of facilities

Table 5.4 shows the responses to **question 5**, which asked respondents where they would choose to locate a number of facilities, some general and some residential, in proximity of their home.

Table 5.4 Comparative Noxiousness of Facilities

Facility Type	Same street	Same neighbourhood	Elsewhere in town	As far away as possible
Library	13%	85%	1%	1%
Primary school	9%	85%	3%	3%
Park	9%	83%	3%	5%
Home for mentally ill	9%	23%	47%	21%
Home for elderly	8%	75%	16%	1%
Hospice	8%	50%	38%	4%
Hostel for homeless	3%	20%	56%	21%
AIDS hostel	3%	21%	49%	27%
Dumpit site (refuse)	1%	19%	34%	46%
Psychiatric hospital	-----	16%	51%	33%
Prison	-----	5%	9%	86%

The two percentages in bold highlight the most favoured (library) and least favoured (prison) facility that people would choose to locate near to their homes. As found by the study by Smith, Hanham and Chang (1978), the most noxious facilities in this survey were perceived to be a prison, a dumpit site and a psychiatric hospital. Although the majority of respondents (51%) when asked about where they would prefer to locate a psychiatric hospital actually specified the choice 'elsewhere in town'. This could be because there is actually a psychiatric hospital in the north-west of Sheffield which has been there for over a hundred years.

Focusing upon the responses to the location of a home for the mentally ill, many respondents made additional comments to this question, for example: "well, it depends upon the type and severity of their illness" and "it depends on what supervision/staffing there is". There were also quite a few positive comments from people who were aware of the existence of the case study mental health facility and a number of people said something like "well, we've got one here and it's no trouble".

Many of these respondents then said that they would actually choose to have the location of a home for the mentally ill in the same street to their home (9%) and in the same neighbourhood (23%). The number of responses for the answer of same street as a home for the mentally ill is greater than for the following facilities: dumpsite; AIDS hostel; hostel for the homeless; home for the elderly; a hospice. No respondents chose to locate a prison or psychiatric hospital in the same street.

This finding is very significant when the relationship between the choice of location of a home for the mentally ill and distance from the actual case study facility is tested; there is a tendency for the people living closest to the facility to choose the location of a home for the mentally ill in the same street or the same neighbourhood (*Pearson chi-square* = .00014). Those respondents living further away, chose to locate a facility further from their home. This result does not tell us whether the respondents are actually aware of the facility, therefore we don't know whether their opinion is based upon their 'perceptual' or 'experienced' view. However, when the relationship between the awareness of the case study residential facility for the mentally ill and preferences as to where one is chosen to be located is examined, there is quite a strong relationship between these two variables (*Pearson chi-square* = 0.018). This implies that the residents who were aware of the mental health facility in their neighbourhood were more likely to choose such a facility closer to their home than those residents who were unaware.

This finding suggests that attitudes toward the siting of a home for the mentally ill, when an individual is living near to the home and is aware of its existence, can be more positive and tolerant compared to those who are giving their perception regarding the location of such a facility, but on a purely theoretical basis. Such views based on experience are obviously heavily influenced by a positive experience of living near such a facility; if local residents reported negative experiences of living close to the facility then probably all of the residents who were aware of the facility would have stated that they would want such a facility to be located as far away as possible. This result suggests therefore that in this case study example, perceptual concerns may have changed over time with the actual experience of living in the vicinity of such a

facility. As discussed by Moon (1988, p.211) when an experiential externality overtakes the perceptual basis to externality, this ‘constitutes a true assessment of the effect of a facility on a particular neighbourhood’.

Examples of this increase in ‘tolerance’ over time of the facility were given in the local resident interviews; interviewee **Key Individual 1** was on the committee of the local residents association and talked about how some local residents, living closest to the proposed site, reacted initially when they heard about the location of the facility:

JJ: “So when [the case study facility] was being proposed, you say that people who lived very close to it were concerned...?”

Key Individual 1: “Yes.... well, it wasn’t a big concern, but they were concerned which was obvious, they didn’t know (pause) when they were building it, people got to know about it and they were on edge and while it was being built and they got to know where they [the residents] were coming from [Middlewood Hospital], I mean it’s only natural that you would get a bit concerned, but as I say, they haven’t caused any concern since they have moved in, it’s before they moved in I’m talking about. I mean, I would be concerned if they were going to build something like it across the road from me, but they have been of no concern since, as far as I know of”.

Key Individual 1 then continued to talk about his observations and views regarding the facility now it has been opened:

Key Individual 1: “They’re mostly all right on their own [the tenants], they go shopping, they go to Quicksave, they go all over the place (pause) I think that if they can get people like that out on their own, without supervision, then I think they’ve cracked it, it’s the return to the community and it’s a better surrounding for them, ‘cos being tied into a mental home (pause) it’s good, it can only be good”

Another interviewee, **Resident 3**, who lives in the same street as the facility, discussed her views with regard to the impact of the facility:

Resident 3: “Yes, I mean, (pause) you see items on the news about schizophrenics and the problems that they can create in the community and if I thought that they were going to be dropped on my doorstep, I should be extremely worried (pause) in actual fact I would be more worried for the children in the neighbourhood than anyone else (pause) but yes, I think people think the worst, but in actual fact, that development [case study facility] doesn’t make the slightest bit of difference, I know that sounds dreadful ‘cos as I say, I talk to the residents [of the facility] when I see them, but what I mean is (pause) it might as well not be there for the impact there’s been on the community, do you realise what I mean, so, you know, you drop the stone in the water, you know, and the ripples spread out, and it all glosses over again.....”

These two residents were therefore saying that although there was some concern initially, when the plans were known that a facility was to open, after some time, as there were no problems, people just accepted the facility, as **Resident 3** added:

Resident 3: “It’s worked, we’ve got used to them being there now to be fair, they’ve integrated very well, there certainly haven’t been any problems, certainly not that I’m aware of.”

This second interview gave the impression therefore that, despite initial resentment with the way the development was built with inadequate consultation with local residents, the facility and the tenants who live there have become established as a visible and relatively accepted part of the community.

Results to **question 5** reinforce earlier research (Smith, Hanham and Chang, 1978; Smith and Hanham, 1981a; 1981b; Burnett and Moon, 1983) in showing that different types of facilities generate different perceptual attitudes with regard to their

location in relation to a respondent's home. Focusing upon the results regarding a home for the mentally ill, Dear and Taylor, (1982) also found that those respondents who were aware of such a facility were 'apparently more tolerant than the unaware' (p.125) although they found the aware group to be significantly more tolerant within their six blocks distance zone with little difference between the aware and unaware groups beyond that distance. Unfortunately in this study, the sample sizes are too small to examine any significant differences between the aware and unaware groups at the different distance zones. However, the overall results from this part of the survey show a similarity in findings to previous studies. In addition, one can tentatively suggest that there is an even greater tolerance and acceptance in this particular location, due to the positive experiences of living in the vicinity of this particular mental health facility.

5.4.4 Potential for involvement in opposition to proposed location of a 'noxious' facility

Question 6 asked respondents, if they were opposed to a proposal for a local site for a 'noxious facility' that they had chosen to locate as far away as possible in **question 5**, what action they would be prepared to take. The intention of this question was to assess their potential to become an 'activist'.

The results to this question are summarised in the Table 5.5:

Table 5.5 Potential for Involvement in Opposition to the Proposed Location of a 'Noxious' Facility

Intended Action	% all of respondents
Sign petition	88%
Attend meeting about facility	80%
Join protest group	58%
Write to newspaper or councillor	40%
Organise a petition	33%
Consider moving	30%
Form protest group	23%
Organise a meeting	23%
Do nothing	No respondents

Different people chose different facilities, as discussed earlier, therefore the results given here are rather general. However, the question as it exists still produced some interesting results and indicates that there was a the potential for this particular neighbourhood to become 'active' toward a noxious perceived facility. The results show that people were more prepared to participate in group action, organised by someone else, than in individual action. But a number of respondents said that they would take more than one action, with 56% of the respondents stating that they would take four or more actions of opposition which would involved actually initiating some action and/or consider moving. Therefore, these findings suggest that the respondents in this study have the potential to become highly active if they opposed the location of a proposed noxious facility in their locality.

Currie, Trute, Tefft and Segall (1989), asked a similar question in their research study carried out in Winnipeg, although they made measures of past and future action concerning community mental health facilities and the results are therefore not directly comparable. But the Sheffield results had a very similar ranking of actions to the Winnipeg study, with the Sheffield survey having higher percentages of

respondents who were prepared to take action. The Sheffield results also vary from those results found by Dear, Taylor and Hall, (1980) who found that one third of a sub-sample of respondents from their study in Toronto would do nothing at all in opposition to a proposal of some type of mental health facility. However, they did find that significant percentages of the population would be willing to participate in some form of group action, especially signing petitions or attending meetings which are the two highest responses from the Sheffield study. Rabkin, Muhlin and Cohen, (1984) found that 90% of the respondents in their survey were 'unprepared to take personal action to block the establishment of a 'mental facility' near their home.' This study was undertaken in New York.

Research by Cox and his colleagues (Cox, 1982; Cox, 1983; Cox and McCarthy, 1982) found that housing tenure was a key determinant of activism, with homeowners being more likely to take some form of action and less likely to consider moving. However, when tests were carried out for this data set there appears no relationships between type of housing tenure and potential for active opposition. A problem with these tests was that only 15% of the sample were renters and therefore this only gave small numbers to work with.

Previous research also suggests that households with children are more likely to be concerned about changes in the locality perceived to be detrimental to the area (Cox, 1983). In the Sheffield sample, 34% of the households stated that there were children under the age of eighteen living there. However, there was no significant evidence that households with children would be more likely than those without to oppose a facility considered to be noxious. Again the tests were restricted because of small sub-sample sizes.

To summarise this section, the only conclusive result is that the respondents of this sample were proven to have the potential to be highly active in opposition to the siting of a perceived 'noxious' facility. This 'potential for activism' appears irrespective of factors such as housing tenure and children, variables which previous studies found to be important.

As already discussed in 5.3.3, it is possible that the recent opposition to the Sheffield Supertram could well have brought the community 'together' against this commonly perceived threat to the quality of living in the locality. Therefore the potential to rise again in some type of opposition has a more experienced and organised base, which seems to overlay other factors which one would normally expect to be more important, according to previous research. This tentative conclusion supports the suggestion that what has gone before will determine what happens in the future and as the experience of the Supertram was extremely localised in effect, then this neighbourhood could be considered to be unique and different compared to how other neighbourhoods might react under similar circumstances.

5.4.5 Awareness of the mental health facility in their local area

As discussed in 5.3.4, one of the major findings of previous studies (Dear and Taylor, 1982; Rabkin, Muhlin and Cohen, 1984) was a low level of awareness amongst local residents regarding the existence of a mental health facility close to their home. The Sheffield study, in comparison, shows relatively high levels of awareness; 45% of the respondents were aware of the case study mental health facility and by 'aware', they knew the correct location of the facility and what type of facility it was. A total of 63% of the sample were aware of a mental health facility in the neighbourhood, although this total included some respondents who gave the wrong location for the case study facility, although knew that it existed (3%) and respondents who gave the name of a different mental health facility (15%).

Most of the respondents who cited another mental health facility were living in the outer two zones (see Figure 5.2), at a greater distance from the case study facility; they gave the names of facilities which are longer established and were in many cases closer to the respondents' homes than the case study facility. These data were derived from **question 11 and 12** of the questionnaire. Table 5.6 shows the awareness of the respondents according to the 'zone' in which they lived. Zone 1 was the inner concentric ring, Zone 2 the next ring out and so on, with Zone 4 being the outer ring.

Table 5.6 Percentage of Respondents Aware of Case Study Facility - By Zone

Zone	% of Respondents Aware
1 (0-200 m distance)	85%
2 (200-400 m distance)	70%
3 (400-600 m distance)	60%
4 (600-800 m distance)	35%

Table 5.6 shows a 'distance decay effect' on awareness of the facility, although the level of awareness still remains relatively high until Zone 4 is reached. The high level of awareness in Zone 1 contrasts markedly with the study carried out by Rabkin, Muhlin and Cohen, (1984) who found that only 24% of the residents living on the same block were aware of the presence of the facility. A similar contrast is found when one compares these results to the Dear and Taylor study, (1982); Dear and Taylor found that only 8.5% of their sample were aware of their case study facility within a distance of 400m from their home whereas the Sheffield study had a total of 78% of respondents in Zones 1 and 2 who were aware of the facility.

A slightly higher level of awareness was found by McConkey, (1987) whose study in Dublin found that one third of respondents were aware of the existence of a group home for people with learning difficulties and less than half of the respondents in another area were aware of a day centre. The researchers wrote of their surprise at such a low level of awareness, especially as the mental health workers had been 'deliberately trying to 'normalise' the newer developments, such as in the two areas chosen for the study' and concluded from this that 'our centres may have been in the community but it is clear (from the results of the survey) that they were not part of that community' (p.70).

However, it is important to recognise the fact that the Sheffield case study facility has been recently built and people would have noticed the construction work, particularly as the site is on the corner of Lister Avenue, a relatively busy road, and visible from

White Lane which is a main route way. The facility is the only use of the building, not like one part of a building as is the case in the Verona study, and which may also be the situation in the studies conducted in N. America.

Question 13 investigated the visibility of the tenants in the local area and their contact with local residents. A significant result from **question 13** is that 46% of the respondents stated that they have seen the people who live in the facility walking around the neighbourhood and 26% of the respondents have talked to them for their job (5%), or for other reasons (21%) when most respondents said that they say hello or pass the time of day with the people that they recognise from the facility. McConkey, (1987) asked respondents similar questions and found that more than three quarters of the people living in the area of the group home had seen the handicapped residents and about a quarter of them had spoken to one or more of the residents (p.75).

These figures are slightly higher than the Sheffield study, although the two studies have looked at different client groups so direct comparisons cannot really be made. Also the Group Home had been open seven years at the time of the study whilst in the Sheffield study, the facility has only been open for about three years. In the Sheffield study there is a strong relationship between proximity to the facility and contact with the tenants (*Pearson chi-square = 0.001*) as one would expect. But unlike the McConkey study, (1987) there is no relationship with the variables of gender or age; McConkey found that women rather than men and the age group 30-49 were more likely to have contact with the facility users.

Reasons to explain such high awareness levels in the Sheffield study can only be tentatively given, because in the questionnaire respondents were not asked how and when they became aware of the facility. But as already discussed, the facility is relatively new and the location of the facility is very visible. As already mentioned, the local population is relatively stable with strong social networks. From the local resident interviews that I carried out, many residents know their neighbours and seem to know what is going in the locality. The resident interview respondents also gave a

number of anecdotal stories regarding the facility and their contact with particular tenants. From my experience of working in the neighbourhood as a stranger to the area, I was often aware of being observed with curiosity or even slight suspicion and therefore I can imagine that anyone who is not known or is perceived as an outsider would be noticed. These factors, although from observation rather than statistical tests, are all that can be offered as reasons for the high level of awareness of the facility from the data set and information available.

5.4.6 General attitudes towards the mentally ill and community care policies

As discussed in section 5.3.5, a recent survey carried out on behalf of the Department of Health, the RSGB’s General Omnibus Survey, suggests that the general public are relatively tolerant towards the mentally ill. Questions from this survey were replicated almost exactly within the Sheffield study and these results can be compared with the Department of Health study at the national and regional levels. The results from the RSGB and Sheffield studies will be shown and evaluated:

First of all the two positive attitudinal questions, where the wording has been identical to the RSGB Survey, will be considered:

Q7 We need to adopt a far more tolerant attitude toward people with mental illness in our society

Percentage of sample who agreed:

RSGB (all regions)	92%
RSGB (Yorkshire and Humberside)	94%
Sheffield study	71%

Q9 As far as possible, mental health services should be provided through community based facilities.

Percentage of sample who agreed:

RSGB (all regions)	77%
RSGB (Yorkshire and Humberside)	77%

Sheffield study	61%
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The Sheffield results follow the general pattern of the RSGB survey results which give an indication of a tolerant attitude towards the mentally ill and the services which serve them, but the Sheffield figures are considerably lower. Many respondents were unwilling to give a straight 'agree' or 'disagree' response to these questions and chose either the 'neither agree or disagree' or 'don't know' response; this accounted for 25% of responses to **question 7** and 21% of the responses to **question 9**. Most respondents gave the reason for this unwillingness to give a 'straight answer' because of the vagueness of the questions; people made comments like "I would like to know more about what type of mental illness/facility you are talking about" and "it depends on what sort of supervision and care they would be getting there."

Questions 8 and 10 were deliberately asking a negative attitude question, to act as a contrast to **questions 7 and 9** to test any contradictions in people's attitudes. The questions were changed slightly for this purpose and because of the nature of this particular questionnaire and the results are the following:

Q8 Having mental patients living within residential neighbourhoods might be good therapy, but the risks to residents are too great.

Percentage of sample who agreed:

Sheffield study	54%
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This question was taken directly from the Dear and Taylor, (1982) study as it fitted well with the other three questions. A similar question asked by the RSGB survey asked:

It is frightening to think of people with mental problems living in residential neighbourhoods.

Percentage of sample who agreed:

RSGB (all regions)	14%
RSGB (Yorkshire and Humberside)	14%

Q10 People should have the right to exclude people with mental illness from their neighbourhood.

Percentage of sample who agreed:

Sheffield study	36%
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The RSGB survey asked the question in a slightly different way, stating that:

No-one has the right to exclude people with mental illness from their neighbourhood.

Percentage of sample who disagreed:

RSGB (all regions)	14%
RSGB (Yorkshire and Humberside)	11%

Although these last two questions are not directly comparable, they do suggest that the Sheffield sample is considerably less tolerant than the respondents questioned in the RSGB survey. Alternatively, it may be the case that the RSGB survey overestimated the tolerance of the general public in their study? As these questions in the Sheffield survey were not followed up by more open-ended questions, it is difficult to suggest reasons for the apparent 'intolerance', compared to the RSGB

survey, of the mentally ill by the sample. To investigate this further, more qualitative research with the same respondents from the Sheffield sample would be required, something that was beyond the scope and time limit of this piece of research.

Dear, Taylor and Hall (1980) found from their research evidence to suggest that people who are 'aware' of a mental health facility are, in general, more favourably disposed to mental health facilities (p.350). The Sheffield study has already shown that those residents who were aware of the case study facility in their locality were more tolerant towards the location of a home for the mentally ill near to their home (question 5). Results from the attitudinal questions further support this view; using the Spearman rank-order test, there is a strong relationship between those respondents who agree strongly to both of the negative questions, **questions 8 and 10**, and those residents who were unaware of the location of the case study facility (*0.001 significance level*). However, there is not a strong relationship between respondents who agreed to the two positive attitudinal questions and were aware of the case study facility as the sub-sample sizes are too small. But it is relevant to note that 39 cases (49% of the sample) agreed to both **question 7 and 9** whereas only 20 cases (25% of the sample) agreed to both the negative **questions 8 and 10**.

The results for the Sheffield attitudinal questions are contradictory as a number of respondents agreed strongly to both the positive and negative questions. For example, 32 respondents out of the 80, which is 40% of the sample, agreed strongly to both **questions 7 and 8**; these people are therefore saying on the one hand that 'we' should be more tolerant towards the mentally ill but in the next question they state that having mental patients living in residential areas is too risky for residents. Also there were 30 cases, which is 38% of the sample, who stated that they agreed strongly that there should be mental health facilities provided in the community in **question 9** but also agreed to **question 8** concerning the risks to local residents.

Such results indicate that many people's attitudes are still confused regarding mental illness. They agree that greater tolerance is required but perhaps such a view is easier to give when the problem is at distance from their personal space. When questions

imply a closeness of the problem, with talk about mentally ill people being in 'residential neighbourhoods' and 'communities', this implies a proximity to mental illness and everything people believe this may entail. At this stage it could be suggested then that the NIMBY syndrome takes over, as discussed by Gleeson and Memon (1994); Dear (1992) and others, where people's perceptual fears and prejudices become the most prominent and attitudes change accordingly.

5.4.7 Influence of personal characteristics on individual's attitudes

Much of the literature suggests that the personal characteristics of an individual will influence their attitudes towards the mentally ill and the facilities that serve them, as discussed in 5.3.6. The Sheffield data gave the following results:

Gender: Rabkin (1980) suggests that men are less tolerant than women towards the mentally ill. The Sheffield study shows no gender difference in tolerance towards the mentally ill (**question 7**); however there seems to be more of an element of 'fear' amongst women with regard to the prospect of having mentally ill people living in their neighbourhood. There is a strong influence (*Pearson Rank 0.005 significance*) whereby women are more likely to agree that having mental patients within residential areas is too risky (**question 8**) and more women than men chose to locate a home for the mentally ill further away from their home in response to **question 5**, (*Pearson Rank 0.002 significance*). These results suggest perhaps that women are more fearful than intolerant towards mentally ill people.

Age: Rabkin (1980) suggested that older people are less likely to be tolerant towards the mentally ill. The RSGB survey suggests from their study that people in the age group 35-44 years hold the most tolerant attitudes. The Sheffield study shows no evidence of the influence of age upon attitudes at all.

Household tenure: it has already been shown within this chapter that there appears to be no relationship between housing tenure and potential to oppose a perceived noxious facility, although the small number of renters within the sample does pose

problems with statistical testing. With regard to the attitudinal questions, again there are no significant relationships between whether people own or rent their homes in relation to their attitudes towards the mentally ill.

Young children: Dear and Taylor (1982) suggest that the presence of younger children in a household will make an individual more likely to reject the mentally ill. The Sheffield study shows no evidence of an influence of young children in the household as affecting attitudes. However, some tests could not be carried out because of the small sub-sample of households with children which was only 34% of the total sample. Some people did talk in interviews about their fear for the children in the local area, for example in the quotation from **Resident 3** (p. 10), so it may be that this variable is important but the statistics just don't show it.

Economic position and occupation: Rabkin (1980) suggests that less skilled occupational workers are likely to be the most intolerant towards the mentally ill. Of the 54% of the sample population who were economically active, there was no evidence of different attitudes according to different occupations.

Education levels: both Rabkin (1980) and Dear and Taylor (1982) suggest that individuals with lower educational levels are more likely to be intolerant of the mentally ill. However, the Sheffield study only asked respondents at what age they left full time education, not what qualifications they had. Therefore it is difficult to make comparisons. Also, as 90% of the respondents left school before eighteen, there would be insufficient variance in the sample for any conclusions to be drawn.

Ethnicity: this variable could be tested from the Sheffield data as all the respondents were British and white.

5.5 SUMMARY OF MAIN FINDINGS

It is unfortunate that the results of this study have been limited by small sample sizes. However, some interesting findings have still emerged which suggest that this questionnaire survey does not replicate the main findings of previous studies. Firstly, the neighbourhood where the case study facility is located is a relatively stable and well established residential area, with a high use by local residents of local amenities and with almost half of the respondents agreeing that they consider there to be a strong 'sense of community' in the locality, although it is acknowledged that this question was problematic with its terminology. The characteristics of a stable population, low population density and a residential land use are listed by Dear and Taylor (1982) as being typical of a 'rejecting' neighbourhood to a mental health facility. Clearly, these characteristics from Dear and Taylor's 'rejecting' profile are not applicable to this study.

In fact, the Sheffield respondents appear relatively 'accepting' of residential homes for the mentally ill, with a relationship found between those individuals who were aware of the existence of the case study facility and those who chose to locate such a facility close to their home. This result suggests that over time, a positive experience of living close to the facility has taken over from perceptual concerns and people have become more accepting and less fearful, as illustrated in the quotations given from local residents. However, this contradicts the findings to **questions 7 to 10**, which reveals 'intolerance' to wider issues of mental illness and community care. Although, as suggested by the finding of variations according to gender, it could be that such an intolerance is in fact more misunderstanding and fear towards mental illness.

However, as discussed, it is also important to note that many respondents disliked these questions, saying that they were too vague without adequate information on which to base an informed decision. I would also suggest that further research is required before unconditionally accepting the RSGB survey findings as an accepted

'baseline' of attitudes. Therefore I suggest that the responses to **questions 7 to 10** should be considered with a degree of caution.

An important variation from previous studies has been the high level of awareness amongst the respondents regarding the existence and location of the case study facility. As discussed, the facility is quite visible and has been recently built which may differ from the circumstances of facilities on which previous research has been based. This suggests that each case needs to be considered independently, without generalisations being applied, in order to give the particular social, cultural and geographical context of each facility an opportunity to be examined.

The existing studies cited in this section were carried out in the 1970s and 1980s in North America and it can be suggested that one should expect different results from a British case study in the 1990s. It is unfortunate that apart from Moon (1988) there are no other British studies of this kind to compare these results with, although comparisons are made within this thesis to the situation in Italy in the 1990s. It is suggested that this particular case study, and people's attitudes towards it, are place and time specific and that one should not expect individual situations and experiences to fit into any pre-determined pattern.

CHAPTER SIX

INTERPRETATIONS OF THE ‘SUCCESS’ OF THE MENTAL HEALTH REFORMS IN SHEFFIELD AND BRITAIN: INTERVIEWS WITH MENTAL HEALTH PROFESSIONALS IN SHEFFIELD.

6.1 INTRODUCTION

This Chapter will discuss the findings from semi-structured interviews that were carried out with eight mental health professionals who worked at the Lister Avenue Project. As already discussed in Chapter Three (3.4), these interviews were all tape-recorded and transcribed in full. The eight mental health professionals interviewed for this research have been given a numbered identification according to their role in the facility and qualifications. This ‘identification’ is detailed in Appendix One and will be used throughout the chapter.

These eight individuals represented the majority of the full time staff at Lister Avenue. None of the staff ‘live in’ but there is twenty-four hour cover, where two members of staff will work over night. All the staff were employed by the Family and Community Services (F&CS). Previous to working at Lister Avenue, they had been all employed by health agencies; all but one of the interviewees had been moved from jobs at Middlewood Hospital to these new positions. So unlike the mental health professionals interviewed in Italy, who predominantly had general nursing training and had never had the experience of working in a mental health institution (9.2), all of the workers at Lister Avenue had most of their nursing experience in mental health in an institutional setting. Those who were qualified staff, the Facility manager and the three psychiatric nurses were all qualified mental health nurses, which gives the status of Registered Mental Nurse (RMN).

6.2 THE ROLES AND RESPONSIBILITIES OF THE MENTAL HEALTH PROFESSIONALS INTERVIEWED

The following quotations illustrate the variety of backgrounds and experience that the staff at Lister Avenue had and what they now do at Lister:

Facility Manager: “Twenty years ago I first started as an unqualified nurse at Middlewood Hospital in Sheffield; after three or four months I went and did my nurse training and became a registered nurse [RMN] and became a staff nurse. Three or four years later than that, I became a charge nurse. At Middlewood Hospital I worked in every environment there was to work in, whether it be acute psychiatry, long term psychiatry, elderly psychiatry, even people who've got learning difficulties. I basically stopped at Middlewood Hospital for eighteen years.... after eighteen years, when this place opened, Lister Avenue, I became the registered manager here and I've been here since, so my career has been largely determined by Middlewood Hospital, the opportunities and so on....”

Psychiatric Nurse 1: “I've worked here for, well as long as it's been opened, for about two and a half years I think it is now, and before that I worked at Middlewood, for, well I trained at Middlewood so that was three years and then I was qualified for two years I did my RMN, registered mental nurse, so that's staff nurse, and then before that, before that I worked as a nursing assistant and before that I worked in old people's homes as a care assistant....”

Support Worker 2: “Two and a half years at Lister, since it opened.....thirteen years at Middlewood (laugh), basically it was elderly, as nursing assistant I did housekeeping for...about 4 years, 5 years ...and then I was a nursing assistant that I worked as before, errm ... before thathairdresser, I had my own hairdresser shop”

Support Worker 4: “I started working at Middlewood as a nursing assistant when I was 17 and I am well, I was just 18 so that’s like 9 years as I’m 26 now, and I worked on various wards at Middlewood. I started on the long-stay ward and then the elderly..... and then I had an interview for here which was two and a half years ago and I got the job and came here.”

Psychiatric Nurse 3: “I did my training in Middlewood hospital and I’m a trained psychiatric nurse [RMN]..... I worked there about, I think it’s about 10 years. I did all aspects of nursing there. I started off on, on a ward that was um designed to integrate people into the community, as they were ready for discharge. It didn’t actually work that way to be honest, but that was the idea behind it. From there I went to work on the resettlement team which was a team designed to help people with chronic long term mental illness problems to integrate them back into the community again..... and then from there I went to a the community psychiatric nurse team, still doing the same sort of work, dealing with people that had long term mental illness problems, but were actually in the community, so I did community work and from there I applied to work here, which is very much part of the same thing, integrating people back into the community after being in institutions for quite a number of years”.

These quotations illustrate the breadth and variety of experiences amongst the staff at Lister Avenue. Their previous experience and present roles contrast greatly with the composition of the staff working in South Verona, whose interviews are discussed in Chapter Nine. The differences between the roles and qualifications of the mental health professionals in Sheffield and South Verona are discussed in greater depth in Chapter Ten.

6.3 VIEWS REGARDING RELATIONS WITH THE LOCAL RESIDENTS

In Chapter Five, the reactions of local residents in Base Green to the establishment of the community-based mental health facility are discussed. When I interviewed the staff at Lister Avenue, I asked them about their relations with local residents as well as the relations of the tenants with their 'host' community:

Psychiatric Nurse 3: "I think initially, before we moved in there was objection and it was probably fearful, you know, not realising what could or would happen. All in all I mean, the other residents keep themselves to themselves basically, um..... we do have some contact via the church next door, um and we have had complaints obviously, we expected to have complaints about people's behaviour on occasions. They have been brought to us in.... in a very reasonable manner, there have been occasions where people could have made an official complaint and they've not and we've encouraged them to do so and they've not, you know, they have been very tolerant really at some of the behaviours of people that are here. So I think they've integrated really well...."

Psychiatric Nurse 1: "I think... I don't think that there was ever a particular problem, I think people have always been, well.....as far as we're aware...as far as I'm aware anyway, people have always been sort of.....just reasonable about the whole thing, there's not been a problem, people have popped in and told us when things are going wrong but, nobody has sort of...I think people have just acted in a sort of neighbourly way, I mean we've had people.....well we have an old lady who occasionally wanders.... wanders around and looks like she doesn't know, but she's perfectly, I reckon she's perfectly capable of getting back.... but she looks like she's sort of....and she often acts like she's sort of in distress..... and people just come and let us know where she is... and it's not like a problem or a complaint..... it's just like a neighbourly thing to do, like the way your neighbours used to be... well just being sort of

helpful and concerned but not sort of over the top or.... panicky, which is excellent..... because we've moved a bunch of..... I mean they're lovely people, we know they're lovely people but they obviously, in some ways, kind of appear a little bit odd, and possibly a bit intimidating to people with no idea of mental health problems... and umm I think the neighbours have just been absolutely brilliant really, just totally accepting it and... I know they are sort of intervening or making their presence felt only if there is a problem and then doing that in a reasonable manner....”

These two quotations highlight a number of issues. First of all, **Psychiatric Nurse 3** repeats the point already made in Chapter Four that there was some concern from local residents before the facility was opened. Most facility workers reported incidences where there had been complaints from local residents but, as stated in these two quotations, the local residents were very reasonable and were often reporting things out of concern rather than criticism. It was interesting that **Psychiatric Nurse 1** referred to the concern of the local residents for the tenants well-being as being ‘neighbourly’. **Psychiatric Nurse 1** also made the important point that if people in the local area were not familiar with people with mental health problems, it was not really surprising that that would find their behaviour a little ‘odd’ and perhaps ‘intimidating’ at first. But on the whole, the local residents now seemed to accept the facility and the tenants. This ‘feeling’ of being accepted, according to the staff, was supported by the findings from the interviews and questionnaire survey carried out with local residents, reported in Chapter Five.

The **Facility Manager** talked about the responsibility that the staff and tenants had to ensure ‘appropriate’ behaviour, ensuring that the local residents did not have cause to complain.

Facility Manager: “While we've got a right to be here, that right is also.... that means we have responsibilities for people to act in a reasonable fashion, which is to not urinate in the street, which is to not dress inappropriately and wandering around half naked [he was referring

to some behaviour that caused complaints when the tenants initially moved into the facility in 1992], people don't have the right to do that and we as staff do have a duty of care towards the people who we care for to make sure that they don't put themselves in that position. We've done that successfully for three years”.

It is interesting that the **Facility Manager** defined the ‘success’ of the facility as the tenants’ ability to behave ‘appropriately’ when outside the facility in the neighbourhood. He seemed to have clear views about what was acceptable behaviour from the tenants and that the staff had a responsibility to ensure that such behaviour was maintained. But he had equally strong views on tenants rights to behave as they wanted to inside their home [Lister Avenue facility]. This separation between public and private space, what is permitted and acceptable in different places, is perhaps a more significant issue for the mentally ill than for other groups. It is an issue that has re-emerged as those people with mental illnesses, who previously lived in the protective and more tolerant environment of mental hospitals with their unique set of norms and values, have been moved into mainstream society. This debate will be discussed further in Chapter Ten.

6.4 VIEWS ON THE ‘SUCCESS’ OF THE RELOCATION FROM MIDDLEWOOD HOSPITAL TO LISTER AVENUE

When the Lister Avenue facility first opened in 1992 all the tenants came from Middlewood Hospital, many of them having lived there for a number of years. So the tenants were relocated from the north of Sheffield to the south-east, to a neighbourhood that they were not familiar with and from an institutional environment to a community one. I asked the interviewees how the tenants coped and adapted to these enormous changes. First of all, some of the interviewees described what the tenants’ lives were like in Middlewood Hospital:

Support Worker 4: “Most of these tenants were sort of long stay people ... I mean like lots of them had lived on wards for 40 years and they had everything taken off them, you know they were only used to sleeping in dormitories with like... at Middlewood... with like, you know, anything from 4 other resi... you know, 4 other patients to, to sometimes there were sometimes as many as 12 patients in a dormitory, I mean it’s not nice is it? So that, that’s what they were sort of used to and they weren’t able to get into mostly, unless they were in rehabilitation wards they weren’t able to get into kitchens because they were locked and they couldn’t go into bathroom the unless they asked the nurse for a key and various things like that whereas here, they live as... well, they live as, like people would live, for example if I a shared a house, yeah.”

Facility Manager: “I think we have to attack a few myths the first myth is that places like Middlewood Hospital, large psychiatric hospitals, is somebody’s home when ‘tenant 1’ who lives here, used to get up in the morning at Middlewood Hospital, he got out of a bed that wasn’t his, he was told to go and eat his breakfast in a dining room with twenty other people..... his dormitory (stressed) so it was a dormitory rather than a bedroom, was locked up and is still locked up in most psychiatric hospitals.... when he wanted a bath he had to seek permission from the nurse to open the door with a big key, and that still happens in most psychiatric hospitals..... he had no control over his destiny on a day to day basis, a charge nurse or a doctor could come in the morning and say that they were shifting him to another ward that day and he had no basic rights, he couldn’t say ‘I want to stop here, this is where I live’, a charge nurse or a doctor or the powers that be, directed his life totally, he had no say in the running of his life. Here [Lister Avenue] (stressed) ..when somebody gets out of bed, they can either stop in bed or get up, go in bathrooms which are unlocked obviously, go into a kitchen and make themselves a cup of tea whenever they want.... there’s a difference” (stressed).

These descriptions of institutional living echoes some of the issues raised by Goffman's study of life in a mental hospital, as discussed in Chapter Two. These processes led to patients becoming institutionalised and totally dependant on others, unable to be independent enough even to make themselves as cup of tea. **Support Worker 2** told me that when the tenants first moved from Middlewood, most of them were unable to do any simple tasks that most people simply take for granted:

Support Worker 2: "They couldn't do anything, when they first came they were all supposed to be able to make a cup of tea and whatever, but they couldn't....."

The Facility Manager told me that it was expected initially that the tenants behaviour and abilities would get worse before it got better:

Facility Manager: "I think for the first six months, first six to nine months, you can expect some regressional behaviour to some extent; it's very frightening for people to be moved out. Institutions are very overprotective and to shift somebody into a house in the community must be terribly frightening, so I think for the first six to nine months you've got to expect some regression. We didn't have that (stressed) much regression and now people seem to be growing at their own pace, which is a positive thing. You can expose people gradually to all sorts of things, like crossing the road, exposing them to a cooker, a fridge, a kettle and all the domestic appliances, exposing people to social settings, pubs, clubs, exposing people to leisure activities, going out shopping etc., and if you let people do it at their own pace rather than force the pace, then they'll be all right...."

The interviewees told me how well they thought the tenants had adapted to their new lifestyles and living environment:

Support Worker 4: “I think it’s just brilliant how quickly they have adjusted, I think most people have developed really well here and they’re like showing abilities that we didn’t even know that they’d got, you know most of them lived like at Middlewood so they knew that area for like years and years so, it’s like over the last 2 years, well like, most of the tenants have sussed this area out completely, you know, they know the local area really well and those that want to go to town know the bus routes, they know how to go to and from here without any difficulty ”.

Support Worker 2: “.... there’s no two ways about it, they’ve come on in leaps and bounds, you know, the majority they get the bus into town now, they even ring a taxi and book a taxi and come back and say “you’ve got to pay for that taxi outside” (said in a mimicking voice, followed by a laugh) you know, they’re not daft far from it.”

Support Worker 3: “It’s probably the little things that we notice, that perhaps an outsider wouldn’t, like making a cup of tea without being told or without asking, you know. We don’t get.... like when we first came, we used to get quite a lot of bizarre behaviour from certain tenants, that’s dropped off a lot now as they realise they don’t have to do that to get our attention, so there are improvements from that point of view. I think it was a major adjustment for all (stressed) of us, because we were used to working on a ward with a lot of staff input..... if something went wrong, there was always someone to go running to basically..... sometimes here [Lister Avenue] you can feel very isolated.....”

Several of the interviewees mentioned the fact that it was also a difficult move for them to make from Middlewood:

Support Worker 2: “I found it hard when I first came, everybody kept saying 'Oooh, come out of Middlewood, they haven't been out for years and years and years.’ The tenants found it hard, the staff found it hard..... I think that's why we all understood how hard it must be, 'cos we had a fortnight without anybody here, without tenants here...and we found it hard going.....so if they found it tough it was hard.....”

Psychiatric Nurse 2: “Middlewood was OK 'cos it had...it was like it had it's own sort of community spirit and everybody sort of knew everybody and.....well that was part of what the patients got...again, a lot of them had been there so many years that it was their home as well so I think a lot of them were scared, and I think staff were as well, but it just takes time...but I think, when I look back now, I mean I've been back to Middlewood a few times, I've still got friends there or been back with people from here on business like, and there is just such a massive difference, I mean they can tell, the tenants, I mean there's one guy from this house, he goes back to Middlewood regularly, just to see people ...but he can see the difference in the place, it's becoming run down and this, that and the otherand he prefers it here, but it's difficult when they've spent so many years in a hospital, it's just different.”

The relationships between staff and tenants have also changed; in the hospital environment there was a far stronger institutional power relationship between nurses and patients. **Psychiatric Nurse 3** told me how these cultural norms from the hospital environment have been difficult to change:

Psychiatric Nurse 3: I think people have adjusted very, very well all in all. Um.... saying that I think people... don't realistically understand what has happened. I mean we still get called nurses on occasion, you know, “nurse, nurse, nurse” and when we have said to people “look, it's your house, you pay a rent” they can't quite conceive that and I think it is probably because they are not actually physically paying a rent because

they don't deal with that side of the money.... and I think it is harder for the people that are here to conceive that idea that it is their home. I think they think it's on loan to them sometimes, not always but I think a lot of people do and I know sometimes there is a fear that they are going to be moved, suddenly somebody's going to come and move us, because that's happened at Middlewood or in their own home with their parents, family whatever, they were moved. Um.. so I think we have got a bit of a battle there with people, but then again some people do accept it is their own home and they'll stay here for as long as they want to, but I do think it is hard to conceive for a lot of people. But all in all, people have adjusted really well to say, you know, it's such a long time since they've lived in an environment like this, all I know is that people have done really well."

Throughout these quotations the interviewees have talked about how hard it has been for the tenants to learn to become independent again and these quotations are strong evidence of how living in an institution totally changed people's ability to function in what we would consider to be 'normal' society, as stated passionately by the **Facility Manager:**

Facility Manager: "Mental hospitals are not homes.... because they devalue the person, they strip that person of their rights..... so what I'm trying to say is that homes (stressed) are not just bricks and mortar, home is where you exercise self-determination, where you have basic human rights, you don't have those rights when you're in hospital, you're not allowed to determine your own lifestyle in hospital, that is a myth that needs attacking and throwing away.... and that's why I think that community care should be a next step forward."

6.5 THE IMPLEMENTATION OF COMMUNITY CARE

I asked all the interviewees what they thought about community care and whether they thought it was the right policy for people with mental health problems. First of all, the interviewees gave me their overall impressions and then I asked them how successful they thought community care was nationwide, in Sheffield and then at the very local scale, at Lister Avenue. Firstly, this is what people told me regarding the policy of community care:

Support Worker 2: “What I think it is..... part of me agrees with it part of me doesn't if I'm totally honest.... I believe that we should get away from big institutions like Middlewood.... and I believe that you should, in the ideal world be in a safe place like this [Lister Avenue] ... in an ideal world that would be, but we don't live in an ideal world and there are a hell of a lot [of people] that fall through the net...”

Facility Manager: “Middlewood.... it's due for closure in a couple of years, the plans have been put back a bit but.... Wakefield had a large hospital, Manchester, York, they've all had large hospitals.... and the provision, there's not been a replacement of provision, people have just been allowed to go wherever they want, without adequate care or support, and there's been vast discharges of people with mental health problems that have ended up on the streets, which, you know, is in nobody's best interests..”

JJ: “Why do you think there had been the inadequate supervision of people being returned into the community. Is it just a case of lack of resources?”

Facility Manager: I don't think it's just (stressed) a lack of resources, I think it's a lack of political will. I think the resources, to a certain extent are bad, I think up and down the country, we are underfunded. The extent to the underfunding I don't think is as dramatic as some people would say they have got.... and I think with a better political will (stressed) and the underfunding, if that were to be addressed, then I think we would actually have a good model of community care that would be accepted world-wide and not just, you know, for ourselves in England.”

Psychiatric Nurse 1: “It's about people having the freedom to live in the community and, and getting, receiving the support that they need to do so.....that's what community care should be. Unfortunately I think there's all sorts of cases of community care going on with people being given perhaps.... too much freedom...and, well, without the support..... they end up homeless and walking the streets and obviously cold and I mean.... it's sort of difficult 'cos people might argue that umm,.... somebody has chosen not to dress properly for the weather, but on the other hand... if they're wandering around and they're obviously freezing cold then I think that person is not receiving enough support.”

This was **Psychiatric Nurse 3's** response to the question “do you think that the policy of community care is the right way forward for mental health?”

Psychiatric Nurse 3: “I do, certainly, but I think there should always be a back up system as well, which tends to fail sometimes. We [at Lister Avenue] have terrible trouble sometimes trying to get people readmitted when they do need hospital care, care that we're not providing here um my main objection is that people may be pushed into living in the community when they just don't want to and you know, I'd hate to think that anybody lived here when in their heart of hearts they wanted to be back in an institution where they felt happy and secure and comfortable. It's all right living in a nice environment but if you're not happy, you

know. So um.... but the idea of community care is very, very good but it needs to be done properly by the people that are trained to do it with the finances behind it”.

The quotations from these four interviewees highlight the complexity of the issues involved; all mentioned negative factors and shortfalls in the policy, but all from slightly different perspectives. It is interesting that they all agree with the rhetoric of community care but all share concerns regarding the actual practice of the policy.

6.5.1 Community care nationwide

The following quotations illustrate the interviewees views regarding the success of community care at the national level:

Facility Manager: “Nationally, I think there are real major problems that the community care act [NHS and Community Care Act of 1990] tried to address, but failed, and I think nationally we can see that, with the recent incidents surrounding people that have actually been murdered..... (long pause) and that's just the tip of the iceberg. There are many people coming out basically..... as large institutions have closed down, people have just got lost in system, and there's been no adequate replacement nationally. As I say, Sheffield I don't think has been too bad.....”

I then asked the **Facility Manager** “do you think that community care has been perhaps more successful in some places rather than others, depending upon the history of the place and what has gone before”

Facility Manager: “Yes, I think places..... large inner cities that have previously had large psychiatric hospitals have created a situation where people think that they can send people back to hospital and that, you know, the hospitals will always be there.... and they won't be there. Most of them have gone, most of the beds are actually gone and.... whilst they

may have performed a..... very well in the past, the large hospitals today they don't meet the need. They don't meet the need of individual care for people and um..... places that....other places up and down the country that have or had large psychiatric hospitals nearby..... (long pause) are not providing the care that they should do for people.....”

The **Facility Manager** here raised many problems that have already been discussed within this thesis in Chapters Two and Four. The differences in community provision between places with the legacy of a large psychiatric hospital and those places without hospital is also an important issue, as highlighted by the Audit Commission Report published in 1994, discussed in 4.3.1.

Psychiatric Nurse 2 found it difficult to give me his views on community care in Britain, as he said that much of his information on which to base such a view was from secondary sources:

Psychiatric Nurse 2: “Umm it's difficult, I mean my own opinions....a lot of it is what you hear from the media isn't it, and what you're told, sort of thing, which doesn't seem to be that good, like homeless people or bad conditions but I don't know how..... if it really is as bad as what people say I'm sure it's not perfect by any means sort of thing... and this [Lister Avenue} I suppose has got to be a better example because... I mean it's well funded, that's one thing....”

Psychiatric Nurse 1 also referred to her views regarding the influence of the media on people's attitudes towards community care:

Psychiatric Nurse 1: I think..... (pause) there's a lot of bad press and I think..... I hope... I'm fairly optimistic... I hope that it's just a case of like the worse cases getting all the, all the news, which is what happens anyway, and I would imagine that a lot of places have a fairly good set up, but obviously there are problems and those are the bits that reach the

papers, there's all the hype about it, I think there are problems, I think it's very difficultI hope that it's not as bad as it actually sounds, I think it's a huge, huge task and I hope it's not as bad as the media likes to make out”

This was the response to the question from **Psychiatric Nurse 3**:

Psychiatric Nurse 3: “Well, it depends where you mean.... it seems to be big cities that fail, although Sheffield’s trying not to.... if I’m thinking more on the lines of big cities like London and Scotland, I know that they’ve had a few problems up there. There’s not the staff, there’s not the follow up care resources available so people are discharged maybe into a bedsit accommodation or, or something and then not followed up. That leads to a break down in mental health, which then leads to other problems, social problems; not being able to feed themselves, not being able to go and get money for themselves, not knowing where to go for help for themselves with GP’s or hospitals, um..... I think it seems to be the large cities that can’t quite keep tabs, tabs on people that have been discharged. In Sheffield it seems to be different, the people that are discharged from Middlewood as far as I know, have back up, have community psychiatric nurses going into... GP’s have practice nurses that, you know, do keep tabs on people and try and encourage them to come for medications and er... it seems to be really good in Sheffield.

This view from **Psychiatric Nurse 3**, who has had quite extensive experience from working in different mental health facilities and community teams in Sheffield (6.2) is interesting. It is important, however, to recognise the fact that none of the mental health workers from Sheffield interviewed for this research had ever worked anywhere other than Sheffield, and that their views on the implementation of community care elsewhere had been based on other sources, as stated by **Psychiatric Nurses 1 and 2** in response to this question.

6.5.2 Community care in Sheffield

Facility Manager: “I think locally, in Sheffield..... (pause) my overall impression is it's not too bad and I know there's been research done, I forget where, that looked at discharges from psychiatric hospitals in Sheffield over the past ...over a period of three or four years, recently, and there was only a few people that actually ended up homeless. I do have some anxieties about some of the private care institutions that are in Sheffield, one or two in particular, um..... which tend to um.....be rather task oriented. By that I mean that..... they don't provide individual care on an individual basis, that the basic necessities are seen as the order of the day, the things like making sure people are fed and reasonably dressed and that's about it and that happens in some private care places.”

In this quotation, the **Facility Manager** talks about two different ways in which the ‘success’ of community care can be measured. A number of studies have suggested that some people who have mental health problems end up being homeless (Warner, 1985; Scott, 1993) or in prison (Wing and Furlong, 1986). Other individuals with mental health problems are often living in appalling conditions in hostels or bed and breakfast accommodation (Scott, 1993); this last group may then be considered to have been ‘successfully’ discharged and now living ‘in the community,’ simply because they still have a roof over their head. This leads to the **Facility Manager’s** second point regarding his concern about private care homes, facilities encouraged by the government reforms, where, in his opinion, the quality of life doesn’t seem to be as high a priority as the simple necessities of life like being fed, clothed and given shelter.

Support Worker 2 was more sceptical about the success of the follow up of discharged Middlewood patients:

Support Worker 2: “Well I'd like to believe that there's no ex-Middlewood patients living on the street, but I don't believe it, I'd like to think so but I don't believe that, I believe that there's some falling through the net..... but I hope... as they fall through the net there is someone at the other end.”

JJ “Really, why do you think people are falling through the net?”

Support Worker 2: “Why? Money (stressed)... plain and simple, money, it's all money.....it's like this place had to be open by a certain date 'cos of money.....it's all money.”

We then continued to talk about Lister Avenue and the fact that it was relatively well funded as it had funding from three agencies, as already discussed in Chapter Four. Then I asked the interviewee about other mental health facilities in Sheffield:

Support Worker 2: “They're not like here, none of them are, no, because we can just go to our manager and say well “we need this or that”.... they [other facilities] raise it, by whatever means they can they raise it. I know someone at another unit... they took their tenants, or clients, whatever they call them, on holiday and they had to raise the money by doing car boot or whatever, but they had to raise money..... they wanted a new carpet.... council offered them so much, they had to find the restthat's not on, not when things cost so much.....”

JJ “So there is money available here at the moment?”

Support Worker 2: “Oh yes, oh yes.....it's the new project, the new baby....”

JJ “Is it quite unique for Sheffield then?”

Support Worker 2: “Oh yes, you go to any council home..... funded by the government, state ... whatever you want to call it..... and ask them if they've got a brand new 'pram', [like a crane, used to get people in and out of the bath] they probably haven't even got one, if they have it's probably on it's last legs”

JJ “So the tenants who are here are...” (interrupted by **Support Worker 2**)

Support Worker 2: “Very, very lucky, very lucky. But I think they're [tenants] entitled to it, after being locked up in institutions for years, I just worry what's going to happen in five years time” [the three way funding arrangement was only for five years].

Support Worker 2 suggested that that there were, in her opinion, disparities in the resources between different facilities in Sheffield, depending largely upon the agency that funded the service. Such a situation within a single city rather mirrors the situation in Verona, with differences in service provision from the three different services, as discussed in Chapter Seven.

6.5.3 Community care within the Lister Avenue Project

The quotation from **Support Worker 2** reiterated the fact that the Lister Avenue Project is relatively well resources from the partnership of three agencies for the first five years of its existence (4.5). Adequate funding is a crucial factor that can be seen to contributing to 'successful' implementation of community care, by providing adequate staffing cover, provision of services and so on. Here are some views from the interviewees regarding whether they believed Lister Avenue was an example of 'good' community care implementation:

Psychiatric Nurse 1: “Ummm..... I think I see Lister Avenue as community care working, it's umm..... people having the freedom to live normal lives. I feel really positive about Lister Avenue, I think its.... pretty, well almost an ideal sort of situation where people have as much sort of freedom..... well obviously they have all the rights as tenants in their own homes and have all the rights, but there's always a sort of a back up system and we, we intervene if we feel it's necessary but ... I mean you would normally be asked to intervene, tenants would come and ask us for.... for help and..... when they think they need it, or we could point out to them that they're dressed inappropriately and we have a reasonable relationship with.... because all of the staff have been around a long time and we have a good relationship with people and we can tell them.....that they're dressed inappropriately and so on”

JJ: “Do you think that Lister Avenue is a bit of a rarity though, if we're talking about Sheffield-wide and nationwide?”

Psychiatric Nurse 1:“Umm..... I think it's possibly the way things are going, I think it, well certainly when it was started [Lister Avenue] it was sort of a relatively new idea, but I think it's possibly, I don't think it's on its own, I think, and I don't think there's anything the same as this in Sheffield because of the funding and whatever, but I think that the actual philosophy behind it is is perhaps the way things are going. I hope, I like to think anyway....”

Psychiatric Nurse 1 had a far more optimistic perspective of community care overall than **Support Worker 2**, and presented the fact that Lister Avenue was perhaps unique as far as service provision went in Sheffield in a positive light. This is how **Psychiatric Nurse 3** answered this question:

Psychiatric Nurse 3: “I think Lister Avenue is a good example of community care, yeah I do. I do, I mean, it can be made better but exactly, you know, like the point before, you know, without finances, without staff training, without the.... tenants willingness to do more for themselves um..... you can't really get much further, but yeah, I do think it is a very good standard of community care for what we're offering from within this environment”.

JJ: “Do you think it is typical though of community care?”

Psychiatric Nurse 3: “No, no I don't, no. Not from what I've heard.”

So **Psychiatric Nurse 3** reiterates the fact that the Lister Avenue Project is seen to be different from other facilities. As I only made a case study of a single community-based facility in Sheffield because of time constraints, I am unable to confirm any of these claims by the interviewees, although I think that they stand by themselves as the interviewees personal views. In conclusion to this section, here are two quotations from the Facility Manager on further reasons why he thought that the Lister Avenue Project was an example of 'successful' community care:

Facility Manager: “We're still here after three years, catering for people, twenty five people that have been in institutional care for a period of between ten and fifty years..... in the three years that we've been opened, one person has had to go back to psychiatric care [in-patient], we've had a couple of deaths which are normal people's life expectancies and two people going into other provision. So there are still twenty of the original tenants living here....”

Facility Manager: “I think it's [Lister Avenue] a positive place; it's a lovely neighbourhood and our neighbours are very nice people, as most neighbours are in any community and I think that we have been accepted because we've made we've said to our neighbours, “if you have a

problem with the behaviour of people that live here, come in and we promise that we'll do something about it" and because we've actually done things, we've actually taken strategies to deal with behaviours that are unacceptable, like that that I mentioned previously [before interview and recording began] then neighbours respect that..”

So the **Facility Manager** defined ‘success’ as the fact the majority of the tenants are living and coping in a community setting after living for so long at Middlewood. Also that he believed that the facility had been accepted by the local community, something already discussed in the Chapter (6.3).

6.6 VIEWS ON HOW THE MENTAL HEALTH REFORMS CAN BE IMPROVED

Finally, I asked the interviewees their views on how they thought community care should be operating, at the different levels of implementation and what problems still existed and concerned them:

6.6.1 At the Lister Avenue Project

Support worker 2: “We all came with these wonderful ideas which..... have not materialised, do you know what I mean.... oh, they’re going to do this themselves, they’re going to do that themselves..... and they don’t. To a degree they do but to a another degree they don’t..... the younger ones are doing more for themselves, but like the older one’s here are getting older, they’re getting more dependent and this is not what this place is built for, or what the philosophy of it is.....”

Psychiatric Nurse 3: “I think there are far more skills here than we.... not that we’ve not acknowledged it, we’ve seen it but we’ve not got the potential, the time, the money to develop that, although that is the theory behind it [the group home set-up]..... we seem to pre-judge here, errr,

you know, people's..... experiences and potential. I think we pre-judge a lot, rather than giving people a chance of actually proving to themselves that they can do it”

Psychiatric Nurse 3 suggested that perhaps staff have not ‘pushed’ the tenants to do more for themselves; this could be a cultural legacy of working in an institution, where the patients were entirely dependent on the staff; it has probably been difficult for both staff and tenants to adjust to the new environment and change in ‘philosophy’ and way of working. However, the **Facility Manager** was more confident in the staff’s abilities to adjust to their new roles of working in a community facility and to re-negotiate their new relationships with the tenants, helping them to develop in new ways:

Facility Manager: “I think there are the skills, amongst staff, um.... existing staff, up and down the country. I think that Lister Avenue has proved that, that we've taken 15 staff from a large providing institutional care, to 15 staff, re-educating themselves, relearning new concepts themselves, and they’re passing that on to the people that they look after, so I think we've got the skills, we've got the talent....”

These quotations highlight differences in opinions and confidence in the ‘system’ between the staff and management, which are common throughout health care and from my experience, in mental health care.

6.6.2 At the national level

Psychiatric Nurse 3 expressed her concerns for the future sufferers of mental illness in a service without mental hospitals or adequate in-patient services:

Psychiatric Nurse 3: “I feel positive about the environments with ... we’re working with and that I see. Um,... what I’m unpositive about or I tend to be worried about, is where do people that are developing long term mental health problems, where are they going to go, who’s going to care for them, will it be a case of: there’s no Middlewood, that big institution to take people with long term mental health problems that need on occasions hospitalisation. Where will those people go? Will relatives be expected to care for them, um within their own homes, which I think will be .. probably end up being the case, err.... that will then or may lead to family problems, family breakdown err... then there is no one to care for these people. I do think they still need somewhere, not necessarily Middlewood Hospital, but somewhere where people will be able to go in for short periods of time for treatments or, you know, whatever’s deemed to be necessary at the time for those people and then be back into the community again.”

The **Facility Manager** spoke about the problems caused by the broadening of definitions of mental illness over time, as discussed in Chapters One and Two, and how he believed that this was putting an enormous strain on mental health services:

Facility Manager: “A hundred years ago, mental illness was comparatively very easy to define, mental hospitals looked after a small percentage of the population. As we progress, a hundred years later, we in psychiatry, mental health or whatever else you want to call it, now seem to be the answer to everybody's ills, and I think that we try and cater for far too many people.... what do I mean by this? I mean that places like London, Birmingham, Glasgow have large transient populations that have special needs and often people that are transient will have mental health problems, so that's a problem in that mental health will be expected to cater for the transient populations of the cities, which it never had done before. If it is expected to cater for the homeless, although they might be mentally ill as well, then the financing needs looking at. There's large

populations of people in prison with mental health problems..... that does us no good, there are all sorts of complex questions surrounding that ... but basically I do think that community care is the next stage forward, I think it does work, but it's a very complex issue, you know.”

Later in the interview, the **Facility Manager** talked about the need to change people’s attitudes towards the mentally ill and why he thought that mental health professionals in the past can be held partly to blame for the prevailing negativity towards the mentally ill:

Facility Manager: If we are to progress, then we need to.... change public attitudes, which can be done, which can be achieved successfully..... (pause) but as I say, you know, if for a hundred years we've put people in cages..... perhaps that's not a very good description for what the lunatic asylum used to be, but certainly it had big fences with spikes on top..... and you know, then we wonder why people have a negative image of people with mental health problems. Society has a negative image of people with mental health problems because of the way the politicians and professionals have cared for people in the past..... and then we say “you're terrible as a community, as a 'Joe Public' ” I don't think the problems with the 'Joe public', I think it's with the professionals and the politicians, in the way that they've delivered in the past for sections of mental health. There were many reasons for that, but I think, you know, we've come to a stage now when we can actively change public perceptions by hard work (stressed). That's what we need, a bit of hard work..... by people working in the community, by professionals accepting responsibility for what professionals have done in the past, by politicians accepting that the mentally ill are part of society and that with a political will (stressed) you can change attitudes with 'Joe Public'.”

The Facility Manager raised some very important issues throughout his interview, as illustrated throughout this Chapter. He also expressed views, not quoted, concerning the need for effective political backing for the mental health reforms by key people who are willing to take responsibility and to be accountable for mental health care in Britain. This call for greater political support echoes the views of mental health professionals in Verona, as discussed in Chapter Nine.

SECTION THREE

CHANGES IN CARE FOR PEOPLE WITH MENTAL HEALTH PROBLEMS IN ITALY AND VERONA

CHAPTER SEVEN

MENTAL HEALTH CARE IN ITALY: THE IMPACT OF LAW 180.

7.1 INTRODUCTION

'The practical breakdown of class marginalization, implicit in the very existence of psychiatric hospitals, has brought about a law in Italy prohibiting the construction of new psychiatric hospitals and making provisions for the gradual closure of those currently in use. The solution to this practical breakdown cannot be fudged by creating a new theory of interpretation or a new set of ideas which nevertheless leaves the reality unchanged. What is happening here is the opposite to what has taken place in other countries.'

(Franco Basaglia, 1979, preface).

In May 1978, the Italian Parliament passed a radical mental health reform act, Law 180, which called for dramatic changes to where and how people with mental health problems should be cared for in the future. This single piece of legislation has been called 'revolutionary' and 'the most comprehensive community-oriented mental health act in the Western industrialised world.' (Mosher, 1982, p.1). This introductory chapter will give an overview to mental health care in Italy, highlighting the uniqueness of the 'Italian experience' compared to other countries, as stated by Basaglia in the quotation provided.

Law 180 set the agenda for sweeping changes, with the main aim being to dismantle the mental hospitals and to replace these with a comprehensive and integrated system of community psychiatric care (Tansella and Williams, 1987). These reforms are radically different to legislation elsewhere, not only in the rapid timescale set by one

single piece of legislation, but also because the reforms were a result of the emergence of a politics of mental health in Italy, being influenced by left-wing ideologies and led by mental health professionals, a situation which was unique to Italy.

This chapter will review the recent changes in mental health care provision in Italy and the impact of Law 180. An important element of this recent history is that the organisation and provision of psychiatric services in Italy is heavily politicised (Tansella, De Salvia and Williams, 1987), therefore an assessment of the role that Democratic Psychiatry has played in the reforms will be provided, as will the contention that Italian politics and the influence of certain individuals working in particular places, has resulted in geographical variations within Italy in the implementation of community care provision. In fact, such disparities are occurring not only at the national level, but also at the local city scale, as the Verona case study will illustrate.

7.2 MENTAL HEALTH CARE IN ITALY IN THE TWENTIETH CENTURY

The history of mental health care in Italy prior to the twentieth century has already been detailed in Chapter Two. From the beginning of the twentieth century until the passing of Law 180 in 1978, mental health care in Italy has remained almost legislative unchanged, with asylums dominating the mental health care system. Before 1978, there were two laws passed regarding mental health care, which will now be briefly discussed.

In 1904, Law no. 36 was passed, which confirmed the social control purpose of asylums by 'stating that people affected by mental derangement must be kept in custody and treated in mental hospitals when they are dangerous to themselves or to others or create public scandal' (Maj, 1985, p.15). In 1909, this was followed by the 'Regulations for the enforcement of the Law no. 36', which gave guidelines for the implementation of the law, dealing with various aspects of the organisation of mental hospitals and admission to them.

According to these regulations, each Italian province had the responsibility to provide a public asylum for the custody and care of the mentally ill. Some provinces, especially in the south of Italy, could not afford the huge expense of building an asylum. Some provinces combined resources to build very large asylums with broad catchment areas, whilst other provinces 'contracted out' the care of the mentally ill of their province to private hospitals (Bollini, Reich and Muscettola, 1988). In consequence of this, in 1978, only fifty-two out of ninety-two provinces had a public mental hospital (Misiti, Debernardi, Gerbaldo and Guarnieri, 1981, cited by Bollini, Reich and Muscettola, 1988) with the majority of the private hospitals in the south of the country

Law 36 remained in force until 1968, when a partial reform was attempted with the passing of Law no. 431. The main provisions of this law was to allow voluntary admission to psychiatric hospitals and also for the establishment of mental health centres, to treat patients discharged from psychiatric hospital in the community (Maj, 1985). Each 'community service' was to be connected to a hospital ward and to serve the same geographical catchment area in order to assure continuity of care, prevention and rehabilitation. This system was designed after the French model of the 'Psychiatrie de Secteur' (Mosher and Burti, 1989). Although this law made some changes, it failed to change the 1904-1909 regulation of compulsory commitments to the psychiatric hospitals or break the dominance of the asylum system for mental health care provision in the country (Maj, 1985). However, this more liberal legislation did make it possible for those mental health professionals with 'vision' and 'dedication' for change to establish pilot initiatives, mainly in small to medium towns in the northern and central parts of Italy (Mosher and Burti, 1989).

In the 1960s a few young Italian psychiatrists, dissatisfied with the prevalence of institutional care, were looking abroad for new ideas and philosophies, and then experimenting with initiatives in a few places where the psychiatrists were in positions of power. The single best known, and most influential, of these local initiatives began at Gorizia, a town in the far north east of Italy, where a young psychiatrist, called Franco Basaglia, was appointed medical director at the large local

mental hospital in 1961 (Donnelly, 1992). Influenced by the therapeutic community approach which he had seen in Britain and America, Basaglia set about introducing a therapeutic community at Gorizia, working hard to humanise the old hospital and to introduce community services. But Basaglia faced a great deal of opposition to his ideas from the local administration and eventually left Gorizia. After a few years in Parma, in 1971 he became director of mental health services in Trieste (Jones, 1988).

Basaglia had by this time attracted support amongst other like minded mental health professionals, and in the late 1960s they began actively to campaign for policy reforms. This new movement was unique compared to mental health reform groups elsewhere, as it was the result of a distinctive meeting of politics and psychiatry, with its philosophies and ideology being derived from socialist and Marxist views of power and social relations (Brown, 1985). At this time in Italy, as elsewhere, there was social unrest with marches, protests and strikes. Kathleen Jones (1988) describes the way Basaglia used this political climate:

'The slogan of the protest movements in Italy was 'anti-emarginazione', that no-one should be marginalised, that is, pushed to the fringes of society by reasons of race creed, sex or disability. Basaglia's special genius was to make the mentally ill a case in point - for what could be more 'emarginating' than being confined by force in a closed institution on the edge of town?'

(Jones, 1988, p.55)

This campaign led to the official birth, in 1974, of the movement for Democratic Psychiatry, (*Psichiatria Democratica*). This organisation became an important professional and political pressure group (Tansella and Williams, 1987), and with allegiances formed with left-wing parties and trade union groups (Donnelly, 1992) the movement campaigned for radical changes in mental health policy, namely the abolition of the asylum system. In Trieste, Basaglia and his supporters had the opportunity to put their ideas into practice, opening up the mental hospital, with cultural festivities involving the whole city, and transferring former hospital patients

into the community. The influence of the 'Trieste experience' spread to other cities in Italy, for example in Reggio nell'Emilia, Perugia, Parma and Naples (Donnelly, 1992), where psychiatrists, influenced by the ideology of the reform movement, were in positions of power to experiment with these new ideas.

The mass media also played its part to sway public opinion, by bombarding the Italian public with reports of the horrors of the asylum system. This succeeded in making the issues surrounding mental health into a public civil rights movement (Donnelly, 1992). By 1978, with left-wing support in the National Assembly for the reforms and under the threat of a national referendum, Law No 180 was passed in May 1978.

7.3 THE POLITICS OF MENTAL HEALTH CARE IN ITALY

Law 180 undoubtedly represents a considerable achievement, by a small professional political movement, of not only getting mental health issues on to the political agenda, but of also getting new legislation passed on this issue. As commented by Tansella in 1987, 'changes as sweeping as those implied by Law 180 must be considered in context' (p.283). It is important therefore, to examine the rapid political, social and cultural change that occurred in Italy in the 1960's which, according to Tansella (1987) 'provided a fertile background for the development of a movement for psychiatric reform' (p.283). This section will therefore explain how and where the politics of mental health emerged in Italy, focusing upon the impact of social and political change in Italy in the 1960's, the influence of Franco Basaglia on the reform movement and how Law 180 actually came to be passed by the Italian government in 1978.

7.3.1 Post-war Italian society

‘Since the Second World War Italy has changed more rapidly and more dramatically than any other Western European nation. In less than forty years, it has been transformed from an economically under-developed country into one of the world’s leading industrial powers. And the major processes of change - industrialisation, urbanisation, mass migration and secularisation - have had profound and long-lasting social and political consequences’.

(Quartermaine, 1985, p.ix)

This statement made by Quartermaine summarises the major changes which have occurred in post-war Italy. Russell King (1992) describes Italy as having progressed ‘from sick man to rich man of Europe’, where Italy has recently overtaken Britain as the fifth biggest industrial power of the west, although it is important to note that there are still economic disparities between Italy’s regions, particularly between north and south. Italy’s birth rate is now the lowest in the world, with one child or even no children becoming the norm (King, 1993). Apart from influencing demographic changes in post-war Italy, these social and economic changes have also had considerable influence of the direction the Italian political system, particularly since the late 1960s.

Italian society is deeply politicised, entwined with politics at every level of social life. But explaining the Italian political system is a difficult task because of its inherent complexities (Pridham, 1985). As discussed briefly in Chapter One, the dominant party in Italy from 1945 until 1992 was the Christian Democratic Party (‘DC’), a party with strong links to the Roman Catholic church. They provided every Prime Minister from December 1945 to June 1981 and several thereafter. But because of the number of parties in the post-war Italian political system, even though the Christian Democratic Party dominated they never had a majority in the Italian government and had to form a successive number of coalition governments with the other main political parties at the time. This system of coalition governments was very unstable,

relying on deals between parties; governments frequently collapsed, many lasting less than twelve months (Furlong, 1996).

The 1950s and 1960s was a period of rapid economic growth and improvements in standards of living throughout the country, although particularly in the north. There was also relative stability in the political system, with a succession of Centre-Right Governments, followed by Centre-Left Governments from 1963-1972. But since the early 1970's, particularly after the breakdown of the Centre-Left formula, the political system in Italy has lurched from crises to crises, with even more frequent changes in Government (Pridham, 1985). From the 1970's onwards the Christian Democratic Party began to lose their domination over governmental control, particularly with their failure to cope with the social protest movement of the late 1960s.

A move to the right in the 1972 elections, with spectacular gains from the neo-Fascist Social Movement (*MSI*), saw a change in ideological direction amongst the major parties, the most dramatic being by the Italian Communist Party (*PCI*), who proposed a 'historic compromise' - a government of national unity to link all democratic parties to combat Italy's social, economic and civil crises. This strategy proved successful, with gains for the communists in the elections in 1976, pressurising the Christian Democratic Party to 'make overtures' to the communists, who assumed a greater role in Italian politics 1976-9 (Slater, 1985, pp.29-30). This was the critical time of interest in respect of the passing of Law 180 and will be returned to shortly.

The catalyst of change in the stability of the political system according to Slater (1985), was the 'hot autumn' of 1969 which saw the development of a powerful worker's movement which continued into the 1970's, with new worker's councils in factories challenging the role of the trade unions who had traditionally represented the struggle of the working classes. The worker's movement campaigned for economic and social reform, with popular protest taking to the streets. But this political and visual protest was not restricted to the workers alone; also at this time two 'new' social interest groups emerged to demand more political and societal rights - women and Italy's youth. These protest movements converged in the late 1960s creating

greater demands on the Italian political system than ever before and by a much wider range of people than in the past. Slater (1985) marks this period as the turning point for Italian politics, where the system became 'overloaded' by political demands, of which the political system has been incapable since of making an effective response.

Women and youth were political forces for the first time in Italy. With more women entering the labour market in post-war Italy, yet still being expected to fulfil the traditional role in the family, with little state support, women's roles in Italian society became increasingly complex. Up until the 1960s, the Italian political tradition offered little to women, with political ideologies based on Catholicism, with its subordinate role for women, and communism which concentrated upon class politics rather than gender. But this began to change with the rise of a new feminist movement in Italy, which was backed by political parties from the left, especially the Italian Communist Party (Sassoon, 1986).

In 1970 a divorce bill was introduced successfully into Italian Parliament. The Christian Democratic Party (*DC*), being closely associated to the Catholic Church, strongly opposed the divorce bill. But in 1974 a referendum, called to oppose the divorce bill was defeated. This was one of the most important defeats of the Christian Democrats in the post-war period, with women voters voting against the Christian Democrats in favour of the divorce issue. Following this, in 1975, a reform of a family law was passed, which changed some of the more anachronistic aspects of the former legislation. In 1977 a law against sexual discrimination was passed and in 1978, again against strong Christian Democratic opposition, abortion was legalised by the Italian government (Sassoon, 1986). This string of new legislation in Italy in the 1970's reflects the rapid social and political change that was occurring in the country, changes which were essentially attacking the status of the important institutions of Italian society, the power of the church and of the family.

The fact that these new political movements emerged, outside traditional class allegiances, is an important outcome of the societal changes occurring in Italy from the 1960s onwards. That these new movements were influencing political decisions and the passing of new laws is of even greater importance. These changes in Italy illustrate the social and political climate into which mental health care issues emerged on to the political agenda in the 1970s.

7.3.2 Politics and psychiatry: how Law 180 came to be passed

In Italy, psychiatry and politics have become inexorably and openly intertwined (Mosher, 1982). The Democratic Psychiatry Party (*PD*) under the leadership of Franco Basaglia, effectively ‘worked’ the Italian political system in order to get mental health issues on to the political agenda and to get new legislation through in 1978 with Law 180. The timing of this political activity on the part of Democratic Psychiatry was crucial; the movement for mental health reforms coincided with the demands for widespread social reforms by the students’, women’s’ and workers’ movements which emerged from 1968 onwards. One of the major demands for social reform was for a better health care system in Italy, so the reform of psychiatric services was seen by the Left as part of a wider struggle for the creation of a national health service (Mangen, 1989).

But before explaining the immediate events which led to the passing of Law 180, it is important to briefly discuss why, how and where psychiatry became politicised in Italy. (Much of the information for this section is taken from Donnelly (1992) and Mosher (1982).

As stated by Mosher (1982), the mental health reforms can only be understood with reference to the convergence between psychiatry and politics in Italy over the two decades leading up to the legislation. In the 1960s, as social discontent was building up within Italian society, signs of discontent were also emerging amongst the psychiatric profession concerning the state of Italian psychiatry and its mental hospitals. At this time, the organisation of psychiatric services elsewhere in Europe

and North America was changing; in Britain the 1959 Mental Health Act was passed which marked a policy commitment to transfer care from institutions to community-based services; the USA in 1963 were proposing the introduction of community mental health centres and in France in 1960 a policy of sectorisation was adopted for mental health services. These developments abroad contrasted pointedly with the situation in Italy, where institutional care continued to dominate (Donnelly, 1992).

Against a background of conservatism, with established psychiatrists unwilling to move away from institutional psychiatry, innovative local initiatives began to emerge in a few places, where younger psychiatrists discontented with the present system, were in authority. These initiatives were focused upon the public system of mental hospitals. Donnelly (1992) describes how 'working 'experimentally' in what often looked to be decidedly marginal conditions, such psychiatrists tried 'to do psychiatry in a new way,' and to break out of the limiting and discouraging circle of '*pericolosita, eredita*' and '*cronicita*' (dangerousness, hereditary taint, chronicity) in which asylum inmates seemed to be caught. What began as isolated initiatives would in the end prove to be 'pilot' experiments, which formed a whole generation of leaders in the eventual movement for an 'alternative' psychiatry' (p.39).

Mosher (1982) describes how at first, at Gorizia, Basaglia adopted Maxwell Jones's therapeutic community approach. The hospital remained open but steps were taken to humanise the environment by introducing small communities within the hospital, drastically changing the former routine of institutional life: physical restraints and institutional rituals were withdrawn; patients were allowed personal belongings; to wear their own clothes; a cafe and beauty parlour were opened for the patients' use. This 'opening up' of the hospital marked an abrupt reversal in established practices (Donnelly, p.41).

These changes particularly challenged the traditional roles played between the staff internally and between the staff and patients; at first the staff were disturbed by these changes but the new emphasis on discussion at a professional 'team' level eventually developed a strong collective orientation amongst the staff. Changes concerning the

patients were even more radical as the first aim of the experiment at Gorizia was to come to know and to communicate with the patients, trying to understand the patients 'lifeworld'; 'how they perceived their world as subjects rather than how they were 'objectified' by diagnostic categories' (Donnelly, 1992, p.42). This adoption of a phenomenological approach in treating the mentally ill was a fundamental difference compared to the existing practices of traditional psychiatry in the country.

Basaglia was influenced by philosophies emerging from the anti-psychiatry movement in Britain and critics of institutions and of professional mystification, for example the works of Goffman, Foucault, Szasz and Laing. Despite being in many respects mutually incompatible (Jones, 1988), the different ideas of these theorists contributed towards the formation of Basaglia's philosophy on how the mentally ill should be treated and cared for. In this way then, as suggested by Jones (1988), Basaglia took what he wanted from the current radical ideas elsewhere in the world 'to fashion a philosophy for a particular time and place' and even 'if it lacked intellectual coherence, it had a political point' (p.55). Basaglia therefore pieced together different pieces of the different philosophies, moulding them together to fit the Italian situation, so with his first experiment at Gorizia, the project developed into 'something more and different than a copy or local adaptation of foreign models' (Donnelly, 1992, p.41).

But Basaglia became dissatisfied the therapeutic approach after a couple of years as this treatment did not seem to motivate the patients into wanting to leave the hospital and move back into the community. Mosher (1982) described how Basaglia perceived the reason for this problem to be the institution itself, and following this realisation, for the next five years Basaglia and his co-workers at Gorizia set about to dismantle to hospital. During this time Basaglia and his colleagues 'evolved a philosophy including the beliefs that psychiatry is politics, that psychiatry provides scientific support of the existing establishment, that scientific neutrality is a myth and that existing standards of normality and deviance result in the oppression of certain groups in society' (Mosher, 1982, p.200). In this way then, the reformers began to move beyond the original phenomenology, drawing upon the notion of

'institutionalism,' with the belief that it was the hospital itself which was making the patients the way they were (Donnelly, 1992, p.44).

As already mentioned, Basaglia had to leave Gorizia and in 1971 he became the medical director at Trieste, where he continued his work and set about the closure of the psychiatric hospital in the city (see Donnelly, 1992, pp. 62-71). A strong network had developed between the centres where alternative approaches were being established, but Basaglia and his colleagues feared that this situation of isolated pockets of reform was limited and wanted to spread the reforms further. In order to extend their influence, the Democratic Psychiatry Party began to develop alliances with left-wing parties and trade unions who, at this time, were deeply involved in supporting other social reform movements in the country.

Therefore from 1968 onwards, Basaglia and his colleagues became involved in Italian politics to promote the 'liberation of the mental patient' as a social reform. The main party that was initially receptive to Basaglia was the Italian Communist Party (*PCI*), that was becoming increasingly powerful by this time. In 1974, the Communists adopted the 'liberation of the mental patient' as official Party doctrine (Mosher, 1982). However, the relationship between the leaders of the Democratic Psychiatry Party and the Communists was rather 'stormy' and after the Communists 'new relationship' with the Christian Democrats after the 1976 elections (as discussed in 9.3.1) no real action was taken by the Communists on behalf of the Democratic Psychiatry Party. The party which played the most crucial role in supporting Basaglia, from 1977, was a small party called the Radical Party, who were then gaining between five and seven percent of the Italian vote. The Radical Party were known as the party of human rights and had been very active in both the recent divorce and abortion campaigns. The Radicals 'took on' the cause of Basaglia and his party.

In Italy, a national referendum may be held on any existing law if 500,000 voters sign petitions to that effect. In 1977, the Radical Party began to collect signatures to change the 1904 asylum law; by June 1977 over 700,000 signatures had been

collected and the party had enough signatures to call a referendum. The two main parties, the Christian Democrats and the Communists, were very nervous about what might happen if a referendum was called in the present social climate, particularly after the recent divorce referendum, and were keen to avoid this mental health referendum. If passed, the 1904 law would be abolished and there would be no legal basis for the operations of the mental hospitals, payment for their staff and so on. Therefore to avoid the risk of a referendum, the Christian Democrats and the Communists each appointed a deputy to write together a new mental health act in December 1977. Basaglia did not actually write the law but he was in constant consultation with these two deputies and the law became commonly known as the 'Basaglia Law' (Mosher, 1982).

7.4 MENTAL HEALTH CARE IN ITALY AFTER THE ENACTMENT OF LAW 180

Law no. 180/1978, officially entitled 'Voluntary and Compulsory Health Assessment and Treatment' was passed in May 1978, with a minimum of discussion and debate and with support from virtually all the electoral parties (Donnelly, 1992).

The main provisions of Law 180 were the following:

- No new psychiatric admissions after 31 December 1979. No re admissions after 31 December 1980.
- No further building of existing psychiatric hospitals, or new ones, from the date of the legislation (1 May 1978).
- 15 designated psychiatric beds per 200,000 inhabitants to be established within general hospitals or in community mental health centres (CMHCs).
- Community mental health centres were to be established by the throughout the country.

- People could be admitted to the new psychiatric facility or to a CMHC by a compulsory order which had been proposed by a psychiatrist and signed by the local mayor and tutelary judge. The compulsory order would be for the duration of seven days, could be renewed and would be open to appeal.

This new legislation called for, effectively, the closure of psychiatric hospitals, by prohibiting further re-admissions after two years of the passing of the Law 180. The main features of this new model of care were: the provision of local services in the community supported by acute psychiatric services in general hospitals or community mental health centres; a sectorisation of services within a single health unit; the integration of the various facilities within geographically-defined catchment areas. There was also new emphasis on multi-disciplinary teamwork, with the same community-based team of mental health professionals providing domiciliary, out-patient and in-patient care within their designated territory (Tansella and Williams, 1987).

Law 180 was incorporated into Law 833, also passed in 1978, which introduced changes in the delivery of health care and established a new National Health Service in Italy. The new National Health Service was based on the British NHS model (Bollini, Reich and Muscettola, 1988), in which all registered citizens were entitled to gratuitous health care. Before 1978, health care was organised through health insurance schemes and health care provision was under the responsibility of the Provincial Administrations. But with the new National Health Service, the responsibility for providing health care now rested with the Regional and Municipal Administrations (Maj, 1985) with a new organisational structure for the provision of health care services, based upon geographical catchment areas. Each newly defined health district came under the responsibility of the newly created local health units '*Unita Locale Socio-Sanitaria*' (ULSS). All health services, the hospitals and community-based services, became integrated and co-ordinated by the local ULSS (Tansella and Bellantuono, 1991).

7.4.1 Law 180: a framework law

'Merely changing the law is no magic formula for altering the practice of psychiatrists, the attitudes of the population or the concerned involvement of politicians and administrators, especially if a comprehensive program is lacking.'

(Pirella, 1987, p.133)

Despite the rapid and apparent consensus agreement that the reforms were required in the 1970s, the reality of the actual enactment of Law 180 has been less successful. The provisions of Law 180 were based on a compromise between the Christian Democrats, the Communists, the Democratic Psychiatry Party and the more mainstream psychiatry organisation '*Società Italiana di Psichiatria*'. As noted by Pirella (1987) not all were in favour of the reforms, especially the radical and rapid nature of them. The passage of the law was followed by a period of sharp and increasingly bitter conflict between the supporters of Law 180 and a newly organised and vocal group of critics, who were concerned with the limitations of the legislation and the shortfalls in care that they envisaged (Donnelly, 1992).

A major problem was that the law was simply set out as a guideline, to state a principle and an ideology; it did not provide any detailed rules and regulations, provided no funds for putting the reforms into place. The law had been drafted, discussed and enacted in very hurried circumstances, with little thought of how the legislation was to actually be implemented. The legal effect of the passage of Law 180 was in fact, for most parts of Italy, to create a vacuum between the abolishment of the mental hospitals and the implementation of community-based facilities (Donnelly, 1992, pp.79-80).

One of the major problems of introducing the new reforms was the regional government system in Italy. Italy has twenty regions, each with its own regional government which have the power to implement all national legislation through regional administration. With the political instability of the national government, the

mechanisms in which to enforce national legislation in Italy are weak. Added to this, due to the lack of guidelines and strict rules on how to actually set up new community-based facilities, each region and province was basically given the opportunity to interpret and implement the law when and as they liked (Maj, 1985). This can be seen as a major drawback of the legislation and one of the reasons why different systems of service provision have developed in different regions and cities.

In these ways then, Italian politics have had a great influence on the progress, or lack of it in some parts of Italy, of the mental health reforms. But also of importance has been the influence of key individual psychiatrists in the particular places, like Franco Basaglia in Trieste, where alternative approaches in psychiatry became established. Basaglia was the architect and inspiration of the reform movement and his role must surely not be underestimated. As stated by Gregory in 1985: 'people make a difference and places make a difference' (p.74) and this has certainly been the case when talking about mental health care in Italy over the last thirty years. Regarding the importance of place, as stated by Tansella, De Salvia and Williams (1987), the reform movement had its origins in the north and central Italy, in places like Gorizia, Trieste, Arezzo, Reggio nell'Emilia, Ferrara and Perugia, 'thus, considerations of geographical diffusion alone would favour a pattern in which changes were greater in the north than in the south' (p. 46).

7.4.2 A new geography of mental health provision

As commented by Tansella, De Salvia and Williams (1987), there is evidence of considerable geographical unevenness across the country in the implementation of the reforms detailed by Law 180. Although, at a national level, there has been a dramatic decline in the number of patients in public mental hospitals in Italy since 1978, from 104,200 (185 per 100,000) in 1975 to 25,400 (44 per 100,000) in 1987, these national figures hide a tremendous variation in rates amongst the different regions (De Salvia and Barbato, 1993). In addition, admission to mental hospitals in some regions has still continued and in a number mental hospitals, chronic and elderly inpatients still remain (Bollini and Mollica, 1989; Lesage and Tansella, 1993).

Recent studies (Bollini, Reich and Muscettola 1988; Crepet 1990; De Salvia and Barbato, 1993), have found sharp regional differences in the provision of community care facilities. Fasolo and Frisanco (1991) reported considerable disparities, in terms of efficiency of community services, from one geographical area to another with the southern regions and the islands, but also large areas in Lazio, the Marches and Abruzzi, 'showing considerable shortcomings, services being static and isolated from the social context' (p.222). Services that have been reported to have fully implemented Law 180 are predominantly located in the north of Italy and are those which had established community-based services prior to the reform, for example: Trieste, Arezzo, Perugia, South Verona, Portogruaro and Parma (Fasolo and Frisanco, 1991; Pergami, 1992).

However, it is important to consider these regional differences in context. Such variations in health care provision reflect the existing differences between the north and south of Italy, with inequalities in wealth and economic development as well as cultural differences. In north/central regions there have always been more resources for health which have facilitated an easier transition to a new model of care. In this way then, the different regions had different starting points from which to implement the reforms.

Another important factor is the geographical distribution of private psychiatric beds; the number of private beds is approximately three times greater in the south than in the north (Tansella, De Salvia and Williams, 1987). Private institutions, predominantly owned by the church, have always dominated the mental health care system in the south of Italy whereas in the north/central regions, the mental hospitals have been predominantly publicly managed. These private institutions are still publicly reimbursed and therefore have a vested interest in maintaining the existing system of provision in those places (Bollini, Reich and Muscettola, 1988). This situation has remained unchanged because of a lack of policy co-ordination at the regional level; the nature of the legislation gave a 'free hand' to regional administrators as to the timescale and methods of implementing the reforms (Maj, 1985) and this has enabled each region to act independently.

Yet even within the north/central regions, where the reforms have been more successfully applied there are variations between places in those regions in regard to the type of mental health care service provision. For example, research carried out by De Girolamo, Mors, Rossi, Ardigo and Munk-Jorgensen (1988), found different models of care in two neighbouring towns in northern Italy, Cremona and Mantua. The mental health services in Cremona are still hospital based whereas Mantua has well developed community-based services.

The geographical variations in the implementation of the mental health reforms introduced by Law are considerable, and at all spatial scales in Italy: national, regional and local. Variations at the local scale is something which was evident in the city of Verona, where I conducted the Italian fieldwork for this PhD in 1994. I chose to make a case study of a northern Italian city because I wanted to see an example of a city which has claimed to have implemented the reforms and is now operating without an asylum. I chose not to make a study of Trieste as many people have done so before, although I did visit the psychiatric services in Trieste whilst I was in Italy. In Verona, there are three mental health services within the same health authority, yet the sectors are managed by different psychiatric services, each providing different models of care. The role played by individual players in shaping the mental health provision in the city appears to be an important influence in determining these differences.

7.5 MENTAL HEALTH CARE SERVICES IN VERONA.

The purpose of conducting research in the city of Verona was to assess the impact of Law 180 at the local scale. The organisation of all of the mental health services in the city was examined to provide an overview of the service provision in the city as a whole. Then a case study was made of the South Verona Community Psychiatric Service (South Verona CPS) for the more intensive research, in order to evaluate the 'on the ground' realities of mental health care provision in an Italian city in the 1990s. In 1994, the South Verona CPS consisted of: an in-patient service at the Borgo Roma

general hospital the '*Policlinico*'; a Community Mental Health Centre providing day care and rehabilitation; small residential facilities, which at the time of the research accommodated ten people with mental health problems. Whilst in Verona, research was also conducted with local residents who lived in vicinity of one of the residential facilities (a questionnaire survey) and with members of staff of the South Verona CPS (semi-structured interviews). The results from this part of the research are reported in Chapters Eight and Nine. Other interviews were also conducted whilst in Italy, as detailed in Appendix One, and these provided information that has been used throughout Section Three of this thesis.

The whole of the South Verona CPS was selected for the Verona case study for two main reasons: there was not a residential facility in Verona on the scale of the Lister Avenue Project, the Sheffield case study, with which to make a comparative study. Secondly, the organisational structure of mental health care in Verona is very different to that of Sheffield; Verona has three separate mental health services which are responsible for providing all services within a defined geographical area; Sheffield has a number of purchaser and provider agencies which have different responsibilities within the same geographical area. In Sheffield in 1994, there were many community-based residential facilities for people with mental health problems; in Verona there were three. Because of the integrated nature of the South Verona CPS and the fact that there were only two small residential facilities, accommodating a total of ten people, it was decided to make a case study of the whole service.

7.5.1 A brief history of mental health services in Verona

Verona is located in the region of Veneto, which is made up of eight provinces. From the end of the nineteenth century, the province of Verona was served by a state asylum called San Giacomo, which was located on the southern outskirts of Verona. The hospital accommodated about one thousand patients and remained open until the late 1960s. In 1968, the old asylum was replaced by the last purpose built mental hospital in Italy which was opened in Marzana, on the outskirts of Verona, to serve the city of Verona and the eastern part of the Verona Province. The western half of

the Province was served by another state hospital at Ponton. The hospital at Marzana, with 760 beds, was run in a traditional way, and had few links with the local community. There were also two private psychiatric hospitals, with a total of 220 beds, which served Verona (Zimmermann-Tansella, Burti, Faccincani, Garzotto, Siciliani and Tansella, 1985).

The walled entrance to the old asylum, San Giacomo, still remain by the entrance to a small park next to the large general hospital in Borgo Roma, the Policlinico, which has replaced the old asylum site. Within the grounds of the Policlinico are a number of buildings previously used by the asylum; one of these buildings is today used by the Institute of Psychiatry of the University of Verona, which was established in 1970. Another previously derelict building was re-opened in 1980, as the Community Mental Health Centre (CMHC) for the newly established South Verona Community Psychiatric Service (Mosher and Burti, 1989). A photograph of the South Verona CMHC is shown as Figure 7.5. In 1994, there were also plans to convert another former asylum building, presently disused, into a residential facility for people with mental health problems from South Verona. This was planned for 1995. This re-use of 'mad spaces' is ironic and as commented by Mosher and Burti (1989) gave 'added significance by geographical coincidence'(p.268) to the choice of these buildings for the new service, created according to a totally different ideology that had led to the creation of San Giacomo in the nineteenth century.

7.5.2 The restructuring of mental health services in Verona

Before 1978, psychiatric services in Verona were focused upon a mental hospital, first San Giacomo and then the new hospital at Marzana. Following the enactment of Law 833 and Law 180 in 1978, the National Health Service Law assigned the administrative and legal responsibilities for health to Italy's twenty regions. Each region was then divided into local health districts, covering a population catchment area. Verona is covered by a single local health authority, ULSS 25. For mental health, the district of Verona, which also included the surrounding area of the city, was divided into three sectors for psychiatric services in 1978, as shown by Figure

7.1. The sectors were created according to the administrative boundaries of the eight '*circostrizioni*' which are defined by the dotted lines on Figure 7.1 and shown clearly in Figure 7.3. In addition, the sectors are also responsible for some of the outlying small towns and villages surrounding Verona, the names of which are given next to the respective sectors in Figure 7.1. Each of the three sectors were given responsibility therefore for a defined geographical area and the population within it.

Figure 7.2 shows the location of the community-based facilities for mental health in Verona. Each sector has an acute ward in the two general hospitals in Verona, at Borgo Trento and Borgo Roma, and these hospitals also provide an outpatient service. In Sector III, operated by South Verona CPS, three internal sectors are shown; these are the three '*territories*' that the sector has been divided into for the community work of the three Community Mental Health Teams, which in South Verona are called '*équipe*'. This is discussed further in section 7.6.

As one can see in Figure 7.2, in Sector III (South Verona CPS) the facilities are very spatially concentrated around the Policlinico. The focus of the service is the Community Mental Health Centre which was established in 1980, close to the general hospital. The service also has two community care homes that accommodate a total of ten patients. In 1994 there were plans for the establishment of two more residential facilities: one on the Policlinico site, as discussed in 7.5.1; one in another part of the territory, which proposes a residential facility and a co-operative workshop for people with mental health problems. This project is being proposed in partnership with the local parish as is discussed in 7.6.2.

Figure 7.1 The Geographical Sectorisation of Mental Health Services in Verona (ULSS 25) (1994)

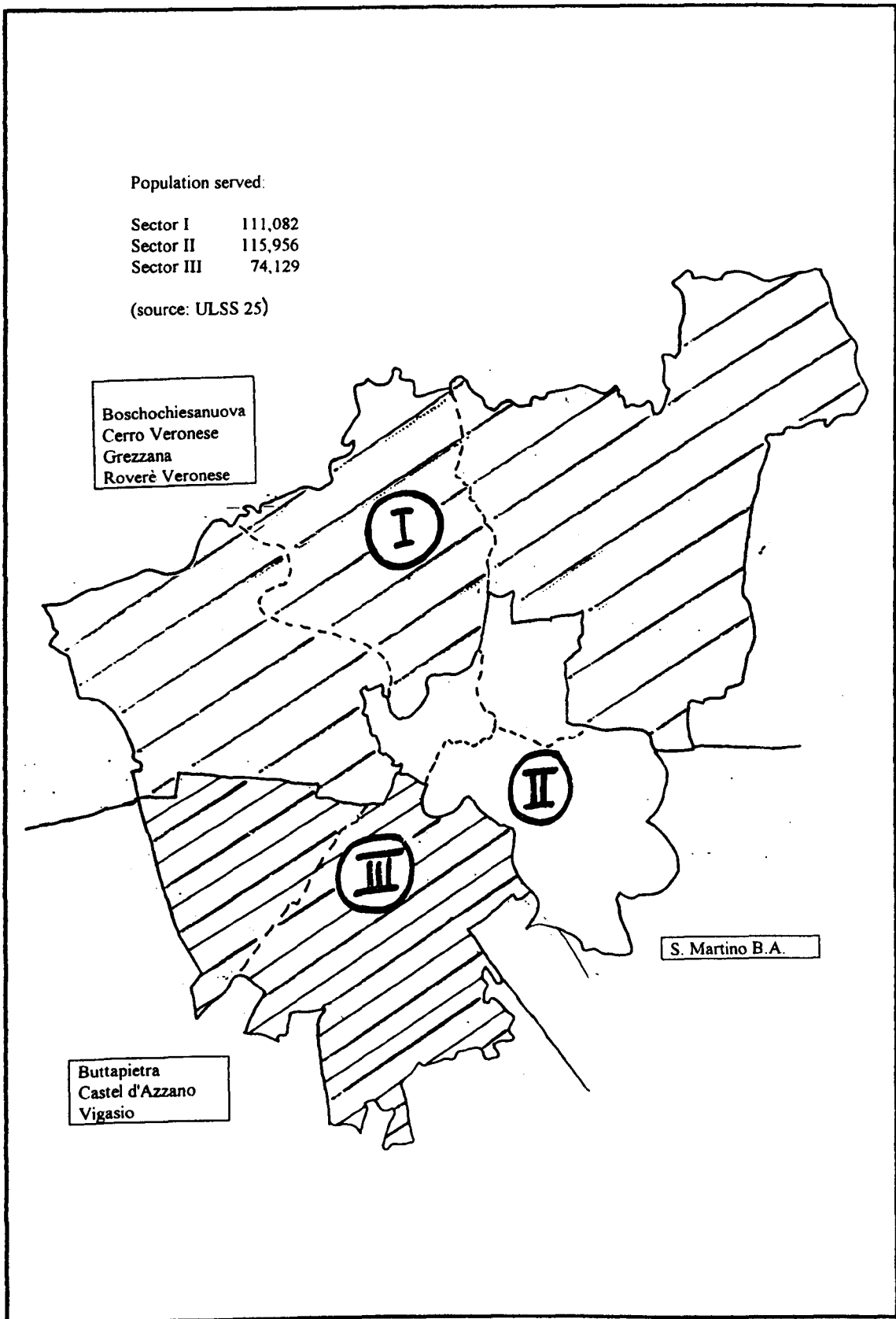


Figure 7.2 The Locations of Community-based Mental Health Facilities in Verona (ULSS 25) (1994)

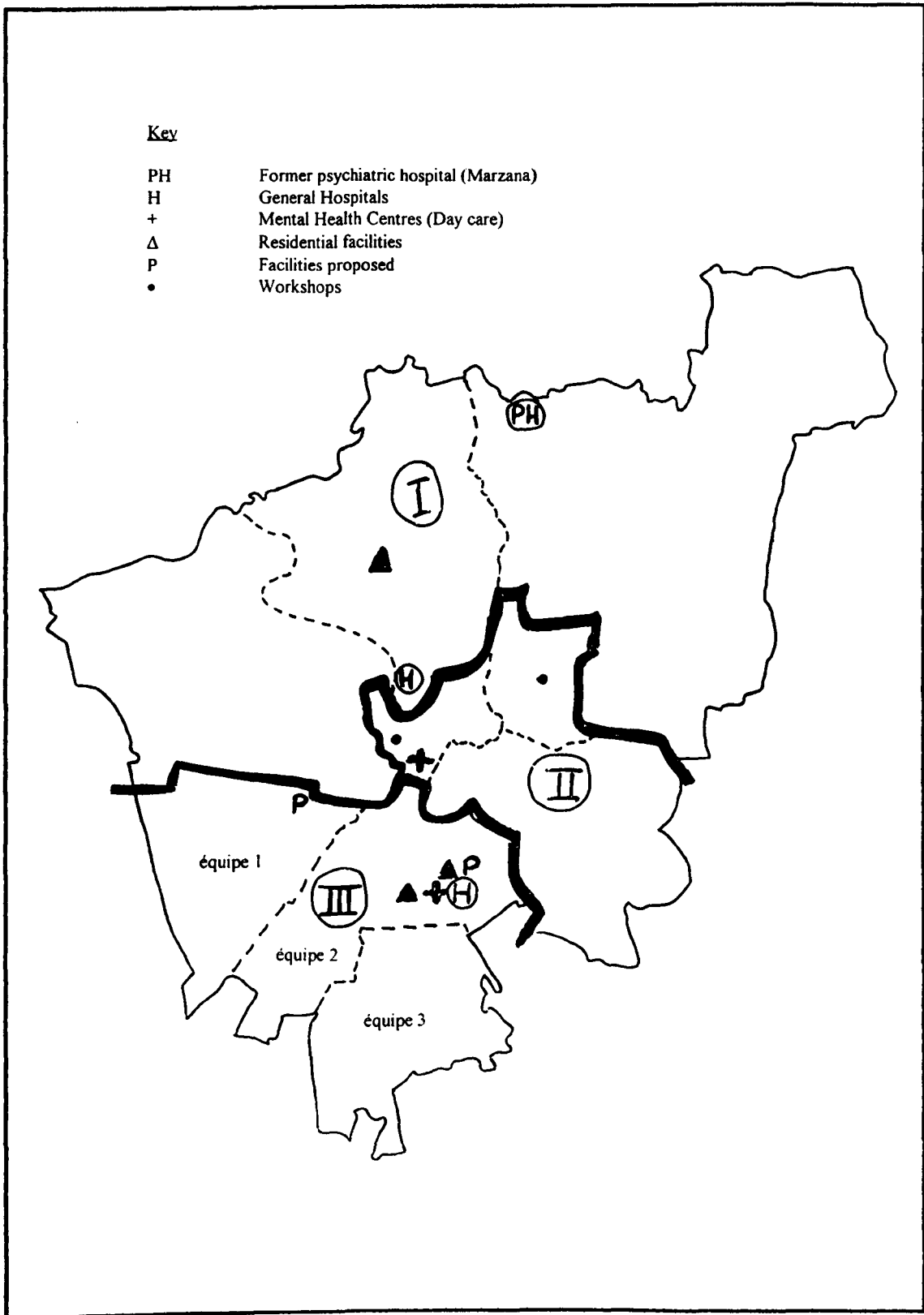
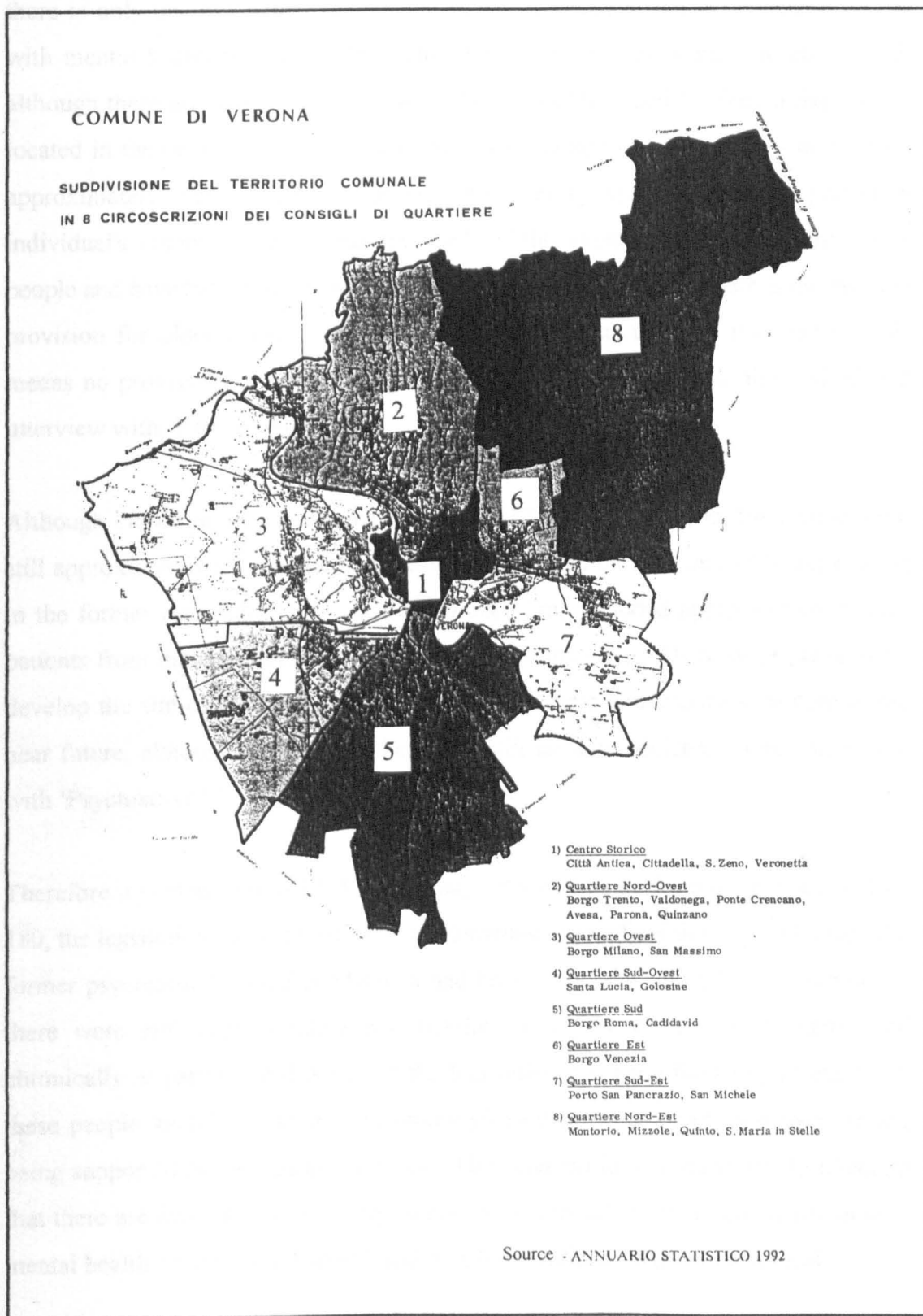


Figure 7.3 The Administrative Organisation of the Comune of Verona with Eight Geographically Defined 'Circoscrizioni'



In the other two sectors, Sector I and Sector II, there are fewer 'static' facilities; ambulatories (a type of day surgery) are held in each local area, often in the local health centre, one day a week, which people have to physically go to. In Sector I there is only one residential facility which accommodates five to six young people with mental health problems. In Sector II there are no residential facilities at all, although there are two co-operative workshops. Sectors I and II, share a day centre, located in the centre of Verona, which was first opened in 1988. The centre serves approximately twenty-five people at one time, offering activities which are part of an individual's rehabilitation programme. All of the clients of the centre are young people and have to be referred to the centre by their psychiatrist. There is no day care provision for older people with mental health problems in these two sectors; this means no provision for de-institutionalised patients (source: visit to the CMHC and interview with 'Psychologist 1').

Although closed to all admissions since 1985 (Tansella, 1991), in 1994 there were still approximately two hundred and fifty patients from the Province of Verona living in the former psychiatric hospital at Marzana. This included approximately twelve patients from the population served by South Verona CPS. There were plans to re-develop the site of Marzana into more of a therapeutic community sometime in the near future, although at this time there was still no date decided (source: interview with 'Psychiatrist 1').

Therefore it is clear that in 1994 in Verona, sixteen years on from the passing of Law 180, the legislation had not been fully implemented throughout the city. Although the former psychiatric hospital at Marzana had been 'officially' closed for eleven years, there were still approximately two hundred and fifty of the most elderly and chronically ill patients still there. If the legislation had been fully implemented, all these people would be living in community-based facilities or in their own homes, being supported by community services. The situation in Verona serves to illustrate that there are inequalities in gaining access to a comprehensive range of community mental health services at all spatial scales in Italy: national, regional and local.

However in the sector managed by South Verona CPS, according to Lesage and Tansella (1993), Law 180 has been properly implemented and evaluated, with the service providing comprehensive and integrated community care without the use of long-stay beds. This service was selected to be the case study for the Italian research.

7.6 THE VERONA CASE STUDY: THE SOUTH VERONA COMMUNITY PSYCHIATRIC SERVICE

'The workers of the Institute of Psychiatry of the University of Verona agreed with the spirit of Law 180 from the outset. They offered to assume responsibility for the implementation of the law in one of the districts of Verona. This decision implied tackling the difficulties of community psychiatry and giving up some of the privileges of an academic institution (such as choosing patients), while keeping up with university duties (teaching and research).'

(Mosher and Burti, 1989, p.264)

The South Verona service had already begun applying the principles of the psychiatric reforms well before 1978 (Mosher and Burti, 1989). The Department of Psychiatry at University of Verona, established in 1970, consisted of thirty-six beds located in the Policlinico, in South Verona. According to the traditional activities of University Psychiatry departments, admissions were usually either people in an acute crisis or those requiring more specialist care (i.e. were more interesting for research); the dangerous and chronic cases were normally sent to the state hospital at Marzana. However during the 1970s, the Department personnel gradually increased their outpatient care, wanting to 'follow up' patients once they had returned to the community. So when, in 1978, Law 180 was passed, according to Mosher and Burti (1989) 'the decision to become part of the public system by assuming responsibility for a catchment area was taken unanimously, without hesitation' (p.268).

Before discussing the South Verona CPS in detail, it is important to briefly mention the unique characteristics of the South Verona service. The service is run by the Departments of Psychiatry and of Psychotherapy of the Institute of Psychiatry at the University of Verona. The Department of Psychiatry incorporates the '*Servizio di Psicologia Medica*', which is a research and teaching unit. The director of the '*Servizio di Psicologia Medica*' is also the director of the South Verona CPS ('Psychiatrist 1'). In 1987, the research unit was designated by the World Health Organisation as a WHO Collaborating Centre for Research and Training in Mental Health. Most of the research is devoted to epidemiological studies in mental health and the Unit publishes its research in national and international journals, as well as books; by 1994 over 250 research papers and 11 books had been published by the Unit.

One of the main research programmes is the monitoring and evaluation of psychiatric care provided by the South Verona Community Psychiatric Service (CPS). The data for this research is collected from the South Verona Psychiatric Case Register, which started operating on 31 December 1978. This case register records basic demographic and clinical data from each client who has contact with the service. This information is used not only for research purposes but also to provide knowledge and information for planning the programmes and organising the South Verona CPS more effectively. (The information regarding the research activities of the CPS has been taken from: Mosher and Burti, 1989; Tansella, 1993; interview with 'Psychiatrist 1'). It was of great advantage to me to be undertaking my Verona case study in the sector where academic research is undertaken.

7.6.1 The South Verona territory and organisational structure

The South Verona CPS supports a population of approximately 75,000 (Mosher and Burti, 1989). The geographical area covered by this service consists of four suburban districts and three small rural communities in the southern outskirts of the city. The four districts ('*quartiere*') served by South Verona CPS are: Santa Lucia; Golosine; Borgo Roma and Cadidavid. The locations of these '*quartieri*' can be found on the

map of Verona shown as Figure 7.3. Santa Lucia and Golosine are the two '*quartieri*' which make up the south-east '*circostrizione*', numbered as four on the map. Borgo Roma and Cadidavid make up the south '*circostrizione*', numbered as five on the map. The three rural communities, Buttapietra, Castel d'Azzano and Vigasio, are small villages outside the commune of Verona, but within the Province of Verona and within the territory assigned to ULSS 25, assigned in turn to the responsibility of the South Verona CPS.

As shown on Figure 7.2, the South Verona territory has been internally divided into three sectors, according to geographical, administrative and population criteria. These three sub-sectors have been numbered on Figure 7.2: Sector 1 serves the '*quartiere*' of Borgo Roma; Sector 2 serves the '*quartieri*' of Santa Lucia and Golosine; Sector 3 serves the '*quartiere*' of Cadidavid and the three villages of Buttapietra, Castel d'Azzano and Vigasio.

Each of these three sectors are served by a community team called an '*équipe*', which go out and visit people in their homes as required. Each '*équipe*' consists of seven to eight people and is multidisciplinary, consisting of psychiatrists, a psychologist, nurses and a social worker. Each '*équipe*' is managed by a psychiatrist and the team meets on a daily basis to discuss the work for the day. All three teams also meet together every morning at 9am, to discuss any arising matters from the previous day all current business. All the staff, apart from those working on the in-patient ward in the Policlinico, work in the different 'geographical' areas of the service, depending upon where clients from their case load are. Therefore they 'follow' their clients and see them where required: in their homes in the community; at the Community Mental Health Centre; in the outpatient service; in the in-patient service. Therefore the staff are spatially mobile, not fixed to one role or location. This provides a continuity of care for the service users.

The members of the community '*équipe*' visit people in their own homes for a variety of purposes: emergency calls, follow-up visits as well as for long term care. Each '*équipe*' serves a population of between 18,500 and 28,000, depending on the size of

each respective territory (Mosher and Burti, 1989). In the '*équipe*' of Golosine and S. Lucia, for example, there are between 700-800 clients who are registered with the service, although not all of these are requiring treatment at the same time. Each '*équipe*' member has a personal case load of approximately thirty clients whom they will see regularly. Depending on the need, the '*équipe*' member may see a client every day, twice a week or once a fortnight, depending upon the circumstances. (source: interviews with '*équipe*' members, see Appendix One). The purpose of these teams, as is the aim of all Community Mental Health Teams, is to provide 'continuing care' and support for clients in the community and to help prevent crises and admission into hospital.

7.6.2 The community-based facilities of the South Verona service

At the time of my research, in 1994, the service had the following facilities within the territory, the locations of which are shown on Figure 7.4:

- Community Mental Health Centre (CMHC)
- Psychiatric unit - an open ward with 15 beds in the Policlinico
- Outpatient department - located in the Policlinico
- Two residential facilities, both located close to the Policlinico.

In 1994, plans were underway for a further two facilities:

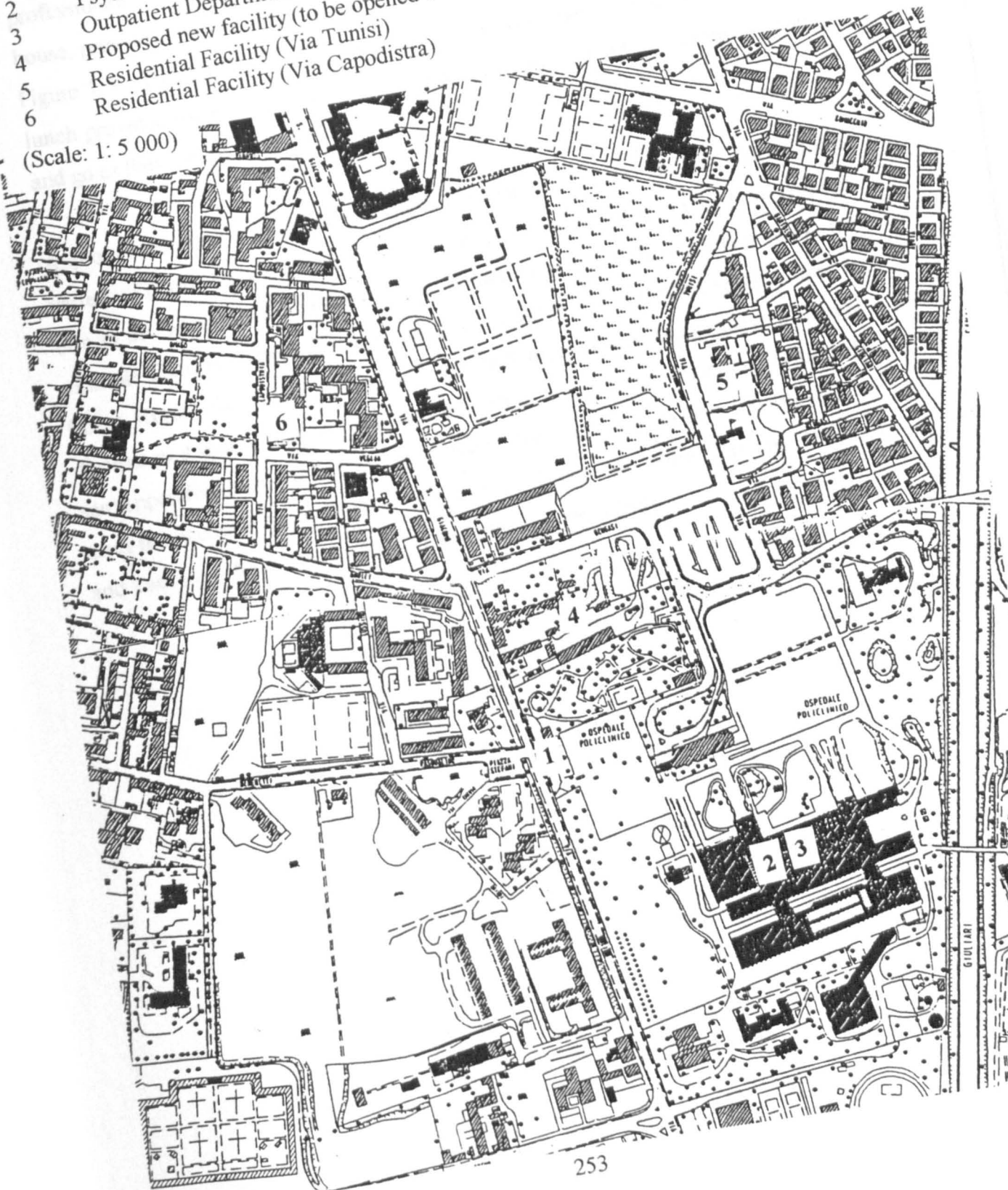
- One apartment, to be a residential facility, located within the Policlinico site
- A project to provide a residential facility and a co-operative workshop for people with mental health problems. This project is in partnership with a local parish church in Golosine (not shown on Figure 7.4).

Figure 7.4 Map showing the Location of the Facilities of South Verona CPS in Borgo Roma

Key

- 1 Community Mental Health Centre
- 2 Psychiatric Unit
- 3 Outpatient Department
- 4 Proposed new facility (to be opened 1995)
- 5 Residential Facility (Via Tunisi)
- 6 Residential Facility (Via Capodistra)

(Scale: 1: 5 000)



The Community Mental Health Centre

The services of the South Verona CPS are focused upon the Community Mental Health Centre (CMHC), which offers support on a drop in basis as well as organising activities every day, therapeutic sessions and consultations with mental health professionals. The CMHC is located close to the Policlinico, in a former derelict house, previously on the site of San Giacomo; a photograph of the CMHC is shown as Figure 7.5. The CMHC is open six days a week from 8am to 8pm; there is a free lunch provided for anyone who wants it, and clients who attend the centre can come and go as they please during the day.

Approximately one hundred people attend the centre in a week, and this will be for a variety of reasons, some clients go to the centre every day, often as they have nothing else to do, whereas other people will only attend one particular activity a week; for example there is a sports group which goes swimming or attends a sports centre in Borgo Roma; there is a knitting group which meets every Wednesday; a therapy discussion group is held on Tuesdays and Thursdays (source: interviews with staff, see Appendix One). In this way then, the CMHC is 'meant to be a flexible tool, to meet the needs of the users at any given time' (Faccincani, Burti, Garzotto, Mignolli and Tansella, 1985, cited by Mosher and Burti, 1989, p.268).

FIGURE 7.5 PHOTOGRAPH OF THE COMMUNITY
MENTAL HEALTH CENTRE OPERATED
BY THE SOUTH VERONA CPS



FIGURE 7.6 PHOTOGRAPH OF A RESIDENTIAL FACILITY
OF SOUTH VERONA CPS IN VIA
CAPODISTRA, BORGO ROMA



FIGURE 7.7 PHOTOGRAPH OF A RESIDENTIAL FACILITY OF SOUTH VERONA CPS IN VIA TUNISI, BORG ROMA



The community-based residential facilities

Figures 7.6 and 7.7 show the two apartment blocks where the two residential facilities of the South Verona CPS were in operation in 1994. Both facilities were located in blocks of public housing and belonged to the Local Authority, the Comune of Verona. The apartment in Via Capodistra was established in 1982 and at the time of the research was a 'semi-protected' facility, which meant it was only staffed during the day, between 8.30am and 3pm. This facility was for people who were being prepared to leave residential care and live on their own or with family or friends. At the time of the research, three women lived full-time at the facility and one woman had moved out to her own apartment but still went to Via Capodistra and the CMHC during the day. The facility was staffed by a facility manager and a support worker, both of which were interviewed for the research. The role played by these workers and the activities of the clients are discussed in Chapter Nine.

The facility in Via Tunisi, shown in Figure 7.7 was established in 1987. The facility consists of two adjacent ground floor flats and in 1994 it accommodated six people with severe mental health problems. The facility was 'protected' which means that it was staffed for twenty-four hours a day, with staff working in shifts. All of the clients were chronically ill and needed constant supervision; the majority of the clients had previously been patients at a psychiatric hospital. The facility was staffed by a facility manager and nine support workers. The facility manager and one of the support workers were interviewed for this research and their roles are discussed in Chapter Nine.

All of the support workers who worked at the facilities worked for a co-operative called '*Farsi Prossimo*'. In Italy there are two types of co-operatives; the 'work' co-operative where the workers work together, for example to run a shop or a gardening business and a 'social' co-operative where the workers provide assistance and support to a 'socially dependent' group like the mentally ill, people with learning difficulties and so on. The co-operative '*Farsi Prossimo*' only works with the mentally ill. '*Farsi Prossimo*' was established in 1987 and has about eighty members of the co-operative; the co-operative belongs to the workers and are all 'shareholders' in the

business. 'Farsi Prossimo' has a contract with ULSS 25 and provides the support workers for the mental health facilities within the Health Authority. These types of 'social' co-operatives are relatively new in Italy (source: interview with Director of 'Farsi Prossimo' Verona 'Key Individual 2').

Future Projects

At the time of my research, South Verona CPS had plans for the establishment of two new residential facilities. The first project was for another 'protected' residential facility to be established for patients who were still living in the hospital at Marzana. These patients were chronically ill and elderly and required twenty-four hour care. The location for this new facility had already been identified as one of the old asylum buildings, now derelict, behind the CMHC on the Policlinico site. It was envisaged that it would be operated very much like the facility at Via Tunisi and was hoped that it would open in 1995.

The second project being planned and which was being developed at the time of my research was the establishment of a residential facility, a co-operative workshop and a 'drop-in' centre for people with mental health problems in another part of the Sector, in the 'quartiere' of Golosine. This project was being developed in partnership with the local parish of 'Santa Maria Assunta' and was actually being located in a building belonging to the parish, immediately adjacent to the church building. Figure 7.8 shows the church of 'Santa Maria Assunta' and the building to the right of the church is where the co-operative workshop, residential facility and 'drop-in' centre were being developed, to be opened in 1995.

FIGURE 7.8 PHOTOGRAPH OF THE CHURCH OF SANTA MARIA ASSUNTA IN GOLOSINE - LOCATION OF A FUTURE COMMUNITY-BASED MENTAL HEALTH FACILITY



7.6.3 Why these sites were selected for community-based mental health facilities?

As just discussed, the location of the new facility in Golosine came about because the proposal was put forward by the local parish, and the building available was quite decent. Compared to Sheffield, very difficult proposals have been involved, not the least aspect of the community-based mental health facilities of the Lower Don...

The project was initiated by the church; the parish priest (Verona 'Key Individual 3') told me that the third floor of the building was no-longer being used and the members of the church wanted to put it to good use. They had approached South Verona CPS because they were concerned that there were no facilities for the people living in Golosine with mental health problems to go, and they were also aware that many of these individuals could not get employment or were unable to work without some kind of supervision. The project was put together by the members of the church and South Verona CPS. The project had three main components:

- A group home that would be a residential facility for three to six people with mental health problems. This facility was planned as a 'semi-protected' facility for individuals presently living with their families or in other facilities.
- The co-operative which was to be operated in conjunction with '*Farsi Prossimo*' that would provide work for approximately forty people: workers from '*Farsi Prossimo*', able bodied 'volunteers' and people with mental health problems from the population served by Sector III.
- A drop-in centre that would provide organised activities and rehabilitation to be run by volunteers from the Parish.

These facilities were to be provided on the third floor of the building. The rest of the building provides a number of functions for the people of the Parish; there was a small theatre, a bar, a small shop and various meeting rooms. The Priest told me that he and the members of the Parish hoped that the mental health facility would become fully integrated with the rest of the Parish's activities.

7.6.3 Why these sites were selected for community-based mental health facilities?

As just discussed, the location of the new facility at Golosine came about because the proposal was put forward by the local parish, and the building available belonged to them. Compared to Sheffield, very different processes have been involved with the establishment of the community-based mental health facilities of the South Verona

CPS. 'Psychiatrist 1' explained to me how the other facilities used by service became established. I started by asking him how the different sites were chosen:

JJ: "One of the things that I'm interested in with my work is the location of the mental health facilities, and what the decision-making processes were behind the choosing of sites, the reason why these particular facilities were selected?"

Psychiatrist 1 "Just.... wait a minute, now it's difficult perhaps for an outsider, to Italy, to understand how we have to, to proceed.... it's very unusual, in these days.... to sit, create a plan, to decide where to draw lines and to proceed according to these plans..... what happens is much more.....bureaucratic and in a situation of confusion, and it's more to do with adapting to a..... changing situation and try to solve the present, most of the time fighting against..... other disciplines, other people who want the same thing and then.... and so the mental health centre was organised there [located close to the Policlinico], just because one day Prof. 'A' [from the University of Verona, Istituto di Psichiatria] discovered what was an old house [a disused building from the old asylum] not used.... and closed, and probably available, and..... that's it. The apartments also, the '*alloggi*', they came.... they were offered to us because they were..... homes available for handicapped people.... or something like that, and so we took them..... and were we able, of course, to make plans and to know what would be..... a good solution for us, but um..... it's difficult to do this now, and will be so for some years ahead"

JJ: "So the house that is now the Mental Health Centre, that belongs to the hospital does it?"

Psychiatrist 1: "It was the property of the Province, in the beginning, and then we managed to have this property transferred to the Municipality of Verona and from the municipality of Verona, it will (stressed) be part of

the hospital, its not yet belonging to the hospital..... so all this is done on a basis of agreement, most of the time written agreement, although not always written agreement, which makes life complicated because, I mean, if we want to repair this house or do some work or spend money on it, it's difficult, I mean.... it should be done by the Local Authority..... so there are further complications, you see this way, but..... the alternative option was not to do anything..."

JJ: "And the two apartments, who do they belong to?"

Psychiatrist 1: "They belong to the community, the Municipality of Verona [Local Authority], and they are run by the local health unit [ULSS 25] ULSS are paying the electricity and so on..... they [the mentally ill living in the facility] don't pay monthly fees [rent] I believe, because the agreement is that the places are provide for free by us (ULSS via S. Verona CPS)"

JJ: "As public housing?"

Psychiatrist 1: "Yes, as public housing"

Therefore unlike in Sheffield, in South Verona there was no 'official' decision-making or planning requirements to be met for the location and development of these facilities. Instead the choice of the sites was totally opportunistic and ad-hoc. **Psychiatrist 1** told me that when Law 180 was passed in 1978 everything happened very quickly in South Verona as the service was set up, they needed to find a building for the CMHC quickly and Professor 'A' more or less 'stumbled over' a disused building and it became the new Centre. As described by Psychiatrist 1, it was 'a situation of confusion' and even now it is difficult to plan ahead with all procedured being very complicated and bureaucratic. As discussed in Chapter Three, this situation appears characteristic of Italian society.

7.7 VARIATIONS BETWEEN THE THREE MENTAL HEALTH SERVICES IN VERONA

An important finding from the research conducted in Verona has been the wide variation in models of care provided by the three different Sectors, as discussed in 7.5.2. Whereas Sector III, operated by the South Verona CPS has developed a range of integrated services which serve people in their own homes as well as in the more formal community settings of the CMHC and the in-patient and out-patient services, Sectors' I and II have not developed such a comprehensive range of community services. Sectors I and II are still very much hospital-oriented and the only work in the 'community' with the ambulatories which are held in the different '*quartiere*' one day a week, which people have to physically attend. At the time of the research, Sectors' I and II did not have any community mental health teams.

From the evidence discussed in 7.4.2, one would expect such differences between regions or even between neighbouring towns, as the paper by De Girolamo, Mors, Rossi, Ardigo and Munk-Jorgensen (1988) illustrated, but not within the same city, as is the case in Verona. There seem to be three main reasons for this situation, all of which are interrelated: firstly, the three Sectors have been operating quite independently from each other, without co-ordination. There had been little communication between the different services; 'Key Individual 1' told me that that the three services were planning to meet on a regular basis in the near future to improve co-ordination between the different services. This was in 1994, sixteen years after the creation of the three services in 1978.

Secondly, the service in South Verona had involvement from the Institute of Psychiatry at the University from the beginning of the 1970s. The mental health professionals at the University were involved in research and teaching, aware of current ideas and research and keen to promote evidence-based psychiatric practice. This leads to the third reason, the fact that in Italy, psychiatrists are still in charge of mental health services. There are no professional 'health managers' as there are now in Britain to make decisions about how to run services, where to locate them and how

to fund them. In Italy all this is done by psychiatrists. Accordingly, the heads of the three mental health services in Verona were all psychiatrists. Therefore, the roles played by these three individuals has been very influential in shaping the type of mental health provision available within those Sectors between 1978 and 1994.

It is evident from the research that in South Verona, the psychiatrist in charge, his staff and colleagues at the University were committed to developing a community-oriented service as determined by Law 180. Even before 1978, psychiatrists from the University started to work in the community 'following-up' discharged patients. As is discussed further in Chapter Nine (9.5) the psychiatrists from the University who were working in South Verona were followers of the work and practice of Basaglia and the reform movement, believing strongly in the need to close the asylums, to treat patients in community settings and to give people with mental health problems the respect deserved as individuals rather than 'patients'. This philosophy was clearly evident in the community-based facilities in which I worked, particularly in the way that the staff treated the clients and the informal and friendly atmosphere within the facilities. In the facilities the staff dressed casually; there were no uniforms or white coats. It is clear that the politics and professional philosophies held by the psychiatrists in South Verona has made the service what it was.

However, the services in Sectors I and II were more traditional and conservative. When I visited the out-patient service of the two Sectors at the general hospital in Borgo Trento, I was quite shocked to see Psychiatrists wearing white coats and a 'psychiatrist's couch' in the '*Primario's*' office. There was a psychiatric hospital atmosphere; the patients looked nervous and uneasy in the waiting room. It was very different to what I had experienced in the facilities in South Verona. The CMHC run by Sectors I and II was less formal, but still different to the CMHC in South Verona.

Of course, community services have been provided in Sectors I and II, with the shared CMHC and ambulatories, the single residential facility in Sector I and the two workshops in Sector II. It could be said therefore that Law 180 has also been implemented in these two Sectors, but with different outcomes 'on the ground'; the

legislation did not specify exactly what the 'community facilities' should be, apart from a CMHC, just that 'community facilities' should be established. This is how such different situations have been able to develop in Verona. The different services, run by psychiatrists with different philosophies and political inclinations, have developed in the way they have because of the key individuals who manage them. Without strict guidelines, these 'key players' have implemented these reforms according to their own political and professional agenda.

In conclusion to this section, it is argued that particular people have been key agents of change in the development of community-based mental health services post 1978 in Verona. The lack of adequate national and local co-ordination as well as the inadequacies of Law 180 have enabled this situation to develop. Political instability in Italy has meant that Law 180 has not been updated with specific guidelines for implementation. Until this happens, it appears clear that each mental health service throughout the country will continue to develop the services that the mental health professionals in charge believe to be best, according to their political and professional convictions. Until such time, therefore, geographical variations in the implementation of Law 180 in Italy, at all spatial scales, appear predictable and set to continue.

CHAPTER EIGHT

THE QUESTIONNAIRE SURVEY IN VERONA: INVESTIGATING REACTIONS OF LOCAL RESIDENTS TO THE FACILITIES OF THE SOUTH VERONA COMMUNITY PSYCHIATRIC SERVICE.

8.1 INTRODUCTION

This chapter will describe and evaluate the attitudes and perceptions of local residents, living in the '*quartiere*' of Borgo Roma in Verona, towards the facilities of the South Verona Community Psychiatric Service and towards people with mental health problems in general. In many instances throughout this chapter, references will be made to Chapter Seven, which provides the background to the operation of the South Verona Community Psychiatric Service and to Chapter Five, where the design and findings of the Sheffield questionnaire are presented; the questionnaire used in Verona was based on the Sheffield questionnaire.

The purpose of carrying out the questionnaire survey in Verona were two-fold. Firstly, it has been an important element of this research project to compare attitudes of members of the British and Italian general public and by so doing, assess the impact of the location of community-based mental health facilities in their respective localities. Secondly, there has been a deficiency in the study of geographical aspects of deinstitutionalisation in Europe. In this way then, the decision to replicate the Sheffield questionnaire survey in Verona was an essential one and the results, which are detailed in this chapter and in Chapter Five, have proved the value of such an endeavour.

8.2 THE LOCAL RESIDENT SURVEY

The method used for the questionnaire survey in Verona is discussed in Chapter Three. Two hundred households were targeted but only forty nine completed questionnaires were collected which was less than expected.

The questionnaire survey was carried in the '*quartiere*' of Borgo Roma, located in the south of Verona. The sample of households targeted for the survey was selected by means of a stratified random sample, the same method that was used for the Sheffield survey. Figure 8.1 shows the sample in diagrammatic form; the four concentric rings represent four distance zones; fifty households within each zone were randomly selected to the sample. The boundaries of the concentric rings represent a distance of two hundred metres; this distance was from a residential mental health facility, managed by the South Verona CPS, which is located in the centre of 'Zone 1', as shown in Figure 8.1. This facility is the 'semi-protected' facility in Via Capodistra; a photograph of the location is shown in Figure 7.6. It was decided to select this facility because it was further away from the *Policlinico* than the facility in Via Tunisi (Figure 7.7) and it was surrounded by a larger area of residential housing.

8.3 THE QUESTIONNAIRE

The main research questions are similar to the Sheffield questionnaire, as discussed in depth in Chapter 5. The main change to the Italian questionnaire from the Sheffield questionnaire was that question 6 (5.3.3), relating to the potential for 'activism' amongst local residents if they oppose a particular facility, was dropped. The main reason for this was that the question is quite complicated and during the Sheffield survey I often had to explain the question in detail for people to understand the purpose of the question. As the Italian respondents were being asked to complete the questionnaire alone, it was considered wiser to omit the question.

Figure 8.1 The South of Verona, Showing the Zoning Method used to Recruit the Verona Local Resident Survey Sample

(Scale: 1: 5000)

Location of residential facility



There was also a question added; question 19 asked respondents whether they had parents or grandparents living with them. This question was added because of an awareness of the greater prevalence of extended family groups living together in Italy, which was reflected in the population figures (Comune of Verona, 1992). The rest of the questionnaire remained relatively the same, apart from slight differences as a result of translation and also to be more culturally and place specific.

The translation of the questionnaire was quite problematic, even with the assistance of Italian speakers. The biggest problem was the translation of phrasal concepts with no direct equivalent in the other language. For example, question 4 of the Sheffield questionnaire asked respondents whether they believed that there was a 'sense of community' in the neighbourhood. Trying to translate this concept into Italian was extremely difficult as there is no direct translation of this term in Italian. The phrase eventually used in the Italian questionnaire was *'ritente di avere un stretto rapporto con il vostro vicinato'* which translates crudely as 'do you believe that you have a tightness of relations with your neighbourhood/neighbours'. This translation seemed to be successful as there was a good response rate to the question. This example of the problems faced with translating from one language to another again illustrates the difficulties of cross-cultural research, as discussed in Chapter Three (3.4.2 and 3.6)

Other alterations to the questionnaire were made to be more place and culturally specific. An example of this is question 3, the same question in both questionnaires, which asked respondents about the social activities that they were involved in, in the local area. A number of activities from the Sheffield questionnaire were removed for the Italian version as they were specific to British culture, for example activities such as going to the pub, working men's clubs or bingo. Specific activities and terms were introduced into the Italian questionnaire to reflect Italian culture and lifestyle, for example the local parish (*'parrocchia'*) was used rather than just saying the 'church', and the term *'bar'* or *'locali'* was used instead of the 'pub'. The list was also made shorter than in the Sheffield questionnaire as I was conscious that respondents were being asked to complete the questionnaire on their own, in their own time, and I was

concerned that if the questionnaire was too long then respondents might have been less keen to complete it.

However, there was place left at the end of the questionnaire for further comments and a few respondents did make use of this, as reported in this chapter. The Italian questionnaire is produced in full in Appendix Three.

8.4 RESULTS FROM THE VERONA QUESTIONNAIRE SURVEY

As already discussed in Chapter Three (3.5) the response rate for the survey in Borgo Roma was low; the survey only resulted in 49 completed questionnaires that were suitable for further analysis. The potential to compare the results from the Italian survey with the questionnaire survey carried out in Sheffield, detailed in Chapter Five, is therefore limited because of this small sample size. However, responses from 49 households in the sample area is still a valuable resource. The results from the analysis of these questionnaires will now be discussed.

8.4.1 The survey respondents

A profile of the respondents to the questionnaire survey, representing 49 households from the sample area in Borgo Roma, is shown in Table 8.1. Figures given in this section, for the '*quartiere*' of Borgo Roma and '*comune*' of Verona have been taken from official statistics produced by the city council of Verona (Comune di Verona, 1992). The most recent data available has been used, which is from the year of 1992.

Gender: The ratio between men and women who responded to the survey is fairly well balanced. This ratio mirrors the gender balance within the '*quartiere*' of Borgo Roma, where the ratio of men to women is 49% to 51% and the ratio within the '*comune*' of Verona as a whole is 47% to 53% respectively.

Table 8.1 Profile of Verona Questionnaire Respondents

Characteristic	% of sample (n=49)
Gender	
Male	53
Female	47
Age structure (pop. 18+)	
18-34 years	29
35-49 years	30
50-69 years	33
70+ years	8
Household Tenure	
owner occupiers	78
renters (private only)	22
Households with children at home (0-18 years)	33
Economic position	
Economically active (in employment)	47
Economically active (out of employment)	2
Economically inactive	51
Occupational structure (economically active)	
Professional/Intermediate	52
Skilled (3N & 3M)	44
Partly/unskilled	4
Age left full time education	
16 years or under (scuola media)	43
16-18 years (scuola superiore)	35
18+ (graduates and those still studying at University)	22
Ethnicity	----

Age structure: the age structure reflects a similar structure to both the Borgo Roma and Verona respectfully. The percentage of respondents over the age of seventy is a little lower than expected at only 8%; the statistics for Borgo Roma and Verona for this age group, are 12% and 15% respectively.

Household tenure: 78% of the households in the Verona sample were owner occupied and 22% of the households were privately rented. It is interesting that all the renters were private rather than public renters. This is quite a contrast to the Sheffield sample of renters (15% of the sample population) where only 2% of the renters were private renters and the remaining 13% were renters of Local Authority housing.

Households with children: the figure of 33% of households with children at home under the age of eighteen is similar to the figure from the Sheffield sample (35%). The figure for the '*quartiere*' of Borgo Roma is higher at 40% of households. In both questionnaire surveys the respondents were asked, if they did have children at home, how many they had. It was interesting to note that 67% of the Verona sample had only one child compared to 46% of households in the Sheffield sample. In the Sheffield sample a further 47% of households had two or three children whereas the Verona sample only had 27% of such households (of those with children).

Economic position and occupations: the economic activity rates for the Verona survey varied slightly from the Sheffield survey; the Verona survey showed less people in economic activity and more being inactive. The percentages for those people retired were similar, with 29% of the inactive population in Verona compared to 31% in Sheffield. The number of housewives was also similar, with 14% of the inactive population in Verona compared to 13% in the Sheffield sample. The main difference and an interesting variation, was that in the Sheffield sample there were no full time students over the age of eighteen whereas in the Verona sample 6% of the inactive sample were still studying. This could be a result of a number of differences between the educational culture and system in Italy and Britain; in Italy it takes five years or more to study for a degree and many students may take time out to work

although still enrolled as a student; in Italy, most students attend the nearest University to their home; there is a University in Verona, with the medical school actually located in Borgo Roma. So it is likely that most of the students in the Verona survey would be attending the University in Verona whilst still living in their family home.

The occupational structure is also different between the Verona and Sheffield respondents. In the Verona sample, 52% of the respondents in full time occupation were professionals compared to 37% in the Sheffield sample. The Verona sample also had lower figures for the two less skilled occupational categories. As already discussed in Chapter Four, the south east of Sheffield is a predominantly working class area and so the number of workers in skilled occupations is not that surprising. South Verona however is more socially mixed and 64.5% of the workforce are employed in the service sector.

Age left full time education: the Verona sample is more highly qualified than the Sheffield sample. There are a number of possible reasons for this, for example; until recently, a higher percentage of Italian students continued to University than in Britain; the occupational structure of the sample populations are different with more people in the Verona sample being in professional or intermediate occupations; the relative prosperity of the Verona region, as discussed in Chapter One, enabling more parents to support their children through University

Ethnicity: because of the 'drop and collect' method of implementing the Verona questionnaire and because respondents were not asked to state their ethnicity, this information was not available.

8.4.2 Extent of 'community' in locality

The first section of the Italian questionnaire is virtually the same as the British questionnaire, apart from a few changes in the wording of questions and number of activities in question 3 (as discussed in 8.3.). **Question 1** asked respondents how long

they had been living in the quarter of Borgo Roma; 61% of the respondents had lived in the area for eleven years or more. This suggests the existence of a relatively stable population, which is a similar situation to the neighbourhood of Base Green which had a figure of 65% of respondents living there for eleven years or more. Responses to **question 2** show that social networks within the neighbourhood were also strong (as they were in Base Green); in the Verona survey 71% of the respondents stated that they knew (to speak to) sixteen or more people in the quarter of Borgo Roma. As with the Sheffield results for these two questions, there is a strong relationship between the length of time people have lived in the neighbourhood and the number of people they know (*Pearson chi-square = .0003*).

The results to **question 3** showed some interesting variations from the Sheffield survey in relation to the involvement in activities in the local area. The results from the Verona survey are shown in Table 8.2:

Table 8.2 **Participation/involvement in local activities**

Activity	% of respondents
Local shops	75
Church	69
Bar	29
Cinema/theatre	25
Sports/clubs	24
Voluntary work	14
Day or evening classes	2
Other activities	2

The list of possible activities for the Italian questionnaire was shorter, place and culturally specific. A big difference to the Sheffield survey was the number of respondents involved in the local church; 69% of respondents stated that they were involved with the church, with more than half of these people stating that their

involvement was frequent rather than occasional. The term used in the questionnaire '*parrocchia*' is more a translation of 'parish' rather than 'church' which implies only a place to worship. Despite secularisation in Italian society, the local parish still plays an important role in the lives of many Italians. The local church in a '*quartiere*' is not only a place of worship; the '*parrocchia*' is frequently also involved in organising sports and social activities, youth clubs and voluntary work and many parishes will have their own church-run schools.

The relatively low percentage of people who used a local bar was considerably different to the percentage of respondents who used local pubs (52%). However, bars in Italy are very different to pubs in Britain; they serve coffee, other beverages and light snacks more than alcoholic drinks (as with pubs in Britain) and are usually busier during the day rather than in the evenings. In Italy people will go out to restaurants in the evenings rather than to bars, whereas in Britain, going to the pub is a popular evening activity.

In Borgo Roma there is both a cinema and a small theatre and a quarter of the respondents attend these. However, it is interesting that 16% of the respondents stated that they used none of the facilities listed; this figure seems high compared to the Sheffield survey where only 2.5% of the respondents didn't use the facilities listed. There does not appear to be any explanation for this difference.

Question 4 asked respondents about their views concerning the strength of community within the locality. The wording of this question was different, as already discussed in 8.3, so direct comparisons with the Sheffield survey results cannot really be made. However, it is interesting that more people seemed able to give a definite answer to this question in the Verona survey; only 2% of respondents answered 'don't know' compared to 16% in the Sheffield survey. In the Verona survey, 43% of the respondents agreed that there was a 'sense of community' in the locality with a further 51% agreeing that there was 'a little' sense of community. Therefore 94% of the respondents agreed that there was some 'neighbourhood feeling' in the area.

To summarise the results from this section, as with the Sheffield survey, the data suggests the existence of a well established and stable community in the neighbourhood where the questionnaire was carried out. The majority of the respondents had lived in the area for eleven years or more and had established good social networks within the locality. The church appears to play quite an important role in many of the respondents' lives; this suggests the existence of an additional 'Christian community' in the area, which is place specific. The variations in participation in activities between the Sheffield and Verona surveys further illustrate the different lifestyles and culture of the two populations.

8.4.3 Comparative noxiousness of facilities

In **question 5**, respondents were asked where, if they had the choice, they would locate the different facilities listed. The responses to this question are shown in Table 8.3.

Table 8.3 Comparative Noxiousness of Facilities

Facility Type	Same street	Same quartiere	Elsewhere in town	As far away as possible
Park	30%	70%	----	----
Library	28%	70%	2%	----
Primary school	14%	86%	----	----
Home for elderly	4%	74%	20%	2%
Hostel for homeless	3%	56%	24%	17%
Home for mentally ill	----	38%	36%	26%
Psychiatric hospital	----	22%	44%	34%
Prison	----	2%	44%	54%
Refuse site	2%	4%	2%	92%

The two percentages are in bold to highlight the most favoured and most unfavoured facilities. These figures are interesting in themselves and also in the way they differ from the Sheffield results to this question. In accordance with the Sheffield study and research by Smith, Hanham and Chang (1978), the three top 'noxious' facilities are a prison, a refuse site and a psychiatric hospital. However, the order of 'noxiousness' in the Verona survey is different, with the refuse site being perceived as the most noxious with 92% of respondents choosing to locate such a facility as far away as possible. Compared to the Sheffield study, the level of perceived noxiousness with regard to a prison is much lower, with 54% of respondents choosing to locate it as far away as possible compared to 86% in the Sheffield survey. This lower figure could be a result of the fact that there is a prison near the centre of Verona. Perhaps the experience of living close to such a facility (the prison is approximately three kilometres away from Borgo Roma) has reduced people's perceptions of its impact.

The response rates for 'salutary' facilities to be located on the same street were greater in the Verona study; 30% for a park in the same street compared to 9% of respondents in Sheffield and 28% of the Italians in favour of a library in their street compared to only 9% of the Sheffield respondents.

Unlike the Sheffield study, which found that 9% of the sample would not be against, by indicating a choice, the location of a home of the mentally ill on their street, in the Verona study no respondents indicated this choice, although 38% of the Verona respondents indicated that they would choose to locate such a facility in the same neighbourhood ('*quartiere*') compared to 23% in the Sheffield sample. This could be a result of the fact that none of the respondents in Borgo Roma was aware of the existence of the residential facility for people with mental health problems in their vicinity (see 8.4.4) and therefore had no positive experience of living close to such a facility, although such a conclusion is only a tentative guess, with no supporting evidence for such a view. It could likewise be possible that such a result shows greater intolerance amongst the Verona respondents. Due to the fact that none of the respondents were aware of the location of the mental health facility, the location of which determined the geographical choice of the sample area, there is no point in

testing the effect of distance on attitudes, as was done for the Sheffield study. A number of local residents were aware of other facilities in the locality, 41% of the sample were aware of the mental health centre and/or the mental health facility at the '*Policlinico*', but there is no statistical relationship between those people who were aware of the facilities and their choice of location of mental health facilities in **question 5**.

Due to the small sample size and lack of knowledge of the residential mental health facility amongst the respondents, there are few conclusions to be drawn about attitudes towards mental health facilities from **question 5**. However, the results do reinforce the Sheffield study and other research (Smith, Hanham and Chang, 1978; Smith and Hanham, 1981a and b; Burnett and Moon, 1983) in showing that different types of facilities generate different perceptual attitudes with regard to their location in relation to a respondent's home. The differences found between the Verona results and other studies also indicate that such perceptual attitudes can be place and culture specific, an issue worthy of further research.

8.4.4 Awareness of the mental health facility in the local area

As already discussed in Chapter Five, one of the main findings of previous studies (Dear and Taylor, 1982; Rabkin, Muhlin and Cohen, 1984) was a low level of awareness amongst local residents of a mental health facility located in their vicinity. The Sheffield study showed unusually high levels of awareness, which, as already discussed, may be influenced by the location and building design of the facility. None of the survey respondents of the Verona study were aware of the residential mental health facility that was selected for the survey. In retrospect, it is possible that the choice of this particular facility was not a good one; it was an apartment, within a block, without features of identification to the outside world other than the name of the Health Authority, rather than the resident's name, for the name plate outside. However, it should not be expected that community-based mental health residential facilities should want to draw attention to their existence, or indeed that local residents will be aware of who all their neighbours are. Therefore the Verona study

should perhaps be considered as another example, similar to the other cited studies, where local residents are simply unaware of the existence of such a facility in their locality.

However, 41% of the respondents were aware of at least one of the facilities of the South Verona Community Psychiatric Service, which included the Policlinico itself, where there is a psychiatric in-patient service and the mental health centre which is located in the grounds of the hospital, on a busy main road. A quarter of all respondents were aware of the existence of the Community Mental Health Centre, located on Via San Giacomo (see Figure 7.5); the centre is quite visible from the road and close to a main cross-roads. Responses to **question 12** also show that the respondents were aware of people with mental health problems living in their quarter; 51% of respondents stated that they had seen people, who they thought were suffering from mental health problems, walking in the street. This result is even higher than the Sheffield result for this question (46%). Other reports of contact are lower than for the Sheffield study; 4% of respondents said they had talked to a mentally ill person in the quarter for their job and 18% for other reasons, although it is also important to recognise the fact that people may suffer a mental health problem but this will not necessarily make them look or behave 'differently'. This point was made by one respondent who wrote, in response to this question, "I can't tell whether or not a person is mentally ill just by seeing them in the street" (man, 35-49yrs, bank worker).

In conclusion to this section, in common with previous studies, according to the results of this survey there is a low level of awareness by local residents of the existence of a residential facility for the mentally ill. However, there was an awareness of the mental health centre and the psychiatric unit at the *Policlinico*. Furthermore, over half of the respondents recognised what they believe to be people with mental health problems walking around the neighbourhood. These levels of awareness are significant and reflect a general awareness amongst the survey respondents, of people with mental health problems living in the community and of the existence of community-based mental health facilities of the South Verona CPS.

8.4.5 General attitudes towards the mentally ill and community care policies

As discussed in 8.3, due to the nature of translating from one language to another, the conversion of **questions 6 to 9** from English to Italian, has meant that the questions have not been directly replicated, word for word. However, the general meaning has been retained and therefore some comparison between the Sheffield and Verona attitudinal results can be made. For each question the version of the question in English is in brackets, with the percentage of respondents who agreed with the question in the Sheffield survey. The percentage of respondents who agreed with the question in the Verona survey is given in bold.

Q6 Do you believe that we should be more tolerant towards the mentally ill?

(We need to adopt a far more tolerant attitude towards people with mental illness in our society - 71% agreed).

Verona study **82%**

Q7 Do you believe that the presence of the mentally ill in the quartiere (neighbourhood), even though it is good therapy for them, brings too serious a risk for local residents.

(Having mental patients living within residential neighbourhoods might be good therapy, but the risks to residents are too great - 54% agreed).

Verona study **51%**

Q8 Do you believe that services for the mentally ill should be, as far as possible, located in the community rather than in the mental hospitals?

(As far as possible, mental health services should be provided through community based facilities - 61% agreed).

Verona study 87%

Q9 Do you believe that we have the right to exclude the mentally ill from this quartiere (neighbourhood)?

(People should have the right to exclude people with mental illness from their neighbourhood - 36% agreed).

Verona study 7%

These results follow the general trend of the Sheffield results, although there are significant variations. The responses to **questions 6, 8** and in particular **question 9**, show a much greater tolerance to the mentally ill and the facilities that serve them, although the response to **question 7** shows a similar fear of the mentally ill. This would suggest that the Italian respondents are far, in abstract, more accepting and tolerant towards people with mental health problems and community-based mental health facilities but, at the same time, there remains the perception that people who are mentally ill can be dangerous to others and there a 'risk factor' is perceived by having mentally ill people living in the neighbourhood.

The Sheffield results showed considerable contradictions amongst respondents in their attitudes towards the mentally ill. The Italian results were markedly more consistent in their views; 67% of respondents agreed to 'positive' **questions 6 and 8**, whereas only 6% of respondents agreed to **question 7** and **question 9**, the more 'negative' questions. The number of respondents' whose responded strongly to a 'positive' question and also a 'negative' question, was far less than with the Sheffield

survey. For example, only 10% of respondents agreed that 'we' should be more tolerant, in **question 6**, but also that the mentally ill were a 'risk' in **question 7**. In the Sheffield survey, 40% of the respondents gave this combination of responses. Similarly, only 12% of respondents agreed strongly (responded 'yes') to **question 8** about the existence of mental health facilities in the community and also agreed that the mentally ill represented a risk to local residents; in the Sheffield survey 38% of the sample agreed to both these questions.

The contradictory dilemma of wanting to express tolerance towards the mentally ill yet still considering them as a danger is an important issue which needs addressing. This dilemma was explained by one respondent who wrote the following at the end of the questionnaire:

Verona questionnaire respondent: "I know that some the answers [given in the questionnaire] are contradictory. Even though I'm aware of the necessity to accommodate the mentally ill in places which are suitable to their needs and which make their lives as happy as possible, I also have to admit that, selfishly, the idea that those people live and in particular move into the neighbourhood makes me worried and I fear for my security and that of my family. I am convinced that if they are out in the neighbourhood, they should always be supervised"

(woman, 35-49 yrs, teacher)

This honest account highlights the contradictions which underpin this whole issue; the great majority of respondents in both surveys were in favour of a greater tolerance towards the mentally ill, yet when the issue becomes closer to home and threatens to 'touch' people's personal lives then individual's perceived fears concerning the mentally ill come to the surface. This was certainly found in the RSGB survey, which has been quoted more extensively in Chapter Five. This survey found that 92% of the respondents agreed to a greater tolerance towards the mentally ill, but questions which suggested a more direct contact with the mentally ill received less positive responses

Overall the results from this section have shown that the respondents in the Verona survey were clearer in their attitudes towards the mentally ill, with few people contradicting themselves when answering **questions 6 to 9**. The Verona respondents were far more tolerant towards the mentally ill and the facilities that serve them than the Sheffield respondents. But why should that be? What factors make these Italians more tolerant towards the mentally ill? Is it a cultural or place specific phenomenon? Further comparative research, with much larger sample sizes, is required in order to begin addressing these questions.

8.4.6 Influence of personal characteristics on individual's attitudes/behaviour

The small sample size has been an obstacle to achieving results from this section. The main finding from the Sheffield survey was that there was an influence of gender upon people's attitudes towards the mentally ill; results suggested that the female respondents were more fearful of the mentally ill. The Italian survey, however, found no variation between men and women in their attitudes. The only significant finding from the Italian data was that respondents who had children under the age of eighteen, living at home, perceived a greater element of risk from the mentally ill. There was an association between respondents who had children and those who agreed to **question 7**, that the presence of mentally ill people in the neighbourhood brought a risk to the local residents (*Pearson chi-square = 0.004*). No such relationship was found from the Sheffield survey.

8.5. SUMMARY OF MAIN FINDINGS

Despite the small sample size of the Verona survey, there have still been some interesting findings, as they stand alone and also in comparison to the results from the Sheffield survey.

The profiles of respondents in the two surveys showed that the respondents from Sheffield and Verona were relatively similar in terms of age, household tenure,

households with children and economic activity. There were slight variations in the gender ratio of respondents. Of most significance, the Verona respondents were more educated and a higher percentage were employed in more professional occupations than the Sheffield sample. However, as illustrated by results given in 5.4.7 and 8.4.6, the personal attributes of respondents had little bearing on the results, unlike previous studies (Dear and Taylor, 1982; Rabkin, 1980; Rabkin, Muhlin and Cohen, 1984; Smith and Hanham, 1981a).

Results from section 1 of the Verona survey (8.4.2) showed a stability and 'sense of belonging' to the locality, as was reflected by similar results from the Sheffield survey. Results to question 5 also showed similarities between the two sets of respondents in their perceived attitudes towards different types of facilities; these findings reinforced previous research (Smith, Hanham and Chang, 1978; Smith and Hanham, 1981a and b; Burnett and Moon, 1983). Such a universality in findings suggests perhaps that generalisations can be made with regard to the perceptions of the general public towards particular facilities, although it is still essential that researchers are sensitive to variations influenced by local, temporal and cultural dynamics. As already mentioned (8.4.3), this is an issue worthy of further attention, although beyond this thesis.

Although there was a low awareness of the residential mental health facility amongst the Verona respondents, they were aware of the location of other mental health facilities in the locality. It is difficult to compare this result to the Sheffield survey because of the greater size and visibility of the residential facility in Base Green. Neither surveys reflected the findings of previous research (Dear and Taylor, 1982; Rabkin, Muhlin and Cohen, 1984) which found much lower awareness levels with regard to the knowledge of a mental health facility in the vicinity of peoples' homes. However, the Sheffield and Verona studies were both carried out in suburban locations; it could therefore be suggested that in residential locations, where the majority of people have lived in that place for a long length of time and know many of their neighbours, then people are more aware of who and what is around and happening in their locality.

The results to the attitudinal questions showed the Verona respondents to be far more tolerant towards the mentally ill and the facilities that serve them. They were also clearer in their views and gave less contradictory responses compared to the Sheffield respondents. However, a similar response, from both sets of respondents, to **question 7** (in the Verona questionnaire) and **question 8** (in the Sheffield questionnaire), illustrates the fact that many people are still fearful, often rather than intolerant, of the mentally ill. This highlights one of the greatest problems which still surrounds the concept of community mental health care, how the perceived risk of the mentally ill amongst the general public can be addressed. However, one of the greatest problems is that, in a small number of cases, there is still an 'actual risk' from the mentally ill, as the chronically mentally ill still hit the headlines as murderers of innocent members of the general public. It is the media publicity of such cases that perpetuates the stigma and fear surrounding mental illness in our society and this phenomenon is surely without cultural boundaries.

CHAPTER NINE

INTERPRETATIONS OF THE 'SUCCESS' OF THE MENTAL HEALTH REFORMS IN VERONA AND ITALY: INTERVIEWS WITH MENTAL HEALTH PROFESSIONALS IN VERONA.

9.1 INTRODUCTION

This chapter will discuss the findings from semi-structured interviews conducted in 1994 twelve mental health professionals and workers who were employed by the South Verona Community Psychiatric Service (South Verona CPS). As already discussed in Chapter Three, the twelve semi-structured interviews were all tape-recorded and then transcribed in full. All but one of the interviews were conducted in Italian; the director of the service speaks good English and agreed to conduct the interview in English. The eleven interviews conducted in Italian were fully transcribed in Italian and then translated into English by myself with the assistance of native Italian speakers. The methodological problems with this process have already been discussed in Chapter Three. As with the Sheffield interviewees, the mental health professionals interviewed in Verona have all been given a numbered 'identification' according to their role in the facility and qualifications. This 'identification' is detailed in Appendix One and will be used throughout this chapter.

Mental health professionals, in both Britain and Italy, used specific terminology. Some terminology used by the interviewees could not be translated directly into English and these phrases have been retained in the translations. For example, the french word '*équipe*' is used to describe a Community Mental Health Team (CMHT) that works in a designated geographical sector, or as the Italian interviewees refer to 'in the field'. Their British counterparts would describe this as working 'in the community'.

The Italian interviewees also refer to the people with mental health problems whom they care for as 'patients', whereas in Britain the mentally ill receiving service provision are now referred to as 'clients' (4.3) or, as in the case of Lister Avenue, 'tenants' (4.5). This term is not universal in Italy; for example in Trieste the people with mental health problems using the mental health services are referred to as 'users'. These different terms seem to vary according to the philosophies of the particular services and personnel.

9.2 THE ROLES AND RESPONSIBILITIES OF THE MENTAL HEALTH PROFESSIONALS INTERVIEWED

The twelve individuals who were interviewed provide a good representation of the different professional roles from which the South Verona CPS is composed. The following quotations illustrate the role and responsibilities of certain individuals and the different professions, as well as illustrating the type of work that the interviewees are involved in:

Psychiatrist 1: "I am Professor of Psychiatry at the University of Verona and I am also Director of the Servizio di Psicologia Medica [see Chapter Seven], where my clinical responsibilities are concerned with work with the care in the community, with the mental health centre etc. But also coordination with in-patient care as well as out-patient care".

Psychiatrist 2: "I coordinate an '*équipe*' of doctors, who are doing their specialised training, nurses and social workers. This '*équipe*' works with patients living in Borgo Roma [one of the three sectors]. As well as my work with the patients, I'm also involved in the training of staff in South Verona [S. Verona CPS]".

I then asked **Psychiatrist 2** for more details about the '*équipe*' that he leads:

JJ: "How many doctors and nurses work in the '*équipe*' of Borgo Roma?"

Psychiatrist 2: "There are 4 nurses, while the number of doctors varies because every year there are some doctors who are here doing their training, so some years there are more doctors, some years less. At the moment there are between 6 and 7".

JJ: "How many patients are you responsible for?"

Psychiatrist 2: "I work with 30 patients directly at the moment [ie. he has 30 patients on his personal caseload], and I'm available for anyone [in the Borgo Roma '*équipe*'] who needs my assistance with their patients".

JJ: "Where do you see your patients? Only at the hospital or in the community as well?"

Psychiatrist 2: "When you are responsible for a patient, you must 'follow' him/her wherever they are at the time; if one of my patients that lives in their own home is admitted to hospital, I go and see them there. There is not a doctor for the 'field', a different one for the centre and another for the hospital, there's a doctor that looks after his patients everywhere".

This last quotation illustrates the way the different components of mental health service in South Verona have been fully integrated, as discussed in Chapter Seven.

Nurse 1: “Before this job I have worked in different places, Genova, Verona, etc. Then I worked as a nursing manager in Verona but after some years I lost interest in it. When I was asked to be the manager here, in the community psychiatric service [in S. Verona], as the ‘*caposala*’ [nursing manager] a newly created post, I accepted it with enthusiasm, especially after a few words with ‘Psychiatrist 1’. So now I manage the community mental health centre, co-ordinating the activities that are organised here for the patients and I also spend a little time working ‘in the field’, with responsibility for a small number of patients.

This quotation illustrates the fact that nurses working in mental health in Italy do not have specialist mental health training, unlike Britain where nurses have to undertake specialist training to qualify as a psychiatric nurse. In Italy, nurses train as professional nurses, what we would call general nursing, and can then work in any medical field, including mental health, without further specialist training. The differences in the training of mental health professionals in Britain and Italy are discussed further in Chapter Ten.

The other five nurses that work in the service are also all professional nurses. Each nurse belongs to one of the three CMHTs and carries a personal caseload of approximately thirty patients. They ‘follow’ their patients in the different parts of the service (in-patients, out-patients and in the community) as required and are also involved in organising and running some of the activities at the mental health centre. This is how some of the nurses described to me what they do:

Nurse 2: “I’m a professional nurse. I’m responsible for the support for our patients ‘in the field’, as we work in a particular sector of territory, and I help to coordinate the work of our ‘*équipe*’”.

JJ: Where do you work most of the time? Here [CMHC where interview was conducted] or ‘in the field’?

Nurse 2: “Most of time, ‘in the field’ but some days we stay at the centre [CMHC], because there are duties to do regularly at the centre, and this we call the ‘pool’” [Nurse 2 actually used the word ‘pool’ in English; there are a number of Anglo-American words that are used in contemporary Italian. In this context, Nurse 2 is referring to a ‘duty rota’ where nurses provide a cover at the CMHC where patients can drop-in at any time when the centre is open]

The two managers of the residential facilities in the South Verona CPS had undergone a special training to become ‘*educatore-animatore*’ which translates directly as an ‘educator’ and an ‘organiser’; ‘*animatore*’ translates as ‘a person that organises activities, who brings ‘life’ and excitement’. The full professional title is usually shortened to ‘*educatore*’ in conversation. It is not a profession that exists in Britain; it is probably most similar to the role of an occupational therapist, who help disabled people to learn, or re-learn, social and daily living skills, like cooking a meal or going shopping. In Italy, an ‘*educatore*’ combines this role with the management of a residential facility. This is how the two ‘Facility Managers’, as I have translated the term ‘*educatore*,’ describe the work that they do:

Facility Manager 1: “I’m a professional ‘*educatore-animatore*’ with the role as coordinator at the protected house [facilities with 24 hour staffing are called ‘protected’] in Via Tunisi. My duties are the organisation and management of the facility [the interviewee actually used the term ‘*comunità*’ rather than facility which is my translation, as small residential facilities for mentally disabled people are often referred to as ‘communities’ in Italy] concerning both the patients and the staff”.

Facility Manager 2 also undertook the specialist training to become a professional ‘*educatore*’. **Facility Manager 2** described the work that she does:

Facility Manager 2: “I work with the patients: we work on *‘quotidiano’* [daily living skills], that is we try to help them learn forgotten skills: doing housework, going shopping, cooking, etc. My specific job is to maintain contact between the *‘équipe’* that support these patients on the territory and the psychiatrists and nurses at the mental health centre. But we especially work on *‘quotidiano’*, most of our activities consist of going shopping, personal hygiene, cleaning the apartment, etc. We try to develop those skills that they still have, the *‘parti sani’* [healthy parts], to make them more independent. All our patients in fact have the prospect of moving to a house on their own, Local Authority housing maybe, or their own house, not paid for by ULSS [the local health authority] anymore”.

The two residential facilities are also staffed by support workers, who are employed by the co-operative *‘Farsi Prossimo’*. Two support workers were interviewed for this research, whom I have called **Support Workers 1 and 2**. In Italian they are called *‘operatore’* which is roughly translated as ‘skilled worker’ in English. In Italy, anyone who does manual work but has had specialist training and has become skilled in that occupation, is known as an *‘operatore’*. This is how the two Support Workers describe their roles:

Support worker 1: “I support the patients during the day at the protected apartment [Via Tunisi], with their household duties, or to accompany them when they want to go out, for shopping or to offices/banks, to help them have a bath etcanything you would normally do in your home.”

Support worker 2: “I work in the *‘comunita’* [residential facility] with an *‘educatore’*, who is ‘Facility manager 2’. Our work is not that different. Maybe she takes part in official meetings more than me. We work to help patients to get back in society, to ‘reactivate’ skills they have lost. We also try to develop the relationships between them, so that they can help each other when we are not present”.

These accounts of the roles played by the interviewees gives an overview of the outcomes of the implementation of Law 180 in South Verona, with the shift from institutional to community services. The changes in the 'sites of care' have altered substantially the roles played by the mental health professionals working in South Verona.

9.3 VIEWS REGARDING RELATIONS WITH LOCAL RESIDENTS

Chapter Eight discussed the reactions of local residents to the community-based facilities of the South Verona CPS. I also asked all the mental health professional interviewees about relations between their patients and other residents in the neighbourhoods (*'quartiere'*) where the service operates. All the following accounts are anecdotal, but they indicate the kind of problems that have arisen and how the mental health professionals dealt with them.

The nurses, who work out in the community and visit people in their own homes, told me about some incidences where there had been complaints from other residents in the same apartment building (in Italian cities the majority of people live in apartment blocks) because of some unreasonable behaviour from the 'patients':

Nurse 5: "There have been a couple of protests concerning two 'patients' that caused disturbances in their building, because they had been drinking heavily and making too much noise. Anyway, these protests weren't due to the fact that they were 'psychiatric patients' [direct translation] but because of their bad behaviour. But after some time normality returned, with us trying to be diplomatic, to compromise. We've always mediated between patients and neighbours, scolding a patient when he/she's wrong, so that living together is possible".

As **Nurse 5** stated, the complaints were more about ‘unacceptable’ behaviour rather than the fact that the patients were mentally ill. However, heavy drinking is often a consequence of mental illness; when people become depressed they often turn to alcohol and/or drugs and it is common that people with mental health problems also have drug and/or alcohol problems and this is termed a ‘dual diagnosis’. **Psychiatrist 1** also told me of an incident when a ‘patient’s’ behaviour caused concern amongst local residents and how they dealt with the situation (this is a direct transcription but with the interviewee speaking in English, his second language):

Psychiatrist 1: “We had a problem after aggressive behaviour was showed by a patient, she was living in one of the apartments [residential facility], she attacked a woman on the street and people who were living around, they protested to us and made it clear that they were not prepared to see her again around..... and what we did was, we admitted the ‘patient’ [admitted to in-patient care] for several months and then we managed to convince them [local residents] and she went there firstly part time, without spending the night and then progressively..... it was a sort of a period of therapy”.

Intervention and mediation between patients and neighbours is an important role of community mental health professionals, by negotiating continued tolerance from local residents as well as trying to ‘teach’ the ‘patients’ appropriate and acceptable behaviour for living in mainstream society. This is a theme that was also raised in the interviews with mental health professionals in Sheffield (6.3). **Nurse 4** told me how he works hard to develop a good relationship with the neighbours who live near his ‘patients’:

Nurse 4: “I try to establish a good relationship with the neighbours, especially those on the same landing [of an apartment block]. Most of the time we succeed, they [neighbours] understand me, they accept my promises and I try to keep them. We try to give them as much information as possible, to inform them of what the law states [Law 180], and that by collaborating together we can achieve it. When people are not well informed, they believe the patient is alone, abandoned, and they stop collaborating, they become ‘wicked’ [direct translation] and determined, and start petitions against us. But regarding the situation with my patients, it’s not too bad: I have just had two really troublesome cases, with strong protests from local residents, especially the immediate neighbours. But generally we try to mediate, and you gain collaboration and support if you are there often and show that the patients are well supported”.

The four interviewees who actually worked in the residential facilities where a group of people with mental health problems lived were able to offer a slightly different perspective to this issue; firstly as they spend a large part of their working time in the one facility and secondly because a group home is likely to have a different impact on neighbours than a family household with one person with a mental illness living next door. **Facility Manager 2** told me about how the relationship between the facility staff and residents and their immediate neighbours was changing over time:

Facility Manager 2: “I only know the people of this building. They talked to us only to complain at the beginning [facility was opened in 1982]: they would say the patients disturbed them at night, had a noisy cough, threw cigarettes from the balcony, etc. Sometimes I got the impression that our patients were made the scape-goat for their problems in the family or the building. I think there are many social problems in this neighbourhood [*quartiere*], here the Council concentrates people with problems. Many families are like that here in Via Tunisi [facility where interview took place], as well and it makes social relationships more difficult if the local residents also have problems. We [at facility] have tried to make our immediate neighbours more understanding, we

have tried to be present more often, to ask them if they have had any problems with the patients. I notice now that they look more interested, they even worry about our patients, they say “I could hear that woman coughing, how is she now ?” From this point of view the situation has improved a lot in the last year and a half, as before some people were aggressive, even played nasty tricks. So the situation has improved certainly but there’s still a lot to do”.

The comments by **Facility Manager 2** that there are many families with ‘problems’ in the neighbourhood were echoed by other interviewees. As discussed in 7.6, the two residential facilities are in apartments provided by the Comune of Verona (local authority) and all the apartments are owned by the Comune and rented to ‘poorer’ families.

9.4 THE IMPLEMENTATION OF LAW 180 AND THE INFLUENCE OF POLITICS

I asked all the interviewees their views regarding the implementation of Law 180. These are some of the more significant points from their responses:

Facility Manager 2: “It [Law 180] was inspired by an ideology of the time [1970’s], it had many good points but no facilities were implemented only now, after several years, are we creating those facilities to put into practice what was on paper. Unfortunately the law was passed under the illusion of getting rid of mental illness just by closing mental hospitals, which is absurdthere was no chance to create immediately any ‘communities’ [direct translation, referring to smaller residential facilities] some places to support people. They were mentioned on paper but only now are they appearing, after many years.”

These comments from **Facility Manager 2** reiterate a number of issues which have already been discussed in Chapter Seven. **Facility Manager 2** also repeated the fact that what was written in Law 180 was not implemented for a number of years. **Facility Manager 1** expanded on these comments made by his colleague:

Facility Manager 1: “As usual in Italy, first you pass a law and then, after a long time, you try to put it into practice. Our facility [‘protected’], for example, was created 8 years after the law; in those 8 years there were great problems, although we have been the avant-garde here in ‘*Veneto*’ [the region where Verona is located]. Such a law was really needed, but there should have been more preparation - it seemed as if they just opened up the asylums and let the patients out: some went back in, some committed suicide, some tried to adapt. I remember, for example, that some people had lived segregated in hospital for 20 years, without ever seeing a car, and once out they found themselves in the traffic. So it’s a good law, but for many that were let out there has been no support.”

There was little doubt amongst the interviewees that Law 180 was an important step in the right direction for Italian mental health care, but that the law had failed in the actual implementation of what had been intended. **Facility Manager 1** referred to the fact that in Italy, it takes a long time for any piece of legislation to be implemented. This is strongly influenced by the unstable political system as well as the regional system which leads to a very slow political process. This has already been discussed in Chapter Seven. Another important influence from the political system was that Law 180 was only intended as a framework law, to give general guidelines. The intention was that Law 180 was to be followed by more detailed legislation, but because of the political instability at that time no further legislation followed, as described by **Psychiatrist 1**:

Psychiatrist 1: “The central Government is still missing a national plan to apply this law. This law is really a frame, it was intended to be a general framework, to indicate the direction, the general trends in organising services for mental health. But we are still waiting I'm afraid to say, for more precise and detailed indications of how to do that..... and this should have been done by the central government, first, and by regional government, after. These details..... we just haven't received them, so this situation is another reason why there is such a big range of different services in Italy.”

So the absence of a strong Government, with a centralised system of monitoring the implementation of the reforms, has had an important influence on the inadequate implementation of Law 180. As already discussed in Chapter Seven, the failure of a nation-wide implementation of the law has led to great unevenness in the development of community-based services and facilities accross Italy, with enormous regional variations. This was an issue that many of the interviewees talked about, as the following section illustrate:

9.4.1 Regional disparities

Psychiatrist 2: “In the north-east of Italy the law has been put into practice, but in some regions nothing has been done, apart from opening mental hospitals and letting patients out, with no help, no shelter, nothing. They say that the law has failed in those areas but this is probably because it was never applied properly.”

Nurse 4: “As far as I know, it [Law 180] has been applied only in some areas. In the north of Italy it's been put into practice well enough, down as far as Perugia [to the north of Rome], whilst in the south of Italy we're still stuck in the situation we were in 30 years ago..... I've heard that from the south of Rome it's a tragedy, it's hardly been enforced [Law 180] and there have been few attempts.... it's a problem strictly linked to the

economic situation and to mentality [direct translation of '*mentalità*', as discussed in 3.4.2] as well. Italy is divided into two parts, in many things, not just in the health sector. In surgery and in medicine, we are the avant-garde in the north, whilst the south is far behind. The politicians there have certainly the wrong mentality, and maybe so do the people. From Rome to the north there's more organization, more initiative, in the south they don't try to change things, they leave things as they are, they lack rigour or common sense".

Psychiatrist 2 raised an important point by saying that it is more a situation of the Law not being implemented in some regions rather than the law having failed. The reasons for this are varied and complex, as discussed in Chapter Seven and repeated in these quotations. However, the comments made by **Nurse 4** are also important, as they correspond to the general climate of the 'North-South divide' discourse in Italy, as discussed in section 3.4.2. At the time of the research, this discourse was becoming increasingly politicised with the rise of Bossi and his Northern League party (*Lega Nord*) with their campaigning for an independent northern state ('*Padonia*'). A similar perspective was given by **Facility Manager 1**:

Facility Manager 1: "It's for reasons of culture and mentality and for deeply rooted problems in many things in Italy the North is more efficient than the South. The North and South have had a different way of dealing with things for years; like industry didn't develop in the South, neither has Law 180. I don't think it's a matter of money, but of culture and mentality, although there have been a few successful experiences in the South maybe it's because we are more active, we pulled our socks up earlier - don't forget that the reform movement for Law 180 started from the North-East, from Basaglia in Trieste. There are positive experiences in the South, but they are a rare occurrence".

The fact that the reform movement was started by Basaglia in the north of Italy, in Gorizia and then Trieste, is another important reason why the reform movement emerged more strongly in the north of Italy. But it was not only the influence of distance from the centre of the reform movement that determined the adoption of the reforms by mental health services in other towns and cities. More importantly, it was whether or not the mental health professionals in authority were attracted by the ideology and philosophy of the reform movement and whether they had the position of power, with a strength of will and determination to make the decision to adopt the reforms, with little external support.

9.5 THE IMPLEMENTATION OF LAW 180 IN SOUTH VERONA: THE INFLUENCE OF PARTICULAR PEOPLE

As discussed in Chapter Seven, following the introduction of Law 180 in 1978 the province of Verona was divided into three geographical sectors, based on population catchment areas, and three mental health services were established for each sector respectfully. In South Verona, psychiatrists at the Department of Psychiatry of the University of Verona, which was based in the '*Policlinico*', the main general hospital in the area, were supporters of the reform movement and had already begun to unofficially apply the new ideas promoted by the Democratic Psychiatry movement. With the sectorisation of mental health services in Verona, the University psychiatrists took responsibility for the establishment and operation of South Verona CPS. So in South Verona, the role played by some key individuals had an important impact of the implementation on Law 180 locally, as the following quotations illustrate:

Nurse 4: “We have been successful in Verona, especially in South Verona, because of the determination and convictions of the doctors..... when I started working here 22 years ago, I found young doctors, with modern ideas and enthusiasm, with the intention to work ‘in the field’ as Basaglia had suggested in his law, so we started very soon to go out into ‘the field’ itself. Prof. A and Prof. B [Psychiatrist 1] worked hard from the beginning I remember I went several times into ‘the field’ with Prof. B and also Prof. C; they were all were convinced the law was good. I was really on the same wavelength with some doctors, and there were no strictly distinct roles, but flexibility. The work involve me more and more. Then they asked 6 nurses to work permanently ‘in the field’, and I accepted.”

Nurse 3: “I believe that people were really important, like Prof.B [Psychiatrist 1], for whom the law mattered a lot. He started from scratch and little by little built up the centre, with nurses etc. And also the University is a determinant..... we have many students that help as if they were doctors or nurses. So we started 15 years ago and we’ve been able to create this service, so new and different”.

Psychiatrist 2 also talked the the role played by the University in the implementation of the reform in South Verona:

Psychiatrist 2: “Here in Verona there is a faculty of psychiatry at the University and it has given much momentum and support to the project [S.Verona CPS]. In other cities this hasn’t happened: in Trieste, so famous in this field, there’s almost no collaboration between services [mental health] and the University. Here there’s a close collaboration.....the University creates culture and opportunities. Also

there's a very good health service here, with funding for flats, centres, etc".

The successful implementation of Law 180 in South Verona can therefore be attributed to a distinct combination of factors. The presence of the University acted as a catalyst for change and no doubt provided a support-base for the adoption of the new ideas that were promoted by Basaglia and his supporters. The psychiatrists from the University, who were young and recently trained, were influenced by the reform movement and were strong and determined enough as individuals to push forward the changes. The setting up of the research unit, the '*Servizio di Psicologia Medica*' at the University, for which **Psychiatrist 1** is the director, has also raised the profile of South Verona CPS as well as attracting external funding for research projects which without doubt, has improved the quality of the service with the implementation of evidence-based practice.

9.5.1 Local disparities

However, as already discussed in Chapter Seven (7.7), the other two sectors for mental health in Verona have developed quite separately and differently to South Verona.

Nurse 1: "We can see, even in Verona, different situations. Here at the centre [the mental health centre in S.Verona] Law 180 is enforced completely, and we notice good results: I believe that it's a good law if it's properly put into practice. At the same time in the other two services in Verona the situation is not so good: in one facility there's really nothing, no mental health care centre or 'activity' [the existence of CMHTs] 'in the field'; there's only a place where to keep patients [residential facility]. In the other centre they don't work 'in the field', although they do have a mental health centre. So in Verona you can see a

sector where the law is totally applied, a sector where it is applied partially, and a sector where it isn't at all.”

In Sectors I and II the philosophy of going out into the community to treat the mentally ill was not adopted as it was in South Verona (Sector III). Nurse 4 described the differences between the services based in Borgo Trento and those in South Verona:

Nurse 4: “In Borgo Trento they cover the north of Verona, but without going into ‘the field’, they just examine patients at the hospital and support them from there. Visits ‘in the field’ are unusual and when the worker feels it is necessary, they are not organized and scheduled like ours, as we think it’s essential to go out. I really believe in working ‘in the field’ because of the enormous advantages: you help the patients as soon as they have the first symptoms. Even from a simple phone call, after 10 minutes, if you know him well you will realize if he needs a visit and so you go. Otherwise you can talk with a relative, you can anticipate or prevent a crisis and the residential facilities are subsequently therefore available for those people that need to stay there urgently”.

Nurse 5 also talked about differences in the implementation of Law 180 in South Verona compared to other services in Verona and elsewhere:

Nurse 5: “Here in Verona, in this centre it [Law 180] is applied 100% because we have three service activities: the hospital, residential facilities and the activity ‘in the field’. However, Borgo Trento, for example, is different from us [South Verona CPS]; they are more conservative. We have fewer compulsory treatment orders [when a patient is admitted to hospital by a compulsory order] and they have a different way of working. It’s really a matter of inclination and determination amongst the mental health professionals, the ‘*Primario*’ [director of service], the nurses etc. to

implement the law [Law 180] despite the fact that there are resources to do so. In Italy there are two opposite situations; one is developed and one is totally backward ['pre-historic' was the direct translation]. For example, in Vicenza [a nearby town] some years ago they found an asylum ghetto [direct translation, referring to when mental hospitals which are supposedly closed are found to still have mental patients living in appalling conditions, totally isolated from the outside world]. In Italy there are two diverse situations with nothing in the middle: one is good and the other is bad”

This quotation and others in this section illustrate that even in the north of Italy, where Law 180 is said to have been more fully implemented, there are disparities within regions and even within a single province. For such a situation to develop, the role of particular people working in particular places seems to have been more influential in the implementation of Law 180 than other factors, such as the availability of resources or the lack of external political support. This argument will be pursued further in Chapter Ten.

9.6 VIEWS ON HOW GREATER IMPLEMENTATION OF MENTAL HEALTH REFORMS CAN BE ACHIEVED

So far this Chapter has perhaps given an unbalanced picture with regard to the achievements of the South Verona CPS - that the Service has implemented Law 180 completely and with total success. All the interviewees talked about how much has been achieved in South Verona, particularly compared to other services, but all acknowledged that there was still more to do and that some gaps in the service provision still existed. They also had views on how the implementation of Law 180 could be improved at the national level.

9.6.1 Improvements to be made in South Verona

Nurse 3 expressed concerns that for some former mental hospital patients, living in the community has put them at greater risk and it is now more difficult to care for them:

Nurse 3: “I spent many years working in mental hospitals, and for many patients the law has been good. But for some of them there’s no benefit at all, they are left to themselves, left to wander around. For example, I’ve been trying to get hold of a patient for two months: he lives on his own and comes back drunk in the middle of the night. In this case, he shouldn’t be just left to wander in the city, causing havoc, he must be constantly ‘followed’ in a protected environment”.

I then asked **Nurse 3** where people lived if they did not have a family to support them or their own flat:

Nurse 3: “The most fortunate ones [patients] live in the flats provided by AGECC [a public housing organization that allocates Local Authority accommodation], whilst there are some people, here in Verona that I know from the old asylum, that live ‘on the streets’. The lucky ones live in this area [S.Verona] and there are our flats and the centre that we can offer them. But in other areas here in Verona many sleep on benches at night, or under bridges, at the station, with no help [he sounded concerned]. The luckiest ones are those that have accepted our help and entered our centre or flats. But there are still too many without care”.

This illustrates the fact that the inadequate provision of community-based facilities across the whole of Verona has meant that there are still people with mental health problems who are ‘falling through the net’. However, he made an important comment by referring to ‘those who have accepted help,’ as it has to be acknowledged that some people with mental health problems don’t want to attend a

mental health centre or received treatment and only if their behaviour is perceived to be a danger to themselves or others, is treatment made compulsory.

Facility Manager 1 talked about the need for more residential facilities which were for smaller groups of people as well as the importance of helping patients with social and welfare issues rather than just concentrating on their health needs:

Facility Manager 1: “I think we could have more apartments with groups smaller than 6 people, here [residential facility] we don’t really have enough room for us all. Instead it would be better if there were fewer patients, with a similar degree of illness, in smaller apartments. But this is a big problem; it’s difficult for anyone to find accommodation and it’s harder still for our patients. So there should be greater involvement in trying to help a patient, not only from the psychiatric and health point of view, but also social, political and economical”.

Facility Manager 2 spoke about how she would like greater communication and collaboration between the different psychiatric services in Verona and also with the local residents of the existing facilities:

Facility Manager 2: “I would really like some more collaboration ‘in the field.’ Sometimes our apartments are very isolated in the ‘*quartiere*’, and one of our aims is to have more meetings with people in the building, with groups of volunteers to ‘test’ our patients in social contexts, so they can really be rehabilitated. The ‘protected accommodation’ [residential facilities] is like a gym where you train, however you must go ‘outside’ into society to ‘test’ your ability to socialize in the outside world. Another thing is that there is not much dialogue with other services, at least I don’t have, I don’t know if the heads of the service do. We don’t meet a lot with workers in the other protected flats and it’s a pity because whenever we do meet, the sharing of experiences is very useful, we learn many things, more than I would in books or journals”.

The sharing of experiences between mental health professionals is all part of the support system and training that is required for mental health professionals, to keep them up to date with new ideas within the professions and this is a further area where improvements were required, according to some of the interviewees. Other issues mentioned included: further specialised training for the nurses working in the CMHTs; a greater use of support workers who can spend more time with patients and release the more qualified staff for more clinical and management tasks; more specialised service provision for the younger generation of people with mental health problems by the service and a greater use of co-operative workshops in South Verona to give patients meaningful daily activities and to assist with their rehabilitation.

9.6.2 How the implementation of Law 180 can be achieved at the national level

Finally, I asked all the interviewees how they thought the implementation of Law 180 could be achieved throughout Italy. Here are examples of some of the responses:

Psychiatrist 1: “It still is important for local politicians that we should have some degree of freedom...but a general plan must (stressed) come from the national level, and also money and budgets (words stressed) should be decided and provided at the central level and distributed regionally”.

Psychiatrist 2: “First of all, the law must be enforced thoroughly and it must give more guidance. Also the situation could be improved by developing more community-based facilities, like these apartments, inserted into the fabric of society that can provide a stepping-stone between living in a hospital and wider society. I believe that many underestimated the problems for people who, once out of mental hospital, found themselves abandoned by their families, all alone. Most of them have filled psychiatric wards in hospitals, and maybe they deserve better assistance. The best thing would be to guarantee them some independence after spending some time in a residential facility, or at least

some form of protected accommodation. In several areas in Italy patients with no family or medical support have become homeless tramps, lost souls, that are lost from any control, any help we might try to give to them. In many areas in Italy also the psychiatric support implies hospital care only, while here in Verona the situation is more complex, more developed and able to meet a variety of needs.

Nurse 1: Psychiatric illness generally continues for a long time, one must work a lot to gain noticeable improvement. I believe that the individual has to be treated holistically, alongside the illness. Any innovation, any idea or new resource is welcome as long as it respects the patient as a human being. Anything that can be invented or introduced here at the centre, however small, must be considered if it truly helps the patient in his social, family or personal life. There's no limit, you can always improve, do something more, with common sense and professionalism.

These quotations highlight a number of important issues that need addressing: the nation-wide development of community-based facilities; the problems of former hospital patients moving back into the community without adequate support; the lack of a spectrum of care provision in many parts of Italy. It seems unlikely that any of these 'gaps' in the present system will be addressed without co-ordination and policy guidance from the national government. Finally, the quotation from **Nurse 1** reminds us of the philosophical reasoning behind the mental health reforms in the first place with the view that people with mental health problems need to be treated first as an individual rather than just as a diagnosis. Many people with mental health problems will never be cured and mental health services in the future need to provide a 'place' for these 'patients,' when all the '*manicomi*' have been finally closed.

SECTION FOUR

MENTAL HEALTH CARE IN BRITAIN AND ITALY

GEOGRAPHICAL PERSPECTIVES

CHAPTER TEN

DISCUSSION

10.1 INTRODUCTION

'Psychiatry continues to be in transition, both in Britain and Italy. Despite the growing similarity in the political climate, and despite an increasing but superficial similarity in the structures of the two mental health systems, the two systems continue to develop along different principles, different modalities of operation, and different cultures. I hope nevertheless that we can learn from each other.'

(Ramon, 1991, p.xxi).

This thesis has focused upon the consequences of temporal and spatial change in mental health care provision since the 1950s in Britain and Italy, from a geographical perspective. It is evident that conducting research from such a standpoint has produced some interesting and useful findings, illustrating that geography indeed does matter and that geographers have a contribution to make to this discourse. As Ramon (1991) comments, it is also clear that following the implementation (or lack of it) of the policies of deinstitutionalisation and community care in Britain and Italy, the mental health care systems in the two countries are still in a period of transition, with an unevenness in the distribution of community-based services at all spatial scales.

This chapter will summarise and discuss the main findings of this doctoral research project, address the question as to whether there are lessons to be learnt for Britain from the 'Italian experience', as was postulated by British commentators in the early 1980s (Lacey, 1984; Heptistall, 1984), and suggest further research that geographers have the potential to contribute towards in this research area. This appeal would be aimed at British geographers, who need not only to 'catch up' with their North American colleagues but to start taking notice of what developments in mental health

care that are occurring on their European 'doorstep'. Throughout Europe in the 1980s and 1990s, psychiatric hospitals have been closing and mental health issues have become more prominent in social policy as people with mental health problems become a more visible part of everyday society. Countries are dealing with these changes in a variety of different ways; for example, in the Netherlands users' organisations have a formal role in mental health services, and in Belgium and France there are innovative family placement schemes for former psychiatric patients in some towns (Ramon, 1996). Such variations and innovations within Europe are certainly worthy of greater attention.

10.2 MAIN RESEARCH FINDINGS

In Chapter One, the three main research objectives of this PhD were outlined. The main findings of the research, which was conducted in order to address these objectives, will now be discussed.

10.2.1 Research objective one

To compare and contrast the geographical implications of spatial changes in mental health care services in Britain and Italy.

Since the 1950s, both Britain and Italy have experienced the policies of deinstitutionalisation and community care, with the closure of long-stay psychiatric hospitals and the move towards community-oriented models of care. However, as Ramon (1991) comments, this similarity is superficial; not only have the timing, methods and outcomes of implementation varied considerably both between the countries and within them; but the principles, circumstances and motivations behind these wide reaching policy changes have also been very different, as discussed in Chapters Four and Seven.

The pace of reform has varied considerably between the two countries. Community care policies were introduced in Britain in the late 1950s, although the majority of the psychiatric hospitals did not actually start to close until the mid 1980s. In Italy legislation to close the psychiatric hospitals was not introduced until 1978, and by the mid 1980s most hospital closures had already occurred, although there is evidence that being 'officially' closed does not necessarily mean that all the former patients have been moved out. It is also important to recognise that these temporal disparities are not unique to the twentieth century; as discussed in Chapter Two the age of 'the great confinement' in Britain was between 1860 and 1910, whereas in Italy the asylums emerged much later and over a shorter time period, from 1894 to 1907 (2.2.1).

The role of politics has been important in the timing and content of mental health legislation in both countries, although in different ways. In Britain, community care has been on the political agenda since the 1950s and has been led very much by politicians; since the 1980s, mental health reforms have been shaped and 'pushed' very much by 'New Right' politics and a drive for cost-efficiency (Walker, 1989). In Italy, the situation has been quite different; the reforms were initiated by a small group of mental health professionals who were influenced by left-wing ideologies and humanitarian motives and who 'worked' the Italian political system in order to get the mental health reforms on to the political agenda. In Italy therefore the mental health reforms were implemented using politics as a 'tool' to achieve reform; in Britain mental health reforms in the 1980s have occurred as a result of changes in the political ideology of the Conservative Government regarding health and welfare in Britain. Therefore the motives and political context in which these changes have occurred in the two countries have been quite different.

The implementation of mental health reforms in both Britain and Italy has led to considerable structural change in the organisation of mental health care services in both countries. As discussed in Chapter Four, in Britain the whole of the NHS has undergone considerable restructuring with the introduction of Purchasers and Providers in both the primary and secondary care arenas. In Italy, a National Health

Service did not exist until 1978. With its creation, following the enactment of Law 833, a new spatial division of the country was established with a system of geographically defined local health units (ULSS), which were to provide all health services for Italy's population. This system was based upon the British NHS model that existed from 1946 until 1993, when the implementation of the NHS and Community Care Act became legislatively complete.

In the 1990s, both Britain and Italy should be operating community-oriented mental health care systems, according to the respective mental health reforms. However, the models adopted and approaches taken to fulfil this policy requirement vary considerably, both between the countries and within them. In Britain, community mental health services have developed slowly, with psychiatric hospitals still dominating services in most places into the late 1980s. Furthermore, as discussed by the latest Audit Commission report, published in 1994, in 1992/3 two thirds of mental health funding was still being spent on in-patient care rather than on community services (Audit Commission, 1994).

In Italy, Law 180 specified that the model of community psychiatry was to be alternative to, rather than to complement, hospital-based services (Tansella and Zimmermann-Tansella, 1988). The shift from hospital-based to community-based care, as prescribed by Law 180, was intended to be rapid and complete, with new methods and 'sites' for the treatment and care of the mentally ill. However, as illustrated in Chapter Seven, the implementation of Law 180 has been patchy, with tremendous variations amongst different regions in the rates of hospital discharges (De Salvia and Barbato, 1993) and considerable disparities in the provision of community-based services (Fasalo and Frisanco, 1991).

Despite the fact that there are recognised variations in mental health provision in Britain (Audit Commission, 1994; Faulkner, Field and Muijen, 1994) national legislation is implemented and co-ordinated at a national and regional level, with regular monitoring from organisations such as the Audit Commission. This has not been happening in Italy, due to a variety of different factors which include: the fact

that Law 180 only provided a 'framework' and did not elaborate on exactly how community-based services should be provided; the lack of co-ordination from national and regional Governments to enforce the Law; the political instability of the Italian political system; the existing variations in health care provision between the different regions; the inequalities in wealth and economic development between the north and south of Italy. The combination of these different factors has contributed towards the situation which have enabled the influences of politics, people and place to emerged more prominently than they have been allowed to in Britain. This situation is evident in Italy particularly at the local scale, as the Verona case study has illustrated.

Sheffield and Verona: research findings at the local scale

Research conducted at the local scale has revealed a number of interesting findings, some of which suggest that the consequences of implementing mental health reforms can be place and culturally specific. An example to illustrate this is the decision-making processes behind the locations of new community-based mental health facilities in Sheffield and Verona, which were entirely different.

In Sheffield, as in the whole of Britain, planning is a formalised procedure with national legislation and Local Authority guidelines to be met. These have acted as strong determinants in the location of community-based facilities in the city, with a spatial dispersion of facilities. As discussed in Chapter Seven, strict planning control has shaped the 'map' of facility provision in Sheffield, preventing a concentration of mental health facilities in the poorer, inner parts of the city, as has been found by previous research conducted in North America (Dear and Taylor, 1982; Dear and Wolch, 1987; Currie, Trute, Tefft and Segall, 1989). Such a 'ghettoisation of the mentally ill' (Dear and Wolch, 1987) does not appear to be occurring in Sheffield, although evidence from other British cities (Giggs; 1973; 1990; Eyles, 1986a; Moon, 1988) suggests that it is occurring to an extent elsewhere. Therefore it is suggested that the situation in Sheffield is particularly place specific.

In Sheffield, professional Planners and Health Managers from a number of different agencies are responsible for the siting and development of new community care facilities. In Italy, this process is not as formalised and is certainly less fragmented, with the heads of individual services making the majority of decisions regarding how and where services operate. In South Verona, there appeared to be little or no prior planning or decision-making involved in the siting of the community-based facilities. As discussed by 'Psychiatrist 1' and reported in Chapter Nine, the establishment of the Service's community-based facilities happened in the particular locations they did, as a result of 'chance' rather than design; the building which accommodated the Community Mental Health Centre was literally 'found by chance' by one of the Psychiatrists from the University at the time that they were looking for suitable premises. The two residential facilities were offered to the service by the Local Authority because they were available. However, as discussed in Chapter Four, the location of the Sheffield case study facility was also 'opportunistic' with the local church offering the land at a time when the Health Authority were looking for such a site.

As discussed in Chapter Seven (7.7) a second important finding at the local level concerns the wide variations in models of care provided by the three separate mental health services in Verona. The same legislation has resulted in very different outcomes in the access to and provision of mental health care within a single city. Such a situation raises questions of territorial justice, as it implies that where an individual lives in the city determines the type and quality of service which they are able to gain access to. Such inequalities have been 'enabled' by the inadequacies of Law 180, a lack of co-ordination and regulation from central and regional governments and the personal decision-making of the individual heads of services involved. In the reorganisation of mental health care in Verona post-1978, politics, place and people have played an influential role.

10.2.2 Research objective two

To identify neighbourhood profiles/characteristics associated with levels of acceptance of the location of community-based mental health facilities.

In this research, two questionnaire surveys were conducted in the locality of the case study facilities in Sheffield and Verona. Previous geographical research which has attempted to gauge the attitudes of local residents towards community-based mental health facilities has suggested that members of a local community will have some kind of a response, almost as a matter of course, and in most cases it is likely to be negative. This part of the research attempted to assess whether the findings of previous work are applicable to all situations, irrespective of time or place, or whether each situation is in fact unique, with its particular circumstances and social actors.

Firstly, both the Sheffield and Verona questionnaire surveys found evidence to support previous research (Smith, Hanham and Chang, 1978; Smith and Hanham, 1981a and b; Burnett and Moon, 1983) suggesting that different types of facilities generate different perceptual attitudes with regard to their location in relation to a respondent's home. Differences in the perceived 'noxiousness' of individual facilities found between the Sheffield and Verona results and other studies, also indicate that such perceptual attitudes can be place and culture specific, an issue worthy of further research.

The general awareness of local community-based mental health facilities in this study was far higher than found by existing research. Particularly in Sheffield, where 43% of respondents were aware of the existence of the case study facility and 63% were aware of such facilities in the neighbourhood. In Verona, none of the respondents was aware of the selected facility, but it was far less visible than the Sheffield facility. However, 41% of respondents in Verona were aware of at least one of the facilities operated by the South Verona CPS. These results suggest that generalisations cannot be made universally and that each situation needs to be considered without pre-

conceptions, taking into account the particular social, cultural and geographical context of each facility.

Responses to the two surveys indicated that both localities had 'communities' that were well established and 'stable', with the majority of residents having lived in the locality for a considerable length of time. Both areas were suburban, residential neighbourhoods, and had some of the characteristics which Dear and Taylor (1982) suggested were characteristic of neighbourhoods 'rejecting' community-based mental health facilities. However, in both of the case study localities, community-based mental health facilities have been developed and opened; even in Sheffield where there was concern amongst local residents, over time it appears that the case study facility is now 'accepted', if only passively, as part of the local landscape. Responses to question 5 in the Sheffield questionnaire, which found that the same percentage of people would choose to locate a mental health facility on the same street to their home as a park or a library, both traditionally 'salutary' facilities, supports this argument.

Existing research (Dear, 1992; Gleeson and Memon, 1994) suggests that the planning process for mental health facilities may be influenced by perceived or actual opposition from potential 'host' communities. In Sheffield, this has not proved to be the case; Health Professionals and Planners interviewed stated that other factors were far more important, like the availability of land and adequate size of site. They also expressed the view that even if community opposition was anticipated, they would continue with a facility proposal that they considered to be feasible according to the needs of the future residents and if the location fitted planning and Local Authority criteria. All the Health Professionals and Planners that I spoke to stated their commitment to provide the best possible locations for community care facilities, or those where people with mental health problems actually wanted to live.

In Sheffield at the time of the research, some proposals for new facilities were 'successfully' opposed by local residents (4.4.5), yet others were not (case study facility). Therefore the NIMBY syndrome certainly does have the potential to cause

problems in locating mental health facilities, as suggested by Dear (1992), yet it seems to be a real ‘hit and miss’ phenomenon that is considerably dependent on the specific situation, location and key actors involved. However, in Verona, when I asked mental health professionals about opposition from local neighbours they only gave me a few examples of complaints about individuals’ behaviours, not organised opposition against a whole facility. In fact, the ‘*Primario*’ of the South Verona CPS told me that he had no experience or knowledge of NIMBYism in Italy in relation to mental health facilities.

Therefore in the light of the results of the two questionnaire surveys and interviews with Health Professionals and Planners, it is suggested that generalisations given by the North American literature about typical accepting and rejecting neighbourhoods and the ‘ghettoisation of the mentally ill’ are certainly useful, but not culturally transferable. The experiences of deinstitutionalisation have occurred later and in different social and cultural contexts in Britain and Italy and need to be considered thus.

10.2.3 Research objective three

To investigate the interpretation of ‘success’ of community care by the different groups involved

As outlined in Chapter One, this research has focused upon the views of a number of different groups as to their interpretation of what makes community care ‘work’ and be ‘successful’. This research was conducted with Health Professionals and Planners, ‘host’ communities to community-based mental health facilities and mental health professionals working in the case study facilities. It is acknowledged that different people have different definitions of ‘community care’ and ‘success’ and these concepts certainly vary in the two different countries and cultures in which the research was conducted.

For the Health Professionals and Planners responsible for finding a location for facilities and being responsible for the development of facilities, actually finding a suitable size of land that fits planning guidelines and then getting the facility operational defines a 'success'. As illustrated in 4.5.1, the Planning Officer responsible for the development of the Sheffield case study facility listed factors such as: the land mass, an area of 'ordinary housing', the role played by the local church and the way in which that influenced the reactions of local residents and the design of the facility which made it 'fit in' with the surrounding environment.

The local residents who responded to the questionnaire survey were not asked directly to define 'successful' community care, although they were asked attitudinal questions regarding mental illness and community-based mental health facilities. The results to these questions showed the Sheffield respondents to be more 'intolerant' than the Italian respondents in respect of the mentally ill and the establishment of community-based mental health facilities in residential environments. The Sheffield respondents gave rather contradictory responses to the attitudinal questions whereas the Italian respondents appeared clearer in their views. Further comparative research is required to expand upon these findings further and, as discussed in Chapters Five and Eight, it is important to take into consideration the fact that the questions were 'worded' slightly differently and the 'baseline' used from the results of similar surveys for assuming tolerance or intolerance is questionable.

From this research it does appear that the general public are in fact 'fearful' rather than 'intolerant' of the mentally ill. Suggested reasons for this situation include a continued stigma of mental illness and lack of knowledge of most people about the causes and symptoms of the variety of mental illnesses. It is recognised that this remains a great problem in all western societies, where the asylum system is a shared legacy, with the social and spatial marginalisation of those people who are deemed to be 'mad' and 'bad'. The role played by the media is also acknowledged as a contributory factor to the perpetuation of such attitudes and perceptions, when only 'murders' and 'suicides' hit the headlines and examples of good practice and 'successful' community integration of former psychiatric patients go unreported.

Interviews with local residents in Sheffield suggest that attitudes towards the location of mental health facilities close to one's home can change when there are positive experiences of such an experience. The case study facility in Sheffield had been operational for approximately eighteen months when the research was conducted. Local residents interviewed stated that although there was concern initially regarding the facility, as there have since not been major problems or incidences they have grown to accept the facility and its tenants as part of the local landscape. As commented by 'Key Individual 1': "I think that if they can get people like that out on their own, without supervision, then I think they've cracked it, it's the return to the community and it's a better surrounding for them..... it's good, it can only be good...". Other residents expressed similar sentiments which suggest that once a facility is established, if there are no negative experiences then local residents become more tolerant and may even regard the facility as 'working' if the tenants are seen out shopping, for example, and coping with their new way of life.

Mental health professionals have faced changing roles and challenges to their professional identities with the transition from institutional to community care. In Britain and Italy, not only have the experiences been different for the mental health professionals working in those services, but the professional hierarchies are also different. For example, in Italy the psychiatrists are still in charge of most, if not all mental health agencies and although in services like South Verona, where more barriers appear to have been 'broken down' between the professions, the psychiatrists still manage the teams and service overall. In Britain, in contrast, psychiatrists still appear reluctant to leave the hospitals and move into community-based services; they rarely manage community-based services, a role which is normally performed by a non-clinical manager or a psychiatric nurse who has moved into a manager role.

In Britain, mental health nurses have greater responsibility, autonomy and status than their Italian counterparts. This situation is illustrated by the fact that in the Sheffield case study facility, the whole facility was managed by a trained psychiatric nurse (Facility Manager). In Britain, there is a specialist training for three years to become a psychiatric nurse (Registered Mental Nurse, RMN) where as in Italy nurses have a

generic training, and those nurses who chose to work in community mental health have had little or no additional training, apart from in a few particular places (Savio, 1991). These differences are relevant because people's experiences, responsibilities and knowledge will have affected their interpretations of whether the community care in which they have been involved in, can be judged as a success or not.

Another important distinction to make is that in the Sheffield case study facility, the majority of the staff and 'tenants' had all moved together out of Middlewood Hospital to the residential facility, located in a different part of the city. As illustrated by quotations from the staff in Chapter Six, they all found it difficult moving from Middlewood to Lister Avenue, working in a more spatially and socially 'open' and informal environment. In Verona, the majority of the mental health professionals interviewed had never worked in an institutional mental health setting and thus did not have this mental health 'cultural' background, nor had they seen the same individuals living in both an institutional and community setting. Finally, it is important to recognise the different social and cultural contexts of the two case study services.

In both Sheffield and Verona, the mental health professionals interviewed spoke more positively about their particular service than about implementation elsewhere in the city or nationally. Because of the experience of the Sheffield mental health professionals, knowing the 'tenants' when they were 'patients' at Middlewood, when asked about whether they thought the case study facility was an example of 'successful' community care they talked about improvements in the quality of life for the tenants, having their own private space rather than the communal living of psychiatric hospitals and having greater autonomy in their lives, for example being able to get up when they want to or make a cup of tea whenever they want. Their attitudes appeared quite paternalistic towards the tenants which is perhaps also a reflection of the power relations in psychiatric hospitals and 'culture of dependency', with the patients being totally dependent on the staff for their whole way of life.

In Verona, the staff talked about 'success' more in terms of what the South Verona CPS had achieved in the establishment of the facilities and the teams which went out and saw the 'patients' in the community. The mental health professionals saw 'good results' in terms of the organisational structure of the service and the fact that they believed that they were providing a comprehensive range of services which they had achieved very much by their own hard work and commitment. This structure enabled the professionals to provide a 'continuity of care' to their 'patients' and to be proactive rather than re-active in the treatment of people with mental health problems without the use of long-stay psychiatric beds.

The words 'tenant' and 'patient' were emphasised above as I found an interesting use of language whilst conducting this research, especially in relation to the specific mental health 'language' which has been discussed at various points within this thesis. People with mental health problems who lived in long-stay psychiatric hospitals were called 'patients' as they were considered to have an illness and to be therefore there for treatment. Such a word also implies their status as being less powerful than the staff who care for them and have ultimate control in the hospital environment. The mental health professionals at the South Verona CPS called the people under their care 'patients' irrespective of whether they lived in a residential facility or in their own home.

I at first thought that this was a cultural phenomenon, due to the dominance of medicine and the 'medical model' in Italian psychiatry. However, when I visited Trieste all the people using the mental health services were called 'users'; Trieste is very strong in the promotion of 'user' involvement in mental health services; staff and users did not have separate 'spaces' in the mental health centres I visited and the atmosphere was even more informal than at South Verona. Therefore the use of the word 'patient' in South Verona was perhaps more place specific, and culturally specific according to the South Verona CPS rather than being a national phenomena.

In Sheffield the situation was different again; in the case study facility the residents went from being called 'patients' in Middlewood to 'tenants' in Lister Avenue. This term implied a higher status in life, with the philosophy of the facility being that the 'tenants' were now living in 'their' homes, which they were paying for, and that they had a right to be there. With the mental health reforms in Britain in the 1990s, other terms such as 'client' or 'user' have been introduced, with the theory that the mentally ill are 'customers' in a market of welfare provision, with rights to receive a good quality of service.

There was an interesting similarity between the mental health professionals in Sheffield and Verona in the way that they defined 'success' by ensuring 'appropriate' behaviour from people in their care. Both the 'Facility Manager' in Sheffield and 'Psychiatrist 1' in Verona talked about their responsibilities to ensure 'good' and 'acceptable' behaviour from the mentally ill for whom they were responsible. This is interesting as it hints that elements of 'control' and power relations remain from the 'asylum culture'. It also illustrated the fact that different types of behaviour are deemed to be time and place specific; 'strange' behaviour would have been more acceptable within the walls of a psychiatric hospital than it is on the streets of Sheffield or Verona. This concept also distinguishes between what is acceptable and 'allowed' in private and public space, with the 'Facility Manager' in Sheffield suggesting that tenants could do what they wanted in their own house but had a responsibility to behave differently outside the facility. This debate was not explored at any depth within this research but is certainly something worthy of further consideration in the future.

10.3 ARE THERE LESSONS FOR BRITAIN FROM THE 'ITALIAN EXPERIENCE?'

'It would be simplistic to think that the Italian model of community-based psychiatry could be exported elsewhere or copied. In implementing community care, general principles and guidelines are useful, but the practices need to be adapted to the particular context in which they are to be applied. Each region and country has to find its own way. Only the past can be copied, the future must be created.'

(Tansella, 1991, p.48).

The 'Italian experience' has shown that the transition from an institutional to a community-based system of care cannot be accomplished by simply halting all new admissions to mental hospitals without providing adequate and appropriate community services. There is still an urgent need in Italy for a transfer of resources from the mental hospitals to community services and the nation-wide provision of good quality community psychiatric services (Tansella and Williams, 1987).

However, this is equally a 'British experience'. The British health service still spends two-thirds of its budget for psychiatric services on the hospital sector, despite declining in-patient numbers (Audit Commission, 1994). There has also been continual concern that there is not adequate alternative provision 'in the community' for the mentally ill (Audit Commission, 1986;1994; Mental Health Act Commission, 1993) as well as an awareness of unevenness in mental health service provision in Britain (Faulkner et al, 1994; Lelliot and Wing, 1994). Ramon (1994) describes the 'ad-hoc' nature of service provision for the mentally ill in the 1990's as 'a matter of luck, geography and personal attraction, (as to) whether a person will get the benefit of a wide range of service or only the minimal level of provision' (p.253). However, these variations should be set in context; Ham (1988) illustrates that there are geographical disparities in the provision of many health services within the NHS, so the situation in mental health is certainly not unique.

When contemplating comparisons between the mental health reforms in Italy and Britain, the argument that 'place matters' is highly pertinent. Social, economic and cultural disparities between the different regions in Italy are striking. Combined with the constant political instability in the country, with slow and complicated political processes (Jones, 1988), the reform programmes in the two countries have had totally different starting points and contexts in which to be applied. These changes have also been operating within different timescales; British community care policies were introduced in the late 1950's whereas they began much later in Italy with Law 180 in 1978, although the speed of change in Italy has since been more rapid.

But there are lessons available from the 'Italian experience'. There are aspects of the Italian reforms which have implications for the organisation of community psychiatry everywhere, for example political and administrative commitment to policy reform is a crucial factor determining the effective functioning of a community-based service. An absence of this commitment in some parts of Italy is largely responsible for the failure fully to apply the reforms in those places. The monitoring and evaluation of mental health services have also been lacking in Italy and this is something that has been practised more widely in Britain (for example: Conway et al, 1994; Muijen et al, 1992; Lelliot and Wing, 1994). But there are elements of certain innovations which have emerged in Italy which could be applicable and 'copied' from one country to another, for example the practice in South Verona of providing a 'continuity of care' for patients with staff 'following' their patients in all parts of the service, and the work in Trieste where Users are being encouraged to become more involved in the running of the community-based facilities. Therefore an important conclusion is that any 'lesson-learning' should be a two way process. This can be facilitated particularly well through the collaboration of mental health professionals working in different countries. (For example: Gater et al, 1995; Lesage and Tansella, 1993; Munk-Jorgensen and Tansella, 1986).

This research supports the view held by Tansella (1991) that models of community mental health cannot be directly transferable. All mental health reforms require political support and national and regional co-ordination; however the local context

must also be taken into consideration because mental health services need to be flexible and sensitive to the needs of the local population that they serve. Community-mental health care therefore has to be 'place specific' to this extent although mental health professionals require greater guidance and support to know what exactly is expected of them in this transitional period in mental health.

10.4 SUGGESTIONS FOR FUTURE RESEARCH

In the 1990s 'the Italian reform is still controversial and incompletely realised' (Ongaro Basaglia, 1992) and mental health professionals continue to campaign for new legislation in order to implement a more rigorous community care policy throughout the country. However, the 'Italian experience' has been undeniably 'the most radical experiment to date anywhere to deinstitutionalize the mentally ill' (Donnelly, 1992, p.xii) and is certainly worthy of continued interest by mental health professionals and geographers alike. As mentioned in 10.1, there are innovations and new experiences in mental health occurring all over Europe that are presenting many new challenges and opportunities in the field of mental health. This in turn presents a challenge to professional researchers, who have the responsibility of evaluating such change and to disseminate the findings to assist others in their work.

This doctoral research project has been the first investigation by a geographer to assess in a comparative context the impact of mental health reforms in two European countries. Other countries in Europe equally require attention, as this research has illustrated in a number of areas; there is a lack of good comparative research with which to strengthen the knowledge-base in this field. As discussed in Chapter Two, the contribution by geographers to this debate has been relatively recent and it is a topic that British geographers have hardly begun to address (Giggs, 1990). Therefore it is important for further research to be conducted, in different places in Britain and elsewhere in Europe, in order to provide greater evidence for or against the findings of this research which suggest that the consequences of the implementation of mental health reforms are more place, time and culturally specific than the previous North American research suggests.

This research has shown that the implementation of mental health reforms affect the lives of many different people. This research has only focused upon a few groups who are involved and affected by community care and unfortunately neglected others. People with mental health problems who have been relocated from institutions to community-based facilities are perhaps the group whose lives have been changed the most by reforms as well as the lives of their relatives, many of whom have now become carers. There are practical and ethical issues involved with conducting research with this group but such research would perhaps provide a wider picture of the consequences of mental health reform.

This research has been conducted from a cross-national and cross-cultural perspective. As discussed in Chapter Three, this type of research can be problematic, not only practically with having to work in another language and having to move to another country for a period of time, but conceptually, with the difficulties of translating experiences which are culturally specific. Working in a different culture as an 'outsider' enables the researcher to begin to understand the different '*mentalità*' of the people in that country, and as illustrated in Chapter Nine, the people in a particular region. This 'way of thinking' is so subtle and taken for granted in our own culture that it is not recognised to be of importance until one starts trying to understand people's attitudes and actions within another. It is clear from the limited cross-national comparisons made in this thesis that the importance of such taken-for-granted '*mentalities*' specific to individual cultures and places is such that similar social policy goals may necessitate different implementation and co-ordination systems in different circumstances. It is also clear that the resultant outcomes may actually 'mean' different things in different places, despite apparent similarities.

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APPENDIX ONE: THE INTERVIEWS

INTERVIEWS CONDUCTED IN SHEFFIELD

Respondent Code	Status/Position at time of interview	Interview type and method of recording	Interview schedule no.	Location of interview
Health Professionals and Planners in Sheffield				
Health Professional 1	Planning Manager with Sheffield Health Authority (SHA) who was also the overall 'key contact' for the Sheffield research.	Semi-structured and tape recorded	Interview schedule one	Respondent's office at SHA
Health Professional 2	Leader of planning and purchasing team for mental health services for Sheffield Health Service Authority (FHSA). Principal Planner for development of Case Study facility.	Semi-structured and tape recorded	Interview schedule one	Interview room at FHSA
Health Professional 3	Deputy Director for Development for Community Health Sheffield (CHS). Previous position - Manager of Mental Health Services for Sheffield (before purchaser.provider split).	Semi-structured and tape recorded *	Interview schedule one	Interview room at CHS
Planner 1	Principal Planning Officer with Family and Community Services (F&CS) (Sheffield City Council).	Semi-structured and tape recorded	Interview schedule one	Respondent's office at F&CS
Planner 2	Assistant Principal Planning Officer, Directorate of Planning, Sheffield City Council.	Unstructured, notes taken	Based on schedule one	Staff canteen

Respondent Code	Status/Position at time of interview	Interview type and method of recording	Interview schedule no.	Location of interview
Mental health professionals working in Case Study facility (abbreviations: RMN = Registered Mental Nurse qualification)				
Facility Manager	Facility Manager (RMN)	Semi-structured and tape recorded **	Interview schedule two	Facility and Dept. of Geography
Psychiatric Nurse 1	Psychiatric Nurse (RMN)	Semi-structured and tape recorded	Interview schedule two	Office in case study facility
Psychiatric Nurse 2	Psychiatric Nurse (RMN)	Semi-structured and tape recorded	Interview schedule two	Office in case study facility
Psychiatric Nurse 3	Psychiatric Nurse (RMN)	Semi-structured and tape recorded	Interview schedule two	Office in case study facility
Support Worker 1	Support Worker (unqualified)	Semi-structured and tape recorded *	Interview schedule two	Office in case study facility
Support Worker 2	Support Worker (unqualified)	Semi-structured and tape recorded	Interview schedule two	Office in case study facility
Support Worker 3	Support Worker (unqualified)	Semi-structured and tape recorded	Interview schedule two	Office in case study facility
Support Worker 4	Support Worker (unqualified)	Semi-structured and tape recorded	Interview schedule two	Office in case study facility

Respondent Code	Status/Position at time of interview	Interview type and method of recording	Interview schedule no.	Location of interview
Key individuals interviewed for background information				
Key Individual 1	Treasurer of Base Green Tenants' Association	Semi-structured and tape recorded	Interview schedule three	Respondent's home
Key Individual 2	Former vicar (recently retired) of church next to Case Study facility. Involvement in negotiation for facility development.	Unstructured and notes taken	Specific topics ***	Respondent's home
Key Individual 3	Local councillor for Birley Ward (constituency that includes Base Green).	Unstructured and notes taken	Based on schedule three	Telephone interview
Key Individual 4	Co-ordinator of the Sheffield Branch of the National Schizophrenic Fellowship (a mental health charity organisation).	Unstructured and notes taken	Specific topics ***	Respondent's home
Key Individual 5	Community Psychiatric Nurse (CPN) who worked in Sheffield and has recently spent three months working in Italy.	Unstructured and notes taken	Specific topics ***	Respondent's office

Respondent Code	Status/Position at time of interview	Interview type and method of recording	Interview schedule no.	Location of interview
Base Green residents, all of whom lived within 250m radius from the Case Study facility				
Resident 1	Base Green resident	Semi-structured and tape recorded	Interview schedule four	Respondent's home
Resident 2	Base Green resident	Semi-structured and tape recorded	Interview schedule four	Respondent's home
Resident 3	Base Green resident	Semi-structured and tape recorded	Interview schedule four	Respondent's home
Resident 4	Base Green resident	Semi-structured and tape recorded	Interview schedule four	Respondent's home
Resident 5	Base Green resident	Semi-structured and tape recorded	Interview schedule four	Respondent's home

INTERVIEWS CONDUCTED IN VERONA

Respondent Code	Status/Position at time of interview	Interview type and method of recording	Interview schedule no.	Location of interview
Mental health professionals in Verona				
(abbreviations: CMHC = Community Mental Health Centre; CMHT = Community Mental Health Team (called an équipe in S. Verona))				
Psychiatrist 1	Director (' <i>Primario</i> ') of South Verona Community Psychiatric Service (CPS) and Professor of Psychiatry at the University of Verona.	Semi-structured and tape recorded	Interview schedule five	Respondent's office
Psychiatrist 2	Team leader of one of South Verona CPS's Community Mental Health Team (CMHT)	Semi-structured and tape recorded (in Italian)	Interview schedule five	Office in CMHC (Sector III)
Psychiatrist 3	Director (' <i>Primario</i> ') of Psychiatric Service for Sector II in Verona	Unstructured and notes taken (in Italian)	Specific topics ***	Respondent's office
Psychologist 1	Works at the CMHC which serves Sectors I and II (I spent half a day with psychologist 1)	Unstructured and notes taken (in Italian)	Specific topics ***	CMHC (Sectors I and II)
Mental health professionals working in Case Study facility				
Nurse 1	Professional Nurse, Manager (' <i>Caposala</i> ') of the South Verona CMHC and member of a CMHT	Semi-structured and tape recorded (in Italian)	Interview schedule five	Office in CMHC (Sector III)

Respondent Code	Status/Position at time of interview	Interview type and method of recording	Interview schedule no.	Location of interview
Nurse 2	Professional Nurse and member of a CMHT	Semi-structured and tape recorded (in Italian)	Interview schedule five	Office in CMHC (Sector III)
Nurse 3	Professional Nurse and member of a CMHT	Semi-structured and tape recorded (in Italian)	Interview schedule five	Office in CMHC (Sector III)
Nurse 4	Professional Nurse and member of a CMHT	Semi-structured and tape recorded (in Italian)	Interview schedule five	Office in CMHC (Sector III)
Nurse 5	Professional Nurse and member of a CMHT	Semi-structured and tape recorded (in Italian)	Interview schedule five	Office in CMHC (Sector III)
Nurse 6	Professional Nurse and member of a CMHT	Semi-structured and tape recorded (in Italian)*	Interview schedule five	Office in CMHC (Sector III)

Respondent Code	Status/Position at time of interview	Interview type and method of recording	Interview schedule no.	Location of interview
Mental health professionals who worked in residential facilities of South Verona CPS				
Facility Manager 1	Qualified manager (<i>'Educatore'</i>) of one of the residential facilities of South Verona CPS	Semi-structured and tape recorded (in Italian)	Interview schedule five	Room in facility
Facility Manager 2	Qualified manager (<i>'Educatore'</i>) of one of the residential facilities of South Verona CPS	Semi-structured and tape recorded (in Italian)	Interview schedule five	Room in facility
Support Worker 1	Unqualified support worker (<i>'Operatore'</i>) in one of the residential facilities of South Verona CPS	Semi-structured and tape recorded (in Italian)	Interview schedule five	Room in facility
Support Worker 2	Unqualified support worker (<i>'Operatore'</i>) in one of the residential facilities of South Verona CPS	Semi-structured and tape recorded (in Italian)	Interview schedule five	Room in facility

Respondent Code	Status/Position at time of interview	Interview type and method of recording	Interview schedule no.	Location of interview
Key individuals interviewed in Verona for background information				
Key Individual 1	Social worker with South Verona CPS and my Case Study 'Key contact'. Total of five meetings/informal interviews.	Unstructured and notes taken (in Italian)	Specific topics ***	Respondent's office
Key Individual 2	Director of a worker's co-operative 'Farsi Prossimo' which provides support workers to the South Verona CPS.	Unstructured and tape-recorded (in Italian)	Specific topics ***	Respondent's office
Key Individual 3	Priest of a Parish in South Verona, who had initiated the development of a new mental health facility, due to open in 1995	Unstructured and notes taken (in Italian)	Specific topics ***	Respondent's office and facility
Key individuals interviewed in Trieste for background information regarding mental health care reforms in Trieste and Italy as a whole				
Key Individual 4	Psychiatrist and Director ('Primario') of Barcola CMHC and sector (I spent 1.5 days with Key Individual 4)	Unstructured and notes taken (in Italian and English)	Specific topics ***	Various locations: CMHC; in the car; in facilities etc.
Key Individual 5	Psychiatrist of Trieste Mental Health Services and Director of the World Health Organisation Centre for mental health research (Friuli Venezia-Giulia Region)	Unstructured and notes taken (in Italian and English)	Specific topics ***	Respondent's office
Key Individual 6	Professional nurse and member of CMHT, based at Barcola (I spent half a day with Key Individual 6)	Unstructured and notes taken (in Italian)	Specific topics ***	Various locations (as KI 4)

Key

- * Tape recorded interviews which had poor recording quality due to a variety of different factors, e.g. disturbing background noise and therefore full transcripts could not be made. Written notes were made from what could be distinguished from the recording and used for background information.**
- ** The Sheffield Case Study Facility Manager gave two interviews. Of the first interview, only the first half came out with the second half being indistinguishable. As the Manager played a key role in the Case Study Facility and had previously worked in the mental health service in Sheffield for over twenty years and had provided a great deal of information regarding this, a second interview was arranged. The Manager came to my office at the University for the second interview.**
- *** For a number of interviews, the respondents had been selected for interview because of their particular role or experience. Therefore there were particular topics which I was interested in that were often unique to that respondent. Thus a more unstructured format was adopted with a limited schedule of a few key topics. As these interviews were mainly for background information only, they were not tape recorded.**

APPENDIX TWO: THE INTERVIEW SCHEDULES

INTERVIEW SCHEDULE 1

HEALTH PLANNERS AND PROFESSIONALS

Date:

Name:

Factual information - Job title and description / responsibilities

Role played by planning department in organisation (SHA / FHSA / F&CS)

Decision-making process behind location of mental health facilities.

Corporate strategy / policy on consultation with local residents - at what stage of proposal / development?

Influence of local community feelings / opposition to siting of mental health facilities on decision-making.

Examples of recent cases in Sheffield where there has been opposition from local residents concerning the location of mental health facilities.

Significance of community opposition compared to other possible problems of implementation of policy (wider context).

Definition and interpretation of 'successful' community care.

Concept of community - ideas about what constitutes a community, is it a geographical / sociological / administrative / political concept?

INTERVIEW SCHEDULE 2

Health Workers (who work in facilities)

- **Factual information** - how long worked there, where worked before, position etc
Always worked in mental health?
- **Lister Avenue** - How well do you think the tenants have adjusted to living here after Middlewood? Have they become more independent over time? Do they go out more on their own?
- **Local Community** - How have you found the local residents in their response to Lister Avenue itself and the tenants and you as staff? Has this changed over time? Is there much interaction between Lister Ave / the tenants / the local local community? Do you have any personal connections with this neighbourhood?
- **Concept of Community** - Do you feel that there is a sense of community in this neighbourhood? How would you define a 'community'...do you think that communities exist in today's society or is it something of the past?
- **Care in the community** - With regard to your view of community then, what do you think about the whole assumption of c.c. that there is a 'community' there is the first place to care for people like those here in Lister Ave?
- **Definition of community care** - how would you personally define c.c.? Do you think that c.c. is the right way forward for mental health? How can you foresee the future, positive or negative image?
- **Definition and interpretation of 'successful' community care.** What makes good c.c. in your opinion? Is Lister Ave an example of successful c.c. in your opinion? Is Lister Ave a typical example of a c.c. fac. or is it more unique in Sheffield
- How well is community care operating in Sheffield, and nationwide in your opinion? Are people falling through the 'net' ? Why?
- **Lister Ave Location** - Do you think that this is a good place for a facility? If so, why? Do you think that some places/locations are more suitable than others?
- **With regard to opposition to community based mental health facilities** - why do you think there is opposition in some places and not in others? Types of people who live there? Do you think that such negative reactions are understandable, can you empathise with them?

INTERVIEW SCHEDULE 3
SHEFFIELD KEY INDIVIDUALS

Date:

Name:

- **Factual information:** how long lived in Sheffield/this neighbourhood?
Involvement in local neighbourhood - activities/clubs/organisations.
- **Concept of community:** Do you feel that there is a strong sense of community in this neighbourhood?
- **Definition of a community:** How would you define a community - is it geographical/people? What are the boundaries of this community in your view?
- **Location of public facilities:** facilities that you would locate as far away as possible, reasons for this e.g. safety of yourself and family, property, value of house prices?
- **Action would take if opposed:** Have you taken such action before? What involvement did you have?
- **Community Care:** what do you think about the location of mental health facilities into residential neighbourhoods? Importance of proximity? Type of people?
- **Rights of residents:** do you think local residents should be entitled to be consulted by the health authority or council who wish to relocate people with mental health problems into their neighbourhood/street?
- **Lister Avenue:**
 - when did you first hear about this proposal?
 - were you/local residents consulted?
 - how do you think the H.A. dealt with the dev. and the consultation of local residents?
 - what were your initial feelings about the proposal?
 - what are your feelings/attitude now, have they changed?
 - any contact with the unit/staff/residents?
 - is this an example of 'successful' community care?
- **This neighbourhood:** Do you think that this is a good neighbourhood for people with mental health problems to be living in? Reasons why? If not, where/what type of facility would be a good place?

INTERVIEW SCHEDULE 4

BASE GREEN RESIDENTS

- **Factual information:** How long lived in Sheffield/this neighbourhood.
Involvement in local neighbourhood - length of time/what does it involve?
- **Neighbourhood activities:** What activities/clubs/organisations are there in this neighbourhood?
- **Concept of community:** Do you feel that there is a sense of community in this neighbourhood?
- **Definition of a community:** How would you define a community - is it geographical/people? What are the boundaries of this community, i.e. do most people who are involved in activities in this are actually live here?
- **Community care:** What do you think about the location of mental health facilities into residential neighbourhoods? Importance of proximity?
- **This neighbourhood:** Do you think that this is a good neighbourhood for people with mental health problems to be living in? Reasons why.
- **Lister Avenue:** Do you know about the mental health facility on Lister Avenue? Have you had any contact with the unit/staff/tenants, have you seen them around. Are you aware of any problems/complaints from local residents/shopkeepers?

Other comments

INTERVIEW SCHEDULE 5

MENTAL HEALTH PROFESSIONALS IN SOUTH VERONA

Introduction

- This interview is strictly confidential and is only for the purposes of my research.
- Use of the tape recorded in place of taking notes and in order to be able to listen again to passages that I don't understand immediately. I can turn it off when you want.

Information

- What work do you do? What are your duties / responsibilities?
- How long have you been doing this?
- Have you always worked with the mentally ill / in centres /services for mental health?
- Have you worked in a mental hospital / asylum?
- Do you work in a team?

Patients /Users

- How many people use the service?
- What do they do - what types of things?
- Where do they go during the day / daily / during the week?

The Community

- Do you live in South Verona?
- Do you think there are close relations between the residents of the district where you work (a sense of belonging to a community)/
- Have there been difficulties or protests by local people about the facilities for the mentally ill / people with problems of mental health?
- Have attitudes changed through time?

Law 180

- What do you think of Law 180?
- Do you think it is fair / efficacious
 - in Verona
 - in Italy as a whole?
- Why do you think that it might have been successful in some places, such as Verona, but not in others? North v. South.
- How do you think services for the mentally ill could be improved?

APPENDIX THREE: THE QUESTIONNAIRES

Sample area:
Interviewer:

Date:

AREA

Q1 How long have you been living in this neighbourhood?

- Less than a year (1)
- 1 to 5 yrs (2)
- 6 to 10 yrs (3)
- 11 yrs or more (4)

LONG

Q2 How many people living in this neighbourhood do you know ?

- None (1)
- 1 or 2 (2)
- 3 to 5 (3)
- 6 to 15 (4)
- 16 + (5)

MANY

Q3 What activities are you presently involved in within this neighbourhood?

Are you involved in.....	No	If Yes do you go	
		Occasionally	Frequently
sports clubs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (1)
other clubs (e.g. bridge)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (2)
bingo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (3)
the local residents association	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (4)
voluntary work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (5)
political organisations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (6)
a local church	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (7)
evening classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (8)
going to local pubs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (9)
going to a working mens' club	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (10)
using the local shops	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (11)
meeting other parents from childrens'school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (12)
other 1.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (13)
2.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (14)
TOTAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INVOL

Q4 Do you feel as though there is a strong sense of local community in this neighbourhood?

- Agree strongly (1)
- Agree slightly (2)
- Neither agree or disagree (3)
- Disagree slightly (4)
- Disagree strongly (5)
- Don't know (6)

SENSE

Q5 If you had the choice, how close to or far away from your home would you like the following facilities:

	Same Street	Same N'hood	Elsewhere in Town	As far away as possible
(General)				
Park	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
Prison	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
Primary school	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
Library	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
Psychiatric hospital	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
Dump site (refuse)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
(Residential)				
Home for elderly	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
Hostel for homeless	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
AIDS Hostel	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
Home for mentally ill	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)
Hospice	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)	<input type="checkbox"/> (4)

PARK

PRIS

SCHOL

LIB

PSYCH

DUMP

ELDER

HLESS

AIDS

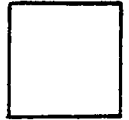
MENTI

HPICE

Q6 Thinking about a facility that you would choose to locate as far away as possible, if there was a proposal to locate such a facility close to your home, for example in the same street, what action do you think you might take?

Do you think you would do one or more of the following:

	Yes	No	Don't know
Attend meeting about facility	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (0)
Write to a newspaper or councillor	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (0)
Form protest group	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (0)
Do nothing	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (1)
Organise a petition	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (0)
Join protest group	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (0)
Consider moving	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (0)
Sign petition	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (0)
Organise a meeting	<input type="checkbox"/> (1)	<input type="checkbox"/> (0)	<input type="checkbox"/> (0)
TOTAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

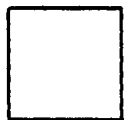


ACTON

The next few questions are about mental illness and community care. Can you tell me whether you would agree or disagree with the following statements:

Q7 We need to adopt a far more tolerant attitude toward people with mental illness in our society

- Agree strongly (1)
- Agree slightly (2)
- Neither agree or disagree (3)
- Disagree slightly (4)
- Disagree strongly (5)
- Don't know (6)



ATTIT

Q8 Having mental patients living within residential neighbourhoods might be good therapy, but the risks to residents are too great.

- Agree strongly (5)
- Agree slightly (4)
- Neither agree or disagree (3)
- Disagree slightly (2)
- Disagree strongly (1)
- Don't know (6)

RISK

Q9 As far as possible, mental health services should be provided through community based facilities

- Agree strongly (1)
- Agree slightly (2)
- Neither agree or disagree (3)
- Disagree slightly (4)
- Disagree strongly (5)
- Don't know (6)

COMM

Q10 People should have the right to exclude people with mental illness from their neighbourhood.

- Agree strongly (5)
- Agree slightly (4)
- Neither agree or disagree (3)
- Disagree slightly (2)
- Disagree strongly (1)
- Don't know (6)

EXCL

Q11 Do you know whether there is a residential home for the mentally ill in this neighbourhood?

- Yes (1)
- No (2)
- Don't know (6)

KNOW

If answer is YES, go to Q12, if answer is NO or don't know, go to Q14.

Q12 Where is it?

Correct location (1)

Incorrect location (2)

WHERE

Q13 Thinking of the people who live in the residential home, have you:

Yes No

Seen them walking around the neighbourhood? (1) (2)

Talked to them? a)because of your job (1) (2)

b)other (1) (2)

Visited where they live? (1) (2)

Invited any of them to your home? (1) (2)

Other(1)

SEEN

TALKJ

TALKO

VISIT

INVIT

OTHER

SEX

These last questions ask for some brief details about yourself. These are just for statistical purposes and are treated in the strictest confidence.

Q14 Respondent's gender

Male (1)

Female (2)

Q15 Which is your age group?

18 - 34 (1)

35 - 49 (2)

50 - 69 (3)

70 + (4)

AGE

Q16 Which type of accommodation do you live in?

Rented (council) (1)

Rented (housing association) (2)

Rented (private landlord) (3)

Owner occupied (incl.mortgage) (4)

Other (5)

ACCOM

If an owner occupier go to Q17, if not go to Q18:

Q17 If owner occupier, were you an owner occupier in this property when you first lived here?

- Yes (1)
 No (tenant first, then bought house) (2)
 Other (3)

OWNER

Q18 Do you have any children?

- Yes (1)
 No (2)

CHILD

If Yes go on to Q19, if No go to Q21

Q19 How many children do you have living at home under eighteen?

- 1 to 2 (1)
 3 to 4 (2)
 5 to 6 (3)
 6 + (4)

MANC

Q20 What are their gender and ages?

	M	F	0-11yrs	12-18yrs
Child 1	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)
Child 2	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)
Child 3	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)
Child 4	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)
Child 5	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)
Child 6	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)
TOTAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GENAG

Q21 What is your occupation ?

.....

OCCUP

Q22 Can you tell me the occupation of the person who acted as head of household in the 1991 census

.....

CENCP

Q23 Can you tell me at what age did you leave full time education?

- under 16 (1)
- 16 - 17 (2)
- 18 - 20 (3)
- 21 + (4)
- Still in full time education (5)

EDUC

THANK YOU FOR PARTICIPATING IN THIS SURVEY

Would you like any information about the findings of this survey to be sent to you?

- Yes (1)
- No (2)

INFO

Would you be willing to be interviewed at a later time?

- Yes (1)
- No (2)

INTER

If yes, can I please take your name and a contact telephone number

.....

Area Campione:

Data consegna:

Data raccolta:

Per favore
non scrivete
in questo
spazio

N.1 Da quanto tempo vivete in questo quartiere?

- meno di un anno
- da 1 a 5 anni
- da 6 a 10 anni
- 11 anni o più

AREA
TEMPO

N.2 Quante persone del vostro quartiere conoscete?

- nessuna
- 1 o 2
- da 3 a 5
- da 6 a 15
- 16 o più

CONOS

N.3 Frequentate i seguenti luoghi di ritrovo del vostro quartiere?

- | | No | Se si:
Ogni tanto | Spesso |
|---|--------------------------|--------------------------|--------------------------|
| centri per attività ricreative
(sport, giochi ecc....) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| parrocchia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| centri di volontariato | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| corsi serali | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| bar/locali | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| cinema/teatro | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| negozi locali | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| altro 1..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

FREQ

N.4 Ritenete di avere un stretto rapporto con il vostro vicinato?

- si
- poco
- no
- non so

STRET

N.5 Se doveste scegliere, dove preferireste avere i seguenti servizi rispetto a dove vivete:

	Stessa strada	Stesso quartiere	Altrove a Verona	Il più lontano possibile
casa di riposo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
prigione	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
biblioteca	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
manicomio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
discarica rifiuti	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
scuola elementare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
alloggio per i senzatetto	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
parco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ricovero per malati di mente	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- RIPOS
- PRIGI
- BIBLI
- MANIC
- DISCA
- SCUOL
- SENZA
- PARCO
- MENTE

Le seguenti domande riguardano i malati di mente e i servizi sociali a loro favore:

N.6 Ritenete che ci dovrebbe essere più tolleranza verso i malati di mente?

- si
- poco
- no
- non so

TOLER

N.7 Ritenete che la presenza di malati di mente nel quartiere, nonostante rappresenti una buona terapia per loro, comporti rischi troppo gravi per i residenti?

- si
- poco
- no
- non so

RISCH

N.8 Ritenete che i servizi rivolti ai malati di mente dovrebbero essere il più possibile localizzati in centri sociali invece che nei manicomi?

- si
- poco
- no
- non so

CENTR

N.9 Pensate che ci dovrebbe essere il diritto di escludere i malati di mente dal proprio quartiere?

- si
- poco
- no
- non so

DIRIT

N.10 Siete a conoscenza della presenza, nel vostro quartiere, di strutture a favore dei malati di mente?

- si
- no
- non so

STRUT

Se la risposta è No o Non so, andate alla domanda N. 12

N.11 Dove sono localizzate?

.....

.....

.....

DOVE1

DOVE2

DOVE3

N.12 I malati di mente del vostro quartiere:

- | | Si | No |
|--|--------------------------|--------------------------|
| li vedete passeggiare per la strada? | <input type="checkbox"/> | <input type="checkbox"/> |
| avete mai parlato con loro? a) per lavoro (negozi ecc) | <input type="checkbox"/> | <input type="checkbox"/> |
| b) per altri motivi | <input type="checkbox"/> | <input type="checkbox"/> |
| siete mai stati a casa loro? | <input type="checkbox"/> | <input type="checkbox"/> |
| li avete mai invitati a casa vostra? | <input type="checkbox"/> | <input type="checkbox"/> |
| altro..... | | |

VEDE

PARLJ

PARLO

LORO

VOSTR

ALTRO

Le domande che seguono servono solamente a scopo statistico. Garantiamo la dovuta riservatezza sulle informazioni che ci verranno fornite.

N.13 Siete:

- Maschio
- Femmina

SESSO

N.14 A quale fascia di età appartenete?

- 18 - 34
- 35 - 49
- 50 - 69
- 70 +

ETA

N.15 Vivete in un alloggio:

- in affitto a) case popolari
- b) alloggio privato
- di vostra proprietà
- altro

ALLOG

Se non siete proprietari del vostro alloggio, andate alla domanda N. 17

N.16 Siete sempre stati proprietari del vostro alloggio?

- si
- no (prima in affitto, poi proprietari)
- altro

PROPR

N.17 Avete figli?

- si
- no

FIGLI

Se la risposta è No, andate alla domanda N. 19

N.18 Quanti figli di età inferiore ai 18 anni vivono in casa?

- nessuno
- 1
- 2 o 3
- 4 +

QUANF

N.19 Ci sono altri parenti (non appartenenti al classico nucleo familiare di genitori/figli) attualmente alloggiati presso di voi?

si
no

PAREN

N.20 Che lavoro fate?

.....

LAVOR

N.21 Qual è il vostro grado di istruzione?

scuola media inferiore
diploma di scuola media superiore
laureato/a
studente
altro

GRADO

GRAZIE PER LA COLLABORAZIONE.

SE AVETE CONSIDERAZIONI DA FARE SULL' ARGOMENTO, VOGLIATE INDICARLE DI SEGUITO:

.....
.....
.....
.....
.....
.....
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.....
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.....
.....



UNIVERSITÀ DEGLI STUDI DI VERONA
FACOLTÀ DI ECONOMIA E COMMERCIO
ISTITUTO DI GEOGRAFIA ECONOMICA

37129 VERONA,
Via dell'Artigliere, 19 - Tel. 8098421 - Fax 8098537

Egregio Signore / Gentile Signora,

Il questionario che segue fa parte di una ricerca condotta nel quartiere per studiare il rapporto dei residenti con il proprio vicinato. In particolare siamo interessati alla Sua opinione riguardo la distribuzione di strutture e servizi pubblici nel quartiere, e soprattutto le strutture di sostegno per i malati di mente.

Voglia essere così gentile da rispondere: ci vorranno solo 5 minuti.

Le informazioni che ci vorrà fornire sono raccolte esclusivamente a scopo di indagine e sono strettamente confidenziali ed anonime: il Suo nome non è richiesto e la Sua abitazione è stata scelta con assoluta casualità all'interno del quartiere.

Per qualsiasi domanda, non esiti a contattare il Dipartimento indicato nell'intestazione, chiedendo della Dott.sa Jones.

Il Suo questionario (compilato o meno) sarà raccolto il ____/____/____.

Cortesemente lo voglia lasciare nella cassetta della posta o in prossimità.

Grazie.

APPENDIX FOUR: INVENTORY OF SHEFFIELD MENTAL HEALTH SERVICES

(1994)

	RESIDENTIAL SERVICE	FACILITY	LOCATION	MANAGED BY	PLACES			
1	Acute/Crisis	Acute Psychiatric in-patient services	Northern General Hospital	Community & Priority Care Services	83 total			
2			Psychiatric Unit, Wards 53,54,56					
3			Whitely Wood Clinic Sheffield 11 Eastgate, Middlewood Hospital					
4	Rehabilitation and Continuing Care	Woodside Unit	Middlewood Hospital	Community & Priority Care Services	66			
5		Northfield Clinic	Middlewood Hospital	Community & Priority Care Services	10			
6		Rehabilitation Services Unit	Middlewood Hospital	Community & Priority Care Services	1x12 bed unit 3x3 bed rehab training units Total = 21			
7		Lister Avenue Project	Basegreen Road	Family and Community Services	1x7 bed unit 2x5 bed houses 2x4 bed houses Total = 25			
8		Abbeyfield Grange	Burngreave	Independent Sector	20 bed unit plus 6 bed house Total = 26			
9		Eagle House Nursing Unit	Sharrow	Independent Sector	24 bed unit			
10		Eagle House Residential Unit	Sharrow	Independent Sector	4x4 bed bungalows Total = 16			
11	Carrwood House Residential Home	Pitsmoor		Independent Sector	1x14 bed unit 1x2 - flats 1x5 bed house 1x12 cottage Total = 33			
12					Westbourne House	Hillsborough	Voluntary Sector	1x10 bed unit
13					Community Action Halfway Home Ltd	Nether Edge, Hillsborough, Upperthorpe	Voluntary Sector	2x5 bed houses 4 flats 2x2 bed houses Total = 18-20
15					Wainwright Crescent	Intake	Family and Community Services	1x7 bed unit
16					Hascot House	Heeley Green	Independent Sector	1x8 bed unit
17	Hollinsend Road Project	Gleadless	Family and Community Services	4				
18	House of Help	Carterknowle	Voluntary Sector	1x12 bed hostel				
19	The Knowle	Nether Edge	Independent Sector	1x11 bed unit				
20	St Pellegrino Hotel	Broomhill	Independent Sector	1x23 bed hotel				
21	Salvation Army	City Centre	Voluntary Sector	8				
22	Sandford House Residential Home	Nether Edge	Independent Sector	1x13 bed unit				
23	Burgoyne Road Project	Langsett	Voluntary Sector	5				
24	Ivy Lodge Project	Broomhill	Voluntary Sector	5				
25a 25b	Core and Extended Core Project	Broomhill	Broomhill	Voluntary Sector	20			
26					Beaufort Road Project	Broomhill	Voluntary Sector	6
27a 27d					The Cluster Project	Crookesmoor Broomhill Manor	Voluntary Sector	22
27b 27c	Sheffield MIND Accommodation Project	Hillsborough, Foxhill, Longley		Voluntary Sector	2x2 bed house			
28a 28b					1x3 bed house			
28c	Shirecliffe Lawns Residential Home	Burngreave		Independent Sector	1x33 bed unit			
29					2x4 bed house			
30	Wootton House	Broomhill	Voluntary Sector	1x13 bed unit				
31	St Elizabeth's Close	Park	Voluntary Sector	14 plus 1 emergency bed				

	DAY SERVICES	FACILITY	LOCATION/SECTOR	MANAGED BY	PLACES
1	Acute/Crisis	Barnsley Road	Firvale	Community & Priority Care Services Unit	Average 30, 15 per day
2		Yews Day Hospital	Worrall	Community & Priority Care Services Unit	
3		Coalbrook House	Woodhouse	Community & Priority Care Services Unit	Average 45, 12-15 per day
4		Beighton Hospital	Beighton	Community & Priority Care Services Unit	SE - max 12, 8 per day SW - max 18, 12 per day
5		Northern General Psychiatric Unit	Firvale	Community & Priority Care Services Unit	
6	Rehabilitation and Continuing Care	City Road	South East Division	Family and Community Services	80
7		Moncrieffe Road	South West Division	Family and Community Services	70
8		Pitmoor Road	Central/North East Division	Family and Community Services	80
9		McMurphys	Central Division	Voluntary Users	Approx. 20 per session
10		National Schizophrenia Fellowship (at Carver Street Chapel)	Central	Voluntary Sector	Approx. 20 per session
11		MIND - Lawton Tonge House	South West Division	Voluntary Sector	Approx. 10-20 per session
12		St Wilfred's Drop In Day Centre	Central Division	Voluntary Sector	Approx. 70 people
		Carmel Centre	North West Division	Voluntary Sector	Variable
13		Sheffield Afro Caribbean Mental Health Association Project	Central Division	Voluntary Sector	Approx. 20 people per session
14		St Bartholomew's Church Centre	North West Division	Voluntary Sector	Approx. 70 people per session

COMMUNITY SERVICES

	SERVICE	MANAGED BY
Acute	Community Mental Health Teams x 5 Crisis Response	Community & Priority Care Services Unit
	Out of Hours Crisis Response	Community & Priority Care Services Unit
	General Practitioners and Primary Care Teams	Family Health Services Authority
Health Service	Approved Social Workers	Family and Community Services Unit
	General Practitioner and Primary Care Teams	Family Health Services Authority
	Community Mental Health Teams x 5 including the Community Rehabilitation Team	Sheffield Health Authority
	Out-patient Clinics	Sheffield Health Authority
	Psychotherapy Services	Sheffield Health Authority
	Woodside Project Team	Sheffield Health Authority
Family and Community Services	Howard Road Support Unit	Family and Community Services
	Southey Green Road Community Support Service	Family and Community Services
	Wainwright Crescent Community Support Service	Family and Community Services
	Social Workers	Family and Community Services
	Community Care Team	Sheffield City Council
	Homelessness Section	Sheffield City Council
	Homecare/Family Aids	
	Sheltered Employment <u>Whitbread</u>	
	Norfolk Park Project	Sheffield Health Authority, Family and Community Services

INDEPENDENT SECTOR

The independent sector offer a range of individual and group interventions for both traditional and alternative therapies including hypnotherapy, aromatherapy, psychotherapy, stress management etc.

COMMUNITY SERVICES

Independent Sector

SERVICE

Co Counselling in Sheffield
Footprint Counselling Services
People in Sheffield
Share Psychotherapy Agency
Sheffield School of Christian Psychotherapy and Counselling
Sheffield Women's Co Counselling Group
Sheffield Women's Counselling and Therapy Service
Community Action Halfway Home
South West Community Support Scheme
SACMHA
The Thursday Club
The Wednesday Group
Mentally Ill Action Group
Advice Centres
Nomad Homeless Advice and Support Unit

Voluntary Sector

* In addition there are a number of voluntary groups which offer support to carers of people with a mental health problem and campaigning groups, for example the National Schizophrenia Fellowship, the Mental Health Forum and the Community Health Council.