

UK Mental Health Policy and Practice

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Introduction

Over five decades, we have seen major changes in mental health policy for adults and for young people, often influenced by shifts in the broader social, political and economic environment. This chapter summarises some of the main changes, drivers and issues, including the introduction of care in the community and the emergence of new discourses around recovery, marketisation and risk during the period 1960–2010.

From Asylum to Community Care

The Mental Health Act 1959 was a step change from previous legislation in foregrounding the provision of treatment, rather than mere confinement, as the core purpose of mental health services. This reflected wider changes in services, with informal treatment becoming available not only for inpatients but also for those outside hospital (with 144,000 outpatient clinic attendances in 1959 compared to virtually none in 1930). However, mental health was still very much a ‘Cinderella service’, with Mental Health and Mental Deficiency Hospitals containing 40 per cent of NHS inpatient beds but receiving only 20 per cent of the hospital budget.¹

With a populist’s ability to identify issues which chimed with the mood of the age, the Conservative health minister, Enoch Powell, saw the old Victorian asylums as being out of step with emerging expectations of a modern Britain. As well as being overcrowded and offering poor standards of care, their very architecture resonated as an uncomfortable symbol of a bygone age of Poor Law and Workhouse. In 1961, Powell captured this in his famous ‘Water Tower speech’ (for more details, see Chapters 1, 31).² He also recognised the attitudes, customs and practices (both social and professional) which were embodied in these buildings – the ‘sheer inertia of mind and matter’ – that would need to be overcome if services were to be transformed.

This landmark speech was followed by *A Hospital Plan for England and Wales*, which proposed the development of small-scale psychiatric units in District General Hospitals, with local authorities providing a full range of community services.³ Much of this chimed with the aspirations of the more progressive elements within the mental health professions, who were keen to move out from the isolation (and perceived inferiority) of the old asylums and become part of mainstream health and social services provision. It suited both those with a more biological persuasion, with its emphasis on treatment rather than containment, and the emerging movement of social psychiatry with its emphasis on the social aspects of rehabilitation. However, despite the recognition of what was needed, and cross-party support for this agenda, financial pressures and institutional resistances continued to

undermine any substantial implementation of community care. Although inpatient numbers were falling (from 160,000 in 1954 to 100,000 in 1974), there was inadequate investment in new community-based alternatives and concerns were starting to be expressed about the gap between rhetoric and reality.⁴

Recognising this, Barbara Castle, the Labour health minister, introduced the 1975 White Paper *Better Services for the Mentally Ill*.⁵ This made explicit the level of community-based NHS and local authority provision that should be provided per 100,000 population, assuming a roughly equal commitment by the NHS and local authorities, with the latter taking on the main responsibility for those requiring longer-term support and reintegration into mainstream community living. It stated that 'joint planning of health and local authority services is essential' and that 'the policy can only be achieved if there is substantial capital investment in new facilities and if there is a significant shift in the balance of services between health and the local authority'.⁶ What was less explicit were the mechanisms whereby this joint planning would be achieved; how 'bridge funding' could be provided for investment in new facilities before old hospitals could be closed and savings made; and how resources could be transferred from the NHS to local authorities to provide social care. These concerns were amplified by the unfortunate timing of the White Paper, coinciding with economic adversity following the oil crisis of 1973.⁷

Nevertheless, government funding was made available to pilot the proposed model of service provision in Worcestershire in an experiment known as the Worcester Development Project.⁸ This allowed for comprehensive services to be established in the community without having to wait for any capital to be released and revenue saved from the closure of the old hospital. On the ground, progress was patchy, with teams in one part of the county moving quickly to relocate all their residents from the former asylum, while others were less committed to giving up previous ways of working – leading to a considerable delay in bringing about its final closure. Although GPs generally saw the new services as better for their patients, they also expressed concerns that they themselves were not properly trained for taking on a greater role in mental health.⁹

Although the intention was for this blueprint for a community service to be properly evaluated, this was not followed through. As a result, lessons were not learned as to what was actually needed, how much it would cost and how quickly the old hospitals could actually close – impeding further roll-out of the new service model. Whereas the Worcester Development Project had the benefit of bridging finance, this was not available elsewhere. Consequently, many people were discharged into lodgings or unsuitable accommodation with minimal support, arousing increasing public concern. During the hospital closure phase, more attention tended to be given to establishing psychiatric teams in new facilities in District General Hospitals than to integrating people back into mainstream community life. Crucially, there was no mechanism to transfer over funds to local authorities to create an appropriate infrastructure of community-based support.

A somewhat different story characterised developments in children's services. Here, there had been an established model of Child Guidance Clinics, located within local authority education services and having a strong psychosocial ethos. However, separate NHS hospital-based psychiatric services for young people were also now being developed alongside new adult provision. Early debates in the 1960s were about how to better integrate these service arms – but with little success.¹⁰ Things came to a head (largely spurred on by all too familiar debates about a lack of adolescent inpatient beds and who should pay for what) in the 1986 report *Bridges Over Troubled Waters*.¹¹ This resulted in the advent of an

integrated Child and Adolescent Mental Health Service (CAMHS) that was no longer split between the NHS and local authorities. However, there remained a lack of clarity as to how this should operate in practice, with the first national guidelines not arriving until the mid-1990s – and CAMHS remained hampered by lack of substantive financial investment.

Rights and Recovery

Although the 1959 Mental Health Act had been welcomed as a great advance, by the late 1970s the government and other stakeholders were suggesting that a review would be timely. Led by their legal director, Lawrence O. Gostin, Mind ‘argued that many aspects of the treatment of those diagnosed as mental ill were an abuse or denial of their rights’.¹² Although the 1983 Mental Health Act retained much of the overall structure of the 1959 Act, a series of stronger safeguards were built in to enshrine the principle of the ‘least restrictive alternative’, including greater independence (and training) for Approved Social Workers; stronger (and quicker) rights of appeal for detained patients; and greater use of second medical opinions in relation to more controversial treatments such as psychosurgery and electroconvulsive therapy. Notably absent from the debates leading up to the new Act was any public or political concern as to the inherent dangerousness of people with mental health difficulties and hence any paramount necessity to protect the public against such people.

A little later in the decade, a new discourse emerged around the rights of young people to protection – which was reflected in the United Nations Convention on the Rights of the Child and the 1989 Children Act. This increased awareness of the need for more specific services to support children and young people with their mental health and well-being.¹³ However, while this had more tangible impacts on local authority children’s services (as in the provision of guardians ad litem to represent children’s interests in court), it was less influential in relation to mental health where, for example, young people could still be sectioned and sent to adult psychiatric wards without any specific safeguards being put in place.

Linking in with wider movements around disability activism, people with lived experience of mental distress (often describing themselves as ‘survivors’ of the mental health system) started to assert their own voice through campaigning organisations such as Survivors Speak Out and the UK Advocacy Network and, to an increasing extent, voluntary organisations such as Mind. Particularly influential was the movement in the 1990s to claim and redefine the term ‘recovery’.¹⁴ Activists such as Pat Deegan in the United States and Ron Coleman in the UK promoted the idea of recovery as reclaiming a life worth living – where it would be for the person (and not professionals) to define what that life would look like. It offered a paradigm shift towards a more co-productive approach to practice – one that did not always sit easily with some of the established attitudes and practices of mental health professionals in its emphasis on areas such as empowerment, peer support and social inclusion.¹⁵

This user voice and the idea of recovery were influential in the development of the National Service Framework – although perhaps not as influential as many would have liked. Instead, it was articulated in documents that were less central to policy implementation: *The Journey to Recovery: The Government’s Vision for Mental Health Care* and *A Common Purpose: Recovery in Future Mental Health Services* (the latter in collaboration with the Royal College of Psychiatrists).¹⁶ Rather than transforming the mainstream of

service provision, its influence tended to be in more circumscribed developments, such as the emergence of Recovery Colleges. Concerns started to be expressed that the idea of 'recovery' had lost its radical edge and had been appropriated by professional interests to support their agendas – for example, as a pretext for withdrawing services.¹⁷ This marginalisation of user-defined recovery reflected a deep ambivalence within the system as to how (and whether) to move beyond rhetoric and situate people not as patients to be cured but as collaborators in their own recovery journeys.

Marketisation

This focus on rights was soon to be overtaken by a newly emerging discourse about management and efficiency in the delivery of public services – which came to dominate the policy agenda during Margaret Thatcher's premiership. Driven by the ideologies of neoliberalism and New Public Management that were taking hold in the United States, the priority was to make public services more efficient and 'business-like' using market mechanisms. A key proposal, based on the ideas of an American economist, Alain Enthoven, was that responsibility for purchasing care and providing services should be separated (the purchaser/provider split). NHS services would be bought from self-governing NHS Trusts which, in theory, would compete with one another, thereby encouraging greater responsiveness and cost-efficiency. A parallel (but different) marketisation of social care was introduced in the NHS and Community Care Act 1990, with local authorities as lead purchasers and the bulk of provision contracted out to the voluntary/private sectors (see also Chapter 3).

For mental health services, this fragmentation within and between different parts of the health and social care system simply exacerbated existing difficulties in ensuring strategic and operational collaboration. Partnership working was, in effect, part of government rhetoric rather than a practical possibility.¹⁸ With no mechanism in place for enabling (or ring-fencing) a shift of funding from hospital beds to community care, many local authorities saw an opportunity, at a time of financial pressure, to cut back or abdicate many of their responsibilities in relation to mental health – apart from the statutory duty of providing Approved Practitioners to assess people under the Mental Health Act.

By contrast, relatively unaffected by marketisation, a more coherent approach was being taken forward in CAMHS. In *Together We Stand*,¹⁹ a tiered model was proposed in which different levels of support and expertise were available in response to different levels of need. This was well received and described as a policy that 'captured the imagination of all and triggered a clear commitment to improve services'.²⁰ However, an unintended consequence was to compound existing problems around transitions (as most areas continued to only see children up to the age of sixteen, with adult services starting from the age of eighteen) – with no provision at all in some areas for sixteen-to-eighteen-year-olds who were either too old or too young for services.²¹

Risk and Public Safety

The primacy of economic efficiency as a policy driver came to be displaced by new discourses around risk and dangerousness that had become a key feature of 'late modernity' in the latter part of the twentieth century.²² There emerged a widely held perception, aided and abetted by both politicians and professional interests, that risk and unpredictability could be eradicated across society by the appropriate application of management tools and

technologies. While this had some positive impacts, for example in improving health and safety practices within industry, its impact on mental health services was less benign (see Chapter 23). By its very nature, mental distress challenges deeply embedded notions of rationality and predictability that underpin the organisation of civil society,²³ so it is perhaps not surprising that efforts to manage this perceived threat took on almost totemic significance for government. Despite the evidence that very few people with mental health problems commit homicides – and that the proportion of overall homicides committed by people with serious mental health problems has actually tended to decline during the transition to community care – certain incidents (in particular the death of Jonathan Zito on 17 December 1992) provided the focus for a widespread ‘moral panic’ fanned by the media (see also Chapters 23, 27, 28).²⁴

While analysis of findings from homicide inquiries suggests that an investment in improving overall service quality and accessibility, rather than in devoting professional time to formal risk management procedures, is more likely to prevent potentially avoidable deaths,²⁵ this has not been reflected in policy or practice. Despite popular (and sometimes professional) misconceptions, research was demonstrating that, using the best available tools, practitioners working in the community cannot predict risk with an accuracy that is of any practical use.²⁶ This led to the unequivocal conclusion that:

The stark reality is that however good our tools for risk assessment become . . . professionals will not be able to make a significant impact on public safety.²⁷

Nevertheless, practices of risk assessment and management came to dominate both policy and practice in the 1990s and 2000s, often to the detriment of more progressive recovery-oriented practice. However, more recently, there have been some shifts towards more collaborative approaches to ‘positive risk taking’,²⁸ recognising that some degree of informed risk is part of normal life and that people cannot move towards recovery if they are overprotected (and potentially over-medicated).

One consistent finding from homicide inquiries was that people were often ‘slipping through the net’ because professionals and agencies were not working collaboratively or communicating well with one another. Unfortunately, this tendency was only exacerbated by the Thatcher government’s market-led reforms. In the early 1990s, while one part of the Department of Health was drafting the NHS and Community Care Act and associated guidance, another part was introducing the Care Programme Approach (CPA) to promote better inter-agency working in managing the risks which were seen to be posed by people with mental illness.²⁹ While the former focused on assessment in relation to a concept of *need*, the latter was concerned with the assessment of *risk*. The former proposed that the key professional role was the *care manager* who had a limited role in terms of assessing need and purchasing services to meet that need. The latter prescribed a much more ‘hands-on’ role for the *key worker* (later renamed care co-ordinator) who would have an ongoing relationship with the service user, working with them to make sure that they were properly supported and services co-ordinated. In practice, the lack of integration between the two methods ‘resulted in duplication of effort, excessive bureaucracy and construction of a barrier to effective joint working’.³⁰ This only started to be acknowledged by government in revised guidance, *Building Bridges*,³¹ and, when this manifestly failed to resolve the splits and confusions, in a subsequent report entitled (with perhaps unconscious irony) *Still Building Bridges*.³²

Modernisation of Mental Health Services

New Labour's approach to mental health policy from 1997 reflected somewhat contradictory drivers. On the one hand, there was a mounting concern in relation to the supposed dangerousness of people with mental health problems – as exemplified by the health secretary's assertion that 'care in the community has failed'.³³ On the other, there was a genuine concern to improve the effectiveness of services and take seriously issues such as stigma and discrimination.

Modernising Mental Health Services provided the first comprehensive government statement about the future direction of mental health policy since *Better Services for the Mentally Ill* in 1975. The following year, the *National Service Framework (NSF) for Mental Health in England* set out a ten-year plan for the development and delivery of mental health services for adults of working age,³⁴ with similar frameworks being produced by the devolved governments in Scotland and Wales. For the first time, there was a focus on mental health promotion – although mental health only came to be formally part of the public health agenda in England much later. For people with serious mental ill-health, the NSF encouraged implementation of functionalised mental health teams (Assertive Outreach and Crisis Resolution), putting greater organisational emphasis on services that could keep people out of hospital – but inadvertently taking the focus away from improving the effectiveness of hospital care itself (see also Chapters 11, 30). Probably the most influential innovation was the mainstreaming of Early Intervention in Psychosis teams, introducing an integrated psychosocial approach that was developed out of research in Australia and the UK.³⁵ Somewhat uniquely, these services spanned the divide between provision for adolescents and young adults – but only for young people with psychosis.

Following on from the NSF, there was a new stress on promoting social inclusion for people with mental illness and in ensuring that services benefited all sections of the population. A flurry of new policy documents emerged, including *Mainstreaming Gender and Women's Mental Health*, *Delivering Race Equality: A Framework for Action* and *Personality Disorder: No Longer a Diagnosis of Exclusion*.³⁶ Beyond this, there was a recognition that taking this agenda forward would require concerted action across government – work that was led by the Social Exclusion Unit within the Office of the Deputy Prime Minister.³⁷

Set against the mainly progressive thrust of much of this policy agenda was a countervailing tendency driven by an overriding concern about managing risk. In framing his introduction to *Modernising Mental Health Services*, Frank Dobson, then secretary of state for health, promised that 'we are going to ensure that patients who might otherwise be a danger to themselves and others are no longer able to refuse to comply with the treatment they need'. This promise became translated into a political push, against concerted opposition from user and professional organisations (including the Royal College of Psychiatrists), to replace the 1983 Mental Health Act with more restrictive legislation. A first step was the appointment of an expert advisory committee under the chair of Professor Genevra Richardson in 1998. Unfortunately for the government's agenda, the committee decided to take a more balanced approach and recommended that the new legislation should foreground the principles of non-discrimination, consensual care and capacity – and that there should be a 'bargain' in which the state's right to take away people's liberty was to be balanced by a statutory duty to provide appropriate services (which, in many instances, might obviate the need to employ compulsion). In a somewhat cavalier

way, the government chose to ignore the committee's recommendations and went ahead in setting out their agenda in the subsequent White Paper, *Reforming the Mental Health Act*.³⁸

The most contentious aspect of the 2007 Mental Health Act was the introduction of Community Treatment Orders (CTOs). Under this provision, patients discharged from hospital could be required to accept medical treatment outside of hospital or face the sanction of a swift recall to hospital. Perhaps for fear of appearing 'soft' on public safety, CTOs came to be used much more widely than originally envisaged – despite the evidence from a randomised trial which showed that CTOs did not improve the effectiveness of community care as people on CTOs were just as likely to require readmission and did not experience any significant improvement in clinical or social functioning.³⁹

From Illness to Well-being

The early 2000s saw an emerging political interest in the well-being of the general population alongside the need to better provide for those with more serious mental health problems difficulties. In 2006, Lord Layard, a health economist at the London School of Economics, published an influential report on the costs of failing to treat anxiety and depression.⁴⁰ The report stated that around 2.75 million people in England visited GP surgeries each year with mental health problems but were rarely offered effective psychological treatments. The central tenet of this argument was economic, based on the number of people unable to work due to mental health problems. Layard argued that 'someone on Incapacity Benefit costs £750 a month in extra benefit and lost taxes. If the person works just a month more as a result of the treatment (which is £750), the treatment pays for itself.'⁴¹ In response, the government announced funding for a new Improving Access to Psychological Therapies (IAPT) programme, with a commitment to train 3,600 new therapists to offer a limited number of sessions of psychological treatment to more than 500,000 people. Whether or not this initiative delivered on its intended economic outcomes has not been evaluated, and the only comparative study to be conducted found that, while patients' well-being and mental health had improved over four- and eight-month intervals, outcomes were not significantly better than in comparator sites.⁴²

Beyond the relatively narrow focus of the IAPT programme, the prioritising of mental well-being outcomes within wider social and economic policy initiatives came to achieve greater traction, particularly in Scotland. In England, a broader cross-governmental focus on mental well-being was taken forward in subsequent articulations of policy, *New Horizons* and *No Health without Mental Health*.⁴³ However, there was little ownership of these strategies within government (nationally or locally) and they were not accompanied by any funding or delivery mechanisms by which to translate such high level visions into reality. They did not link to any concerted investment in measures that might have ameliorated those adverse personal, social and economic circumstances that increase the likelihood of developing mental health problems – and, in particular, those adverse experiences affecting young people.⁴⁴

Conclusion

As is usually the case with reviews of policy development, the picture that emerges is not one of consistent direction or continuous improvement. It is instead characterised by the influence of major competing discourses and pressures that both emerged internally within and more usually came to bear from outside of the immediate field of mental health (often

influenced by broader economic, social and political changes). Overall, it is probably fair to judge that mental health services in 2010 were both substantially more effective and significantly more humane than those prevailing in 1960. However, were we to start with a blank sheet of paper and to design the most effective mental health service within the resources available, it might still bear relatively little resemblance to what has emerged over time. Of course, no generation starts with a blank sheet of paper, and there remains the challenge of how to think 'big' enough and engage co-productively with communities and those with experience of mental health difficulties, alongside professionals and other stakeholders, in envisioning and implementing a properly 'joined-up' strategy for delivering better mental health.

Key Summary Points

- The Mental Health Act 1959 and *A Hospital Plan for England and Wales* in 1962 set a direction for mental health services away from inpatient and towards outpatient and community care which enjoyed support across the political spectrum.
- There has been a shift of focus over time from rights and recovery to marketisation, risk and safety, modernisation and, finally, to well-being.
- There has been greater coherence in policy and consensus among staff in child and adolescent mental health than its adult counterpart, but service developments were hampered by chronic underfunding.
- Though, overall, it is probably fair to judge that mental health services in 2010 were both substantially more effective and significantly more humane than those prevailing in 1960, they have not fulfilled the aspirations held widely at the beginning of the period.

Acknowledgements

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