

MENTAL HEALTH POLICY FOR NURSES

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1 THE HISTORY OF MENTAL HEALTH POLICY IN THE UNITED KINGDOM

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Chapter Overview

In this introductory chapter to the book Professor Nolan provides an overview of mental health policy in the UK. Like any book there is a very good chance that by the time this is read there will have been further developments and occurrences of note, however, he has provided you the reader with an opportunity to see the development of policy in a broad historical sweep and with reference to social events that may well have informed the policy development. As alluded to in the introduction to this volume, policy does not occur in a vacuum.

So as you will see here there are wider social and political events and movements that can be said to have shaped the world within which you now practise. The history of policy has certain pivotal moments and in this chapter you can clearly recognise the influence of those who we would now describe as reformers: individuals who possessed a vision of how care and treatment could be improved and delivered in a more humane way. This perhaps reached its peak with the de-institutionalisation programme of the 1980s from which in some senses we are still emerging. The water towers are now few and those that remain in the midst of housing estates do so as 'listed' reminders of a past age.

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As this book was nearing completion the NHS was still undergoing close scrutiny and this was exemplified by the Francis Report (2013) which investigated the failings of care in Mid Staffordshire. It is possible that mental health services had their 'Francis moment' many years ago, but there is still a need to be vigilant and also aware that the current service models provide for those in our society who number amongst the most vulnerable.

INTRODUCTION

In the second decade of the twenty-first century, policy has assumed a much greater degree of importance in the design, delivery and direction of mental health services than was previously the case. Health is now seen as a fundamental human right that is indispensable for the exercise of other human rights and every human being is entitled to attain a standard of health conducive to living a dignified life (Andersen et al., 2006; Penhale and Parker, 2007). But there are other reasons also, including an ageing population, increasing demands on mental health services, advances in medical technology, efficiency savings in the NHS, and heightened expectations on the part of patients and service users. If those responsible for the provision of health care become so preoccupied with administrative minutiae then it is possible that health-care provision could become deeply embedded in routine and unable to respond to need, with the result that it becomes little more than a mechanism for perpetuating the social, economic, and political order of an inequalitarian society (Sullivan, 1987; Goodwin et al., 1999). Addressing all of these issues requires understanding and consideration of the varying perspectives of providers, consumers and the general public. In addition, health policy must currently confront a challenging economic climate in which uncertainty is all pervading. Governments faced with rising health-care costs must seek ways of achieving higher quality and productivity without increasing expenditure (Propper, 2011). In the UK and elsewhere, policy makers are challenged by numerous questions: does competition or collaboration produce better healthcare; how can closer working relationships be brought about between providers; what should be the roles of the private and voluntary sectors; how can a strong consumer voice exist alongside, but distinct from, the regulators (Dixon, 2011).

It is apparent that, given such complex circumstances, a systematic development of mental health services and sustained improvement are unlikely to occur without a clear mental health policy. While the boundaries of health policy are regularly contested and redefined, four objectives seem to remain constant:

- Devising services which can be accessed early and easily.
- Ensuring that services are diverse and appropriate.

- Training health-care workers so they are appropriately skilled to deliver services.
- Putting in place suitable support for people recovering from mental health problems in ways that can be seen as constituting 'recovery capital'.

This chapter offers a succinct overview of the evolution of mental health policy in the UK, briefly examining why certain policies were introduced at certain times and concluding with a discussion of the challenges that both confront those who formulate policy and those who are charged with implementing it. Although mental health policy throughout the UK is largely similar differences do occur, both with respect to content and focus, and these will be highlighted and briefly discussed towards the end of the chapter. Although few mental health nurses will be directly involved in formulating policies, all nurses – irrespective of their position or grade – have a responsibility to be informed about these and active in their implementation. The seeming indifference of nurses towards mental health policy has been due in previous decades to a perceived lack of professional autonomy that arose from an anachronistic, 'handmaiden' relationship with psychiatric medicine (Barker, 1989). Until recently, the work of nurses was poorly defined and largely shaped by the culture of medically-dominated institutions and the preferences of psychiatrists and managers for specific therapeutic approaches. It was inconceivable to the majority of nurses that centralised policies might impact directly on their work.

Analysts have noted that mental health-care policy has not only lagged behind other areas of health care, but also that it is one of the most neglected facets of health care worldwide. However, it would be inaccurate to assert that policies in other branches of health care always determine interventions or are always implemented homogeneously; *theory is not always made incarnate* (Weiss, 1995). On the contrary, argue Greenhalgh et al. (2011), most interventions – including those in mental health – are driven by hypotheses, hunches and aspirations. While policies are directed at populations, services are provided for individuals in circumstances which vary considerably. However, it is generally agreed among policy commentators that without the spur of policy to direct practice, some people with mental health problems have been poorly treated while others have received no treatment at all, and as a result, these individuals have experienced disrupted relationships, unemployment, social exclusion, and increased exposure to the criminal justice system.

Public attitudes towards mental health services have fuelled policy neglect, with attitudes based on the belief (held even by some of those who provide mental health care) that people with mental health problems could get well 'if they really wanted to'. Ignorance impedes the development of services: mental health problems are poorly understood both by the general public and by practitioners; researchers have not illuminated sufficiently the causes of mental illness; treatments are idiosyncratic and conjectural; and few in public life champion those who suffer with mental health problems (Koffman & Fulop, 1999; Pilgrim & Rogers, 2001).

However, when prominent people have supported improvements in the quality of services they have effected change, even if not to the extent that they would have hoped for (Pilgrim & Rogers, 2001). In the 1950s in the UK, Donald Macintosh, a Conservative MP, doctor and ex-psychiatric patient, used

his influence as a parliamentarian to get mental health care onto the political agenda. He highlighted the poor conditions in which the mentally ill were cared for in comparison to patients in other branches of medicine and the lack of access to effective treatments. Similarly, in the 1990s Ian McCartney, a Labour MP, spearheaded a policy review of conditions and practices in mental health, while Tessa Jowell, in the same decade, sponsored a number of private members' bills relating to aftercare provision for service users (the latter drew on her extensive previous experience in mental health care as the Training and Education Director for MIND). Equally dedicated was former Tory Minister of Health, Virginia Bottomley, an ex-psychiatric social worker who regularly participated in debates on mental health policy and services. While the work of these few is admirable, it is also remarkable by virtue of the fact that it is confined to such a small number, given that one in five of the 650 MPs in the House of Commons has admitted to having experienced a mental health problem at some point in their lives (MIND, 2008). This almost unanimous failure on the part of MPs to advocate for the mentally ill has seriously impeded the development of services and their availability and accessibility. The UK has seen very little of the courage demonstrated by the Norwegian Prime Minister, Kjell Magne Bondevik, who developed a mental illness while in office, disclosed it, and acknowledged that it prevented him from carrying out his duties as Premier. His honesty stimulated an outpouring of sympathy and understanding from all sectors of society, and his candour was rewarded by his being re-elected with an increased majority (Knapp et al., 2007). This incident has much to say about how political leadership can be instrumental in increasing public awareness, interest and commitment.

REMIT OF MENTAL HEALTH POLICY

Carpenter (2000) states that the student of health policy should commence by focusing on the process of policy making rather than undertaking an exploration of what it was that specific policies were designed to achieve. He contends that policy is an umbrella term encompassing legislation, research, economics and politics, all of which are distilled to yield an indication of what can realistically be provided and achieved. Policy, he continues, should take into account the culture of public services and the variety of ways in which mental health services can be made available to people from a variety of cultural and social backgrounds. Mental health policy has to be viewed from multiple standpoints. How has policy evolved? How is it presented and what language is used to express it? What implications does it have for resources? How is it to be implemented? What recommendations, if any, are there for how it is to be evaluated? And most importantly, what are the limitations of a specific policy and to what extent does it conflict or overlap with other policies?

All policies – regardless of their intentions – constitute a discourse between the individual and the state, and although there is disagreement about the precise

definition of policy it is generally agreed that it provides a vision of how a particular society would wish things to be (Andrews, 2001). Policies are essentially declarations of an intended direction of travel, and of necessity these will change over time in accordance with changing social circumstances: they are not absolute edicts meant to be adhered to regardless of circumstances, and should not appear to be unrealistically utopian in their aspirations. In contrast to the law which is mandatory, public policy is expressed in the regulations, decisions and actions of government: it does not only refer to the actions of government, but also to the intentions that determine those actions. In short, public policy consists of the political decisions that are taken in implementing programmes to achieve societal goals (McCool, 1995). Explaining why policies are necessary, Grayling (2006) states that these support human societies to evolve in a reasoned, compassionate and civilised way, while Osbourne (2008) suggests that policies should attempt to define health and highlight tried and tested strategies for its maintenance: it is thus the function of policy to state unequivocally what people should expect by way of state provision in order to be healthy. Osbourne considers that without transparency and candour, health-care providers are liable to interpret directives in different ways, giving rise to postcode lotteries which can result in both apparent and real injustices with respect to the availability of services and treatments. Mental health policy should paint a vision of what the future should look like and act as a declaration of the level of wellbeing that a government seeks to attain for the population it serves.

Osbourne also contends that in a state-run health service it is incumbent on the government to explain the political and economic ideologies that gave rise to its policies, to provide evidence of public need, and give an assurance that what is being proposed is deliverable and affordable. As the NHS is a tax-funded system and the chief means by which people take care of each other, it is – of necessity – an intensely political institution. Good health service governance requires the commitment of three key stakeholders if its implementation is to be successful, namely users, funders and workers. In formulating and implementing policy, government seeks to foster a dialogue and build consensus between professionals, service users and the public. Differences in the social and cultural context of health care in different countries or regions of the same country, in the personnel involved in delivering it, in costs, in perceived consequences for the community as a whole, and in people's expectations inevitably result in health-care policy that is constantly changing. Providers and professionals will therefore not universally comply with policies, and these may be seen as unstable and as externally-imposed constraints which threaten professionals' self-interest (Pilgrim & Rogers, 2001).

Behavioural economists will frequently invoke 'nudge theory' in examining the importance of policy, the essence of which is to persuade people of the rightness of what is being suggested (Thaler & Sunstein, 2009). Closely aligned to this is *libertarian paternalism*, which holds that state involvement in the welfare of citizens does not have to compromise or ignore individual autonomy. People's choices can be steered in directions that will improve their welfare but without the coercive proscription of certain courses of action. Andrews (2001) argues that all policies,

regardless of their theoretical assumptions, are no more than navigational aids and do not provide clear explanations as to how they should be implemented. While policies must be persuasive, intelligible and credible, they must also appear to be pragmatic and achievable – and above all, clearly capable of contributing to the improvement of people’s lives. To attain a high level of agreement on policy between state and public, Andrews (2001) posits certain *a priori* conditions: there must exist an educated population capable of critical thinking and reflection; there must also be debate and discussion that include all sections of society; and time must be set aside to allow people to explore the meaning and implications of certain courses of actions. People must be sufficiently public-spirited to see what is in the best interest of others as well as themselves. These conditions are especially relevant as those managing and delivering services come under increasing pressure to cut costs, to be more transparent, and to include members of the public in exploring how improvements could be initiated and sustained.

EVOLUTION OF MENTAL HEALTH POLICY

In his history of psychiatry, Shorter (1997) asserts that mental health policy can be related to three phases in the development of mental health services: the establishment of the asylum system; the beginnings of community care; and finally, the expansion and consolidation of community services. In the nineteenth century, the principal concern of policy makers was to manage a social problem by confining the insane and removing them from the public gaze. At the end of the following century the objective was to create a system whereby support for people with mental health problems would be derived within the communities in which they lived. Porritt (2005) concludes that while both sets of policies impacted on where and how services were provided, their main outcome was to redefine individuals’ relationship with the state and their immediate environments. Communities are not just places where people live – they comprise a set of mediating agencies between individuals and their mental health and wellbeing. It is perhaps surprising that some of the fiercest opponents of community care have been mental health professionals who seemed unhappy to confer the rights of full citizenship on people whose personhood they considered to be severely limited, as evidenced by their need for ongoing monitoring by psychiatric personnel (Porritt, 2005).

Writings by social philosophers in the eighteenth and nineteenth centuries were highly influential in the development of social philosophies that encompassed the weak and the vulnerable, and which eventually influenced the setting up of institutional mental health services in the mid-nineteenth century. Much consideration was given to the relationship that should exist between the public and those in power, and particularly to how the disenfranchised should be treated. French and English Enlightenment writers such as Rousseau, Voltaire, Hobbes, Locke and Mill examined political and ecclesiastical powers and speculated about how the church and the state acquired their power and then maintained it, appearing to place their own survival foremost. In societies where church and state wielded considerable power,

these writers felt that injustice abounded and inequalities in access to resources and assistance were not challenged. Rousseau and Hobbes referred to the theory of *possessive individualism* to explain how individuals who held power were driven by primitive urges of self-interest and avarice, often at the expense of others and especially the poor whose lives, as Hobbes remarked, were so often 'nasty, brutish and short' (Malcolm, 2002). Mill, however, contended that the social order was negotiable and did not have to be either unjust or unkind (Capaldi, 2004). A civilised society would allow the sovereignty of the people to be supreme and ensure that political power was in service to the people. Good political governance would restrain the excesses of the strong, empower the weak, make justice available to all, and strive to achieve the greatest happiness of the greatest number of people. For the people to be able to participate in their own governance, they had to have access to education, be able to make judgements, exercise freedom of thought, and have the autonomy to make choices in their own best interests. Laws and policies should be judged not by their intentions but by their effects.

In terms of mental health legislation and policy making, many of today's issues would have been familiar to our predecessors in the eighteenth century. How is it possible to balance caring for people suffering from mental distress and controlling them, or to respect individual liberties and personal autonomy? What amount of public funding should be allocated to addressing the causes of mental ill health and alleviating its effects? What should governments do about public attitudes towards the mentally ill? What role should they play in trying to reduce stigmatisation? What can health services and professionals realistically achieve?

The origins of mental health policy in the UK, where the state intervenes directly in the lives of people, can be traced back to the Vagrancy Act of 1744, which enabled those who were considered a threat to civil order to be securely detained. While the act sought to reassure the public that they were safe from possible threats to life and limb posed by the mentally ill, it reinforced the association between mental illness, poverty and dangerousness in the public mind. As no extra resources were provided to implement the act, local officials had little choice but to make use of existing facilities such as prisons, workhouses and Houses of Correction in order to confine people. This exacerbated the overcrowding that already existed, led to a deterioration in standards of care, and in many instances, added to the burden of the physical and mental ill health of inmates (Porter, 1987). By the beginning of the nineteenth century, the need to remove the mentally ill from public places had been replaced by anxiety relating to what should be done with them once they were securely confined.

At the end of the eighteenth century, a number of events served to increase public awareness of mental illness and to stimulate interest in what types of treatments or interventions could be provided to remedy the anguish that mentally ill people had to endure. These events included the madness of the monarch, King George III, the opening of the York Retreat in 1796, the founding of Ticehurst House in 1797, and the trial of James Hadfield in 1800 (who had attempted to assassinate the king but was found to be of unsound mind and so not accountable for his actions). These events not only enlightened public opinion, but also prompted those in authority

to seek ways of managing the mentally ill while at the same time alleviating the effects of mental illness. The nineteenth century brought new stimuli for the state to increase its involvement in health care, education and welfare provision in which until this time – as Karl Marx noted – it had taken little interest (McLellan, 2006). Rapid urbanisation saw epidemics of diseases such as cholera which affected people regardless of class. The Eugenics movement raised concerns about the breeding stock of the nation, and in Germany Bismarck's domestic policies (1871–1890) which entailed the state taking responsibility for health and education appeared to have contributed to the country's strong economy (Farmer & Stiles, 2007). Social ills and political theories, coupled with the perceived threat of the growing numbers of mentally ill people, gave rise to the passing of Acts of Parliament which affected the whole nation. Prior to the nineteenth century these acts usually related only to particular counties, cities or towns.

Between 1801 and 1807 no fewer than 71 bills, reports from select committees and inquiries relating to mental health were published. The County Asylums Act of 1808 required asylums to be built in 'airy and healthy' locations and to admit patients who were too 'dangerous to be at large'. Few counties however in fact responded and little additional provision was made available for the mentally ill. A humanitarian emphasis on protecting 'lunatics' against abuse led to the 1828 Madhouses Act which required all asylums and private hospitals to have a medical officer. Patients who had recovered were to be discharged by Justices of the Peace. In 1845, the Lunatics Act strengthened the 1808 County Asylum Act and made it compulsory for each county to have specialist provision for the mentally ill: it also established an inspection system to be overseen by the Lunacy Commission. Pilgrim and Rogers (2001) see this act as a triumph of confinement and a sop to those who wanted the threat of moral contagion posed by the mentally ill to be removed from civilised society. The new asylums were designed with magnificent facades but these often disguised the fact that those working inside were preoccupied with security and control (Busfield, 1986). Nursing staff, called attendants, were poorly paid and poorly treated, and were probably not highly motivated to improve the lot of inmates confined to 'refractory wards' who were restrained in padded cells and sedated at night. Medical staff spent most of their time on administrative and supervisory duties, but were becoming increasingly powerful inside the asylums as the General Medical Registration Act (1858) decreed that only those with training in biological disorders could oversee the management and treatment of the insane.

By the time the Lunacy Act (1890) was passed, over 100 asylums had been built across the country. The act allowed for Justices of the Peace to oversee and certify the admission of patients, while at the same time increasing the status and power of the medical superintendent and psychiatry. However, the hoped-for medical cures and outcomes were not forthcoming. Some superintendants expressed regret that owing to their poor quality attendants were ill-equipped to play their part in achieving the therapeutic aspirations of medical staff. In 1885 a training course became available for asylum doctors, and in the same year the *Handbook for the Instruction of Attendants of the Insane* was published. Rayner (1884) saw training as the chief means of invigorating the work of mental health personnel by conferring professional

credibility and satisfying the lunacy commissioners that more effective ways of managing and treating the mentally ill were being pursued. A few enthusiastic doctors went on to devise a national training scheme for attendants: the course took three years and the first qualified asylum nurses received their certificates in 1893.

The First World War made unprecedented demands on the asylums with over 100,000 soldiers requiring treatment for various psychiatric conditions, principally in what is now termed post-traumatic stress disorder. This demand impelled a new interest in psychiatry in approaches to treating the mentally ill. The British Psychological Society was founded in 1919, strongly influenced by Freudian theories, and a year later, the Tavistock Clinic opened to provide psychoanalytic treatment for outpatients. *The Royal Commission Report* (HMSO, 1926) significantly stated that mental and physical illnesses were not distinct and its recommendations were restated in the Mental Treatment Act (1930) which further strengthened the power of doctors by permitting forced treatments. As a result medical interventions such as, hydrotherapy, insulin, narcosis and electrical therapies became more widespread.

During the Second World War, psychiatrists and psychiatric nurses were recruited into the armed forces in the belief that providing an immediate on-site response for shell-shocked soldiers was preferable – both therapeutically and financially – to removing them from the battlefield and treating them elsewhere (Harrison & Clarke, 1992). As is often the case, war had focused government policy in a way that peace time conditions had not. It was as a direct result of the experience of treating large numbers of military personnel that therapeutic communities, group therapies and Civil Resettlement Units (CRU) for ex-prisoners of war were established (Newton, 1988). The main focus of the CRUs was to help ex-POWs reintegrate into society and reclaim their previous work skills. Vocational guidance and help in finding work aimed to rebuild confidence and develop resilience. Families were also encouraged to be involved in soldiers' rehabilitation. This approach was quickly adopted into mainstream psychiatry and became a foundation for the community-based services that were subsequently to emerge.

The post-war period was one of optimism. Following the inauguration of the NHS in 1948, there was unlimited access to free health care and this heralded state intervention on a much larger scale than ever before. The state had now replaced private charities as the main provider of personal and social services. Keynes (Sullivan, 1987) argued that state intervention in healthcare should only aim to provide those services which people cannot provide for themselves. However, such was the range of services provided that financial problems soon began to emerge. It became apparent that 75% of NHS beds were being occupied by psychiatric patients. Once the responsibility for admitting patients was handed over to doctors admissions escalated, with the result that there were 150,000 people in mental hospitals by 1954. By 1956, 2000 more beds had been made available and there were 1000 more psychiatric nurses and 77 more consultants (Rogers & Pilgrim, 2001). This expansion took place without adequate planning and the country could not afford it. The Percy Commission was convened to address this serious situation, and its 1957 Report underpinned the Mental Health Act (1959) which introduced the voluntary admission of patients and recommended short stays in hospital.

Government policies of the time acknowledged that institutionalising the mentally ill could lead to their degradation as persons and the corruption of care: institutions designed to look after very vulnerable people ended up betraying the trust placed in them (Martin, 1984). The Department for Health and Social Security commissioned a development project in Worcester in 1968 which demonstrated that a large psychiatric hospital could be replaced by community-based facilities (Hall, 1992). However, community alternatives to institutional care – although attractive in theory – did not yet appear to be a feasible option.

POLICY-DRIVEN DEINSTITUTIONALISATION

Clare (1976) described the 1960s as the ‘decade of rhetoric’. Enoch Powell announced the government’s intention to begin shifting hospital-based psychiatric services into the community (Powell, 1961). This was a time of severe staff shortages, particularly in nursing, and many hospitals were forced – albeit reluctantly – to accept unsuitable recruits with a subsequent impact on standards of care. It quickly became apparent that it had been easier to establish institutional services than disestablish them. However, the government pressed on and the publication of *Better Services for the Mentally Ill* (DHSS, 1975) accelerated the running-down of psychiatric hospitals and the provision of more treatments and support in community settings. This was the first attempt at pulling back state control in the field of health care, an attempt that was to be accelerated under the first Thatcher government in 1979. While the idea of community care found acceptance among health-care practitioners, they were given little guidance in how to implement it nor any information about how it was to be monitored. Community care represented a denunciation of the past and hopeful vision for the future which amounted to no more than hypothetical conjecture. Finch and Groves (1980) predicted that as community care evolved, greater responsibilities would fall on relatives and carers, and especially on women, as they would have to pick up where the statutory services left off.

From the early 1980s there was more direction from central government about the shape and content of community services. The Mental Health Act (1983) addressed the sensitivity needed to distinguish between people who wanted to be left alone and those who wanted treatment in the community. It reflected on how human rights should be incorporated into mental health services and under what circumstances someone should be forcibly taken into a psychiatric facility. There was also consideration given to what constituted a duty of care in relation to discharged patients. The rise of service-user movements increased the sense of urgency in relation to the reorganisation of mental health care. In a climate of liberal thinking, the scientific basis of psychiatry was questioned. The process of reaching a diagnosis by means of clinical investigation was seen as part of a now denigrated institutional culture. Johnstone (1992) argued that as long as problem identification remained the focus of doctors, scant progress could be made in understanding the causes of mental health problems and how to help people once treatment

ceased. Growing insecurity and uncertainty at the heart of psychiatry affected the work of planners, commissioners and providers who were initially ambivalent about committing to primary mental care initiatives, inter-agency working and shared funding arrangements.

Further assistance in the form of policy arrived with the introduction of the Care Programme Approach (CPA) (DH, 1990) as a form of case management, with the aim of improving community care for people with severe mental illness. Its adoption implied that despite the rolling back of state power the state had a duty of care to individuals, and that professionals could not necessarily be relied on to deliver policy-directed care. While at one level state control of health was waning, at another it appeared that the state was engaging in the micro-management of individual care. The CPA represented a new direction, signifying the direct involvement of government in how services should be delivered. Simpson et al. (2003) concluded that it was a flawed policy that had been introduced inappropriately in an inhospitable socio-political and financial context, thereby exacerbating clinicians' resistance to political and managerial interference and raising new objections to the bureaucratisation of care. The CPA also presumed levels of community resources and inter-professional team working that were patently absent. Nevertheless, today it remains central to the care of people with severe mental health problems in the community and is used as a tool in the allocation of scarce resources.

Towards the end of the decade the White Paper, *Safe, Sound and Supportive* (DH, 1998b), signalled a major modernisation agenda in healthcare. In the following year the *National Service Framework for Mental Health* (DH, 1999) was published, which stated that service delivery should aim to achieve seven standards over a ten-year period. These tackled five areas: health promotion and stigma; primary care and access to specialist services; the needs of those with severe and enduring mental illness; carers' needs; and suicide reduction.

- **Standard one:** addressed mental health promotion and strategies to combat discrimination.
- **Standards two and three:** set out how primary care should work, including onward referrals, access to round-the-clock care and NHS Direct.
- **Standards four and five:** described effective services for those with severe and enduring mental illness, including crisis plans, round-the-clock access, in-patient treatment and rehabilitation care.
- **Standard six:** established annual checks for carers of those with severe and enduring mental illness, and written and implemented care plans.
- **Standard seven:** was a composite of standards one to six, with additional guidelines to ensure staff could assess the suicide risk, learn lessons from local suicide audits and be supported to prevent prisoner suicide.

Delivering the standards called for much closer cooperation between NHS staff and those employed by local authorities working in social care. In order to meet those standards and achieve a better integration of services, the necessity of improved education and training – as well as the recruitment of new staff and their retention – was recognised.

This was followed by the *NHS Plan* (DH, 2000) which set out specific targets for the establishment of 220 assertive outreach and 335 crisis resolution teams by 2004. To assist in creating a robust culture and structure for the coordination and implementation of policy and practice, a National Institute of Mental Health for England (NIMHE) was suggested, based on a model from the USA. NIMHE's role was to bring together research and legislation and then disseminate good practice so that effective partnerships could be developed between agencies, service users, carers, professionals and managers.

NIMHE's mission was to improve the quality of life for people of all ages experiencing mental distress. At the outset it identified conceptual vagueness as a major impediment to planning preventive services, with multiple definitions of primary, secondary and tertiary prevention being used. Research lacked coherence and often failed to inform policy, while policy initiatives were found to have a patchy impact on practice rather than being adopted in a widespread manner. The quality of services varied nationally as did the quality of education and the training of mental health personnel. Medical practitioners had a vested interest in the diagnosis of disorders and their treatment as opposed to the creation of conditions in which problems could be prevented or minimised. With the intention of bringing about closer collaboration between services NIMHE was given responsibility to coordinate the whole of mental health services – that is, of all services for people of all ages including primary, secondary and tertiary care.

Improving community care and focusing on health promotion were central to *Our Healthier Nation* (DH, 1998a) and to WHO (2003b). These documents stated that mental health promotion should be informed by a different set of assumptions from those that informed the treatment of the mentally ill, and should enshrine the belief that services users have rights of citizenship and should have access to all facilities that could be regarded as recovery capital. These ideas were further developed in the Helsinki Agreement (WHO, 2005) in which it was stated that the following priorities should be adopted by EU countries:

- Promoting individual and societal mental wellbeing.
- Tackling stigma, discrimination and social exclusion.
- Preventing the causes of mental health problems.
- Providing comprehensive and effective interventions for people with mental health problems whilst offering involvement and choice.
- Rehabilitating and including in society people who have experienced serious mental health problems.

WHO (2010) declared that there was 'No Health Without Mental Health' and that mental health was pivotal to individual and community wellbeing. It recommended that societies should endeavour to minimise the distress-inducing effects of rapid social change, poor working conditions, gender discrimination, social exclusion, unhealthy lifestyles, and human rights violations. In policy terms, a theme was emerging that the factors that would make a difference to people with mental health problems were not associated with psychiatrists, nurses or psychologists, they were

instead good housing, supportive social relationships and safe communities. *No Health Without Mental Health* (DH, 2011) states that the role of government is to assist citizens to have more control over their lives and build more capable communities, although it remains conjectural as to how that will be achieved across the country. Responsibility for mental health is not the responsibility of one department, but rather a cross-department responsibility of all government divisions. Citizenship now encompasses the obligation to take responsibility for one's own mental health and that of others, and to challenge all forms of stigma and discrimination which could adversely affect human flourishing.

In order to make mental health everyone's business, *No Health Without Mental Health* called on organisations and government departments to work together on key shared objectives:

- More people will have good mental health.
- More people with mental health problems will recover.
- More people with mental health problems will have good physical health.
- More people will have a positive experience of care and support.
- Fewer people will suffer avoidable harm.
- Fewer people will experience stigma and discrimination.

MENTAL HEALTH POLICY AND DEVOLUTION

It is undoubtedly the case that mental health policy within the UK has tended to be anglocentric, although since devolution this is no longer so. *No Health Without Mental Health* (DH, 2011) refers specifically to England but notes that many of the problems confronting mental health services are similar to those presenting to other UK administrations. However, while the challenges may be similar, England, Wales, Scotland and Northern Ireland each adopts its own strategies for helping people with mental health problems. In England, the strategy devised by the coalition government is based on principles of freedom, fairness and responsibility, principles that are highly dependent on the financial and human resources for their implementation. Government policy presents itself as less directive and more facilitative than has been the custom. The responsibility for improvements in mental health is devolved to local authorities and agencies on the understanding that they are best placed to confront health inequalities, reduce stigma, and foster better mental well-being in their communities. Action at a local level will lead to whole population outcomes, including improved life expectancy, better educational achievement, reduced health risks behaviour and anti-social behaviour, higher levels of social interaction and participation, and greater happiness and fulfilment.

In Northern Ireland the public are invited to become actively involved in shaping policy, identifying deficits in health care, and suggesting areas for development (Priorities for Action, 2010). This approach focuses on how policies are formulated and to what extent they are capable of bringing about change in how services are delivered. Its review captured the experiences of people with mental

health needs and learning disabilities as well as those of their families and carers, and explored people's priorities for effective health and social care services. When the responses were collated they provided fascinating insights into how people viewed services:

- More rapid access to care and treatment was urgently requested.
- People were not convinced that community care was effective and questioned its planning, delivery and availability.
- Service users and carers wanted to be more involved in their care and to have care plans which they could hold in their own homes.
- Young carers' needs were not being prioritised.
- Services must be available for all, regardless of age, gender, creed and location, and the standards applied equally to all groups.
- Better communication between health and social care staff at all levels was needed – people wanted to have greater continuity of care and not to see different people at every appointment.

Rather than rewriting the current policy framework, Wales by contrast sought to strengthen the existing Mental Health Act (1983) by introducing a number of measures to assist individuals in the receipt of services and involved in recovery programmes following contact with services. There is a strong understanding that mental health services should mean more than simply identifying and treating conditions, but should also help people to resume their normal social, domestic and occupational lives. The Mental Health (Wales) Measure (2010) drew on evidence that advocacy could lead to an improved experience for the service user by providing independent support for decision making around appropriate interventions, engagement with services and desired outcomes. The measure has been focused both at the macro policy level inhabited by planners and service managers and at the micro level where individuals are concerned about their daily lives, housing, benefits and ongoing support. Closer collaboration between primary and secondary services, health boards and local authorities is suggested, with GP services at the centre.

The measure also adopted an admirably realistic approach to its implementation by being phased in gradually during 2012 so as not to over-burden those with responsibility for overseeing it. The rationale for this was to address criticism of the kind of multiple level reorganisation that education and health have been required to engage in during recent years. The measure has four aims:

1. To assess and treat a person's mental health within primary care across all of Wales.
2. To create statutory requirements around treatment planning and care coordination for people in secondary services.
3. To ensure that secondary mental health services can provide a timely assessment for previous service users.
4. To ensure that all patients receiving care and treatment, be they detained under the act or not, have access to an independent and specialist mental health advocacy service.

Scottish mental health policy considers culture and values as central to the improvement and maintenance of good quality mental health care (Rights, Relationships and Recovery, 2011). Policy aims to ensure that recovery from mental illness goes hand in hand with social inclusion and citizenship. Services should endeavour as far as possible to provide support without resorting to the use of compulsory powers. At the micro level, carers who provide support on an informal basis should receive appropriate information and advice and have their views and needs taken into account. Mental health nurses are seen as fundamental to the development of therapeutic relationships with service users, families and carers, and to ensuring that the cultural change which is needed at every level of health care is brought about.

In order to enable mental health nurses to play the part for which their role equips them so well, training and education in values-based practice should be a feature of all pre-registration programmes, and all nurses – regardless of status – should have access to post-basic training. Training should be multidisciplinary and involve service users and carers. Nurses are encouraged to have *personal development plans* and to access good quality clinical supervision, as the evidence suggests that these give rise to a higher quality of care giving.

REFLECTIONS ON MENTAL HEALTH POLICY

The history of modern mental health policy is closely allied to the history of mental health nursing. Without the contribution of nurses, little of any substance would have been achieved in mental health services. Treatments have in the past been delivered by nurses and, to a large extent, continue to be so. The Munich Declaration (WHO, 2000) recommends that nurses be central to mental health services because they are in a position to tackle public health challenges and are manifestly cost effective. The WHO (2003a) singled out mental health nurses as primary agents in combating psychiatric morbidity and the impact of stigma. However, the potential of nursing remains limited owing to its subordinate relationship to medicine, a relationship that is sometimes enshrined in law, and frequently described in protocols and procedures. Other factors constraining nurses include limited time for face-to-face-contact with service users and their carers, increasing administrative demands, a lack of quality training courses, and decreasing opportunities for career advancement.

In recent years, mental health policy has directed mental health services and shaped the content of what is being delivered. The quality of some services has improved, but high quality care is not consistent across the country, and access to services is inequitable. It would be foolhardy to conclude that policy has achieved all that it set out to do. As Webster (1998) remarked, only about a third of all policy is implemented in the way intended, and some is never considered for implementation. Policy has consistently failed to acknowledge that mental health problems are far more complex than diagnostics, research and therapeutics would imply. Burnside (2010) is critical of the simplistic approach adopted by policy makers and points to the deep spiritual malaise that underlies the country's

mental health problems. We live in an age of anxiety in which many people feel trapped in a meaningless existence and are intellectually, culturally and spiritually paralysed. Porritt (2005) talks of a time of cognitive dissonance when it is difficult to understand how to achieve objectives for people who have multiple and conflicting interests. There are limits to economic growth, and limits to human resources, and neither government nor individuals may be the free agents they would like to think themselves to be.

There is also growing distrust of large-scale institutions such as churches, banks, schools, universities and healthcare organisations which are seen to promise more than they are capable of delivering. The post-modern world invites people to be critical of public services, and to make themselves the final arbiters of the quality of services (Seldon, 2009). They are persuaded that how they live and behave is a matter of individual choice. It is not surprising, therefore, that in such an ethical and social climate there is little enthusiasm for the democratic process, for undertaking civic duties, and assuming responsibility for one's own health and that of others (McKnight, 1995).

In comparison to what has been achieved in cancer and cardiovascular care and infectious diseases, mental health care has been far less successful. Many policies verge on the utopian and in reality amount to little more than 'window dressing' (Burnside, 2010). Adopting a policy-first approach as a means of transforming services fails to take account of the political, economic and social differences that exist nationwide, many of which are the direct causes of social and health inequalities (Marmot, 2005; Dowding, 2008). Without an understanding of, and willingness to address, the social determinants of poor health, mental health policy cannot lead to effective action (Lewis, 2008).

Starfield and Shi (2002) found little evidence that the quality of health care was linked to policy. They concluded that the most significant factors affecting the health status of a population were the structure, location and delivery of health services. In short, people's perceptions of health services were dependent on where services were located and the types of people who worked in them. Countries which have achieved overall good levels of health enjoy an equitable distribution of resources, public financial accountability and comprehensive family-orientated services. In the UK policy makers have failed to take into account the context in which their policies must be implemented (Chinitz, 2006). Out-of-date practices and entrenched organisational cultures stifle policies. Policies are frequently poorly explained to health-care professionals working in clinical practice, and too few opportunities are provided for them to participate in health improvement plans. Without an enlightened and motivated workforce that can initiate and sustain change, it will not be possible to achieve quality health outcomes with limited resources.

Else (2011) contends that too many policies focus on individuals and are simplistic. The origins of mental health problems are to be found not in individuals, but in the social environments in which people live – the gap that exists between the rich and the poor which affects life expectancy, levels of crime and violence, and the prevalence of mental illness. Being trapped in poverty exacerbates the emotional pain and isolation associated with divorce, ill health and unemployment.

This viewpoint is supported by Stuckler et al. (2009) who state that conditions in workplaces are not generally supportive of people with mental health problems. Many feel obliged to keep their mental illness hidden from their employers and colleagues for fear of being ridiculed or sacked (Shaw Trust, 2010). Fifty per cent of managers in the Shaw Trust study revealed that they would not employ a person with mental health problems for fear of how other employees might respond, yet the report also revealed that some industries, most notably supermarkets, found that employees with mental health problems were more reliable, enthusiastic, better able to communicate with the public, and less prone to time-wasting and absenteeism than other staff.

There is much assistance that can be given to people to help them safeguard their own wellbeing, such as providing facilities and encouragement for them to be physically active, engage in lifelong learning, and volunteer in their local communities so as to connect with family and neighbours (The Foresight Project, 2009). Much may be learned from the voluntary sector about how people can look after themselves if adequately supported and given information in a form they can understand and utilise (Goddard, 2001). By contrast, mental health services remain wedded to the diagnosis and treatment of severe forms of mental illness, such as the psychoses and major affective disorders, at the expense of developing services that can educate people, enable self-help and promote individual responsibility. Mental illness remains a taboo subject and people with mental health problems still feel marginalised and discriminated against. There are too few opportunities for them to attain a better future outside the health-care arena. Failing to acknowledge and confront prejudice renders governments complicit in its persistence. Frequent changes of government, short-termism, the fact the health departments are spending ministries rather than wealth-creation ones, and that not all government departments have understood the importance of mental health in the way suggested in various White Papers (DH, 2011) are further obstacles to effective policy implementation. Changing public attitudes is a slow process, but striving to create a culture in which mental health is accepted as everybody's responsibility must nonetheless be the aim.

Reflective Exercises

1. Can you identify any contemporary social or political influences upon mental health policy in the UK today?
2. To what degree do you think that any institutional response to individual issues is out of step with a society based upon the needs and rights of individuals?
3. If mental health services truly had their 'Francis moment' years ago with the worst excesses of institutional care, then what are the protective factors to ensure safe and effective services now?
4. What do you consider will drive change in the future? Will it be economic factors or the promise of treatment breakthroughs driven by emerging science?

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