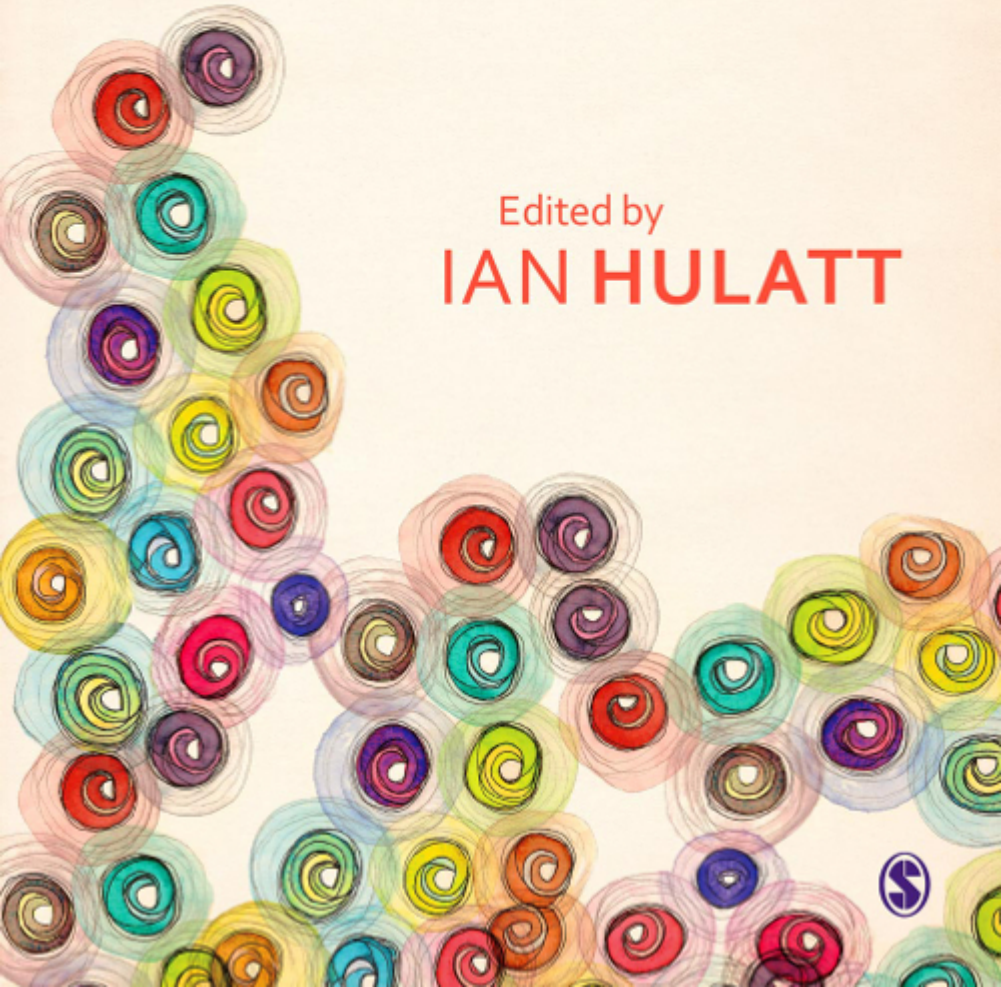
MENTAL HEALTH POLICY FOR NURSES



Edited by

IAN HULATT

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Ben Hannigan is a Reader in Mental Health Nursing in the School of Healthcare Sciences at Cardiff University. In his research into mental health systems he has addressed these interrelated areas: policy; service organisation and delivery; work, roles and values; the characteristics and wellbeing of the workforce; practitioner education; and the experiences of users. He has published widely in these areas in nursing, health and social scientific journals and in books. He blogs at http://benhannigan.com

Ian Hulatt has been the mental health adviser in the nursing department at the Royal College of Nursing since 2004. Prior to this role he spent 20 years as a teacher of nurses at both undergraduate and post graduate levels. He undertook Thorn training at the Institute of Psychiatry and has maintained a keen interest in this area of practice ever since. His role at the RCN requires him to advise on mental health nursing policy and practice across the UK and whilst based in Wales he continues to travel the country in his work. Ian has engaged in many regional, national and international policy initiatives for the RCN and continues to be a passionate advocate for what he describes as the "craft" of mental health nursing.

Ann Jackson's clinical background is in acute in-patient mental health care. She has 20 years' experience working in practice development and research; working with teams as external facilitator to systematically review practice and integrate with best evidence and policy. From 1998, she was at the Royal College of Nursing and gained a wealth of experience working across national policy, research and practice agendas, primarily in mental health and social inclusion. Secondments to the Department of Health (Offender Health) and Leicestershire Partnership NHS Trust from 2005-2010 led to specific policy making and practice around women's mental health in the criminal justice system. From February 2012, she has been the Director of Nursing at St.Andrew's Healthcare, the largest UK charitable provider of specialist mental health services. She has particular interest in violence against women and mental health and equalities.

Fiona Jones has lengthy experience of using mental health services and has latterly volunteered with EmPowerMe (formerly Lancashire Advocacy) a service user-led voluntary sector organisation. Recently she has taken up the position of research assistant working alongside colleagues at the University of Central Lancashire. Fiona is also active in the university's community engagement and service user involvement initiative, Comensus, making a significant contribution to teaching and learning. On the research front, she has helped plan and deliver a number of projects that have benefited enormously from her lived experience and unique skills. This work has included a study of involvement in secure services across Yorkshire and an appreciative inquiry project to develop recovery orientated practices with mental health inpatient teams

on Merseyside. Current studies focus on recovery and involvement practices in a high secure setting and the experiences of relatives of forensic patients in Scotland.

Cheryl Kipping began her career as a general nurse at Guy's Hospital before going on to train in mental health at the Maudsley. She has held clinical and managerial posts in the statutory and voluntary sectors, in mental health and addictions. Cheryl completed a social psychology degree at the London School of Economics, and a PhD at King's College, London. She has worked as a consultant nurse in dual diagnosis for 12 years. Cheryl has provided dual diagnosis expertise to a range of national advisory groups including the Department of Health and NICE. She has given conference presentations nationally and internationally, and published about dual diagnosis. Cheryl is a member of PROGRESS, the national consortium for consultant nurses in dual diagnosis.

Tim McDougall is Nurse Consultant and Clinical Director for Tier 4 CAMHS and Trust-wide CAMHS at the Cheshire & Wirral NHS Foundation Trust. Tim has worked in a range of CAMHS settings including community child mental health teams, adolescent in-patient services and secure adolescent forensic services. With a National profile in CAMHS and, with over 100 book and journal publications, Tim has spoken at National and European conferences about the mental health of children and adolescents. Tim was formerly Nurse Advisor for CAMHS at the Department of Health in England and was a member of the National Advisory Council for Children's Mental Health and Psychological Wellbeing. Tim is currently Chair of the UK Nurse Consultants in CAMHS Forum and the Quality Network for Inpatient CAMHS (QNIC) Executive Committee. He has been involved in the development of NICE guidelines on Psychosis and Schizophrenia in Children and Young People and Bipolar Disorder in Children, Young People and Adults.

Mick McKeown is a mental health nursing researcher in the School of Health at the University of Central Lancashire. He instigated the Comensus service user and carer involvement initiative at the university which has a growing reputation for extensiveness and authenticity of involvement practices. Recent research has explored service user and staff alliances for involvement in secure services and appreciative inquiry with inpatient mental health teams. Mick edited the book *Forensic mental health care: a case study approach* (Churchill Livingstone) and co-ordinated the production of the collectively written text: *Service user and carer involvement in education for health and social care* (Wiley-Blackwell). Mick is a Unison activist and interested in democratic alliances with mental health service user/survivor movements. This intersects with efforts to ensure universities become assets in their local communities, to this end Mick supports an international network of scholars committed to 'Mad Activism in the Academy'.

Catherine McQuarrie has been a lecturer in mental health nursing at the University of Salford since 2006. Prior to this, she was a lecturer/practitioner, working as a Clinical Nurse Specialist with the Manchester, Bolton, Salford and Trafford Substance Misuse Directorate. She has worked in the field of substance misuse (alcohol and drug services) since 1995 and completed an MSc in Drug Use and Addictions in 2003 and an MSc in Public Health and Society in 2010. She has a strong interest in

promoting mental health and social inclusion. Cath was jointly responsible for 'A synthesis of grey literature around public health interventions and programmes' for NHS North West taking editorial responsibility for mental health and well being. She has recently developed and delivered training to the Being Well Coaches in Salford, a new initiative in relation to working with people in relation to behaviour change.

Peter Nolan was born in the West of Ireland and undertook mental health and general nurse training in London in the 1960s. He spent time in various posts including working as an Occupational Health Nurse in the Sahara Desert, as a journalist for the North African Radio Service based in Tripoli, Broadmoor Special Hospital, and subsequently as a Professor of Mental Health Nursing at the universities of Birmingham and Staffordshire. His research interests have included the changing face of mental health provision in the UK, Ireland, Sweden and the USA. He has had a long-standing interest in the relationship between spirituality and mental health and the extent to which some service users experience a 'crisis of meaning' in the modern world. He has published widely in the field of the history of mental health policies, institutions, interventions and the origins of various mental health disciplines. He is currently working on community care prior to the establishment of asylums.

Karen M. Wright is a mental health nurse and academic. She is the principal lecturer and lead for mental health within the School of Health at the University of Central Lancashire (UCLan). Karen designed and delivered the first MSc in Personality Disorder in the UK and continues, as part of the course team, to deliver this programme to a range of healthcare professionals at UCLan.

Karen originally trained as an RGN, specialising in cardio-thoracic surgery before moving to mental health in 1986. Since then she has worked in a range of clinical practice areas including acute in-patient services, community mental health, crisis intervention services and forensic services. She still works clinically within an in-patient service, on a weekly basis and sees this as vital to her role as an academic and researcher. Her most recent research activities have focussed on the therapeutic relationship, attitudes to violence and aggression, and service user involvement in forensic services.

Norman Young became interested in mental health after studying biochemistry and psychology at Keele University. After graduating he moved to Cardiff and qualified as a mental health nurse in 1994. Norman soon wished to follow a clinical academic career focusing on psychosis. After gaining therapy skills in congnitive and behavioural psychotherapy he set up, with Ian Hulatt, the first Thorn course in Wales. After this he developed an educational programme in acute care and collaborated in setting up the national accreditation of inpatient services. He subsequently led quality improvement initiatives in inpatient care and patient safety. Norman currently works as a Nurse Consultant with Cardiff and Vale University Health Board and Cardiff University.

Norman's current research interests are in organisational approaches to safety in mental health. Norman continues to provide care and treatment to people with psychosis and in involved in local and national improvement projects. Norman was a member of the NICE guideline development group for schizophrenia and psychosis in 2014.

LIST OF ACRONYMS

AC	Approved Clinician
ADHD	Attention Deficit Hyperactivity Disorder
AIMS	Accreditation of Acute Inpatient Mental Health Services
AMHP	approved mental health professional
ANARP	Alcohol Needs Assessment Research Project
ANP	Advanced Nurse Practitioner
BBC	British Broadcasting Corporation
BME	Black and Minority Ethnic
BPS	British Psychological Society
CAB	Citizen's Advice Bureau
CAMHS	Child and Adolescent Mental Health Services
CAS	Citizen's Advice Scotland
CBT	Cognitive Behavioural Therapy
CHC	Community Health Councils
CHI	Commission for Health Improvement
CMHNs	Community Mental Health Nurses
CMHT	Community Mental Health Centres and Teams
CRHT	Crisis Resolution and Home Treatment Teams
COHSE	Confederation of Health Service Employers
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSIP	Care Services Improvement Partnership
CRHT	Crisis Resolution/Home Treatment
CRU	Civil Resettlement Units
CTO	Community Treatment Order
DAT	Drug Action Team
DH	Department of Health
DHSS	Department of Health and Social Services
DHSSPS	Department of Health, Social Services and Public Safety
DoH	Department of Health
DRE	Delivering Race Equality
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSPD	Dangerous with Severe Personality Disorder
DUCIE	Developers of User and Carer Involvement in Education
DWP	Department for Work and Pensions
EC	European Commission
EDHR	Equalities, Diversity and Human Rights

EHRC	Equality and Human Rights Commission
EU	European Union
GP	General Practitioner
HAS	Health Advisory Service
HEI	Higher Education Institution
HIV	Human Immunodeficiency Virus
HMSO	Her Majesty's Stationery Office
IAPT	Improving Access to Psychological Therapies
ICD	International Classification of Diseases
IPS	Individual Placement and Support
LIT	Local Implementation Team
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Questioning
LSE	London School of Economics
MAPPA	Multi-Agency Public Protection Arrangements
MHA	Mental Health Act
MHA	Mental Health Alliance
MHAC	Mental Health Act Commission
MHHE	Mental Health in Higher Education Network
MHP	Mental Health Practice
MoC	Models of Care
MoCAM	Models of Care for the Treatment of Alcohol Misuse
MSc	Master of Science
NCSS	National CAMHS Support Service
NCI	National Confidential Inquiry
NCISH	National Confidential Inquiry Reports into Suicide and Homicide by People with Mental Illness
NDTi	National Development Team for Inclusion
NHS	National Health Service
NHSE	National Health Service Executive
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Clinical Excellence
NIMHE	National Institute of Mental Health for England
NMHDU	National Mental Health Development Unit
NPSA	National Patient Safety Agency
NHS	National Service Framework
NSF-MH	National Service Framework for Mental Health
OCTET	Oxford Community Treatment Order Evaluation Trial
ONS	Office for National Statistics
PALS	Patient Advice and Liaison Service
PD	Personality Disorder
PMS	Psychiatric Morbidity Survey
PPI	Patient and Public Involvement
QNIC	Quality Network for Inpatient CAMHS
RCN	Royal College of Nursing
RCP	Royal College of Psychiatrists

RGN	Registered General Nurse
RMA	Risk Management Authority
SCIE	Social Care Institute for Excellence
SCMH	Sainsbury Centre for Mental Health
SEAL	Social and Emotional Aspects of Learning
SHC	Scottish Health Council
SNAP	Scottish Needs Assessment Programme
SRI	Scottish Recovery Indicator
STR	Support, Time, Recovery
SURGE	Service Users in Research Group, England
UCLAN	University of Central Lancashire
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
USA	United States of America
WAG	Welsh Assembly Government
WAT	Workforce Action Team
WHO	World Health Organization

INTRODUCTION

Welcome to this edited volume of chapters addressing the issue of mental health policy and how it impacts and indeed determines your practice as a nurse. You will see from the chapter topics that they contain a broad range of practice areas and will touch on most areas of contemporary mental health nursing practice. If you have come to this topic with a question such as 'What has policy got to do with me?', then I trust you will leave the book with at least that question answered.

It is the basic premise of this book that policy determines much of what nurses actually do on a daily basis. It will be argued that in all areas of practice the actual process and means and indeed nature of services that mental health nurses work in are shaped by the influence of policy.

Policy itself is a complex issue with many determining factors. As we all know, at present in Britain the influence of the wider economic/political agenda impacts in a real way upon the delivery of health care. It may be that like many readers of this book you will have had to undergo yet another re-organisation of the service you work in order to address the diminished resources that are available for health care. Whilst economic determinants may seem obvious and indeed painful there are other more subtle and yet profound influencing factors that shape policy.

The whole ethos of the delivery of mental health services has been greatly shaped by the influence of the society it is delivered in. It is the current views of society and contemporary culture that have greatly influenced the way mental health care is delivered. Just as public health had its big leap forward in the realm of clean water, hygiene and housing, mental health made huge changes in ways that may now seem archaic. Our almost universal ambivalence to the asylum era makes us quickly forget the huge investment in both resources and energies that was required in addressing the scandals of private 'madhouses' and the inhumane conditions these provided for people in distress. The huge building programme that was compelled by law was part of an era of social change and the gradual dawning of an air of optimism that had never been present before. That change – built upon revulsion at the cruelties exposed by various Royal Commissions – was later mirrored by further public disquiet at the warehousing and 'therapeutic nihilism' that eventually characterised the end of the asylum era. It could be argued that this mood of disquiet was harnessed by those who were keen to promote a community-focused model of care.

Social policy underpinned by political leverage has produced much change, not only in the physical estate in which services are delivered but also and obviously in the resources available to provide these. This reaches far back into the education and training of the professionals available to deliver them and the resources allocated to the research and development of new modes of care and treatment. We have seen how central directions of a policy nature have shaped (if not actually

required) the ways services are provided. Who will not recall the huge expansion of different forms of service models that have been centrally required? The growth in models of care has given rise to many new forms of service. The list probably appears bewildering at times as professionals and service users attempt to differentiate between Assertive Outreach, Home Treatment, Early Intervention, First Episode, Reablement, Recovery and Peer Led. This list will of course continue to grow as new models are developed and introduced.

As has been argued, policy has to respond to the public mood as well and not purely in ways that seem to be in the interests of individuals alone. Policy has also had to respond to public concern when a strict utilitarian concern has arisen that the needs of the wider society should outweigh (or must be balanced against) those that are purely of the individual. Such public concern in the late 1990s initiated a long and expensive revision of the 1983 Mental Health Act – and indeed, will probably prove a strong disincentive to the legislation being addressed again for many years to come! Yet that change of legislation saw requirements not only in the way that service delivery had to change but also in the legal requirements that could be placed upon how individuals had to behave. This was best evidenced through developments such as community treatment orders.

It is of course tempting as mental health nurses to argue that we practise in a manner that is devoid of others' influence, and that we make assessments, decide on programmes of care and monitor their implementation with a detached air of professional autonomy. However, this book will clearly discuss the many and varied influences which shape the policy that drives and determines the way we work. It has become an accepted truism that 'culture devours strategy': I would like you to think carefully as you read through the following chapters about how social policy determines the culture of the profession you belong to and practise in.

Each chapter will begin with a brief introduction from me and this will contain a number of questions that you can refer to after you have completed the chapter. I hope that these will stimulate you to consider why you do what you do and how you have decided to do it. You may also wish to discuss these questions in the context of a group of colleagues, perhaps in an educational setting. Wherever you do so I trust they will enable you to reflect not only on the chapters you have read, but also (and more importantly) upon the service you provide for those service users, carers and families you care for.

HOW THE BOOK IS ORGANISED

Chapter 1 – The history of mental health policy in the United Kingdom

Chapter 1 sets the scene for the entire book by placing the current developments in an historical context. You will see how the evolution of policy has attempted to deal with issues of social concern in a variety of ways and how current concerns can also be of a longstanding nature.

Chapter 2 – The European context

This chapter places the way we deliver mental health services in the UK in the context of fellow European countries. You will be able to recognise how mental health nursing is not a European-wide practice as we know it here in the UK. In addition, there is an opportunity to ask why mental health nursing has developed in such divergent ways from familiar and shared practices in the past.

Chapter 3 – Community services

Transitions that form institutional models of care to community-delivered services show a wide divergence across Europe, yet here in the UK these have proven to be the most radical transformation (though yet to be completed) of service provision. The chapter will explore this policy 'triumph' here in the UK, with all its attendant concerns and successes

Chapter 4 – Psychosis

Individuals who have been labelled with psychosis have traditionally provoked the most austere policy responses, yet it has been the case that this area of practice has seen wide and far-reaching changes in service provision. The chapter will explore this area and offer a commentary on service providers' concerns and achievements.

Chapter 5 – Older people

With the growth in effective treatments for previously life-limiting conditions older people are now present in more and more services. The need to reconsider images and perceptions of aging will be explored together with the various implications for policy and service.

Chapter 6 – Dementia

Dementia was perhaps one of the reasons for the very creation of the asylum system, and whilst poorly understood it challenged earlier generations to provide a humane service response. The chapter will express the progress and challenges that remain for mental health nurses in providing services for clients in a group considered as destined to grow exponentially in number.

Chapter 7 – Personality disorder

People with a diagnosis of personality disorder possess a label that retains professional, public and political anxiety. Poorly understood and loaded with therapeutic nihilism it remains contentious, and this chapter discusses the challenges in the policy response.

Chapter 8 – Service user involvement

Perhaps next to the actual location of services this has been the biggest transformation in the culture of mental health services. The journey from patient to co-producer – and indeed peer support worker – has transformed many services and lives. This chapter unpacks the agendas and actions that achieved this change.

Chapter 9 – Equalities in mental health nursing

While it may be tempting to consider mental health services as hermetically sealed against the broader society this clearly isn't the case. The broader social agenda regarding equalities resonates clearly with some service users' experiences and the chapter discusses the challenge that nurses (amongst others) face.

Chapter 10 – Child mental health policy in the UK

Children and young people are not 'little adults' and their needs in the context of mental health services are far from being just a smaller version. Thus, the chapter places children's and young people's policy in the wider context of social perspectives on children and their needs. The clear transition from being ignored to having a legitimate and assertive voice is demonstrated in the policy responses provided.

Chapter 11 – Dual diagnosis

The interaction between mental health and substance use is fraught with many complex balances. The picture of therapeutic interactions is further complicated by its proximity to the criminal justice system. The chapter demonstrates how policy makers have tried to ensure that such a fine balancing of priorities remains secondary to client need.

Chapter 12 – Policy into action?

The challenge for a long time has been to try and ensure that policy becomes practice. Common terms today – such as 'nudge', 'policy levers', and even 'traction'– all try to describe how this can be achieved. This final chapter takes a wry look at just how difficult this process can prove to be.

1 THE HISTORY OF MENTAL HEALTH POLICY IN THE UNITED KINGDOM

Peter Nolan

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 inegalitarian 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 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