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New Services for Old – An overview of mental health policy

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Introduction

When the Sainsbury Centre for Mental Health (SCMH) was created in 1985 as the National Unit for Psychiatric Research and Development, mental health policy and the development of services were at a pivotal point. The closing two decades of the 20th century marked a shift from reforming zeal to a more fragmented pragmatism.

This chapter aims to give an overview of mental health policy in the United Kingdom over the past 20 years and to note some of the key changes that have taken place. But to do this justice we need to examine the policy developments in the preceding decade of the 20th century, and particularly the effects of the developing welfare state after 1948.

Developments before 1948

The development of psychiatric services (later mental health services) during the 20th century has been characterised by a movement away from large mental hospitals, which had grown during the nineteenth century, towards extramural forms of care. This movement was not new and had begun in the nineteenth century when, for example, attempts were made to stimulate an integration of psychiatry into the universities (Hill, 1969). In the early 20th century isolated attempts had been made to establish outpatient departments in general hospitals and there were calls for moves to prevent mental disorder and to provide treatments for those patients with disorders not severe enough to warrant incarceration. In 1923 these aims were realised, to some degree, when the Maudsley Hospital was opened to provide treatment for ‘voluntary’ (informal) patients.

The 1930 Mental Treatment Act was the first official Act since the 1890 Lunacy Act to be directly concerned with the mentally ill. It introduced the possibility of informal admission to mental hospitals, emphasised the importance of community support and aftercare, and encouraged the development of outpatient departments and the opening of observation wards. However, in practice little changed and the practice of psychiatry remained

firmly in the large asylums, headed by the medical superintendents and administered by the local authorities.

Developments 1948-1970

The National Health Service (NHS) came into being on 5 July 1948 and with it came the beginning of the development of the modern welfare state that provided the conditions for a shift in policy and practice (Rose, 2001). The provision of social welfare benefits meant that it was no longer necessary to remove the unwaged mentally ill to asylums, and the provision of public housing meant that they could be sheltered outside institutions. In addition, the development of an improved system of primary medical care allowed general practitioners to provide drug treatments in non-custodial settings, and the consolidation of medical and psychiatric social work within local authorities allowed for supervision outside hospitals.

The NHS inherited a large number of municipal, voluntary and mental hospitals which were nationalised and, importantly for psychiatry, meant that mental hospitals operated under the same conditions as other branches of medicine. But the mental hospitals still had a separate governance system, under the Lunacy and Mental Treatment Acts, which required that the Chief Officer should be the Medical Superintendent.

By the 1950s the need for a change in legislation became increasingly apparent and was met by the 1959 Mental Health Act. This new legislation was an outcome of the Royal Commission on Mental Illness and Mental Deficiency, 1954-1957. The Commission had been set up for several reasons (Ramon, 1982). First, the 1930 Act had not repealed the 1890 Act, making legislation too cumbersome. Second, the general atmosphere of affluence encouraged contemplation of further, more liberal, legislation. Third, the media, MPs and professionals were pressing for changes as a result of a series of scandals and concern about poor hospital conditions. Finally, the burden on services, both inpatient and outpatient, was increasing.

The intent of the 1959 Act was “to repeal the Lunacy and Mental Treatments Acts, 1890 to 1930, and the Mental Deficiency Acts, 1913 to 1938 and to make fresh provision with respect to the treatment of mentally disordered persons and with respect to their property and affairs” (quoted in Rollin, 1977). The Act emphasised community care (indeed the Royal Commission’s report was the first government publication to use this term) and implicitly obliged the community (in the form of the local authority) to set up services for those who did not need or no longer needed inpatient care. However, as with the 1930 Act, this was not mandatory and there was no date set for meeting the recommendation of the Royal Commission that central government should provide direct financial support to local authorities for community care.

The occupancy of beds in mental hospitals reached a peak in 1955, after which it began to decline. During the early 1960s optimistic forecasts were produced concerning the reduction of beds in mental hospitals. These were seized upon by the Minister of Health, Enoch Powell, and in 1962 the Conservative Government produced a *Hospital Plan for England and Wales* (Ministry of Health, 1962). A year later they produced *Health and Welfare: The Development of Community Care* (Ministry of Health, 1963). These set the scene for future government policy and predicted that by 1975 there would be a reduction by nearly half in the numbers of local hospital beds and that there would be a split between community agencies and general hospitals.

The development of alternatives to the large mental hospitals began, but was slow and patchy, often relying on enthusiastic and dedicated innovators. Psychiatric units were developed in District General Hospitals, beginning in the Manchester area. Outpatient departments opened; the beginnings of a community psychiatric nursing service emerged; day hospitals were established. But there was no effective system of planning, no overall organisation of community services and no financial backing to allow substantial development. Warnings were made at an early stage that community care for the mentally ill was not helpful if the rhetoric could not be met with adequate resources (Titmuss, 1961).

In the early 1970s, the reorganisation of welfare services by the integration of social work into the new local authority social services departments, recommended in the document known as the Seebohm Report (Barratt *et al.*, 1968), removed the psychiatric social workers from their otherwise collaborative roles with mental health services.

The context in which this post-war development of psychiatry occurred was that of the Keynesian Welfare State. The optimism and hope generated in this period brought with it three major developments in the care of people with mental health problems: the open door policy; the introduction of antipsychotic and antidepressant medication in the 1950s; and the drive to put care back into the community at large (Jones, 1972). Added to these were the desire for psychiatry to gain the status of other medical specialities, and the costs of incarceration and the maintenance of buildings (Rose, 2001). The move away from asylums was supported by research findings demonstrating the importance of living conditions on elements of behaviour and symptom formation previously accepted as an inherent characteristic of the disease itself (e.g. Wing & Brown, 1970).

The impetus to empty asylums existed prior to the development of the new drugs – studies in Britain and elsewhere in Europe had revealed that the introduction of new drugs made only modest impacts on release figures (Shepherd *et al.*, 1961; Odegard, 1964). Later claims that discharge and the re-emergence of social rehabilitation were due largely to the introduction of effective medical treatments are not substantiated by the evidence. Increased discharge rates, shorter stays in hospital and day care for chronic patients were accepted norms in advanced centres before the introduction of effective new medications. Nonetheless, drug therapy did play an important role and fuelled optimism. As

a result, more patients than hitherto became candidates for open wards, and later for placement in the community.

Within this post-war era of corporatist politics grew a number of influential anti-psychiatry movements. These emphasised the mirage of diagnostic categories (e.g. Szasz, 1961), the dangers of hospitals (e.g. Rosenham, 1973), the role of society and the family as primary causal factors in mental illness (e.g. Bateson, 1972; Laing & Esterson, 1964) and the meaningfulness of psychotic phenomena, such as delusions (Laing, 1960). These provided a radical perspective on the need for deinstitutionalisation.

The 1970s

The year 1971 witnessed the first clear statement of government policy *Hospital Services for the Mentally Ill* (DHSS, 1971) which emphasised the importance of non-hospital facilities, and the gradual phasing out of large mental hospitals and their replacement by District General Hospital (DGH) units. In 1975 the White Paper *Better Services for the Mentally Ill* (DHSS, 1975) attempted to provide an analysis of objectives and means of making progress towards a new pattern of services based on experience since 1962. It set out four broad policy objectives, as shown in Box 1.

Box 1: The policy objectives of the 1975 White Paper *Better Services for the Mentally Ill*

1. Expansion of local authority residential, day care and social work support services.
2. Relocation of specialist services in local settings.
3. Establishment of the correct organisational links between day and residential care services, between specialist teams and primary care services, between local authority administrators and planners and between professionals and non-professionals.
4. Staffing improvements which would make possible assessment, review, early intervention and preventative work.

The White Paper emphasised that the suggested guidelines were tentative and that “...even in favourable economic circumstances it would obviously take a long-term programme to achieve in all parts of the country the kind of change we are advocating...even within a 25 year planning horizon...discharge from a hospital into a community which lacks the hospital facilities...may well be a change for the worse”.

If the building blocks of the services had been put down in the 1950s and 1960s, then the 1970s were a time of modest expansion. Rates of bed occupancy fell from a maximum

of 350 per 100,000 population in 1954 to 151 per 100,000 in 1982. In general, overall admission rates increased owing to the increase in readmissions, but the number of new admissions fell until the 1970s. There was an associated decrease in the length of admissions and an increase in the proportion of elderly residents. By 1975 there were 130 psychiatric units in DGHs and this figure rose to 164 by 1981.

The day care of patients was a typically British concern and the first day hospital was established by Josuah Bierer in 1946. The number of day hospitals increased from two in 1949 to 65 in 1966. By 1975 there were 6,000 day hospital places and this rose to 15,300 by 1981. Day centres, meanwhile, were created by local authorities and the first one opened in 1945, but it was not until the creation of local authority Social Service Departments in 1971 that they showed significant development. The number of day centre places rose from 3,403 in 1975 to 5,025 in 1982. The number of places in homes and hostels rose from 3,911 in 1975 to 6,044 in 1981, the main increase being in unstaffed accommodation.

The 1980s onwards

The context has now been set for the examination of the changes in policy and services since 1985. The basis of the modern mental health service had already been laid, but no asylum had yet been closed and only a few community mental health teams and centres existed (the first were set up in 1978) (Sayce *et al.*, 1991). Mental health services were under-funded and the main resources were locked in the large hospitals. By the end of the 1970s the political and social climate had changed.

Since the mid 1970s two identifiable transformations had occurred in the core capitalist states: a general shift to the right of many governments and a decline in the economic climate. The transformations represented a crisis of capital occurring in several economic, political and ideological dimensions. In economic terms the symptoms of the crisis included high levels of unemployment and inflation, a reduction in output and world trade and a growth in the public debt. In political and ideological terms it was represented by a rolling back of the boundaries of the state and an emphasis on the values of individualism. In the UK this was represented by the policies of ‘Thatcherism’: a social market economy and ‘authoritarian populism’ (Hall & Jacques, 1983). These changes were to have an effect on health services in general and mental health policies in particular.

When SCMH opened in 1985, there were two government documents that highlighted the concerns and changes for the 1980s. In 1983 the new Mental Health Act came into operation. This was a consolidation of the 1959 Act and the Mental Health (Amendment) Act, 1982. Its main emphasis was on patients’ rights and it was criticised for the introduction of legalism and bureaucracy – factors that would influence policy in the next two decades. Like the 1959 Act it made recommendations about patient care but the only

legal obligation was for local authorities to provide aftercare facilities for some compulsorily detained patients.

No new resources were allocated to meet the provisions of the 1983 Act. This inadequacy of funding was acknowledged by the report of the House of Commons Social Services Committee (DHSS, 1985) which had received evidence from health services, professional and voluntary bodies and concluded that they were “providing a mental disability service which is under-financed and under-staffed both in its health and social service aspects”. It made three important recommendations regarding health service fiscal policy. First, that policy could only be achieved by a real increase in expenditure; second, that an equivalent proportion of the resources, services and amenities devoted to the most severely mentally disabled should continue to be so devoted in the future; third, that the DHSS should create a central bridging fund. This final recommendation was to figure highly in debates about how to create feasible community services so that the large institutions might be closed.

Two years before the opening of the Sainsbury Centre for Mental Health, the Department of Health had issued a directive to Regional Health Authorities requiring them to attempt to close their large psychiatric institutions. But the NHS faced a critical Catch 22. They had to close institutions whilst at the same time creating effective community services that were adequately financed at the time when all health and social services were under-funded. This led to a series of documents highlighting the plight of patients in the community (e.g. Audit Commission, 1986; 1992; 1994), policy being increasingly directed towards those with severe mental illness (Care Programme Approach, Supervision Registers, Ten Point Plan) and the introduction of the NHS internal market (Griffiths, 1988; *NHS and Community Care Act*, House of Commons, 1990)

During the past 20 years one component has been significant: the increase in official government and voluntary sector documents relating to mental health policy. Prior to the 1980s such documents were uncommon and the majority have been covered earlier in this chapter, but the past 20 years have seen repeated moves to re-organise NHS services and an increasing concern about the provision of services. A brief survey of the Department of Health website (www.dh.gov.uk) at the end of 2004 revealed over 60 official publications directly relating to mental health policy in England. In view of this it is not feasible to review all official policy documents and their development, so the remainder of this chapter will examine main trends in policy over the past 20 years.

Managing risk

Perhaps the most profound change in policy since the 1970s has been related to mechanisms for the control of risk. This is reflected in the types of services that have developed and in the obligations of mental health workers and the organisations providing care. With the demise of the asylums control of patients living in the community has been of central concern. Whereas before the high profile incidents that led to official inquiries related to poor practice and care (e.g. DHSS, 1969) in recent years it has been highly visible tragedies involving the public and others (e.g. DHSS, 1988; Ritchie *et al.*, 1994) that have precipitated policy change.

In common with the rest of the NHS since the 1984 Griffiths Report (Griffiths, 1984), policymakers have sought increasingly bureaucratised solutions such as the Care Programme Approach and the introduction of supervision registers. The new assertive outreach services are an attempt to form highly organised supervision teams for people whose behaviour is regarded as problematic and hard to engage. The increase in the number of medium secure units offers another institutional solution to mental illness and contributes to the return to asylums along with the virtual asylums of hostels and homes for the mentally ill.

The state has been accused of increasing the social control functions of mental health professions, most notably in its attempts to bring in a new Mental Health Act, which has been vigorously opposed by an alliance of mental health professionals, voluntary and charitable organisations and the legal profession. Dubious official pronouncements that ‘community care has failed’ have been voiced, often as a prelude to further policy developments of control.

Current policy and trends

During the 1990s mental health attained a higher profile and priority among government policies, reflected perhaps by its inclusion as one of the priority areas in the 1993 *Health of the Nation White Paper* (DH, 1992) which set out key priority areas for health in England and Wales. It has retained this status and the first of the Labour government’s National Service Frameworks (NSFs) was for Mental Health in adults of working age (DH, 1999). Subsequent NSFs have included mental health care for children (DH, 2004c) and for adults over 65 years (DH, 2001). The Mental Health NSF has been generally welcomed but has been criticised for its prescriptive nature. It has added to the range of services for people with mental health problems and has highlighted the need for improved mental health promotion and the provision of services in primary care. The NSFs have been brought in with the associated promise of increased spending on the health service as a whole and

mental health services in particular, but the increased funding may not have been getting down to the local services (SCMH, 2003).

Standards in mental health services still fall below the rest of the NHS despite the clear advances in treatment and provision of services over the past 20 years: for example Mental Health Trusts were more likely than Acute Trusts to receive a zero star rating in recent assessments (Healthcare Commission, 2004). Increases in funding have been required throughout the post-war period and it remains a concern that funding remains low and poorly distributed (DH, 2004a). Some areas such as mental health promotion, primary care services and rehabilitation remain poorly developed (possibly as a consequence of the focus on acute care associated with the emphasis on control).

The true costs of the Mental Health NSF are probably not realised and are likely to be far greater than the increases in funding have allowed for, and there is certainly a shortfall of trained staff to deliver its demands (DH, 2004b). The commissioning of services is also poorly developed. The effectiveness of the chosen approach of using targets and inspections to improve quality remains to be seen.

Across medicine there has been an increasing demand for evidence-based treatments, represented at the policy level by the creation of the National Institute for Clinical Excellence (NICE), and this as a whole has been well received in mental health practice, perhaps because of the recognition that many historical practices have had dubious validity. Nevertheless, the evidence base in mental health service provision is weak, despite improvements in research over the past two decades, and an exclusive reliance on scientific forms of knowledge has been questioned (Laugharne, 2004).

The changing demographics of society and increasing geographical mobility have altered the social environment in which mental health services are delivered. Policies have now been issued with regard to ethnicity and social exclusion (e.g. DH, 2005; SEU, 2004). A dominant response to changing societal demands has been to place the idea of choice into service policy. This may reflect no more than populist government policies. It indicates the consumerist stance of policy making and indeed may be of little relevance to many with severe mental illness. At its best it reflects an important change towards the increasing voice of users in public services (DH, 2000).

There has been a welcome and increasing emphasis on the central position of the patient or user in the delivery and planning of public services. The previous hegemony of the professions has to a significant extent been eroded away. For health care professionals as a whole, and mental health professionals in particular, these moves create their own tensions. Health care is a competitive economy and not only are professionals asked to provide expert opinions and clear communication that resonates with users' wishes, but they are also expected to act as gatekeepers to finite resources acting on professional judgements not patient preference. This is a political nettle that has yet to be grasped: a policy based around the voice of the consumer, with its associated rising expectations,

cannot be met at the same time as resources are restricted. For mental health professionals, demands for increasing social control provide an additional dimension at a time when users are encouraged to demand an increasing say in their treatments and in the practice of services.

The context of mental health policy in the 1990s to some degree reflects the changes begun in the late 1970s with the rolling back of welfare state provision and a move from collectivist ideologies to an increasing emphasis on individuals and a growing reliance on multi-agency and market solutions to the delivery of public services. The crisis of capitalism in the 1970s gave way to a renewed confidence in its dominant ideologies following the demise of Communism in Eastern Europe. Management of the UK economy has allowed increases in public spending, but the move of public service provision as a whole remains in the direction of a mixed economy with ever increasing emphasis on private sector provision (Pollock, 2004).

There remain, however, essential tensions and contradictions at the heart of policy. The gap between rich and poor has increased over recent years and we are facing widening inequalities in society which have implications for the health of both individuals and communities; evidence suggests that what matters within societies is not so much the direct health effects of absolute living standards so much as the effects of social inequalities (Wilkinson, 1996). Health is powerfully affected by social position and by the scale of social and economic differences among the population. In the developed world, it is not the richest countries that have the best health but the most egalitarian. Wilkinson (1996) argues that an important characteristic shared by the healthy egalitarian societies is social cohesion: that they have a strong community life. Thus instead of social life stopping outside the front door, public space remains a social space; individualism and the values of the market are restrained by social morality; people are more likely to be involved in social and voluntary activities outside the home; there are fewer signs of antisocial aggressiveness and society is more caring. In short the social fabric is in better condition.

This is crucial to mental health and illness and is a barrier to improving the mental health of the nation and the social environment in which mental health services are delivered.

Conclusion

Mental health policy has changed over the course of the 20th century as have the location and practice of mental health services. The central shift occurred after the Second World War with the development of the modern welfare state, which provided some of the material and ideological conditions to move from institutional care to community-based services. The post war consensus began to be eroded in the last quarter of the 20th century and the optimism of the post war decades now seems like a bygone age. The

shift in policy has been from one that reflected this optimism to one that pays increasing attention to control. Nevertheless, almost 200 years after they began, all the asylums in England have closed, many have been sold, there are an increasing number of community-based facilities, and fears about the ex-inmates of institutions filling the ranks of the homeless have not been realised. And mental health matters have at last become a real priority for health policy, as evidenced in the ever increasing number of policy documents produced on the subject.

Direct threats to mental health services come from their continued under-funding, patchy policy implementation, the continued fragmentation of services, the growing emphasis on social control and the chronic shortfall of trained personnel. Broader threats arise from the increasing inequality seen both at a national and a global level and from the neo-liberal policies which have given rise to it. Modern practice arose from the development of welfare state provision and modern services have been developed on the back of these. Today the very concerns that gave rise to the welfare state sixty years ago are as powerful and as urgent as ever.

Sample chapter from

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The last 20 years have seen dramatic changes in UK mental health services. From a system dominated by large Victorian hospitals to a service based on a growing range of community services, mental health care has been transformed in the last two decades. This book charts that progress and examines the key issues facing mental health services. With contributions from many of the country's leading experts in mental health care, it is essential reading for anyone wanting to learn about recent developments in policy and practice.

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