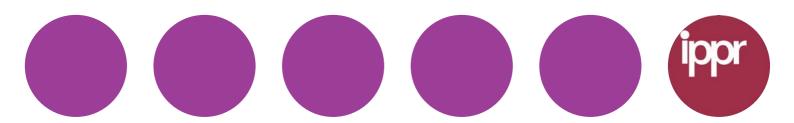# Mental Health in the Mainstream

Developments and trends in mental health policy

JENNIFER RANKIN

WORKING PAPER **ONE**

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rethink
severe mental illness

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The Institute for Public Policy Research (ippr) is the UK's leading progressive think tank and was established in 1988. Its role is to bridge the political divide between the social democratic and liberal traditions, the intellectual divide between academia and the policy making establishment and the cultural divide between government and civil society. It is first and foremost a research institute, aiming to provide innovative and credible policy solutions. Its work, the questions its research poses, and the methods it uses are driven by the belief that the journey to a good society is one that places social justice, democratic participation, economic and environmental sustainability at its core.

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About Mental Health in the Mainstream

What would it take to move towards a society that fully supports the rights and inclusion of people with mental health problems and knows the value of good mental health?

Mental health is at a crossroads. On one side mental health policy is changing in response to the new agenda of human rights, anti-discrimination and social inclusion; on the other it remains shaped by concerns over public order and risk management. Within specialist services, there are tensions between therapy and management and between greater user choice and service control. In society at large, there are emerging concerns about the state of public mental health and wellbeing which are evident in the growing concern about rising use of anti-depressants. Amid these different trends, there is no clear direction about the future of mental health.

ippr are working with Rethink on a new project that will set out a future vision for mental health policy. The main output will be an ippr report, due to be published in Spring 2005. This report will be rooted in the experience of service users and will draw on original qualitative research. The aim is to influence future developments in mental health policy, drawing lessons from policy experiences since 1990.

In the run up to this publication, ippr will publish three short working papers, with the aim of discussing some selected issues ahead of the publication of the report next year. We hope they will help engage a wide range of people in the debate. Each working paper will be a short introduction to a few key issues rather than an exhaustive study of the topic. As such, the working papers will focus on particular examples to illustrate the different themes that are shaping mental health policy:

- Working paper 1, November 2004: **Developments and Trends in Mental Health Policy**
- Working paper 2, December 2004: **Mental Health and Social Inclusion**
- Working paper 3, March 2005: **The Future of Mental Health**

Scope of the Project

Mental health problems are more common than asthma. Up to one in six people suffer from them over the course of their lifetime, while 630,000 people have severe mental health problems at any one time, ranging from schizophrenia to deep depression. Beyond this, mental health has a far wider impact on families: there are over 1.5 million carers supporting people with mental health problems (including dementia).

As in other areas of people's lives, mental health is complicated. Mental health problems encompass a broad spectrum of experiences that affect people across the life-cycle. People do not experience mental health problems in isolation; in particular severe mental illness is frequently linked to poverty, discrimination and other complex needs. Health and social care services are demarcated by labels that mask the imprecision of people's lived experiences.

Mental Health in the Mainstream aims to reflect this diversity of experience. However, the project does focus on adults with severe mental health problems, although this will be situated within mental health issues more broadly. It is an opportunity to explore the distinction between 'severe' and 'common' mental illness, and examine the concept of public mental health. The project is primarily focused on England, but will draw on examples from the devolved countries and may be of interest beyond England.

About the author

Jennifer Rankin is a researcher in health and social care policy at the ippr. Her publications include *Meeting Complex Needs: The Future of Social Care* and *Who Cares? Building the Social Care Workforce*, she has also written for the December 2004 issue of ippr's journal *New Economy*.

Introduction

This paper is motivated by a paradox. Mental health is one of Government's top three priorities for the health service and has seen sustained policy activism and extra resources. Yet despite both money and activity, there is a widespread sense of unease that improvements are not happening fast enough and not making a real difference to the lives of service users. While it is increasingly accepted that the NHS is delivering better services, there is a concern that mental health is not keeping pace with either rising expectations or general improvements in the NHS.

Of course, all government departments struggle to close the gap between official pronouncements and policy implementation. Arguably, this is especially true of mental health. Neither cancer nor coronary heart disease services, the other two of the top three priorities for health services, have had to overcome the same legacy of under-resourcing, public stigma and mistrust of medical professionals, which all combine to create distinctive challenges for the mental health reform agenda.

This working paper aims to show how the changes introduced by Government policy, as well as broader social trends, have had an impact on the development of mental health services. At the time of writing, the Government is half-way through the ten year plan, set out by the National Service Framework (1999). As such, this is an opportune time to consider how mental health services are developing. This paper is not a complete audit of the impact of Government policy in mental health. Rather, it offers an introduction to the financing of mental health services and an examination of selected targets, in particular early intervention. Through these, it aims to highlight some contrasting developments and tensions within policy.

The primary focus of this work is on adults of working age with severe mental illness. While the work programme will address all aspects of mental health, this working paper is exclusively concerned with severe mental illness in the context of broader provision of mental health services. It is hoped this will help to open further discussion about the development of policy to date and suggest some areas for future change.

Developments and trends in mental health policy

Over the last two decades the ethos of mental health services has changed significantly. In the early 1980s service users and carers were rarely involved in the planning and management of services; the number of user groups was small and independent advocacy was still a novelty. The debate has now moved on: providers no longer dispute the right of users to be involved, but discuss the best mechanisms for ensuring that user involvement is meaningful.

Labour came to power with aspirations to create more personalised and responsive health and social care services. In many respects, these were an extension of earlier aims established under the NHS Community Care Act 1990. This heralded a system led by demand rather than pushed by supply, as well as a greater role for service users and their families in decision-making. At the centre of mental health policy is the National Service Framework (NSF), which sets out national standards for users with all kinds of mental health problems (Department of Health (DH) 1999). While the NSF has not avoided criticism, it is generally commended for setting standards of good practice across a range of areas, including mental health promotion, primary care, services for carers and preventing suicide. These aspirations have been detailed by numerous targets covering the quality and quantity of front-line services and supported by extra planned resources totalling £1 billion over five years. However, as this paper will show, the impact and effectiveness of targets and extra resources over the period 1997–2002 has been much disputed.

Changes in policy have been paralleled by the emergence of a new agenda in psychiatry. In recent years, there have been calls for a new focus on people and their lived experience in order to deliver more effective services. For example, writing in the *British Medical Journal*, two prominent psychiatrists have argued that the profession should strive towards greater user involvement. They argue that this would be a powerful force to reconcile the profession with the 'anti psychiatry' or survivors movement: 'This government (and the society that it represents) is asking for a very different kind of psychiatry and a new deal between health professionals and services users' (Bracken andThomas 2001).

The development of a more person-centred psychiatry did predate this rallying call. Prior to this, other professionals have argued that services need to take closer account of how service users report their own needs and wellbeing (Oliver et al. 1996). However, the call to look 'post-psychiatry' is a reminder of how far the profession still needs to go in order to adapt to promoting user-led services.

In future, it is likely that the Human Rights Act, 1998 (which came into force in 2000) will have an impact on the position of service users. The extent of that impact is uncertain, with some experts suggesting that the Act does not go far enough in promoting the autonomy of service users (Bindman et al. 2003). These broad social changes are a response to the demands of users, who for decades have challenged the presumption that the medical profession knows best.

The new policy landscape in mental health services is shaped by two central aims that are common across public services. Firstly, the goal of delivering more personalised, responsive services and secondly, social inclusion for people experiencing multiple deprivation. However, mental health problems are surrounded by stigma and myth and therefore mental health operates in a different context to other public services. As such, there are contradictory aims at the heart of policy.

Personalisation in mental health services

Personalisation is a term that covers a broad spectrum of practical realities about involving people in their own care. At one end, it covers consultation, for example when users of mental health services are consulted about the day-to-day management of a mental health trust. On a

more ambitious level, personalisation means that users act as 'co-producers' of their own care and are able to take responsibility for determining when and how they are treated. In practice, this could mean greater choice for service users in decisions about medication and treatment, or using a direct payment to purchase their own care.

Arguably, mental health services have made more progress in the former area. With over nine hundred formal user groups, the user movement is in a fair state of health. Over the last decade, there has been progress in putting users' voices and views into services from involving users in the development of national policy (for example, the NSF) to the local forums charged with implementing it (Williamson 2004). As the experience of mental health trusts demonstrates, putting user involvement into practice entails a major cultural shift, but can be successful in breaking down mutual stereotypes that divide professionals and service users. Promisingly, user involvement in the management of mental health services predicts higher levels of engagement in care (Perkins et al. 2004).

Less progress has been made in ensuring that service users are fully involved in decisions about their own care. Traditionally, mental health services have been associated with coercion and control and these elements remain prominent. In this case, some of the promises contained within the policy framework have yet to have a real impact on the ground for many service users. The National Service Framework promised users on the Care Programme Approach a written copy of their own care plan.[1] Some years on, many users do not even have a care plan or a care co-ordinator, let alone a copy of the plan (Commission for Health Improvement (CHI) 2003). The absence of a care plan is symptomatic of the fact many users are uninvolved and disengaged with their own care. Likewise, the take up of direct payments among people with mental health problems is very low – although the Social Exclusion Unit (SEU) has signalled this as a priority for the future (SEU 2004). Evidence of lack of engagement and lack of choice is reinforced by the findings of the first ever official survey of mental health patients. Although three quarters of patients rate their care to be good, very good or excellent, many wished to be more involved in decisions about their own care (Healthcare Commission 2004). Significantly, the formal evaluation by the Commission for Health Improvement has found some mismatch between official views on targets and user perceptions of the service received (CHI 2003).

The trend towards more personalised services is also reflected in the aspirations for better support for carers. There are over 1.5 million people caring for people with mental health problems (including dementia). Contained within the National Service Framework was a promise that carers would no longer be marginalised, but would receive their own care plan to assess their individual caring, physical and mental health needs. Again, results are mixed. A survey of carers in touch with Rethink found that almost half believe that support for carers had improved. However, one in six said they had no local support in their area (Pinfold andCorry 2003a). In practice, the local services that carers (might) want will vary and there is no single model of service provision that suits all carers (Arksey 2002).

The aspirations for more personal services have also been driven by an awareness of people's different experiences of public services, according to race, culture and gender. There is widespread recognition that mental health services have failed many ethnic minority patients and in particular, African-Caribbean men. Studies have shown that they are more likely to be diagnosed with schizophrenia and less likely to be diagnosed with depression. In treatment, they are subject to a restrictive care regime and less likely to receive therapeutic interventions (Keating et al. 2002). This can be contextualised against the fact that some ethnic minority families, including black, Bangladeshi and Pakistani communities have a higher than average experience of poverty (Paxton and Dixon 2004). Yet, as the inquiry into the death of David Bennett found, the problems in mental health services have been discovered and rediscovered

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1 The Care Programme Approach was introduced in 1991 to ensure comprehensive care for people with severe mental health problems.

over many years. So far, understanding the problem has yet to lead to real changes throughout services (Independent Inquiry 2003).

The 1980s saw the emergence of a feminist critique of mental health services which questioned the approach that women's mental health was inevitably related to biological functions. Gender sensitive analysis showed that women are more vulnerable to depression and men are more vulnerable to alcohol disorders. Women and men also experience mental health problems differently, for example men with schizophrenia are less likely to have independent living skills than women with the same diagnosis (Astbury 1999). However, there has been little progress in developing women-only services over this time (Barnes et al. 2002). This has been redressed by the development of implementation guidance on developing women's mental health services (DH 2003a). However, so far progress has been mixed. In one survey, almost a quarter of respondents reported that they were being accommodated in mixed sex wards, despite the Government's claim that they were practically eliminated (MIND 2004).

In recent years, the shift towards a user perspective has encouraged a greater focus on issues around mental health and social exclusion. Allied to this is a greater willingness to look at the interconnected nature of people's needs and how poor mental health can be undermined by other problems, such as substance abuse, bad housing and a lack of social support (Rankin and Regan 2004). The Social Exclusion Unit's report on mental health and social exclusion signalled a strong commitment to tackling the links between poor mental health, poverty and exclusion from employment and social opportunities (SEU 2004). The second paper in this series will consider these issues in greater detail.

Taking a long view, personalisation and social inclusion are recent trends in mental health. These ambitions are challenged by the older culture of fear and discrimination that surrounds severe mental illness. Although mental illness has long been stigmatised, the early 1990s marked a new intensity in public fear, when a series of public inquires into the mental health system discredited the concept of community care. While the number of homicides committed by people with mental health problems has remained stable over the last forty years, strong media and political interest on small number of cases of personality disorder has fostered the impression that mental illness is inextricably linked to dangerousness (Laurance 2003).

It is widely feared that the proposed Mental Health Act will restrict the liberty and rights of people with severe mental health problems. However, the likely impact remains extremely contested, as Ministers argue it will have an impact on 300–600 people and campaigners suggest it could affect 50,000 people. Certainly, the discussions have ensured that coercion and risk management have remained at the forefront of discussions around severe mental illness.

It is evident the impetus to minimise risks and manage people is partly driving the mental health system. For example, it has been suggested that the increase in the numbers of secure beds is a result of this tendency. Between 1995–6 and 2000–1 all parts of England saw an increase in the number of secure beds, with the largest increase (ninety-five per cent) taking place in London (McCrone 2003). There is a need for a more precise understanding as to why the closure of old psychiatric hospitals has been followed by a substantial growth of care in more restrictive care settings. More careful scrutiny of the coercive aspects of the mental health system is essential to ensure that overall goals of rights and inclusion are not displaced by risk management and exaggerated public fears.

Where did all the money go?

Like much of the Government's agenda for public services, resources for mental health have been tied to reform. Yet in reality, many have cast doubt as to whether the language of priorities has been matched by the necessary financial commitment. There are two key criticisms: firstly that the headline figures pledged have not even reached services and secondly, that the extra
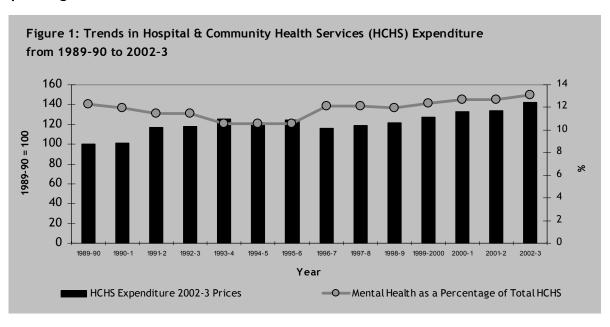
resources have had little impact on the development of frontline services. A related charge is that the extra resources and targets have distorted priorities and created perverse incentives.

The majority of the money for mental health services comes from central funds distributed by the Department of Health. In addition, local authority social services spend around five per cent of their annual budget on services for adults with mental health problems. In the context of health and social care services, mental health has long had a reputation as a 'Cinderella service'. Statistical evidence indicates why this claim gained such wide currency. Figure 1 shows that between 1990–95 the proportion of spending on mental health was falling even though resources for hospital and community health services were rising in real terms.

An integral part of the Government's reform strategy is extra resources for health services. Between 1998 and 2008 spending on the health service is expected to increase at the rate of around seven per cent a year in real terms, bringing UK health spending as a proportion of GDP into line with other EU spending. As Figure 1 shows, mental health has shared in this growth. It has seen an increase in spending and a one per cent increase in spending as a proportion of hospital and community services.[2] Figure 2 shows the real term growth in mental health spending in local authority social services. Between 1994–5 and 2002–3 social services expenditure doubled in real terms and mental health shared in this growth.
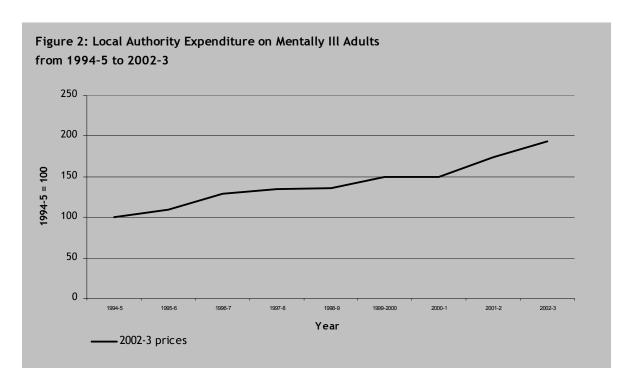
It is unlikely that there will be any new developments in funding for mental health over the 2001–5 Parliament. One important fact is that the rate of growth in social services spending is due to fall. Social services proved to be the surprise loser of the 2004 Spending Review: over the years 2006–8, the rate of growth in the personal social services budget will fall to 1.3% a year in real terms, which is less than the underlying rate of growth in the economy. This fact has been somewhat obscured by the Treasury's deployment of the figure of 2.7%, which shows average growth over three years (Robinson 2004)

Spending Trends in Mental Health

Figure 1: Trends in Hospital & Community Health Services (HCHS) Expenditure from 1989-90 to 2002-3

Source: Hospital and Community Health Service data provided by the Department for Health.

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2 'Hospital and Community Health Services' (HCHS) include acute services, obstetric, geriatric, learning disability, mental health and community services such as health visiting, district nursing, prevention, chiropody, family planning, and school health. Information provided by the Department of Health.

Figure 2: Local Authority Expenditure on Mentally Ill Adults from 1994-5 to 2002-3

Source: Personal *Social Services Expenditure and Unit Costs England* 2002–3 and *Finance Statistics of Council Social Services Departments* 1994–5 to 2002–3.

Evidently, money for mental health is increasing, both in real terms and as a proportion of NHS spending. However it is difficult to trace the final destination of the money and its impact on services. In theory, over £1 billion were made available for mental health services between 1997 and 2002. The White Paper *Modernising Mental Health Services* (1998) pledged £700 million into the development of new services, including: 'extra beds of all kinds, better outreach services, better access to new anti-psychotic drugs, 24-hour crisis teams, more and better trained staff, regional commissioning teams for secure services, and development teams'. Following this, *The NHS Plan* (2000) pledged that over £300 million would be made available to 'fast forward' the National Service Framework. These figures have been repeatedly cited. For example, in 2004 the Primary Care Progress Report stated that three hundred million of 'extra investment' had gone to support the implementation of mental health services across primary care (Department of Health 2004). As in other public services, policy makers' repeated assertions about the scale of the extra resources have intensified expectations. This may have been a tactical error, as it seems the extent of the new resources has not matched up to the £1 billion promised.

The Government's own figures show that the total sum falls short of this headline figure. In answering a Parliamentary question, the minister responsible for mental health showed that the total additional amount allocated to mental health services between 1999 and 2002 was £295.35 million (Smith 2001). This was the period that was covered by the spending of £700 million announced in 1998. Even under the most generous interpretation, which takes into account the Government's controversial double and triple counting of the money announced in the 1998 Comprehensive Spending Review, the sum still falls short. Using this method to examine spending over 1999–2002, it has been estimated by Rethink that the total rises to £623.35 million. Although this is a considerable sum, it still falls slightly short of the promised £700 million (Rethink 2002). This indicates a problem; lack of transparency makes it difficult to trace whether

new resources reached their intended destination. As such it is difficult to measure the precise impact of new money on frontline services.

Despite extra resources, it is evident that mental health trusts are generally below the standards of the average health trust. According to performance ratings, mental health trusts have the lowest number of three and two star trusts and the highest number of no star trusts, in comparison to acute trusts, primary care trusts, specialist trusts and ambulance trusts (Healthcare Commission 2004b). Notwithstanding ongoing contention over the robustness of the star ratings, it is striking that even by the Government's own standards mental health trusts are lagging behind the rest of the health service. The Commission for Health Improvement considered that historical neglect was still evident in low staff levels, reliance on agencies and poor clinical leadership (CHI 2003). More than half of mental health trusts have had difficulties in implementing their action plans and many stated that these difficulties arose through funding constraints (Audit Commission 2003). In a survey of Local Implementation Teams, managers cited budgetary constraints as hampering the implementation of NSF and NHS Plan targets. The survey also highlighted that staff shortages and inherited debts have held back the development of new services (Sainsbury Centre for Mental Health 2003). Other experts have judged that some health authorities 'disinvested' from mental health services during this period (Perri 6 and Edward Peck 2004).

The Wanless report raised fundamental questions about optimal spending on healthcare and how much needs to be spent to achieve high quality health services. Firstly it drew attention to underfunding of services. Specifically for mental health, it calculated that in order to successfully implement the National Service Framework, spending on mental health services for adults would need to increase by £3.1 billion by 2010–11, roughly doubling existing spending (Wanless 2002). However, so far, the Government has not taken up this invitation to direct resources into mental health from the centre. There needs to be greater understanding about the optimal level of spending for mental health services. Discussions on spending go beyond the NHS, there also needs to be greater consideration of the appropriate level of resources required for other services to promote a mentally healthy society.

By 2008, Government will need to assess the impact of extra spending on health services. Inevitably, there will also be questions about progress towards better mental health services. If services do not meet expectations, some may ask whether there was a missed opportunity to put more resources into mental health. As has been indicated, these questions are clouded by the fact that it is difficult to measure the impact of current spending on frontline services.

Early Intervention

Early intervention teams are part of the new wave of specialist services introduced by the NHS Plan (2000). Along with Crisis Resolution Teams and Assertive Outreach Services, they constitute a network of active community services in severe mental illness, which are due to be fully developed by the end of 2004.

NHS Plan Targets

Assertive Outreach: 260 teams (220 assertive outreach teams by 2003)
Crisis Resolution: 174 teams (335 crisis resolution teams by 2004)
Early Intervention: 48 teams (50 services by 2004)

Source: Durham Service Mapping www.dur.ac.uk/service.mapping/amh. At the time of writing, the data from Durham Service Mapping is complete until 2003. The figure of forty-eight is taken from the September 2004 table and this is likely to change when the datasets are completed in November 2004. The 2003 data shows that some teams had no cases and no or very few staff. This suggests that several are still in the process of being established rather than fully up and running. In many areas early intervention is restricted to *teams*, rather than previous pledge of *services*. This is a significant distinction from the original target.

Early Intervention Teams possess many of the characteristics of the new user-centred focus in mental health policy. Although they are relatively new, their aims have evolved quickly and in practice are likely to vary in different parts of the country. Originally, the early intervention teams were set up to stop the development of psychosis and tackle the duration of untreated psychosis in young people between fourteen and thirty-five. Some observers are optimistic that as the services continue to develop the duration of untreated psychosis will fall (Burns 2004). These aims soon expanded to encompass a growing interest in helping with the personal and social crisis that accompanies the onset of severe mental illness. As such, it is likely that there will remain a significant degree of variation amongst the services. In practice, an early intervention service can vary between several teams of around forty-five staff to just one nurse who works on early intervention for a Child and Adolescent Mental Health Services (CAMHS) (*see* www.dur.ac.uk/service.mapping/amh).

The development of this type of service is a consequence of new knowledge in psychiatry. New evidence shows that schizophrenia is treatable during the critical period of its early development and does not mean a gradual and inevitable decline for the individual. Among the research community, the efficacy of early intervention services is debated, but there is recognition that the principles behind the service can lead to better outcomes for people with severe mental illness (Pelosi and Birchwood 2002). More recently, there has emerged a new enthusiasm amongst clinicians to prevent psychosis before it develops.

The creation of specialised services, such as early intervention teams suggests the question: what is the future for the (bog) standard Community Mental Health Team (CMHT)? These teams have not received an injection of resources, indeed they may have been subject to reduced resources since the creation of specialised services (Singh et al. 2003). Moreover it is likely they have lost trained staff and intellectual capital, following alleged 'recruitment raids' (Pelosi and Birchwood 2002). Community mental health teams provide services to the majority of people with severe mental health problems. It has been considered that these teams, lacking in high profile advocates, will find it difficult to meet people's needs (Burns 2004). The quality of life of people who have lived with poor mental health for many years may have been overshadowed by the drive towards more preventative services for people who are acutely unwell. Surveys by voluntary organisations have pointed to the fact that long term service users experience poor quality of life, loneliness and isolation (Corry et al. 2004). There is a risk that the focus on assertive community services for younger people with more severe problems leads to the development of islands of high quality specialist services among poorer quality, routine services.

Some are sceptical about formalising the concept of early intervention around a service driven to reduce psychosis, as opposed to making early intervention 'a core task for general psychiatry' (Whitwell 2001) It has been argued that early intervention can be situated within a generic community mental health team (Whitwell 2001, Paxton 2003). Inevitably, the development of these new services raises questions about what happens to existing services and users who don't fit the early intervention model. Almost half of first time psychotic episodes happen above thirty-five years and this is particularly true for women, where psychosis peaks between the ages of forty-five and fifty-four (Craig 2003). There are unanswered questions about what happens to people who leave the early intervention service after three years. Neither is anything known about troubled young people who exhibit psychotic-like symptoms, but are not taken on by the service.

Overall, early indications suggest that early intervention services could be a welcome development to promote prevention and easy access. The service helps to promote better outcomes for users and reducing the duration of untreated psychosis can reduce coercion and long term disengagement with mental health services. These services are symptomatic of the best developments in mental health services. However, their real value should be understood in

the overall context of mental health services. To an extent, targets have served to divert resources to the 'acutely unwell' away from more long term service users.

Access

Early intervention services need to be viewed in the context of general access to mental health services. The NSF set standards for access: services should be available to people with common and severe mental health problems twenty-four hours a day, all year round.

Recent reports highlight that early access remains problematic for people with severe mental illness. Two fifths of patients had had an appointment cancelled or changed at least once within a year (Healthcare Commission 2004). There remain frequent problems in accessing services out of hours. In some trusts only one in four people had access to crisis care. Disturbingly, the Commission for Health Improvement found that in some areas police cells are the only place of safety for service users (CHI 2003). A survey by Rethink showed that one in four people took more than eighteen months to get the help that they needed (Pinfold and Corry 2003b). It is noticeable that while questions of access (i.e. waiting lists) have dominated the agenda in acute services, there has been no corresponding public pressure for speedy access to mental health services.

Anti-stigma

The current shift towards preventative public health augurs well for mental health promotion. Although *Our Healthier Nation* (1999) is pre-eminently concerned with suicide reduction, it did present a vision for good mental health for the whole population.

It is well recognised that one of the biggest potential barriers to mental health and early intervention is stigma and discrimination facing people with mental health problems. Recent years have seen numerous campaigns from the Government, the Royal College of Psychiatrists and a number of voluntary organisations to tackle discrimination against people with severe mental health problems. These campaigns reveal some inconsistency in public attitudes. Whereas the Department of Health survey showed a decline in acceptance for people with mental illness, others have shown some marginal increase in public tolerance. A survey conducted by the Royal College of Psychiatrists following their campaign, *Changing Minds: Every Family in the Land*, showed that five per cent fewer people thought that people with schizophrenia were dangerous, although there was less change in the general population's views on addictions (Department of Health 2003, Crisp 2003). This limited change suggests how far discriminatory attitudes still need to be overcome.

Changing Minds is an interesting example of an anti stigma campaign. It emphasised the prevalence of mental illness by headlining the fact that as many as one in four people experience some kind of mental health problem, thus making it something that affects every family in the land. Yet serious mental disorders are not common. As one observer has commented the strategy 'risks confusing frequency with fairness' (Smith 2002). Moreover, there is some evidence to suggest that the public are sceptical about the 'one in four' statistic and don't link severe mental illness to common mental health problems (Sayce 2000). There is a clear disconnect between mental health promotion for common and severe mental health problems. Some have criticised the existing strategy for focusing on acceptance at the expense of equality. Furthermore this might be open to interpretation that only people 'like us' deserve treatment, a strategy which undermines tolerance for people with severe mental illness. Consequently, it has been argued that the goal should be acceptance of difference, rather than denial of difference (Smith 2002).

There is increasing awareness of the different components that ought to make up an anti-stigma campaign, covering aims, audience, method and evaluation (Mental Health Awareness in Action 2003). One positive feature of anti-stigma strategies is that people are responsive to hearing service user's stories and can change their mind after encountering user perspectives (Burns 2004). This suggests the importance of emphasising users in any public campaign and is a lesson that the Department of Health has taken on board in the new campaign *From Here to Equality*.

Undeniably, changing minds is slow work. As the Social Exclusion Unit report highlights, anti-stigma remains an area of ongoing work for the Government (SEU 2004). There have been positive steps to support anti-discrimination; such as the extension of legal protections to people with mental illness under the draft disability bill. In future, there needs to be a commitment to an adequately resourced anti-stigma campaign, accompanied by a positive vision of wellbeing and social support for people with severe mental illness.

Conclusions: The Politics of Mental Health

'Priority' is a prominent word in political vocabularies. It is likely that the consequences of designating mental health one of the Government's 'top three priorities' will remain contested. Mental health policy is a work in progress, with signs of positive change as well as evidence that policies have not challenged some long-standing problems.

It is clear over the last two decades that services have benefited from wider social changes, such as the growing strength of the user movement. It is also possible to say that mental health services have benefited from reforms implemented in recent years, for example, greater attention to the needs of carers, service attempts to be user-driven, as well as the development of early intervention and assertive outreach.

It is too soon to reach definitive conclusions about new services. Casting a spotlight over early intervention has shown how these services might lead the way in promoting a new ethos within mental health. But to some extent, mainstream services have been left in the dark. Targets on specialist teams for the acutely unwell could be diverting attention and resources from community mental health teams, which offer services for people who have long-term mental health problems. In general, people with mental health problems have poor quality of life, although this is an issue that is rising up the political agenda. Still, it is likely there is a substantial group of people who are yet to reap the benefits of the Government's prioritisation of mental health.

Mental health services have not benefited consistently from extra resources. Despite additional resources, service quality remains variable and in some places, personalised care is more aspiration than reality. There is evidence of ongoing staffing problems as well as a failure to respond to the complexity of individual needs. Long-standing concerns over funding remain.

Between 1997 and 2003 money for mental health increased in real terms both within the NHS and local authority social services. However these extra resources have not allayed concerns that mental health is under-resourced.

It is hard to avoid the conclusion that the way extra resources have been presented have damaged the delivery of reform. As with other public spending announcements, the Government's readiness to talk up 'investment' has been followed by disillusionment when the actual sums arrived. Just as the Government has talked up spending, it has talked down reduced growth in spending, as is the case with resources for the personal social services after 2006. This is suggestive of a general reluctance to articulate the case for putting resources into services for vulnerable or socially marginalised people, such as those with mental health problems. Without a sustained political argument as to why these services need to be resourced appropriately, this could leave future services at risk of cuts and policies at risk of reversal.

On a practical level, the lack of clarity around the extra resources makes it difficult to trace their impact on frontline services and outcomes for service users. There is a need for greater transparency on government spending on mental health. Firstly, this will contribute to a better understanding of the impact of extra resources. Secondly, it will help to determine the right level for future spending and open up discussion about optimal spending on mental health services.

It is doubtful that mental health services have made good on decades of under-resourcing. Despite improvements, mental health has not kept pace with the general level of improvements in the NHS. One telling fact is that the standards of the average mental health trust are lower than other health trusts, according to the Government's own ratings. The Wanless report (2002) suggested that resources for mental health would need to double if the National Service Framework is to be fully implemented. (In the long run some of these costs might be offset by

savings in the cost of mental illness and crime). It is highly likely that mental health will need a bigger share of the NHS budget if mental health services are really to see a step-change in quality. Beyond the NHS, there are questions about the optimal level of spending required to address the prevalence of mental health problems and promote a mentally healthy society.

This paper has focused on people with severe mental illness. Notwithstanding real and substantial problems of stigma and public fear, the prospects of a person with severe mental illness are better than ever before, especially in terms of care and treatment. Yet there is much further to go before people with mental health problems are empowered by their care and treated as equal citizens in the community. These issues will be considered as part of our next working paper.

References

- 6 P, Peck E (2004) 'New Labour's Modernization in the Public Sector: a Neo Durkheimian Approach and the Case of Mental Health Services', *Public Administration* 82 (1) 2004
- Arksey (2003) 'Scoping the field: Services for Cares of People with Mental Health Problems, *Health and Social Care in the Community* 11 (4)
- Astbury (1999) *Gender and Mental Health:* Global Health Equity Initiative Project at the Harvard Center for Population and Development Studies
- Audit Commission (2003) *Achieving the NHS Plan*: AC
- Barnes et al. (2002) *Women Only and Women Sensitive Services:* The University of Birmingham
- Bindmen et al. (2003) 'The Human Rights Act and Mental Health Legislation', *British Journal of Psychiatry* 182
- Bracken P, Thomas P (2001) 'Post Psychiatry: a New Direction for Mental Health', *British Medical Journal* March 24th 2001
- Burns T (2004) *Community Mental Health Teams*: OUP
- Craig T (2003) 'Editorial: a Step Too Soon or a Step Too Far?' *Journal of Mental Health* 12 (4)
- Crisp A (2003) 'An Update on the College's Anti Stigma Campaign Website' *Psychiatric Bulletin* 27
- Commission for Health Improvement (2003) *What CHI has found in Mental Health Trusts*: CHI
- Corry P et al. (2004) *Lost and Found: Voices from the Forgotten Generation:* Rethink
- Department of Health (1998) *Modernising Mental Health Services*: DH
- Department of Health (1999) *National Service Framework for Mental Health*: DH
- Department of Health (1999) *Saving Lives: Our Healthier Nation*: DH
- Department of Health (2000) *The NHS Plan*: DH
- Department of Health (2003) *Mainstreaming Gender and Women's Mental Health - Implementation Guidance*: DH
- Department of Health (2003) *Press Release, ref 2003/0239* from www.doh.gov.uk/public/england.htm
- Department of Health (2004) *The NHS Improvement Plan*: DH
- Healthcare Commission (2004) *Healthcare Commission Patient Survey:* Commission for Healthcare Audit and Inspection
- Healthcare Commission (2004) *NHS Performance Ratings* 2003-4: Commission for Healthcare Audit and Inspection
- Independent Inquiry (2003) *Independent Inquiry into the Death of David Bennett*: Available at www.guardian.co.uk
- Keating et al. (2002) *Breaking the Circles of Fear*: The Sainsbury Centre for Mental Health
- Laurance J (2003) *Pure Madness: how Fear Drives the Mental Health System*: Routledge
- McCrone P et al. (2003) *Mental Health Service Activity in London*: The King's Fund
- Mental Health Awareness in Action (2003) *How Can we Make Mental Health Education Work:* Available at www.rethink.org
- Mind (2004) *Ward Watch:* www.mind.org.uk
- Oliver J et al. (1996) *Quality of life and Mental Health Services*: London, Routledge
- Paxton R et al. (2003) 'Early Intervention in Psychosis: a Pilot Study of Methods to Help Existing Staff Adapt', *Journal of Mental Health* 12, 6
- Paxton W, Dixon M (2004) *The State of the Nation: an Audit of Injustice in the UK*: ippr
- Pelosi A, Birchwood M (2002) 'Is Early Intervention for psychosis a waste of valuable resources', *British Journal of Psychiatry* 182 196-8
- Perkins R et al. (2004) 'Reality out of the Rhetoric: User Involvement in a Mental Health Trust', *Mental Health Review* volume 9, issue 1
- Pinfold V, Corry P (2003a) *Who Cares?* : Rethink
- Pinfold V, Corry P (2003b) *Reaching People Early:* Rethink

- Rankin J, Regan S (2004) *Meeting Complex Needs*: ippr/ Turning Point
- Rethink (2002) *Missing Millions*: an unpublished report by Rethink
- Robinson P (2004) *Review of the Week 15th July 2004*: www.ippr.org
- Sainsbury Centre for Mental Health (2003) *Money for Mental Health*: SCMH
- Sayce L (2000) *From Psychiatric Patient to Citizen*: London, Macmillan
- Smith J (2001) *Parliamentary Answer to Lynne Jones 1Oth July*: Hansard
- Smith M (2002) 'Stigma', *Advances in Psychiatric Treatment* (8)
- Social Exclusion Unit (2004) *Mental Health and Social Exclusion:* Office of the Deputy Prime Minister
- Wanless D (2002) *Securing our Future Health*: HM Treasury
- Whitwell (2001) 'Service Innovations: Early Intervention in Psychosis as a Core Task for General Psychiatry', *Psychiatric Bulletin* 25
- Williamson T (2004) 'User Involvement – a Contemporary Overview' *Mental Health Review 9 (1)*