

Policy Matters in Mental Health

A talk to Sandhurst and Crowthorne Labour Party members

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Andrew Hughes

Social Inclusion – A Challenge for Europe

In December 2000 Heads of State and Governments of the European Union adopted the European Social Policy Agenda. Common objectives were agreed establishing ways to combat poverty and promote social inclusion.

Mental Health Europe and partners have put together guidelines to improve social inclusion for people with mental health problems. These were arrived at after consultation with groups of mental health service users and ex-users in Austria, Finland, France and the United Kingdom.

The guidelines are aimed at policy makers, service providers and the public.

In addition to many specific guidelines, general guidelines include the following:

To Policy Makers

- Ø Non-discrimination legislation should cover all areas of society.
- Ø The opinions of people with mental health problems should be valued equally with any other voice, particularly in sectors that affect their lives. Self-help and advocacy groups should be supported financially to enable this aim.

To Service Providers

- Ø Awareness raising should be organised for all sections of society, including decision makers, the public and service providers in health, education, employers, Trades Unions etc. Fully financed positions for user-led information services are required to meet this need.
- Ø Mental health needs should be addressed with respect to gender, cultural, spiritual and religious backgrounds.

To The General Public

- Ø Families and friends supporting people with mental health problems should have access to appropriate support.

Challenges the UK Government faces in Mental Health Policy

The Importance of Mental Health

- Ø In the West mental health problems account for 25% of all time spent living with a disability. Depression, manic depressive illness, schizophrenia, alcohol abuse and obsessive compulsive disorder are five of the ten leading causes of disability.
- Ø The total cost of mental health problems to the economy has been recently estimated at £32billion.

Highlights of current Government Policy

- Ø It is comprehensive
- Ø It gives mental health greater priority than ever before
- Ø It promises real growth in spending

Fundamental Challenges for the Near Future

- Ø Tackling discrimination
- Ø Managing the change to a comprehensive system of care
- Ø Getting the right organisational models
- Ø Getting staff with the right skills in sufficient numbers
- Ø Developing suitable leadership at local level
- Ø Developing infrastructure to support change

Solutions to Tackle These Challenges

Discrimination

Employment is central to many services users' sense of worth and to social inclusion. The NHS and local authorities could lead here by setting targets for the employment of mental health service users. Mental Health Services themselves would be a good place to start.

The benefits trap faced by many who have experienced mental health problems in the long term must be removed.

Change Management

Current acute psychiatric care provides an unacceptable environment for many users. Neither is there evidence to suppose it is therapeutic. Alternatives need to be developed.

Appropriate and intensive community services offering sensitive alternatives tend to draw skilled staff away from acute in-patient settings as well as demanding much management capacity.

Skilled professionals committed to clinical management, suitably trained with adequate professional development pathways, must lead change. The Government will have to drive this agenda.

Organisation

Commissioning

The pool of commissioners suitably experienced to commission and carry out strategic planning for mental health care is small. As health authorities grow in size, it will almost certainly be necessary for commissioning to take place jointly across health and social care. Alternatively, Primary Care Groups and Primary Care Trusts will need to pool commissioning expertise.

Provision

Specialist mental health trusts may be set up to deliver mental health services, such as that now in existence in Manchester. Alternatively, Primary Care Trusts may provide specialist mental health services with only highly specialised services provided by a trust.

Workforce

There is, and will almost certainly continue to be for some considerable time, a shortfall of numbers and skills in the mental health workforce that radical measures will need to be made to achieve progress such as that laid out in the National Service Framework for mental health.

Leadership

Powers of decision making and budget management need to be devolved to the lowest possible levels, to allow control within community and hospital teams and thus re-empower grass roots workers.

Infrastructure

Spending on workforce recruitment and development has been laid out. Considerable sums will have to be set aside to bring the mental health estates up to the required standard for the twenty first century.

Reform of the Mental Health Act

The Mental Health Act 1983 is currently under reform. A White Paper was published last December. Enactment is likely to be two to four years away. The Government initiated reform with the setting up of the scoping committee chaired by Professor Geneva Richardson. Regrettably, this committee's work ran concurrently with Government attacks on community care.

Among the fundamental changes currently proposed are:

- Ø The introduction of compulsory care in the community
- Ø A different role, and possibly composition, for mental health tribunals. These will now have to authorise compulsion and agree care plans.
- Ø Entry to compulsory treatment will be changed to include a wider definition of mental disorder
- Ø The removal of Approved Social Workers from the process of compulsion
- Ø An enhanced role for advocacy
- Ø A possible introduction of advance agreements or directives

Possibly the most contentious of these proposals for many service users is the introduction of community treatment orders. There is a widespread concern that these will increase significantly the use of compulsion, that relationships between users and their workers will be compromised and that many users will go "underground" to avoid the threat of compulsion. There is also concern about the practicability of compulsion for treatments other than, say, E.C.T. and anti-psychotic medication. These would be administered in a clinical setting.

Many service users see the role of the A.S.W. in assessments under current legislation as providing a foil against the predominantly medical model view usually represented by the attending psychiatrist or other doctor. It is felt, almost universally, among service users that an holistic view of their circumstances should be taken.

Good advocacy leads many service users to gain the most from their care and treatment, ensures they receive appropriate and sensitive treatments, supports them towards self-advocacy and can itself be a therapeutic process. Though the government aims to provide access to advocacy to people subject to any new Mental Health Act, there are currently no models of advocacy favoured. Around the country advocacy services have emerged and developed in a very piecemeal fashion over the last twenty years. Advocacy of poor quality can be very detrimental to its clients.

Advance agreements or directives are a solution that some self-help groups of service users and survivors of psychiatry have favoured for some time. They have never achieved a national profile, and have only been granted legitimacy in certain areas of the country. Many service users favour this kind of arrangement. Advance directives give people the right to express their wishes at times when they are well about the types of treatment they prefer to receive when unwell.

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